# NURSE EXPERIENCES OF GRIEF AND COPING IN THE INTENSIVE CARE UNIT

by

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As members of the DNP Project Committee, we certify that we have read the DNP Project prepared by Michelle Sato entitled "Nurse Experiences of Grief and Coping in the Intensive Care Unit" and recommend that it be accepted as fulfilling the DNP Project requirement for the Degree of Doctor of Nursing Practice.

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## ABSTRACT

Background: Intensive care unit (ICU) nurses may experience cumulative loss as they are routinely exposed to traumatic situations, patient suffering, and death. They must also deal with personal grief and grief of patients' family in a time of uncertain crisis. Currently, there is minimal literature that acknowledges grieving and coping in the ICU. The grief and coping experiences of medical intensive care unit (MICU) nurses is little understood.

Purpose: Explore grief and coping amongst registered nurses working in the MICU at a major metropolitan hospital in Hawaii.

Method: A qualitative descriptive approach was used. Open-ended interviews and a brief demographic questionnaire were used to collect data from five registered nurses who work in the MICU. A pragmatic approach to qualitative data analysis was used.

Results: The findings of this study are presented in two main categories: grief and coping. Subthemes of grief are further described in the following categories: 1) circumstance of death; 2) keeping professional boundaries; 3) being supported; and 4) learning from experience. Coping is addressed by describing the main methods used by the nurse participants. Coping includes: 1) talking and being heard; 2) finding a support system; 3) using humor; and 4) spirituality. Findings suggest that MICU nurses have unique grief experiences and their coping is individualized. The nurses are aware of the effects grief has on their personal and professional lives. Additionally, they all seem to have developed effective coping habits to manage grief.

Conclusion: There is no single method to manage grief responses. However, there is a level of mutual understanding of experiencing death in the MICU, which yields support and

camaraderie amongst MICU nurses. Further research is needed to explore differences in other ICUs.

# CHAPTER 1: INTRODUCTION

The intensive care unit (ICU) serves patients with life threatening injuries and illnesses. It is often not envisioned as a place where a peaceful death can be achieved. Since 1991, serious medical conditions requiring ICU admission have become more frequent. This is partly due to the increasing aging population and greater reliance on technology and medical advances to keep patients alive (Society of Critical Care Medicine [SCCM], 2013). Varying cultural, societal, and individual or family expectations can complicate care goals, which can lead to numerous invasive procedures, prolonged hospital stays, and sometimes, unforeseen outcomes. More patients die in critical care facilities with advanced technological life-saving equipment than in hospice facilities or at home with hospice services (Institute of Medicine [IOM], 2013). Nurses in the ICU may be at high risk for physical, emotional, and psychological distress due to frequent exposure to death and the impact of sudden or tragic outcomes. The purpose of this DNP project is to explore grief and coping among registered nurses working in the medical intensive care unit (MICU) at a major metropolitan hospital in Hawaii. Chapter 1 will include: 1) defining the purpose of an ICU and challenges faced by nurses; 2) description of ICU patients and services; 3) the ICU nurse role and significance of their grief experiences; 4) define terms associated with end of life in the ICU; and 5) discuss the advance practice registered nurse (APRN) role in grief.

ICU nurses may experience cumulative loss as they are often routinely exposed to patient suffering and death. They must also deal with the suffering and grief of the patient's family in a time of uncertain crisis. High patient mortality, the nature of death, observing patients die despite aggressive measures, and sudden changes in pace of work are some factors identified within the ICU that contribute to profound stress in nursing staff (Burgess, Irvine, & Wallymahmed, 2010;

King & Thomas, 2013; Gerow, Conejo, Alonzo, Davis, Rodgers, & Domian, 2010). Nurse responses to patient deaths may vary. Some nurses thrive in the ICU while others become distressed, leading to burnout, illness, absenteeism, reduced staff retention, and other negative impacts (Burgess et al., 2010; Mealer, Jones, & Moss, 2012).

While literature substantiates nurses being impacted by patient deaths physically, emotionally, and psychologically, it does not specifically address how ICU nurses cope and integrate such experiences into their lives and nursing practice (Gerow et al., 2009; Wilson & Kirshbaum, 2011). Bereavement may affect nursing performance, delivery of care, and clinical outcomes (Piquette, Reeves, & LeBlanc, 2009). It is imperative for organizations to acknowledge nurses' experiences of complex scenarios, their grief, and coping strategies. Nurses should feel supported and empowered to grieve in their positions. Exploring and understanding nurse experiences of grief and coping following patient deaths will allow organizations to offer necessary support to nurses and potentially improve patient care and staff satisfaction.

## Purpose

The purpose of this DNP project is to explore grief and coping amongst registered nurses working in the MICU at a major metropolitan hospital in Hawaii. With the increasing number of critically ill patients being admitted to ICUs nationwide, nurses face daily challenges of caring for patients with little chance of surviving hospitalization or returning to baseline functioning. Currently, there is minimal literature that acknowledges the effects of patient deaths on MICU nurses and their personal grief and coping experiences. Nurse experiences of grief can help to understand how nurses cope, why they continue to remain in the field, and how organizations or managers may retain, recruit, and provide necessary support or education to staff and future

nurses. An adaptation of Margaret Newman's (2011) theory of health as expanding consciousness will be used as a framework to help guide understanding of the nurse-patient relationship in relation to the grieving phenomenon.

## Research Questions

This DNP project aims to describe grief and coping experiences of MICU nurses from their perspective with regard to varying demographics and professional (i.e., years of ICU nursing experience, gender, education) factors that affect the grief process and their preferred coping strategies. This study aims to answer the following questions: 1) Do ICU nurses believe they experience grief? 2) What circumstances in the medical ICU elicit grief for the individual nurse? 3) What is the ICU nurse's experience dealing with the loss of a patient? 4) What are nurses' responses (i.e., thoughts, feelings, and attitudes) to grief? 5) What demographic and professional factors influence the ICU nurse's ability to grieve and cope when working in the ICU? Findings of this study may be valuable in identifying factors that lead to both negative and positive coping behaviors. Also, the findings could be considered for use in determining grief and coping support needs and appropriate interventions for ICU nurses and future nurses.

## Background and Significance

### ICU Nurse Role

ICU nurses have multiple roles and require specialized training. Nurses are at the frontline of initiating, implementing, and evaluating medical treatments for patients in the ICU. More than 400,000 critical care nurses work in ICUs across the United States (Mealer, Shelton, Berg, Rothbaum, & Moss, 2007). ICU nurses are licensed registered nurses who are specially trained to provide care for critically ill patients with life-threatening conditions (American

Association of Critical-Care Nurses [AACN], 2013). They are also trained to use specialized machines and complex medical technology for the care of the critically ill.

ICU nurses also often attempt to assist patients in achieving a "good death." The Institute of Medicine (IOM, 1997) defined a "good death" as one that is free of avoidable distress and suffering for the patient, family, or caregivers, is in agreement with the patient's wishes, and is consistent with cultural and ethical standards (Borowske, 2012). The role of the ICU nurse also involves serving as patient advocates, providing education, supporting decision-making, and intervening when the best interest of the patient is questioned (AACN, 2013). They are responsible and held accountable for assuring patients and families receive quality care. An ICU nurse may feel responsible for participating in aggressive therapies or causing suffering to a patient with a poor prognosis. Along with their role, ICU nurses are frequently exposed to numerous traumatic and stressful stimuli, including addressing end-of-life decisions or prolonging life by artificial means. Managing traumatic events such as death greatly depends on a nurse's coping abilities.

**Significance of Grief on Nursing**

Frequent exposure to death can have profound impacts on individual nurses and the profession as a whole. Grief can have psychological and physical effects on an individual. Saunders and Valente (1994) mentioned that patient deaths could be a threat to health and work performance, an occupational hazard that causes negative reactions with ongoing distress. Nurses who encounter death daily and may become conscious of their own mortality, often giving rise to "death anxiety," a negative emotional reaction provoked by the anticipation of a state in which the self does not exist (Peters et al., 2013). Nurses who have anxiety toward death may be less

comfortable providing care to patients with end of life issues. Caring for the dying can also provoke distressing feelings of anxiety, sadness, guilt, and anger.

Brosche (2003) described the stress cascade (Figure 1) may occur when nurses unsuccessfully cope with a stressful stimulus, such as a patient death.

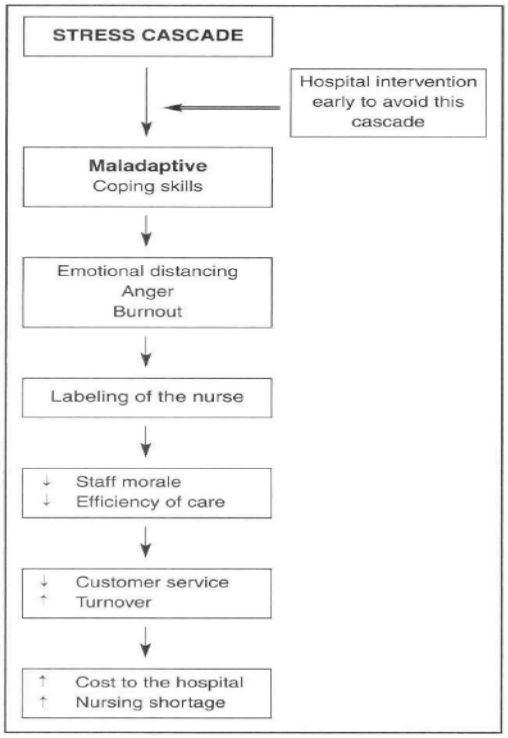


FIGURE 1. The Stress Cascade (Brosche, 2003).

The stressful stimuli in combination with the nature of the ICU environment and the need for ongoing care of other patients may not allow for adequate support or time to grieve. In the stress cascade, if the nurse does not cope effectively through learned education, experiences, coaching, or underuses available coping resources from the employing facility, the nurse will continue with ineffective or maladaptive coping skills (Brosche, 2003). Maladaptive coping can lead to emotional distancing, compassion fatigue, and burnout (Brosche, 2003; Gerow et al.,

2010). Burnout and compassion fatigue are concerns for nursing due to its association with reduced quality of care, poor communication, increased costs related to high turnover and absenteeism, and decreased job satisfaction in staff. An uncaring attitude or burnout can lead to labeling the nurse as having a behavior problem, which can contribute to reduced staff morale and efficient delivery of patient care. Numerous unresolved grief processes can lead a nurse to develop unhealthy and potentially harmful behaviors, such as substance abuse (O'Connell, 2014). Ultimately, consequences of the stress cascade include decreased quality of patient care delivery, high turnover, increased costs, and a potential nursing shortage. High stress has also been associated with a lack of teamwork, workplace tension, increased medical errors, impaired performance, and sickness (Burgess et al., 2010; Karanikola et al., 2012; Mealer, Jones, & Moss, 2012). A number of studies support the fact that ICU nursing is stressful and vulnerable to high staff turnover. Psychological distress could lead nurses to seeking other less distressing employment opportunities. There is an expected national nursing shortage of 260,000 registered nurses by year 2025 (Mealer et al., 2012). Nurses make up the largest group of health care workers in acute care settings and a shortage could negatively affect patient care in the ICU. Thus, retaining nurses in the ICU specialty is important.

Grief may also cause positive responses that promote professional development and increased consciousness or meaning of the nurse's own mortality (Saunders & Valente, 1994; Peters et al., 2013). Verbalizing feelings and expressing emotions can help a nurse process loss. Nurses who cope effectively with challenging situations are more apt to providing quality end of life care and remaining in ICU nursing. Resilient nurses are also less likely to develop any

traumatic stress disorder (Mealer et al., 2012). Such behavior could be related to learned experiences over time.

One's past experience on a personal and professional level and potentially unresolved grief can influence their professional ability to cope and care for patients. Anngela-Cole and Busch (2011) mentioned competence and education level can ease stress; those who perceived themselves to be highly competent had more positive experiences with death than those who perceived themselves as less competent. Grochow (2008) mentioned it takes two to three years of work experience to reach a competent level, emphasizing the need for ongoing education and support for newer nurses. Assimilating new nurses into the acute care setting can be challenging for both new graduates and experienced nurses. Aside from education and work experience, a nurse's ability to cope and grieve with death may depend on a number of other possible factors including, work environment, societal or cultural competence, gender, and even generational differences of nurses.

