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Professional grief among nurses in Spanish public health centers after caring for COVID-19 patients

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Abstract

Aims and objectives: The aim of the present study is to investigate the professional grief suffered by nurses in various medical units, after coping with the COVID-19 pandemic for the last 18 months.

Background: Addressing and acknowledging the reality of professional grief is of fundamental importance to nurses' mental health, as this condition has both professional and personal consequences.

Design: A qualitative, content analysis approach was taken.

Methods: Based on 25 interviews with nursing professionals working in different health centers units were performed. The following sampling schemes were used: first, convenience sampling, then nominated sampling, and finally theoretical sampling.

Results: From our analysis of the data obtained, three main themes were identified: the impact on nurses of COVID-19 outcomes; the symptoms of professional grief; and cognitive reactions. These core elements interacted with 12 subtopics, including symptoms of grief and the cognitive impact produced.

Conclusions: A large proportion of the nurses consulted in this study have suffered and suffered professional grief and report many related symptoms. In response to the present pandemic and any future occurrence, the question of professional grief needs to be addressed.

Relevance to clinical practice: To help them cope better with this type of situation, nurses should receive appropriate training. Moreover, healthcare institutions should be made aware of the problem and be encouraged to offer assistance to address the impact produced on nurses by the deaths of their patients.

Clinical relevance: This study shows the impact of professional grief on nurses in the context of the COVID-19 pandemic. Nurses are affected personally by the deaths of patients and by alterations to their working conditions. In many cases, this grief remains unresolved and its various symptoms persist.

KEYWORDS
coronavirus infection, grief, mental health, nurse–patient relations, qualitative research

INTRODUCTION

On March 11, 2020, the World Health Organization assigned pandemic status to the COVID-19 outbreak, due to the alarming rapidity and severity of the infections produced (World Health Organization, 2020). The virus, which is airborne, often provokes complications requiring intensive care, and rates of mortality are high (Huang et al., 2020). To date, the virus has caused around 5.6 million deaths worldwide (The Center for Systems Science and Engineering at XXX (blinded) University (2021)). Healthcare professionals caring for COVID-19 patients are significantly exposed to the risk of infection (Gibson & Greene, 2020; Wang et al., 2020). Moreover, the risk is not only physical but also psychological, as nurses dealing with the consequences of the pandemic witness many deaths suffer an overload of work, and fear for their own safety. These and other considerations may provoke mental health problems among the health professionals involved (Pappa et al., 2020).

Studies of mental health problems among healthcare professionals affected by the pandemic have identified problems of depression, anxiety, insomnia, and anguish (Pappa et al., 2020; Sun et al., 2021; Urzúa et al., 2020). Rates of anxiety and depression are higher among women than men (Sun et al., 2021) and among nurses than other hospital staff (Pappa et al., 2020). Doctors present lower mean scores than nurses and other healthcare staff on all scales for depression, anxiety, insomnia, and distress (Urzúa et al., 2020).

Front-line nurses are especially subject to psychological distress (Nie et al., 2020), with 43% suffering depression and impaired quality of life (An et al., 2020). Somatic symptoms, post-traumatic stress syndrome disorders, and decreased resilience have also been reported (Afshari et al., 2021; Zakeri et al., 2021).

Therefore, different problems can arise in health professionals in complex situations, such as: compassion fatigue, which is defined as "the combination of secondary traumatic stress and burnout experienced by helping professionals and other care providers" (Figley, 1995); burnout or cumulative stress, defined as "the state of physical, emotional, and mental exhaustion caused by a depletion of a person's ability to cope with one's environment" (Maslach, 1982); secondary traumatic stress has been defined as "the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1999); and moral damage which is a "long-lasting psychological and emotional effect that arises from actions carried out that go against personal moral values or beliefs" (Dean et al., 2019).

These problems are different from professional grief, caused by the death of a patient, and which can be felt as a personal or professional loss, a trauma, or a union of them. But although they are different, in some cases it can give rise to similar symptoms, especially when the duel involves trauma or moral damage (Chen et al., 2018).

Patient deaths are shocking events for healthcare professionals and these deaths start the process of professional mourning (Rabow et al., 2021). This occurs due to the bond that is built between the patient and the nurses that leads to the experimentation of grief, which is characterized by the presence of different emotional, physical, cognitive, and behavioral alterations (Worden, 2018), this situation is known as grief professional (Wenzel et al., 2011).

There are important aspects developed in the existing theoretical frameworks on professional grief. In the one developed by Papadatou, it indicates that losses produce different symptoms such as sorrow, anger, guilt, despair in health professionals and mourning occurs as a process of fluctuation between experiencing and refraining from experiencing one's own pain in the face of loss (Papadatou, 2000). Within the theoretical framework developed by Chen et al., it is indicated that as a result of the experiences of a large number of patient deaths, long-term positive or negative changes could be produced in the professional, and also indicates that there are some differences and similarities between family and professional grief (Chen et al., 2018).

Grief follows a series of stages or phases. These phases are a process and not fixed sequences or stages, therefore there is no clear separation between the phases, and fluctuations can also occur between them. One of the most widely used theoretical phases is that of Bowlby, in which grief is classified into four phases: the dazed phase or shock phase, the longing and searching phase, the disorganization and despair phase, and the reorganization phase (Bowlby, 1980).

On many occasions, professional grief is ignored (Medland et al., 2004), but there is a possibility of treating and even preventing grief, a training project for professionals that touched on issues of burnout and compassion fatigue, risk and contributing factors, review of grief models and strategies to support resilience/address compassion fatigue, managed to be beneficial in relation to professional grief (Esplen et al., 2022).

