



Experiences of loss and grief among hospital nurses
by Jo Thorson Kelly

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University

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Abstract:

Nurses in clinical practice are frequently confronted with patient-care situations which are either characterized by loss or involve loss as a part of the over-all clinical picture. Little is known about nurses' responses to these situations or about their experiences of grief and loss. The purpose of this study was to explore and describe nurses' experiences of loss and grief which develop within the context of the nurse-patient relationship in the hospital setting.

The data gathering method for this exploratory-descriptive study was the semi-structured, in-depth interview based on the principles of ethnographic inquiry. Using a preliminary survey among registered nurses employed at three Montana hospitals, a convenience sample of 20 was obtained for the study interviews. Each nurse participated in one personal interview which was tape recorded and later transcribed for use in the data analysis. Using content analysis methods, interview data were classified and analyzed to identify the themes in nurses' experiences and the factors and processes which related to and influenced these experiences.

Nurses' experiences of loss and grief were found to be related to interpersonal involvement with patients and families. This was influenced by nurse, patient, and family factors and certain factors and processes in the practice setting. Nurses reported brief, as well as intense, prolonged experiences of grief and the full range of feelings and responses known to occur during the grieving process. While these feelings and responses were painful and distressing, they also reported difficulty in performance of their work responsibilities in instances of intense grief, as well as a carry-over effect in their personal lives.

Although professional and personal investment and involvement in the nurse-patient relationship was the norm for study nurses, they believed that this involvement and their personal responses in the nursing role were unusual among nurses and unprofessional. Together with the pain and distress of loss, this led to efforts to detach from patients and a sense of isolation from colleagues. Nurses identified mechanisms which they believed would be helpful in dealing with experiences of loss and grief.

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A thesis submitted in partial fulfillment
of the requirements for the degree

of

Master of Nursing

MONTANA STATE UNIVERSITY
Bozeman, Montana

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Jo Thorson Kelly

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I dedicate this thesis to my mother, who understands the importance of nurse caring, and to the memory of my father, whose death during this project taught me about nurses' grief in a very personal way.

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ABSTRACT

Nurses in clinical practice are frequently confronted with patient-care situations which are either characterized by loss or involve loss as a part of the over-all clinical picture. Little is known about nurses' responses to these situations or about their experiences of grief and loss. The purpose of this study was to explore and describe nurses' experiences of loss and grief which develop within the context of the nurse-patient relationship in the hospital setting.

The data gathering method for this exploratory-descriptive study was the semi-structured, in-depth interview based on the principles of ethnographic inquiry. Using a preliminary survey among registered nurses employed at three Montana hospitals, a convenience sample of 20 was obtained for the study interviews. Each nurse participated in one personal interview which was tape recorded and later transcribed for use in the data analysis. Using content analysis methods, interview data were classified and analyzed to identify the themes in nurses' experiences and the factors and processes which related to and influenced these experiences.

Nurses' experiences of loss and grief were found to be related to interpersonal involvement with patients and families. This was influenced by nurse, patient, and family factors and certain factors and processes in the practice setting. Nurses reported brief, as well as intense, prolonged experiences of grief and the full range of feelings and responses known to occur during the grieving process. While these feelings and responses were painful and distressing, they also reported difficulty in performance of their work responsibilities in instances of intense grief, as well as a carry-over effect in their personal lives.

Although professional and personal investment and involvement in the nurse-patient relationship was the norm for study nurses, they believed that this involvement and their personal responses in the nursing role were unusual among nurses and unprofessional. Together with the pain and distress of loss, this led to efforts to detach from patients and a sense of isolation from colleagues. Nurses identified mechanisms which they believed would be helpful in dealing with experiences of loss and grief.

CHAPTER 1

INTRODUCTION

Background and Rationale for the Study

Nurses in clinical practice are frequently confronted with patient-care situations which are either characterized by loss or involve loss as a part of the over-all clinical picture. The terminally ill or injured patient and the suicidal patient represent the most easily identified patient-care situations involving patient loss. The nurse's experience with loss, however, is not limited to loss of a patient through death. Other examples of care situations involving loss commonly encountered by the nurse include nursing care of patients with loss of body part or function, impairment in emotional or cognitive function, developmental or sociocultural change, and loss of hope or will to live.

While the frequency of nurses' experiences with patient loss is well known among nurses and health care professionals in general, little is known about nurses' responses to these experiences. This researcher became interested in nurses' experiences of loss and grief during graduate school course work in the specialty of psychiatric-mental health nursing. While searching the literature for a paper relating to loss and the grieving process, it became apparent that few investigations of nurses' responses to the multitude of losses they encounter on a regular basis had been reported in the literature.

Results of studies relating to the experience of loss and the grieving process in a number of populations document that loss is a stressful event in an individual's life (Lindemann, 1944; Parkes, 1972). The response to loss, known as grief, is the process through which an individual comes to terms with the loss and the changes precipitated by the loss. During this process, individuals are known to experience emotional, cognitive, physical, behavioral, and attitudinal changes which are distressing and often painful. An understanding of the experience of loss and the grieving process suggests that the nurse's loss and grief may contribute to disrupted nurse-patient relationships as well as to the amount of work related stress experienced by the nurse.

Statement of the Problem

Performance in the professional nursing role requires commitment to the ideals of providing protection, help, and comfort to patients. Thus, nurses have certain expectations of themselves in care situations. At the same time, nurses often form personal attachments to patients who, for a variety of personal and professional reasons, become important to the nurse as a person. In the hospital setting, nurse-patient relationships are influenced by the degree of intensity and intimacy required in nursing care and also by the duration of the relationship over time. These professional, personal, and contextual factors all potentiate a personal sense of loss for the nurse in response to patient losses, suffering, and death.

Purpose of the Study

The purpose of this study was to explore and describe nurses' experiences of loss and grief which develop within the context of the nurse-patient relationship in the hospital setting.

Definition of Terms

In order to facilitate an understanding of the remainder of this study, the following definition of terms is provided:

Loss is the state of being deprived of or being without something that one has had (Peretz, 1970a).

Grief is a specific syndrome characterized by emotional, cognitive, physical, behavioral and attitudinal changes occurring in an individual in response to loss (Frears and Schneider, 1981).

Grieving process is the adaptive process whereby an individual comes to terms with loss and the changes generated by the loss (Bowlby, 1980).

Hospital setting is an acute care, general community hospital.

Nurse is a registered nurse employed in the hospital setting.

Basic Assumptions

The following basic assumptions were used in the development and implementation of this study:

Individuals can verbally report and describe their personal responses to other people and to other people's characteristics.

Individuals will honestly report how they have experienced a situation.

Individuals attribute meanings to interpersonal situations and can describe these meanings.

Summary

The literature related to loss and grief describes the experience of loss as a stressful event with potential personal and interpersonal consequences. Although it is known that nurses are exposed to patient losses in their work on a regular and frequent basis, the effect of this exposure is not known. Little has been done to investigate nurses' own experiences of loss which develop in relation to patients.

The expectations of performance in the professional nursing role as well as certain factors in the practice setting facilitate the nurse's sense of involvement in relation to patients. As personal feelings of attachment and caring develop in the nurse, personal vulnerability to the experiences of loss and grief also develops.

Because of the lack of foundational research relating to nurses' experiences of loss and grief, the problem was examined from the

broad framework of a qualitative research design using exploratory-descriptive methodology and the ethnographic approach. This study examined nurses' experiences of loss and grief and was based on the literature and reports of research related to these concepts. Interpersonal theory in nursing as well as literature relating to the interpersonal aspects of nursing and the practice setting provided the framework necessary for studying and describing nurses' experiences. A review of this literature and the conceptual framework for this study are presented in the following chapter.

CHAPTER 2

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

This study was based on the literature related to loss, grief, and the grieving process; a review of this literature is presented first in this chapter. Next, a review of nursing theory and the literature illustrating the interpersonal aspects of nursing is presented, followed by a discussion of the practice setting. In conclusion, the above conceptual framework is integrated to provide a basis for understanding nurses' experiences of loss and grief.

Loss

Loss may be described as a universal experience, a central issue in the lives of all individuals (Frears & Schneider, 1981). Not only is loss inherent in the process of human growth and development, it is also the result of planned change and haphazard coincidence (Headington, 1981; Peretz, 1970a). While the experience of loss is most often thought of in connection with the death of a significant, loved other person, loss is far more pervasive in an individual's life and indeed, occurs throughout life in association with all major change (Bowlby, 1974; Heikkinen, 1979).

Peretz (1970a) defines loss as a "state of being deprived of or without something one has had" (p. 4). He further states, "loss is

simultaneously a real event and a perception by which the individual endows the event with personal or symbolic meaning" (p. 6). Since early studies by Lindemann (1944) which describe the symptomatology of acute grief following the death of a loved other person, the field of study relating to loss has broadened to include the study of responses to other types of loss (Fulton, 1977; Rosenblatt, Walsh & Jackson, 1976).

The experience of loss may relate to the loss of an important or significant other person, place, or object in the environment or to the loss of a part of the self which is familiar and valued (Peretz, 1970a). Loss of a significant other may be temporary, as in the case of separation, or permanent, as in divorce or death. Acute or chronic illness and disability represent partial losses which may be temporary or permanent. Loss of some part of the self may include loss of self-image or self-esteem and loss of body part, function, social role, or perceived positive attributes (Peretz, 1970a; Werner-Beland, 1980). Each loss also makes one vulnerable to the threat of additional loss as a result of changes engendered by the initial loss (Peretz, 1970a).

Loss includes not only the actual loss of a tangible external object or an intangible intrapersonal perception but also the loss of purpose or one's old understanding of reality. It is this loss of meaning which Headington (1981) refers to when she states, "Loss is a unique, isomorphic experience. As such it cannot be measured by some outside criteria" (p. 338). To understand another's experience of loss, one

must understand the personal value and meaning attached to that which was lost and the emotional investment involved (Marris, 1982).

Attachment theory provides a framework for understanding the biological basis for the human experience of loss and the consequences which may occur as the result of loss. According to Bowlby (1974), "Attachment theory is a way of conceptualizing the propensity of human beings to make strong affectional bonds to particular others and the many forms of emotional distress and disturbance, which include anxiety, anger, and depression, to which unwilling separation and loss give rise" (p. 292). This theory is based on Bowlby's research over the past thirty years in which he has studied the responses of normal infants and children to separation, either temporary or permanent, from the mother or mother-figure (Bowlby, 1982).

Bowlby (1974) has identified a group of behaviors, which together he calls attachment behavior, having a biological function distinct from and equally as important as the functions of feeding and sexual behaviors. "Attachment behavior is any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world" (Bowlby, 1982, p. 668). Examples of attachment behaviors include "following, clinging, crying, calling, greeting, smiling, and other more sophisticated forms" (Bowlby, 1974, p. 292). This behavior is evident in the sixth month of life, reaching its peak at approximately age three years. It does, however, persist throughout life and forms the basis for affectional bonds established by an adult with other adults

(Bowlby, 1980; Marris, 1982). Attachment behavior is especially evident in adults during times of fear, distress, or illness (Bowlby, 1980).

Based on evidence from ethology and from his own research, Bowlby (1974) believes that the biological function of attachment behavior is protection and self-preservation. This behavior "contributes to the individual's survival by keeping him in touch with his caregiver(s), thereby reducing the risk of his coming to harm..." (Bowlby, 1980, p. 40).

Bowlby (1974, 1980) has described caregiving behavior as the complementary response to attachment behavior. The function of caregiving is protection of the attached individual and the provision of security. Caregiving behavior "is commonly shown by a parent, or other adult, towards a child or adolescent, but it is also shown by one adult towards another, especially in times of ill health, stress or old age" (Bowlby, 1980, pp. 40-41).

Attachment theory provides a basis for understanding the function of attachment behavior and relationship formation in early life. Based on further studies by Bowlby (1982) and others (Parkes, 1972; Weiss, 1982), attachment behavior and the formation of attachment relationships continues throughout life. As Marris (1982) states, "adult bonds of love seem to grow out of these earliest attachments" (p. 185). These affectional bonds provide a sense of meaning and security in an individual's life through the development of learned purposes, understandings, and feelings in the relationship. When the

attachment is threatened or lost, meaning in one's life is also threatened. Within this framework, loss may be seen to have far-reaching consequences, interpersonally as well as personally.

Grief and the Grieving Process

Grief may be defined as the emotional, physical, cognitive, behavioral, and attitudinal or spiritual response of an individual to actual or perceived loss of some valued or significant aspect of that individual's life (Frears & Schneider, 1981). These changes, when viewed as a process occurring over time, are known as the grieving process. This is an adaptive process which facilitates an acceptance of the fact that a change has occurred and an integration of this fact in one's internal world of meaning and externally in one's attachment behavior (Bowlby, 1980).

The experience of grief and the grieving process has been studied in different populations by a number of investigators. Lindemann (1944) documented the acute grief syndrome experienced by survivors of disaster; Kübler-Ross (1969) has studied loss and grief in patients with terminal illness; Parkes (1972) has examined grief in spouses following bereavement; and Bowlby (1980) has studied infant attachment behavior and the consequences of separation from the mother. While these studies focus on the grieving process occurring in response to the loss of a significant other through death or separation, other individuals have documented grief which occurs in response to other types of loss. Parkes (1972) and Werner-Beland (1980) have

documented the grieving process in those developing long-term disability, and Fried (1963) has examined the frequency of occurrence and the symptomatology of grief in individuals following relocation of residence.

The above literature documents that the grieving process follows any loss which is perceived as significant by the individual experiencing the loss. While the grieving process may vary in duration and magnitude in relation to the degree of perceived significance of the loss, there is marked commonality of experience in the range of symptomatology observed in and reported by grieving individuals.

Frears and Schneider (1981) describe a variety of symptoms which may occur during the process of grieving. The grief model proposed by these authors is useful in that it depicts an organismic response to loss; that is, the individual as a whole responds to the loss. Using this model, the symptomatology of grief may be described as follows:

1. Emotional response: anger, rage, numbness, confusion,
* shame, sadness, disgust, guilt, anxiety, helplessness,
hopelessness, and loneliness.
2. Cognitive response: disbelief, detached observation, rumi-
nation, preoccupation, decrease in problem solving ability,
* and self-doubt.
3. Behavioral response: protest, search, detachment, passive
* withdrawal, crying, sleep disturbance, physical self-neglect
and abuse, and escape.

4. Physical response: physiological alarm reaction, lowered resistance to infection, pain, exhaustion, heaviness, and muscular tension.
5. Attitudinal or spiritual response: loss of meaning or purpose, cynicism, destruction of ideals, emptiness, existential crisis, and belief in external control (Frears & Schneider, 1981, p. 347).

This symptomatology is a reflection of the distress experienced by an individual in the event of personal loss. In terms of attachment theory, initial reactions are aimed at restoration of the lost attachment and, in effect, stimulate others to care for the distressed individual. Despair and apathy, punctuated by occurrences of hostility, develop when it becomes clear that efforts to restore the lost attachment are unsuccessful. Finally, detachment from that which was lost develops (Bowlby, 1980). In brief, grieving has to do with resisting the loss, acknowledging the loss, and reorganizing one's behavior in order to go on without that which was lost.

The grieving individual has been described by Bowlby (1980) as being in a state of biological disequilibrium. During the process of grieving, the individual intermittently renews efforts to restore the lost attachment; this repeated reactivation of attachment behavior is experienced by the individual as chronic distress while the condition of the individual may be described as one of chronic stress (p. 42).

In stressing the potentially healthy nature of grief and the grieving process, Bowlby (1980) uses an analogy developed by Engel (1962, 1964). Engel (1964) states, "...we can compare the experience of loss to the wound, while the subsequent psychological response to the loss may be compared to the tissue reaction and the processes of healing" (p. 94). As with a physiological wound, healing the wound of loss may take a healthy course or the individual may experience impairment of function or pathology as a result of inadequate or improper healing. Thus, the possibilities for outcome following loss include healthy grieving leading to integration, restored wholeness, and renewal of attachments or unhealthy responses leading to physical, emotional, behavioral, and/or social pathology. Peretz (1970b) has described a variety of possible reactions to loss: (a) "normal" or healthy grieving; (b) inhibited, delayed, or absent grief; (c) chronic grief or perpetual mourning; (d) depression; (e) hypochondriasis and exacerbation of pre-existent somatic conditions; (f) development of medical symptoms and illness; (g) acting-out, which may include psychopathic behavior, substance abuse, or promiscuity; and (h) specific neurotic and psychotic states (pp. 22-35). Lindemann (1944), Engel (1962), Parkes (1972), and Bowlby (1980) also support the concept of healthy or adaptive grieving with deviations leading to less healthy functioning or actual pathology.

The eventual outcome of healthy grieving results in a withdrawal of the emotional investment in that which was lost and a restored ability to form new relationships (Bowlby, 1980). This process is

influenced by a number of factors. Among these are the individual's early life experience in attachment relationships, the number and significance of the roles filled by that which was lost, the security of the attachment, and the social support provided following the loss (Bowlby, 1974). Factors which disrupt the grieving process and potentiate pathological or less healthy outcomes include the following: situations in which the loss is not socially defined as a loss or in which the loss is socially unacceptable, inaccessible support or alienation from social support, the need to be strong and in control or to assume the social role of the strong one, uncertainty over the loss, the occurrence of multiple losses, and the reawakening of a previous loss which remains distressing and painful (Burgess and Lazare, 1976, pp. 424-426).

Impediments to healthy grieving, then, may be found within the individual and within the social system in which the individual is embedded. Because the grieving process is intermittently extremely painful on many levels of the individual's experience and awareness, an attempt may be made to avoid the experience and the necessary expression of emotion. Also, the individual may not express emotion easily or may believe that it is not appropriate in any circumstance. The individual's fear of "going crazy," the result of experiencing the symptoms of grief, may also contribute to avoidance of the grieving process.

Social support appears to be a necessary ingredient in the facilitation of a healthy grieving process (Bowlby, 1980; Caplan, 1981;

Engel, 1962). This support provides a feeling of increased comfort and security in face of the threat of losing an attachment (Bowlby, 1974). Security arises through the provision of love, affection, and nurturance. Additionally, the support provides cognitive assistance, validation of feelings, reminders of self-identity and worth, and stimulation to continue with the work of grieving (Caplan, 1981).

It is documented in the literature that the experience of loss constitutes a stressful event and that grieving constitutes a state of chronic stress. Successful outcomes to the experience of loss may be facilitated given the wealth of information available about the grieving process and the variables which influence the process. The following sections in this chapter develop concepts related to the interpersonal aspects of nursing and the practice setting which contribute to the nurse's vulnerability to loss and grief.

