


# “Fighting for life and losing”: Intensive Care Unit Nursing Staff’s Experience With COVID-19 Patient Deaths During the First Two Waves: A Qualitative Study

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## Abstract

The study explored the experiences of intensive care unit nursing staff caring for COVID-19 patients who eventually died during the two first pandemic waves. We used - descriptive-qualitative-phenomenological. The findings included four main themes—the first vs the second COVID-19 waves, fighting for life and being unable to win, a chronicle of pre-determined death, and nurse’s emotional coping with patient death. Based on these findings, we have concluded that in order to enhance nurses’ mental health, policy makers and governments need to create an appropriate support system for them.

## Keywords

COVID-19, patient death, intensive care corona unit, nurses, emotional coping

### What do We Already Know About This Topic?

Intensive care unit nursing staff experience patients’ caring which often is characterized by aging, chronic diseases, and successful in savings life.

### How Does This Study Contribute to the Field?

The study reveals and gives an in-depth new understanding of ICCU (Intensive Care Corona Unit) nursing staff experience with COVID-19 (Corona Virus Disease) patients’ death. ICCU nurses’ experience with COVID-19 in the first two waves, fighting and trying saving life but loosing, death systematic, emotion coping with COVID-19 patient death.

### What Are Your Research’s Implications Toward Theory, Practice, or Policy?

Based on the findings it is necessary to build a theoretical model of emergency decision-making for future crisis and emergencies times based on corona pandemic experience. Additionally, there is a need to develop and implement plan, providing the essential practice and skills for nurses to be able to manage complex patient’s death situations, characterized by sudden and extreme demands of caring for patients. To strength nurses’ mental health, there is a need for policy makers and governments to create a support system during and after such events.

## Introduction

At the end of 2019 a novel virus, the acute respiratory syndrome coronavirus, was found in Wuhan, China.<sup>1-4</sup> The virus rapidly expanded globally and was defined by the World Health Organization as a pandemic<sup>4</sup>. Health care professionals were affected in many ways, and as the pandemic advanced nurses specifically found themselves at the forefront of the pandemic all over the world.<sup>5-7</sup>

In the first wave in Israel there were 500–700 new confirmed cases a day. In addition, Israel had a death toll of less

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than 300 persons, demonstrating 33 deaths per million and a fatality rate of 1.67%, lower than in most of European countries.<sup>8</sup> However, in June 2020, the amount of new confirmed cases of COVID-19 began growing, to 4000–6000 new cases a day in mid-September. The number of deaths reached about 1200 or 130 deaths per million. At this time, with a total of nearly 1,80,000 confirmed cases, 50,000 of which were active, Israel became the most infected country. This occurred in the second wave.<sup>8</sup>

The COVID-19 virus spreads primarily through the respiratory tract, with direct contact causing a severe respiratory disease.<sup>9</sup> Infection symptomatology ranges from no symptoms at all to severe health complications, such as severe respiratory distress syndrome, organ failure, and ultimately death.<sup>10</sup> Treatment for COVID-19 patients in the intensive care environment may be crucial.<sup>11</sup> ICU (Intensive Care Unit) health care teams face many challenges, including limited staffing, contamination prevention and control, and staff protection.<sup>12</sup> The treatment necessary for these patients is mainly implemented by nurses. Therefore, occupational hazards of nurses' exposures to the COVID-19 virus are extensive.

