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RESEARCH

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Grief reactions and coping strategies of Muslim nurses dealing with death

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Abstract

Background: An intensive care unit (ICU) features high mortality rates. Witnessing subsequent deaths may affect nurses psychologically and spiritually. Islam has an influence on Muslims' life and death. Nevertheless, little is known about Muslim intensive care nurses' experiences of grief in dealing with the deaths of patients.

Aim and objectives: This study aimed to describe the grief reactions and coping strategies of Muslim nurses in dealing with the death of patients.

Design: This is a qualitative study with a phenomenological approach.

Methods: Semi-structured individual interviews were conducted. Fourteen participants from an ICU in an Indonesian tertiary public hospital participated in this study. Data were analysed by thematic analysis. Trustworthiness was established by Lincoln and Guba's criteria.

Results: The findings identified four reactions of grief, four factors influencing reactions of grief, and three coping strategies used in dealing with death in an ICU. The reactions of nurse's grief were crying, being sad, feeling disappointed, and feeling guilty. These reactions were related to several factors including the circumstances of the patient's death, nurse's expectation of patient's recovery, relationships with the patient, and the reactions of family. Coping management strategies used by nurses in dealing with their grief comprised: sharing with colleagues, avoiding dying and death situations, and engaging in spirituality.

Conclusions: The Muslim ICU nurse participants experienced their grieving through a variety of psychological reactions influenced by several factors. Personal coping strategies were revealed in dealing with their grief. However, avoiding dying and death situations affected their duty.

Relevance to Clinical Practice: Attention to nurses' grief should be paid to maintain their psychological well-being and quality of end-of-life care. Providing formal support to enhance grief management is recommended.

KEYWORDS
bereavement, grief, intensive care, intensive care nurses, qualitative research

1 | INTRODUCTION

An intensive care unit (ICU) is the unit in a hospital that offers intensive medical and nursing care for critically ill patients.[1] Even though the ICU is expected to sustain life, ICUs usually have high mortality rates resulting in ICU nurses having to deal with many deaths of patients. According to the Society of Critical Care Medicine,[2] mortality rates of patients admitted in ICU average 10%-29% around the world. In Indonesia, the mortality rate in an ICU was reported as 40.2%.[3]

Grief is defined as a response to a loss or bereavement.[4,5] Dealing with multiple patient deaths was reported to affect nurses physically and psychologically.[6] However, nurses' experience of grief is not

widely acknowledged which may be caused by professional stigma. Professional stigma is a condition whereby nurses are expected to deliver professional care to patients and families while they grieve but they cannot admit their own and their colleagues' grief.[7] Nurses may experience grief because of the death of a patient, but they may not have time for resolving their own grief. In this situation, nurses need to acknowledge their grief so that they can cope effectively.[6]

Islam is a monotheist religion conveyed by the Prophet Muhammad as a messenger of God.[8] Islam has become the second largest religion in the world.[9] It was estimated that there were 1.6 billion Muslims around the world representing 23.3% of the world population.[10] Those Muslims contribute to the health care system, either as nurses or as patients. Islam is practiced by Muslims as a way of life that influences aspects of living and dying. Death is believed as a journey in a spiritual world.[8] Illness is understood as a test from God, and therefore, Muslims will engage in a spiritual activity during their illness. Saving a life is considered as the highest good deed and any treatment to avoid premature death should be performed. However, if it is determined that treatment is no longer possible to improve the condition, withholding or withdrawal treatment is allowed.[9] In dealing with death, Muslims are encouraged to be patient and accept the death.[11] Mourning is permissible but excessive display of grief is not acceptable.[11] The way Muslims react to grief may affect the way Muslim nurses deal with their grief due to them experiencing many deaths of patients.

