

From the Top Down: Assisting Critical Care Nurses in Coping with Job Stresses

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Abstract

Critical Care nurses are faced with traumatic scenarios on a daily basis at work and are expected to remain professional in the face of chaos. In the midst of caring for their patients and catering to each family's emotional needs, their own mental health tends to get pushed aside. Nurses are expected to remain supportive to sick patients and their families while enduring psychologically disturbing images and sounds, witnessing phases of the dying process, and hearing end-of-life care decisions being made. Because these nurses are only human, their energy reserves are rapidly depleted and they are left emotionally exhausted. Nurses must be shown effective ways to cope with the many stresses on their units or they will experience burnout quickly, as many studies have already shown. The public is largely uneducated on this particular topic because the main focus in an intensive care unit is the patient and the patient's family, as it should be. However, if the nurse is neglected and suffers, the patient care will also likely suffer.

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Within an intensive care unit (ICU), there looms a stressful atmosphere in which critically ill patients and their anxious families may need to deal with the inevitability of death. In this environment in which patients need careful one-on-one care, a nurse is continually assessing the health status of their patients and implementing interventions where necessary. At this critical point in time, the family members of these sick patients are also in need because they are beginning to walk through the stages of grief, in which they will process the illness and often, the impending death of their family member. The nurse, in addition to his or her regular care for the patient, provides supportive measures to help the family and friends cope with the situation. These supportive techniques can range from being present in the room with the family to therapeutic listening and answering questions. In a sense, the nurse is also caring for families and the emotional needs are cumbersome. Because the nurse is viewed as the comforter in the situation, often he or she feels unable to grieve properly, causing increased grief and stress for the nurse. Additional situations, such as ethical dilemmas and end of life care often multiply emotional stress. Hospitals need to be aware of the psychological and emotional harm inflicted on the critical care nurse so that they will be able to implement appropriate coping strategies for nurses and therefore, increase the nurse retention rate.

Traumatic Stress in the Intensive Care Unit

There is no question as to whether nurses face stressful situations in the hospital. In a recent study, 108 nurses were interviewed and identified a mean of eight serious events that happened to them in the last 5 years of working. The results of the study showed that 98% of nurses have experienced a traumatic stress in the hospital. The most

common event, which was identified by 95.7% of the nurses, was the death of a patient. Approximately 92.8% of the nurses said they experienced an emergency transference of a patient to the intensive care unit. Nurses who have walked a patient through suffering made up 88.4% of the population interviewed. Verbal aggression (87%) was ranked as more common than physical aggression (43.5%), but both experiences can have a high psychological impact on an individual. Nurses in this study that were older than 34 years of age demonstrated significantly higher responses to this study, although the rationale for this finding is unknown. However, it is surmised that the reason for this is because these nurses are more experienced, and therefore may have encountered these cases more in their careers (Beijer, Buurman, Mank, & Olf, 2011).

Critical Care Nurses Impacted Psychologically

The negative effects of this intense and demanding critical care nursing career on the individual have been demonstrated through various studies. Certain posttraumatic stress disorder (PTSD) symptoms and burnout syndromes have been recognized in nursing populations due to the complex demands at work. A study conducted at the University of Colorado Hospital examined four groups of nurses, each group on different units: ICU nurses, inpatient non-ICU nurses in high stress areas, other inpatient nurses in non-ICU areas, and outpatient nurses. These four groups of nurses were studied and given a survey to complete regarding psychological symptoms they have experienced for months prior to the survey. It was evident from the results that nurses from all four areas suffer from symptoms of anxiety and depression. However, the critical care nurses had more symptoms of PTSD than those that work outside of the ICU. Through the answers selected in detailed questionnaires, it was found that 87% of nurses had symptoms of

anxiety, depression, PTSD, or burnout syndrome. Of the 332 nurses who completed the survey, 16% were positive for anxiety, 13% were positive for depression, and 18% met the criteria of PTSD based on their personal responses to the posttraumatic self-diagnostic scale (Burnham, Goode, Mealer, Moss, & Rothbaum, 2010).

