Nurses' Experiences of Grieving When There Is a Perinatal Death

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Abstract

Many nurses grieve when patients die; however, nurses' grief is not often acknowledged or discussed. Also, little attention is given to preparing nurses for this experience in schools of nursing and in orientations to health care organizations. The purpose of this research was to explore obstetrical and neonatal nurses' experiences of grieving when caring for families who experience loss after perinatal death. A visual arts-informed research method through the medium of digital video was used, informed by human science nursing, grief concepts, and interpretive phenomenology. Five obstetrical nurses and one neonatal intensive care nurse who cared for bereaved families voluntarily participated in this study. Nurses shared their experiences of grieving during in-depth interviews that were professionally audio- and videotaped. Data were analyzed using an iterative process of analysis-synthesis to identify themes and patterns that were then used to guide the editing of the documentary. Thematic patterns identified throughout the data were growth and transformation amid the anguish of grief, professional and personal impact, and giving–receiving meaningful help. The thematic pattern of giving–receiving meaningful help was made up of three thematic threads: support from colleagues; providing authentic, compassionate, quality care; and education and mentorship. Nurses' grief is significant. Nurses who grieve require acknowledgment, support, and education. Supporting staff through their grief may ultimately have a positive impact on quality of work life and home life for nurses and quality of care for bereaved families.

The experience of grieving a loss is a significant human experience (Pilkington, 2006). According to the Report on Bereavement and Grief Research by the Center for the Advancement of Health, "Many health care providers experience grief—sometimes profound grief—when a patient dies" (Genevro, Marshall, Miller, & Center for the Advancement of Health, 2004, p. 550). While the literature confirms that nurses grieve the loss of their patients (Brunelli, 2005; Cutler, 1998; Davies et al., 1996; Gerow et al., 2009; Wilson & Kirshbaum, 2011), it does not specifically address how nurses—especially nurses who care for families who experience perinatal death—integrate this experience into their nursing practices. Grieving the loss of a patient is most often researched with respect to nursing practice in oncology, palliative care, and critical care (Wilson & Kirshbaum, 2011); however, nurses caring for families who experience perinatal death and loss may also grieve and thus it is important to explore the experience of grief in this context.

Grieving a loss is a universal human experience that has particular relevance in nursing practice (Saunders & Valente, 1994). Nurses experience losses in different ways according to Papadatou (2000): bearing witness to the suffering of others who are grieving; experiencing grief when a patient, with whom they have developed a close relationship, dies; and grieving their own past or anticipated future personal losses, including the *death of self*—all of which add to the complexity of the experience of grieving in nursing practice. Pilkington (2006) conducted a synthesis of five phenomenological-hermeneutic studies on grieving in which she identified that, regardless of the context of the loss, human beings experience *turmoil, anguish*, and *yearning*. Through the process of grieving a loss, people clarify what is important, what is not, what endures, and how one chooses to continue living (Pilkington, 2006). Loss is something that does not go away, but rather, human beings learn to live with loss in new ways. The reality that nurses grieve and bear witness to the experience of others who are grieving has not been sufficiently

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addressed in the practice setting, and yet, according to Saunders and Valente (1994), bereavement is a "well established threat to health and work performance" (p. 318). Nursing students have described experiencing turmoil when accompanying dying patients (Van Rooyen, Laing, & Kotze, 2005) and have expressed a need for further education and preparation when caring for persons who are dying (Allchin, 2006). Similarly, nurses reportedly struggled with grief and moral distress when they recognized the impending death of a child (Davies et al., 1996). Brosche (2003) suggested that nurses may not even realize their own need to grieve.

We were unable to find any studies that focused specifically on obstetrical and neonatal nurses' grieving when there is a perinatal death. However, two studies were found that explored labor and delivery nurses' experiences of caring for families who experienced perinatal loss (Jonas-Simpson, McMahon, Watson, & Andrews, 2010; Roehrs, Masterson, Alles, Witt, & Rutt, 2008). In Jonas-Simpson et al.'s (2010) qualitative study, nurses described their experiences of caring for families whose babies died as very difficult and requiring courage but it was also an experience that they valued and felt privileged to have. Nurses in the study wished for support from colleagues who listened and truly understood when they could not find this from their family and friends. Nurses worked hard to comfort bereaved families and some nurses also described how they continued to think about the mothers and families, wondering how they would continue on after leaving the hospital. Support from colleagues was a key finding and one participant suggested that a support group for nurses would be helpful on the anniversaries of the babies' deaths, which is often remembered vividly. Similarly, Rashotte (2005) found that, for critical care nurses, focusing on the meaning of stories that haunted them provided "ways to journey through their grief and to live with the mystery of life and death" (p. 34), and Spencer (1994) found support groups and continuing education to be helpful for intensive care unit (ICU) nurses after a patient dies.

