Original Article

Coping of the nursing team in the death-dying process in a neonatal unit

Coping da equipe de enfermagem no processo morte-morrer em unidade neonatal

Coping del equipo de enfermería en el proceso muerte-morir en unidad neonatal

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Abstract

Objective: This understanding is essential to subsidize interventions of nursing professionals in order to care for families.

Method: A qualitative study in descriptive exploratory approach involved ten nursing professionals. Recollected stories collected from professionals in the care of the process of death and dying in neonatology was the means for data collection. Data organization, treatment and analysis was based on Bardin's content analysis and the software *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*.

Results: Two categories emerged from the analysis interface and the foundations of Skinner's Motivational Theory of Coping, nursing staff and Motivational Theory of Coping in death in neonatology; Threat regulatory action and coping with death in neonatology. The coping strategies of the nursing team studied show that cognitive patterns and behavioral responses refer to the very way of dealing with the daily suffering experienced in the family, where professionals seek information to overcome the threat, a coping with helplessness and escape from welcoming.

Conclusion: The self-referential processes experienced in stressful situations by nursing professionals favor empathy, bonding and communication with the family of infants. The indicators of frailty in training remain predisposing to difficulties in coping with death-dying.

Resumo

Objetivo: Compreender o *coping* dos profissionais de enfermagem no processo morte- morrer em neonatologia.

Método: Estudo qualitativo na abordagem exploratória descritiva, participaram dez profissionais da enfermagem. Histórias rememoradas dos profissionais no cuidado do processo da morte e do morrer em neonatologia foi o meio para a coleta de dados. Organização, tratamento e análise dos dados fundamentado na análise de conteúdo de Bardin e no *software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*.

Resultados: Emergiram duas categorias da interface da análise e os fundamentos da Teoria Motivacional de *Coping* de Skinner, Equipe de enfermagem e a teoria motivacional de *coping* na morte em neonatologia; Ação regulatória de ameaça e o enfrentamento da morte em neonatologia. As estratégias de *coping* da equipe de enfermagem estudada mostram que os padrões cognitivos e respostas comportamentais referem-se à própria maneira de lidar com o cotidiano do sofrimento vivenciado em família, onde os profissionais buscam informação para ultrapassar a ameaça, num enfrentamento de desamparo e de fuga do acolhimento.

Conclusão: Os processos autorreferenciais experienciados em situações estressantes por profissionais da enfermagem favorecem à empatia, o vínculo e a comunicação com a família de neonatos à morte. Os indicativos de fragilidade na formação mantêm-se predisponentes para as dificuldades no enfrentamento da morte-morrer.

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Conflicts of interest: nothing to declare.

Resumen

Objetivo: Comprender el *coping* de los profesionales de enfermería en el proceso muerte-morir en neonatología.

Métodos: Estudio cualitativo de enfoque exploratorio descriptivo, donde participaron diez profesionales de enfermería. Las historias contadas por los profesionales sobre el cuidado del proceso de muerte y del morir en neonatología fue el medio para la recopilación de datos. La organización, el tratamiento y el análisis de los datos fue fundamentado en el análisis de contenido de Bardin y en el *software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*.

Resultados: Surgieron dos categorías de la interfaz de análisis y fundamentos de la teoría motivacional de *coping* de Skinner: Equipo de enfermería y la teoría motivacional de *coping* respecto a la muerte en neonatología y Acción reguladora de amenaza y el afrontamiento a la muerte en neonatología. Las estrategias de *coping* del equipo de enfermería estudiado muestran que los patrones cognitivos y las respuestas de comportamiento se refieren a la propria manera de lidiar con la cotidianidad del sufrimiento vivido en familia, donde los profesionales buscan información para superar la amenaza, en un enfrentamiento de desamparo y de fuga de la acogida.

Conclusión: Los procesos autorreferenciales vividos en situaciones estresantes por profesionales de enfermería favorecen la empatía, el vínculo y la comunicación con la familia de neonatos a fallecer. Los indicios de fragilidad en la formación se mantienen predisponentes para las dificultades de afrontar la muerte-morir.