This same single study also showed a positive correlation between work-related psychological symptoms and difficulty in areas of life including household chores, relationships, and leisure activities. Furthermore, over 35% of the nurses reported having nightmares related to traumatic work experiences which included end-of-life related issues and caring for combative patients or those with open wounds or injuries involving massive bleeding. This same study showed that 56% of critical care nurses reported having nightmares as a result of end-of-life issues, when only 31% of non-ICU nurses with nightmares reported this traumatic experience as being the reason. This study is only one of many that confirms the harm done to nurses' mental health as a result of their ICU career experiences (Burnham et al., 2010).

Critical Care Nurses Impacted Emotionally

Nurses in the ICU and nurses in every unit of the hospital are prone to compassion fatigue, which is the result of failed or inadequate coping mechanisms. The phrase was coined in 1992 by C. Joinson and is used to describe the exhaustion that nurses have while watching their patients go through a crippling illness or trauma. Compassion is a core value in the nurse-patient relationship, but when this value is fully demonstrated to its highest potential, there is a cost. An overwhelming grief either plagues nurses to turn off their emotions or causes them to experience stress, anger, and feelings of helplessness in response to their patients' battles (Yoder, 2010). Compassion

fatigue stems from unresolved and cumulative grief. In an attempt to cope with grief, nurses tend to distance themselves by detaching emotionally or by choosing to get overinvolved with the patient which can lead to compassion fatigue. Detaching emotionally, although it seems effective in patient care at the time of illness, is unhealthy for the nurse because he or she is unable to properly grieve. Becoming overinvolved with the patient is also a failed coping mechanism because of the extra work and stress it places on the nurse. Over time, these failed coping mechanisms may lead to performance issues in the hospital or burnout (Houck, 2014).

The symptoms of compassion fatigue may include anger, cynicism, sarcasm, apathy, dreams, flashbacks, feelings of being overwhelmed, hopelessness, and irritability. The opposite of compassion fatigue is compassion satisfaction, which is when the nurses walk away from a situation feeling enriched from offering care to those in a crisis. According to a study looking at palliative care nurses, there was a negative correlation found between compassion satisfaction and burnout. In addition, it was found that nurses in the study who worked 12-hour shifts had less compassion fatigue than those that worked 8-hour shifts. Speculation suggests that this finding could be explained by an increased time away from work that these nurses have to replenish their energy after they have worked long 12-hour shifts. Studies have shown that ICU nurses are more at risk for compassion fatigue than ED (Emergency Department) nurses, and that finding may be due to the relationship that ICU nurses build with their patients and with patient families over time (Butler, Clark, Griffin, Leslie, Lyons, Mason, & Walke, 2014).

Almeida, Cunha, and Morais (2016) provided more evidence for the emotional impact of caring for patients in the ICU setting. The study involved interviewing nurses

who worked on a neonatal intensive care unit (NICU), a specialized environment filled with babies that are in life-threatening conditions and in need of constant monitoring and treatment. In a unit such as this, it is crucial for nurses to build therapeutic relationships with the parents and families of the newborn to reduce anxieties or fears. This involves explaining different types of equipment and the routines of the unit as well as answering any questions regarding the child. In addition to these jobs, the nurse provides grief care to families that have less fortunate outcomes. The goal of this qualitative study was to assess how nurses working on the NICU deal with the grief of these families and how this affects their own lives.

When nurses in this study disclosed information on their own experiences, common themes were identified from their questionnaire answers. The most significant theme mentioned was that losing a baby in the NICU is not only difficult for the parents, but also for the nurses. Many nurses suggested the circumstances were especially hard because they formed a bond with the baby and family whether they wanted to or not. They verbalized that the death of a child is harder to accept than that of an adult and that effective coping mechanisms are necessary to make it through the grief process (Almeida et al., 2016).

Some might guess that NICU and pediatric intensive care unit (PICU) nurses may experience more emotional stress when they have children of their own because they personalize their experiences in the hospital. Though this is true, emotional demands from the workplace affect both nurses with children and without children; they each face different kinds of demands. According to one nurse without children who worked on a NICU for a period of time, a NICU nurse is often asked by parents if he or she has

children. In one instance, a mother told this NICU nurse without children that she had no idea what the mother was going through. These childless nurses were made to feel inadequate, which was emotionally taxing on them because they felt as if they did not have the resources to help the mother (Cricco-Lizza, 2014).