The second study found on labor and delivery nurses' experiences of caring for families with perinatal loss was conducted by Roehrs et al. (2008), using a qualitative descriptive method. Ten labor nurses were surveyed and interviewed. Through content analysis, two major categories with corresponding themes were identified. The themes that defined the first category, *coping and providing care*, were (a) focusing on the care the patient needs, (b) finding support while providing care, and (c) recovering after providing care. The second category, *influencing the context of providing care*, was further defined by the themes (a) how to assign nursing staff to provide bereavement care, (b) how to avoid compromising care, and (c) how to become more comfortable and knowledgeable about the care. While both of the foregoing studies (Jonas-Simpson et al., 2010; Roehrs et al., 2008) acknowledged the difficulty and the privilege nurses experienced when caring for families whose baby dies, neither study focused specifically on the nurses' experiences of grieving.

There is limited preparation for encountering the phenomenon of grieving in formal nursing education (Valente & Saunders, 2002). Feldstein and Gemma (1995) noted that few nursing curriculums include courses on death and dying and, we would add, the human experience of grieving a loss. Wilson and Kirshbaum (2011) concluded that education along with support is "useful in helping staff to develop coping strategies and manage their responses to death" (p. 563). More specifically, Chan, Lou, and Arthur (2010) surveyed 573 nurses from three Asian cities about their attitudes toward perinatal bereavement care. The researchers concluded that while there were some differences, the nurses' attitudes were generally positive and moreover, "the goal of quality bereavement care will be enhanced by addressing the educational and training needs of nurses" (Chan et al., 2010, p. 531). We sought to address the research gap and educational need by producing a research-based documentary on nurses' experiences of grieving when families experience a perinatal loss. Art-based mediums have been found to provide meaningful ways to share research findings (Mitchell, Jonas-Simpson, & Ivonoffski, 2006).

The purpose of our research was twofold: (a) to create a research-based documentary that explores nurses' experiences of grieving while caring for a family whose baby dies; and (b) to evaluate how well the research-based documentary affirms nurses in their experiences of grieving and how, if at all, it enhances nursing practice from the perspectives of nurses who view the documentary. This article will report findings related to the first purpose of our study. We believe that our documentary has the potential to provide nurses with support while serving as a powerful teaching tool for health care and teaching organizations on a topic that is often difficult to speak of.

Theoretical Framework

The researchers were informed by human science perspectives in nursing (Newman, 2008; Parse, 1998, 2007; Watson, 2008), which focus on meaning, patterns of relating, presence, and transcendence. Concepts from the grieving literature consistent with a human science nursing perspective also informed this research such as meaning reconstruction (Neimeyer, 2001), relearning the world (Attig, 2004), and continuing bonds (Klass, Silverman, & Nickman, 1996). Together, these concepts create a theoretical tapestry that supports a conceptualization of grieving as a lived experience filled with meaning and patterns of relating rather than a problem or pathology to be fixed. Guided by this theoretical tapestry, the researchers sought the answer to the following research question:

> What is the experience of grieving for obstetrical and neonatal nurses caring for families who experience perinatal loss?

Method

The research was conducted using interpretive phenomenology informed by van Manen (1990) and Parse (2001). According to van Manen, "Phenomenological reflection and explication is [intended] to effect a more direct contact with experience as lived" (p. 78). Parse describes phenomenology as "a noncausal method that relies on description to enhance understanding of human experiences. It is a method of discovery, not verification" (p. 77). Direct contact with experience as lived was enhanced with the use of digital videography (Rahn, 2008; Shrum, Duque, & Brown, 2005) during in-depth interviews, which captured participants' descriptions of grief. Discoveries of nurses' grieving were identified in the description of their lived experiences. The analysis reflected van Manen's processes of reflection, description, writing, and rewriting.

Procedure

Recruitment for the study began after obtaining ethics approval from the university. Six nurses volunteered to participate after receiving an electronic invitation and information flyer through a maternal-child interest group network at the provincial level. Five nurses worked in obstetrics (Labor and Delivery, Family Birthing Center Education, Early Pregnancy Clinic, and Maternal/Child Professional Practice) and one participant worked in a neonatal intensive care unit (NICU). Two of the nurses were between 20 and 35 years of age, three were between 36 and 50 years of age, and one nurse was above 51 years of age. The nurses had practiced between 3 and 30 years with an average of 17 years experience. Among the six nurses, three held a BScN with one working on her MScN; two, a MScN; and one, a diploma along with Perinatal Nursing Certification in Canada. The nurses were all Caucasian and identified their ethnocultural backgrounds as Italian, Russian, Mennonite, and Canadian Jewish. One nurse did not identify her ethnocultural background. One nurse identified herself as Jewish and four identified themselves as Christian; one of the Christian participants specified that she was Protestant, and another, as Roman Catholic. One nurse said she did not have a religious affiliation (see Table 1).