However, to our knowledge, no previous studies have focused specifically on the professional grief that nurses may suffer in the present pandemic situation, which is characterized by the deaths of large numbers of patients and by major changes in working conditions for hospital staff.

Although the question of professional grief has received little research attention, it has been observed that symptoms of despair, social isolation, and somatization may appear in professionals (Feldstein & Gemma, 1995), together with "compassion fatigue," resulting in a loss of self-esteem, decreased productivity (Wenzel et al., 2011; Yoder, 2010), anger, anxiety, and irritability (Lerias & Byrne, 2003), intrusive mental images (Boelen & Huntjens, 2008) and stress (Ko & Kiser-Larson, 2016).

In our opinion, the impact produced on the medical staff, both personally and professionally, by the deaths of their patients merits further research attention. The relevance of this question is

heightened in moments such as the present when healthcare personnel is faced with an unprecedented global pandemic, presenting extreme morbidity and mortality (Chen et al., 2018).

The aim of the present study is to investigate the professional grief suffered by nurses in various medical units, after coping with the COVID-19 pandemic for the last 18 months.

DESIGN

This qualitative study was based on grounded theory, that involved a meticulous work of systematization and data analysis for the adequate construction of the theory of the study, with a method of constant comparison, coding and categorization of data, and memo writing (Glaser & Strauss, 2006; Hallberg, 2006). The design was relevant for this study in order to have a conceptual and contextual understanding of the impact produced by COVID-19 in nursing care, and the standards for reporting qualitative research (SRQR) were followed (O'Brien et al., 2014). Analyst triangulation was applied to ensure credibility, using multiple observers.

MATERIAL AND METHODS

Participants

The following categories of nurses were included in this study: case management nurses (CMN), family nurses (FN), palliative care nurses (PCN), and intensive care unit nurses (ICUN). All were Spanish nationals and worked in public health centers or hospitals in Spain.

The only inclusion criteria applied were that the nurses should have been working throughout the pandemic in their department and continued to do so when the study was conducted.

A convenience sampling was used at first, contacting the professionals of the different units by email, and then nominated sampling was added by asking the participants for the recommendation of other professionals. Subsequently, theoretical sampling was carried out by the authors with the search for confirming and disconfirming cases for the selection of cases that enrich and challenge the researchers' conceptualizations (Gill, 2020).

A total of 25 participants were included in the study, at which time saturation was reached, all the nurses were of Spanish nationality and worked in public centers. The demographic characteristics are presented in Table 1.

Data collection

The study data were compiled by three nurses who were members of the research team (two women and one man), from May to July 2021, by means of face-to-face individual, semi-structured interviews, following guidelines developed from an exploratory literature search and by consensus among the research team.

The following main questions were presented:

Were you particularly affected by the death of any patient during the pandemic?

In general, were you affected by the deaths of patients during the pandemic?

What were your feelings about these deaths?

How did they influence you?

What factors might have made the death of a patient especially difficult for you?

What other feelings, thoughts or reactions have you had concerning the pandemic?

No further questions were added during data collection because the final open question was considered sufficient. Nevertheless, the answers made to this question highlighted certain issues other than those anticipated. During the interview, the participants were urged to freely express their ideas and feelings, and to go beyond the specific question asked if they wished, to best express their feelings and opinions. The interviews took place in a site chosen by the participants, outside the workplace. Each one had a duration of 45–75 min. An audio recording was made and later transcribed for analysis.

Data analysis

Each transcript was read by two members of the research team, both of whom had expert knowledge of the subject addressed and had performed qualitative research in this field. Their notes and impressions were then coordinated to accurately reflect the information obtained. The entire team then manually examined and coded the findings obtained. The themes generated from the interview were established by describing the phenomena of interest, identifying data as described by participants, reading the transcripts in detail, selecting significant statements, identifying the themes, and, finally, returning the identified themes to participants to verify that the meaning of their statements was correctly understood.

RESULTS

This analysis revealed three central elements in the data, highlighting the situation of the COVID-19 pandemic from the perspective of care nurses, and their reactions to the many deaths witnessed and the changes experienced in living and working conditions. Table 2 describes the conceptual structure applied to these findings.

TABLE 1 Participants' characteristics

ID no.	Health center area	Age	Sex	Professional experience (years)	Experience in current area (years)
1	CMN	52	Female	31	18
2	CMN	56	Female	31	18
3	CMN	52	Female	31	19
4	CMN	53	Male	32	19
5	CMN	57	Female	36	19
6	CMN	57	Female	33	19
7	FN	63	Male	41	16
8	FN	54	Female	33	10
9	FN	47	Female	23	3
10	FN	58	Male	6	4
11	FN	62	Female	34	29
12	FN	54	Female	31	31
13	FN	51	Female	31	16
14	PCN	59	Female	37	12
15	PCN	56	Female	33	10
16	PCN	38	Female	17	1
17	PCN	55	Female	32	6
18	ICUN	24	Female	3	2
19	ICUN	23	Female	3	2
20	ICUN	28	Female	6	2
21	ICUN	29	Female	8	1
22	ICUN	24	Female	3	2
23	ICUN	25	Female	4	1
24	ICUN	32	Female	11	1
25	ICUN	31	Female	7	1

Abbreviations: CMN, case management nurses; FN, family nurses; IICUN, intensive care unit nurses; PCN, palliative care nurses.