Society, culture, and norms may also have influence on values, behavior, and perceptions of stress and grief. Hawaii is largely multicultural. The United States Census Bureau (2012) mentioned ethnic minorities make up a majority of Hawaii's population: Black persons (2%), Asian (39%), Native Hawaiian or Pacific Islander (10%), Hispanic or Latino (9%), American Indian or Alaska Native (0.4%), persons of two or more ethnicities (22.9%), and white persons not Hispanic or Latino (22.9%). Cultural differences or a lack of cultural competence, race, or religion can increase nurse distress and conflict, which can be an obstacle to providing effective end of life care (Crump, Schaffer, & Schulte, 2010). In Chinese culture for instance, discussing death and dying in front of the patient is considered offensive (King & Thomas, 2013). Avoiding

end of life discussions or holding in one's emotions can lead to emotional strain on a nurse. Differences in cultural beliefs and language barriers between patient, family and the medical staff can also add to complexity of care. ICU nurses have reported that caring for family needs also contribute to emotional exhaustion and stress (O'Connell, 2008). Nurses may come from diverse backgrounds and strategies are needed to ensure cultural barriers are overcome and nurses are prepared to work with a multicultural community.

Though nurses may come from diverse backgrounds, differences in gender may provide interesting insight in grief experiences of ICU nurses. Nursing has had a long association with woman and has not attracted as many men as other professions. In 1980, there were about 45,060 male nurses but by 2004, the number of male nurses increased to 168,181 (Robert Wood Johnson Foundation, 2011). Today, men make up about 7% of all registered nurses (RNs). Men and women bring different perspectives to the field of nursing and differ in their coping mechanisms.

Traditionally, masculine norms suggested men were thought to be rational decision makers, less expressive, internalize feelings, not show vulnerability, and expected to act tough or thought of as a protector. Prior literature has also mentioned women to be more sensitive than males or implied males to be thought of as more masculine and less caring. However, a study by Wu, Oliffe, Bungay, and Johnson (2014) found that male ICU nurses could concurrently embody and counter such gender ideals. Male ICU nurses were able to demonstrate strong patient advocacy, empathy, emotions such as crying at the bedside, and sharing of their feelings with others. O'Connell (2014) found that females reported statistically significant higher moral distress than males. Understanding gender differences in grief responses and coping behavior could provide insight on developing diverse interventions for promoting wellbeing and coping

support for males and females. Recognizing gender differences in coping and overcoming stereotypes may also be important in recruiting and retaining a diverse group of men and women to ICU nursing.

Generational differences may also provide diverse insight on grief and coping. Today's nursing workforce spans four generations. Different generations have unique work habits, beliefs, and attitudes. Each interacts with and process work environments in different ways, which may affect grieving behaviors and coping practices. The three main generations in today's workforce consists of Baby Boomers (born 1946-1963), Generation X (born 1964-1980), and Generation Y (born 1981-2000) (Lavoie-Tremblay et al., 2010).

Baby boomers define themselves by their work, are hardworking and more willing to work overtime, seek to please, and are highly motivated by competition and material rewards. They may also be critical of those who have differing opinions. Generation X members do not define themselves by their work, have less job loyalty and are more skeptical. However, they are independent, motivated by praise and opportunities to learn new things. Generation Y members are technologically savvy, seek frequent feedback and direction, and prefer to work for organizations that have fast-track leadership programs where contributions are acknowledged (Lavoie-Tremblay et al., 2010). Generation Y members view challenges less positively than other generations and report higher work stress, which lead to a higher intention to quit. Acknowledging grief across generations may help to focus on strategies that organizations may use to improve work environments and support programs for all generations.

## Definitions

### Intensive Care Unit (ICU)

The intensive care unit (ICU) is an area of the hospital that cares for the most seriously ill patients by specially trained staff (American Thoracic [ATS] Society, 2013). Staff may include doctors, nurse practitioners, nurses, respiratory therapists, dieticians, social workers, rehab therapists, and pharmacists. Over 5 million patients are admitted into ICUs each year in the United States (SCCM, 2013). Common ICU admission diagnoses include respiratory insufficiency/failure, postoperative management, ischemic heart disease, heart failure, sepsis, shock, multi organ system failure, and gastrointestinal hemorrhage (SCCM, 2013). Admission to the ICU is often sudden and the patient is unable to participate in decision-making of treatment and goals of care. About 11% of patients spend more than a week in the ICU within their last six months of life and of ICU admissions only 35% to 50% survive to discharge (Borowske, 2012; Crump et al., 2010). In the ICU, the level of nursing care, patient monitoring, and nurse to patient ratio is higher than other areas of the hospital (ATS, 2013). Patients may require mechanical ventilation, cardiovascular support, invasive monitoring, artificial nutrition and hydration, frequent laboratory tests, frequent radiologic imaging, and hemodialysis. The ICU environment may be highly stressful due to incessant noises from alarms and requiring specialized training to manage monitors, pumps, and ventilators.

### Grief

Grief can be defined as an unhappy and painful emotional reaction to a major loss, or death (Buglass, 2010). It may also be experienced if an individual or patient has a chronic condition that negatively affects quality of life or there is no cure for the illness. Grief is resolved

through the process of mourning, or active expression of grief behaviors and emotions. Through the process of grieving, people may clarify what is important and meaningful in their lives, choose how to continue living, and learn to live with loss in new ways (Pilkington, 2006). Grief may be affected by personality, culture, beliefs, or relationship with the deceased or the nature of death. Managing grief is a way of coping.

**Coping**

Coping is a way of coming to terms with loss and expressing and managing difficult emotions (Buglass, 2010). This is a process of moving on with everyday life. A person must deal with the experience of loss and the changes that may result from it. Each individual is unique and copes in his/her own way. However, if coping is ineffective, it can lead to negative behaviors such as depression, anxiety, or interfere negatively with daily life. Understanding coping processes of ICU nurses is valuable to supporting other nurses and their ability to thrive and cope effectively in the ICU. Discovering characteristics of those who are able to maintain healthy and stable psychological functioning in spite of major stressors may be helpful for supporting future and fellow ICU nurses.

## Role of Advance Practice Nurse

The current health care system is complex, chaotic, and constantly changing. Increasingly complex health care systems require leaders that are adaptable, flexible, and have the ability to synthesize large amounts of knowledge and deliver valuable outcomes. The Doctor of Nursing Practice (DNP) degree was created in response to challenges and gaps in the current health system. A nurse practitioner (NP) is in an advance practice registered nurse (APRN) educated at a Masters or post Masters level and in a specific role and patient population (National Council of

State Boards of Nursing, 2014). They are prepared and certified to assess, diagnose, manage patients, order diagnostic exams, and prescribe medications. The DNP prepared NP is suited not only for clinical practice but also to perform as a leader in identifying problems, forming innovative solutions, and facilitating change to improve patient care and system level outcomes (Montgomery, 2011). A DNP prepared NP is an expert in implementing research in the clinical area and can facilitate initiatives to expand and improve outcomes in all systems (Sonson, 2013).

This DNP project supports the role of the DNP prepared NP as a leader in identifying and exploring potential issues of grief and coping amongst ICU nursing staff. The NP can also identify needs for further grief or coping education or support services within the organization. Nurse wellness (i.e., mind, body, spirit) has a direct impact on the quality of care nurses provide (Dumpe, 2009).

## Summary

Nurses in the ICU are repeatedly exposed to traumatic and stressful situations. ICU patients are critically ill and have a high mortality rate. Such stress can cause nurses grief, emotional distress, and burnout. While some nurses are highly resilient, cope effectively, and thrive in the ICU setting, others may become distressed overtime and seek other employment settings. At a time where nursing shortages are on the rise, understanding coping abilities and nurse experiences of grief in complex situations is important. Findings can assist organizations and managers with finding solutions to improve job satisfaction, support nurses, and retain or recruit staff. Currently, there is limited qualitative research available on examining ICU nurse grief and coping abilities. The role of the DNP prepared NP is not only to clinically provide care

to patients but also to serve as a leader in research with intent to create innovative changes within the organization and develop the nursing profession with research findings.

# CHAPTER 2: REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

## Grief and Bereavement

This chapter will discuss the context of grief, manifestations, and process of grief with views by various theorists. Later in the chapter, the conceptual framework for the study will be discussed. Grief is often experienced in settings of life-threatening illness. Death and loss are common situations that nurses frequently encounter in their line of work. Nurses who understand their reactions and responses to grief and bereavement are in a better position to cope effectively and provide support to patients and families.

## Grief Context

Grief is defined as a natural human response to separation and loss, particularly of a loved one (Buglass, 2010). Grief is resolved through the process of mourning. Mourning is an outward and active expression of grief. Bereavement is the state of having experienced a loss, which grief and mourning occur (Buglass, 2010). The terms are often used interchangeably.

Fulton and Fulton (1971) in Doka (2006) proposed the concept of "anticipatory grief," which referred to the patient or family member anticipating death and beginning the grieving process early on when they perceived a terminal prognosis. Furthermore, if the situation was prolonged, family members may withdraw from the dying person and express little grief at the actual time of death (Doka, 2006). An illness may cause many different types of losses that lead to grief. Perceived losses may be intangible such as, loss of future dreams; or tangible such as, loss of critical functions, body parts, jobs, relationships, and independence. Furthermore, Doka (2006) explained that grief does not only pertain to a death. In fact, prolonged illness can

produce intense grief by causing increased uncertainties about a loss and even create ethical conflicts such as withholding or withdrawing treatment.

## Manifestations of Grief

Grief may be experienced throughout an illness and after a death. Grief may have emotional, physical, behavioral, cognitive, social, and spiritual dimensions (Buglass, 2010). It may be manifested in a variety of ways.

Physical reactions may include nausea, headaches, or other body aches and pains. Grieving individuals have been associated with increased cardiovascular death, heart disease, and depression (Jurkiewicz & Romano, 2009; Mostofsky, Maclure, Sherwood, Tofler, Muller, & Mittleman, 2012). This may be related to a grieving person's lifestyle factors such as poor diet or lack of exercise (Doka, 2006). Stress could also have negative effects on health. Emotional responses to loss includes, anger, guilt, anxiety, sadness, and withdrawal.

Cognitive responses to grief include, shock, denial, inability to process information, impaired judgment, and limited concentration. Grief can also affect behaviors, which may include lethargy, hyperactivity, sleep disturbances, eating habits, and engagement in risky behavior.

Spiritual responses to grief include a struggle with spiritual questions, views of death as a punishment, or a search for meaning in the nature and timing of death or illness (Doka, 2006). Finding benefit in death can sometimes alleviate grief for certain individuals. The various emotional, physical, behavioral, cognitive, social, and spiritual manifestations of grief may be affected by numerous factors. Theories of grief have been formed over time in attempts to describe the general phenomenon.

## Theories of Grief

Each society constructs its own way to understand grief and mourning (Rosenblatt, 2001). Exploring and understanding the stages and influences of grief can help to cope with issues experienced during a loss. A number of theories and models of grief help describe the process and stages involved.

Early models viewed the process of grief as a pre-determined, sequential set of steps an individual experiences during a loss. For example, Kubler-Ross (1969) mentioned a dying or grieving individual goes through stages: 1) denial and emotional detachment; 2) anger and blame; 3) bargaining; 4) depression and sadness; before reaching 5) acceptance (Buglass, 2010). However, recent theorists recognize that such an approach lacks individual and cultural differences in grief experiences.

Freud (1961) considered grief as a solitary process, where grieving individuals withdrew from the world so detachment from the deceased could be a gradual process. This approach emphasized extensive cognitive and emotional processing of the loss, which could exacerbate grief (Doka, 2006). Grief was believed to free an individual from bonds with the deceased. Letting go of, or detaching from the deceased helped to overcome grief. However, avoiding thoughts of the deceased and excessive reflection is thought to be maladaptive (Doka, 2006).

Another theorist Bowlby (1973) emphasized the importance of human attachment developed in early life. Attachment and relationships begin in infancy between child and parents and later between adults (Buglass, 2010). Grief evolves through the overlapping and flexible phases of shock, yearning, despair, and recovery (Buglass, 2010). Emotional distress results when the bonds or attachments formed (i.e., with other people) are broken and lost. Working

through grief means that one must confront the experience of loss and reality to come to terms with death and avoid negative consequences such as insomnia or social withdrawal.