Nursing: Interpersonal Aspects

Nurse theorists generally conceive of nursing as the nurse-patient relationship process, professional and inter-professional roles, and task performance employed to promote, maintain, or restore health and to care for the sick (Stevens, 1984). Nursing is based on a body of scientific knowledge drawn from many fields, including nursing, and uses this knowledge in the delivery of nursing care (Lindberg, Hunter, & Kruszewski, 1983). The nurse-patient relationship may be viewed as the vehicle for the delivery of nursing care and is more or less prominent depending on the specific context in which the nurse works.

Interpersonal Theory. Several nursing theorists describe nursing as interpersonal in nature (King, 1981; Orlando, 1961; Parse, 1981; Paterson & Zderad, 1976; Peplau, 1952; Travelbee, 1971; Watson, 1979). An interpersonal theory of nursing was first described in 1952 by Hildegard Peplau. She defined nursing as "a human relationship between an individual who is sick, or in need of health services, and a nurse especially educated to recognize and to respond to the need for help" (pp. 5-6). In Peplau's view, the nurse's facilitation of an individual's movement toward health is based on a therapeutic interpersonal process between the nurse and the patient (p. 16).

Travelbee (1971) describes nursing as an interpersonal process due to its primary focus on people. Nursing is "...always concerned with people either directly or indirectly" (p. 7). She describes the importance of the "human-to-human" experience of nursing with potential not only for assisting and comforting the ill person, but also for affecting and changing the person of the nurse (p. 123-124).

More recently, Paterson and Zderad (1976), in their description of humanistic nursing theory, state that "nursing is an experience lived between human beings" (p. 3). They emphasize the "interhuman relating" quality of nursing in which the nurse responds to a purposeful call by one in need and relates with "the goal of nurturing well-being and human potential" (p. 26).

The view of nursing as an interpersonal process is based on the premise that nursing is the practice of caring for other human beings (Watson, 1979). The caring aspect of nursing has recently become the

focus of a number of studies by nurse researchers (Leininger, 1980, 1981). Leininger (1980) believes that "caring is the most important and central focus in nursing" (p. 135). Based on her research as a nurse-anthropologist, she has hypothesized the significance of caring in the survival of mankind over time. She states, "my thesis is that caring is one of the most critical and essential ingredients for health, human development, human relatedness, well-being and survival" (p. 136). Her conceptualization of caring as an essential factor in species survival is a view which parallels the work of Bowlby (1982) in which he hypothesizes the biological function of attachment behavior and caregiving as that of survival and protection.

Caring in a general sense is defined by Leininger (1980) as "those human acts and processes which provide assistance to another individual or group based on an interest in or concern for that human being(s), or to meet an expressed, obvious or anticipated need" (p. 136). The implication of caring, then, is that it is a process which occurs between or among individuals; that is, caring is interpersonal in nature. Watson (1979) maintains that the interpersonal mode is the only effective way to demonstrate and practice caring (p. 8).

According to Watson (1979), caring in nursing requires the development of a helping-trust relationship which she views as a basic element in high-quality nursing care. In a helping-trust relationship the nurse comes to know the patient as a separate, unique, thinking, feeling individual whom the nurse values and cares about. This in

turn encourages the development of patient trust, faith, and hope in nursing care (p. 25).

Caring in nursing requires the nurse's commitment to and involvement in the nurse-patient relationship in addition to expertise in the performance of tasks required in the professional nursing role. Nursing, then, engages the nurse in the realms of personal and professional being, in other words, as a "fully human person" (Sarosi, 1968, p. 394). This view is reiterated by Simms and Lindberg (1978) when they state, "A nurse is a human being. In professional practice, he or she acts, reacts and interacts as a unique and whole being" (p. 3).

In spite of the known interpersonal aspects of nursing, little has been done to study the nurse-patient relationship from the perspective of nurse involvement. Sociologist-educator, Kathleen Gow (1982), has conducted an extensive study of the concept of affective neutrality and nurses' emotional reactions in nurse-patient relationships. Her study was based on the written reports of 275 practicing nurses collected over a period of five years. As part of a written course assignment, nurse participants were asked to describe a situation in which they felt helpful with a patient and one in which they felt unhelpful. They documented their conduct in the nurse-patient relationship as well as their accompanying thoughts and feelings. Of relevance to this investigator, Gow found that nurses inevitably had emotional responses to patients (p. 302). As stated by Gow, "to be concerned, sensitive, and caring is not to be affectively neutral" (p. 300).

Based on her review of current literature and research related to the health care practitioner-patient relationship as well as on her own study, Gow (1982) concludes "...that the lack of research in this entire area of emotional involvement with patients is serious" (p. 14). This view is reiterated by Cartwright (1980) in her review of the literature relating to occupational stress in health careers. She states that the emotional reactions and problems of health care providers can seriously interfere with the care of patients. The distressed provider may experience impairment in the relationship with the patient as well as in cognitive and technical competencies (p. 420). Based on the work of Gow and Cartwright, research related to the interpersonal aspects of nursing may ultimately contribute to nurses' knowledge and understanding of their own reactions as well as improved patient care. This research would also contribute substantiation for interpersonal theory in nursing.

Nursing education. During the process of learning required to become a nurse, students are educated in the knowledge base required for nursing practice as well as in the professional values of protecting, comforting, helping, and supporting those in need of care. Socialization in the professional role requires that these values are taken in to become a part of one's professional self-image and thus establish expectations of the self in professional practice. These values provide a basis for a "way of being" in relationships with patients (Watson, 1979).

At the same time, students are taught certain skills and facilitative interpersonal processes which contribute to the development of a helping-trust relationship. Among these are empathy, non-possessive warmth, and congruence or genuineness (Aiken and Aiken, 1973; Haber, Leach, Schudy & Sideleau, 1982; Watson, 1979). Each of these processes engages the nurse as a total person in relation to the patient and is valued due to its contribution to the development of effective helping-trust relationships and high-quality nursing care (Watson, 1979).

The process of educating student nurses also includes implicit messages related to the values of "saving" and "curing" and the nurse's roles related to these values. These messages are conveyed throughout the educative process during which the student develops a knowledge base related to disease and trauma and their treatment and learns skills appropriate to the roles of saving and curing. Nurse researchers Quint (1969) and Vachon (1979) describe how these messages are further communicated in work environments which include the equipment, medications, procedures, and staff specifically designed and trained to prolong life and combat death. In the hospital setting, the role of the nurse is most often thought of in association with restorative and curative care (Flynn and Heffron, 1984).

This emphasis on curing and saving instills these values within the nurse so that the expectation of the self in the professional role is expanded from one who cares, comforts, and helps to one who also

cures and saves (Holsclaw, 1965). This role contributes to the personal involvement of the nurse through the personal meanings attached to the professional self-identity (Bugen, 1979).

Summary. The nurse becomes personally involved with patients due to a number of interacting factors. Foremost among these is that the practice of nursing is interpersonal in nature and that the interpersonal relationship is the mode of care delivery. Nurses are taught to use facilitative interpersonal processes in order to establish effective and therapeutic interpersonal relationships with patients. These processes tend to engage the person of the nurse; that is, the nurse relates to the patient as a person as well as a professional caregiver. Together with these processes, professional values related to comforting, helping, and supporting foster engagement of the nurse as a person. And lastly, the nurse personally invests in relationships with patients due to a professional self-identity which encompasses a curing or saving role. A review of literature related to the practice setting is presented next to provide further clarification regarding the nurse's involvement in the nurse-patient relationship and the potential personal ramifications of this involvement for the nurse.

Practice Setting

The practice setting is the environment in which the nurse provides patient care (Stevens, 1984). It includes not only the physical surroundings but also the people in the environment such as families and other staff. Of importance for this study was the influence of the

practice setting on the nature of the nurse-patient relationship and how this in turn related to nurse responses.

Nursing care in hospitals. In the field of nursing practice, hospital employed nurses have a relatively great potential for intensity and intimacy in nurse-patient relationships. This is due in part to the types of patients seen in this practice setting and the types of nursing care required by these patients. Hospitals differ from other nursing practice settings in that hospitals provide most of the care received by patients with acute illnesses (Wolff, Weitzel, Zornow, & Zsohar, 1983). In this setting, the patient population reflects a group of individuals with conditions which require continuous or at least intermittent nursing care each day. Nursing care requirements of this patient population range from short-stay ambulatory or emergency care to long-range care needed for rehabilitation or terminal care in chronic illness or trauma.

Among health care professionals employed in the hospital setting, it is nurses who assume responsibility for patient-care on a daily basis (Bugen, 1979; Hay & Oken, 1979). In addition to providing care during a given work shift, patient-care may also extend over a period of several days or weeks (Beland, 1980). This frequent and extended contact with a patient often leads to contacts with family members and other individuals in the patient's social and support network. The patient, then, becomes known to the nurse as a person with needs, functions, and an identity which extends beyond the limited boundaries of the hospital environment.

In either the short-stay or the long-range care situations nurses may be involved in the delivery of high-intensity nursing care which requires high levels of concentration and effort (Hay & Oken, 1979; Price and Bergen, 1980). Often this intensity is combined with a personal and professional investment in curing and in saving as described earlier.

Because of the type of nursing care needed by patients in the hospital setting, the nurse may come to know patients in a deeply human way. Intimate physical care, for example bathing, feeding, dressing changes and assistance with elimination, provides an avenue for close interhuman relating. This sense of closeness often allows patients to be "fully themselves" with the nurse, thus increasing the nurse's awareness of the patient as a person (Schwartz & Schwartz, 1972). Hay and Oken (1979) believe that nurses' attachments to patients are due, in part, to the amount and frequency of direct care involving the most private aspects of life. As described in the words of nurses themselves:

Nurses deal with the most basic of human needs: feeding, heartbreak, warmth, elimination, suffering, loneliness, birth and death.... With our hands and eyes we touch the lives of others and are admitted to the privacy of their inner space without even asking (Diers & Evans, 1980, p. 27).

Relationships between nurses and patients are also influenced by the patient's loss of health, function, or life and the changes engendered by these losses. During these stressful situations and difficult transitions, the patient depends on the nurse to provide competent

care as well as protection and comfort. From the framework of attachment theory, the patient may come to view and rely on the nurse as a source of strength, knowledge, protection, and nurturance. Because of the patient's needs for assistance and care, the nurse responds with caretaking behavior appropriate to the professional nursing role (Mooney, 1976).

The interplay of these factors in the hospital practice setting acts to influence the nurse's professional and personal involvement and investment in the nurse-patient relationship. This provides the basis for the nurse's own sense of loss in relation to patients. Because the patient has become important to the nurse as a person, the nurse may experience a sense of personal loss in response to patient disability, disfigurement, suffering, death, or even discharge or transfer (Castles & Murray, 1979; Davitz & Davitz, 1975, 1980). When the patient's condition involves irrevocable loss of health or function, the nurse may feel a loss of self-esteem or self-confidence in the professional role (Garfield, 1979; Shanfield, 1981; Stowers, 1983). The nurse may also experience feelings related to loss of control, power, or immortality due to an increasing awareness of the limits of the ability to save or cure another or even oneself (Burnett-Beaulieu, 1982; Shanfield, 1981).

Work stress. Literature related to the occupational stress experienced by health care professionals has identified the "highly emotional"

nature of these professionals' work as a source of work stress (Cartwright, 1980; Maslach, 1978, 1979). Patrick (1981) states that important antecedents to burnout among cancer nurses include the nurse's relationship to life-threatening illness, death and dying, and the loss of hope. She states, "...these dying people and their feelings of pain, anguish, and fear require a degree of human-to-human giving and involvement that may be emotionally draining for the nurse" (p. 117).

Gray-Toft and Anderson (1981), in their study of the causes and effects of stress experienced by nursing personnel (N=122) in the hospital environment, identified seven major factors contributing to nurse stress. Of these factors, the death and dying of patients was consistently identified as a major source of stress, second only to workload.

Although the highly emotional nature of health care professionals' work and the relationship of these individuals to death, suffering, and loss have been described in the literature as stressful elements in the work setting, little is known about these elements from the practitioner's perspective. Cartwright (1980) states that there is "evidence that emotional distress is an occupational hazard for some health professionals" (p. 419) and recommends that future research relating to work stress in health careers include efforts to identify the sources of health care workers psychological and emotional distress. She states, "The assessment of the psychological problems of health professionals is a new area and there is still much to be learned" (p. 443).

The studies done by nurse researcher Mary Vachon and associates (Vachon, Lyall & Freeman, 1978; Vachon, 1979, 1982, 1983) represent the most extensive work reported in the literature which examines the nature, extent, and causes of distress among health care professionals. Vachon believes that burnout is "...too narrow a concept to comprehend what happens to caregivers working constantly with the critically ill and dying" (1983, p. 2). Her research findings, based on extensive interviews with 200 caregivers, anecdotal interviews with another 200, and data obtained in numerous workshops, describe the processes in the practice setting which contribute to staff stress and caregiver suffering. Among these processes are the staff-patient relationship and the emotional responses of staff. She describes the staff's significant personal investment in patients that are dying as a factor which exacerbates other processes contributing to staff stress (1978, pp. 367-368). She also states that "...staff may experience grief reactions due to unresolved sorrow over the constant and unacknowledged loss of many significant others" (1979, p. 16).

Nurse loss and grief. Loss and grief among caregivers has been described by a number of authors in professional papers and in anecdotal descriptions of their own experience in professional practice and their observations of other caregivers (Baker & Lynn, 1979; Burnett-Beaulieu, 1982; Fulton, 1979; Garfield, 1979; Hedlund, 1978; Jones, 1981; Millerd, 1977; Pett, 1979; Shanfield, 1981; Sonestegard, Hanson, Zillman & Johnston, 1976; Sovik, 1981; Stowers, 1983; Weisman, 1981). In a seminar on the mourning of the health care professional, Shanfield

(1980) found that senior medical student and nurse participants experienced loss, grief, and the grieving process in relation to their patients. "Intense grief responses, often lasting for prolonged periods, were common [among participants]. Brief grieving reactions were also described" (pp. 389-390). Shanfield maintains that because of health professionals repeated exposure to loss, death education seminars must address the professional's own grieving process. Legitimizing their own grief diminishes avoidance and withdrawal from patients while allowing the professional to seek psychological support for themselves (p. 393).

Psychiatric nurse consultation to assist staff nurses with experiences of loss and grief has been described by Baker and Lynn (1979) and Hedlund (1978). In the situations described by these authors, consultation was provided for staff nurses because of their continuous exposure to loss or threat of loss and their personal feelings related to loss and care of dying patients.

While these examples from the professional literature describe the authors' valid personal observations related to caregivers' experiences of loss and grief, reports of research in this area are extremely limited. One study (Lerea & LiMauro, 1982) specifically examines grief among health care workers. Two other studies (Castles & Murray, 1979; Davitz & Davitz, 1980) describe nurses' loss and grief within larger study purposes relating to nurses' responses to patients in general or to nurses' perceptions of caring for the dying patient.

Lerea and LiMauro (1982) examined the prevalence and nature of the grief response among nurses and nurse aides employed at a general hospital and at three skilled nursing facilities. Using a two-part self-administered questionnaire designed by these investigators, the grief prevalence rate (N=162) was found to be 98%. One hundred participants selected from the original sample completed the second questionnaire which elicited data related to the physical and psychological symptoms experienced at the time recalled as their most poignant grief experience in relation to a patient. The most common physical symptoms reported were the following: fatigue (55%), headache (44%), sighing respiration (42%), and insomnia (41%). Common psychological symptoms were thinking or talking about the patient (92%), feelings of helplessness (84%), crying or despondency (53%), disbelief or shock (51%), difficulty concentrating (51%), anger (50%), anxiety (47%), and irritability (43%). A number of additional symptoms were reported by less than 40% of the participants. The second questionnaire also elicited data related to the duration of the grief response which was reported by participants as ranging from less than one hour to over one month.

As a part of their long-term study related to factors that influence nurses' judgements about the degree of suffering experienced by patients, Davitz and Davitz (1975, 1980) conducted small group interviews with nurses practicing in metropolitan New York hospitals. Among other things pertaining to the study focus, these nurses were asked to describe their reactions to the suffering of patients. Based

on data obtained in these interviews, Davitz and Davitz concluded that "of all the daily problems encountered by nurses, the death of a patient is emotionally the most devastating" (1975, p. 1509). Nurses' reactions to death and the dying patient elicited the strongest emotional reactions and included feelings of helplessness, depression, anger, and despair. These investigators recommended an intensified effort to develop a psychological understanding of the nurse and a continuing effort to expand concern for those caregivers who deal with mortality in their daily work (1975, p. 1510).

In their study which focused on a number of factors related to death in the hospital setting, Castles and Murray (1979) interviewed 83 nurses about their perceptions of dying patients and the care of these patients. When these nurses were asked to describe their own feelings when a patient they had cared for died, they reported feelings "...of the same kind and intensity any person would have" (p. 217). These included sadness, shock, relief, loss, sorrow, emptiness, frustration, and anger. While numbers of nurses with the above feelings were not reported by these investigators, they did state that "only very few persons indicate that they are not affected by the death of those in their care" (p. 219).

These studies, in addition to the anecdotal descriptions and professional papers in the literature, document that nurses experience loss and grief in relation to their patients. The lack of rigorous, descriptive research in this area has been identified in this review of the literature and substantiates the need for in-depth studies of nurses'

experiences of loss and grief from the nurse's perspective. As stated by Werner-Beland (1980), "the grief that nurses and other caregivers experience in relation to patients with whom they develop close, caring relationships is an area needing extensive study" (p. 37).

Conceptual Framework

The framework for this study was developed from concepts related to the human experiences of loss and grief. Interpersonal theory in nursing and literature related to the interpersonal aspects of nursing were used to explicate the basis for nurses' experiences of loss and grief in relation to patients. Certain factors in the practice setting which contribute to nurses' vulnerability to loss and grief were discussed.

Loss has been described as a stressful event in an individual's life. The loss may be something tangible in an individual's life or environment or a loss of meaning. Grief and the grieving process occur as a response to loss. Based on attachment theory, this process is seen to have its basis in the biological need for protection and species survival. When an individual is threatened by loss, or when meaning in an individual's life is threatened by loss, protest and despair occur. The manifestations of protest and despair tend to engage other individuals in caring for and protecting the grieving person. This support facilitates reorganization in the grieving person so that eventually, new attachments and new meanings in living may develop.

Nurses experience loss and grief in relation to patients for a number of reasons. Based on the known interpersonal aspects of nursing and certain factors in the practice setting, the expectation is that nurses do become personally as well as professionally involved with patients. The implication of this is that the nurse would experience the full range of human responses which individuals are known to experience in interpersonal relationships. Nevertheless, only limited descriptions of nurses' personal involvement and responses in relation to patients are available. Literature related to the occupational stress of health care providers identifies the provider-patient relationship and providers' emotional responses to patients as sources of work stress. At the same time, the emotional state of the provider is being recognized as a factor in the quality of patient care. The need for detailed, intensive studies of nurses' involvement with and responses to patients is clearly indicated.