As the pandemic continues, the published studies mainly emphasize the disease's clinical features.<sup>13,14</sup> However, all over the world nurses are feeling anxiety, physical fatigue, and helplessness vis-a-vis its circumstances,<sup>2,15</sup> and only a few studies have dealt with the effects of the COVID-19 pandemic on nurses,<sup>16,17</sup> even though they are exposed to serious danger, and even death, while caring for COVID-19 patients. Nurses work under stressful conditions, new patients are admitted to hospitals every day, and hospitals do not have sufficient capacity. Surprisingly, in a study conducted by mixed methods design with 105 nurses working in COVID-19 units, most expressed high to moderate compassion satisfaction.<sup>18</sup> Accordingly, it is important to examine the nurses' experience with COVID-19 patient care,<sup>19</sup> and one of the significant challenges for nurses is dealing with the deaths of COVID-19 patients.<sup>20</sup>

The literature demonstrates that the nurses caring for COVID-19 patients are subjected to psychological distress by witnessing COVID-19 patients' death. In qualitative study, nurses mentioned that the death of patients, especially young ones, was agonizing for them. When patients were suffering from respiratory distress, and the nurses were unable to do anything for them, this had a huge negative impact on the nurses' spirits.<sup>20</sup> Nurses experience anxiety and distress due to COVID-19 patients' death. Death anxiety is a multidimensional construct, involving cognitive, emotional, and experiential aspects.<sup>21</sup> Other cross-sectional and exploratory survey studies showed that nurses from oncology field may not be prepared to communicate with dying patients and their families,<sup>22</sup> and nurses' with early experiences may become anxious while observing dying patients.<sup>23</sup> Moreover, to the best of our knowledge there is not much research on ICCU (Intensive Care Corona Unit) nurses'

copied with COVID-19 dying patients and their families. Accordingly, our main research aim is to explore the experiences of intensive care unit nursing staff caring for COVID-19 patients who eventually died during the two first pandemic waves.

## Methods

### Research Design

In planning this study, research design we used—descriptive-qualitative-phenomenological.<sup>24</sup> It was used to explore intensive care nurses' lived experience via phenomenological research to uncover this phenomenon.<sup>25</sup>

### Participants and Recruitment

Participants were senior nurses with a hospital intensive care background from Central Israel. Participants were recruited by the PI (Principal Investigator) through social networks as WhatsApp text messaging. The inclusion criteria were nurses with a bachelor's degree and a history of work in general intensive care, who have now moved voluntarily to work in the ICCU exclusively. Exclusion criteria included new nurses (less than two years of experience), nursing students or practical nurses with no experience in an intensive care unit.

Twenty-four ICCU nurses participated in the study. The average age was 39.64 (SD = 7.14). They worked in the ICU an average of 7.77 years (SD = 7.69) and in ICCU an average of 8 months (SD = 2). Demographic characteristics as gender, educational background, work experience, and years of work in intensive care (see Table 1).

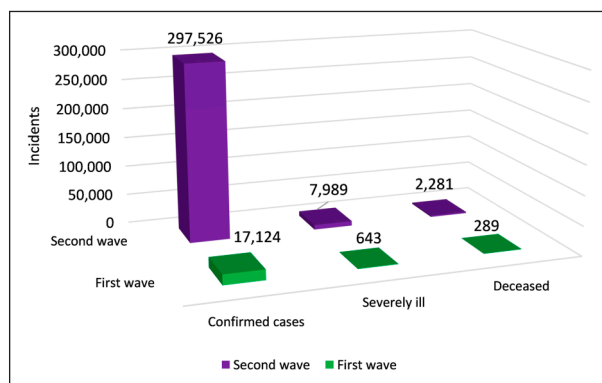
Table 1 shows that most of the participants were female (18; 75%), married (18; 75%) and Jewish (12; 50%). The family situation of the study participants is not unique to nurses in ICU in Israel. Half (12; 50%) had a bachelor's degree and the others had master's degree (12; 50%). Most of them defined themselves as traditionally religious (10; 41%) and worked as register nurses (21; 88%).

The results describe a phenomenon in which ICCU nurses take care of COVID-19 patient characterized by uncommon death. ICCU nurses described the uncommon death amount phenomena of first as compared to the second COVID-19 waves. They also described giving intensive care for patients that eventually did not help. In addition, the results describe a phenomenon of COVID-19 patient pre-determined death which ICCU nurses experienced and this eventually caused them emotional burden.