The dual process model of coping by Stroebe and Schut (1999) described a flexible approach to interpretation and management of grief. It explains how a person copes with the experience of loss in everyday life, with other lifestyle changes that occur as a result of the loss or, recreating a new life despite a loss (Buglass, 2010; Doka, 2013). There is a two-way process (dual) of coping in which the person moves between grief and coming to terms with the loss (Buglass, 2010).

Health professionals such as critical care nurses, often form relationships with patients and family members. The death of a patient may be a personal loss to a nurse. Furthermore, one may experience the loss of unmet goals or expectations. Unexpected deaths or deaths of young patients may challenge a nurse's beliefs about life, bring up past unresolved or anticipated losses, and compound grief. The theories of grief are helpful in understanding whether nurses do in fact go through stages and cope in the midst of their work.

## Coping Strategies

Coping strategies refer to efforts people use to overcome, tolerate, reduce, or minimize stressful events (Taylor, 1998). Two broad categories of coping styles have been distinguished: problem-solving coping and emotion-focused coping (Taylor, 1998; University of California Los Angeles [UCLA], 2014). Problem-solving coping are efforts to do something active to alleviate a stressful situation. Emotion-focused coping involves efforts to control emotional consequences of a stressful situation. Literature indicates that people use both types of strategies (UCLA, 2014).

Additionally, coping strategies are characterized as active or avoidant. Active coping strategies involve an awareness of the stressor followed by behavioral or psychological responses that attempt to change the nature of the stressor or how one thinks about it. Some specific active coping strategies include humor, seeking support, problem-solving, relaxation, physical recreation, adjusting expectations, denial, self-blame, and venting (UCLA, 2014). On the contrary, avoidant coping strategies are characterized by ignoring the stressor and lead people into activities such as alcohol or drug use (Taylor, 1998; UCLA, 2014). Ineffective coping or maladaptive coping can occur if grief is not resolved effectively and can be referred to as complicated grief (Smith & Segal, 2014). Complicated grief can disrupt daily routines and relationships.

## Effects of Grief on Nursing

Dealing with death is hardly thought to be easy and yet, death is unavoidable by all. ICU nurses are confronted with end of life issues and death on a daily basis. The effects of grief on nursing are vast and may potentially influence positive and/or negative reactions emotionally, spiritually, psychologically, and physically. Experiences of death may only be understood through the study of dying, when individuals encounter their own death, or share the experience of another's death (King & Thomas, 2013).

### Emotional Effects

Some nurses may grieve together with the patient and family. Whereas, some nurses may avoid emotional connection with the dying patient. Grief and complicated grief can lead to intrusive thoughts or images of the deceased, avoidance, fear, anger, or feelings of emptiness, helplessness, and sadness (Smith & Segal, 2014; Brysiewicz & Bhengu, 2000; Papadatou &

Bellali, 2002; Tyra & Crocker, 1999). Philosophers such as Kierkegaard (1980) and Heidegger (1927; 1962) wrote about the universality of humans avoiding thoughts about nonexistence, as it causes anxiety and dread (King & Thomas, 2013). A nurse's attitude toward death, experience level, and individual beliefs can affect objectivity in caring for patients.

Peters et al. (2013) found that regardless of cultural settings in which nurses worked, younger nurses under the age of 30 consistently reported greater fear of death and negative attitudes toward end-of-life care. However, nurses that participated in a six-hour workshop on death and dying reported significantly less fear of death. Peters et al. (2013) also found studies from other countries showed worksite death education programs reduced death anxiety. This evidence suggests that those with negative attitudes towards death may benefit from death education. Nurses have also reported feeling unsatisfied with the preparation and education for death and dying in undergraduate nursing programs (Kent, Anderson, & Owens, 2012). Puntillo et al. (2001) revealed support services such as ethics consults and grief counseling for staff rarely or never occurred (King & Thomas, 2013). Kent, Anderson, & Owens (2012) found that only about half of respondents (53%) agreed they knew where to get support if needed, after dealing with a patient's death. Lastly, Gelinas et al. (2012) found that a major stressor for ICU nurses was just not dealing with the death of their patient, but the vast efforts that a nurse must take to advocate for the dying patient to provide respectable conditions. Other qualitative studies have pointed out critical care nurses report suffering along with the dying patient, dissatisfaction with the nursing profession related to the level of suffering, personal conflicts, and even avoidance and removal of emotional connections with the dying patient (King & Thomas, 2013).

**Secondary Traumatic Stress**

The psychological effects of critical care nurses related to their work environment are also important. Since ICU nurses work in demanding environments where they are continuously exposed to traumatic situations, they may be at risk for experiencing physical and mental exhaustion. Such exhaustion can lead to secondary traumatic stress (STS), burnout, and compassion fatigue. STS, burnout, and compassion fatigue are often used interchangeably (Sheppard, 2014). Nonetheless, each concept is closely related and there are many studies that have defined each terminology separately.

STS is defined as the negative emotions and behaviors experienced as a result of being exposed to other people's traumatic experiences (Von Rueden et al., 2010). STS has also been defined as a condition of symptoms that are nearly identical to those in posttraumatic stress disorder (PTSD) (Jenkins & Warren, 2012). PTSD is also associated with exposure to traumatic experiences. Repetitive exposure to extreme stressors such as witnessing traumatic patient deaths can be associated with increased prevalence of symptoms similar to PTSD in nurses (Mealer et al., 2007). Mealer et al. (2007) found that ICU nurses in a metropolitan area had an increased prevalence of PTSD-like symptoms such as anxiety, nightmares, irritability, anger, and depression compared to general medical-surgical nurses. About 20% of nurses had symptoms consistent with possible anxiety disorders and 30% had symptoms of depression (Mealer et al., 2007). Another study by Mealer et al. (2012) identified characteristics of highly resilient ICU nurses using the validated Connor-Davidson Resilience Scale (CD-RISC) and compared traits to nurses with PTSD symptoms. They found that resilient nurses (CD-RISC scores of 92+) accepted death as a natural part of life, utilized active coping skills such as prayer or laughter,

maintained optimism, and were able to find a positive role model. Whereas, the group of nurses who exhibited PTSD symptoms reported little to no support from family or friends, sleep disturbances, and were less likely to identify with spirituality or optimism. Of note, it was unlikely that most of the care nurses met formal or definitive diagnostic criteria for PTSD but shared similar characteristics. These findings increase awareness that symptoms similar to PTSD occur more in ICU nurses and can lead to future interventions to improve mental health, job satisfaction in the ICU, and address nurse retention. Understanding characteristics of nurse grief experiences can help employers and educators to develop grief-training programs or create supportive environments that nurture effective coping habits.

**Burnout**

Another possible effect of grief on nursing is burnout. Burnout is described as the ineffective ability to cope with stress at work and encompasses decreased overall wellbeing (Poncet et al., 2007). Symptoms of burnout are related to emotional exhaustion and develop gradually overtime. Symptoms include, fatigue, illness, sense of helplessness or hopelessness, lack of productivity, decreased job performance, and negative relationships with others (Young, Cicchillo, & Bressler, 2011). Work environment, workload, and unfair treatment are some contributing factors of burnout (Sheppard, 2014; Young et al., 2011). Poncet et al. (2007) used the Maslach Burnout inventory questionnaire and found that one-third of ICU nurses had severe burnout. This suggested that preventive strategies are urgently needed. Another effect of grief includes compassion fatigue, which overlaps with burnout and STS.

**Compassion Fatigue**

Compassion fatigue (CF) refers to reduced work satisfaction or when the job causes more distress than satisfaction (Stamm, 2010). The Professional Quality of Life (ProQOL) instrument by Stamm (2010) addresses risk of CF by assessing the three components that make up CF: burnout, STS, and loss of compassion satisfaction. Compassion satisfaction is the sense of accomplishment and pleasure associated with caring for a patient (Hinderer et al., 2014; Sheppard, 2014). Compassion fatigue may be manifested by low morale, apathy, cynicism, hopelessness, and irritability (Sheppard, 2014). Other characteristics of CF include sleep disturbances and errors in judgment (Jenkins & Warren, 2012). Nurses who are exposed to repeated deaths over time and lack adequate coping strategies have been found to be at higher risk of CF (Melvin, 2012). Studies have also found that greater than 65% of ICU nurses reported experiencing moral distress and compassion fatigue (Mason et al., 2014). Such effects can lead to becoming mentally, physically, and spiritually exhausted and may lead a nurse to absenteeism or leaving the profession prematurely, which can contribute to a potential nursing shortage. Thus, helping nurses cope with death is critical to recruiting and retaining ICU nurses and improving the work environment.

**Nursing Shortage**

Due to increasing demands in ICU level of care, the demand for ICU nurses is expected in increase in the upcoming years. By year 2025, it is estimated there will be a nursing shortage of 260,000 registered nurses and 114,000 vacant critical care nursing positions in the U.S. (Mealer et al., 2012). According to a previous national survey, a common reason for considering leaving a job was related to work stress (Stechmiller, 2002).

## Conceptual Framework

Grief has been recognized as a universal phenomenon that is inherent in the human life and death cycle (Jonas-Simpson, Pilkington, MacDonald, & McMahon, 2013; Walter & McCoyd, 2009; Bonanno, Goorin, & Coifman, 2008). However, grief manifestations are unique and diverse across individuals and groups. Many nurses grieve the loss of patient deaths but their grief is often unacknowledged or discussed (Jonas-Simpson et al., 2013). Recent qualitative literature on the phenomenon of caring for the dying has focused on research-selected variables such as stressors, anxiety, barriers to care, or burnout. Research on the entirety of the grieving phenomenon is needed, especially in the ICU setting. Thus, an adaptation of Margaret Newman's (2011) theory on health as expanding consciousness will be used as a conceptual framework to guide this study in understanding the grief experiences in the ICU nurse. Newman's theory was inspired by her own personal experiences and ideas of other scholars who focused on the connections between mind, body, and spirit to improve human health (Newman, 1994; 2008). The individual grief experiences of ICU nurses and its influence on the mind, body, and spirit inspire the inquiry of this DNP project.

### Conceptual Framework: ICU Nurse Grief and Health as Expanding Consciousness

Many principles of Margaret Newman's (2011) theory of health as expanding consciousness can be applied to the nurse grief phenomenon. Margaret Newman is a nurse theorist whose focus is on caring and health, where health refers to disease, non-disease, and even death. Newman believes that building caring relationships is a defining aspect of nursing practice and expanded consciousness is a manifestation of health and caring (Newman, 2003).

Newman's (2011) theory, "health as expanding consciousness" proposes a mutual process between the nurse and client by which meaning and understanding of the client's health patterns are recognized in order to gain insight and facilitate potential action (Crawford, Shearer, & Reed, 2004; Reed & Shearer 2011). Consciousness is the informational capacity of the human and is revealed in the evolving pattern of the whole (i.e., person, environment, self-awareness, health). As consciousness expands, the client becomes more of his/her real self and may find greater meaning in his/her life and the lives of others (Newman, 2011). A crisis pushes an individual to a higher level of consciousness, where he/she becomes more aware of the environment and may take actions to improve one's health. In terms of grief, a nurse may use experiences of loss and patient relationships to work through crises to gain a higher level of consciousness and awareness of death and grief, which enables moving forward in their lives.

At the highest level of consciousness, the client remains in the present, there are no boundaries, no opposites, and all experiences (disease and non-disease) are considered equal (Newman, 2003). The more successfully a person interacts with the environment, the higher the level of consciousness.

Also in Newman's theory (2011), patterns reflect interactions between person and environment and are formed from responses and experiences (Jones, 2006; Meleis, 2012). People go through patterns of order and disorder that is continuously evolving. Through nurse-client-environment interactions, a large part of the nurse role is to assist patients in pattern recognition. Once a client/patient recognizes the patterns and effects of certain health behaviors, one gains awareness of what changes need to be made and act on it. Pattern recognition helps the client gain insight to understanding and uncovering meaning in a person's life and take new action. As

ICU nurses interact with his/her environment and ongoing situations involving death or dying, they can gain insight of grief and coping methods. The process of expanding consciousness creates an environment of caring that promotes healing and healthy behaviors.