Indonesia is a country with the largest Muslim population in the world.[12] Based on the data of Ministry of Religious Affairs Republic of Indonesia,[13] 87.2% of Indonesian people believe in Islam. Islam influences many aspects of Indonesian life including end-of-life care in health care settings. At the time of dying, it is required for other Muslims to be around the dying person to recite *shahada* (the statement of the oneness of God). Therefore, in respect of end-of-life care, each ICU is required to provide a private room for dying patients.[14] However, this may not always be achievable.

Grief among nurses has been the subject of several studies. Research has shown that younger nurses have a great fear of death and negative attitudes towards end-of-life care.[15] Furthermore, nurses expressed many feelings from facing death situations, but lack of coping strategies was noted.[16] Nurses distanced themselves from death situations and showed emotion by crying and only few of them received emotional support.[17]

Among those studies exploring nurses' grief, studies conducted among Muslims are limited and most focused on end-of-life care rather than on grief and paid more attention to patients and families rather than nurses.[18,19] Because of the limited number of studies, further research is needed to explore grief among Muslim nurses in dealing with deaths of patients. This paper focuses on nurses' grief reactions and coping strategies; a sub-study of research was previously reported by Betriana and Kongsuwan.[20] Understanding how nurses react and cope with their grief is vital for new insights to inform intensive care practice and end-of-life care.

WHAT IS KNOWN ABOUT THIS TOPIC

- Nurses experience grief in dealing with the death of patients.

WHAT THIS PAPER ADDS

- Muslim ICU nurses express various psychological reactions and coping strategies in dealing with patients' death.
- The grief reactions are influenced by patient, family, and nurse factors.
- Spirituality and culturally sensitive interventions can be considered for the management of Muslim ICU nurses' grief.

2 | AIM

This study aimed to describe the grief reactions and coping strategies of Muslim nurses in dealing with the death of patients.

3 | DESIGN AND METHODS

3.1 | Design

A qualitative phenomenological approach was used in this study to describe human experience.[21] In this study, the researcher aimed to describe the grief reactions and coping strategies of Muslim intensive care nurses in dealing with the death of patients.

3.2 | Setting and sample

The setting was an ICU in a public hospital in Indonesia. This ICU consists of 8 beds with 16 nurses. Other health care professionals are physicians, pharmacists, and nutritionists. All nurses are Muslims. Nurses working in this ICU are required to follow training for critical care qualifications, including basic trauma and cardiac life support, advanced life support, and ICU training. All nurses are registered nurses with either a vocational qualification or bachelor's degree of nursing. The nurses care for patients until they are transferred to general units or die. Bereavement support for patients and families is given by nurses, because the patients are at the end of life. In Indonesia, ICU nurses should have at least basic and advanced life support training.[14] In this study, the qualification of training was not included in inclusion criteria. The inclusion criteria of participants included: (a) being a Muslim nurse; (b) having experience of the death of patients; and (c) working for at least 1 year in an ICU.

3.3 | Ethical approval

Ethical approval was obtained from the review board of The Social and Behavioral Sciences, Institutional Review Board, Prince of Songkla University, Thailand, number 2017NSt-Qn 039. Prior to approaching the participants, the hospital setting issued permission letter number 099/250/RSAM-SDM/X/2017. After the permission letter was granted, the researcher contacted the head nurse of the ICU. The head nurse contacted eligible participants and asked if they were willing to participate, the researcher contacted the participants. Participants were informed about the study and invited to sign informed consent forms once they agreed to participate. The explanation included the procedures of the study, and the risks and benefits of joining this study. Participants were assured that their participation was voluntary. They had the right to withdraw any time without any penalty. Their personal information was kept confidential.

3.4 | Data collection procedures

After obtaining a permission letter, the researcher contacted the head nurse of the ICU and explained the study and the eligible criteria for participants. Based on the regulations of the hospital, it was required to contact the head nurse before approaching the participants. The head nurse contacted eligible participants. If the participants conveyed verbally that they were willing to participate, the researcher contacted the participants and explained the details of the study. There were 16 nurses and 14 agreed to participate. There was no existing relationship between the researcher and participants, which might cause risk of coercion among participants. Before signing the informed consent, they were informed that their participation was voluntary and there would be no consequences if they declined to participate.