The nurses were contacted by email to arrange an interview. Once informed consent was obtained, an in-depth, semistructured interview was undertaken using questions connected with the human science nursing concepts of meaning, patterns of relating, and transformation. The following are examples of the prompts and questions participants were asked: "Tell me about your experience of grieving when you care for families whose baby died"; "What changes have you experienced related to grieving while caring for a bereaved family?" "How have you grown through your experience of grieving?" and "What helps you when you are grieving?" Further depth was attained using prompts such as "Can you go on?" "What was that like for you?" or "Could you tell me more about that?" Interviews were professionally audio- and videotaped and lasted from 1 to 2 hours, depending on the time required for each participant to share what she wished to share about her experience of grief.

Data Analysis and Methodological Rigor

Data were analyzed using a simultaneous process of analysis-synthesis. As a team, we individually read and reread the transcripts and identified our own interpretations of the data. We came together to share these interpretations and then went through the transcripts together while watching the videotaped interviews. This immersion in the data enabled us to further refine emerging themes and patterns. Consistent with the underpinning human science and phenomenological perspectives, thematic analysis was viewed as "the process of recovering themes that are embodied and dramatized in the evolving meanings and imagery of the work" (van Manen, 1990, p. 78). The visual representation of the data significantly enhanced immersion with the data given that only the principal investigator (and not all research team members) was present at each of the interviews. An advantage of digital recordings is that they do not lose their audio and video quality, and nonlinear editing systems make it possible "to manipulate audio and visual data as if it were text, that is, to edit, cut, paste and modify media for analysis, comparison and presentation" (Shrum et al., 2005, p. 7). Details about the process of data collection and data analysis using digital technology and film editing software will be presented in a forthcoming article.

Participants in the study were each given a copy of the documentary prior to the final cut and were invited to provide feedback. We wished to ensure their comfort with the way their lived experiences of grieving were represented through the clips, photographs, and additional footage. All six of the nurse participants were moved by the film and expressed pride in being a part of the research documentary. The process of data analysis and member-checking provides evidence for trustworthiness of this analysis. More specifically, the above processes helped ensure rigor with respect to Guba and Lincoln's criteria of credibility, dependability, confirmability, and transferability of findings (as described in Streubert & Carpenter, 2011). We continue to learn about the transferability and authenticity (Streubert & Carpenter, 2011) of our findings as we present our research to thousands of nurses and other health care professionals. For example, we have learned that the research is transferable, in that it has relevance beyond nurses practicing in perinatal settings and beyond nursing to health care professionals of many disciplines. Authenticity is continually affirmed by those who view our film and report that it genuinely represents how they experience grieving in practice. For example, many audience members tell us that the nurses in the film could be

Table 1. Demographical Data.

Variables	Total *n*
Age (years)	
20-35	2
36-50	3
51+	1
Practice setting	
Labor and Delivery	2
Family Birthing Center—Education	1
Maternal/Child Professional Practice/Education	1
Neonatal intensive care	1
Early pregnancy assessment clinic	1
Years in nursing practice	
Range = 3-30 years	6
M = 17 years	
Educational background	
Diploma and certificate in perinatal nursing	1
Baccalaureate in nursing	3
Master of Science in Nursing	2
Master of Science in Nursing candidate	1
Race	
Caucasian	6
Ethnocultural background	
Italian	2
Russian	1
Jewish Canadian	1
Mennonite	1
Unidentified	1
Religious background	
Christian	4
Jewish	1
No religious affiliation	1

them, that they spoke the exact words they have spoken or have thought over the years.

Findings

Our analysis produced three thematic patterns and three thematic threads. We have called our findings *thematic patterns* because they were not discrete, stand-alone themes but rather interconnected patterns woven throughout the data like a tapestry. This approach to the data is consistent with human science perspectives in nursing that view human experience as patterns and as a unified whole (Newman, 2008; Parse, 1998, 2007; Watson, 2008). The three thematic patterns were (a) *growth and transformation emerging with the anguish of grief*, (b) *personal and professional impact*, and (c) *giving–receiving meaningful help*. The third thematic pattern, *giving–receiving meaningful help*, was further defined by three threads: *support from colleagues and others; providing authentic, compassionate, quality care*; and *education and mentorship* (see Table 2). With each thematic pattern and thread, we have provided examples from our data that are

mostly different from those in our research documentary (Jonas-Simpson, MacDonald, McMahon, & Pilkington, 2011) to share more of our data.

Growth and Transformation Emerging With the Anguish of Grief

Participants discussed how growth emerged through the difficulty, challenges, and anguish of grieving while caring for families with a perinatal loss. Although experiencing grief while with families who experienced a perinatal loss was described as being "hard" and "difficult," or as "an emptiness," and "a big black hole sometimes," it was also viewed as a rewarding experience that inspired change and growth. One participant said, "I will still remember that experience because it changed me, it changed me, who I am, it changed me, everything, emotionally because that was really a close experience, because I never had a baby die [in my practice before]." The participants often spoke of their discomfort with earlier experiences that shifted in time to greater comfort. One nurse said, she had "a very traumatic experience" when a baby died while she was working in Labor and Delivery. She said, she "shied away from ever caring for a woman undergoing a loss for a very long time after that"; however, she was able to increase her comfort level once she started working in the pregnancy clinic where she cared for women experiencing loss on a daily basis. Over the years, comfort with death grew and an ability to be with those who were bereaved developed, not only in the nurses' practices but also in their personal lives, as one nurse described,

> I think something that is very positive for me is that I learned to be comfortable with my own tears with families and that was a really good place for me to be at—that I didn't have to hold everything back that I could be open about my feelings of grief along with theirs.