A purposive sampling strategy<sup>26</sup> was used to recruit 24 IC (Intensive Care) Covid-19 nurses able to provide in-depth, detailed information regarding the phenomenon under investigation. This sampling strategy is most used in phenomenological research, as it allows for selection of participants who have rich knowledge of the phenomenon.<sup>27</sup>

**Table I.** Characteristics of Intensive Care Unit Nurses.

Variables		N = 24	
		Frequencies	Percentages
Gender	Male	6	25
	Female	18	75
Marital status	Single	3	12.5
	Married	18	75
	Divorced	3	12.5
Religion	Jewish	12	50
	Muslim	9	37
	Atheist	3	13
Degree of religiosity	Secular	9	38
	Traditional	10	41
	Religious	5	21
Education	B.A.	12	50
	M.A.	12	50
Role in the intensive care corona unit	Register nurse	21	88
	Clinical instruction (nurses, with professional knowledge and skill and ability to guide students in the clinical field)	2	8
	Nurse in charge	1	4



**Figure 1.** The incidence of confirmed cases, severely ill and deceased in the first and second waves.

**Research Setting**

Usually, a typical hospital in Israel is divided into three parts. The first part, “internal division,” includes units belonging to internal medicine; the second part, surgery division, includes units belonging to surgical departments; and the third part, outpatient clinics, is related to different medicine sections. Intensive Care department with extension of ICCU belong to the “internal division.”

The Intensive Care Corona department includes two sections. The first is the control-monitoring room, and the second is the patient area. At the beginning of the shift, the nurses enter the control and monitoring room for patient health status updates. They then go through the protection process, which includes putting on the necessary garments and accessories from a kit designed to protect them from the virus. The

kit includes boots, overalls, hat, face shield, gloves, and mask. Following the protection process, the nurses enter the patient area and work under pressure for 2 hours. When the two hours are up, they change places with the nurses in the control—monitoring room. As much as we know The nurses did not receive any kind of mental or emotional support.

In addition, Figure 1 describes the comparison between COVID-19 patients’ circumstances during the first and second waves that nurses of ICCU underwent.

As Figure 1 shows, in the first wave there were a total of 17,124 confirmed cases, 643 severely ill and 289 deceased. In the second wave, there were a total of 297,526 confirmed cases, 7,989 severely ill and 2,281 deceased.<sup>28</sup>

**Data Collection**

All interviews were conducted via Zoom™,<sup>29</sup> and were audio and video recorded. The data collection continued until saturation was achieved, thus ensuring reliability and confirmability, and decreasing bias in describing the nurses’ experiences.<sup>30</sup> The interviews were transcribed, as were the notes written by the interviewer. The study followed by Consolidated Criteria for Reporting Qualitative Studies (COREQ).<sup>31</sup> For Interview questions, see Table 2.

**Data Analysis**

Data were analyzed in an ongoing process, we conducted a systematic thematic coding process, eventually grouping the data into higher level conceptual themes, which were then verified and refined.<sup>30</sup> Four researchers reviewed the findings, drawing similar conclusions.<sup>24,26</sup>

**Table 2.** Interview Questions.

No	Questions
1	Can you describe the lived experience of intensive care corona nurses in the COVID-19 war?
2	Describe the caring process during your shift in the department when working with a COVID-19 dying patient?
3	What was your main challenges while take care of a COVID-19 patient that in the end he passed away?
4	Is there a difference between working with corona patients in first wave compared to the second wave?
5	Describe one case where you had negative feelings and one case where you had positive feelings regarding take care of COVID-19 patient
6	Did the corona pandemic create new pressures in your life? If so, how did you deal with them?
7	Do the thoughts about COVID-19 dying patient you take care, and their families accompany you after the shift?
8	Were there any difficult circumstances with COVID-19 dying patient in which may influenced you? If so, how?