The interviews were conducted at a convenient time for the participants. Most of them chose to be interviewed after work. Before the interview, they were informed that they may be referred to a psychologist if they needed counselling or emotional support. During the interview, the researcher listened to their grief stories and facilitated them to express their feelings.

Each interview was conducted in Indonesian language by the first author and lasted for about 45 minutes to 60 minutes in a private room inside the ICU. Each interview was recorded with two recorders and notes were taken. Data collection was ended after reaching data saturation. Data saturation was established when there was no more new information from interviews.[22] Data were collected from October 2017 to December 2017.

The interviews were conducted following guided interview questions. The questions were: “How did you feel when you dealt with the death of your patients?,” “Why did you feel that?”, “What were your reactions when the patients died?,” and “What did you do to make yourself feel better in dealing with the deaths of the patients?” Probing questions were asked when it was necessary to explore and clarify the participants' statements.

3.5 | Data analysis

Data were analysed using thematic analysis following van Manen's approach.[23] The phenomenon described in the text was approached in terms of meaning unit and themes[23] and were classified into thematic categories. The themes refer to the notion which occurred frequently in the transcription text.[23] In this study, audiotaped interviews were transcribed, and then the transcriptions were read and analysed line by line to obtain the meaning unit. The translation process employed the verbatim translation method.[24] Interview transcriptions were translated into English by the primary investigator. One translator (primary investigator) took the responsibility to translate, because using one translator would maximize the reliability of the data (Twinn, 1997 cited in Reference 24). The translated version was validated by an expert who was proficient in English and Indonesian languages. The translated version was analysed by both the researchers. The themes that emerged were arranged in accordance with the aims of the study which dealt with the reactions of grief and coping strategies. Data were supported by the reflection notes taken by the researcher during data collection.

3.6 | Trustworthiness

Trustworthiness was maintained through credibility, dependability, transferability, and confirmability.[25] Credibility was established through triangulation using data from interview transcriptions and reflexivity notes. Transferability was obtained by thick description of the experience of grief. Dependability was reached through an external audit with an expert and confirmability was established by reflecting on the reflexivity notes.

4 | FINDINGS

A total of 14 nurses participated in this study. Three were male and eleven were female. Eight were bachelor degree graduates and 6 were vocational graduates. Their ages ranged from 25 years to 40 years. The meaning units, themes, and major thematic categories are presented in Figure 1. The identity of the participant was replaced by P (participant) and code number.

4.1 | Reactions of grief

The reactions of participants towards patients' death were crying, being sad, being disappointed, and feeling guilty.

Some participants expressed their feelings by responding to the death of the patients by crying. They admitted that their tears were shed and they cried when their patients died.

> There was also a dead patient. Her other child was five years old. Then, that child always said, “Mommy. mommy, wake up. Let's play again,” At that time, I cried. (P.7)

Participants stated that they felt sadness, pity, empathy, and were touched when they faced the death of the patients.