On the other hand, nurses that are also mothers experience the grief and suffering a little differently than those without children. They look at the infants they care for and are reminded of their children at home. Because they have seen so many sick babies in their lifetime, they live in fear that their own babies will not be healthy. Several nurses described instances when their own babies were placed in a NICU and described how they experienced flashbacks to painful memories made at work. Through this interview, it was evident that the boundaries that lie between ICUs and the outside world seem to be more porous than they appear due to these NICU nurses' ability to suppress their feelings (Cricco-Lizza, 2014).

Ethical & Familial Stresses

Similar to nurses in the NICU, PICU nurses who are caring for children who are dying have immense stressors to overcome. In a survey conducted by authors McConnell, Porter, and Scott (2016), hospital staff on pediatric units recorded their top hardest experiences in their careers. Both hospice and hospital staff recorded that the ethics of decision making at the end of a child's life was a challenging obstacle. There is an invisible line of transition between curative measures and end-of-life treatments, but deciding when this transition occurs is dreadfully hard on both health care workers and parents. Nurses reported increased anxiety when families insisted on continuing treatments that were not in the child's best interest. Another big stressor experienced in

this type of unit was the fact that nurses were not able to share the entire truth with children if their family members did not permit it. This also raised ethical concerns because if the child knows less, the child has less of a view and control of their own care. Communication with the family is another difficulty that professionals have identified as stressful. Doctors and nurses reported that sometimes they end up avoiding the families altogether because they feel they are at a loss for words and are anxious about using the terms *death* or *dying*.

Not only are ICU nurses prone to job stress because of traumatic events they experience, but the extra work demands due to family presence seem to impose harm on the nurse as well. After new evidence surfaced that supported the theory of the effectiveness in Patient Family Centered Care (PFCC) and how it increased the healing of a patient, ICUs nation-wide have started encouraging families to remain with their loved ones during their care at the hospital. This PFCC approach places an emphasis on collaboration with health care workers, patients and family members of the patients. In PFCC, patients define their family and determine how these members will participate in their care and decision-making. This perspective is based on the recognition that patients and families are essential allies for the care for the patient (Denham, Rippin, Samuels, & Zimring, 2015).

PFCC can be good for the patient until the family starts to overstep boundaries. For example, the patient may need to rest in order to heal from a traumatic brain accident; however, the visiting family may want to turn on lights, talk loudly, or wake the patient up, all of which can add stress to the patient. The family may also take up a nurse's time and resources, resulting in missed tests, delayed treatments, and nurses falling behind in

charting. However, if nurses are trained to always put their patients first and learn how to communicate effectively with families, stress could be alleviated (Denham et al., 2015).

Denham, Rippin, Samuels, and Zimring's study showed nurse responses to PFCC in which they shared about the additional challenges that came as a result of this program. As suspected, the feedback from nurses indicated that some family occurrences put more stress on nurses by impeding their ability to care for their own assigned patients. In the critical care setting, nurses often are responsible for two patients at a time because of the high acuity of the patients. Some nurses in the study pointed out that at times, their two patients and their two families competed for the attention and care of the nurse. This could mean having to prioritize one critical patient above another for fear of upsetting the family. Some nurses experienced extra stress when they were having to answer questions from one family of one patient while the other patient needed their attention in the next room. Overall, the nurses verbalized that there is a complexity created when they are expected to care for entire families because they are forced to balance between transparency and sensitivity toward the families (Denham et al.).

Several Neuro ICU nurses in the study described PFCC as being good in theory but still questioned whether it is appropriate in a critical care setting, especially in the Neuro ICU. Hands-on care of the family may be appropriate for stable patients but some unstable patients require safeguarding from the very things that can cause stress. In a patient with a severe head injury that will be found in the Neuro ICU, it is important to keep the intracranial pressure below a certain level. Physical touch, loud conversations, and bright lights are factors that may increase the intracranial pressure, which could potentially cause a more damaging outcome for the patient. This study concluded that

the dynamic of PFCC creates a paradoxical nurse-family dynamic because the nurse may have to make others unhappy when he or she must tell the family to clear the room. After nurses shared their honest opinions of the PFCC system, several registered nurses requested additional training, education, and team-based strategies to help them navigate through potentially challenging scenarios. Other nurses at the end of this study requested more information on their own roles and responsibilities in these situations (Denham, et al., 2015).