Introduction

Attitudes towards stressors of nursing workers and professionals characterize certain ways of facing and transpose situations of suffering. Coping strategies are called coping. It is about cognitive and behavioral efforts to support and control events of suffering and stress. Coping with the health team in the process of death and dying of children in a hospital unit leads professionals to face and conduct different ways of coping with these limit situations.[1] Death requires to be perceived as a natural stage of life. Attention in the process of professional education in the health area discuss and bring approaches to qualified care practice in this experiential stage. The response that each person presents in the face of an event, event of suffering and pain is understood as coping in a particular and unique way by the human being. Death, as an undeniable experience of existence consists of events that bring out beliefs, religions, cultures, human convictions and experiences, causing each human being to develop a proper and particular way of coping. There is description in the literature to the association of care strictly with the cure of the disease. Presenting a posture of indifference of some team professionals, suffering, badly lived grief, lack of team dialogue, lack of theoretical and practical knowledge, as factors that hinder newborns' right to die worthily. Evidencing as harmful and fragile factors to the grieving of relatives.

Neonatal Units are presented as an environment of great technological support, specialized and qualified health care, linked to speed and reliable clinical and observational information. This requires specific knowledge and skills in neonatology care and humanized attitudes. The creation of bonds related to sometimes prolonged coexistence interferes in the form of humanized care for newborns and relatives. In this scenario, hospitalization has a dimension that involves the physical, psychological and social spheres of relatives and professionals. The situations experienced in the hospital environment can be evaluated as stressful and need to be discussed to justify the event, which affects the lives of professionals and the nursing team, in socioprofessional aspects.[3] Furthermore, compassion fatigue limits coping in moments of end-of-life of a patient.[4] In this perspective, Motivational Theory of Coping describes that human behavior is developed to respond to three basic psychological needs: competence, bonding, and autonomy or self-determination.[5] This theory is a recent proposal for stress coping analysis, considering coping a regulatory action that perceives any event as stressful from the moment that challenges or threatens the basic psychological needs of relationship, competence and autonomy.[6]

The identification of occupational stressors and their coping strategies are relevant, as they help to understand and select effective coping strategies, rethinking the care work process and making the hospital routine more productive and less exhausting, transforming the quality of care provided by the nursing team, especially regarding the process of death and dying in neonatology because it is a scenario of prematurity for life and, also, to death.

This generates in the nursing team attachment, hope, frustration and pain.[7]

Therefore, Motivational Theory of Coping proposes to conceive a psychological view of development. The construct is understood as a result of confluences of physiological, genetic and social processes specific to the vital phases of life. Coping responses should be understood as intrinsic competencies associated with temperamental characteristics, affective bonds and the context that the individual is inserted in. Coping has as perspective protective factors or vulnerability, which are linked to psychopathological symptoms. Individuals may thus present internalizing or externalizing tendencies, resulting from poorly adaptive forms of stress reaction.[8] The individual avoids the threat and begins to develop a series of escape, distancing and acceptance maneuvers. Individual efforts, both behavior and cognitive, aim to help the individual to manage their stressful situations.

Attitudes towards the stressors of nursing workers and professionals characterize certain ways of conducting and overcoming situations of suffering. It points to the emergence of research on the death of children in intensive care and the expansion of the knowledge of nursing and health professionals on how to deal with the suffering of others and from the child perspective.[9] This, considering the above, refers to the objective of this study to understand the coping of nursing professionals in the process of death and dying in neonatology.

Methods

This is a qualitative, exploratory-descriptive study, used in studies that encompass understanding and interpretation that refer to the object in question. It was developed in a university hospital of southern Brazil, in the Neonatal Unit, which receives newborns at risk under intensive care and continuous multidisciplinary care. The unit consists of 12 active beds, a team of 11 nurses and 40 nursing technicians. Six nurses and four nursing technicians participated in the study. This convenience sample followed the inclusion criteria of participants: being a nurse and technician in activity during the research period, introduced in the work scale in the established shifts of unit activity, with participation of professional care in the process of death and/or neonatal death in the unit. Exclusion criteria: nurses and nursing technicians away from work, on health leave, maternity leave, or vacation. Data collection was conducted after the research was presented to professionals, and the Informed Consent Terms were signed. A form was presented, with a guiding heading for information on professionals' characteristics and for telling the story of an event experienced by the death of a newborn. Two modalities of option for the participation of respondents, orally or in writing, to guide the counting, some questions were asked to involve respondents in remembering the theme: What does death mean to you? How did you feel when the event of death occurred? What things have been going on in your mind? How do you describe the bond with patients and family? How did you face the situation? A field diary was used to record the researcher's observations experienced during data collection. A field diary allowed observations and records of situations experienced during data collection. The mean time to return the written history was seven days and the oral time was fifteen minutes. Data collection, carried out by the researchers, took place between September and October 2019 in professionals' work unit, according to the team's availability. The stories printed by the participants were returned to the researchers via e-mail or in a specific folder filed in the unit. The report of information was recorded and at the end transcribed, to be validated by the respondents. Two stories were orally told, and eight were described, without duplication of response from participants in the presented modalities. To designate the interviews and provide the respondents with anonymity, the letters N (Nurse) and T (Technician) were used, followed by the number corresponding to the order in which the interviews were conducted (N1, N2, T3...). For analysis, the IRAMUTEQ software (R interface pour les Analyzes Multidimensionnelles de Textes et de Questionnaires) was used in order to objectify the data and research reliability. Among its possibilities, classical textual statistics are verified,