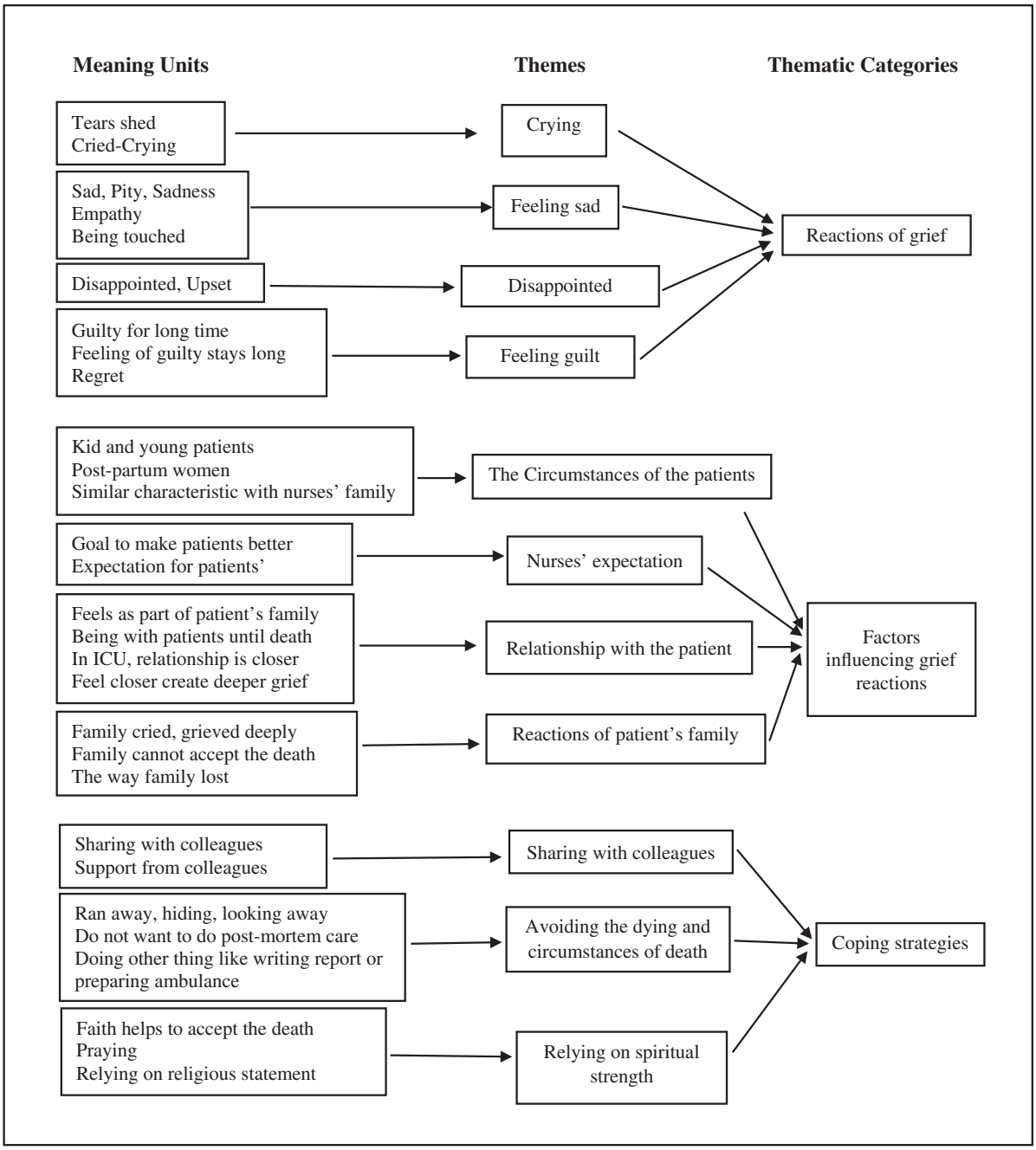

FIGURE 1 The meaning units, themes, and major thematic categories

> That dead patient, she was supposed to get better. I felt sad too. (P.6)

Participants expressed their grief by being disappointed and upset. Their disappointment was related to their expectations about the patients' death. Participants also admitted that they felt guilty and regret and questioned how the patients could die.

> Disappointed, really. They were supposed to get better, but in fact it's not… But, when our expectation is high, I felt like… how to say? That feeling… what we say that? (P.4)

> About young men … I feel guilty if they die during my shift… The feeling of guilt cannot go away, until now it cannot go away. (P.2)

4.2 | Factors influencing grief reactions

The reactions of grief were influenced by several factors. These included: the circumstances of the patient, nurse's expectation, relationship with the patient, and reaction of the patient's family.

Participants experienced grief when their patients died in accordance with the circumstances of the patient. These circumstances included: children and young patients, postpartum patients, and the patients with similar family characteristic as the nurses' family members.