TABLE 2 Topics arising in the interviews

Topic	Sub-topic	Open code
Impact on nurses of the COVID-19 pandemic	• Anguish on witnessing patients' worsening condition and death. • Difficulties in communication. • So many patients dying every day, each with their own personal characteristics. • Fear of dying. • Sensation of being overwhelmed and of insufficient resources, resulting in fatigue and guilt. • Fear of personal rejection.	• Death with dignity. • Inadequate communication between patients and nurses. • Remote working. • Dying alone. • Number of deaths. • Premature death. • Becoming infected and spreading infection. • The death of nurses. • Exhaustion. • Feelings of guilt. • Perceived rejection.
Symptoms of professional grief	• Mental numbness. • Need for points of reference. • Disorganization and despair. • Reorganization.	• Non-awareness of events. • Loss of patients and normal life. • Lack of control. • Normalizing and overcoming the situation. • Resilience.
Cognitive reactions	• Personal protection. • Social behavior.	• Need for personal protection. • Negative thoughts toward society. • Denialism and lack of social awareness.

The impact on nurses of the COVID-19 pandemic

The COVID-19 pandemic has led to major changes in how patients are treated, due to the severity of the disease and the enormous numbers of persons affected, and the clinical isolation required has greatly reduced or eliminated patients' contact with their families and friends. This unprecedented situation has also impacted nurses, whose testimony reflects the following consequences, classified into six sub-topics.

Anguish as patients suffers a prolonged, painful death. On seeing that a patient's life cannot be saved, some nurses believe it is their duty to ensure that the inevitable death should be as dignified and comfortable as possible. However, this process is sometimes lengthened by the increased use of technological resources, a situation that can have a severe emotional impact on the nurses involved.

Participant 22: *"[I suffer when] patients' lives are drawn out even when there is no hope, and when they are not allowed to die in peace."*

Communication difficulties. Nurses often found it difficult to communicate with patients and relatives. Communication is impossible when the patient is intubated, and even when the intubation is withdrawn, if the patient is terminal, prior memories may no longer exist. Difficulty in communicating with the patient's family was also commonly reported.

Participant 22: *"I was deeply affected by one case, when the patient report (information transmitted when one nurse takes over from another) said the patient was very near the end of life. After he passed away, we called his wife in to see him. But as soon as she came in, she turned around and went out again, in deep shock at seeing her husband lying there dead, when she hadn't seen him for several days and had only heard his voice, once a day, on the phone. I'll never forget how his wife broke down as she left the room, she was totally in shock."*

Communication difficulties may also occur outside the ICU, if nurses lose direct contact with patients and their families due to changes in work patterns, such as the introduction of teleworking, when communication is only possible by telephone.

Participant 5: *"The craziness of having to leave my patients in a situation of helplessness, the feeling that sometimes I've had to abandon them."*

Sometimes, too, it was difficult to get in touch with relatives, and some patients died completely alone. This situation also led to cases in which the health professionals had to take decisions that in other circumstances would be made by the family, when the patient could no longer decide for herself.

Participant 3: *"She died alone. Her family couldn't say goodbye, and the decision (on sedation) was left to someone else".*

So many patients dying every day, each with their own personal characteristics. The ICU nurses were most directly, and most frequently, exposed to these deaths. According to their accounts, the most shocking aspect was the first wave of COVID-19, which created a situation they had never experienced before.

Participant 19: *"What hit me hardest was after coming off duty on a Wednesday, at eight in the morning, I arrived back in the ICU on Thursday at eight in the evening and found that out of fourteen patients, eleven had been extubated* [disconnected from mechanical ventilation] *and died, after being hospitalised for almost four weeks. So, it wasn't just one death, but eleven at once, and I still remember all their names."*

The characteristics of those who died also impacted strongly on the nurses, since many of these patients would not have died were it not for COVID-19.

Participant 23: *"A young woman had been in the unit for months. The hardest time for me was when she was extubated and I saw that her family just had to accept this, and when I thought that her young children would only know of her what they were told."*

Fear of dying. Among other concerns, the nurses were constantly afraid of infection and death from COVID-19, especially as regards transmitting it to their families. Indeed, only two referred to the possibility of becoming infected themselves and of their own death from the disease.

Participant 12: *"I've been very afraid, especially for my family, my parents in particular, who are elderly and vulnerable."*

Participant 19: *"Very scared. I was scared to see that this virus was devastating thousands of people and to think that any of them could be one of my family or me".*

The nurses also spoke of the intense fear they felt when they tested positive for COVID-19, that they might have infected colleagues, relatives, and patients before being diagnosed with the virus. Moreover, as they usually witnessed only severe cases, they felt an intense fear of dying from the disease.

Participant 5: *"The only time I might have felt guilty was when I didn't know whether I was PCR positive while I was working, the idea that I might have been infecting my colleagues and my patients. This upset me a lot."*

Participant 4: *"Uncertainty, because I went through it and because they said that you could die in seven or eight days. I was counting the days and during that time I was scared, for myself and for my family, wondering if they might catch it, and how badly it would affect them."*

Sensation of being overwhelmed and of insufficient resources, leading to fatigue and guilt. All of the ICU nurses interviewed referred to the situation as one they had never experienced before. They spoke of being physically and mentally exhausted, due to the long duration of the pandemic, the many hardships involved in caring for patients, and the fact that in many cases their dedication and effort were not rewarded by a successful outcome.

Participant 22: "*I was afraid because the situation appeared uncontrollable and it seemed that even giving 100% we could not cope*."

Participant 21: "*At first, there was a lack of information and resources. Later, I was worn down by extreme fatigue, and a feeling of not being up to the task*."

Participant 22: "*Sometimes there were feelings of guilt when you just couldn't cope. One patient was unwell and you had to neglect another, and there were no colleagues to help you because they were equally busy*."