A Different Type of Grief

Although most nurses recognize that they experience grief when their patient dies, they do not receive even minimal training in school regarding how to take care of themselves when caught in the middle of this storm of emotions. In fact, in a study conducted in a pediatric setting, all staff said they lacked experience when dealing with end-of-life issues. Education is the highest associated variable for improving a nurse's end-of-life care and one of the only modifiable factors for reducing death anxiety in pediatric nurses (McConnell et al., 2016). Most of the instruction received in school involves training in how to be of support to the family or ways in which they can provide comfort interventions to ill patients. Not only is there a need to be aware of this ineffective coping epidemic in nurses or a need to enact supportive coping measures, but there is especially a need to yield valuable information for the education of future nurses (Alonzo et al., 2010).

To understand the problems of unresolved grief from the perspective of a health care professional, one must first have a proper understanding of the grieving process stages. The five stages of grief were identified by Elisabeth Kübler-Ross in the 1960s.

The phases are denial, anger, bargaining, depression, and acceptance. Psychologists suggest that every individual should go through all stages of grief in order to sufficiently cope with their grief. However, ways of grieving manifest differently in different individuals. For example, the order of the stages might vary depending on the individual. Kübler-Ross, when forming these stages, even expressed that there is no single formula that can be applied to all when it comes to grief (Wustenhagen, 2015).

Denial tends to be the immediate reaction the individual has when receiving bad news. This is the stage in which the person affected may verbalize expressions of disbelief and may use the denial as a buffer to protect themselves. The stage of anger follows the denial stage, and the individual tends to express frustrations toward whatever is triggering the feelings. In the bargaining stage, the person is finally beginning to acknowledge the seriousness of the situation, yet tries to find ways to negotiate and achieve better conditions. The depression stage includes the mourning of the event, in which the individual fully grasps the loss that has occurred and develops sorrow as a result of this realization. The stage of acceptance is the turning point when the person finally accepts the reality, inevitability, and irreversibility of the loss. This stage is vital because it allows the individual to accept what has happened and move on. When the process is not completed, the burden of grief can weigh on a person and cause chronic problems (Wustenhagen, 2015).

Another important step in coping is acknowledging the death of the patient. Nurses are experiencing disenfranchised grief, which is a type of grief that is not resolved because the loss is not openly acknowledged or socially validated. Brushing off the grieving process and dismissing it as inappropriate can lead to physical illness, behavioral

disturbances, and cognitive changes (Mortell, 2015). Nurses are commonly expected to be the comforting figures in the hospital and because of this, many times they are not able to properly grieve for the death of a patient. They are either too busy focusing on helping the friends and family through the grieving process, they are emotionally detached, or they may be keeping themselves busy with helping friends and family in order to emotionally detach (Houck, 2014).

In the United States health care system today, the process of death is no longer seen as a natural course but an act that can be halted or prevented with the proper treatments. Because of all the technological and medical advancements, death is no longer present in the daily lives of many because it is beginning to occur more often in intensive care units. This view of death among health care professionals may cause their experiences in walking through the grieving process to be much more difficult. Many health care providers look at death as a failure because they were not successful in sustaining life as long as they believed they could (Almeida et al., 2016).

In a study conducted by McConnell and associates (2016) that aimed to explore the experiences of healthcare professionals who provide care to children at the end of life, disenfranchised grief was described by many nurses, physicians, social workers, and psychologists. Some described how they felt they must maintain a professional reputation because they felt they did not have anyone to go to for help. Some reported that they resorted to crying in bathroom stalls or crying on the way home from work. Nurses reported feeling the weight of the grief inside and outside the hospital; when out with friends or family, they felt guilty sharing their sad work stories. Doctors reported

feeling drained when they were home and because of this fatigue, they distanced themselves from their children and family members.