> Sometimes for young patients, I feel pity, because they are still young. (P.9)

> I felt sad if the patients were pregnant women or post-partum women. (P.11)

> For elderly patients, I feel empathy because I think about my parents. (P.9)

The participants reported that when they cared for patients, they had expectation that the patient would get better. Although in some conditions, the patient could not be saved. This caused them to feel grief, especially if their patients were thought to have a good chance of survival.

> How can I say, when we take care of the patients, our goal is to make patients get better. But in fact, their condition declined, even as we did our best, patients died. I felt sad. (P.1)

The ICU is a setting in which nurses create close relationships with patients, because nurses spend most of the time with these patients.

> Because I took care of them for a long time, I had always met the patients, had contact with them, so I felt pity for them. (P.8)

Furthermore, the way family react to the death influences nurses' response. When the family responded in an accepting way, nurses admitted they responded effectively. However, when the family responded with the great grief and cried, it caused nurses to feel and react in the same way. They admitted getting carried away when the family grieved so deeply.

> If they (patients' family) cried, I would cry also. But if they didn't cry, I was okay. (P.11)

4.3 | Coping strategies

Three coping strategies were identified. Those included: sharing with colleagues, avoiding the dying and the circumstances of death, and relying on spiritual strength.

Some participants reported that sharing with colleagues helped them to cope with their grieving. Colleagues usually gave them support which made them feel better:

> Sometimes I talked with my colleagues. Oh, that dead patient! (P.3)

However, participants also reported that they tried to avoid the situation of the death and post-mortem care.

> Sometimes I ran away… I felt pity easily, sometimes I could not face that. (P.2)

Spiritual strength was also reported by participants as helping them cope with their experiences of grief. They resorted to spiritual strength by seeking religious statement about death, undertaking prayers, and believing that death was ordained by Allah.

> Since there is a statement in our religion that death is already decided, so I feel it affects my thinking in dealing with patients' death. (P.10)

> For me personally… I pray. Oh Allah, please strengthen me not to shed my tears. Sometimes I recite every prayer I know. (P.11)

5 | DISCUSSION

The nurse participants' grief is professional grief and the relationship between nurse and patient is unique and different from that between family members and patient. In describing nurses' grief, Kavanaugh's identification of seven behaviours and feelings as part of coping process[26] can explain the situation of nurses' grief. Those seven behaviours describe the emotional stages and reactions as part of coping strategies in dealing with the loss experienced by nurses. The seven behaviours are: shock and denial, disorganization, volatile reactions, guilt, loss and lonely, relief, and reestablishment. Even though every stage may not be experienced by participants, some stages can explain the meaning of their experience of grief, namely shock and denial, volatile reactions, and guilt. In this study, participants expressed their reactions by crying, feeling sad, being disappointed, and feeling guilty. The way they responded to patient's death related to several factors. Feeling sad and crying were reported as the way they responded in their grief, because they expected their patients would recover. In addition, the participants' grief reactions were also related to the reactions of the patient's family. Even though the participants responded with various expressions of their grief, spirituality played a vital role in helping them in the coping process.

In one of the fundamental patterns of knowing, Carper[27] emphasized "empathy" as a key part of the aesthetic way of knowing. Empathy is a condition whereby nurses feel another's feeling. In the context of grief in this study, nurses felt the way the patient's family grieved; thus, they reacted in the way the family reacted to grief. The feelings of disappointment and guilt were linked to nurse's expectations concerning a patient's recovery. As they cared for their patients, they set a goal that the patients should get better. When the outcome did not meet their goals, they perceived the death of their patients as their failure; this created feelings of disappointment and guilt.