Another important factor was that during the pandemic hospitals focused their attention on the COVID-19 cases, sidelining other pathologies and patients, which produced feelings of guilt in some nurses. Inadequacies of human and technical resources also led to feelings of guilt among the nurses.

Participant 2: "*There's a feeling of guilt, because everything about the pandemic took first place, while other patients, who were also vulnerable, were set aside and didn't receive all the help and attention they needed*."

Fear of personal rejection. During the pandemic lockdown in Spain, healthcare staff were nightly applauded from windows and balconies. Nevertheless, the nurses in our survey also perceived a degree of rejection, possibly due to the fear of contagion from professionals whose daily work brought them into close contact with the virus.

Participant 16: "*I had a fear of being rejected. In some places, we were afraid to say we were nurses, especially during the worst months of the pandemic. People went from being all thanks and smiles to being scared to come anywhere near us*."

Symptoms of professional grief

The nurses underwent various stages of professional grief, even though the people dying from COVID-19 were not their own relatives or friends. Most of the participants in our survey said they were affected by feelings of closeness and empathy with their patients. In many cases, a bond was formed with the patients and their families, humanizing the relationship and the healthcare provided. Some nurses said that any of those died could have been members of their own family, that they were aware of the patient's personal circumstances and could relate these to their own context.

Participant 24: "*Feelings of sorrow and fear. To think that this could be my grandmother or my parents. Seeing those patients cry before being intubated*."

Bonds between nursing staff and their patients were created in various ways. For example, Participant 19 said:

"*During lockdown, the families could not visit, but they sent letters for us to read out to the patients. For me, it was very difficult to read those letters, knowing that the patient had little chance of survival*."

The following phases of professional grief were identified, according to the symptoms presented:

Mental numbness: Difficulty in remaining aware of what is happening and in accepting reality. Tasks are performed automatically, so as not to think about what is happening.

Participant 10: "*The deaths upset the daily routine and keep you from concentrating on what you are doing.*"

The need for points of reference. This phase involves a range of feelings including impotence, sadness, anger, anguish, consternation, frustration, hopelessness, disquiet, failure, and guilt. Reference is lost not only to the patients who have died but also to the former normal life, which has also disappeared.

Participant 9: "*Feelings of uncertainty, fear, tiredness, lack of sleep*."

Participant 4: "*Restlessness, twinges. I don't have the peace of mind that I had before. I wouldn't call it anxiety, it's just an unease in my stomach*."

Participant 2: "*Sadness, discouragement, anxiety, anger, impotence, lack of professional control of the situation, no way out*."

Disorganization and despair. Feelings of not being able to control the situation, seeing people's vulnerability to the pandemic, and not knowing how long it will last or how far its effects will extend. These sensations were expressed by many of the nurses interviewed, together with their feelings of guilt and helplessness at not being able to manage the problem.

Participant 14: "*During the first few months, guilt, at not knowing how to deal with the situation, and frustration because despite working day and night we were unable to stop what was happening*."

Participant 12: "*Despair, helplessness, not knowing how to stop all this and seeing that it's getting away from you and you can't control it. Impotence*."

Reorganization. The above phases of nurses' grief are gradually being overcome as they learn to cope with the situation and reorganize their work, making it part of normality, in full awareness that the problem still remains.

Participant 22: "*At first, I was strongly affected, but eventually we came to accept it as normal, even if it wasn't.*"

Participant 10: *"I just want to cope and to get it over with. Right now, I think that's the most important thing."*

Rising to the occasion, despite all the negative consequences, has also enabled some nurses to observe personal improvement.

Participant 25: *"I think this situation has made me stronger and more humane. It's taught us the importance of caring for others and accompanying them in the worst moments."*

Cognitive reactions

Living through the pandemic has led nurses to rationalize and process the situation, changing their behavior and ideas, fostering the will to understand reality and reveal their own responsibility and that of society, and thus adapt to the circumstances produced by the pandemic.

Personal protection. Realizing that the pandemic has changed the world, the nurses in our survey believe it necessary to enhance their personal protection, by taking measures to reduce the chance of infection and, at the same time, avoiding negative feelings of guilt or fear.

Participant 2: *"I had a feeling of fear, not for myself, but for my family, that I might infect them – some were extremely vulnerable – and fear of the consequences. That fear made me even more careful about protective measures."*

Participant 23: *"I didn't feel good if I was meeting someone, and like many people, I went several months without seeing my family."*

Social behavior. The nurses also observed that it wasn't their responsibility alone to make changes; rather, the entire population should be involved, since social behavior directly influences how far and how fast the pandemic will spread. The nurses were deeply angered when they saw people failing to adopt protective measures.

Participant 7: *"I felt angry and disappointed at the behaviour of people in general.".*

Participant 21: *"I was angry when I went out and saw people living a normal life, and not following the rules for public safety."*

The nurses were also concerned about other aspects of people's reactions to the pandemic, such as denial and lack of awareness.

Participant 18: *"Since the start of the pandemic I've often felt angry and disappointed at the attitudes of some people (deniers, anti-vaxxers, etc.), and thought that they should have been in our position and experienced what we've been through."*

Participant 24: *"There's a feeling of impotence. Even after explaining what I'd seen, telling people that COVID doesn't only affect the elderly, telling them I worked in the ICU and saw patients who were really ill, people still couldn't understand how important it was."*

DISCUSSION

This study considers the professional grief caused to nurses from their continual witnessing of the deaths of patients from COVID-19 and by the radical changes undergone, both at work and in general.

Interviews were conducted with 25 nurses at four public health centers in Spain. The issues raised enabled us to identify certain key characteristics of professional grief, observed during the COVID-19 pandemic.