Newman's theory (2011) supports the concept of grieving as a lived experience filled with meaning and patterns of relating rather than a problem to be fixed. The theory of health as expanding consciousness offers a nursing perspective that acknowledges and honors clients' histories, unique experiences, desires, and goals. According to Newman (2008), it is important for a nurse to be completely present and attend to the patterns that occur in clients' lives to create a safe environment to adapt and cope with life's directions. A nurse must be willing to accept periods of ambiguity and chaos in order to move on to higher levels of consciousness. Consciousness is not bound by time or space and all humans are part of a greater consciousness. The care provided by the nurse and interactions experienced may also expand nurses' consciousness.

Bateman and Merryfeather (2014) describe a nurse who realized that intentionally interacting with clients in meaningful ways to assist them in achieving goals allowed her to increase her self-awareness, advance her levels of consciousness, and knowledge that evolution is a life-long venture. Furthermore, the nurse was able to increase her own effectiveness at work after attending to patterns in her life and enacted change on elements that held her back (Bateman & Merryfeather, 2014). Zust (2006) described a cancer nurse's experiences of caring for two dying patients helped expand her consciousness in different ways. The nurse had not encountered the process of dying prior to the first patient's death. She realized that nursing was not primarily about technical nursing skills used to treat and cure disease (Zust, 2006). Her

consciousness was expanded by the experience and was able to move through a period of chaos to peace by taking that experience using her new understanding of death for future interactions.

My adaptation of Newman's (2011) theory includes similar perspectives but focuses on acknowledging and understanding the experiences of grief/crises on the nurse. ICU nurses may go through flexible phases (e.g., shock, withdrawal, despair, acceptance) of grief as mentioned by various theorists (i.e., Kubler-Ross, 1969; Freud, 1961; Stroebe & Schut, 1999) to confront the experience of loss, bonds formed, and the reality of death, to come to terms with loss. Death is not the end of consciousness but rather a major fluctuation in one's pattern to a greater consciousness.

Literature has provided evidence to show that situations involving death, dying, and end of life decisions, place burden on doctors and nurses in intensive care units (McMillen, 2008). Acknowledging the experiences of the ICU nurses can help them discover meaning or new understandings of what has happened during past encounters, see what has been done, re-establish relationships, and form connections to life goals.

## Summary

Grief is a natural human response to separation and loss, particularly of a loved one and is resolved through the process of mourning (Buglass, 2010). Grief may have emotional, physical, behavioral, cognitive, social, and spiritual components. It may be influenced by one's environment, past experiences, culture, and support network. A number of processes may help to explain grief. For instance, the dual process model of coping by Stroebe and Schut (1999) described a flexible approach to interpretation and management of grief. It explains how a person copes with the experience of loss in everyday life, with other lifestyle changes that occur as a

result of the loss or, recreating a new life despite a loss (Buglass, 2010; Doka, 2006). There is a two-way process (dual) of coping in which the person moves between grief and coming to terms with the loss. Since patients in the ICU require complex assessments, intense therapies and interventions, and continuous nursing care, the ICU can be a highly stressful setting. ICU nurses are also often exposed to repeated traumatic work stressors including, addressing end of life needs, and high patient mortality or morbidity. Such stress may lead to negative health effects, burnout, and decision to leave ICU nursing. Using principles of Margaret Newman's (2011) theory of health as expanding consciousness can help to discover ways nurses increase their knowledge of grieving, create meaning from patient death, and how experiences affect their nursing practice.

# CHAPTER 3: METHODS

## Design

A qualitative descriptive approach was used to explore experiences of grief and coping from the MICU nurse's perspective. Qualitative descriptive research draws from principles of naturalistic inquiry, implying a commitment to studying something in its natural state. Studies present comprehensive summaries of the phenomenon and produce findings closer to the data, where facts are presented in everyday language (Sandelowski, 2000; 2010).

Qualitative descriptive research may also have overtones of theoretical and philosophical underpinnings for collecting or analyzing data. However, findings may not produce any theoretical rendering of the target phenomenon (Sandelowski, 2000; 2010). Although this inquiry is qualitative descriptive in nature, it includes a conceptual framework relating ICU nurse grief.

By listening to the ICU nurse experiences of grieving and coping after patient deaths may reveal how their consciousness is expanded, move on with life, and remain working in the ICU setting. When nurses engage in dialogue with full presence, the sharing of their experiences can be a way to reflect and understand a deeper sense of their clinical encounters and the nurses' role in them (Wolff, 1976 in Zaner, 2006; Aloi, 2009).

## Sample and Setting

The Queen's Medical Center (QMC) Punchbowl is a private, non-profit, acute medical care facility with 533 acute care beds and 28 sub-acute beds. It is a Level II trauma center and the only designated trauma center in Hawaii. QMC is the largest private hospital in Hawaii and the leading medical referral center in the Pacific Basin (QMC, 2014). QMC is also accredited by The Joint Commission and is the first and only hospital in Hawaii to receive Magnet recognition

from the ANCC.

The setting of this DNP project concentrated on the medical ICU (MICU) at QMC Punchbowl. The MICU consists of 19 private rooms. Common patient conditions that are treated in the MICU include, myocardial infarction (MI), shock (e.g., cardiogenic, sepsis, distributive), chest pain with EKG changes, life threatening arrhythmias (e.g., SVT, VT, heart block), cardiac invasive thrombolytics, respiratory failure, obstetric patients with cardiac complications, and overflow from trauma and neurosciences ICU (QMC, 2014).

The sample focused on registered nurses (RNs) from the QMC Punchbowl MICU only. Purposive sampling was used. RNs working in the MICU with greater than one month of ICU experience and who spoke English were invited to participate in the study. RNs not working in the MICU and who were without any ICU experience were excluded from participating in this study. Diversity in age, experience level, education level, and cultural background were sought. Five nurses (n=5) from the MICU volunteered to participate and all completed the study.

No power analysis was conducted to determine the number of participants needed. Since this is a qualitative study, generalizabity is not as much an issue as in quantitative studies. Rather, the sample is selected in order to understand phenomenon.

**Recruitment**

After approval was obtained form the University of Arizona IRB and the Queen's Medical Center IRB, recruitment of the sample participants began. QMC MICU nurse participants were recruited through verbal notifications of the upcoming study in daily staff huddles each shift (morning and night), followed by dissemination of the study information via attached flyer (Appendix C). A few (3-4) flyers were passed around during huddle for viewing

and one flyer was also posted on the information board in the staff lounge. Interested participants contacted the principal investigator (PI) if they were interested in participating. Nurses who were interested and verbally agreed to participate in the study were contacted in person, by phone, or email to arrange the interview time and place of choice. Participants scheduled one-on-one interviews at a time that did not conflict with their work hours or require them to miss work. The interviews were all held in a private QMC conference room,

## Procedures

Participants were required to provide consent by signing the attached informed consent form (Appendix D) to participate in the study. Consent was obtained at the time of the interview at the negotiated time and location. The PI was responsible for explaining and administering the consent form to each participant.

## Data Collection

After informed consent was obtained, in-depth semi-structured, open-ended interviews took place. At the interview, participants were also asked to fill out a brief questionnaire form regarding demographics and professional data (Appendix A). Interviews were audio recorded and transcribed verbatim. The audio files and questionnaire data were kept in a secured and encrypted digital file, accessible only by the PI. Audio recordings were destroyed immediately after transcription. Participants' identities were kept confidential. Both the questionnaire and interviews used only a participant number for identification (i.e., participant #1, #2, #3). All five nurses participated in completing the questionnaire and interviews, a process that lasted approximately 30-45 minutes.

The open-ended interview questions aimed to encourage participants to engage in

dialogue with the PI about grief and coping experiences in the MICU. See Appendix B for the interview questions. Interview questions were based on the PI inquiry to understand the grieving and coping phenomenon in ICU nurses. The interview and questionnaire questions have been chosen to answer the study's research questions: 1) Do ICU nurses believe they experience grief? 2) What circumstances in the medical ICU elicit grief for the individual nurse? 3) What is the ICU nurse's experience dealing with the loss of a patient? 4) What are nurses' responses (i.e., thoughts, feelings, attitudes) to grief? 5) What demographic and professional factors influence the ICU nurse's ability to grieve and cope when working in the ICU?

Data collection was primarily through researcher-participant interaction and open sharing of stories and experiences in their own terms. The interaction between researcher and participant produces the data and therefore, the meanings the researcher observes and defines (Mills et al., 2006). Charmaz emphasized keeping the research close to participants by keeping their words intact throughout the process of analysis in order to maintain the participants' presence (Mills et al., 2006). Results from the data can be enhanced when the research includes a description of the situation, interaction, person's affect and perception of the interview (Mills et al., 2006).

## Risk

Participants were notified prior to the interview, that participation could potentially elicit negative emotions or reactions. The participant was highly encouraged to seek professional help if experiencing any negative emotion or reaction (i.e., inability to function at work/home, intrusive thoughts, anger, guilt, sadness, emptiness, etc.). Participants were advised to contact a local grief counselor or mental health professional right away if the reactions occurred. The participant could also seek help from their preferred specialist. Otherwise, the participants were

be reminded they were eligible as a QMC employee, for free confidential and professional counseling services at the Employee Assistance of the Pacific for personal or work issues.

## Compensation

Participants were given one $20 gift card from the PI as a token of appreciation for participating in the study. Participants were to receive the gift card regardless if they completed the entire study or not. This project was not funded by anyone but the PI.

## Data Analysis

Summaries of interview data were done at data analysis and included precise depictions of events and data that most people, including the researcher and participants would agree is accurate. Some quantitative analysis was also done to summarize data from the Demographics and Professional Characteristics Questionnaire (Appendix A).

Qualitative content analysis is the strategy of choice in qualitative descriptive research (Sandelowski, 2000). It is used to describe a phenomenon and is appropriate when existing research literature is limited (Hsieh & Shannon, 2005). This type of analysis is the least interpretive approach and intends to summarize informational content of narrative data in its own terms while identifying prominent themes or patterns (Polit & Beck, 2012). Analysis techniques used in qualitative descriptive studies are based on a "factist" perspective, where data is assumed factual, accurate, and truthful indicators of reality.

Analysis was systematic and organized to easily locate information and trace results back to the context of the data. During analysis, the PI was immersed in the data, reading transcribed interview data word for word multiple times to allow category codes to emerge from the data. Any general themes that emerged from the data were noted. Furthermore, words and phrases that

were repeatedly used by nurses were highlighted. This process was done multiple times over a couple of weeks. Categories and themes were modified or even discarded throughout the analysis process. Data was then organized into the two main categories of grief and coping.

Specific strategies were used to ensure rigor of this study. Trustworthiness of the data analysis is described according to Guba's (1981) and Lincoln and Guba (1985) criteria of credibility, transferability, dependability, and confirmability.

Credibility is defined as the confidence that can be placed in the truth of the findings (Guba, 1981; Anney, 2014). To establish credibility, multiple data sources (i.e., questionnaire and interviews) were used to produce understanding of the phenomena and examine integrity of participants' responses. This is also known as triangulation. The research PI had prolonged engagement in the participants' world or research site, in this case, the MICU; interviews and descriptive analysis occurred over two and a half months, and member checking of field notes was done at the end of each interview. Furthermore, peer debriefing was done with a faculty member of this project's research committee.

Transferability refers to the extent findings could be applied to other situations (Anney, 2014; Lincoln & Guba, 1985). Efforts were made to write the narrative data, any interpretations, and research processes clearly and concisely with thick description. Furthermore, purposive sampling was used to select individuals based on the specific purpose to answer the research questions of this study. The sample was chosen to contribute valuable insights and relevant information related to grieving and coping. Through thick description of the research participants, setting, and processes, others may be able to determine transferability of findings.

Dependability refers to the stability of findings remaining consistent over time and the ability be replicated (Guba, 1981). This was accomplished through attempts to maintain an audit trail to determine how decisions were made during analysis. The audit trail included the transcribed interviews, notes taken during the interview, and written descriptions of themes or categories that emerged and were reformulated over the analysis period.

Confirmability refers to objectivity of the data. This was accomplished with the audit trail and triangulation.