The literature indicates that nurses' grief experiences are common. A qualitative study of factors in nurse involvement in the nurse-patient relationship could provide a basis for assisting nurses with the grieving process. Identification of factors contributing to nurses' loss and grief could point to interventions which would ultimately promote improved patient care.

In the following chapter the research design for this study is described. In addition, the methodology of the study is described.

CHAPTER 3

METHODOLOGY

This chapter focuses on the research design used in the development of this study and the procedures and methods used in data gathering and analysis. Specifically, the following topics are described: exploratory-descriptive research design, ethnography, protection of human subjects, sample selection, setting for the study, data collection, and data analysis methods.

Research Design

The statement of the study purpose provided direction in the development of a qualitative research design. The need for a qualitative approach in this study was supported in the review of the literature which indicated a general lack of knowledge about nurses' experiences of loss and their responses to loss.

In addition, a qualitative research design is recommended when a study deals with "...topics that pose difficulties for study because of their personal nature and the emotionally laden meanings associated with them" (Benoliel, 1975, p. 189). Other investigators, including Davitz and Davitz (1980), Gow (1982), Oiler (1982), Parkes (1972), and Rosenblatt, Walsh, and Jackson (1976) also recommend a qualitative research design in studies dealing with suffering, loss, and death.

Exploratory-Descriptive Research. Two aims of qualitative research are description of the phenomena of interest and exploration of factors which relate to the phenomena. Because these aims coincided with the study purpose, an exploratory-descriptive research design was used to develop the study methodology.

The aim of descriptive research is to develop descriptions of phenomena through observation, recording, and classification of data related to the phenomena (Polit and Hungler, 1978). These same authors state that descriptive studies are "extremely important in laying the foundation for later research" (p. 141). The exploratory component of the research design was used in order to expand the descriptive focus to include the identification of factors which influence, affect, or relate to the phenomena. The exploratory research approach is also viewed as appropriate in "early stages of investigation of a problem" (Polit and Hungler, 1978, p. 182).

Within the context of this study, the research design provided direction in the development of methodology which allowed for a description of nurses' experiences of loss and grief while simultaneously identifying and exploring factors which influenced or related to those experiences. The personal interview, one exploratory-descriptive research method (Brink and Wood, 1978), was used in this study as the data gathering method. Because nurses' subjective descriptions of their own experiences were desired, the interview method was based on the principles of ethnographic inquiry (Spradley, 1979).

Ethnography. The ethnographic approach is a method of research used in anthropology to gather data to describe a specific culture or subculture (Taylor, 1982). Spradley (1979) defines ethnography as "the work of describing a culture" (p. 3). It is the means of learning from people through gathering data from their point of view; it is an attempt to describe a culture based on how members of that culture define their world (Spradley, 1979).

Spradley (1979) defines culture as "the acquired knowledge that people use to interpret experience and generate social behavior" (p. 5). Spradley (Spradley & McCurdy, 1972; 1979) advocates the use of ethnography not only for the study of simple societies with specific geographic boundaries, but also for the study of complex societies within which there are numerous cultures, subcultures, and cultural scenes. A cultural scene is defined as the "information shared by two or more people that defines some aspect of their experience" (Spradley & McCurdy, 1972, p. 24). Cultural scenes are known to some members of the larger culture but not to others (Spradley, 1979).

Within the framework proposed by Spradley, hospital employed nurses are viewed as having access to knowledge about their situation and experience which is not shared with members of the larger culture or other subcultures to which they belong. Interviewing techniques based on the ethnographic approach used in this study are described below in a discussion of the data collection.

Protection of Human Subjects

The requirements for the protection of human subjects in research were met prior to the initiation of this study. Approval for this study was given by the Human Subjects Review Committee, College of Nursing, Missoula Extended Campus, Montana State University. Approval for this project was given by the Directors of Nursing Service at the three hospitals participating in the study prior to data collection.

Sample and Setting

The study sample included registered nurses employed at one of the three participating hospitals. These hospitals were located in the western region of Montana and had 30, 48, and 213 beds respectively. A preliminary survey, designed for this study to be self-administered by registered nurses working at the participating hospitals, was used in order to obtain a sample pool from which to select interview subjects.

Sample selection. The preliminary survey, with an attached letter of introduction (see Appendix A), was distributed either by the Director of Nursing Service to hospital registered nurse staff or by head nurses to registered nurses on their clinical units; a total of 115 nurses received the preliminary survey. Nurses were asked to complete and seal the survey in the envelope provided with each survey form and place the envelope in a study folder on their work unit. Study folders were collected by the researcher on a date specified on the preliminary survey form.

Following collection of the study folders from each hospital, surveys were analyzed to develop a sample pool of nurses who met the following criteria: (a) a minimum of two years of employment in nursing, (b) current employment in nursing, (c) female sex, (d) a YES response to the question: Have you ever experienced a sense of loss or grief in relation to your patient's physical or emotional condition? and (e) agreement to participate in the study.

Because of the differences in the size of the sample pools among hospitals and among clinical units at the 213-bed hospital, both probability and non-probability sampling procedures were used to secure the interview sample (Brink and Wood, 1978). In each of the smaller hospitals and on two of the clinical units at the larger hospital, a convenience sample was obtained due to the limited number of surveys returned which met study criteria. That is, all nurses who met the study interview criteria were selected for inclusion in the study. For a sample of the remaining seven clinical units, a simple random sample of interview participants was obtained by randomly drawing a predetermined number of surveys from a shuffled pile representing each clinical unit.

Sample setting: Clinical practice areas. In all, 20 informants for the interview were selected, including 3 from each smaller, rural hospital and 14 from the larger hospital. The latter were selected from the following clinical units: emergency room, medical, mental health, oncology, orthopedic-neurological, pediatrics, renal dialysis,

special care unit (a combined service including intensive care and coronary care), and surgical (see Table 1).

Table 1

Interview Informants' Area of Clinical Practice ($n = 20$)

Area of Clinical Practice	Number of Interview Subjects	
	Small Hospitals	Large Hospital
Emergency Room	1	2
General Care	5	
Medical		1
Mental Health		1
Oncology		2
Orthopedic-Neurological		2
Pediatrics		2
Renal Dialysis		1
Special Care Unit		2
Surgical		1

As illustrated in Table 1, the nurses working in the smaller hospitals provided care most often as generalists. Neither of the smaller hospitals provided renal dialysis care, however, study subjects from these hospitals reported caring for patients within all other practice areas described above in addition to the area of obstetrics and newborn care. Three of the 20 nurses included in the interview sample had regular administrative and supervisory responsibility as well as involvement in direct patient care.

The study was designed to include the opportunity for contrast among groups of nurses in two different ways. First, interviewing

nurses from smaller hospitals in rural areas and also nurses from the larger hospital allowed for an exploration of the differences and similarities in nurses' experiences related to community and hospital size. Secondly, nurses' experiences could be compared and contrasted in relation to area of clinical practice.

Sample. A sample of 20 informants was selected for this study based on the principle of exploratory-descriptive research that relevant data can be obtained from detailed, intensive "studies of a few" (Parkes, 1972, p. 119). Parkes (1972) describes three studies in which detailed information relating to the experience of bereavement was obtained from a limited number of study subjects. Respectively, these studies included 21, 22, and 19 subjects (p. 119). Parkes sees these small, intensive studies as necessary prerequisites for evaluation of the significance of later statistical studies representing larger samples (p. 119).

Likewise in ethnographic research, "only a small number of key informants need to be interviewed on a topic to learn what is cultural knowledge shared by the group" (Evaneshko and Kay, 1982, p. 50). Enough informants are interviewed to identify emerging data categories and themes related to the phenomena of interest. Also, an adequate number of informants are interviewed in order to saturate data categories and themes; saturation has occurred when nothing new is emerging in the data.

This study design included the flexibility of including additional study informants if, after interviewing 20 subjects, additional data

seemed necessary in order to identify cultural themes. During content analysis, it was found that category and theme emergence and saturation occurred during analysis of the 14th interview; analysis of the remaining interviews provided substantiation for the emerging themes in the nurses' experiences.

Data Collection

Each informant was contacted by telephone by the researcher and an interview was arranged at a time, date, and place mutually agreed upon. One private interview, ranging in length from 60 to 90 minutes, was conducted by the researcher. Sixteen of the interviews were conducted in prearranged, private conference rooms located at participating hospitals; the remaining four interviews were conducted in informants' homes in order to accommodate their personal needs and schedules. In all cases, the interview was private and had few, if any, interruptions.

Prior to initiation of the interview, the study purpose and the basic structure and process of the interview were explained. In order to standardize introductory remarks by the researcher, a written narrative study description was provided for the subject to read (see Appendix B). Informed signed consent and demographic data were then obtained (see Appendix C).

The interview was designed to elicit nurses' subjective descriptions of their experiences of loss and grief. Through the use of an interview guide including semi-structured questions relating to specific

areas to be covered, standardized areas of content were included in each of the 20 interviews (see Appendix D). Following the principles of ethnographic interviewing, the informant was asked a descriptive question "designed to encourage an informant to talk about a particular cultural scene" (Spradley, 1979, p. 85). As the informants talked, they were asked to expand, clarify, or answer further questions generated through their own descriptions.

Each interview was tape recorded and notes were made by the researcher about points or topics brought up by the informant which needed expansion or clarification. Field notes about the quality and process of the interview and the setting for the interview were made after each interview. When the 20 interviews had been completed, they were transcribed for later use in the data analysis.

Data Analysis

Using the transcribed interviews, a content analysis was done in order to classify and summarize the interview data. Content analysis is defined as the systematic procedure for the categorization of verbal or behavioral data (Fox, 1982; Polit and Hungler, 1978). It is a method used in the analysis of unstructured data obtained in exploratory-descriptive studies (Brink and Wood, 1978).

Content analysis is consistent with an ethnographic approach in which the researcher analyzes data for cultural themes. A cultural theme is a recurrent common assumption about the nature of experience which connects different subsystems of the culture (Spradley, 1979).

For purposes related to this study, data categories derived from the literature were developed prior to the collection of data. These categories included (a) patient characteristics, (b) nurse characteristics, (c) nurse-patient relationship characteristics, and (d) interpersonal setting. While these pre-established data categories were useful in developing the interview guide and the initial mechanism for data classification, the in-depth, open-ended interview structure and content analysis methods allowed for the emergence of new data categories which more accurately reflected the informants' reported experiences.

During the content analysis, statements made by the informant were initially classified in one of the pre-established data categories. As the data analysis continued, new data categories were identified and themes in the informants' experiences could be recognized.

Consultation regarding content analysis was obtained through the research committee chairperson, a nurse-anthropologist-researcher. Emerging data categories and themes were determined through mutual review of interviews and data classification.

In the following chapter, research findings, including the results of the preliminary survey, demographic characteristics of the sample, and interview findings are described. Data categories and the themes in the informants' experiences are also described. These findings are illustrated using quotations from the informant interviews.

CHAPTER 4

FINDINGS

Study findings in this investigation included results of the preliminary survey, demographic characteristics of the sample, and interview findings. Findings of the preliminary survey are described first. Next, the demographic data obtained from the interview participants are presented. The remainder of this chapter is devoted to a description of the interview findings.

Interview findings are presented using the categories which emerged in the data analysis. Themes in the informants' experiences of loss and grief are described first. Following is a description of the informants' interpersonal experiences in the nurse-patient relationship. Four interacting factors and processes were found to influence informants' involvement in relationships with patients and included nurse factors, patient factors, family factors, and certain factors and processes in the practice setting. These are described next. Finally, informants' experiences in coming to terms with loss is described. This description includes the informants' views about what would be helpful in managing experiences of loss and grief in the nursing role.

Preliminary Survey Results

The preliminary survey, used to enlist volunteers for interview participation, was distributed to 115 nurses employed at the three hospitals in the study; 89 completed surveys were collected by this investigator (response rate = 77%). Forty nurses who completed the survey met study participation criteria and comprised the pool from which the sample was selected.

In response to the question, have you ever experienced a sense of loss or grief in relation to your patient's physical or emotional condition, 84 nurses responded YES, 2 responded NO, and 3 responded CANNOT SAY. These findings indicate a grief prevalence rate of 94% among the nurses completing the preliminary survey.

Demographic Data

Nurse informants represented a variety of current clinical practice areas as illustrated earlier in Table 1 (page 37). In addition, these nurses reported a wide range of prior nursing experience in varied nursing practice areas. Five nurses reported no change in their clinical practice areas during their employment in nursing. Nurses in the sample represented both full-time and part-time employment status on all three of the hospitals' work shifts (see Table 2).

Table 2. Informants' Employment Status and Work Shift ($n=20$).

Employment Status	Work Shift		
	Day	Evening	Night
Full-Time	6	5	2
Part-Time	3.5 ^a	3.5 ^a	

^a_n: This subject (.5) worked both day and evening shifts.

Informants' ages ranged from 25 to 54 years and their years of employment in nursing varied from 2 to 32 years. The year in which the study informants had completed their initial educational preparation in nursing ranged between 1951 and 1981. These data are illustrated in more detail in Table 3.

Table 3. Informant Profile: Age, Years of Employment in Nursing, Year of Nursing Education Completion ($n=20$)

Age	Years of Employment in Nursing	Year of Nursing Education Completion
25	3	1980
25	2	1981
26	5	1979
26	4	1980
28	6	1976
28	7	1977
28	7	1976
28	6	1977
29	8	1975
29	5	1979
32	10	1973
33	10	1971
33	12	1971
33	12	1971
35	5	1978
35	12	1969
38	9	1967
40	17	1965
43	4	1976
54	32	1951

Of the nurses in the sample, 15 were married, 2 were divorced, and 3 were single. Fourteen had children and 19 reported sharing their home with an emotionally supportive adult. Informants reported a variety of sources of emotional support both outside of the work setting and more formally in the work setting itself. These findings are illustrated in Tables 4 and 5.

Table 4. Informants' Sources of Emotional Support Outside of the Work Setting ($n=20$).

Number of Informants Reporting	Source of Support
14	Friends
13	Family
12	Husband
4	Church
2	Co-worker friends
2	Nurse friends
1	Boyfriend
1	Eastern Star
1	Hospice
1	Neighbors
1	Pastor

Table 5. Informants' Sources of Emotional Support in the Work Setting (n=20).

Number of Informants Reporting	Source of Support
12	Peer nurse
9	Physicians
5	Nurse supervisors
5	Staff at work
4	Head nurse
4	Peer nurses on other units
3	Administrative nurses
3	Religious leaders
2	Group support meetings
2	Unit secretaries
1	MNA nurse members
1	Nurses in other hospitals
1	Pharmacist
1	Psychologist
1	Sessions with mental health staff

In terms of rural/urban characteristics of the sample, six nurses lived in communities with a population of less than 5,000. Hospitals in these communities had 30 beds and 48 beds respectively. The other 14 nurses in the sample resided in a community with a population of 38,000 and were employed in a hospital with 213 beds. Six nurse informants were originally from Montana; 14 were from other geographic regions of the United States and were raised in communities ranging in population size from 200 to 1 million. Informants' length of residence in Montana ranged from 1 year to 40 years (see Table 6).

Table 6. Informants' Length of Residence in Montana ($n=20$).

Number of Informants Reporting	Length of Residence in Montana in Years
9	1 - 10
4	11 - 20
4	21 - 30
3	31 - 40

Interview Findings

Initially during the data analysis, informants' statements and descriptions were classified in one of the four data categories identified in the literature review as a factor related to experiences of loss and grief in general. These four categories included the following: (a) patient characteristics, (b) nurse characteristics, (c) nurse-patient relationship characteristics, and (d) interpersonal setting. As the analysis progressed, it became apparent that these data categories were restrictive in terms of emerging data and did not account for the interactive quality of the factors which related to and influenced the nurses' experiences. In the final analysis, the following data categories emerged: (a) nurse loss, (b) nurse grief, (c) interpersonal aspects: nurse-patient relationship, (d) nurse factors, (e) patient factors, (f) family factors, (g) practice setting factors and processes, and (h) coming to terms with loss. Nurses' statements and the descriptions elicited in the interviews were classified in one of the above data categories and when each nurse's response was analyzed in relation to other nurses' responses in a given data category, themes in their experiences were identified.

In the remainder of this chapter, data categories which emerged in the analysis described above are presented. In each of these categories the identified themes in nurses' experience are described; these themes are illustrated using direct quotations of the study informants. These quotations have been edited in some cases to minimize redundancy and to achieve clarity; efforts were made to retain the original meaning and intent.

Nurse Loss

For consistency, the study interviews were conducted using the interview guide developed to standardize content areas to be covered (see Appendix D). During the interview each informant was first asked to describe what event or experience had come to mind when she had answered YES to the question, Have you ever experienced a sense of loss or grief in relation to your patient's physical or emotional condition? Thirteen informants responded by describing one or more particular patient-care situations; the other seven responded to this question with more generalized descriptions about their work and the emotional aspects of their work. Some of these more generalized descriptions are illustrated in the following quotations:

I don't think there was one patient, maybe a few patients flashed through my mind.... I think it was two days ago the exact subject was brought up in the emergency room by another nurse to me. A student nurse was having some trouble with her feelings.... I feel like in the emergency room these feelings are more present... every day there is something extreme one way or the other (emergency room nurse).

I really felt a loss with everybody, you know. Only [with] patients that died, I was in some phase of grief, you know...resolving my own grief. You were always at a different stage with whatever patient you had lost. So I was dealing with my own grief...plus...helping families through their grieving process...also helping patients through their own grieving process (renal dialysis nurse).

I think the other things I thought about right away were memories I have of experiences of being with somebody when they had their first psychotic episode...to see somebody lose their mind for the first time is a very helpless and a very sad thing (mental health nurse).

Informants were also asked about which patients seemed to elicit a sense of loss and grief for them and to describe their relationships with these patients. Thus, further descriptions of patient-care situations and nurses' responses to these situations were obtained.

During the interviews each of the informants described a number of patients and patient-care situations which she recalled as being associated with feelings of loss and grief for herself. Some of the situations described were recent occurrences in the current area of clinical practice; other situations had occurred several years prior to the interview, and in some instances, had occurred in clinical practice settings different from the current area of practice. In all, nurses described 102 different case examples in which they had experienced a sense of loss.

While the experience of loss among informants was found to vary among nurses and also for the same nurse depending on the specific situation described, some common themes related to nurse loss were identified. The primary finding related to loss was that it was a common occurrence for these nurses in their clinical practice. Descriptions

of the frequency of nurses' experiences of loss were elicited from 14 informants when they were asked: How often are you aware of a sense of grief, sadness, or loss in relation to your work with patients? Despite efforts to be consistent, this question was omitted from six interviews because of anticipated difficulty in the interpretation of responses. During the data analysis as the findings were noted and categorized, the experience of loss was found to be a frequent occurrence among the informants who were asked this question (see Table 7).