The topic "Impact on nurses" addresses various situations, such as the possibility of a "bad death", which may be regarded in different ways according to the individual's culture and profession (Cottrell & Duggleby, 2016). In an earlier study of this question, nurses regretted that their patients could not have a "good death" (De Jong & Clarke, 2009). However, opinions differ on how this term should be defined, and some physicians conclude later than others that life is no longer viable (DelVecchio Good et al., 2004; Steinhauser et al., 2000).

The influence of communication difficulties, due to COVID-19, between nurses and patients, and between patients and their families, was cited as a serious problem by all of the nurses interviewed. The absence of communication also heightens the pathological grief suffered by the families of deceased patients (Eddy, 2021; Morris et al., 2020).

Focusing on professional grief, to our knowledge, no previous studies have been undertaken to consider the impact made on nurses by the first wave of the pandemic, during which large numbers of patients died, taking into account the personal characteristics and the speed at which these deaths occurred. It has been noted, however, that this situation provoked severe, persistent grief among many nurses, as indicated by the theoretical framework developed by Chen et al. (2021) and that has been verified in the present study.

In the present study, it was possible to observe that the nurses demonstrated the situation of professional grief from different points of view: in some cases, they felt like a personal loss as a result of the very different situations that occurred with special bonds with the patient, empathy, and think that it could be a family member of yours since the situation was overwhelmed; as a professional loss since it was experienced as a situation of professional failure and as a lack of control; and also as a trauma since it produced very strong psychological feelings and symptoms in some nurses. This aspect coincided with the theoretical framework developed by Chen et al. (2018) that differentiates professional grief from family grief and gives similar importance to this grief situation.

Our findings regarding nurses' fear of becoming infected or of infecting others are in line with those reported by other studies in this area. In particular, these fears concern the possibility of family members being infected (Liang et al., 2021). Perceptions of high risk of infection are related to symptoms of anxiety, anguish, insomnia, social dysfunction, and depression (Gázquez Linares et al., 2021; Labrague & de Los Santos, 2021), and many of these symptoms were reported in our interviews.

The current outbreak of COVID-19, which on many occasions has overwhelmed health system resources, has provoked mental and physical fatigue among nurses. According to a previous study, this fatigue was suffered by half of all front-line nurses (Zhang et al., 2021). It is also experienced by those who witness traumas associated with COVID-19 (Lasalvia et al., 2021). Feelings of guilt are exacerbated by fatigue, which reduces efficacy, and by changes in healthcare formats, such as the introduction of teleworking, a new experience for many.

Another problematic situation, and one that was novel in Spain, was the social rejection that some nurses underwent. The unpleasant feeling of being discriminated as a worker potentially exposed to COVID-19 may have serious consequences. Thus, the perception of discrimination due to their profession has been associated with negative impacts on nurses' mental health (Labrague et al., 2021).

The phases of grief indicated by the nurses in the study corresponded to those developed by Bowlby (Bowlby, 1980), and they suffered a large number of symptoms, some of which corresponded to those indicated by Papadatou (2000).

At the professional level, it is not usually taken into account that nurses are people, too, and that like everyone else they may suffer grief; this is an aspect that can favor grief (Shi et al., 2022). During the COVID-19 pandemic, many factors combined to produce this outcome. The nurses involved experienced grief when patients died (Chen et al., 2021) and were also deeply affected by the loss of their normal work practices and personal routines. An important aspect of this question is that these nurses usually empathized strongly with their patients, who were often alone and isolated from their families. During the first wave of the pandemic, some nurses found it difficult to comprehend what was happening, having never experienced such a situation before. Later, as the number of deaths rose unstoppably, the nurses were hit by sensations of guilt and impotence. Eventually, however, and thanks to the selfless dedication of healthcare professionals, the crisis eased. Indeed, some nurses found their resilience enhanced, and felt stronger and more humane after having lived through the pandemic.

The participants in our study were aware that they had to address the situation and cope, despite the ongoing pandemic and the fact that significant numbers of patients were still dying. On the contrary, overcoming such a difficult experience requires time and reflection (Honkavuo & Lindström, 2014), which cannot usually be found during the pandemic; as soon as one patient dies, nurses must continue working with others, and so their mental health and stability have no time to recover.

Furthermore, not all nurses underwent the same experience. The front-line nurses in the ICU were the most exposed to the rigors of the pandemic. Other units were engaged in teleworking, a situation that also affected them, but more indirectly, and patients' deaths had a less immediate impact. The nurses who best withstood the pandemic deaths (although they too expressed consternation at the suffering witnessed) were those who worked in palliative care. Greater resilience might have been achieved by these nurses having because they have been trained to view death as another stage in the life cycle. As a result, they are better equipped to cope with the situation. Accepting the inevitability of death, the nurses' aim is no longer to save patients' lives but to allow them to die with dignity.

Participant 16: *"I felt sadness and consternation at so much pain. Although we must consider death as another stage in life, it must have been extremely hard for these patients, who were dying alone, without any of their family members nearby."*

The pandemic, apart from professional grief, provoked cognitive reactions among the nurses involved, who were subjected to changes in their personal life and required to adopt strict measures of physical protection. The participants wished to see the rest of society adopting similar measures. Seeing some people refuse to do so made the nurses both disappointed and angry, emotions that were also aroused by those who denied the seriousness of the situation and by the anti-vaccine movement.

The present study, to our knowledge, is the first to conduct an in-depth analysis of professional grief among nurses in Spain during the COVID-19 pandemic.