Different Nurses Handle Stress Differently

Although the ICU's intense environment is a major part in creating extra stress and burnout syndrome for nurses, many individual factors play a role in how a nurse handles stress and grief. In a recent study conducted in 2013, 395 nurses were selected and completed a Ways of Coping questionnaire. The results of this questionnaire showed that sociodemographic, educational, and job characteristics may have an impact on the ways in which a nurse will cope. In this questionnaire, it was discovered that nurses with more education and more work experience were able to better come up with problem-solving strategies than others with less education and experience. The nurses with less education relied more on prayer than nurses that graduated from universities who relied more on problem solving. Women also are more prone to use emotional strategies to cope such as prayer and the search for divine intervention, while men were more prone to use strategies focused on problem solving. The gender findings were expected, according to the authors of the journal detailing this study (Alikari et al., 2016).

Another study conducted by Burgess, Irvine, and Wallymahmed showed that work experience in the ICU was negatively correlated with stress from home-work conflict and dealing with patients and their relatives. Therefore, the higher the number the years of experience, the less stressed perceived. However, when the same group of people studied nurses with more non-ICU experience, no statistically significant correlations were shown in comparison to stress levels of ICU nurses. This may mean that ICU experience rather than general nursing experience is of more help in coping with

the ICU stresses. However, a number of reasons could contribute to this finding. For example, maybe the ICU nurses are more adjusted to the environment and therefore, more ready to take on stressful situations. These nurses, once adjusted to the ICU, have more autonomy which could lead to an internal locus of control, or the belief that they can change their circumstances. This type of way to cope with stress is beneficial because it reduces their perceived workplace stress. Another aspect that could be involved is the bond that critical care nurses have on the unit, creating a support system and therefore, increasing the ability to conquer stressors. Regardless of the reasons why, there is strong evidence for the value of ICU nursing experience rather than general nursing experience when it comes to dealing with patients and their relatives (Burgess, et al., 2010).

Work engagement is another aspect that affects the coping strategies of a nurse. This term refers to the positive attitude and high level of energy that a nurse exhibits despite the job becoming hard. This is not to be confused with job satisfaction, but an inward positivity that allows workers to perform better than those that are less engaged in their job. Work engagement may occur as a result of social support, feedback, opportunities for autonomy and variety in the hospital, or from a growth of the employee's own resources such as self-esteem and confidence from experience on the job. A study that focused on nurses who worked on the Surgical Intensive Care Unit indicated that the higher the work engagement an individual has, the lower burnout and compassion fatigue. Correspondingly, nurses demonstrating higher positivity had more compassion satisfaction. From this study, it could be tentatively concluded that positivity can work as a shield of resilience for critical care nurses (Butler et. al., 2014).

Some researchers contest that the coping techniques of nurses depend on the personality type (Alikari et al., 2016). The basis for one study was the fact that some nurses thrive in ICU environments and maintain a passion, while other nurses become severely distressed and ill from working the job. According to the study, it is already widely known that personality does play a role in coping strategies and what is perceived as stressful. For example, the optimistic person has been shown to use more problem-solving strategies while the pessimistic person is not as likely to try out new solutions. The question as to whether there are innate personality traits to help combat stresses in the ICU was studied in depth through the administration of questionnaires. Eighty three nurses working in the ICU were sampled and they submitted demographic data as well as their answers to the questions asked. The personalities were measured using the Neuroticism-Extraversion-Openness Personality Inventory (NEO-PI), which measures personality qualities in addition to consciousness and agreeableness. The second questionnaire was called the Nurse Stress Index (NSI) and this test measured the individual's perceptions of workplace stress. This questionnaire was originally developed with the purpose of testing those at the charge nurse level and above, but since ICU nurses already have more experience and autonomy than other nurses, this was an appropriate instrument to use to gather this information. The third questionnaire that was used in this study measured the coping ability of the individual (Burgess et al., 2010).