Table 7. Frequency of Loss Experience (n=14).

Number of Nurses Reporting	Frequency of Loss Experience
3	Frequent/often
3	Daily
2	Once a month
2	Several times a week
2	With every patient
1	It's just part of my work
1	Once for every 5-6 patients

The analysis of nurses' responses related to their experiences of loss in the case examples they described allowed for the identification of themes or the general ways in which these nurses experienced loss. These themes included the following: (a) loss of someone of personal significance, (b) loss related to the patient's condition, (c) loss of professionalism, and (d) loss of the comfortor/helper role.

Loss of someone of personal significance. All of the nurses in the study sample described a personal sense of loss when certain

patients died or left the work unit through discharge or transfer; each of these informants reported that certain patients had become important to them in a personal way. The absence of these particular patients was experienced as a loss. A generalist nurse (one who practices nursing in general care clinical practice) described this type of loss in this way:

I'm with an OB [patient] all evening and we finally have that baby and everything is wonderful and then I send them home the next day. There is a sense of loss right there. You get so close and then you never see them again.

The two pediatric nurses spoke of the sense of loss when certain children were discharged:

Some people you can get really close to and then you even feel a sense of sadness sometimes when they go home from the hospital because you're not going to see them again or their smiling little faces every day.

When he went home I had to give him up because he became my child and I had put all this time into him... then I had to give him up. Not only did he leave the hospital, but he left the town, and left the state, and his parents were gone...that was sad giving him up.

This same nurse described her sense of loss in this situation:

Just an absence, you know. A presence of somebody that is not there. Like walking through the unit and going over to say 'Hi.' Only there was nothing to say 'Hi' to and there was no baby to walk in your spare time.

A nurse describing the death of a patient which had occurred ten years prior to the interview stated, "I just sat for a long time and thought about [what we had] talked about...and how awful I felt and how much I would miss her." And another nurse, when talking about the death of a patient and her feelings about the death, stated, "Now

[when] I think about her and [realize] she's not going to show up any more, it makes me really sad." This absence, or vacancy, felt by some nurses after the death of a patient, was described by a generalist nurse in this way:

I just felt that she wouldn't be coming anymore and she stayed with us for probably the last three weeks. And so then it was an empty room.

Loss related to the patient's condition. Nurses in this study experienced emotional distress, sadness, and loss in relation to their patients' losses. They talked about patients' loss of options and potential, loss of body part, loss of physical appearance and beauty, disfigurement, loss of function, loss of old roles and relationships, and loss of will and hope. Through empathic and caring attitudes and relationships, the nurses shared their patients' suffering and felt their patients' losses. Following are a number of quotations which illustrate this theme of nurse loss:

She was extremely upset about such things as holding her children, that she would not be able to do that... when she would tell me that.... I just felt all of the strength I had leave and I would just cry along with her.... I wanted to give her my ability to hug my kids just for a day. To make it OK. I told her 'I ache that I can't give you that. I know what you are missing' (orthopedic-neurological nurse).

I just really couldn't sleep very well for a few nights... he had both arms cut off and was badly burned...he had [lost] really part of his life. [I thought about] how it was going to affect him and his family and trying to resume his normal pattern...I'd dream about this whole situation, I don't know why he bothered me that much (emergency room nurse).

[I felt] pain, lots of pain. I cried many times. He was burned over almost 95% of his body.... How long did I grieve? Probably a couple of months.... I think there

was a whole new grief process about his disfigurement.... I mean, we could work miracles with their bodies...so many [patients] did not adjust to their disfigurement and that really caused me a lot of pain (generalist nurse describing pediatric burns-trauma nursing).

She had been an athlete and her whole future had just been pulled out from under her. Not only was she going to be a quadraplegic but all her plans for the future that involved being an athlete were gone.... There were nights I would go home and all that emotion I was holding in would have to let go. I would sit down and cry...and then I could pick up the pieces and get ready for another day of facing it (pediatric nurse).

She would kind of apologize for being so crazy, which was so sad. She knew she sort of lost her mind.... I mean she was going to be very terribly schizophrenic. It's just awful and I could never get any kind of assurance that she would ever get much better [or] return to any reasonable level of function. There was no good news and it was awful (mental health nurse).

There was always sadness there too because you knew that he was never going to leave the hospital, that at one point in time he would be dying (pediatric nurse).

His mother and I sat out in the hall and cried one day just over, what a loss. His potential for the things that he had planned on were now just shot.... It just wasn't going to be (pediatric nurse).

There was another lady and probably the reason why I didn't even bring her up is because it bothered [me] bad enough that I tried to put it in my unconscious.... She came in and she had radiation treatment...her whole physical beauty was gone.... We were all [staff] involved in that woman because she was such a beautiful person... and to see that gone. It was just hopeless, there was nothing we could do (orthopedic-neurological nurse).

The other two themes related to nurse loss identified in the data analysis related to the professional aspects of the nurse-patient relationship. While these two themes are closely related, the analysis of nurse responses indicated that nurses experience loss related to their

professional role in two, somewhat different ways. These two themes are presented next.

Loss of professionalism. The experience of the loss of professionalism was related to nurses' perceptions of their performance in the work role. At times they questioned whether or not they had done the right thing and whether they had been in control of the situation in the manner in which they perceived they should have been. They reported feelings of distress related to perceived failure and inadequate performance.

An emergency room nurse assigned to life-flight helicopter duty described the following situation:

I guess it was just my option [not to take an EMT on the flight] and I was the only one out there. He was obviously dead when we got there. None of his co-workers knew, or started CPR, and had he lived...the quality [of life] wouldn't be there.... That time I felt like I didn't have any control...a very frustrating feeling like what went wrong, where did I lose control?

Two nurses described a feeling of loss of control as emergency admissions occurred in the small hospitals in which they worked:

[It was] getting to be towards the end of the day and I can remember...making my plans to leave and this woman runs in the door...holding an obviously blue baby that was dripping wet and I knew the kid had drowned one way or the other. [When it was all over I felt] that I had been through a lot. Just when you think you have things under control and that nothing can go wrong, something like that happens.

I mean all of these things add up to a nightmare situation.... It's the loss of professionalism too, that you try to be organized and do your job and in that situation I felt totally inadequate.... I felt like I should have been more prepared and that kind of thing.

Another nurse described her sense of inadequate professionalism in this way:

The doctor elected to try to get her to [a larger hospital] to deliver and she didn't make it. She delivered in the ambulance...we did CPR on the baby...he was too tiny.... I felt like I should have pushed harder to deliver her here.

A nurse describing her experiences of loss when working in a neonatal intensive care unit and as a generalist nurse said this about her professional role:

Well, we knew that they were going home and they weren't better.... A lot of times we would tend, I think we do it even now, you send patients home knowing full well that they are not any better, that they are not going to get any better and you say 'It's wonderful you're going home.' I feel a sense of loss sometimes, kind of a betrayal. You're sending them home as if it's so wonderful and I guess betrayal is a real feeling I feel in nursing sometimes.

Loss of the comfortor/helper role. All of the informants described experiencing a sense of loss when their nursing care efforts did not help or comfort a patient. An oncology nurse described her feelings as she cared for a 37-year-old patient terminally ill with cancer:

She finally died but it took her so long and all of us [staff] just cringed every time her light came on because we felt so inadequate about helping her. If you can put a patient at ease and out of pain you feel like you accomplished an awful lot. But with her, she was always in pain.... [It was] just like a torture chamber every-time you had to go in there.

A nurse working on a medical unit, when asked to describe how often she felt a sense of loss or sadness in relation to patients, said this:

Once every two weeks there is somebody that gets to me...maybe not because they are dying or anything but because they are having such a hard time, and [then] not helping them much.

Later this same nurse commented further about helping patients:

I think, even though we know it is not true, you think back and say 'I am a nurse and I want to help you' and you can't help them. You know, what am I doing? I'm not doing my job...it bothers me, but I realize you can't [always help].

A generalist nurse described her feelings as she cared for a patient with cancer:

I remember crying with her...like when I would change her dressings and stuff towards the end...she would be in pain and I knew I was hurting her and I felt frustrated that I couldn't help her.... I really couldn't take her cancer away.

A nurse working in a special care unit said that in some situations, she is more hurt by a patient's living than his or her death. She stated:

We are often very cruel in ICU as far as the things we do...you intubate a person and stick needles in them everywhere and tie them down. It's terrible things.... If I can help or can alleviate the discomfort, if I could even do that, then I would feel like I was doing something. But sometimes you can't.

As illustrated by this quotation, the helping/comforting nursing role was conflicted at times because required nursing procedures were painful to patients. Performance of these painful procedures was especially difficult for nurses when it was believed that no cure or hope for a change in the patient's condition would result. As stated by an oncology nurse, "It hurts us so bad to see people put through so much to live a life that is not any good at all, you know, quality-wise and pain-wise. It's sad."

Loss relating to the helping role also had to do with the inability to save patients in certain situations. Two nurses described this type

of loss which occurred as they worked with patients who died as a result of a spinal cord injury:

And [I felt] feelings of frustration and maybe...a little guilt...there ought to be something that you can do and you can't...there have been feelings where there is something I am not catching, or if I had noticed that a half hour sooner, maybe things wouldn't be this way... there is a little bit of 'Yes, I am a nurse and I am supposed to perform miracles and why can't I pull one out of my hat?' (pediatric nurse).

The x-rays came back and her neck was totally severed but nobody would stop working [on her]. It was just a sense in the whole room, and myself included, that it can't be. It was a refusal to accept the fact that there was absolutely nothing we could do.... It took me a long time to get over her (emergency room nurse).

Summary. Experiences of loss among nurses in this study were found to be common occurrences. Loss occurred in several ways for these nurses, including the loss of a patient who had become personally significant, loss related to the patient's condition, loss of professionalism, and loss of the helping/comforting nursing role. As evidenced in the words of these nurses, personal involvement with patients through caring and empathic relationships and professional commitment to the ideals of helping, comforting, and saving were the norms for this group of nurses. Descriptions of nurse's responses to loss follow.

Nurse Grief

Nurses' responses to loss occurred in both the personal and professional aspects of their lives. That is, nurses personally grieved

in response to their experiences of loss and, at the same time, experienced feelings and thoughts about their work which were directly related to their losses. In some situations they recalled behavioral changes in their work performance and in their personal lives following a loss.

As nurses were interviewed they described their feelings of grief which had arisen in relation to certain patients or to particular patient-care situations. At times these descriptions were accompanied by the emotions which had occurred earlier in the context of the case example being discussed; at these times, the nurse's suffering and distress was still apparent. Nine nurses reported that they continued to have feelings about certain patients they described, often after several years. As illustrated in the words of a nurse when describing a situation which had occurred in 1974, "I still think about it occasionally, so I don't know if you could say I'm even finished grieving yet." Another nurse, when asked to describe how long she had experienced sadness about a particular care situation which had occurred in 1976, said this:

I guess it's always stuck with me, even until now because this is one of the things that comes back to me often. It would come back to me as I was holding my own kids when they were babies, thinking that mine were okay and why did that happen. I don't even remember the baby's name...I feel for the mother.

In other situations described, nurses were distressed for shorter periods of time and recalled coming to terms with the loss within a brief period. A nurse working in orthopedic-neurological nursing

described her response to a 70 year-old woman following a leg amputation:

I felt a loss for that woman. At that age she had to endure that sort of grief and a loss of a body part.... I think maybe the ache [I felt] came from the knowledge about how much adaptation this woman had to make in her life, how difficult that has to be for a woman that age.... I can say [that I had feelings about her] at least that evening and by the next night I was able to be strong for this woman, I needed to support her.

Informants used a variety of expressions to describe their responses to loss. They talked about pain and aching, sadness, depression, despair, grief, helplessness, hopelessness, shock, disbelief, loneliness, relief, anger, and guilt. They also talked about frustration, fear, and apprehension. A portion of the dialogue between this investigator (I) and a pediatric nurse (N) which occurred during one of the study interviews is presented next to illustrate some of the feelings experienced by the informants.

(I) How was that for you when you heard of her death? How did you react to that?

(N) A whole lot of feelings just kind of tumbling. Anger, a relief that it was over, a sense of frustration that I couldn't have done more, there must have been something I could have done, and just a sense of peace. Her suffering was over. I could remember her as she was...but I didn't have to face that day-to-day stress.

(I) Then how long after that did you feel sad when you talked about her?

(N) I still do [two years later].... It's just plain not fair. Life is not fair...It was one of those situations where I don't know how else to describe it. There was no justice in it.

(I) Sure. Some anger accompanies that?

(N) Oh, definitely, definitely. And feelings of frustration and maybe, you know, a little guilt that...there ought to be something you can do and you can't.

Another nurse described her responses to a situation in the emergency room involving the death of a three year old from child abuse:

(N) I really felt a lot of grief with that and I took that home with me.... I also felt some of the suffering he must have felt, he was just covered with bruises and fractures.

(I) You said you felt a lot of grief and that you took it home with you. Can you describe how it was that you felt?

(N) I did take it home. I think I saved my grief for on the way home from work that night...on the job and during the moment I felt...those butterflies in my stomach...and kind of chilled and I felt like I didn't want to work anymore that shift, felt like I didn't want to see anymore patients...but I kept all of that inside me.

(I) Did you cry [on the way home]?

(N) I did but I think I talked too.... I felt real sad because the child had died, real sad and I...would say things to myself like how awful it must have been for that little boy to have been hit, knocked around, shoved and pushed and made to cry and not loved.

(I) How long was that with you in a painful way?

(N) I'd say that was with me in a painful way for two weeks or a month. But it wasn't so that it affected the way I was at home...or at work. I mean it was in my mind and...if I had a moment and thought about it, I felt bad again, but time seemed to ease it.... I still remember [after six years]...I will never forget it but...my recall of it doesn't necessarily mean that I still grieve about it.... I think it is just, I think it is emotional.

While emotional responses were most frequently recalled by the informants, they also reported other symptoms or changes following some experiences of loss. The most frequent behavioral changes reported

were crying and talking about a patient or patient-care situation. All 20 informants reported that they had cried and talked with others in response to losses that had been particularly distressing to them.

In terms of particular situations in which these nurses had cried, 11 recalled crying at home, nine recalled crying with a particular patient, four had cried with a patient's family, and three had cried with other staff members. Talking about their feelings related to a particularly difficult situation was also most frequently reported as having occurred outside of the work setting. They had talked about particular patients and patient-care situations and their own related feelings with their husbands most frequently; they also reported talking with boyfriends or other close friends, nurse friends, and other family members including a mother, a son, and a cousin. While this sharing of painful experiences most often occurred during a personal contact with a significant other, four informants reported talking about a particularly distressing patient-care situation during telephone calls; for three of these, this sharing occurred during long-distance telephone conversations with close friends or family members. Talking about their feelings about patients with other staff in the work setting was recalled by seven nurses. The following quotations are presented to illustrate some of these aspects of nurses' grieving:

I think I was a little depressed...for the first week I was very weepy. You know, my husband would look at me and say something, or I would read an article in one of the women's magazines and just break down crying (surgical nurse).

So both patients had died...one died about...1 o'clock and the other one died about 6:30 and the same mortician came and got both of them.... I had never taken care of either one of them and I didn't know the family... didn't even bother me until I called the second doctor and told him. I started crying. I didn't even know that I felt that way at first, like I had really covered it up (special care unit nurse).

As far as my emotions, I was talking a lot, my thoughts were scattered, I was in disbelief. My first feeling of shock, I can't believe that I was part of this...or did this really happen? I could see that. I was rattled because I was behaving in that way. I definitely knew I needed to have a psychological break. I had to go home and talk about it, as to what happened to me (generalist nurse).

I think I had kind of a sobby day.... He died early on our shift and through the rest of the day every once in awhile it kind of hits you as you're walking down the hall or something and start crying and I think I did cry that evening, too. My family was aware of it because I had been talking about it too. There are some things you just can't leave at work...when you have a dying patient at the hospital and you're going to go back there again tomorrow [and] probably see that same patient. You just can't leave that there (pediatric nurse).

Other behavioral changes following losses that were significant were reported by nine informants and included dreams, nightmares, and insomnia. The following situations were described by nurses when asked about any changes they had noted in their personal habits after a difficult loss at work:

Nightmares and couldn't sleep for quite awhile. I guess... wondering [and] thinking, if only I could have done something different to it. There wasn't. The baby was as it was long before I ever came on the scene. And feeling the guilt toward the mother. Wishing that there was a way I could have told the mother that it was okay, that it was normal. I remember not wanting to deal with that mother as she woke up (generalist nurse describing a situation in neonatal intensive care).

I had dreams...for a week or so after I starting caring for him and then they stopped. I dreamed about him every night. [I'd] hear his little alarms going off and his monitors going off. In fact, one night I was sleeping in with my son. He was having a bad night and I woke up in the middle of the night with just a start. I couldn't hear his monitor beeping and he was laying on his stomach and how could he possibly be breathing properly... I just took [my son] and I rolled him over real fast and I thought, 'I'm home' (pediatric nurse).

Informants also recalled cognitive, physical, and attitudinal changes as they grieved some of the losses they experienced at work. The phrases used by these nurses which indicated cognitive changes included the following: thinking about it a lot, thinking about it even now, preoccupation, it haunted me, worrying, confusion, poor concentration, loose ends, my thoughts were scattered, my mind was not as clear, and I had flashbacks. In all, 15 nurses reported cognitive changes.

Physical symptoms of grief were recalled by 14 informants and included headaches, loss of appetite, shakiness, numbness, lowered resistance, feeling the symptoms of the patient that was dying, depleted energy, heaviness, tiredness, nausea and stomach pain, pressure in the chest, and tightness in the throat.

The spiritual and attitudinal aspects of grief for informants related mainly to two specific themes, one having to do with issues about justice, fairness, and the realities of human suffering, loss, and death. The other theme related to issues specific to the work of nursing, including quality of life, prolonging life in what were seen as hopeless situations, and caring for patients when nursing care was painful.

Among informants, the realities of human suffering, loss, and death were most difficult to deal with when the patient was an infant, child, or young adult. In these instances, they questioned and struggled with issues about fairness and justice in life; they felt that these patients had not had a fair chance to grow up and experience life. They grieved patients' loss of potential to experience living.

As stated by a pediatric nurse:

They are so little, they have not had that chance, and that's not fair either, that nobody should have to die traumatically or unexpectedly but it happens. At least in adults they had a chance. Kids just haven't had a chance to do, to be, to grow up. That was hard.

Another pediatric nurse, when asked to describe her feelings of grief about a particular patient, said this:

Boy, I don't know. It really was sort of a feeling of relief more than almost anything else, except that you still wanted to believe that maybe he did have a chance to have grown up and have been a normal child and experience all the wonderful things that normal children do get to experience as they are growing up.