such as identifying the quantity and frequency of words, single words (Hapax coefficient), as well as finding words in line with the identified grammatical classes. Regarding the analysis of simple textual data, the IRAMUTEQ was used to perform word frequency calculations, which are presented in a word cloud. This software allowed identifying the interviews that contained a textual approach, words of repetition and that were interconnected.[10] After organization, the second stage of data processing was carried out, analysis of stories in the light of Motivational Theory of Coping. A framework with the cognitive coping strategies was structured and the regulatory processes of challenge and threat were described and analyzed according to Bardin.[11] Analysis went through the three described phases of reading the word cloud relationships, transcribed stories, Motivational Theory of Coping and field diary observations. The research met the ethical aspects of Resolution 466/2012 of the Brazilian National Health Board (CNS – *Conselho Nacional de Saúde*), considering respect for human dignity and the protection due to participants in scientific research involving human beings. Approval by an Institutional Review Board (IRB) of a university in southern Brazil, under Protocol 3.419.006/2019 and CAEE (*Certificado de Apresentação para Apreciação Ética* - Certificate of Presentation for Ethical Consideration) 05869518.7.0000.0121. The method of this study followed the criteria indicated for qualitative research, described in the Consolidated criteria for reporting qualitative research (COREQ).[12]

Results

From the lexical analysis of the words, in the word cloud, from the IRAMUTEQ software, the similarity and frequency of appearance of the words emerged: Baby, 39 times (situation, believe); Death, 30 times (born, life, child, feeling, sad); Family, 22 times (death, father, mother, life, team, bond, pain, dying and care) (Figure 1).

From the relationship between the results of the words, the cognitive coping strategies presented in

Figure 1. Representation of emerging words by similarity

the stories of nurses and nursing technicians, there are, of the 12 cognitive coping strategies, six referring to challenging regulatory actions: accommodation, negotiation, problem solving, seeking information, self-confidence and seeking support; and four regulatory threat actions: opposition, helplessness, delegation and flight. It reveals the analysis of themes related to participants' behavior characterized in challenges and threats. The outcome of the coping process regarding resilience appears at the end of the discussion. From this relationship, two categories of analysis emerged.

1st category - Nursing team and Motivational Theory of Coping in death in neonatology. Here, the internal and external actions of the nursing team professionals in coping with the death of children in neonatology are evidenced, in addition to the emotional, technical and psychological nuances of care for death in the space of care and families. Fragments of some of the oral and written histories are registered that reveal strategies adopted to experience the process of death with newborns and their families.

> *"Each one faces according to his religion, his experience. This I think makes it easier, I'm a Spiritist, my religion interferes a lot in coping with life, including death… the fact of believing that nothing is by chance, that dying hasn't ended helps me a lot. But I can't pass it on to the family, even because I don't think it's my job" (N6).*

"What I always try to do is talk to the parents, encourage the baby to touch, put him on the parents' lap, even when the clinical condition is unstable, I allow visits, ask if they want to bring someone to pray or baptize and I say that the baby's mission is being fulfilled, when I realize that the family is religious... All this care helps to reduce our suffering a little, bringing the feeling that we could contribute to a dignified death, with quality care in the finiteness of a newborn child and with minimization of the suffering of relatives, who can participate in the process, say goodbye and perform the necessary rituals, so that their hearts can be comforted for having accomplished what was within their power." (N2).