# CHAPTER 4: RESULTS

## Demographics

One of the research questions of this study aimed to answer what demographic and professional factors influence the ICU nurse's ability to grieve and cope when working in the ICU. Demographical and professional data of nurse participants was obtained from the Demographics and Professional Characteristics Questionnaire (Appendix A). One hundred percent (n=5) of the five participants completed the study and answered all questions in the questionnaire form.

Table 1 summarizes the demographics of the participants and answers research question five: 5) What demographic and professional factors influence the ICU nurse's ability to grieve and cope when working in the ICU? All five of the nurse participants work full-time 12-hour day, night, or rotating shifts. Registered nurse experience of the participants ranged from four to 12 years. MICU nursing experience of participants ranged from one to eight years. Two nurse participants hold Bachelor of Science in nursing (BSN) degrees. Two nurse participants hold associate's degrees in nursing (ADN). One participant holds a Master's degree in nursing (MSN).

Two of the five participants were male gender and three were female gender. They identified themselves as being of Asian and Caucasian ethnicity. Participants indicated they were born between the years of 1963 and 1987 (ages 28-52). One participant is from the Baby Boomer generation, two participants are from Generation X, and two participants are from Generation Y.

Less than half (n=2) of sample participants have indicated they had prior death education, which was either provided by a prior hospital organization or have attended a death seminar. The

remainder of sample participants (n=3) indicated they did not receive any death education prior to working as a nurse or in the ICU. The level of education and work experience of the nurses in this study did not seem to reveal obvious grief and coping differences amongst participants.

At the time of study participation, one participant experienced a patient death greater than or equal to five weeks ago, two participants experienced patient deaths two weeks ago, one participant experienced patient death one week ago, and one participant had experienced patient death less than one week ago.

TABLE 1. Results on Research Question 5: *Demographics* (N=5)

| | | | | |
|---|---|---|---|---|
| **Age** | 21-30=1 | 31-40= 3 | 41-50=0 | 51-60 =1 |
| **Generation Profile** | Baby Boomer=1 | Gen X=2 | Gen Y=2 | |
| **Gender** | Female=3 | Male=2 | | |
| **Ethnicity** | Asian=1 | Caucasian=3 | Asian+Caucasian= 1 | |
| **ICU Experience** | 1-3 years=1 | 4-6 years=2 | 7-9 years=2 | 10-12 years=0 |
| **RN Experience** | 1-3 years=0 | 4-6 years=3 | 7-9 years=1 | 10-12 years=1 |
| **Education Level** | ADN=2 | BSN=2 | MSN=1 | |
| **Prior Death Education** | Yes=2 | No=3 | | |
| **Last Patient Death** | <1 Week Ago=1 | 1 Week Ago=1 | 2 Weeks Ago=2 | 5+ Weeks Ago=1 |

The questionnaire also provided supplemental data to address research questions one and four: 1) Do ICU nurses believe they experience grief? 4) What are nurses' responses (i.e., thoughts, feelings, and attitudes) to grief? Table 2 describes the effects of grief experienced by participants after patient deaths and the frequency experienced. These findings indicate that MICU nurses do experience grief and are affected by their patients' deaths. However, it appears that the ICU nurses are able to cope with ongoing patient deaths well enough to not experience negative consequences often or very often. Further answers to the research questions are displayed in the narrative findings.

TABLE 2. Results on Research Question 1 (*Do ICU Nurses Experience Grief*) and Research Question 4 (*Nurse Responses to Grief*) (N=5)

| Participant | Experienced After Patient Death | Frequency |
|---|---|---|
| Participant 1 | Anger, sadness | Sometimes |
| Participant 2 | Anger, insomnia, guilt | Rarely |
| Participant 3 | Nightmares, insomnia, sadness, guilt, anxiety | Sometimes |
| Participant 4 | Sadness, relief | Rarely |
| Participant 5 | Anger, insomnia, sadness | Sometimes |

## Findings

The questionnaire data and interviews with participants appear to show evidence that MICU nurses do indeed believe they experience grief. Study participants described many elements of their MICU nursing experiences, which offers a source for better understanding the grief and coping phenomenon. The findings of this study are presented in two main categories: grief and coping. Subthemes of grief are described in the following categories: 1) circumstance of death; 2) keeping professional boundaries; 3) being supported; and 4) learning from experience. Coping is defined by the main methods used by the nurse participants. Coping includes: 1) talking and being heard; 2) finding a support system; 3) using humor; and 4) spirituality. Table 3 briefly summarizes the answers to research questions two and three: 2) What circumstances in the medical ICU elicit grief for the individual nurse? 3) What is the ICU nurse's experience dealing with the loss of a patient?

TABLE 3. Results on Research Question 2 (*Grief Circumstances*) and Research Question 3 (*Nurse Experiences of Grief)*

| **Research Question** | **Answer** |
|---|---|
| *What circumstances in the MICU elicit grief for the individual nurse?* | Grief<br>• Circumstance of death<br>o Sudden change in patient stability leading to death<br>o Preventable situations<br>o Patient appears distressed<br>o Young age of the patient<br>• Ability to maintain professional boundaries<br>o Compartmentalize<br>o Importance of fulfilling RN role/duties<br>• Being supported<br>o Family, peers, professional, organization<br>• Learning from experience<br>o Increased knowledge of death<br>o Personal thoughts, values, and beliefs of death became clearer/broader<br>o Positive influence on behavior |
| *What is the ICU nurse's experience dealing with the loss of a patient?* | Coping<br>• Talking/Being heard<br>o Share experiences<br>o Let out frustrations<br>o Acknowledgement of care provided<br>• Support system<br>o People to confide in<br>• Humor<br>o Making situation less grim<br>• Spirituality<br>o Prayer, meditation, religion |

## Grief Factors

### Circumstance of Death

To begin to understand the grieving experience in MICU nurses, the grief inflicting circumstances that are reported by MICU nurses must be explored. Participants discussed at

length the situations in which they experienced some form of grief. The death of a patient is a common circumstance that appears to elicit grief reactions in ICU nurses, including feelings of sadness, guilt, and relief. The nature of the circumstance though, is what varied among nurses. Certain circumstances mentioned by the participants consisted of sudden changes in patient stability leading to death, preventable situations, patients who appear distressed, and young age of the patient.

In the ICU, a patient's status can deteriorate rapidly at any given moment. A change in patient stability with a quick progression from stable to unstable is one circumstance that provokes grief in ICU nurses. The amount of effort put in to stabilizing an acutely ill patient in the ICU can be overwhelming and take a toll on any nurse.

> "I had a patient from Ghana in for an MVR. I took care of her post op. She downgraded to telemetry after a few days. While in telemetry, she coded... We opened her chest at bedside and eventually got her into the OR. She had an SVC tear. Ended up giving multiple blood products along with maxing her out on multiple vasopressors. It was exhausting. During the night, she stroked out. She was so unstable we couldn't even bring her down for a head CT. She was a hard patient to loose. Not sure if it was her actually dying that made me sad or the fact that we worked so hard to bring her back and she ended up stroking" (Participant 1).

The rapid decline of ICU patients and their deaths can sometimes be sudden or unpredictable. However, when circumstances resulting in death could have been prevented,

nurses did report grief. For instance, circumstances that were "provoked or exacerbated by the patient's own doing" (Participant 5), may cause upset. Another nurse similarly stated,

> "It is really hard when a patient dies that has been in and out of the hospital related to taking illegal drugs or are non-compliant. Those situations just make you feel terrible. You care so much and they don't care … something wrong there" (Participant 2).

Another part of death that elicits grief in nurses is seeing the patient suffering or appearing to be in distress. One especially distressing condition reported was patients in respiratory distress.

> "Recently, I had a patient that had passed. She was all comfort care after an extubation. She looked like she was laying in distress, breathing hard and fast. But she didn't want any medication. She didn't want to be sat up to breathe better and she was pretty tightly wound, kind of an angry person. So that made it really hard to actually feel compassion" (Participant 4).

Another nurse described a multitude of distressing events the patient had to undergo,

> "I remember thinking he was really struggling to breathe, sitting up at 90 degrees and appeared anxious... He ended up being intubated for respiratory distress…later his breathing became more labored… He went into VTACH and we called a CODE. We coded him for over an hour. Finally, when it was obvious we were not going to be able to save him, the doctor called a time of death. We were all very upset and crying, even the doctor" (Participant 2).

The age of those involved in the death event also seems to affect the ICU nurses in notable ways. Two of the participants associated the young age of the patient at the end-of-life to a negative experience. And/or nurses related the age of the patient's loved ones, who were somehow affected by the patient's death, to their own personal lives. The death of younger patients appears to be more upsetting than the death of older patients. "I was taking care of a young 20-year-old male. It was distressing to see someone so young and so sick" (Participant 2).

Furthermore, grief may be provoked when the patient's age has some relevance to the nurses' personal lives. Feelings of empathy and even anger were clear:

> "I definitely have a hard time with younger people. I recently had a young pregnant woman that was admitted with a blood cancer. She died that night. My daughters are all young adults and I empathized with the grief of the patient realizing they are going to die; and the family. Maybe even angry when they had been diagnosed with such a disease that ends life before it really has begun" (Participant 2).

Another nurse explained,

> "The times I've experienced the most significant grief is anytime I've dealt with a situation where a child was directly involved. Whenever I've ever had a patient who had a young child similar to the age of my own daughter, or whenever the patient was young who had more of an unforeseen circumstance" (Participant 5).

Although the circumstances mentioned were associated with grief, once the process of death was over, nurses commonly reported a sense of relief and satisfaction that the patient is no longer suffering.

> "I feel more relieved that a patient is no longer suffering. Being in the ICU is torture" (Participant 1).

Additionally, when patients had chronic conditions such as comorbidities or did not care for themselves, nurses found the situation satisfying.

> "There's patients who are so ill and have so many comorbidities that in essence, their passing was more of a relief to myself, and even some of their families having to watch them suffer. A lot of times it's very satisfactory, brings a lot of satisfaction. Because it's really easy to identify these people are in pain or are experiencing suffering or distress. Being a part of a passing, meaning when someone dies, in a peaceful way, is extremely satisfying, it's gratifying" (Participant 3).

**Professional Boundaries**

It was apparent that many of the ICU nurses' grief is largely influenced by the thought of maintaining professionalism and setting boundaries. Boundaries exist to protect the patient and professional. Boundary referred to the extent of involvement between the nurse, patient, and family. It also referred to the ICU nurse participants' ability to separate work from personal life and ideals.

The keeping of boundaries as described by nurses, such as emotional separation, is a way of protecting one's self. Crossing boundaries could lead to overwhelming grief or burnout. There is a need to avoid attachment to the patient in order to be present and provide necessary care. Caring for the patient and family were held as a top priority.

> "If you become attached to a patient, it could be harder…I kind of just do my job with the most respect I can give. I just try to be exactly what they [patient/family] need me to be at that time and I cope" (Participant 4).

Buglass (2010) mentioned emotional distress results when attachments formed are broken or lost. Thus, when ICU nurses are able to set boundaries, it may prevent such a consequence. Newer or more inexperienced nurses may potentially have a harder time with boundaries.

The ICU nurse participants also seem to manage grief by maintaining clear professional boundaries. The role and responsibilities of the nurse is a boundary in itself. There seemed to be an idea of doing the work that is expected and moving on. One nurse demonstrated the ability to keep work strictly professional,

> "I think I'm pretty good at compartmentalizing. Work is work. I don't really bring things home. You act sad in front of the patient. It's what is expected. As soon as I'm out of the room it's back to business and off to see my other patient" (Participant 1).

Furthermore, showing expressions of personal grief such as, emotions at work can be considered as crossing a professional boundary. This might interrupt with the ability to carry out their job. ICU nurses need to be able to stay focused on helping the patient or family.

> "I don't ever cry at work, which is a blessing. I do cry at home, for sure. I guess being a professional includes being able to keep your emotions in check. I think being a good nurse, you know, you have to be in touch with your emotions enough to support people who are going through grief. Sometimes it's ok to shed a few tears along side next to someone as an expression of solidarity of what

> they're going through. But if your own grief takes over and you start to show your emotions, it could affect the way you carry out your job, and that's not ok. You have to be able to perform your job without crying. Especially like in codes, you can't be crying. I guess my training has taught me not to get emotional at work. I have been emotional at work but most of the time I'm able to be really professional" (Participant 3).