An emergency room nurse described her feelings of sadness and frustration following the drowning death of a six year old:

Well it was frustrating that we couldn't do anything here [in the emergency room] you know, because you feel like you should be able to save everybody sometimes. If they're 90 years old, you don't mind it so much.

The suffering, losses, and deaths of older adult and elderly patients raised issues that were more directly related to the professional role. Informants brought up issues related to the ethics of saving lives, the realities of saving or prolonging life when the care outcomes are poor, and their distress about being unable to comfort or help

patients as illustrated earlier. These issues were identified by a generalist nurse in this way:

I think head injury [presents]...a real problem that we are saving them physically and what is death? Is it death of the spirit or death of the body...? I can see [his wife] dying a million deaths a day knowing that [he] is over there [Warm Springs]. Here again, it's personal coming into my work, but sometimes I wonder why we are saving these people? Who am I to say? Of course, I want to save. Professionally you want to do all you can, but there is such a fine line....How do I help the next person go through the same thing?

A special care unit nurse described her response as she cared for a woman with congestive heart failure:

I really couldn't do anything for her other than give her morphine and support and I find that harder to deal with than just right out death. She isn't one who lived very long but death was very painful for her...it just gets so frustrating you don't want to deal with it anymore. You want to go away and come back and have her dead...those days I feel like I just want to get away and read a book and forget about everything and everybody, including my family. Just kind of repair all of the wounds that are there.

As illustrated in the findings related to nurses' grief, informants experienced feelings and other changes in response to loss which were painful and distressing. This distress and discomfort had led to tearful sharing with others and verbal expression related to the distressing event and their feelings about the event; physical, cognitive, and attitudinal responses were also recalled. Some informants believed that their grief and distress following significant losses had influenced their performance in the work role as well as certain aspects of their personal lives. A generalist nurse described her thoughts about the loss of professionalism and how this affected her work performance:

Then trying to carry on with our job, it was really hard.... I think that it decreases from your ability to work, for sure. Your mind is not as clear as it should be...we could hardly concentrate.

This same nurse described her observations of other staff following an unsuccessful resuscitation in the emergency room:

But anyway, after that the nurses still had to finish their shift and they were just walking around, they looked to me [to be] in shock. Wide, dilated eyes and just very spaced out.... I just started talking to them about what a good job they had done, asking...what they needed, to help totally reorient them to what they needed to do.... When I [had gone into the emergency room] no one was talking, they were just...standing around and cleaning up things slowly and there was such a feeling of tension and anger toward each other.

Another generalist nurse described the staff's response to the traumatic death of a 2-year-old child in the emergency room:

Now that one was one that all the staff grieved together. The whole rest of the day we couldn't even work without crying.... But one of the nurses who was on shift was a neighbor of this family and she just became completely incapacitated. She had to go into the lounge and lie down and cry and a number of the other staff held her, cried with her, and then ended up working overtime so that she could go home.

A nurse having administrative duties made the following observation about the effects of loss on staff nurses' performance:

I see it in the department a lot of times as far as audit functions.... It seems like during those times when we've had a lot of painful things happening the night shift nurse comes up with a whole lot of errors that [were] made during that time. She's the one that does the daily audit functions on the chart.... In some cases it's been loss. Sometimes I'll start looking to see why I've got all these mistakes and that's when I find something has happened that's been painful so maybe that's why. You know, it's hard to say yes for sure.... And that happens even if we haven't had one of those painful times, so it's hard to know whether it's just being too busy...or because of those patients' deaths.

Two informants described instances in which staff nurses had been sick following particularly distressing patient-care situations. An orthopedic-neurological nurse made the following observation:

They must have taken it all home because you can tell by the end of the day they were just drained, completely emotionally drained but [they] would not say a word... and then they would be sick for a couple of days.

An emergency room nurse recalled the following incident:

It came up because one of the flight nurses said whenever she had a bad flight, which she had just had that week...two of the people died in flight, she takes it home with her [and becomes] real physically sick. [She] said that her physical response was to stress and...it takes her about ten days and then [she] sort of resolves it and feels like she can fly again.

In addition to the effects in the work setting itself, the pain and suffering of nurses as they grieved their losses at times influenced experiences in their personal lives. A pediatric nurse recalled her reactions to the death of a three months old male infant:

My little girl was less than a year old and she wasn't much older than him. I had this obsession [that] something was going to happen to her. For about a week I would go in and check on her all the time. Or I picked her up that night and held her. She was sound asleep but I needed that contact, my baby was alright.

Following the birth of a deformed infant, a generalist nurse recalled the following response:

It haunted me. Again, [during] each of my three pregnancies I had a horror...that I would have a baby like that...and I have to admit, even now when I know there is a gal in labor and she is having a lot of problems, that comes back [and I think] please don't let that be what is wrong.

As illustrated in these findings, the informants experienced grief, sadness, and distress in relation to certain patients and certain patient-care situations. The analysis of interview data led to the identification of sources of these experiences of loss and grief and some factors which related to these experiences.

Interpersonal Aspects: Nurse-Patient Relationship

The sources of loss and grief for nurses in this study had to do with the interpersonal aspects of their work role. As they talked about their feelings, they described their personal and professional involvement with patients and how they came to be involved.

Informants used a number of terms and phrases when describing their relationships with patients who evoked feelings of loss and grief for them. They talked about being close to patients, involved, and attached. They spoke of tenderness, love, emotional care and emotional bonding, empathy, sympathy, and investment. They described family feelings with patients, knowing the patient as a person, and knowing the spirit of a patient. They also talked about common interests, friendships, and what they learned from certain patients. The theme related to personal involvement in their work role was that certain patients became important to them as people. Some patients came to be viewed as individuals that were important beyond the scope of required nursing functions and professional responsibilities. These nurses experienced personal feelings and responses in their relationships with these patients.

In the case examples discussed during the interviews, involvement ranged from empathic distress due to the patient's losses or predicament to an experience of the patient as a part of the nurse's family. In some instances, nurses felt as if they were a part of the patient's family.

A generalist nurse described her feeling of sadness as she empathized with a patient. "She didn't know if she was going to keep the baby or what was going to happen. I just pretty much listened to her and cried right along with her." This same nurse described her involvement with another patient in these words: "I had become emotionally involved...just by being there and being a human being."

When asked to describe what she meant by feelings of attachment, another generalist nurse stated, "Well, like you love them, like they were a member of your own family. I felt like she was my grandmother." A pediatric nurse described her feelings for a five month old infant as a "certain degree of love." This same nurse described the emotional bonding which takes place between herself and some of the child-patients she cares for: "I think...your motherly instincts come out....it is sort of like a mother and child." Another nurse, when describing her experience in 1967 with a three-month old infant, said this:

The loss that I can remember most vividly is the first time I was taking care of an infant [who] died during my shift. I can remember holding that baby and just thinking that if I hold it long enough and get it warm enough...I'll be able to give her [the mom] the baby.... I remember thinking that maybe you can sort of infuse them with life so that mother could have [her] baby alive.

A pediatric nurse described her involvement with some patients in this way: "There are a few who, for some unknown factor, wiggle their way into your emotional being more than other patients do."

And about a particular patient, she stated:

I found myself just being a little bit more involved with that little boy and that I took more time to give comforting. I worked extra shifts to make sure there were enough people around for him and just went the extra mile, I guess, because for some reason he was special.

This nurse further stated that this child, in a sense, had "become my child."

A renal dialysis nurse described her involvement in nurse-patient relationships in these words:

I feel if you are really going to be a good nurse and give good nursing care, you have to become emotionally involved...at least I do...I probably do get a little more involved emotionally with people than other people do but I guess that is my makeup.

This same nurse described her relationship with a particular patient:

She got to be a very, very special friend, and I think it was difficult to lose her because I feel that these people are almost a part of the family. You get so well acquainted with them. In fact, sometimes you are almost closer to them than family because they really confide in you and they trust you and...they probably tell us things they can't tell their families.

Another nurse described her work with patients on an oncology unit. "I get some personal involvement no matter what. No matter if you try to keep it personal or not." She further described her relationship with a young leukemic patient. "We really got down to talking about what type of things she wanted to expect out of life, what she

wanted to go through." Another nurse also talked about her relationships with oncology patients: "You're giving more in an emotional way and in a spiritual way, I think. And not so much medical." When describing nurses' involvement with patients she stated, "We're with the patient so much and the doctors are not...they don't get inside the patient like the nurses do."

Nurses working in the smaller, rural-area hospitals believed that their involvement with patients was influenced by the size of the community and hospital. They often knew patients as community members, friends, and neighbors. The following quotations illustrate how these nurses, in part, viewed their involvement with patients.

It is a small hospital and we get real close to people here and we see a lot of the same people over the years so that you know people when they come in, most of them. Or because they've had a family member in here then you've [already] met them.... So you already know them already. You know them as people, outside of the patient.

This is a small town though and so a lot of the people you know or you deal with. It's not like in a big town where you've never heard of these people and you'll never see them again.

I remember another one, this [woman] and her husband used to come in and they both had congestive heart failure and diabetes.... I worked one Fourth of July and watched a parade with them.... We stopped and we were visiting and things and then he came in and died...and I just put my arm around [his wife] and she was just crying and I felt like I was kind of member of the family.

In some situations, informants were able to identify reasons for their involvement with patients. A comment by a special care unit nurse is an example: "Very few patients know your name, so you can have a lot more distance with them. When they know your name

and recognize your voice, you get a lot more involved." At other times, they had more difficulty identifying how it was that a patient had become important to them. As a mental health nurse stated, "I don't know why, but I became very invested in this girl.... I became very much her advocate." And an emergency room nurse said this: "I'm not sure what emotionally binds you to certain patients.... I don't know what it is, you just become connected emotionally [with some patients]."

Among the case examples described by informants, experiences of loss and grief most commonly occurred in relationships with patients who had become personally important to the nurse. In these relationships, nurses also experienced empathic distress related to the patient's condition or the responses of the patient's family. Although the loss of professionalism and loss of the comforter/helper role also generated feelings of grief in the nurse, these experiences were more frequently described in relation to patients in which the nurse had developed a personal involvement and investment. As nurses' responses were analyzed, the following factors were found to be related to nurse involvement in the nurse-patient relationship: (a) nurse factors, (b) patient factors, (c) family factors, and (d) factors and processes in the practice setting. Each of these related factors will be described next.

Nurse Factors

Among study informants, the theme having to do with the relationship of certain nurse factors to their personal involvement with patients and their resultant experiences of loss and grief was found to be the following: these nurses interacted with patients as complete and whole persons. That is, the professional self and the personal self were not separate entities but, rather, interacted together in the form of the whole nurse-person. This theme is illustrated in the words of several of the informants:

I cannot disassociate myself...sometimes you can leave it at the hospital and sometimes you don't. You are so involved you just don't. I mean, we are humans and we are not robots, and we cannot turn ourselves off and on. Really, it is difficult (renal dialysis nurse).

We are dealing with people, we are dealing with humanness, we can't help but pass that barrier (surgical nurse).

Really, you can't put people on a shelf. When I was in [nurses'] training...empathy was the big thing. You empathize but you don't sympathize. That's stupid. You can't, I just don't [separate professional from personal] (generalist nurse).

The nurse factors which were found to influence informants' involvement with patients had to do with their values related to involvement with patients and the personal meanings associated with certain patient-care situations. It was found that these nurses valued personal involvement with patients; some believed that the quality of their work and the meaning they found in their work would be adversely affected if they were not involved with their patients. As stated by a generalist nurse:

I...hope I would never lose that sense of hopelessness or sadness, or I don't know what the word is, but I would feel bad if I lost it.... If I were so hardened to [death] saying that 'Well, his physical responses quit and that's that,' I mean, what kind of a person would I be? I would hope that I would be able to stay open enough to people so that I can feel some of their responses.

An emergency room nurse expressed her concern that the personal element with patients was often missing in the emergency room nurse role. She described her efforts to personalize her involvement following the unsuccessful efforts to resuscitate a 14-year-old drowning victim:

It was clear that I was upset or sad...I went to look at this young man because...I feel like when you are in the middle of one of these resuscitations out in the field or in the ER [it's] almost not a person.... I wanted to take a look at the face that had drowned and that I had tried to save.... I didn't want him to be flight #___ or the drowning at _____ even though I didn't know his name.

And a special care unit nurse said this about involvement:

You have to be involved with some people [or] it's not worth it.... Soon as you stop being involved, you just won't experience half of life.

The personal meanings that most frequently related to these nurses' involvement with patients had to do with the nurse's own experience of loss in her personal life and with a vicarious experiencing of a patient loss or death. Nurses re-grieved their own losses as they grieved for and with their patients. As illustrated in their own words:

She looked a lot like my sister...and I'm very far away from my family right now...and I kind of had a renewal of almost having to get over the fact that I had moved

away from home.... [Her death] really kind of hit home, I think (surgical nurse).

I know one of the things I thought of when that child a year ago died...was that I was still working out some things about my sister's baby that died about seven or eight years ago.... I had dreams about her child for nights after that and so I knew then that it was having something to do with my grief. You know, I thought I had worked that all out a long time ago (generalist nurse).

When describing her grief related to the death of an 18-month-old infant, a special care unit nurse said this:

Well, you see...we had been in a [car] accident when I was eight months [pregnant] and had a stillborn child so it kind of came back, all of this losing a child.... So it brought all these feelings of unfulfilled motherhood back and then I was afraid. I was pregnant and I thought anything could happen.... I was really sad. I don't know if I grieved because I was losing a child or I grieved because that child didn't have much of a life, I'm not sure.... I don't know if you ever really get over something like that. You put it in the back of your mind and you don't bring it out.

Personal losses also influenced nurses' involvement with patients through increasing their sensitivity to the patient's situation. Personal loss at times increased a nurse's ability to understand and empathize with certain patients. An informant described how her father's death affected her work with oncology patients:

My father did die of a cancer, he has been gone for seven years.... It was after his death [that] it was very easy for me to identify other men...that were going through the same thing.... I felt that I learned a great deal through his dying and his death, about how other people react and how they feel.... I have an extreme amount of empathy for men...who have died of prostate cancer.

The personal meanings that the informant associated with certain patients was also related to the age and family of the informant.

There was often a "what if" quality in experiences with patients. For example:

That hit closer to home because I have a kid that's almost that age...like how would I feel if I lost my daughter? (emergency room nurse).

She was only 62. She had a couple of daughters that were about my age.... This summer my dad had open-heart surgery and I had a really hard time and then my mom had a heart attack...that makes me very afraid for them (medical nurse).

I remember worrying about both my brothers [who] have small children. I was overly concerned about them for awhile...I would call them up and ask about the kids (mental health nurse).

I know what does come to mind several times for me is just imagining that, what if that were my child laying there in that bed? I just almost immediately take to the patient a little bit sooner or closer than if that child hadn't hit me with some sort of likeness or resemblance to my kids (pediatric nurse).

We had a quadriplegic young woman in this fall and she had two small children and this gal unnerved me greatly.... when a person is close to my age [or has] children the same age, in that way there are carryover factors (orthopedic-neurological nurse).

The other nurse factor found to influence informants' involvement with patients and their responses to loss had to do with personal beliefs regarding suffering and death. They believed that infants, children, and young adults should not suffer and die. They also believed that their role as a nurse had to do with preserving human dignity and facilitating a patient's comfort and quality of living. When these beliefs were challenged or compromised by the reality of a particular patient-care situation, these nurses became distressed and suffered personally.

Patient Factors

As informants described the patients and patient-care situations which had elicited feelings of loss and grief, they described a wide-range of patient factors which related to their experience and to their involvement. They described newborns, infants, and children. They described adults and elderly patients. They talked about traumatic injuries, disfigurement, and patients with a poor prognosis. Patients' deaths were described as sudden, unexpected, and untimely as well as slow and drawn-out. Some patients were known as strugglers and fighters, others were known as courageous and accepting. Some were pests and characters, some were patient and sweet. In the case examples described some of the patients lived and some died.

In the analysis of nurse responses, certain patient factors were identified as being more frequently associated with nurses' loss and grief. The patient's age and condition were brought up most often. As discussed earlier, infants, children, young adults, and patients close in age to the nurse's age, elicited the most distressing reactions, especially when the patient's condition involved severe, permanent disability or death. For these patients, the care outcomes were viewed as unfair and untimely. In addition, the nursing care of these patients often involved painful procedures which were distressing to the nurses and, in some instances, life-saving measures which were viewed as inappropriate.

Sudden and unexpected death was another patient factor which was repeatedly mentioned by nurses in the study interviews. This

factor, while always distressing, had a more profound affect on the nurse if the patient was young.

The other most frequently mentioned patient factors related to nurse loss and grief were the quality of a patient's death and certain patient characteristics. In terms of the quality of death, those patients who suffered a great deal in their dying or whose dying was slow were most difficult for the nurses. A pediatric nurse said this:

To just have this dying process...to go on for quite a long period of time, probably a week from the time he came in to the time he died, and everyday he'd just feel a little bit worse and worse. And it was hard, very hard to watch him do that and not be able to do anything for him.

Another patient factor frequently mentioned by the informants was the patient's attitudes about death. Patients who accepted their inevitable death calmly and with courage were viewed as someone from whom the nurse could learn. Nurses came to be close to these patients as they attempted to understand their patients' attitudes. An orthopedic-neurological nurse said this:

She did need a respirator but she chose not to have one and probably within that next week she died. But she was teaching us a lesson because she was so prepared to die. She wasn't afraid.... It was hard because I couldn't understand where she was coming from.... I found that the tables were turned in her case, she was supporting us.

In terms of patients' personality characteristics, those viewed as having pleasant, friendly, and cooperative attributes were mentioned most often. These qualities allowed for a greater closeness and attachment to develop between the nurse and patient. A generalist nurse described this in the following way:

I think [I became attached] because of her personality.... She was just never complaining...you could tell by her expression and watching her that she suffered quite a bit but she never complained...and she was always so nice and patient...just so graceful.

And an emergency room nurse made this observation:

I mean it is easier for me to become...closely related in a patient-nurse relationship if a person is a likeable person, doesn't complain, real easy-going, good sense of humor, you know.

Family Factors

Patients' families were important to nurses in this study and had a strong influence on nurses' sense of involvement with particular patients. All informants talked about families and when their responses about families were analyzed, a number of themes in their experiences were identified.

Family-patient relationship. Patients' relationships with their families influenced nurses' involvement with patients primarily in two different ways. First, in care-situations in which the family demonstrated care and concern by regular contact with the patient in the practice setting, nurses came to know and be involved with the patient as a person who was vitally important to significant family members. In these situations, actual nurse contact with the family and patient may have been brief, as in certain emergency care situations, or more prolonged as in chronic or terminal care. This theme is illustrated in the following quotations:

It's really easy for me not to be attached to the patient, and then, when they have families, people around, you realize they are a person, and they were loved, and

then that's hard to deal with. Because then you feel a loss for the family (special care unit nurse).