Religion emerges as a way of understanding the finitude of life and helps to accept the death-dying process. Even in the face of a painful fact for relatives, the way professionals welcome relatives comforts the family. However, these professionals suffer and are frustrated with the death of newborns.

"Impotence, the questioning (Why? Did we do something wrong? Did it take us long?) They are the most difficult deaths, there was already a link and it came as a surprise (although we know that this is always possible) (N4)."

"I always try to keep myself "strong" in front of the family, transmit security, but I've cried with the death certificate. Empathy with each family regardless of time (extreme premature or full-term NB)." (T1)

"The father screamed in despair and said that he no longer believed in God because he had prayed a lot during every pregnancy and God had done nothing for them. I was very sorry for the situation, and unfortunately he was unable to hear anything and would not allow himself to be comforted. In general, I realize the fragility of the subject and how difficult it is to face it." (N3)

2nd category – Threat regulatory action and coping with death in neonatology. It reveals the different attitudes and feelings of the team, considering the clinical severity and prognosis of newborns. Here, it appears that the team perceives the outcome of newborns due to clinical conditions of hospitalization. The team creates strategies for this outcome, seeks a certain distance from newborns, who know they will not evolve well. It is observed in the statements.

"Sometimes, the baby in the NEO ICU, extremely premature, when he dies, for us it can be up to the expected outcome. We know that it would only go on for much longer and it would have a bad outcome." (N1)

"The baby's condition is related to the feeling that mobilizes us. If it's a viable baby, we suffer more. If it's a baby we think would have sequelae, we suffer less." (N1)

"Extreme preterm, syndromes incompatible with life, multiple malformations are "more acceptable" to death, because as a professional and not being part of the family network, we are able to act with reason, physiologically understand the reason." (T1)

"The suffering is intense and we, professionals who are in direct contact with the patient and relatives, suffer together. Sometimes we don't know what to say, what to do and how to approach." (N2)

Discussion

With regard to the health-disease process, death is shown as a reality of another person, far from the individual reality of professionals. Thus, it is observed that professionals deal with death and the grieving process by creating their own strategies to experience this moment, even if family and colleagues often have the impression that they value in assistance, the specificity of treatment and physiological, technical care and technological of the disease.

Nursing professionals are essential to the needs of competence, bond and autonomy worked, given the period they remain experiencing and developing

professional care with this clientele. Health professionals have benefited from studies of "human attitudes", building a theoretical framework for practical use in order to expand the relationship of these attitudes to care in the process of death and dying, in pain and suffering.[4] Thus, nursing professionals present mechanisms of reactivity and regulation, which are built over time.

The study emphasizes that information-knowledge about death and dying is fragile during the period of academic training. The findings corroborate what is described in Motivational Theory of Coping, that self-referential processes influence strategies for coping with stressful situations. In this universe of coping, negotiation in accordance with Motivational Theory of Coping is about putting oneself on the other's shoes, realizing that events relating to life and death can happen to anyone, anywhere, at any time.

As parents of newborn children, empathy is present in the care of nursing professionals, reflected through touch and focusing on beliefs and religiosity. It is shown as a need requested by parents, whether in the form of prayer, objects of religious sacraments that are a significant symbology as holistic care that privileges the physical, emotional, mental, spiritual and social of the entire care process.[13]

Regulatory actions of problem-solving and information seeking within Motivational Theory of Coping are shown in this study by professionals' ability to present themselves resilient, to compare their own life trajectories and that of children to death and their families. They do not omit that there is a silent suffering, but they are reluctant to it through actions that provide parents with moments to understand the process of loss through death. In the coping actions developed by the nursing team, it is observed that there is autonomy in the choice of strategies used, whether due to the fragility of information and knowledge about how to deal with and face stress, death and dying processes of children and families, or by the lack of support networks in the professional environment.[14]

Religiosity/spirituality is significantly important in understanding and relativizing suffering in the face of death and dying. In which, in this process of finitude, spirituality is linked to the sacred dimension, to the divine, that is, to what gives meaning to life for people. While religiosity is related to institutionalization and the belief system, which brings human beings closer to the sacred.[15]