Another nurse connected her growth with her ability to mentor novice nurses and her growing comfort with perinatal death and bereavement, even though it was at the same time difficult:

> When I first started doing the work, as I said . . . I was very nervous, and I found that it almost took away from my support with the families because I was so nervous. I didn't know what to say, I felt awkward. I felt terrible for the families but didn't know how to support them except for just being there making them comfortable. So, when I say I think I have grown, I feel like now I am sort of able to take the younger nurses or the newer nurses under my wing and tell them it is okay to talk about it, it is okay to feel while you are in there. It is okay to cry—that sort of thing. So I feel that maybe it is a comfort level thing. So maybe I am just more comfortable with it. Each experience is unique and each experience is devastating.

Table 2. Findings: Thematic Patterns and Threads With Supportive Quotes.

Growth and transformation emerging with the anguish of grief
- "It really helped me grow personally and professionally being given that opportunity to . . . make the distinction between what are my needs and what are their needs."
- "I think how I have grown is by educating myself and going to workshops. Listening to bereaved parents tell their stories."

Personal and professional impact
- "As a mother, now, it is very different for me now because I think this very well could have happened to me. So that connection to being a mother I think is strong, and so the grief is strong. It feels very real and I feel like I am really there with them, and it is very sad."
- "My own personal grieving experiences . . . has influenced how I come alongside families who have experienced grief because I did reflect on my own grief and things that were positive and negative and sometimes I relived my own personal grief and sometimes I didn't but I think it did have a huge impact on how I was able to come alongside [bereaved] families."

Giving–receiving meaningful help
- Support from colleagues and others
  - "There [are] times like when I will just sit and I will go up to [my colleagues and ask] can we just talk about everything that just happened? And sometimes there isn't that time, and it might be weeks or months or even . . . years down the road . . . like I said, you never forget and you carry it with you."
  - "I draw on my colleagues and my friends for support. And most of my colleagues are very supportive."
- Providing authentic, compassionate, quality care
  - "I think that helps the family, we were all grieving for them too [and] . . . here is some tangible proof something that they can come back to and say, "Oh my God, everybody signed this card."
  - "That was always so important to me I just really wanted to be authentic."
- Education and mentorship
  - "Be prepared for having to look after women who are experiencing a loss . . . Any courses and seminars that are available, take them. Do them. Anything you can do to sort of educate yourself and open your eyes to what it is like to look after women who are having a loss."
  - I would just like go in the room and do my vitals and checks and run right back out because I didn't know what to say. It wasn't until I started to educate myself and talking to people that I became a lot more comfortable."
  - "I am able to offer more to the patients now that I have more knowledge and more experience so its I don't want to say rewarding because it is such a terrible thing but I guess I just feel more comfortable being able to say how I feel and show how I feel."

The nurses' descriptions of caring for families with perinatal loss reflected how the anguish of grief changed their lives personally and professionally.

Personal and Professional Impact

Participants described how grief had an impact on them personally and professionally. We chose not to separate the professional from the personal, as these coexist in life. Sometimes grieving overwhelmed the nurses. For instance, one participant described having to leave some patients for a moment to "collect" herself, while another said that after seven babies were stillborn in 1 month, she felt she was going to "lose it." Participants also spoke of their personal losses and how these influenced their practices, such as knowing it is important to have someone to be with and listen and knowing when their grief may interfere with care. For example, one nurse remembered how people were with her when a close family member died and how hurtful it was when some did not acknowledge her loss. This helped her understand the importance of being present and listening to the bereaved. Nurses also spoke of taking their grief home (e.g., coming home sad) and how it was at times difficult not to. One nurse explained what happened when she got home from work:

I would usually say to my family you know what, this was tough, I experienced looking after a family that had a loss or [the baby] died soon after birth and they always knew to sort of give me space.

Nurses also spoke of appreciating and cherishing their family even more; thinking about what would it be like to lose a child; not being able to fully enjoy pregnancy, knowing the possibility of loss; and appreciating the significance of loss even more after becoming a mother. One participant said,

I have a daughter, so you get to cherish everything that she does, and you get to connect with her. She is everything . . . you get to understand, what the [bereaved] mother was feeling, although it was different because it was her own unique experience.

Becoming comfortable with bereaved persons outside of the work setting was described as a positive impact that emerged with nurses' experiences of grief. One participant explained,

It is a positive impact because people recognize quite quickly if you are comfortable talking about sad situations, losses, grieving experiences, and they are much more readily able to talk to me about that because I do feel they sense that I am open to listening.