The reported experiences of grief in this study mirror the findings of two previous studies. Stayer and Lockhart[28] conducted a study among paediatric ICU nurses caring for dying patients in the United States. Their study revealed that nurses were affected emotionally by the death of their patients through expressing sadness, being upset, and feeling guilty, especially if the nurses had close relationships with the patients. This was particularly so if the patients had similar characteristics as their own children and the nurses witnessed the families seeing their children die. Moreover, that study showed that nurses discussed their feelings with colleagues and sought and received support from them and this helped them continue working in the unit. Another study explored the grief of Japanese nurses. It revealed that cultural factors contributed to nurses' grief after patients' death; these included longer hospitalization and use of the primary nursing care system.[6] Grief was expressed through sadness, crying, and keeping a distance from patient and family to protect themselves from emotional pain.

In terms of coping strategies, participants used several strategies to help them to cope. As it is generally understood that grief among nurses is not well accepted, the coping strategies they used were mostly informal. They understood their own feelings and they sought their own personal ways to cope. In this study, nurses' grief comprised sharing with colleagues, avoiding dying and death situations, and employing spiritual measures. They informally shared their feelings with colleagues as they understood that colleagues were those who best knew about their situation relating to the death of their patients. Most reported that they received emotional support from their colleagues, and this made them feel better. The coping strategy of avoiding dying and death is similar to other studies.[6,17] This coping strategy disturbed their obligation in end-of-life care.

Spiritual measures were also employed by nurses to cope. For Muslims, it is believed that death has been determined and should be accepted in an accepting way. Crying is permissible; however, excessive expression of grief is not acceptable, because it shows unwillingness to accept God's will.[11] In the Quran, it was written that "And We surely test you with something of fear and hunger and a loss of wealth and lives and fruits, but give good tidings to the patients, who when misfortune strikes them", say, "Indeed we belong to Allah and indeed to Him we will return" (Quran, 2: 155-156). This guiding concept assists Muslim nurses to cope. In this study, nurse participants employed spirituality as a management strategy in dealing with their grief. Even though they experienced grief, they successfully recovered by relying on Muslim religious teaching about death and grief.

This study showed that grief experience occurs among Muslim nurses, which might also occur with other nurses regardless of country, faith, and culture. However, the way nurses express their grief, the factors influencing the grief, and their coping strategies might be different depending on their background. Therefore, understanding nurses' grief by considering such background is vital. Spirituality and culturally sensitive interventions can be considered as management for nurses' grief.

6 | LIMITATIONS OF THE STUDY

This study was conducted in a single ICU in a public hospital in Indonesia where the majority of communities are Muslim. Therefore, the findings of this study may not be the same and relevant to the grief felt by Muslim nurses in countries with Muslims as a minority. However, the knowledge from the findings can inform ICU nurses' regarding the grief phenomena which occur. Thus, the interviewing of participants from different cultures and faiths, settings, backgrounds, and regions is recommended for future comparison studies.

7 | CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

Muslim ICU nurses experienced grief in dealing with the death of patients and expressed various psychological reactions which were influenced by patient, family, and nurse factors. These nurses sought their own way to cope with their grief by sharing with colleagues, employing spirituality in relation to Islamic concepts and rituals, and avoiding the dying patients and death situations. Nevertheless, distance from dying and death could affect their care.

The findings of this study can contribute to knowledge of nurse's professional grief and can be used as reflection for nurses to understand their own grief and become aware of other nurses' grief. For nursing managers, the findings assist them in becoming aware of grief that may occur among their nursing staff in ICUs. Bereavement sessions or peer sharing discussion combined with spirituality such as prayer or dhikr (repeated prayers to remember God) are recommended as formal management strategies of Muslim nurses' grief. Providing these support methods may help to maintain nurses' psychological well-being and prevent negative consequences resulting from ineffective grief.

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AUTHOR CONTRIBUTION

F.B. and W.K. contributed to the study concept and design of manuscript. F.B. contributed to data collection. F.B and W.K. contributed to the analysis of the study. F.B. and W.K. contributed to manuscript writing. F.B. and W.K. contributed to final approval of manuscript version.

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