Almost all of the participants mentioned part of their ICU nursing responsibility was to assist the dying patient in an ideal death, or one that does not include pain or suffering. Many ICU deaths take place due to the withdrawal or withholding of life supportive measures. Nurse perceptions of a patient's suffering during end of life may vary. This perception can contribute to the grief that ICU nurses experience.

> "We can all just hope to die in the most dignified, less painful way" (Participant 1).
>
> "My bottom line is no one should ever die in pain or be frightened, if it can be helped" (Participant 2).
>
> "I consider it an incredible privilege to be with someone in their final moments, it's an honor to be tasked with helping to keep them comfortable, helping the family or loved ones through he process of what dying may look like" (Participant 3).

**Being Supported**

Participants commonly mentioned having adequate support or resources from family, peers, friends, and the professional organization to help them grieve. However, support could also come self-sufficiently. Other means included one's spirituality and comfort from pets.

Organizational support may come through the providing professional services or through the form of management.

> "I have a really supportive boss so it's really nice to be able to debrief with her" (Participant 3).

The Queen's Medical Center provides free professional counseling services to employees. However, only one nurse mentioned utilizing such services.

Peers may also provide comfort and support as well.

> "Sometimes I share with other nurse friends. Not always though, because they really have to have an understanding of the ICU. I mean not they wouldn't care or listen, but really, I think only ICU nurses can understand the unique experiences of working in the ICU and dealing with death and loss in the ICU. Whereas I wouldn't be able to understand labor and delivery and losses they experience, or pediatrics, or oncology. There are a lot of things that are just unique to each specialty" (Participant 3).

Feeling supported is also a way the nurses' grief was acknowledged.

> "…My husband is supportive and does nice things for me when I get home. He does tell me my patients are lucky to have me, which makes me feel good" (Participant 2).

**Learning from Experience**

Through the time spent working in the ICU, most of the nurses have reported some level of increased knowledge about their views of death or dealing with grief. Through experience, their knowledge of death and personal ideals are clearer, broader, and are more prepared to cope for their future experiences.

> "Throughout the years I;ve gotten better at compartmentalizing. It was harder to separate things when I was first starting out as a nurse" (Participant 1).

Being a part of the dying process for many patients, the nurses' experience of grieving over time and working in the ICU for numerous years has allowed participants to reflect on their own mortality, elaborate on their ideals of death, and form life values. It also has helped nurses think about their personal end of life decisions.

> "I feel like I have gained a healthier outlook on death. I live life differently, knowing how fragile it actually is. I find it easier to talk about the things I do want and don't want when it comes to my care if I were in a situation that I required intensive care. I have no problem vocalizing those or putting them down in writing" (Participant 5).

Not only were nurses able to reflect on personal end of life decisions but also those of their family members. Another nurse stated,

> "It's adding a lot of patient experiences to my life experiences that really broaden my concept of death, I suppose. I have just seen more, know more now about ways in which to die. So I've grown and have a richer bank of experiences drawn.

> I care a lot more about my own choices at the end of life and those of my family members" (Participant 3).

Furthermore, the experience of working in the ICU has led some nurses to understand that life on earth is delicate. A nurse talked about realizing the value of living life and cherishing the people in it.

> "I try to live my life every day and realize that telling our family and friends things we want to say… Well, it needs to be said sooner rather than later. I appreciate that part" (Participant 2).

Grief experiences have also positively influenced nurses' behavior and actions. In essence, a negative experience led one nurse to realize the need for change and inspired her to make a positive impact on the unit. The nurse described gaining professional growth by taking what was learned from the negative experience to create something positive.

> "When I had the traumatic death last year, I decided to start working on the falls committee. I mean I knew nothing would bring back this person who had died or changed the particular situation for that family. But I thought I could use that negative experience to create something positive to come out of it for the future of our patients" (Participant 3).

It was evident that various patient experiences have even contributed to the development of new knowledge and preparation. One nurse mentioned gaining preparation for his future nursing practice.

> "The more I work, I can see when things are taking a turn for the worst. That growth or experience helps prepare me for other end of life situations" (Participant 4).

Nurses expressed their views of death as a natural part of life. "I look at death as just another aspect of life. We all will die someday" (Participant 1). Perhaps that understanding allows nurses to accept the idea of death more easily.

Experiences of grieving patient deaths have also reinforced nurses' beliefs and spirituality. Finding spiritual meaning in patients' end of life was evident.

> "My view of death has opened up my mind to the possibility of God working in those last moments of someone's life. Of course, I always knew that but I wasn't actually a witness to it. So my view of death has just gotten broader. I believe that God is still present when someone is dying. One way He shows himself is through our caring for the person that's dying. If you hold that belief, then it makes the job incredibly sacred" (Participant 3).

## Contextual Coping Factors

Coping is a way to overcome grief. The nurse participants indicated numerous coping strategies including talking, humor, spirituality, and utilizing a support system.

### Talking and Being Heard

Majority of the nurses mentioned two important factors of coping with ongoing patient deaths are talking and being listened to. Talking is a way to share their experience(s) and let out frustrations.

> "I'd say talking about it is the best. Sometimes it takes me awhile before I can talk about it but eventually I get it out. I have no problem talking about things with my wife because she knows what it's like; she's done the same thing I do [ICU nursing]. So I'm not shy and coping tends to be talking bout it, letting out frustrations" (Participant 5).

Being able to talk to others that are knowledgeable of the ICU environment or have had similar experiences simply understand how to listen and are able to provide relief and comfort. Even talking to a professional such as a therapist or counselor can be beneficial for coping.

> "It started after the [traumatic] death last year; I went to the Employee Assistance of the Pacific (EAP) to talk about it, which I found very helpful. Everyone should have an outlet to speak about things going on in their lives, whether personal or professional. I think going to a professional is very important for a number of reasons" (Participant 3).

Being heard or listened to is another coping factor mentioned by the nurses. It is a way for the ICU nurse to feel supported and be acknowledged of the care they provide, even if being listened to by someone who has no medical background.

> "I talk to my husband about it. He is not in the medical field but he is a really good listener. I'm sure he doesn't appreciate hearing all the gory medical stuff, but he is supportive and does nice things for me when I get home. He does tell me my patients are lucky to have me, which makes me feel good" (Participant 2).

**Support System**

The ability to cope amongst ICU nurses appears to be largely affected by the people in the nurses' lives, those people who serve as a support system. A support system may be defined as a trustworthy network of people or another person that can provide emotional support or practical encouragement. This may include any person that the nurse can talk to such as family, a spouse, friends, or colleagues.

**Humor**

A sense of humor may be described as finding fun ways to make the situation less grim. Some nurses use humor and laughter to get through the solemn events that occur in the ICU. When asked to talk about preferred coping strategies and expression of grief, one nurse replied,

> "Laughter and happiness with co-workers, it just happens. We kind of just make light of things." (Participant 4)

Another nurse explained humor provides relief,

> "I'm a big promoter of laughing and having some fun at work. It may not always look appropriate to patients or patient's families but it's how I and other co-workers relieve stress… I joke around a lot. My sense of humor has gotten a bit darker working on the unit. But you can't be sad a work all the time. You'll burn out quickly" (Participant 1).

**Spirituality**

Another coping method that was mentioned by participants includes embracing spirituality. Spirituality may have different meanings to people, including prayer, meditation, or participation with an organized religion. A couple of nurses in this study reported the importance

of seeking relief from their spirituality, particularly Christianity. Prayer and the Bible appear to be powerful sources of coping.

> "I spend a lot of time praying, talking to God. I read my bible every day. I utilize that as a source of strength when I'm going through something tough. And when I know that someone is praying for me, that's very powerful to me, too" (Participant 3).

Even praying for and with patients can provide a sense of comfort.

> "I've even prayed with patients, they've asked for that. Most times, I pray for my patients that I take care of" (Participant 4).

## Generational Differences

The characteristics described in the generational definitions section of this paper corresponded with the generation profile of the participants. The study results reveal that participants' generational traits may indeed affect their grief.

The one Baby Boomer nurse participant in this study correlated with the description of other Baby Boomers. First off, the nurse revealed in the interview "a desire to please" the patient and family. The nurse assured the patient's dad she would take care of his son. However, a significant amount of grief was felt when the nurse's patient died and she was not able to fulfill that goal.

> "…The doctor called a time of death. We were all very upset and crying, even the doctor. The family was inconsolable and was angry; asking, 'what happened to him?' Very horrible and so sad for all the staff, doctor, and family… I do hope that he knows that we really tried to help him. I feel really guilty for telling his

dad I would take care of him" (Participant 2).

Secondly, the Baby Boomer participant expressed approval for a "material" gift after patient death. The nurse mentioned receiving a small gift coupon after experiencing a bad night or patient death at a prior employer. This type of recognition prompted positive feelings after a grim situation: "It made me feel good that my grief was acknowledged" (Participant 2).

Furthermore, two of the Generation X participants reflected a sense of independence and self-sufficiency in their preferences for coping and grieving. When asked about what type of assistance is acceptable during grieving patient deaths, both of the Generation X participants expressed a preference for self-reliance. Assistance from others may possibly be more detrimental to the grieving and coping process for this generation.

> "I don't like assistance when I'm grieving over a patient's death. I find it makes me uncomfortable when someone or anyone is trying to console me. I will talk about things when I'm ready to talk about it. I find some of those consoling statements almost more offensive then helpful (i.e., "oh, it was God's will"; "it's the circle of life"). It rips me" (Participant 5).

However, these findings may be limited because both Generation X participants were male. Thus, other groups (Generation X and other genders) could be further studied.

## Gender Differences

For this study, it is difficult to say that there were significant differences in grieving and coping between genders. Female gender norms portray sensitivity and emotion. While male gender norms often focus on stoicism, strength, internalizing of emotions, and not showing vulnerability. However, some of the participants shared mixed characteristics of both genders.

Though one of the male participants displays masculine traits, he mentioned he does become tearful at times and is not shy about it. This demonstrates that males are able to be aware of their emotional state and articulate what triggers grief. This finding supports recent literature suggesting that male ICU nurses can concurrently embody masculinity and empathy. They are able to be expressive of emotions just much as females. On the other hand, two of the female participants clearly embodied female gender norms and were very open about talking and sharing their experiences in detail. They even became emotional during the interviews and cried openly. One of the female participants was more stoic and not emotional during her interview.

It appears males and females can be equally sensitive, self-reliant, protectors. As well as be expressive. Thus, it is important not to stereotype genders and the support given to males and females. In this study, one of the male participants did allude to the stereotypical ideal of females being emotional:

> "I don't need any counseling or talking to anyone in particular…It seems more of like females need that because they get more emotional. They might not even know the staff, the patient, or anything but, they can just be right there. It's an acceptable thing, but I don't really need anything" (Participant 4).

Findings of this study have provided valuable awareness on the ways in which males and females grieve and cope in the ICU. Nurses may uphold traditional gender norms but also can concurrently embody traits of the opposite gender when grieving and coping. Understanding gender differences in grief and coping behavior provides insight to develop diverse interventions for promoting wellbeing for both males and females. Overcoming gender stereotypes is equally

important in offering support to nurses, recruiting, and retaining a diverse group of men and women to ICU nursing.

## Ethnicity

This study consisted primarily of Asian and Caucasian participants. Most of the study participants did mention feeling more knowledgeable and prepared for their own end-of-life decisions. However, specific aspects of grieving and coping related to their ethnicity or culture were not mentioned in their narratives.

## Recommendations for ICU Nurses

Each of the ICU nurse participants were asked about recommendations they might have for other nurses or future nurses working in the MICU specialty. Nurses can support other nurses entering in to the MICU by providing guidance and advice beforehand. Recommendations by the MICU nurse participants focused on being honest with one's self, living healthy, creating life-work balance, and finding a strong support system.

Creating balance between work and life was suggested. While some nurses may naturally be good at separating the two, others may struggle with not bringing work home or bringing personal issues to work. Participant 1 said, "Leave work at work." It is important to realize when time away from work is needed and when to avoid situations that may trigger grief.

> "Know when you're starting to get burned out, or tired, or exhausted, or emotional. It may not show at work but it may show in other areas of life. Know when it's time to take a break. Don't feel ashamed to take time off. If there were a particular situation that's too close to home, I would advise the nurse to maybe avoid it for a little while. Lets say, just lost a family member, a recent experience

with cancer, suicide; anything that might feel a little too close for comfort for the time being, wait awhile before they have to step into that role" (Participant 3).