For one participant, however, the personal impact of her grief and perinatal loss created an experience of isolation. She said,

> Sometimes I am much more withdrawn, socially withdrawn. I turn down more social invitations than I accept, because people will say, "So how is your job?" I have gotten to the point where I don't even want to talk about it anymore, because it is not a happy place to work. So it has impacted me.

Giving–Receiving Meaningful Help

Much of the participants' description about their experiences of grief revolved around giving and receiving meaningful help. The threads woven throughout this thematic pattern were (a) *support from colleagues*; (b) *providing authentic, compassionate, quality care*; and (c) *education and mentorship*. These threads are expanded upon below.

Support From Colleagues and Others. As described by participants, support from colleagues was very significant in helping them to find their way through grief. Most often, the meaningful support came from fellow nurses and when it was not available, it was clearly missed, as one participant stated,

> It is very therapeutic to be able to talk about your experiences after the shift, and sometimes the birth occurred just at the end of your shift and you were done and you went home, and I always missed the opportunity to chat. And so I would keep some of those things inside of me and then it took longer to—the grieving was different if I wasn't able to share that soon after the experience. It was definitely helpful to process my own grieving if I had a colleague there that could connect with me.

Other colleagues, including physicians, chaplains, and social workers, were also described as helpful. One participant stated, "One doctor in particular has been very supportive. On one day that I just didn't think I could cope she just hugged me, gathered me into her arms."

While the nurses' family members tried to help, it was their colleagues who understood their experience of grief and provided the most support. This thread of support also wove with the personal impact of grieving, given that the nurses' families, especially husbands, while sympathetic, could not often understand in the same way, which could leave family members at a loss. One participant said,

> I come home sad and my husband feels a little helpless but he understands, too, and he will say, "tell me about it, but if you want to call your sister I will understand" because she would be the first one I would call, right? Because she would understand [sister is a nurse in Labor and Delivery]. So I guess it impacts my relationships in that people who are there for me or want to be there are not quite sure how to be.

Nurses also described how they protected their families from the reality that babies die and thus relied on their nursing colleagues for support:

> So you have to protect your family and friends; so that is why you need your nursing colleagues and something more formal sometimes after a bad situation—you need a debriefing, you need counseling where the nurses involved or the health care team and the members involved in the situation need to get together and talk about what has happened and how they are feeling.

However, one nurse who worked in the NICU said she found solace in grieving with her husband and with the mother of the baby who died. She said,

> The mom was the main support for me, because we grieved together and we got to say good-bye [to the baby]. The other person who helped me was my husband, because he was close to me at that time and I got to share with him my experience and tell him everything that I was feeling.

Providing Authentic, Compassionate, Quality Care. Participants discussed how providing authentic compassion and high quality care in the event of perinatal loss helped them to feel better about their own grief, because it was something they could do for the bereaved family. Even though it was a difficult experience filled with anguish and pain, the nurses wanted to make it the best experience for bereaved families. One participant stated,

> It is hard, it is very difficult, but on the other hand, I am also glad that I am there, and that I am a familiar face to them and that they can open up and that they can voice their fears and concerns . . . Then that is where I see the satisfaction in my job, that people—they leave and they say, "Thank you so much, I don't know what I would do if your clinic was not here. You are all so wonderful"—and that is what keeps you going.

Another participant described the importance of being authentic:

> Well just the sense of authentic compassion and caring and that you weren't there just because you were on shift—but you really cared . . . so that was always so important to me I just really wanted to be authentic.

Participants also described how they developed a repertoire of care that comforted the bereaved families which in turn comforted themselves—by providing excellent care they were making the best of a terrible situation. Most participants said they never forgot the bereaved families for whom they cared. As one participant described,

> There are some patients that have come back with repeated losses, just bad stuff every time, and it is hard to go back and say "hi" to those patients, too, because you feel every time you see

them it is in a bad situation. But I still find those patients are so appreciative of the fact that you remember them, and that you went out of your way to find them to say, "I have not forgotten you, I am thinking about you."

The participants also said that it was okay to cry—to show oneself and *be human* with bereaved families—and that crying did not mean the nurse temporarily abandons professionalism. One participant who still grappled with showing her emotions said,

> We have to accept the fact that we are human, too, and it is okay, even though some of us older nurses don't really, you know, we were not taught that way. We were taught you maintain professionalism at all times, you don't need to show emotion in front of your patients, and so that has been a hard thing for me because–maybe it would be easier if I could just cry with my patients rather than run out of the room.

Creating mementos was a significant way of providing compassionate, quality care while recognizing the challenges and pressure to get it right, knowing what it meant to families. One participant expressed this importance,

> We have an excellent bereavement package and . . . we try and collect as many mementos from the baby and I am not so good with collecting the hair samples, I must say, the little ones, it is just impossible, but the hand and the foot prints, Oh my God, so, so meaningful . . . The parents are so appreciative of that it is just great.