Lessons learned following the Covid-19 pandemic

After the pandemic, we have learned several important aspects, such as the importance of having adequate communication with the patient and their relatives, fundamentally in matters related to a family bereavement, since nurses also empathize with the bereavement of family members and both are affected, this situation was reported by all the nurses interviewed. It is advisable to maintain adequate communication both with the patient and with their family members. If a similar situation occurs, it is advisable to encourage online communication between the patient and family members, and between nurses and family members.

Communication is also affected by teleworking, which produces a feeling of abandonment by patients and their families. This aspect of teleworking should be as small as possible, focusing only on people who may transmit the virus at a given time.

Another aspect to highlight is that professional grief occurred in most of the nurses, producing a significant impact and with multiple symptoms. This was due to their comments indicating the large and continuing number of deaths and also not having any way to get support, communication about professional grief, and training. This significant number of deaths also produced a shocking situation of fear in the nurses, in relation to deaths, especially of their relatives and some cases themselves, this can profoundly affect when it comes to work. For all these reasons, it is important not to deny the situation of professional mourning and take measures at the level of the training and support institution for professionals.

We have learned that the Covid-19 situation produced an overflow of existing resources, also producing fatigue and guilt in nurses for seeing that they could not adequately address the needs of patients. It is important that the institution is aware of the resources that are needed in problematic situations.

For all these reasons, diagnosis of professional grief and, if necessary, specific interventions are encouraged. The use of standardized language has been proposed as a first step in establishing professional traumatic grief as a diagnostic category (Gilart et al., 2021). The Inventory of Complicated Grief can be used by nurses and health care professionals for the diagnosis of prolonged or complicated grief disorders (Kustanti et al., 2021). Furthermore, during the COVID-19 pandemic, it was highlighted the importance of addressing anticipatory grief in healthcare professionals (Khanipour-Kencha et al., 2022). Thus, mental health support should be provided not only for patients' families but also for nursing and other health professionals.

LIMITATIONS

Although we attempted to obtain a heterogeneous sample of nurses, from different patient care services, few male participants were recruited, not due to a lack of interest on their part, but because there is many fewer male than female nurses in Spain. This imbalance may limit the generalisability of our findings. Another possible limitation is the fact that all of those interviewed worked in the public health system. Additional input from the private health system might have altered our findings. Finally, the absence from the literature of previous studies on professional grief greatly limits the comparability of our findings. On the contrary, we suggest interesting lines of future research in this area.

CONCLUSION

This study provides information on how the pandemic has affected care nurses. It also shows that nurses are affected personally by the deaths of patients and by alterations to their working conditions. To help them cope better with this type of situation, nurses should receive appropriate training. Moreover, healthcare institutions should be made aware of the problem and be encouraged to offer assistance to address the impact produced on nurses by the deaths of their patients.

It is important to understand the professional grief experienced by attending nurses during the COVID-19 pandemic, in order to enhance the care provided. Ignoring this problematic situation, or pretending it does not exist, will not resolve the problem. A large proportion of the nurses consulted in this study have suffered and suffered professional grief and report many related symptoms. Such a situation may reoccur in any future pandemic or related crisis. Consideration of our findings may alleviate future problems in this respect.

CLINICAL RESOURCES

Grief and Loss Among Healthcare Workers: Finding Support and Connections: https://www.vitas.com/for-healthcare-professionals/making-the-rounds/2020/may/grief-and-loss-among-healthcare-workers

Continuing Education and Training for Healthcare Professionals: https://www.vitas.com/for-healthcare-professionals/education-and-training

Grief Support Tips For Medical Professionals: https://resources.acls.com/free-resources/knowledge-base/industry-topics/grief-support-tips-for-medical-professionals

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CONFLICT OF INTEREST

None.

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REFERENCES

Afshari, D., Nourollahi-Darabad, M., & Chinisaz, N. (2021). Demographic predictors of resilience among nurses during the COVID-19 pandemic. *Work (Reading, Mass)*, *68*(2), 297–303. https://doi.org/10.3233/WOR-203376

An, Y., Yang, Y., Wang, A., Li, Y., Zhang, Q., Cheung, T., Ungvari, G. S., Qin, M. Z., An, F. R., & Xiang, Y. T. (2020). Prevalence of depression and its impact on quality of life among frontline nurses in emergency departments during the COVID-19 outbreak. *Journal of Affective Disorders*, *276*, 312–315. https://doi.org/10.1016/j.jad.2020.06.047

Boelen, P. A., & Huntjens, R. J. (2008). Intrusive images in grief: An exploratory study. *Clinical Psychology and Psychotherapy*, *15*(4), 217–226. https://doi.org/10.1002/cpp.568

Bowlby, J. (1980). *Attachment and loss. Vol.III. Loss: Sadness and depresion*. The Hogart Press.

Chen, C., Chow, A., & Tang, S. (2018). Bereavement process of professional caregivers after deaths of their patients: A meta-ethnographic synthesis of qualitative studies and an integrated model. *International Journal of Nursing Studies*, *88*, 104–113. https://doi.org/10.1016/j.ijnurstu.2018.08.010

Chen, C., Chow, A., & Xu, K. (2021). Bereavement after patient deaths among Chinese physicians and nurses: A qualitative description

study. *Omega*, 30222821992194. Advance online publication. https://doi.org/10.1177/0030222821992194

Cottrell, L., & Duggleby, W. (2016). The "good death": An integrative literature review. *Palliative and Supportive Care*, *14*(6), 686–712. https://doi.org/10.1017/S1478951515001285

De Jong, J. D., & Clarke, L. E. (2009). What is a good death? Stories from palliative care. *Journal of Palliative Care*, *25*(1), 61–67.