The results of this study showed how personality does have an effect on what the individual considers stressful in the workplace. The answers in the questionnaire showed that nurses who reported higher levels of openness and extraversion had lower levels of stress when dealing with difficult patients and families in the ICU. People with higher

levels of conscientiousness perceived little stress when it came to time pressures and management stressors. According to these results, the personality traits of openness, extraversion, and conscientiousness may have a protective effect on perceptions of workplace stress (Burgess et al., 2010).

In addition, this study's results demonstrated how individuals with certain types of personalities use different coping techniques. Those who scored higher in the openness personality type commonly used reframing and planning, which could indicate that openness is linked to problem-focused coping. Those that scored higher in the conscientious personality type commonly used active coping and planning, which suggests that those who are conscientious can actively plan to address the stress factors and therefore have a higher chance of modifying them. Nurses that scored high in agreeableness used active coping, planning, and reframing techniques to handle their stress, which shows they can alleviate stresses using problem-focused coping. Lastly, in those that scored high in the personality trait of neuroticism were more likely to use venting as a coping strategy, which means people of this personality are more likely to express their feelings verbally to deal with stress (Burgess et al., 2010).

Beijer and associates have cited within their own 2011 study that the levels of traumatic stress experienced by nurses could be explained by the various coping styles used by these same nurses, which is very important information when considering the nursing shortage. The strategies for preventing and handling grief are the same strategies used to prevent and handle compassion fatigue. It is common for facilities to encourage their nurses to take care of themselves emotionally by maintaining a balance between their work life and outside life. For example, unplugging at the end of the day and doing

something they enjoy can help alleviate stress. Nurses with religious beliefs have protection against some grief and resulting fatigue because faith can promote healing from grief while providing rest for fatigue. Other self-care activities include yoga, meditation, and listening to music in order to assist nurses in the process of healing (Houck, 2014).

Effective Coping Strategies

Butler interviewed nurses working on the Surgical Intensive Care Unit and asked the question “How do you replenish yourself?” The top answer was self-care (54%), and other answers were associated with relationships with the professionals they worked with (23%), and compassion/empathy (23%; Butler et. al., 2014). Other journals have validated the research that relaxation techniques have been proven to help manage anxiety symptoms (Alikari et al., 2016). An important self-care tip that nurses say is crucial to maintaining mental health is to leave it all there at the hospital when they go home from work. Many nurses struggle with actually doing this, but having a life outside of the nursing career is an effective way to live this out. Whether it’s reading a book or participating in recreational activities with friends, these activities can afford an escape and renewal of energy (Cricco-Lizza, 2014).

Education can potentially play an important role in coping because it can teach newer nurses what they need to look for in regards to compassion fatigue and burnout syndrome in order to avoid it. Studies showed that educational seminars on compassion fatigue increased both awareness and resources for the prevention of emotional stress in the future. Participants in this study verbalized that they felt more at peace after the intervention (Bakker, 2015).

Because many nurses feel they are unable to grieve publicly, they are hindered from resolving their grief. However, if these nurses took necessary steps to grieve for themselves by first acknowledging the death of a patient, such as attending the funeral, the nurse might be better able to process the death by finding closure. A funeral service is a common example of the rituals that help many Americans grieve the loss of loved ones. It helps to make the death real and helps people work through how they will go on living. Finding meaning in the death can help an individual move on, and the finding of this meaning typically occurs through the interaction of others. The act of a ritual especially works because it adds public acknowledgement and support that one would not ordinarily receive when walking through disenfranchised grief. The ritual is crucial to coping, and if an individual is deprived of ritual, it will hinder their ability to mourn (Houck, 2014).

When nurses do not feel that it is socially acceptable to grieve, such as in the illness and death of a patient they have only known for a month, they are less likely to search for help. Researchers have identified this behavior as self-disenfranchisement, in which there is a silencing of the self for the sake of social expectations. In this case, the griever is not only the disenfranchised, but the disenfranchiser because they are robbing themselves of the ability to make things better. Shame can hold nurses back, causing them to turn inward and create more injury. Without the social expression of pain on the inside, the griever fails to receive empathy from their community and must face the enormous mountain of grief in solitude (Houck, 2014).