### Ethical Considerations

The study was approved by the Ethics Committee (Institute review board—IRB) of the Ariel University. The researchers ensured that all participants had signed the informed consent form and were aware of the research goals. The researchers ensured participant data confidentiality and guaranteed that the information would be published anonymously.

### Findings

The results describe a phenomenon of ICCU nurses caring for COVID-19 patients characterized by uncommon death. ICCU nurses described the uncommon death amount phenomena of the first compared to the second COVID-19 waves. They also described giving intensive care to patients that was not helpful. In addition, the results describe a phenomenon of COVID-19 patient pre-determined death which ICCU nurses experienced, causing them emotional burden.

The content analysis process yielded four main themes, with the first one being the first vs the second COVID-19 waves. Second theme was fighting for life and being unable to win. Third theme was a chronicle of pre-determined death. Fourth theme evident in the data was nurses' emotional coping with patient death. Below are quotes from the participants' words expressing the different themes.

#### Theme 1—The First vs the Second COVID-19 Waves

Most nurses emphasized the difference between the two first waves, with the second demonstrating higher mortality rates and younger patients, and less favorable reaction to caregiving. This came to the interviewees by surprise and caught them unprepared.

One nurse described

“So, in the first wave, the patients were relatively OK; but then the second wave came, and the patients were really in very serious condition, most of them died, we had very high mortality

rates in the second wave” (ICCU nurse, 27 years old, 4 months ICCU experience).

Another nurse emphasized that

“In the second wave, that was the wave with the high mortality rate, we’re talking about 45 to 65 years old, patients in very serious condition, mostly young people, more serious illness, more serious and more difficult to treat” (ICCU nurse, 24 years old, 5 months experience).

In the interviews, the nurses discussed not only the issue of higher mortality rates in the second wave than in the first, but also the fact that the dying patients were, overall, younger this time round. They were not used to seeing such young patients die under their care, despite their extensive experiences in the ICU. The nurses found this impossible to deal with.

One nurse

“The patients were difficult to save, despite everything I did, the final result was death. A very high mortality rate, different from the first wave” (ICCU nurse, 37 years old, 8 months experience).

One of the nurses said

“For example, in the second wave it was simply difficult to wean them from the artificial respiration. It was heartbreaking. This is one thing. Another thing is the fact that the families couldn’t visit” (ICCU nurse, 29 years old, 4 months experience).

Another nurse said

“In the first [wave] it was like, everyone somehow made it. In the second wave, all the massive care, and yet they, somehow, don’t work. Even the ones we sent to the ECMO didn’t make it. They died there” (ICCU nurse, 25 years old, 6 months experience).

A nurse described

“In the first wave the patients were in a better condition, older, . . . we were euphoric. In the second wave, the patients were in a serious condition, very difficult to treat, mostly younger, with

much higher mortality (ICCU nurse, 24 years old, 5 months experience)”

One of the central topics that came up in the interviews related to the differences between the first and second waves was the issue of intensive care as artificial respiration. The patients did not respond well to the intensive care provided by the nurses, something that stood out in the second wave as compared to the first.

This leads us to the second theme, describing how the nurses fought for patients’ lives and felt that they are losing.

## Theme 2—Fighting for Life and Being Unable to Win

The nursing staff was extremely frustrated when fighting for the provision of intensive care which did not help. The staff felt it was fighting for each patient breath. Losing after providing such intensive care caused the nurses to feel disappointment and despair.

The nurses provided intensive care which did not help. One of them said

“We fought for each and every one, gave every possible treatment, and they still don’t recover, even those with ECMO didn’t recover, they died” (ICCU nurse, 34 years old, 5 months experience).

Another nurse shared a case which demonstrated nurses’ feelings:

“A patient who was hospitalized with us for about two months. It was up and down, a really exhausting war. There was a time we thought he will begin to recover, but no, eventually he died. It was a rollercoaster” (ICCU nurse, 37 years old, 5 months experience).