Dean, W., Talbot, S., & Dean, A. (2019). Reframing clinician distress: Moral injury not burnout. *Federal Practitioner*, *36*(9), 400–402.

DelVecchio Good, M. J., Gadmer, N. M., Ruopp, P., Lakoma, M., Sullivan, A. M., Redinbaugh, E., Arnold, R. M., & Block, S. D. (2004). Narrative nuances on good and bad deaths: internists' tales from high-technology work places. *Social Science and Medicine (1982)*, *58*(5), 939–953. https://doi.org/10.1016/j.socscimed.2003.10.043

Eddy, C. M. (2021). The social impact of COVID-19 as perceived by the employees of a UK mental health service. *International Journal of Mental Health Nursing*, *30*, 1366–1375. https://doi.org/10.1111/inm.12883

Esplen, M. J., Wong, J., Vachon, M., & Leung, Y. (2022). A continuing educational program supporting health professionals to manage grief and loss. *Current Oncology*, *29*(3), 1461–1474. https://doi.org/10.3390/curroncol29030123

Feldstein, M. A., & Gemma, P. B. (1995). Oncology nurses and chronic compounded grief. *Cancer Nursing*, *18*(3), 228–236.

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Brunner/Mazel.

Figley, C. R. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed., pp. 3–28). Sidran.

Gázquez Linares, J. J., Molero Jurado, M., Martos Martínez, Á., Jiménez-Rodríguez, D., & Pérez-Fuentes, M. (2021). The repercussions of perceived threat from COVID-19 on the mental health of actively employed nurses. *International Journal of Mental Health Nursing*, *30*(3), 724–732. https://doi.org/10.1111/inm.12841

Gibson, D. M., & Greene, J. (2020). Risk for severe COVID-19 illness among health care workers who work directly with patients. *Journal of General Internal Medicine*, *35*(9), 2804–2806. https://doi.org/10.1007/s11606-020-05992-y

Gilart, E., Lepiani, I., Núñez, M. J., Roman, I. C., & Bocchino, A. (2021). When nurses become patients. Validation of the content of the diagnostic label professional traumatic grief. *Healthcare (Basel)*, *9*(8), 1082. https://doi.org/10.3390/healthcare9081082

Gill, S. L. (2020). Qualitative sampling Methods. *Journal of Human Lactation: Official Journal of International Lactation Consultant Association*, *36*(4), 579–581. https://doi.org/10.1177/0890334420949218

Glaser, B., & Strauss, A. (2006). *The discovery of grounded theory. Strategies for qualitative analysis*. Aldine Transaction.

Hallberg, L. R. M. (2006). The 'core category' of grounded theory: Making constant comparisons. *International Journal of Qualitative Studies on Health and Well-Being*, *1*, 141–148. https://doi.org/10.1080/17482620600858399

Honkavuo, L., & Lindström, U. Å. (2014). Nurse leaders' responsibilities in supporting nurses experiencing difficult situations in clinical nursing. *Journal of Nursing Management*, *22*(1), 117–126. https://doi.org/10.1111/j.1365-2834.2012.01468.x

Huang, C., Wang, Y., Li, X., Ren, L., Zhao, J., Hu, Y., Zhang, L., Fan, G., Xu, J., Gu, X., Cheng, Z., Yu, T., Xia, J., Wei, Y., Wu, W., Xie, X., Yin, W., Li, H., Liu, M., … Cao, B. (2020). Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China. *Lancet (London, England)*, *395*(10223), 497–506. https://doi.org/10.1016/S0140-6736(20)30183-5

Khanipour-Kencha, A., Jackson, A. C., & Bahramnezhad, F. (2022). Anticipatory grief during COVID-19: A commentary. *British Journal of Community Nursing*, *27*(3), 114–117. https://doi.org/10.12968/bjcn.2022.27.3.114

Ko, W., & Kiser-Larson, N. (2016). Stress levels of nurses in oncology outpatient units. *Clinical Journal of Oncology Nursing*, *20*(2), 158–164. https://doi.org/10.1188/16.CJON.158-164

Kustanti, C. Y., Chu, H., Kang, X. L., Liu, D., Pien, L. C., Jen, H. J., Shen, S. H., Chen, J. H., & Chou, K. R. (2021). Evaluation of the performance of instruments to diagnose grief disorders: A diagnostic meta-analysis. *International Journal of Nursing Studies*, *120*, 103972. https://doi.org/10.1016/j.ijnurstu.2021.103972

Labrague, L. J., & de Los Santos, J. (2021). Fear of COVID-19, psychological distress, work satisfaction and turnover intention among frontline nurses. *Journal of Nursing Management*, *29*(3), 395–403. https://doi.org/10.1111/jonm.13168

Labrague, L. J., De Los Santos, J., & Fronda, D. C. (2021). Perceived COVID-19-associated discrimination, mental health and professional-turnover intention among frontline clinical nurses: The mediating role of resilience. *International Journal of Mental Health Nursing*, *30*, 1674–1683. https://doi.org/10.1111/inm.12920

Lasalvia, A., Amaddeo, F., Porru, S., Carta, A., Tardivo, S., Bovo, C., Ruggeri, M., & Bonetto, C. (2021). Levels of burn-out among healthcare workers during the COVID-19 pandemic and their associated factors: A cross-sectional study in a tertiary hospital of a highly burdened area of north-East Italy. *BMJ Open*, *11*(1), e045127. https://doi.org/10.1136/bmjopen-2020-045127

Lerias, D., & Byrne, M. K. (2003). Vicarious traumatization: Symptoms and predictors. *Stress and Health: Journal of the International Society for the Investigation of Stress*, *19*(3), 129–138.