There is much significance in discussing feelings related to the incident. While communicating with the patient and the family is crucial, caring for and supporting peers

is another essential role of the critical care nurse. During an interview for a study conducted in 2011, a nurse compared the experience of caring for patients enduring the withdrawal of life support to shoe boxes stacking up on shelves. While shoe boxes can be stacked on shelves, it is only a matter of time until the shelf is full and the experiences need to be brought to light. An informal support system is needed between coworkers, even if it is just a quick conversation over coffee. Support from people outside the hospital may not be as effective because they do not understand the intensity of working in the ICU (Fothergill-Bourbonnais, Malone-Tucker, Slivar, & Vanderspank-Wright, 2011). For example, a NICU nurse in a study decided against confiding with her family in her grief because they thought that she held babies and fed them all day long. She stated how hard it was for her family to comprehend the type of work she did, making it hard to talk with them about it (Cricco-Lizza, 2014).

Therefore, conferences, emotional support groups, and debriefing within the workplace are an effective ways to cope with work stresses. These support systems will also help nurses to see that they are not facing these battles alone (Fothergill-Bourbonnais et al., 2011). Studies have shown that the timing of debriefings may play a crucial role and can be more detrimental if they are pushed off until later. One nurse that may have found a place for his or her grief, through the experience of a late debriefing, may suddenly find themselves back at the beginning of the process (McConnell et al., 2016).

As a result of strong connections formed in group therapy activities, support groups can spur people on to exchange advice and suggestions for coping. This way, they can feel as if they are helping others and their self-esteem increases. Groups in the past have especially been effective when the leader is warm, empathetic, genuine, and

educated in the grieving process and when those in the group share similar experiences (Mortell, 2015).

Some units come together to form a team-like bond to help each other through the hard times in nursing. Unit teamwork can be very beneficial when it promotes a supportive environment between workers; when nurses help one another, they are less likely to get burned out. Offering proper resources and flexible aid on a unit that is well staffed can go a long way for nurses. When new nurses are assigned to mentors, they have an easier time adapting to the unit. During periods of stability, nurses will often engage in easy conversation about movies, restaurants, and social activities to take a break from the intensity. Nurses recommend in their interviews that humor can help a person to cope with hard situations as well. A supportive environment can maintain nurse confidence and could possibly lessen the burnout syndrome (Cricco-Lizza, 2014).

In order to help the nurse experiencing disenfranchised grief, empathy should be offered in the form of active listening and in careful assessment of why this type of grief has occurred. A way of therapy that has been suggested is the Empty Gestalt Chair technique, where an individual that is mourning sits across from an empty chair and pretends there is a trusted person sitting in front of them. The griever is encouraged to engage in dialogue in which they share their thoughts, feelings, and behaviors. Those experiencing grief have emotions running rampant and this type of therapy can help them become more mindful of their situation and may even help to uncover suppressed thoughts and emotions (Mortell, 2015).

Nurses can also benefit from discussions by gaining new perspectives from those with whom they can connect. New perspectives can come from support groups on the

unit they work on or even from the families they care for. For example, the NICU nurses that were interviewed regarding their own coping mechanisms in the workplace said that when they helped the parents cope with a child's death, it was a rewarding experience. In fact, some nurses shared experiences of families coming back to express their gratitude to the nurses. A feeling of accomplishment reframed the situation, which helped combat feelings of guilt or failure. Nurses, with the development of their new perspectives, may also come to believe that death is a normal part of the life cycle. These important lessons can help nurses live through these situations with less suffering because it will remind them that they did everything that was possible to save the patient (Almeida et al., 2016). Despite the evidence of how many intensive care nurses have distanced themselves in order to protect from compassion fatigue, one study showed nurses with positive attitudes towards dying patients because they knew they provided the utmost and dignified end-of-life care that they could (Cant et al., 2013).

Nurses have also suggested that exerting control over details on the critical care units can help to cope with the stress. The NICU nurses interviewed said they could become what they called a super nurse by focusing on a task to be done and putting forth high expectations to save the babies they cared for. This type of coping mechanism helped nurses to gain confidence and control the stress on a unit up until they lost a baby despite their heroic efforts. However, when the babies survived and got better, these nurses were reinforced with pride. This positive attitude can be a coping mechanism that may be worthwhile (Cricco-Lizza, 2014).