In the field, ideally...you're going to have someone remove the family and control the crowd [but] it doesn't work that way. So, there again, I don't see their faces because I am far too busy, but I hear what they are saying and I hear them crying and I hear the mother scream when I intubate him and I just think, boy...oh, I know how they must feel..... This is somebody's son, this is somebody's brother (emergency room nurse).

The family-patient relationship also influenced nurses when the family had withdrawn from the patient and was less frequently in the practice setting. In some instances, nurses assumed the role of surrogate family member and became as distressed about patient losses as if the patient were their own family. Illustrations of this theme are presented in the words of pediatric nurses:

I think...you can develop an emotional bonding...when the parents aren't there very often. You're usually the person who is caring for that patient, for that child, rather than the parents being there and taking them for rides in the wagon and giving them their baths and stuff.

His parents were those type of parents that [are] frustrating for every nurse. But demand the most of you and give nothing of themselves. They may see him once a week, they may see him three times a day, they may not show up. It was just very hard to have him suddenly go that way without any preparation, without being able to say goodbye.... I wonder, his parents, that they didn't seem to care.

Family response. Informants frequently talked about family members suffering and grief and their own responses to family suffering. Nurses cared about and empathized with families and felt their suffering. Their own family feelings allowed them to deeply sense the suffering of patients' families; at times they expressed a desire to care

for their own families through their care of patients. This theme is illustrated in the words of several nurses:

It was just really sad to see the family too. I think I get more upset thinking about the family than the patient. They suffer probably more than the patient has in their way and it's just really hard.... After awhile, you feel like you are in their family.... I keep hoping that what I am doing for some of these patients, maybe somebody back there will do for my dad, too. I don't know, you just feel like a member of the family after awhile (oncology nurse).

I get into families a lot, a lot of times more than the patients.... I don't know, I guess I see [patients] that remind me of my folks, you know. And I just know what I would like to have done for them, as a family member of a patient, what I would like to have done for them as a patient (medical nurse).

[With] most of my patients, its the family that I become more involved with.... I don't know if I grieve so much for that person as for the family that's losing them (special care unit nurse).

I think you get involved with the family more especially if it's a death. You don't get involved with a dead person (emergency room nurse).

Family as care-recipient. The nurses in this study viewed families as in need of nursing care and, often, families and nurses became closely involved as nurses provided patient and family care. A pediatric nurse said this:

We do tend to get a lot closer to the family. In pediatrics, we're always open and we do deal with the family a lot more than the adult floors do. They need that. You are caring for the family in some situations as much as you are caring for the patient.... You have to take time out to talk to Mom and kind of feel her sadness as she's crying. Maybe you'll start crying a little bit too.

Another informant said this as she talked about her previous work with oncology patients:

I am not so sure if its the patients themselves that need as much as it is the family. I have found that the families need a tremendous amount of support and they look to us [nurses] for that support...[families'] just don't have the same feeling with [the doctor] as they do with the nurse.

A nurse working on an orthopedic-neurological unit described a situation in which the staff, being very involved with the care of a dying woman, had been unable to provide care and support for the husband whom they believed had also needed nursing care:

I didn't even think about it until a few days before she died. Her husband was completely distraught. He wasn't hospitalized but it was really strange that he wasn't, he was in such bad condition. He had no one else to help him. They had a son and daughter who lived far away and were not close to the parents at all.... And so this man, the husband, was there all by himself.... [He] would lay his head on her bed, just crying and crying. And we were so involved with keeping her alive that we didn't even realize [what was happening to the husband] until after the death.

In this situation, the staff believed that they had performed less than optimally in the nursing role because they had not attended to the husband's needs.

Summary. Families were important to nurses in several ways as discussed above. The family-patient relationship and the degree of family involvement affected nurses' involvement with patients. Families' responses were found to be related to nurses' responses; that is, nurses suffer as families suffer. And finally, nurses in this study saw the family as care-recipient. In the process of providing care for families, they came to know and to be involved with the concerns of the family. As stated by a surgical nurse:

A lot of times the doctor will come in with me to tell [the family] they are dead; then he leaves. So here I sit... it takes a lot of energy from me. I guess I feel emotions very well. I deal with [emotions] because I know that's an important part of family care and patient care.

Practice Setting Factors and Processes

In addition to the previously described factors relating to nurse, patient, and family, experiences of loss and grief among informants were found to be influenced by several interacting factors and processes in the practice setting. For each of these factors and processes, themes in the informants experiences were identified.

Patient-care requirements. Certain factors related to patient-care requirements influenced nurses involvement with patients and their subsequent experiences of loss and grief. These factors included intensity, density, and duration of patient care. Intense patient-care situations are defined as those which are critical and/or extremely demanding of the nurse's immediate involvement and attention. Dense patient-care situations are those which require frequent, repetitive, time-consuming nurse contact with the patient. Duration in a patient-care situation has to do with the time-span of the nurse-patient relationship.

The patient-care requirements among the case examples described by informants were related to each nurse's specific area of clinical practice. That is, nurses working on specific clinical units generally provided care for groups of patients whose health conditions imposed demands for certain types of nursing care. In this study, emergency

room nurses most often provided high-intensity patient care of short duration. Among nurses working on medical, mental health, oncology, orthopedic-neurological, pediatric, renal dialysis, and surgical units, high-density patient care of a longer duration was most often reported; on each of these units, high-intensity care situations were less frequently encountered. Special care unit nurses most often provided patient-care which was combined high-intensity and high-density; duration of care ranged from one shift to several weeks.

Because of the smaller hospital size in the rural communities, the generalist nurses often worked in a variety of nursing roles during a given work shift and also over a period of time. In some situations these multiple roles influenced nurses' experiences of involvement with particular patients. After describing the hopelessness of resuscitation measures provided for a young child who was brought into the emergency room dead-on-arrival following an accidental injury, a rural-area nurse said this:

I was a delivery room nurse at that child's birth, so she was two years old...I thought that was one of the neatest deliveries that I can remember in my mind and I think...I did a lot of work on that one at home. A lot of crying, a lot of dreaming.

In this example, the nurse had been involved in the child's care during birth and death, both of which were high-intensity care situations. In addition, nurses working in the smaller hospitals often described case examples which involved care delivery including features of intensity and density which spanned a period of time.

In the interview analysis it was found that nurses most often experienced loss and grief in those care-situations that included high-intensity and/or high-density factors. In the high-intensity patient-care situations, nurses had a significant professional investment in the outcomes of their care and, in some instances, formed a personal attachment to the patient even when the nurse-patient relationship was of short duration. The following examples illustrate the high-intensity patient-care factor as a source of nurses' involvement:

You can go through labor with a patient and [although] you don't really know the specifics of them, you know the spirit of them. I think when you go through either real happy times or real bad, that's one of the advantages...we have the privilege of being with life and death (generalist nurse).

I wanted the little sucker, very badly, to live.... I spent an hour looking at his little face, washing his eyes out with saline to make sure he wasn't going to get any worse than he already was. If anything, that probably gave me a little more connection to him (mental health nurse describing an emergency room situation).

In other situations, high-density patient care promoted the nurse's involvement with the patient. In these situations, the nurse spent more time with the patient, often over an extended period. In the following quotations, high-density patient care is illustrated:

She started to die the first day [I was on the unit] and she died about the ninth day. Well, at that stage of the game we were pretty close. We had a long involvement with her [the patient]. We had worked so hard, you know, turning and regularly checking on her (surgical nurse).

That was one of the [patients] we talked about a lot at work.... For one thing, she was a lot of care, somebody that takes up a lot of your time.... She had a lot of things, you know, IV's, meds, and a lot of physical care.... When you have that much care you also get

involved more with the actual patient because you are spending a lot of time with them (medical nurse).

When describing her response to patients with cancer, an informant illustrated the three factors related to patient-care requirements and how these influenced her involvement:

Everything seems so acute because it's the first time they deal with it [a diagnosis of cancer]....I tend to get really attached to leukemic patients too...I am assigned to them a lot more...they have a lot of care, even basic things, teaching, drugs, chemotherapy, and I can teach them.

In specific patient-care situations described by this nurse, recurrent admissions for treatment and thus, nurse-patient relationships of long duration, were common occurrences. In situations such as these, nurse involvement was influenced by the initial high-intensity care requirements as well as by the high-density care provided over a long period of time.

It was found in this study that nurses had more intense reactions to patients whose care included high-intensity, high-density contact in spite of the duration of the nurse-patient relationship. Duration influenced nurses' reactions in some care situations in which the patient, because of nursing contact over time, became more personally known to the nurse.

Nurse-role requirements. The responsibilities and requirements of performance in the nursing role were found to influence nurses' involvement with patients and the ways in which they experienced grief and distress in particular care situations. This finding is closely related to patient-care requirements. That is, as nurses delivered the

care needed to meet patient-care requirements, they became involved with patients and experienced responses to them.

Because the sample was composed primarily of nurses whose main nursing responsibility consisted of the delivery of direct patient care, nurse involvement was discussed most often in this context. That is, loss and grief arose for these nurses as they carried out nursing responsibilities in direct relation to the patient. Whether the nursing role involved the short-term provision of emergency care and resuscitative procedures or the long-term provision of maintenance and comfort measures, nurses experienced loss and grief in relation to the performance of their professional responsibilities. The following quotation illustrates this theme in the informants' experiences:

Life-flight events usually aren't very ordinary. You see the nurses come back, I have come back myself and felt that way...they are overwhelmed. You know, they did what they had to do and they probably did it well. Now it is over and you can just see on their faces [that] they need to...share that. It can be real difficult in a small helicopter on a black night, it can be real difficult (emergency room nurse).

Another theme related to nurse-role requirements which emerged in the analysis had to do with nurses' work-load and patients' emotional needs. On the one hand, nurses in this study believed that emotional care for patients and families was a legitimate aspect of the nursing role as well as an important aspect of patient care. On the other hand, their experience was that the work-load did not allow them to provide the emotional care which they believed was important. A related theme which emerged was that as they provided emotional care

for patients, the nurses themselves became increasing emotionally vulnerable.

Recalling her experiences when working with oncology patients, one of the nurses made the following comments:

They [administrators] don't always give us time to interact with the patients on that basis. Their interest is in us taking care of the physical needs and I don't know that they are interested in emotional needs, though I don't feel that you can really separate them.... [For example] some [patient] who might be having a lot of pain, you can get them a hypo and that's all they need. Maybe [another patient] doesn't need a hypo, they need...you to spend some time just talking with them, just giving them a backrub or just holding their hand and not saying anything, just being there.... If we are doing this type of nursing we feel guilt because you can't always document all these things, 'Stood for half-an-hour holding patients hand.'

A nurse with supervisory responsibility said this about nurses' and patients' emotional needs:

I think the literature has to be geared toward the nurse. If you think about it, a lot of the literature we read [has to do with] how to deal with the man who's dying.... When you talk about emotional needs of the patient, well, you can't do that until your own emotional needs [as a nurse] are met effectively.

A pediatric nurse described her emotional involvement when meeting the emotional needs of children and how this related to her role:

There have been times when I have gone to [the head nurse] and said, 'I just can't take care of this patient anymore because I am getting too close, I need some space to be able to back away from this child'.... You know that this child needs a little extra love and support and for you to give it would just bring that attachment too close to you and you either can't handle it because of the stress situation on the [unit] or the [work load] is such that you will not have time to give that child a little bit extra and you don't want to put them through 'I don't have time for you'.... You feel guilty

when you do that...you are supposed to provide for all the needs of the patients and sometimes you can't.

As described by this nurse, emotional nursing required the time to provide emotional care. It also involves the emotions of the nurse.

As stated by an orthopedic-neurological nurse:

Emotional nursing care requires an emotional commitment from you.... [Whenever] you have to give something emotionally or psychologically its going to affect you.

This same theme is illustrated in the words of a special care unit nurse:

I feel that nursing is an emotional job and I feel that if a person cuts [that off] completely, they become too mechanical and they're not a caring person anymore. And we need support. We need to understand our feelings about how we're involved with our patients, our patient's family. We need some support.

Interpersonal context: Staff. The staff interpersonal context of the practice setting was also found to relate to nurses' experiences of loss and grief. Staff responses to certain patient-care situations affected informants' experiences and their perceptions of these experiences. In a situation described by a generalist nurse, a sudden pediatric death involved her in assisting another staff nurse whose own infant had died several months earlier:

It was so much like her own that she had lost. She was crying and it was real hard for me to help her.... I had to first help with the code and then know when to transfer and the nurse I worked with, like I said, was hysterical and so I just had to kind of help her along and I just had so many things to do that I just...kind of blocked it off and cried about it later.

Another nurse described her response to a patient whom she had not been assigned to:

I never met this patient. She was on our floor...for a month. I never had the opportunity to take care of her but the other nurses would talk about her. [She went home to die] and it kind of freaked me out [when] I opened the paper the next day and saw her name in the [obituaries].... I felt like crying, it really upset me...I just don't know why I should feel such a sense of loss over somebody I didn't know (medical nurse).

This patient was known to this nurse as a result of the interpersonal context of the work unit and, in spite of having no direct involvement in her care, she had emotional responses to the patient's situation.

These examples illustrate some of the ways that nurses' experiences of loss and grief were influenced by the interpersonal context of the work unit. It was also found that the staff interpersonal context conveyed certain messages pertaining to nurses' involvement with and responses to patients.

Informants' views about the appropriateness of their own personal involvement with patients were related to how they perceived other nurses' opinions about such involvement. And, while there were some differences among work units, certain norms relating to nurse involvement could be identified.

The norm relating to nurse involvement among study informants was that nurses should not get involved with patients. At the same time, if nurses make the mistake of getting involved, they should not show their feelings, especially with other staff. These norms led to the belief that their personal involvement and feelings about patients and their emotional reactions in certain care-situations were unprofessional, unusual, and unacceptable. Nurses in this study did not know

how other nurses felt about their patients. The following quotations illustrate these norms:

I often wanted to send cards to people, sympathy cards, but I have never done it.... I guess [I think] it is not professional or something. Who cares if a nurse at the hospital feels sad, you know.

Nobody ever commented.... There was no supportive statement about myself or anything. [The message was] if we harden our hearts, we would be okay. I just felt so totally isolated. Was this [involvement] okay in nursing? You know, am I wrong? Do I get too involved? Where's the right and wrong in nursing?

I don't know about other nurses' involvement with patients. I wonder if I get carried away.... And I think most of [us] nurses, a lot of times, don't know how bad we really feel.

I honestly believe we have been educated...that we just go on [in spite of our involvement and feelings], even close the book and we just go on. But as nurses we have to be educated and supported verbally that it's okay if we are human. And its okay to give more than 50% to that [patient].

One of them [other staff], in fact, said to me something to the effect that I can't take it, why do I let myself take it that hard. I'd better get a handle on it. And I thought that they were wrong.

On the work unit which seemed to convey an acceptance for nurse involvement, these nurses did not know about how nurses employed on other work units were involved with patients. And, in addition, for individual nurses who believed that emotional involvement and response to patients was acceptable for them, lack of knowledge about other nurses' experiences in relationships with patients was the common theme.

Summary. Specific factors and processes in the practice setting were found to influence nurses' experiences of loss and grief. Patient-care requirements determined the intensity, density, and duration of the nurse's contact with the patient. In the performance of the nurse-role requirements, direct contact with patients and their families influenced nurses' involvement. Nurses believed that nursing care involved emotional care for patients and, at the same time, they viewed their work-load as an interference in the provision of emotional patient-care. Norms related to nurse involvement in the nurse-patient relationship, as conveyed through interpersonal context of the work unit, were also found to influence nurses' experiences.

Coming to Terms with Loss

When informants were asked to describe what had helped in coming to terms with their experiences of loss, they talked about the people and events which helped them manage their feelings as well as how they had coped with their responsibilities at work. They also talked about what had been unhelpful and how they could be helped more effectively in the future.

Several themes were identified which related to how these nurses had managed their experiences of loss and grief. Within each of these themes, an analysis of what was viewed as helpful and unhelpful allowed for the identification of these nurses' views on how their experiences of loss and grief could be more effectively managed.

Expression, support, and understanding. As described earlier, all nurses in this study had processed experiences of loss and grief through sharing their feelings and thoughts with others. This expression and sharing had most often occurred with a trusted, significant individual in the nurse's personal life. While a member of the nurse's family was most frequently reported as providing attention and support for the distressed nurse, close friends, nurse friends, and peer nurses at work were also recalled as being helpful in some situations. In all cases, emotional expression and the discussion of feelings occurred within the context of a trusted relationship. A generalist nurse described what helped her after a particularly distressing loss at work:

My sister [helped most] I think. Mostly just being there and caring and crying with me. Just understanding. To talk, to express your feelings, to demonstrate your feelings with other people.... One supervisor at the hospital...was helpful. They understood well enough to let me talk and [they] listened (generalist nurse).

Of particular importance to nurses in this study was the sharing of feelings with someone whom they believed understood their feelings and experience. Thus, although nurses often shared feelings with trusted individuals in their personal lives, they believed that sharing their distress with an individual who understands the experience would be more helpful. The following quotations illustrate informants' views about expression and support:

My mom is always willing to listen to what is bothering me at work. The only problem is, when you are trying to talk to a person who is not at all familiar with the medical field, they usually really have no understanding about what you've been trying to say as far as any

stressful thing that you might have come up against but you really need to talk to someone. They'll gladly sit there and listen but they won't know a thing about what you're talking about.... You just want to quit [talking] (pediatric nurse).

I told my husband about it that night but he only listens, he's not real communicative. I don't know; I wanted more from him then but I didn't get it. It is hard for him because he doesn't know the hospital and he doesn't really understand, I think. But he was a good listener and I knew he cared.... I remember being frustrated because there was nobody on the job to share my feelings with (emergency room nurse).

Even when sharing with another nurse on the work unit, understanding was viewed as important. As stated by another emergency room nurse:

The two gals that work with me during the day, they are pretty good about this [listening to me] but neither one of them fly. They have never been there so...I don't think they can relate to it.

Informants believed that expression and support in the work setting would be helpful in dealing with their distress about patients. This seemed to be important to them even when they felt supported outside of the work setting. As stated by a medical nurse:

It sure helps to have someone at home that you can talk to about your day. And I guess I have sometimes even told my sisters long-distance about somebody [a patient]. Having a friend at work helps a lot. Other than that, I don't really have any idea [what would help except] maybe getting it more out in the open that you have feelings like that.... I think about all that I would ever really need is a person at work, we could get together and talk about it.