It is considered that in the regulatory action of challenge, based on Motivational Theory of Coping, nursing professionals addressed coping strategies that bring to term a positive outcome. The outcome centered on resilience, of adaptive ways of behavior, feelings and emotions to care for newborns, shows that the nursing team is able to face adversity in a positive way. Considering the coping strategies used by professionals as positive to a condition of stability for work, facing death in neonatology, reflects resilience, which denotes an adaptation by the process and work environment and the social influences acquired in daily living.[16] The death of newborns is interpreted as an interruption in their biological cycle and this causes in the nursing staff the feeling of impotence, frustration, sadness, pain, suffering and anguish. The feelings that are subjectively interconnected with grief are numerous, related to sadness, anxiety and fear, which highlights the need for support strategies for families and teams.[17]

Health professionals need to have knowledge and practices aimed at the human and social sciences in a complementary way. The need for the team to develop adequate communication skills and establish good use of them during newborns' death process is noticeable. The openness to the participation of parents in this process is highlighted in the literature, as the post-mortem moments are the most important for relatives and those that mark their memories, and may thus be sad or traumatic moments in the face of what happened.[17]

The nursing team, in practice, presents professional and personal difficulties that end up interfering with the care and dynamics of care provided to patients. Some of these difficulties relate to feelings of anguish related to the possibility of patients' death. The scientific literature discusses how the acceptance, by professionals, in the face of infant death, is difficult and presents obstacles.[16]

Motivational Theory of Coping, in this study, showed that the helplessness and flight of profession-

als demonstrate the lack of psychological attributes that help them to monitor the final stage of newborn patients. Professionals can set aside the limitations, feelings and perceptions of patients, thus ending up not offering the necessary or dignified care, not providing them with one of the care given to them, emotional assistance. Studies show that, in the face of the death of a newborn and/or child, those involved emotionally experience different feelings, one of them being impotence, which ends up being the most common among professionals.[18] The difficulties of dealing with this process in care emphasize the need for team preparation and reflection on professional training, requiring discussions and approaches in relation to patient care beyond the therapeutic possibility of cure.[9] The attempts of nursing professionals to provide humane care and attention make it possible to signify pain and suffering. Therefore, professionals' coping is related to bonding and compassionate recognition, in addition to physical illness. It is to focus nursing care/assistance on understanding the personal aspects of families who experience the process of death.[15]

The time of contact with newborn patients, follow-ups, evolution of clinical cases and living with the family end up resulting in greater difficulty in accepting death, resulting in suffering, whether due to families' pain and acquired bond, or to the different ways of coping with this situation by professionals and relatives. Difficulties in accepting the other's coping create a distance from professionals to family care. Thus, living together is not always enough to establish an affective bond so that there is an understanding of professionals' coping strategies regarding the loss of the other and that results in suffering, being part of the routine of nursing professionals who accompany the suffering of newborn patients who receive care, sharing moments of pain, suffering and sadness with relatives. In a Neonatal Unit, this involvement ends up being even more intense for both parties.

The limitations of a study, which deals with coping with the death and dying of newborns, is not free from difficulties. From the approach of space and people to enter the research scenario to the process of telling and remembering the lived stories and their intensities. This, therefore, brings out their own personal limitations in accordance with individualities, beliefs and culture.

Conclusion

It is considered that the coping of the nursing team is directly proportional to the experiential and professional learning process, linked to the set of beliefs and approaches to the spirituality of each individual. It was found that, from the use of Motivational Theory of Coping intertwined with interviews and observations, the sociality of professionals as individuals participating in a community, in addition to work, strongly influences the care to be provided to patients and families in the death and dying process. in neonatology. The understanding of coping by nursing professionals, facing death and dying in the neonatology unit, reflects the categories listed in the universe of Motivational Theory of Coping. From the 12 patterns of cognitive strategies, the behavioral responses that are integrated as threats and challenges, from the gap in learning strategies to deal with death in the training process, permeates the comparison of specific events with death to the strong use of religious and spiritual factors. They bring to term how nurses and nursing technicians deal with stressful processes of suffering and pain in the event of children's death and the grieving of their families, and that the characterization of working time and age appear as factors that determine coping.

Collaborations

Silveira CM, Bellaguarda ML, Canever B, Costa R, Knihs NS, Caldeira S collaborated with the study design, data analysis and interpretation, article writing, relevant critical review of intellectual content and approval of the final version to be published.

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