There are many services available to a critical care nurse to help him or her cope with stresses in the workplace. These formal support systems that are already in place

can be of great use to struggling nurses in the ICU. Some hospitals have special organizations called Employee Assistance Programs that are accessible to all staff. In addition, spiritual care staff and the clinical ethicist are always readily available to staff who need more formal discussion and debriefing (Fothergill-Bourbonnais et al., 2011).

One large example of a study conducted by Barber to improve communication and therefore improve stress levels in the ICU was a study published in 2012, which was broken up into two phases. The study demonstrated that the implementation of an intensive communication strategy regarding end-of-life practices in the ICU was associated with a reduction in burnout syndrome by 50% and a reduction in depression by 60%. In the first phase, caregivers were given questionnaires so that the evaluation and prevalence of burnout syndrome could be tested. The second phase would include an evaluation after a communication intensive strategy had been developed and implemented. The communication intensive strategy was developed by a team of physicians, nurses, nursing assistants, and psychologists. These professionals formed the strategy by conducting clinical interviews with caregivers to identify areas of intervention for burnout syndrome. The main goal of this strategy was to improve communication with caregivers, patients, and patients' families to relieve stress for caregivers (Barbar et al., 2011).

The communication strategy formed by the healthcare team emphasized an increased availability of the healthcare workers to talk with the patients' families and an increased open communication between coworkers, such as daily meetings and debriefings. In addition to this strategy, caregivers were encouraged to participate in

brainstorming groups within the ICU with the goal of improving the delivery of care and in conflict management on the unit (Barbar et al., 2011).

Beijer and associates' study of 2011 also presented findings that did not match up with the majority of studies in support of group therapy sessions and support groups as a means to protect the emotional and psychological health of the nurse. Interestingly, this study suggested that seeking social support increased the chance of traumatic stress, whereas active coping protected against this traumatic stress. The exact reasons for these outcomes were not determined through this study. In the discussion, the authors concluded that maybe positive appreciation from others is not enough to help the nurse with coping. They suggested that reassessing the situation and using emotion-focused coping techniques, or active coping, is more effective. However, the study is outnumbered in its conclusions that support is not helpful.

Another way to battle the anxieties and stresses that typically occur in an intensive care unit setting is through spiritual sanctuary. A nurse's belief in a higher power helps to give purpose to everything that happens, which then helps that individual to form more positive beliefs about death and dying. One study's results showed that the more religious a nurse was, the less anxiety he or she had when facing the death of a patient. These nurses were more positive about caring for their patients during death because they saw it as the gateway to the afterlife and as a natural part of life (Cant, et al., 2013).

When nurses care for a patient, their job includes caring for the whole person, which includes spirituality. When nurses are taking care of patients in vulnerable positions, they see what really matters to that patient. They start to have more

conversations about life and death, heaven and hell, meaning, hope, and guilt. During the time near death, nurses can choose to open up and be attentive to subtle cues that they may receive from patients. After attending to their patients' spiritual needs, the spiritual involvement with the patient helped the nurse too. In different studies, nurses commented that they felt good after they attended to spiritual concerns of their patients because they felt that what they were doing was meaningful (Cone & Gisk, 2015).

Conclusion

In the near future, the United States healthcare system will experience an enormous nursing shortage which could potentially lead to a national emergency. Although there are multiple factors that play a part in the nursing shortage, it is still crucially important for nursing managers and administrators to be aware of the reasons for the nursing turnover and brainstorm solutions to prevent this departure. With all the shortages that may occur in the future, hospitals must remember that the mental health of a nurse should not be sacrificed for the sake of caring for too many patients. If the mental health of a nurse is not supported, there will be a greater deficit in nurses and therefore, a greater problem. Retaining experienced critical care nurses is crucial to successfully implementing orientation for all the newly graduated nurses starting their careers. Through the acknowledgement of these demands and through providing resources as well as education to care for the mental health of their nurses, hospitals may be able to make changes in the nursing retention, therefore softening the blow of this nursing shortage. If nurses take care of themselves better, the patient care will be greatly improved because this type of movement trickles from the top down.

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