Thus, while nurses valued and felt helped by support away from the work unit, they also wanted and needed support and understanding within the context of the work environment. At the same time, lack of

personal support and understanding at work was the theme in these nurses' experiences. One of the informants said this about support for nurses on her work unit:

There seems to be no plan when these feelings take place.... There is no understanding at all [about how to manage your feelings at work] so most people just end up taking it with them to their friends and possibly share it then...there is no plan for nurses' feelings. [The message is that] you can't get upset about this and that you have got to deal with it. I guess my point is that you do deal with it so it is still okay to be upset.

Legitimizing nurse feelings. Other nurses who were having similar experiences in patient-care situations were viewed by informants as individuals who understood because they really knew what it was like. This understanding provided affirmation for the nurse's self-worth through the legitimization of the nurses' feelings. The theme related to this process had to do with the importance of knowing that nurses' feelings about patients and their distress in certain care-situations were legitimate and acceptable.

A nurse with supervisory responsibilities said this:

I've never seen a head nurse come up to me and say, 'Gee, it sounds like you guys really had a bad time last night [with] the lady dying.' They may comment about it but not in a way that they really want any information about how you're doing about it. [It would be helpful if they said] 'Yeah, it was terrible and it's okay to feel that way and I feel that way too.'

This nurse believed that it would be helpful to talk with a head nurse who wanted to know how she was doing and who let her know that her feelings were okay and shared by others. Another nurse, when asked to describe what she meant when she had said "We could have had more support", made the following comment:

I guess at that point I was talking about [that it would have been helpful to know] that it was okay to be upset. It was okay to be upset when somebody died or when you sent them home.

Another nurse said this about what she believed would help nurses:

I think it should be known [that] as a nurse it's okay to be involved. Nurses don't know that.

Sharing among work unit staff was found to be inhibited due to the norm regarding expression of feelings in the work role. When asked about the extent to which nurses share their feelings with one another, an informant said this:

[Nurses], especially when they're on duty, feel that you should be professional, that you should be able to handle things and so you learn to block a lot of feelings or hold them inside or not show them until later and you just get used to holding them and then you don't talk about them later.

The significance of legitimizing nurses' feelings and the value of this in contributing to nurse understanding and support was described by another informant in this way:

The things that helped me the most were the people that came up and said, 'You know, everybody...needs these emotions to help you grow. They give you insights.' That was so much better to know that it wasn't abnormal to cry because you lost a patient or to feel guilty about that loss. It made you a better person because if you didn't get something positive out of it, you wouldn't be able to handle it. Nurses would burn out with grief.

Cognitive assistance. In care situations in which informants had been particularly distressed, assistance with problem solving had been found useful. As illustrated earlier in the findings related to nurse grief, specific nurse actions aimed at helping distressed staff cope with the on-going demands of the work role helped others to complete

their work and manage their responsibilities. Less distressed nurses, on occasion, were able to assist with this sort of problem solving when other staff were unable to cope.

A frequently mentioned aspect of cognitive assistance was the helpfulness of critical-incident conferences and patient-care reviews. These meetings, in which staff processed what had happened in particularly difficult care-situations or how they were managing a particular patient, provided nurses with a mechanism for dealing with their feelings related to loss of professionalism and loss of the comforter/helper role. When nurses knew that they had done their professional best and received this feedback in critical-incident conferences, they were able to manage their feelings better. Patient-care reviews also relieved guilt, ambivalence, and apprehension as nurses came to terms with the realities of a particular care-situation. At times, processes involving feedback for the nurse occurred less formally. The following quotations illustrate this aspect of nurses' experiences in processing their loss and grief:

I had a lot of support from Dr. _____ who is our medical advisor.... I guess it was a real decision type of thing for me and I wanted someone to tell me that I made the right decision (emergency room nurse).

I think that it's really excellent to go over all emergency deaths, any deaths, and talk about what happened to ease people's sense of guilt.... I think it's a must for people to feel like they can go on, because you can really just take that in and become incapacitated by thinking 'I just can't do this' (generalist nurse).

As helpful as these formal and informal review and planning conferences had been, several processes in the practice setting were

seen to interfere with achieving maximum benefits from them. Critical-incident conferences were not regularly or consistently planned in the staff schedule. That is, difficult care-situations and critical incidents were not always reviewed. In addition, when these were scheduled, the review may have occurred several weeks following the incident. Nurses needed to consistently process distressing situations at a time when the event was current. An emergency room nurse said this:

You know, if we could have discussed her case and just gone over it step-by-step...it might have helped to know some of the facts.... We share informally [among the staff]...but when you're the only one there and at the last minute you scream for help.

In this situation, a formal critical-incident conference would have helped this nurse who had been alone at the out-set of a particularly difficult situation. Another nurse said this:

Our monthly [unit] meetings are usually a waste of time.... I think those meetings need to be more personal. [There needs to be] more sharing, talking about patients, what might have happened to one of us, or what took place and how we felt about it...I always felt that we should join together as a group and discuss things that have taken place...and why they were bad and why they were good and next time what might be different.

Critical-incident conferences and the care-situation reviews were seen by these nurses as useful in helping them come to terms with what was distressing to them. At the same time, these staff discussions provided the opportunity for nurses to share their knowledge and thus to sharpen their skills. Improving skills, both technical and interpersonal, was seen as something that had been helpful. Informants also believed that continual skill improvement would help them

manage their feelings better in the future due to increased competency.

Two generalist nurses described this in the following ways:

One of the things that I found most helpful for me personally [was] a couple of [staff] sessions with the mental health people...one of the most helpful things is to have somebody give you a few words to use...[I felt] more skilled.

The Hospice group and a girlfriend [who worked with Hospice] helped a lot. I was...asking her about things that I should be doing with the husband, how can I help him deal with it...I did go to some [Hospice] workshops at that time too to find out more about it. Techniques I could use and how to deal with it better.

Physical assistance and support. Nurses in this study continued with the work shift and their regularly scheduled work assignments when they had experienced loss even in situations where they had been intensely distressed. Instances were recalled by five of the nurses in which other staff had needed time off from the regular work schedule due to intense distress or acute grief. Informants described the belief that they had needed time away from work at times and some had built in this time away by working part-time. In some instances, nurses recalled being given a lighter assignment after some distressing experiences. Needs for physical relief and/or time away from the unit are illustrated in the following quotations:

Our supervisors on night shift are really good about it if they know you have had a really rough night the last four nights, give you something easy, give you an easy load, ask you if you want to take that patient again, give you a choice.

I think you would find less burnout...and I think they would probably have fewer sick days if the nurses had more emotional support. I think sometimes they get sick of being here and they just have to stay away.

Denial and detachment. A frequently mentioned aspect of nurses' experience of distress in relation to patients was the need to protect oneself from the personal pain and distress which develops in the context of caring for patients. When describing this, informants talked about building a wall between themselves and patients, distancing themselves, avoiding certain patients, transferring patients to another unit, and standing back from certain situations. They believed that a focus on physical and technical aspects of care, that is, the hands-on and mechanical responsibilities, provided some protection from emotional involvement and the emotional pain which this involvement generated.

The following quotations illustrate informants' views on detachment and denial and their experiences as they attempted to protect themselves from the pain of involvement:

I wanted to stay and keep my distance, do you know what I mean? I felt like she was going to die...but yet [I was] just becoming more and more attached to her each time I saw her. Because of the reasons, like I said before, she was so nice about everything and had to go through so much.

We have a couple of patients up there now that I have found I'm kind of emotionally standing away from. When they've been [on the unit] so long, I think if I really went in there and got to know them, that I would grieve for them. I just have to because the person is so neat and you don't know what to do, and you're so sad.... I emotionally cut myself off with the ones that are long-timers.

You can't afford to let yourself get emotionally attached to every patient or you could just not stand the stress or grief.... That's real hard to say how you put the distance between yourself and your patients because it is almost an unconscious shield and you are not sure how you do it, you just know you do.... There's just not enough of you to go around.

This same nurse elaborated later during the interview about emotionally distancing from patients:

Well, every time you get burned, you back off, build those walls up a little bit higher and thicker. The things I do as a nurse [hurt] and those walls are necessary to avoid hating yourself.

She had also found that, at times, attachment and caring developed despite efforts at distancing:

I was not going to get hurt.... What surprised me so much was that I hadn't recognized the attachment I had for him until the moment of death.

A nurse on another unit made the following observation:

A greater percentage of the staff on the unit, they deny, they separate, and you can almost see the wall. There is the emotional [over here] and the physical [over here] and you just put all your energy into the physical.

For the informants in this study, attachment and caring in nursing often generated feelings of grief, sadness, and loss that were painful and difficult to deal with. Nurses attempted to create emotional distance from patients in order to avoid the pain associated with caring. Sometimes these efforts were successful in protecting the nurse and, at other times, involvement and attachment developed in spite of the nurse's effort to protect herself.

Study informants believed that their patients had emotional needs and, thus, emotional care was a component of the nursing care provided. As nurses provided this type of care, however, they themselves became increasingly vulnerable to their patients' pain and suffering; they became vulnerable to personal pain, loss, and grief as

they came to know the emotional aspects of their patients. As described above, nurses attempted to keep some distance from patients when their own vulnerability was threatened. Thus, nurses providing emotional care needed to be emotionally supported themselves.

Summary

Study findings, including results of the preliminary survey, demographic characteristics of the sample, and interview findings have been presented in this chapter. Interview findings related to informants' experiences of loss and grief were described using the data categories and themes identified in the content analysis. Factors and processes which were found to influence and relate to these experiences were presented. Throughout the presentation of interview findings, the themes in informants' experiences were identified and described. Direct quotations from the interviews were used in order to illustrate the data categories and themes related to nurses' experiences of loss and grief which emerged in this study.

In the final chapter, a discussion of these findings is presented. This discussion includes a summary of the findings and related conclusions. The implications of the study are described and study limitations are discussed. In conclusion, recommendations for future research are presented.

CHAPTER 5

DISCUSSION OF FINDINGS

In this chapter a summary and discussion of the study findings is presented first. Conclusions and the implications related to these are then discussed. A discussion of the study limitations follows. In conclusion, recommendations pertinent to nursing theory, education, and practice are presented.

Summary and Discussion of Findings

The nurses participating in this study experienced loss and grief in their clinical practice in the hospital setting. These experiences were found to occur in both the personal and professional aspects of their lives. As stated earlier in the presentation of study findings, the norm for this group of nurses was personal involvement with patients through caring and empathic relationships and professional commitment to the ideals of helping, comforting, and saving lives.

These nurses experienced loss related to the suffering and losses of patients and their families and to the discharge or death of certain patients who had become personally important to them. They also experienced loss when they felt inadequate in their professional role performance or when nursing care did not comfort or protect, or save a patient's life in some situations.

These findings suggest that it is not simply the association with patient losses that is distressing to nurses. Rather, loss has to do with the values and meanings attached by the nurse to a particular patient-care situation and the nurse's emotional investment in the nurse-patient relationship. These findings coincide with views related to bonding, attachment, and loss in adult life as described by Marris (1982).

In terms of attachment theory (Bowlby, 1980), patients and their families relied on the nurse for care, comfort, and support. In response to this, nurses provided needed caregiving as a part of their professional role. In providing this care they became involved as a person with patients and, in some situations, with the patient's family. When efforts to protect, comfort and provide security for those in their care were unsuccessful, these nurses suffered both personal and professional loss and distress.

Nurses in this study experienced grief in response to their losses and described changes in their feelings, thought processes, behavior, physical health, and attitudes as they grieved. The intensity and duration of grieving varied among nurses and for the same nurse over time depending on the perceived significance of a particular loss. Some losses resulted in only brief feelings of sadness, while others led to intense distress and a wide-range of symptomatology lasting for several days or weeks. In some instances, nurses continued to have feelings and thoughts about specific care-situations months or years after the event.

Emotional and behavioral responses to loss were most often reported by nurses in this study as they described their experiences of grief. All nurses had experienced feelings of sadness, helplessness, hopelessness, and guilt in situations described. In instances of intense distress, they had cried and talked with others about the distressing situation and their feelings about it. This finding is consistent with findings by other investigators (Bowlby, 1980; Engel, 1964; Lerea & LiMauro, 1982; Lindemann, 1944) who have reported the most frequently experienced symptoms of grief to be psychological in nature.

Using the grief model proposed by Frears and Schneider (1981) in this study also allowed for the identification of cognitive, physical, and attitudinal responses to loss. For example, nurses experienced preoccupation, difficulty concentrating, headaches, digestive disturbances, fatigue, and attitudinal distress. Thus, study findings document that nurses experience grief reactions which include the symptoms found in other populations in which loss and grief have been studied (Kübler-Ross, 1969; Lindemann, 1944; Parkes, 1972).

Experiences of loss and grief had both personal and professional ramifications for nurses in this study. In addition to sharing their thoughts and feelings about particular care-situations with other individuals in their personal lives, these nurses had also experienced pervasive distress and sadness which was reflected in insomnia, dreams, and nightmares and fears about their own families. Preoccupation with and concern about particular patients extended into their

off-work time and had resulted in the desire and efforts to keep informed of a patient's condition or to make contact with a patient or a patient's family following a death or discharge.

In terms of professional consequences, nurses had experienced difficulty in concentrating on required tasks; they had also felt the need for assistance and relief in their work assignments. In some instances, nurses had worked an extra shift or had returned to the unit to work on a day off in order to provide care for a patient about whom they were particularly concerned or distressed.

Based on nurses' descriptions of their experiences, loss and grief were very real and common experiences for them in their clinical practice. In some situations, extensive consequences, both personal and professional, had accompanied their experiences. It was also found that nurses' experiences were not dependent upon the clinical practice area. That is, all nurses experienced loss and grief in relation to their work with patients regardless of the particular clinical practice area in which the nurse worked.

Experiences of loss and grief developed within the interpersonal context of the work situation and were related to the nurse's personal caring and involvement and professional investment in certain care-situations. In the case examples described, loss and grief had occurred in relationships in which the nurse's involvement ranged from empathic sharing to those in which the nurse experienced bonding or family feelings in relation to the patient. These relationships were characterized by nurse caring as described by Leininger (1980).

Patients were viewed and valued by nurses as separate and unique individuals whom they came to care about (Watson, 1979).

This caring and valuing in relation to patients, experienced and enacted within the boundaries of the professional nurse role, affected the person of the nurse and elicited emotional responses in the nurse. Gow (1982) described this process of reciprocal effects in the nurse-patient relationship when she stated that concerned, sensitive, and caring nursing actions give rise to emotions in the nurse (p. 300). Nurse theorists Tavelbee (1971) and Paterson and Zerad (1976) also contend that the nurse-patient relationship has the potential for affecting the person and experience of the nurse.

Several interacting factors and processes, including nurse, patient, and family factors and certain factors and processes in the practice setting were found to influence nurses' involvement and investment in care-situations. Nurse factors included their values related to involvement in the nurse-patient relationship, the personal meanings associated with particular care-situations, and their personal beliefs. Nurses in this study valued personal involvement with patients and their families and believed that this contributed to the meaning which they found in the work of nursing.

Other personal meanings most often associated with particular care-situations were found to be related to the nurse's age and family and personal losses in the nurse's life. When a patient's age was close to that of the nurse, when the patient in some ways resembled a member of the nurse's family, or when the patient's loss or death reminded

the nurse of a personal loss, the care-situation assumed a very real representation of that nurse's actual or potential personal experience. In these situations, the associated meanings for the nurse had to do with personal feelings stemming from similar past experiences or from experiencing the situation as if it were, or could be, her own. Thus, in working with patients, nurses re-grieved earlier personal losses and they related with a high degree of empathy when patient's losses resembled their own. They also anticipated future, inevitable personal losses as they cared for their patients.

These findings substantiate the belief that nurses are fully human beings (Sarosi, 1968) who react and interact as unique and whole persons (Simms & Lindberg, 1978). The nurse brings personal values, beliefs, characteristics, and a realm of past experience and personal feelings to the work of nursing. These personal nurse factors acted to engage the nurse in relation to certain patients and to contribute to the nurse's emotional vulnerability to particular care-situations.

A wide range of patient factors relating to experiences of loss and grief were described by the study nurses. Of importance was the finding that nurses grieved not only when patients died, but also when patients were discharged or suffered irreversible losses related to their health condition. Those patients that were young or close in age to the nurse's age, patients whose death was sudden or unexpected, and patients whose condition or death involved intense patient or family suffering were most distressing to nurses.

Two other patient factors, including the patient's attitudes about death and personality characteristics influenced the way in which nurses became involved with patients. Those who were accepting of death and those with positive personality attributes were seen as individuals from whom the nurse could learn and with whom the nurse established closer relationships.

Certain family factors were found to strongly relate to nurses' experiences of involvement in relation to patients and their subsequent loss and grief. Nurses' responses in care-situations related to the family-patient relationship and family responses; feelings of loss also developed as nurses provided care for families. When the family was frequently present in the practice setting the nurse came to know the patient as a person through that patient's relationship with significant family members. This was particularly influential when the patient was unconscious. In other cases, nurses became involved with patients when, for whatever reasons, the family was rarely in contact with the patient. The nurse-patient relationship in these cases assumed characteristics of a family relationship and nurses grieved in the absence of family grieving. This finding supports the contention that caregivers frequently become surrogate grievers in the withdrawal or absence of family support (Fulton, 1979).

When families were present in the practice setting, nurses experienced distress and suffering in relation to families' suffering. In many instances, nurses had accepted the patient's condition and care outcome and then, however, grieved with and for the family as they

suffered and grieved. Closely related to this empathic suffering was the belief among nurses that families were often in need of care and were legitimate recipients of nursing care. Nurses provided emotional support and comfort for families. This, in addition to an empathic awareness and experience of families' emotional pain, increased study nurses vulnerability to personal suffering and pain.

A number of factors and processes in the practice setting were found to relate to nurses' involvement with patients and their subsequent experiences of loss and grief. These included patient-care and nurse-role responsibilities and certain processes occurring in the interpersonal context of the work unit.

In terms of patient-care requirements, nurses experienced loss and grief in relation to the intensity and density of their contact with patients and to the duration of the nurse-patient relationship over time. High-intensity and high-density care-situations (those involving frequent repetitive, time-consuming nurse-patient contact), regardless of the duration, elicited the most intense emotional responses among nurses. In relationships of long duration, the intensity and density factors may or may not have been present. In these relationships, however, nurses became involved and had emotional responses due to extensive interacting with the patient over a period of time.

The nurse-role requirements for nurses in this study had to do with the provision of direct patient care. Thus, nurses' experiences of loss and grief developed within this context. In other words,

nurses were affected by and responded to patients and patient-care situations as they carried out their professional responsibilities.