Balance also includes caring for the whole self and 'finding physical, spiritual, mental outlets.'

"Early on, if working in the MICU is taking a toll, it might not be for them. I would say a good thing is to seek out a spiritual faith. It doesn't even have to be Christianity but I think that would help" (Participant 4).

A part of having balance is maintaining a healthy lifestyle, which may foster effective coping habits. According to the nurses, this may include physical activity such as exercise, eating well, and cooking healthy food. Or, making good decisions that lift self-worth and avoiding internalizing feelings. Mental health can also be refreshed by taking time away from work, going on vacation, or traveling.

Having supportive people around was another common recommendation that majority of participants suggested. A support system allows nurses to have someone to confide in, provide companionship, and take their minds off of work.

"Be sure they have a good support system around, people they can talk to. I would tell them to find ways to be honest with themselves about their feelings and how they view life and death and losing patients. Because it's always a matter of time before it [death] is going to happen. This is a high stakes game of hot potato we're playing." (Participant 5)

## Discussion

Findings of this study reveal ICU nurse responses to patient death may vary. However, MICU nurses are able to deal with the experiences of death and traumatic situations without assuming heavy burdens, burnout, CF, or STS. None of the participants identified themselves to be experiencing CF, burnout, or STS in their narratives. However, no formal quantitative instrument such as Stamm's (2010) ProQOL was used in this study to determine such conditions. There are a number of quantitative studies available that have revealed evidence of STS, burnout, and CF in other nursing specialties such as, trauma, cardiology, emergency, pediatric, and oncological medicine. More qualitative literature is needed to explore the nurses' first hand accounts of grief and coping, especially in ICUs.

The circumstances of death that elicited grief in participants were unique to this study. No other current literature was identified that described or supported specific situations of grief in the MICU.

Interestingly, the professional boundaries that nurses described were similar to other qualitative studies on grief. The professional duties of the nurse took precedence over investing themselves emotionally in the patient. Nurses caring for dying patients put up boundaries to maintain professionalism and protect themselves from negative consequences (Gerow et al., 2009; Hopkinson, Hallet, & Luker, 2005). Boundaries also provided a way for the nurses to compartmentalize the experience and move on.

Past encounters with grief (personally or professionally) may have contributed to the development of effective coping. The coping preferences of nurses described in the findings of this study may be related to the nurses' prior experience. All of the

participants worked as registered nurses in other areas prior to entering the MICU, giving them a chance to develop coping effective methods. Furthermore, the participants all worked full-time. The amount of time and physical presence on the unit may increase exposure to traumatic situations opposed to other employment statuses such as per diem or part-time. Current qualitative literature on employment status was unable to be found.

Talking and sharing experiences with a support system was a source of relief and comfort mentioned by the participants. However, talking must be timed appropriately. The timing of the individual's readiness to talk or finding available time in the midst of a chaotic environment must be considered. Hopkinson, Hallet, and Luker (2005) pointed out a high number of patient deaths over a short period of time can create much physical work, making it difficult to talk to colleagues. If nurses did not feel supported, grief was experienced. Gerow et al. (2009) revealed that nurses who felt isolated and not supported in early significant patient experiences, the nurse became traumatized and carried the turmoil forward. However, the nurses who felt supported during initial death experiences were able to learn and establish a healthy basis for the future.

Other coping strategies mentioned by nurse participants such as utilizing a support system (i.e., pets, family, friends, colleagues), participating in health promotion behaviors such as exercising, spirituality, and professional counseling were all similarly reported in a quantitative study of STS in trauma nurses (Von Rueden et al., 2010).

Grief and coping for the MICU nurse participants may also be influenced by factors such as gender, ethnicity, education or experience level, and age or generational.

Ethnicity and culture are known factors that influence views and decisions on life and death. According to the American Psychological Association (APA) (2015), ethnic groups may have different values about using treatment, artificial or life supportive measures, trusting health providers, and participating in decisions about end-of-life care. APA (2015) also reported that Caucasians and Asians use advance directives more than other ethnic groups, suggesting they are more comfortable discussing end of life issues. However, this study's data does not provide enough information to determine if the participant's ethnicity plays a significant role in the ICU grieving and coping phenomenon. Other ethnicities should be further explored.

Furthermore, no participants in this study acknowledged their nursing preparation or prior end of life education to make any type of contribution to the way they grieved or coped within their narratives. Perhaps they were uncertain of its impact. Kent et al. (2012) mentioned curriculum and training on death and dying was minimal up until a few decades ago. Recent literature suggests that experiences with death and dying have been identified as being highly stressful in new nurses and students. Negative incidents have even led some nurses to consider leaving the profession. However, the details of the participants' stories suggest they had a level of knowledge beyond someone without any end of life preparation. Newman (1999) suggested a continuous and un-fragmented view of life in which stability and chaos create an ever-evolving pattern. Since there are no boundaries between past, present, and future, one's life is a process of creating new experiences with past experiences. The participant narratives revealed their thoughts and behaviors were informed through both new knowledge and experiential learning. One's

education and prior death education is an area that could be further explored with a larger sample size of different nurse backgrounds.

The entire context of the participants' end of life experiences ultimately allowed them to increase their knowledge, broaden their views, influence their behaviors, and gain preparation for their current and future nursing practice. Each of the participants were able to work through difficult situations and move forward with their nursing practice to higher consciousness and understanding. Findings support my adaptation to Newman's theory on expanded consciousness.

## Conceptual Framework Connections

Newman's (2011) theory of health as expanding consciousness includes the health of all people, where health includes the absence and presence of disease. Every person regardless of his or her situation is part of a process of expanding consciousness. Newman supported the belief that life is an evolving process of synthesizing new experiences with past experiences (Zust, 2006). The past, present, and future grief and coping experiences of nurses is and has been constantly evolving to increase their knowledge, consciousness, and interaction with life's patterns. As one participant expressed, "it's adding a lot of experiences to my life experiences that really broaden my concept of death" (Participant 3).

My adaptation of Newman's theory suggests the nurse may experience expanded consciousness as a result of working with patients and families at end of life. Through acknowledging and exploring the experiences of grief in the nurses, it is evident that ICU nurses may go through flexible phases of grief (e.g., shock, withdrawal, despair, acceptance) or variations of order and disorder (Newman, 2011). Fluctuations through various stages in their

work and life allow the nurse to confront the experience of loss, relationships formed, and the reality of death in order to come to terms with loss. As consciousness expands, the client (i.e., nurse) becomes more of his/her real self and finds greater meaning in life and the lives of others (Newman, 2011). The nurse participants reported gaining healthier outlooks on life, appreciating the value of life and the people in their lives, and even found deeper meaning in their role as a nurse. In addition, the nurse was encouraged to take positive actions, for example, becoming involve din the falls committee in the MCIU.

Pattern may also reflect the person-environment interaction. Interactions with the environment may include the physical aspects of space, dealing with blaring monitor alarms, and even the busy tasks involved of caring for the dying. The nurses must also process the psychological environment of the ICU, including the patient's, family, or even one's own emotions. The nurse participants described the need to keep their emotions together at work to avoid disrupting their work and environment. This was a coping method. For instance, it can be distracting and unproductive to cry during a high adrenaline code situation.

Through experiences of grief and coping, nurses realized that their interactions with patients and families and attempts to assist them in achieving a goal of a peaceful death, allowed increases in self-awareness, knowledge, and consciousness. The interactions with the nurse participants and myself as the researcher was also a part of expanding consciousness. Our interactions together allowed both parties to engage in self-reflection, acknowledgement of oneself, find meaning in situations, and discover new dimensions of connectedness with other people. For instance, some were able to better address their own end of life choices and even discuss death more openly with patients and families.

## Implications for Practice

There is a need to recognize and better understand the types of circumstances that elicit grief and factors that influence nurses' ability to overcome grief in the ICU. Acknowledging the uniqueness of nurses' experiences, thoughts, and feelings is important. Organizations, management, and health care teams can use this information to increase awareness of grief and coping in the MICU setting and can provide the appropriate supportive interventions to ICU nurses. With the right amount of support and when nurses feel acknowledged, nurses may not only feel more empowered but will be able to provide better quality care.

The findings of this DNP project can further provide an opportunity for the DNP prepared NP to contribute to establishing proactive and innovative measures to increase nurse resilience, improve patient/client outcomes, enhance patient care and safety, and advance nursing practice. DNP prepared practitioners can also perform needs assessments to identify the need for debriefing sessions or educational opportunities. They may even be able to expand this study and explore nurse grief and coping in other ICUs. They may also serve as a support resource. The DNP prepared practitioner often participates in the care and management of the ICU patient. Offering one's presence at the time of a patient's end-of-life, acknowledges to other nurses that grief is not always easy. The NP may also offer their presence to the patient and family members at the bedside. This may be helpful to the family to hear detailed explanations of the process of dying and palliative care. However, the DNP practitioner must also respect an individual's preference to decline such offers and allow solitude to facilitate coping.

Sensitizing others to these issues can reduce a nurse's sense of isolation at work, and can facilitate teamwork with colleagues. This will help create a supportive ICU environment that

acknowledges death as a difficult event for nurses. Discussions about death and grief can also be viewed as a part of the unit norm.

## Limitations

The findings of this study are relevant to those who participated in this study. The experiences of MICU nurses in this study may not be generalizable to all ICU nurses. Participation was voluntary and their intent to do so is unknown. Although this study included males and females, this study may be limited by the small sample size and small range of nursing experience levels. Furthermore, this study focused on the experiences of nurses specifically working in the MICU. Other ICUs may have different nursing practices, organizational structure, and support resources may vary in other ICUs, states, and countries.

The grieving phenomenon should be further explored using qualitative methods with a different selection of participants and in different ICU settings such as, nurses working in trauma and neuroscience intensive care units. It is important to determine if there are commonalities to nurses' grief across ICU environments to enable working together for the development of supportive interventions that can have generalizability to all ICUs.

## Self-Reflection

Throughout the course of this project, I frequently reflected on my own grief and coping experiences. I also realized ways in which my own consciousness has expanded.

Since I remained as a MICU RN working at the bedside during this study, I found myself paying attention to end of life situations more then ever before. When a patient was dying, I became more aware of the behaviors of those around me (e.g., patient, patient's family, colleagues), observed the effects on myself and others, and thought about the current support

resources available at QMC. As a result, my own practices changed as I attempted to make myself fully present during a patient's end of life. To care for the whole person (i.e., mind, body, spirit) required me to accept periods of ambiguity and chaos in order to move on to higher levels of consciousness and create a healthy environment. At the same time, I feel that I have become more attentive to recognize signs of STS and made efforts to prevent negative consequences. According to Newman (2008), it is important to be completely present and attend to the patterns that occur in clients' lives to create a safe environment to adapt and cope with life's directions.

Engaging with the nurse participants also helped me to reflect on the circumstances that cause personal grief, the effects death has on my personal and professional life, and what I do to cope. I was able to relate to the experiences of the participants and realized the amount of solidarity ICU nurses share. Additionally, since such experiences are not often spoken about in depth on a daily basis, I recognized a sense of comfort and reassurance that I am not alone.

I was initially surprised at the minimal literature that described ICU nurse responses of the grieving and coping phenomenon. Their thoughts, feelings, and experiences *need* acknowledgement. I feel empowered to further expand this research to other areas and identify the need for educational opportunities in grief and coping. Although I *have* received formal education on end of life issues in my graduate nursing program, I honestly could not recall it. Perhaps at that particular point in time, I was not in the right frame of mind to relate to the content or I did not have the right amount of willingness to accept that valuable knowledge. This makes me realize the importance of having meaningful end of life curriculum in undergraduate, graduate, and hospital organization programs. Furthermore, various support resources should be made available to nursing staff.

I now have a better understanding of grief, its processes, influential factors, and possible consequences of unresolved grief. I have an increased insight of the uniqueness of grief and coping in ICU nurses. And I recognize that grief may be experienced throughout the entire context of a patient's illness. As I embark on a new journey toward becoming a DNP prepared NP, I am taking the results and experiences of this study with me. I hope to offer my full presence and support to colleagues, patients, and/or families during and after a patient's end of life. But I will also respect anyone's preference for solitude. Overall, I feel more empowered to provide meaningful end of life care to my patients and families I encounter.