Education and Mentorship. The nurses who participated in this study was helpful to their grieving process. They said that through taking courses, discomfort shifted to comfort. One participant advised the following:

> Be prepared for having to look after women who are experiencing a loss. How do you prepare yourself? I went in completely unprepared and sort of learned along the way. Any courses and seminars that are available, take them. Do them. Anything you can do to sort of educate yourself and open your eyes to what it is like to look after women who are having a loss.

The nurses also had many suggestions and tips for new nurses and students such as follows: be authentic, seek knowledge, mentorship, and support and listen to families. One participant responded with the following when asked what message she would give to students:

> A huge message is know your true feelings and thoughts and if you have to be a fake then don't be there. If it is not in you, don't push it because you are not going to be authentic and you are not going to be genuine.

In addition, the nurses suggested that bereavement education be included in schools, in orientation, and also provided widely to the public. One participant stated,

> I think education is really, really important, and helping people understand through the stories that we tell and, through our experiences, that we can help educate the people that need to be educated, the health care professionals, the families, the families of the families, and . . . maybe we need to have some public service announcements . . . on how pregnancy loss affects families and affects people, or the loss of a child. So it is not hidden, and it shouldn't be hidden.

Discussion

The findings in this study uniquely weave a tapestry of the complexity of the phenomenon of nurses' grief in the context of caring for families experiencing perinatal loss. No other study was found focusing specifically on nurses' grief in a perinatal setting; however, we found some consistencies with the two studies that explored nurses' experiences when caring for families with perinatal loss (Jonas-Simpson et al., 2010; Roehrs et al., 2008), as well as consistencies with other literature regarding nurses' grief in other practice settings (Gerow et al., 2009; Shorter & Stayt, 2010; Wilson & Kirshbaum, 2011). The first thematic pattern, *growth and transformation emerging with the anguish of grief*, is comparable with Jonas-Simpson et al.'s (2010) study theme, *an honor filled with difficulty, responsibility, and opportunity to learn and grow*. Likewise, in a study with nurses from various practice settings, Gerow et al. (2009) reported that, "through death experiences, the nurses grew and changed as human beings. Most nurses felt gratitude for the experience and for the ways they were transformed along the journey" (p. 126). These findings link to concepts from human science nursing theories such as transcendence, transforming (Parse, 1998, 2007; Watson, 2008), and expanding consciousness (Newman, 2008). Nurses caring for families experiencing perinatal loss are confronted with an unexpected and painful event that evokes anguished grief, while also presenting an opportunity for growth and transformation, personally and professionally. Indeed, Newman (2008) proposed that it is precisely such disruptive life events that create choice points for expanding one's consciousness and creating new patterns of living. Similarly, Papadatou (2000) proposed a model for health professionals' grieving processes that includes transcendence of loss

> through a series of behaviours, thoughts, and emotions . . . that allow investing in life and living . . . Through such transcendent activities one goes within and beyond self . . . Thus, a new sense of self and of life is recreated which expands far beyond work. (p. 69)

This theme of growth and transformation amid grief is consistent with what Calhoun and Tedeschi (2006) called posttraumatic growth where facing or experiencing the suffering of self or others may lead to patterns of growth such as greater self-confidence, increased connectedness in relationships with others, stronger existential awareness, and spiritual growth. Calhoun and Tedeschi also suggest that there are opportunities for *vicarious growth* when caring for persons

and families who have experienced major loss. In bearing witness to how persons experience major loss, health care professionals or clinicians may become aware and appreciate that "we as human beings are more vulnerable to loss than we had hoped, but we are also stronger than we had imagined possible" (Calhoun & Tedeschi, 2006, p. 168). They go on to say that clinicians may rethink their lives, their choices, and reflect upon what truly matters in their lives, especially the importance of their loved ones (Calhoun & Tedeschi, 2006), which was clearly evident in our research and links to the next thematic pattern we identified, *personal and professional impact*.