Nurses believed that the provision of emotional care for patients and families was a legitimate and important aspect of their professional responsibility. This type of care tended to engage the emotions of the nurse and thus, to increase the nurse's emotional risk. At the same time, emotional care was viewed as an aspect of care that was time-consuming while little priority had been given for emotional care in the nurse's daily work assignment. They viewed their work-load, in general, as being too demanding to provide the emotional care they believed was necessary. In one way, then, the provision of emotional care for patients increased the emotional involvement and thus, vulnerability of the nurse. And in another way, being unable to provide emotional care resulted in feelings of guilt and professional inadequacy.

The findings related to the practice setting included data related to the staff interpersonal context. Nurses responded to patients at times due to their relationships and interactions with other nurses providing care for particular patients. They also responded to the distress and loss experienced by other nurses with whom they worked.

The staff interpersonal context also conveyed messages related to the appropriateness of nurse involvement and response in the nurse-patient relationship. It was found in this study that nurses believed that they should not get personally involved with patients and in the event that they did, they were not to share their feelings and thoughts about this involvement in the work setting. This was an interesting

finding in view of other study findings which documented that nurses valued and found meaning in personal involvement with their patients and in the work of nursing. While nurses valued involvement and found in their experiences that involvement was a reality, they were not certain that this was an experience shared with other nurses or that this involvement was professionally acceptable. And while the study nurses described instances in which they had supported other staff in relation to their emotional distress, they did not know specifically how other nurses felt or the extent of their involvement with patients.

A number of themes were identified in nurses' experiences as they dealt with their loss and grief. As described in the study findings, nurses had needed support and understanding, legitimization of their feelings, cognitive assistance, and physical assistance and support. They also believed that efforts to detach themselves from certain patients and situations had been necessary to protect themselves from the pain and personal suffering of closeness and caring.

All nurses in the study had shared their feelings and thoughts about particularly distressing care-situations with others in their personal lives. This sharing was viewed as helpful but often incomplete because these significant others did not understand the nurse's professional experience or the hospital environment. Thus, while expression of feelings was important and helpful to some extent, these nurses also needed to be understood. They viewed understanding as being

possible primarily through sharing with other nurses who had experienced the same or similar situations.

Understanding of this nature had the effect of legitimizing the nurse's feelings and responses. That is, when another nurse understood the experience, certain messages were conveyed to the nurse that it was acceptable and legitimate to be involved and to have feelings about patients. These findings are supported by Bowlby (1980), Caplan (1981), and Engel (1962) who have emphasized the importance of social support and understanding in coming to terms with loss. Caplan (1981) has also stressed the importance of the validation of feelings and the provision of reminders of self-identity and worth during the grieving process. It appears that for nurses participating in this study, these needs could best be met through sharing experiences and processing feelings with colleagues in the work setting.

This finding is particularly significant in relation to the theme that study nurses experienced a lack of personal support and understanding at work. Because of the lack of time during the work shift for staff interaction and also because of the norm related to the expression of feelings in the work role, nurses did not generally share and communicate their feelings about patients among themselves. Together, these processes may potentiate disrupted grieving and less than optimal outcomes to the grieving process (Burgess and Lazare, 1976).

Nurses in this study had also found cognitive and physical assistance to be helpful following intensely distressing patient-care situations. Nurses had helped each other in the completion of tasks and had found a lighter assignment or a change in patient assignments helpful. Critical-incident conferences and patient-care reviews had also been experienced as helpful. These activities provided the mechanism for staff feed-back and sharing related to the care of specific patients and the mechanics of care-delivery. And, while not specifically designed to process staff feelings, these activities had the affect of relieving guilt, ambivalence, and apprehension related to professional losses.

Additionally, these activities had the effect of competence building through the sharing of knowledge and experiences among staff. This collegial sharing also served to validate and reinforce nurses' feelings of self-worth and identity.

Nurses in this study had experienced the need to detach from certain patients or situations in order to protect themselves from personal distress. They had attempted to avoid or disengage from certain patients or situations which they believed would ultimately lead to personal feelings of loss, grief, and suffering for themselves. When this finding is examined in relation to findings about support and understanding and the need for nurses to know that their feelings are legitimate and acceptable, it is likely there is a relationship among these processes. Lack of support and understanding in the work setting, together with the belief that involvement and response in

relation to patients was unacceptable, may have contributed to nurses' attempts to detach themselves from patients. This process, in addition to the desire to avoid the pain of loss and grief, may diminish the potential therapeutic effects of the nurse-patient relationship for the patient.

Conclusions and Implications

Loss and grief were common experiences among nurses in this study who reported brief, as well as intense, prolonged experiences of grief. They reported the full range of feelings and responses known to occur during the grieving process. While these feelings were painful and distressing to these nurses, they also reported difficulty in performance of their work-role responsibilities in instances of intense grief, as well as a carry-over effect in their personal lives. Based on these study findings, experiences of loss and grief can be viewed as stressful events for nurses with potentially disruptive consequences.

Professional and personal investment and involvement in the nurse-patient relationship was the norm for this group of nurses who valued interpersonal commitment in their work. They also valued and were committed to the provision of emotional nursing care for patients and their families which had the effect of increasing the nurse's emotional vulnerability in care-situations. Nurses became attached to some of the patients in their care for a variety of personal, interpersonal, and professional reasons. Attachment led to deep feelings of caring in

the nurse which also increased the nurse's vulnerability to the pain of personal loss and grief. In spite of these commitments and effects, nurses believed that their emotional involvement with and responses to patients were unusual among nurses and unprofessional. The pain and distress of loss and the sense that personal involvement and response were unacceptable led to efforts to detach from patients and a sense of isolation from colleagues. These effects were complicated by the fact that nurses' work-load and daily patient-care assignments were seen as too demanding of their time to provide adequate emotional care for patients or to deal with their feelings with colleagues in the work setting.

Several implications of these study findings can be identified. Professional commitment and investment as well as interpersonal involvement are realities in the work experiences of nurses practicing in the hospital setting. Another predictable reality is the nurse's experience of loss and grief. Practicing nurses need to know that these realities are acceptable and legitimate aspects of their nursing experience. Mechanisms which encourage collegial sharing and support among nurses need to be developed. And finally, nurses' work-load needs to be assessed and modified to allow for the provision of emotional care for patients and the processing of staff feelings.

In summary, it is evident that nurses grieve in response to patient losses and family suffering. This relates to nurses' interpersonal involvement with patients and families. Factors which influence interpersonal involvement include nurse, patient, and family factors

and certain factors and processes in the practice setting. Experiences of loss and grief occur for nurses in all clinical practice areas represented in this study. The major difference among nurses' experiences is that those practicing in the smaller, rural-area hospitals know and have associations with patients and families in the community. Thus, nurses in this practice setting have a greater potential for interpersonal involvement with care-recipients.

Limitations

The design for this research project was based on the review of the literature which indicated the need for qualitative, descriptive study of nurses' grief and loss; no reports of foundational, qualitative exploration of this topic were found in the literature. In addition, the exploration of sensitive topics having to do with personal feelings, loss, and grief is best accomplished using a qualitative research approach.

The methodology provided for the accomplishment of the study purpose which was to explore and describe nurses' experiences of loss and grief which develop within the context of the nurse-patient relationship in the hospital setting. Twenty nurses from ten different clinical practice areas each provided in-depth descriptions of their experiences during an open-ended, semi-structured interview with the researcher. An ethnographic approach was used during interviews. Descriptions were classified using content analysis procedures for the

identification of themes in nurses' experiences and factors which influenced and related to these experiences.

The framework for this study was developed from current literature related to loss and grief, interpersonal nursing theory, and the hospital practice setting. Investigator immersion in this conceptual framework may have influenced the collection and interpretation of data in ways that cannot be accounted for.

While the sample for this study was a convenience sample and the number of informants was relatively small, the experiences that nurses shared in the interviews are probably common ones for nurses. Only key informants can provide this kind of information from which hypotheses can be generated and later tested to learn about the prevalence of experiences of loss and grief among nurses. How common these experiences are is a question for further study.

Only from in-depth interviews with practicing nurses is it possible to learn about nurses' experiences of loss and grief. Repeated interviews with a smaller number of informants would provide more information about nurses' experiences and the related issues and concerns of these nurses.

Recommendations

Further qualitative studies of nurses' experiences of loss and grief are needed. Research studies employing exploratory-descriptive methods and the principles of ethnographic inquiry or similar methods will yield additional useful data about nurses' experiences of loss and

grief from the perspective of practicing nurses. Recommended study methods include the use of smaller samples, repeated interviews with interview subjects, and concurrent data collection and analysis. Such procedures would allow for maximal exploration and description of each nurse's experiences and, at the same time, the in-depth exploration of themes in the experiences of nurses as they are identified during the interviewing process. Future studies of this nature would contribute to an understanding and appreciation of the interpersonal aspects of nursing and the consequences of grief for nurses. When nurses' involvement with and responses to patients are better understood, the effects of these processes on patients may also be studied.

Based on current literature related to loss and grief, interpersonal nursing theory, the hospital practice setting, and findings in this study, several specific recommendations for further research are proposed. In terms of nursing theory, little is known about the nature and extent of personal involvement between patients and nurses. Research is needed to determine the parameters of involvement in the nurse-patient relationship and to describe the potential personal and professional ramifications of this for nurses.

In the educational setting, the ways in which student nurses are taught about the professional nurse-patient relationship need to be examined. Issues related to nurses' personal investment and involvement in relation to patients and the significance of collegial support and sharing among nurses need to be considered by nurse educators.

Research studies which examine how students are taught about nurse-patient relationships and the personal involvement of the nurse may provide useful data in determining the elements which contribute to professional norms relating to nurses' expectations of the nurse-patient relationship.

And, finally, the suffering, grief, and distress of nurses and the processes of nurses' detachment from patients and isolation from colleagues, as realities in the nurses' work experience, need to be further examined in the practice setting. Studies relating to the work stress of nurses must include a consideration of the nurse-patient relationship and interpersonal process as a source of that stress. Future research in the practice setting will provide further documentation and clarification of the actual experience of the nurse in relation to patients and the effects of this experience on the nurse, as well as the effects of this on the patient. It is possible that when nurses are better understood and supported in their work, patients will benefit from improved nursing care.

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APPENDICES

APPENDIX A
LETTER OF INTRODUCTION
PRELIMINARY SURVEY FORM

Letter of Introduction

August 10, 1983

Dear Registered Nurse,

I am a graduate student in the Montana State University School of Nursing and am doing a research study in the area of the nurse's experience of loss and grief which develops within the context of the nurse-patient relationship. Little has been documented about nurses' subjective reactions to patients or to the relationships which occur with patients in nurses' clinical practice. I believe that your assistance with this study will benefit nurses at large and the profession as a whole by adding to our knowledge regarding nurses' emotional reactions in care situations.

Attached is a preliminary study survey intended to identify the numbers of practicing registered nurses who have experienced a sense of loss and grief in their work with patients. This survey is also designed to elicit volunteers for a personal interview; a limited number of nurse volunteers will be randomly selected from those who agree. The interview would be approximately one hour long and would be scheduled on a date, time, and place mutually agreed upon by you and this nurse-student. I will take some notes during the interview as well as tape record the interview session.

Your participation in this study is voluntary. Your responses to this survey and the responses of nurses participating in interviews will remain confidential and anonymous. Responses will be analyzed and summarized together for the entire group of participants and individuals will remain anonymous.

Whether or not you are able to volunteer for an interview, please complete the attached survey. I will appreciate your help with this study. If you have any questions, you may call me at 543-3358.

Sincerely,

Jq Kelly

Jq Kelly, R.N.

PRELIMINARY SURVEY: NURSES' EXPERIENCES OF LOSS AND GRIEF

1. How long have you been actively employed in nursing? (Provide approximate years or months.) _____
2. Are you currently working: A.) FULL-TIME _____ B.) DAYS _____
PART-TIME _____ EVENINGS _____
NIGHTS _____
3. Please indicate your sex: FEMALE _____ MALE _____
4. What is your current area of clinical practice? (Check all those that apply to you.)

_____ C.C.U.	_____ ONCOLOGY
_____ CARDIAC	_____ O.R.
_____ E.R.	_____ ORTHO-NEURO
_____ GENERAL PRACTICE	_____ PEDIATRICS
_____ I.C.U.	_____ RENAL DIALYSIS
_____ MEDICAL	_____ SUBSTANCE ABUSE
_____ MENTAL HEALTH	_____ SURGICAL
_____ OB-GYN	_____ OTHER (Specify: _____)
5. Have you ever experienced a sense of loss or grief in relation to your patient's physical or emotional condition?
 YES _____ NO _____ CANNOT SAY _____
6. If you answered YES to the above question, would you be willing to participate in a personal interview?
 YES _____ NO _____
7. If you are willing to participate in an interview, I will need the following information: (Please complete this section ONLY if you want to be considered as a study interview volunteer.)
 YOUR NAME _____
 TELEPHONE NUMBER _____
 WHEN IS A GOOD TIME TO CALL YOU? _____

Thank you for your help in completing this survey.
 If you agreed to an interview and you are selected
 in the interview sample, I will be contacting you
 this month to arrange an interview.

Please seal this completed survey in the attached
 envelope and place it in the STUDY ENVELOPE on
 your unit. I will be collecting these surveys on
 this date: _____.

APPENDIX B
STUDY DESCRIPTION

STUDY DESCRIPTION

It is a common occurrence that patients and patient care situations lead to feelings and emotional responses in the nurse. In addition to being common, these feelings are also very normal. For example, feelings such as happiness, frustration, sadness, affection, amusement, depression, grief, pride, or irritation seem to occur quite regularly for the nurse in her work with patients.

No one has done much to examine or describe these emotional responses. Little attention has been given in nursing education or in the nursing literature to this aspect of the nurse's experience. Nurses themselves often don't talk about or share their emotional reactions with their nurse friends or colleagues. In spite of the silence, however, as nurses we know or suspect somehow that we are, indeed, human after all. We laugh, we withdraw at times, and we cry (or at least we feel like crying) in response to our patients. Sometimes our patients "get to us" in some profoundly human way. During these times we may worry about our feelings "getting in the way" of our best nursing care. We take our feelings home with us too sometimes, even though we have every intention of leaving them at work.

Some situations seem to be more difficult than others for nurses in general. One of these is the experience of grief and loss. During this interview, I am interested in learning about your experiences with patients that have contributed to a feeling of loss for you. This includes not only your experiences with dying patients but also any of those patients or care situations which seem to generate feelings of grief in you. Feelings such as sadness, depression, helplessness, anger, guilt, and apathy and hopelessness at times accompany grieving. Physical symptoms and changes in our attitude, behavior, and way of thinking also occur sometimes, as well as reminders of other losses in our lives.

I will guide you through this interview with the intention of learning all that I can about your unique experiences. Please read the attached consent form. I would like to answer any questions you have before you sign the consent form.

APPENDIX C
CONSENT FORM
DEMOGRAPHIC DATA FORM

Consent to Act as a Participant
in the Study Entitled:

NURSES' EXPERIENCES OF GRIEF AND LOSS

The purpose of the study, as explained to me by Jo Kelly, a registered nurse in the graduate program at the Montana State University School of Nursing, is to explore and describe hospital nurses' experience of loss and grief which develop within the context of the nurse-patient relationship. I will be asked to describe my own reactions to patients and to the patient-nurse relationship and, during this process, I may experience recollections of other losses I have experienced in my life. Although I will be asked to describe specific patient characteristics, the identity of any individual patient will remain anonymous.

While my participation in this study may not benefit me personally, nurses at large and the nursing profession as a whole will benefit through the addition of information and understanding regarding nurses' emotional reactions to the patient. Ultimately, when nurses are better understood and supported in their work with patients, the patient will benefit from improved patient care.

My involvement in this study will include a tape recorded interview in private with Jo Kelly. This interview has been arranged at a date, time, and place mutually agreed upon by the interviewer and myself. I have the right to stop the interview at any time, for any personal or professional reason. Additionally, I may withdraw from the study at any time; such a withdrawal would be confidential and would, in no way, reflect on my job. Whatever my responses during the interview, no negative consequences shall occur to me or to my employing agency.

My responses and descriptions during this interview will remain confidential and anonymous. Notes and tape recordings will be analyzed and summarized together with data from other interviews. Individual responses will be anonymous. Any interview data which might identify me personally will be destroyed at the conclusion of the study. I understand that the results of this study may be shared with other nurses through publication.

I have had the opportunity to ask my questions about the study and have received satisfying answers. I am aware that I am not being paid for my participation in this study. I agree to participate in the study "Nurses' Experiences of Grief and Loss". If I have questions regarding the study, I may contact Jo Kelly at 543-3358.

Signature _____

Date _____

Interview # _____

DEMOGRAPHIC DATA

For the Study Interview:

NURSES' EXPERIENCES OF GRIEF AND LOSS

1. What is your age? _____
2. When did you complete your initial nursing preparation? _____
3. How long have you worked in your current area of clinical practice? _____
4. In what other clinical areas have you worked? _____
5. What is your marital status? _____
6. Do you have any children? YES _____ NO _____ AGES? _____
7. Where did you grow up? _____
What was the size of the town? _____
Did you live in town or in the country? _____
8. Are you originally from Montana? _____
How long have you lived in Montana? _____
9. How long have you lived in this community? _____
What is the size of this community? _____
10. Briefly describe your sources of emotional support (those with whom you can and do share your concerns and feelings):
A. Informal (for example: family, friends, social clubs or groups, groups, etc.): _____

B. Formal (for example: peer nurses on your unit or another unit, head nurse, supervisor, other staff, physicians, religious leaders in your hospital, group support meetings, etc.): _____

11. Do you share an emotionally supportive relationship with another adult in your home? YES _____ NO _____
12. If you would like to receive a copy of the summary of study findings please provide the information requested below. This information will be detached from this questionnaire and filed separately for use upon study completion. Study findings will be mailed to you in January 1984.

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP CODE: _____

APPENDIX D
INTERVIEW GUIDE

Interview # _____

INTERVIEW GUIDE

For the Study:

NURSES' EXPERIENCES OF GRIEF AND LOSS

1. When you answered yes on the preliminary survey to the question, have you ever experienced a sense of loss or grief in relation to your patient's physical or emotional condition, what event or experiences came to mind?
2. Tell me about an experience of grief that is particularly clear in your memory.
3. Which patients seem to trigger a sense of loss and sadness for you?
(CUES: sex, age, diagnosis, acquaintance or friend)
4. Describe the relationships that you had with these patients.
(CUES: professional role responsibility, length of time involved in care, intimacy of care, identification, empathy)
5. Would you tell me, how often are you aware of a sense of grief, sadness, or loss in relation to your work with patients?
(CUES: time frame?)

Tell me about the patient.

Tell me about your relationship with that patient.

Tell me: How did you feel?
How long did you feel this way?
How did you manage to deal with your feelings?
Was anyone helpful to you?
What did you find helpful?
6. When you experience loss or feel sad or depressed in relation to your patient, are you reminded of other patient experiences or any personal losses? Tell me about it.

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