## Conclusion

Grief is commonly perceived as a reaction to death. However, it is evident that grief may be experienced throughout the entire context of a patient's illness, especially if it is life threatening. One may undergo grief from the crises of a new diagnosis into the deterioration of a patient's illness, and even beyond death (Doka, 2006). The loss of a patient(s), especially unexpected deaths may challenge one's own beliefs about life and professional practice. Other times, the loss of a patient may bring about relief and can evolve one's own beliefs and practice in positive ways.

This study contributes to knowledge on the entirety of the grieving and coping phenomenon in MICU nurses caring for cumulative patients who pass away and their families. It also takes into account specific circumstances that elicit grief in MICU nurses.

Overall, findings suggest that MICU nurses do experience grief and they are aware of the effects on their personal and professional lives. But their grief is individualized. There is no single method to manage grief responses. However, there is a level of mutual understanding of

experiencing death in the MICU, which yields support and camaraderie amongst MICU nurses.

All of the participants in this study appear to have developed effective coping habits to managing grief. Each of the MICU nurses also reported unique coping methods, just as their grief experiences varied. A number of factors appear to influence coping including, the ability to talk, share experiences, be listened to, having a support system, and having a sense of humor. Hospital organizations, management, and unit staff must be aware of unique grief experiences and coping differences in staff in order to provide adequate support.

# APPENDIX A:

# DEMOGRAPHICS AND PROFESSIONAL CHARACTERISTICS QUESTIONNAIRE

Demographics and Professional Characteristics Questionnaire

1. In what year were you born?
2. Gender F M
3. Ethnicity
    1) Asian (specify: Chinese, Japanese, Korean, Vietnamese, Filipino)
    2) Caucasian
    3) Native Hawaiian/Pacific Islander
    4) Hispanic
    5) African American
    6) Other (specify)
4. Number of days, months, or years working in MICU?
5. Number of days, months, or years working as a registered nurse?
6. Employment status/Hours worked?
    1) Full-time 36+ hours/week
    2) Part-time 20-32 hours/week
    3) Call-in
7. What is your highest level of education? List type of educational degree(s) obtained
    1) Associate
    2) Bachelor
    3) Graduate degree
    4) List degree(s) obtained: _____
8. Have you had prior death education? If so, please explain:
9. When was the last time you experienced a patient death?
    1) Less than a week ago
    2) 1 week ago
    3) 2 weeks ago
    4) 3 weeks ago
    5) 4 weeks ago
    6) 5+ weeks ago

10. Have you ever experienced any of the following after a patient has died? (Choose all that apply)
    1) Anger
    2) Nightmares
    3) Insomnia
    4) Sadness
    5) Guilt
    6) Anxiety
    7) Flashbacks
    8) Other: List___

11. On average, how long/how frequent do you experience the above?
    1) Rarely
    2) Sometimes
    3) Often
    4) Very often

# APPENDIX B:

# INTERVIEW AND PROMPT QUESTIONS

# Interview and Prompt Questions

Interview Questions:

"Can you please tell me about your experience of a time you experienced grief while working in the MICU?"

"What is it like dealing with the loss/losses of patient you cared for in the ICU?"

"Describe how you cope with ongoing patient deaths and families following these deaths?"

"How do you typically express grief? / Describe your coping strategies."

"What type of assistance is acceptable to you when you grieve over a patient's death?"

"How have you grown through your experience of grieving?"

"What helps you when you are grieving?"

"How has your view of death changed since you began working in the MICU?"

"What recommendations do you have for other nurses/future nurses working in this area of practice which might allow them to continue over long periods of time?"

Prompting questions:

"Can you go on?"

"Could you tell me more about that?"

"How did that make you feel?"

# APPENDIX C:

# PROJECT FLYER

# Grief and Coping Research Study

You are invited to participate!
Looking for volunteers for ICU nurse grief study.

Participants will be asked to complete a short questionnaire and interview lasting approximately 30 minutes to 1 hour to share experiences of grief and coping in the MICU.

Eligibility:
In order to participate in this study you must be:

- Able to speak English
- Have more than 1 month ICU nursing experience

Why participate?

- Share your experiences of grief and coping
- Participants will provide valuable insight on grief from the ICU RN perspective
- Compensation will be provided

Interested? Need more information?

- Contact Michelle Sato
  - Cell: (808) 554-2587
  - Email: michellesato@email.arizona.edu

# APPENDIX D:

# INFORMED CONSENT FORM

Participant # _____

Informed Consent Form

THE QUEEN'S MEDICAL CENTER
HONOLULU, HAWAII

**INFORMED CONSENT TO TAKE PART IN A RESEARCH STUDY**

Title of Study: NURSE EXPERIENCES OF GRIEF AND COPING IN THE INTENSIVE CARE UNIT

Principal Investigator:
Michelle Sato
michellesato@email.arizona.edu
808-554-2587

INFORMED CONSENT

You are being asked to take part in this research study because your experience as a registered nurse working in the Medical Intensive Care Unit (MICU) can contribute to a better understanding of the grieving and coping phenomenon amongst nurses. The purpose of this research study is to describe MICU nurse reports of their grief and coping experiences following patient deaths at a major metropolitan hospital in Hawaii. This research will ask for your participation in completing a brief questionnaire and an interview lasting approximately 30 minutes to one hour.

Before you decide whether or not to take part in this study, you must understand the purpose, how it may help, any risks, and what you have to do. This process is called informed consent. The researcher will talk with you about the study and the informed consent form. The consent also gives you information about what health information will be collected as part of the research study and how that information will be used or disclosed. Once you understand the study, and if you agree to take part, you will be asked to sign this consent form. If you sign this form you are agreeing to take part in this study and to allow the use of the information you decide to share. You will be given a **signed** copy to keep. If you do not sign this consent form, you may continue to receive care, but not as part of this study."

Before you learn about the study, it is important that you know the following:

- Taking part in this study is of your own free will.
- You may decide not to take part in the study or stop being in the study at any time without it making any difference to your care now or in the future, or to any benefits that you are allowed.

- If the study changes in any way which could make a difference to your taking part, you will be told about the changes and may be asked to sign a new consent form.

PURPOSE OF THE STUDY

Nurses in the ICU may be at high risk for distress due to frequent exposure to death and the impact of sudden or tragic outcomes compared to other areas of the hospital. Nurse responses to patient deaths may vary. Some nurses thrive in the ICU while others may become distressed, leading to negative consequences such as burnout, illness, absenteeism, and job dissatisfaction.

I would like to find out how ICU nurses cope and integrate grief experiences into their lives and nursing practice. Grieving and coping may be affected by numerous individual and professional factors (i.e. years of ICU nursing experience, gender, education). I would like to learn about what circumstances in the MICU elicit grief and what factors in the MICU influence the ICU nurse's ability to grieve and cope. I believe the sharing of your experiences will be helpful in understanding ICU nurse beliefs and responses to dealing with the loss of a patient(s).

It is important for organizations to acknowledge nurses' experiences of complex scenarios, their grief, and coping. Nurses should feel supported and empowered to grieve in their positions. Understanding nurse experiences of grief and coping following patient deaths will allow organizations to offer necessary support to ICU nurses and potentially improve patient care and staff satisfaction.

PROCEDURES

You are invited to take part in this research project that can help improve understanding and awareness of ICU nurse grief and coping. If you accept, you will be asked to fill out a brief questionnaire form regarding demographic and professional data and participate in an interview with myself (the interviewer). The interview and questionnaire completion will last approximately 30 minutes to one hour or, however long you need to share your experiences.

During the interview, I will sit down with you in a comfortable place, such as a QMC conference room. The interview will contain questions regarding your experiences with grief while working in the MICU. If you do not wish to answer any of the questions during the interview or on the questionnaire, you may say skip them and move on to the next question. No one else but the interviewer will be present during the interview.

The information recorded on the questionnaire form and interview is confidential. Your name is not being included on the forms or interview, only a number will identify you. The entire interview will be audio-recorded. No one else except myself will have access to the information documented during your interview. The audio file will be transferred to my password-protected computer immediately after the interview takes place and saved to a password-protected folder. The audio file will be permanently deleted from the recorder at this time. Audio files will be transcribed as soon as possible after interviews take place and permanently deleted from the

computer hard drive once transcribed. All transcriptions will be stored in a password-protected folder. Questionnaire forms will aslo be scanned into the same password-protected computer and saved in a password-protected folder on the computer.

RISKS

Thinking about experiences of grief might illicit memories of traumatic situations and negative emotions. You may share some personal or confidential information by chance, or you may feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in the /interview/survey if you feel the question(s) are too personal or if talking about them makes you uncomfortable. Employee Assistance of the Pacific offers confidential, free, professional counseling for personal or work issues as a benefit provided by QMC. You may contact them if needed.

Employee Assistance of the Pacific
1221 Kapiolani Blvd, #730
Phone: 808-597-8222
Website: www.EAPacific.com

BENEFITS

ICU nurse experiences of grief and coping will be acknowledged. ICU nurses may feel supported and appreciated by sharing their experiences. Your participation is likely to help provide more insight and awareness about how ICU nurses grieve and cope. Such knowledge can be used to help organizations offer necessary support to nurses.

CONFIDENTIALITY

**Federal Privacy Regulations provide safeguards for privacy, security, and authorized access to health information.** The confidentiality of all study-related records will be kept according to all applicable laws. Information gained during this study and information known about you will be confidential (private) to the extent permitted by state and federal law. The results of this research may be presented at meetings or in publications; however, your identity will not be disclosed.

Right to Withdraw or Stop Taking Part in the Study

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job in any way. You may stop participating in the interview or questionnaire at any time without penalty. I will give you an opportunity at the end of the interview to review your questionnaire remarks and field notes. You can ask to modify or remove portions of those, if you do not agree with my notes or if I did not understand you correctly.

COSTS

There are no monetary costs involved with participating with this study. Participants can schedule an interview time that does not conflict with work hours or require them to miss work. Non-monetary costs may include the participant's personal time for the interview.

COMPENSATION

Participants will be given a $20 gift card from the researcher as a token of appreciation for participating in the study.

SHARING RESULTS

Quotes and references from the interview and questionnaires may be used as content in the final paper of this project. However, nothing will be attributed to you by name. The findings from the research will be shareable with the participants upon completion of this study and they can receive a summary of the results.

WHO TO CONTACT

If you have any questions about your rights as a volunteer or any other matter relating to this study, you may call Michelle Sato at 808-554-2587 and talk about any questions that you might have.

If you cannot get satisfactory answers to your questions or you have comments or complaints about your treatment in this study, you may contact:

Research & Institutional Review Committee
The Queen's Medical Center
1301 Punchbowl Street
Honolulu, HI 96813
Phone: (808) 691-4512

AGREEMENT TO TAKE PART AND CERTIFICATION

I have read and understand the description of this study such as the purpose and nature of this study, its expected length, the procedures to be done, reasonably known risks and discomforts, and benefits to expect.

I am taking part in this study of my own free will. I may withdraw (stop taking part) and/or withdraw my authorization for use of shared information at any time after signing this consent form without it making a difference to my job or in the future or any loss of benefits that I am allowed. My consent does not take away my legal rights in case of carelessness or negligence of anyone connected with this study. My signature means that I have read the information above or that it has been read to me, my questions have been satisfactorily answered, and at any time I have other questions, I can contact the researcher listed on the first page.

cc: **Signed c**opy of consent/authorization form to patient

| _____ | _____ | _____ |
|---|---|---|
| Subject's Name (Print) | Subject's Signature | Date/ Time |
| _____ | _____ | _____ |
| Witness' Name (Print) (Witnessing Signature Only) | Witness' Signature ********** | Date/ Time |

I have explained this research to the above subject. In my judgment, the subject is voluntarily and knowingly giving informed consent and has the legal capacity to give informed consent to take part in this research study.

| _____ | _____ | _____ |
|---|---|---|
| Investigator's Name (Print) (Individual obtaining Subject's consent) | Investigator's Signature | Date/ Time |

(Investigator: fax a copy of this signed page to Research Regulatory Office at 691-7897 within 24 hours of signing.)
[Please leave 2 inches at the bottom of this page blank. This is reserved for the RIRC stamping.]

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