The nurses fought hard to save lives, as expressed in the words of one nurse:

“... I’m telling you, when people died, with no pre-existing diseases, nothing, and when you give yourself, all of you, and you get nothing, he still dies. You suddenly see that all your care is worth nothing” (ICCU nurse, 29 years old, 8 months experience).

“We cope with so much death. With COVID-19 patients there was no logic, we didn’t know what would happen during the caring, the patients’ condition deteriorated even when we fought hard. It was very challenging keeping the patients alive” (ICCU nurse, 37 years old, 5 months experience).

## Theme 3—A Chronicle of Pre-determined Death

Slowly, over time, the nurses began to identify and describe patterns in patients’ death, patterns, and processes. For example, (a) patients enter the ICU alive with a respiratory difficulty, (b) use assistive respiratory devices, and (c) following

further respiration deterioration, and die. This made them wish to go back to taking care of regular patients, and some even to leave the ICCU.

They describe a poor systematic prognosis. The patients needed artificial respiration, received it, had a poor prognosis, and died. One nurse described

“It is a very complex situation. Even if the patient entered the ward conscious, I already knew he would get assistive with respiratory devices and his deterioration would probably be very swift when you took care of him. You know that these might be his last days or weeks” (ICCU nurse, 24 years old, 5 months experience).

Both waves included people on artificial respiration with a poor prognosis. Thus, the staff tried as much as possible to put off the inevitable (putting them on artificial respiration), as they knew their chances of making it were small. Artificial respiration became a well-known sign of death.

A nurse claimed

“We would see a patient having trouble breathing. You try to communicate with him; he is speaking, and you understand that you are going to put him on artificial respiration. If not in an hour, then at the end of the shift, a chronicle of pre-determined death” (ICCU nurse, 27 years old, 8 months experience).

A nurse describes the process of the disease through cases where she understood that this was a chronicle of a pre-determined death:

“I had quite a few cases with systematic prognosis, where we received conscious patients, and I spoke to them and thought they would be OK and will recover. It was only a few days of difficulty breathing and then they became Xs” (ICCU nurse, 27 years old, 5 months experience).

“I can’t forget my last case, a 43-year-old man. On the last day I took care of him he was really distressed, at the beginning of the shift he was on artificial respiration, and his respiratory distress was very, very difficult, and we wanted to transfer him to ECMO, he had serious hypoxemia that he had a brain herniation, and we were told he will die in a few hours.” (ICCU nurse, 37 years old, 5 months experience)

Another nurse claimed

“We saw so much death. We saw that as soon as we put them on artificial respiration they would die. This is something we did not often see in the regular ICU. With a regular ICU patient, you put him/her on artificial respiration, you stabilized him/her and knew where it was going.” (ICCU nurse, 25 years old, 6 months experience)

## Theme 4—Nurses’ Emotional Coping With Patients’ Death

The caregivers felt that death was penetrating all their barriers. There were quite a few cases where they cried and felt



suffocated. When they tried to describe the most difficult situations, they described how difficult it was for them to wrap the bodies, and the sense of a thundering silence immediately following a patient's death.

Another nurse describes how much patient death spilled over into her personal space, including her personal and family life.

“. . . it doesn't leave you, all this death you see are right in front of you" (ICCU nurse, 37 years old, 5 months experience).

The nurses could not bear the emotional burden and describe situations where their emotional reactions included crying during their shift and following it.

One nurse told the story of a particular case:

"The wife of one of the patients asked to speak to him. He couldn't do this; he was on artificial respiration at this stage. But she called with my phone, and she would just speak to him. It was heartbreaking (crying)" (ICCU nurse, 37 years old, 5 months experience).

Another nurse described his emotional difficulties, as well as the team's, expressed in an emotional reaction of choking and crying to patient death, as well as an emotional reaction to a letter written by the children to a patient who died.