Liang, H. F., Wu, Y. C., & Wu, C. Y. (2021). Nurses' experiences of providing care during the COVID-19 pandemic in Taiwan: A qualitative study. *International Journal of Mental Health Nursing*, *30*, 1684–1692. https://doi.org/10.1111/inm.12921

Maslach, C. (1982). *Burnout-the cost of caring*. Prentice-Hall.

Medland, J., Howard-Ruben, J., & Whitaker, E. (2004). Fostering psychosocial wellness in oncology nurses: Addressing burnout and social support in the workplace. *Oncology Nursing Forum*, *31*(1), 47–54. https://doi.org/10.1188/04.ONF.47-54

Morris, S. E., Nayak, M. M., & Block, S. D. (2020). Insights from bereaved family members about end-of-life care and bereavement. *Journal of Palliative Medicine*, *23*(8), 1030–1037. https://doi.org/10.1089/jpm.2019.0467

Nie, A., Su, X., Zhang, S., Guan, W., & Li, J. (2020). Psychological impact of COVID-19 outbreak on frontline nurses: A cross-sectional survey study. *Journal of Clinical Nursing*, *29*(21–22), 4217–4226. https://doi.org/10.1111/jocn.15454

O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: A synthesis of recommendations. *Academic Medicine: Journal of the Association of American Medical Colleges*, *89*(9), 1245–1251. https://doi.org/10.1097/ACM.0000000000000388

Papadatou, D. (2000). A proposed model of health professionals' grieving process. *OMEGA-Journal of Death and Dying*, *41*(1), 59–77.

Pappa, S., Ntella, V., Giannakas, T., Giannakoulis, V. G., Papoutsi, E., & Katsaounou, P. (2020). Prevalence of depression, anxiety, and insomnia among healthcare workers during the COVID-19 pandemic: A systematic review and meta-analysis. *Brain, Behavior, and Immunity*, *88*, 901–907. https://doi.org/10.1016/j.bbi.2020.05.026

Rabow, M. W., Huang, C. S., White-Hammond, G. E., & Tucker, R. O. (2021). Witnesses and victims both: Healthcare workers and grief in the time of COVID-19. *Journal of Pain and Symptom Management*, *62*(3), 647–656. https://doi.org/10.1016/j.jpainsymman.2021.01.139

Shi, H., Shan, B., Zheng, J., Zhang, Y., Zhang, J., & Hu, X. (2022). Grief as a mediator of the relationship between empathy and compassion fatigue. *Psycho-Oncology*, *31*(5), 840–847. https://doi.org/10.1002/pon.5875

Steinhauser, K. E., Christakis, N. A., Clipp, E. C., McNeilly, M., McIntyre, L., & Tulsky, J. A. (2000). Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA*, *284*(19), 2476–2482. https://doi.org/10.1001/jama.284.19.2476

Sun, P., Wang, M., Song, T., Wu, Y., Luo, J., Chen, L., & Yan, L. (2021). The psychological impact of COVID-19 pandemic on health care workers: A systematic review and meta-analysis. *Frontiers in Psychology*, *12*, 626547. https://doi.org/10.3389/fpsyg.2021.62654

The Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU). (2021). COVID-19 dashboard. [Cited 27 January 2021]. https://www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6

Urzúa, A., Samaniego, A., Caqueo-Urízar, A., Zapata Pizarro, A., & Irarrázaval Domínguez, M. (2020). Salud mental en trabajadores de la salud durante la pandemia por COVID-19 en Chile [mental health problems among health care workers during the COVID-19 pandemic]. *Rev Med Chil*, *148*(8), 1121–1127. Spanish. https://doi.org/10.4067/S0034-98872020000801121 PMID: 33399779.

Wang, C., Horby, P. W., Hayden, F. G., & Gao, G. F. (2020). A novel coronavirus outbreak of global health concern. *Lancet (London, England)*, *395*(10223), 470–473. https://doi.org/10.1016/S0140-6736(20)30185-9

Wenzel, J., Shaha, M., Klimmek, R., & Krumm, S. (2011). Working through grief and loss: Oncology nurses' perspectives on professional bereavement. *Oncology Nursing Forum*, *38*(4), E272–E282. https://doi.org/10.1188/11.ONF.E272-E282

Worden, J. W. (2018). *Grief counseling and grief therapy* (5th ed.). Springer Publishing Company, LLC.

World Health Organization. (2020). *Declaration that coronavirus disease (COVID-19) is a pandemic*. [Cited 14 March 2020]. https://www.who.int/es/news/item/27-04-2020-who-timeline---covid-19

Yoder, E. A. (2010). Compassion fatigue in nurses. *Applied Nursing Research: ANR*, *23*(4), 191–197. https://doi.org/10.1016/j.apnr.2008.09.003

Zakeri, M. A., Hossini Rafsanjanipoor, S. M., Zakeri, M., & Dehghan, M. (2021). The relationship between frontline nurses' psychosocial status, satisfaction with life and resilience during the prevalence of COVID-19 disease. *Nursing Open*, *8*, 1829–1839. https://doi.org/10.1002/nop2.832

Zhang, X., Jiang, X., Ni, P., Li, H., Li, C., Zhou, Q., Ou, Z., Guo, Y., & Cao, J. (2021). Association between resilience and burnout of front-line nurses at the peak of the COVID-19 pandemic: Positive and negative affect as mediators in Wuhan. *International Journal of Mental Health Nursing*, *30*(4), 939–954. https://doi.org/10.1111/inm.12847

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