The second thematic pattern woven throughout our data, *personal and professional impact*, highlights the idea that nurses' grief when caring for families experiencing perinatal loss is an integrated response that extends beyond the workplace to encompass their lives, generally. This finding was also evident in Roehrs et al.'s (2008) findings where the personal impact of caring for families who are bereaved was evident in nurses' need "to recover from the intense and stressful work of providing bereavement care" (p. 636). In the present study, participants described pervasive ways in which perinatal loss influenced their thoughts, emotions, and practices, and how, for relief, they at times withdrew or tried to distract themselves. A key finding in a review of the literature on the effects of patient deaths on nursing staff was that the impact on nurses was experienced within and outside their work environments and potentially affected relationships with others (Wilson & Kirshbaum, 2011). Wallbank and Robertson (2008), in a critical review of qualitative research on nurses' and midwives' responses to perinatal death, concluded that the staff's need to provide empathic care was in conflict with their need to withdraw in order to protect themselves emotionally. Gerow et al. (2009) used a metaphor, *creating a curtain of protection*, to reflect this phenomenon in their research, where "the curtain enveloped the patient and nurse together as a special relationship was forged, allowing vulnerability to be both expressed as well as constrained" (p. 124). Shorter and Stayt (2010) described "a complacency toward death" for nurses in the ICU "as a means of coping with it and the associated grief" and yet they also spoke to the importance of "meaningful engagement" (p. 165). Papadatou (2000) described a similar tension in her model of health professionals' grieving process, in which there is "an ongoing fluctuation between experiencing grief reactions by focusing on the loss experience, and repressing or avoiding grief reactions by moving away from it" (p. 59). Similarly, Pilkington (2006), in a synthesis of five studies on grieving, suggested that the rhythmical pattern of connecting–separating, or engaging and moving away from the intensity of grief, is universal in the grieving process. It was evident that nurses experienced a relearning of their worlds (Attig, 2004), professionally and personally, as they constructed new meanings of their grieving experiences (Neimeyer, 2001) and integrated these experiences into their lives.

The third thematic pattern, *giving and receiving meaningful help,* was further defined by three threads: *support from colleagues and others; providing authentic, compassionate, quality care;* and *education and mentorship*. These ideas were also evident in the literature. For instance, informal support from colleagues and others is consistent with research on nurses' experiences of death in perinatal settings (Chen & Hu, 2013; Jonas-Simpson et al., 2010; Roehrs et al., 2008) and when death is experienced in the ICU (Shorter & Stayt, 2010). In the present study, as well as in the literature, most nurses identified colleagues as their main source of support. Participants also indicated that they usually cried with the bereaved family. This sharing of grief with families is suggestive of Gerow et al.'s (2009) theme from a study with nurses from various settings: reciprocal relationship transcends professional relationship, wherein "the nurse not only gave to the relationship but also received, making it a reciprocal experience" (p. 125). This notion is related to our second thematic thread, providing authentic, compassionate, quality care. Here, nurses described how they developed a repertoire of care aimed at making the best of a terrible situation not only for the families but also for themselves. Providing excellent care in our study ameliorated the nurses' grieving to some extent. Similarly, Shorter and Stayt (2010) found that "the magnitude of the grief experienced by critical care nurses [was] influenced by the perceived quality of care delivered to the dying patients" (p.165). These ideas are evident in the perinatal context with Roehrs et al.'s (2008) theme of focusing on the care the patient needs, and in Jonas-Simpson et al.'s (2010) theme, connecting with families while connecting families with their babies provides comfort amid the unbearable loss. In each of these studies, supporting families in their grief by providing authentic, compassionate, quality care was also a way for nurses to live with their own grief—that is, the benefits were reciprocal (Gerow et al., 2009). The grieving concept of continuing bonds (Klass et al., 1996) is descriptive of the strong connection nurses have with bereaved families—a connection that often continues throughout their careers, even if only through thought and contemplation.

The third thread in the thematic pattern, giving-receiving meaningful help, was education and mentorship. The need for mentorship and education around providing care to bereaved families identified by our participants is consistent with other studies conducted worldwide on nurses', midwives', and health care professionals' responses to, experiences of, and needs regarding perinatal death (Chan & Arthur, 2009; Chan, Wu, Day, & Chan, 2005; Chen & Hu, 2013; Gardner, 1999; Jonas-Simpson et al., 2010; McCreight, 2005; Montero et al., 2011; Roehrs et al., 2008). For instance, Roehrs et al.'s (2008) category, *influencing the context of providing care*, included the themes: (a) how to assign nursing staff to provide bereavement care, (b) how to avoid compromising care, and (c) how to become more comfortable and knowledgeable about the care. Similarly in the present

study, nurses described the importance of appropriate patient assignments, given that pregnant nurses may feel vulnerable caring for bereaved families, as might the bereaved families receiving that care.

Limitations

This study was limited in several ways. Nurses who volunteered to be in the study were all Caucasian; their diversity consisted primarily in their ethnocultural background (e.g., Mennonite, Canadian Jewish, Italian, and Russian), practice setting, and years in practice (3-30). All participants worked in different practice settings and two worked in the same health care organization. While we had a small participant group with minimal diversity, the literature supports that nurses and midwives from various countries, Western and Asian, experience intense emotional responses when patients experience perinatal loss (Gardner, 1999; Gerow et al., 2009; McCreight, 2005; Wallbank & Robertson, 2008; Yam, Rossiter, & Cheung, 2001). In a subsequent survey evaluating how people experience viewing the research-based documentary, we have asked respondents to identify their ethnocultural background. We hope that the survey results will help us understand the cultural relevance and transferability of our findings. Thus far our findings, as presented in the film, have resonated with nurses from different backgrounds based on feedback after several presentations and more than 9,200 hits to the online link to our research documentary to date (Jonas-Simpson et al., 2011). We have collected more than 200 surveys from audience members in the United States and Canada and through our online survey filled out by mostly nurses and also other health care professionals. We have been surprised and gratified that the relevance of our findings has gone beyond nurses in the perinatal setting to nurses in other settings as well as other health care professionals. Our survey findings will be available in a forthcoming article.

Implications for Nursing Practice, Research, Leadership, and Education

The findings of this study were presented in two formats: the text-based format presented here and the research documentary (Jonas-Simpson et al., 2011). As summarized in Table 3, these findings shed light on nurses' experience of grieving following perinatal loss and have the potential to impact practice in several ways—first and foremost, through acknowledging nurses' grief and thus supporting those nurses who experience it. The research documentary uniquely captures the tapestry-like complexity of nurses' grief experiences presented here in thematic patterns and threads. The documentary was viewed more than 1,350 times online in the first 6 months, and over 9,000 times in 2 years, which reflects the significance of this often hidden experience. Perhaps Doka's (1989) concept of *disenfranchised grief* may

Table 3. Key Messages.

1. Nurses' grief has a significant personal and professional impact.
2. Growth and transformation can emerge through experiences of grief.
3. Support from others, especially in the form of listening by colleagues who understand, is essential.
4. Providing authentic, compassionate, quality care helps to ameliorate the pain of grief.
5. Education and mentorship are needed to support nurses who are grieving when caring for bereaved families.

account for why nurses often hide grief in that they may not feel they have the right to grieve the loss of the baby. Doka defines disenfranchised grief as, "the loss that is not or cannot be openly acknowledged, publically mourned or socially supported" (p. 4). Wilson and Kirshbaum (2011) also identified the potential for disenfranchised grief among health care professionals when there is a patient death.

During the interviews, to help participants highlight what was most significant to them, they were asked what question they would like to be asked with regard to their experience of grieving. Their questions have implications for nursing practice, research, education, and leadership. In the practice context, one participant suggested that the following questions be asked of nurses: "Are you okay? Is there anything that you want to talk about? How has this impacted, and changed, your life? And, how do you care for families with perinatal loss?" Questions for nurse leaders to ask their staff are as follows: "How can we help you during this process? And, what could we put in place to help you and other people?" With regard to further research and education, the nurses suggested these questions: "How do educational preparation and discussions impact individuals, and particularly younger nurses with less experience?" and "How does that impact their ability to process their own grief, as well as provide care for those who are grieving?"

Our findings support a growing consensus in the literature that education and support need to be offered to nurses and others involved in caring for families experiencing perinatal loss (Chan & Arthur, 2009; Chan et al., 2005; Gardner, 1999; Gerow et al., 2009; Jonas-Simpson et al., 2010; Limbo & Kobler, 2010; McCreight, 2005; Roehrs et al., 2008; Wilson & Kirshbaum, 2011; Yam et al., 2001). The thematic patterns and threads identified in this research provide nursing leaders in educational and clinical settings with knowledge regarding the grieving experience of nurses who care for families experiencing perinatal loss, and regarding nurses' needs for education and support. In particular, our findings suggest that education and support in nursing practice could be enhanced by supporting nurses to attend workshops and seminars on the topic of perinatal loss and bereavement care; incorporating discussions on supporting families, patients, colleagues, and oneself in bereavement care during orientation to the unit and ongoing education; debriefing after perinatal loss; and

providing staff with a bereavement mentor. Providing this important education and support is likely to enhance nursing work life and retention in perinatal practice settings. With respect to nursing education, curriculum development on care of oneself and others while grieving in the midst of providing care should provide a foundation of theoretical knowledge as well as an opportunity to role-play. The opportunities to gain this knowledge and experience may provide new nurses with more confidence in their ability to provide care to families and in their ability to recognize and seek support for their own grief in the situation. Our research documentary can be and is being used to begin the dialogue with nurses during orientation and in hospital continuing education as well as in formal educational settings. An evaluation of the impact of using our documentary will be published in a forthcoming article.

While this study focused on nurses' grief, further research into the grieving of other health professionals involved in the care of pregnant women and neonates may provide additional insights into how interdisciplinary team members can provide support to each other when perinatal loss occurs. This knowledge could lead to identifying strategies for team building.

Conclusion

Grief is not easily or readily spoken about and yet it is a significant experience that nurses and other health care professionals face when providing care to families whose babies die. The findings of this study, presented here and in our research documentary, include three thematic patterns that describe nurses' experience of grieving when caring for families who have experienced perinatal loss and what helps them in moving through the grieving process. We hope this research provides nurses with an opportunity to acknowledge and affirm their own experiences of grieving, to explore their feelings, and to feel affirmed and supported by hearing other nurses' stories, because they are not alone in their grieving. When their experience of grieving is acknowledged, nurses may feel better supported, which ultimately could lead to enhanced nursing practice and quality care for the bereaved, as well as enhanced quality of work and home life for nurses.

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