"I heard crying, I looked behind me, the two women (other nurses) who were on shift with me just cried out loud. That was the first time that I saw the staff crying" (ICCU nurse, 25 years old, 6 months experience).

It was very difficult for me. I wanted to be the strong one, but I choked" (ICCU nurse, 25 years old, 4 months experience).

Another nurse illustrated the emotional difficulty of wrapping bodies through examples from her work:

"There is no nice way to put it, to wrap, I had to take care of a dead patient almost at the end of every shift. Not every shift, let's say every two shifts, something like that. That's difficult" (ICCU nurse, 24 years old, 5 months experience).

Another caretaker described the difficulty surrounding the sudden cessation (death) of the process/patient:

"It's frustrating. It's depressing, it's sad. It's like you care for someone for a week, two weeks, and they don't live. That's it, silence, and in the end, you feel like, it's very difficult to . . . it's really depressing" (ICCU nurse, 37 years old, 5 months experience).

Due to the difficult emotional state, some nurses recalculated their path and asked to go back to take care of "regular" patients, those with familiar disease processes.

A nurse said

"I could not emotionally handle the pre-determined death process, where people came and left in sheets. I just felt the need to be allowed to go back to the regular patients that I was familiar with, that I knew how to take care of more confidently" (ICCU nurse, 25 years old, 8 months experience).

One nurse said

"At some point all you see are bodies, bodies, bodies. How can I emotionally handle this? When we care for a patient and he gets better and better over time, you become more motivated. In ICU it makes you doubt the profession" (ICCU nurse, 27 years old, 5 months experience).

## Discussion

Qualitative research regarding the experiences of ICU nursing staff caring for COVID-19 patients who eventually died during the first two pandemic waves is innovative and important for improving future preparedness, not only for COVID-19 but also for future illness crisis situations. This study has explored the phenomena of ICU nurses caring for patients with COVID-19 who eventually died in the state of Israel. The main theme was, first vs the second COVID-19 waves, fighting for life and unable to win, chronicle of pre-determined death and nurses' emotional coping with patient death, were the four main themes that emerged from the nurses' interviews.

The first central theme identified in our study was the first vs the second COVID-19 wave. Most ICU nurses emphasized that the second wave was worse than the first, with higher mortality rates, young deaths, and patients not responding well to treatment in the second wave as compared to the first, as was the case in European countries.<sup>32</sup> Similarly to our findings, a study found that during the second wave there were much higher infection numbers, more patients in ICUs, and in some countries also more deaths, as compared to the first wave.<sup>32</sup> Another study, conducted with a semi-structured questionnaire with 662 participating, found that the second wave of COVID-19 in India was different than the first, with a younger demography, fewer comorbidities, and a greater frequency of breathlessness.<sup>33</sup>

The second central theme identified in our study was fighting for life and unable to win. The ICU nurses were extremely frustrated by providing intensive care which did not help, with the patients eventually dying due to lack of response to treatment. The staff felt they were fighting for every patient's breath and losing them caused them to feel despair and disappointment. These results are very concerning especially in light of other research qualitative research findings that show, nurses were extremely unprotected from psychological distress as compared to other health professionals during the pandemic. The death of COVID-19 patients can negatively affect nurses' mental health.<sup>20</sup>

The third central theme identified in our research was a chronicle of pre-determined death. COVID-19 patients who enter the ICU in a fully conscious state often experience respiratory deterioration, followed by respiratory assistance, then a rapid deterioration and death. This made the nurses wish to leave the COVID-19 patients and care for regular patients, and some even considered leaving the ICU altogether. This process described by the nurses, a pre-determined chronicle of death, is also supported by the literature. Cohort research design with 61 patients with Covid-19 demonstrated that infection symptomatology varies radically from no symptoms to life-threatening complications, including acute respiratory distress syndrome, multisystem organ failure, and ultimately death.<sup>10</sup> The respiratory failure may lead to invasive mechanical ventilation, and eventually some of the patients will not survive.<sup>10,13</sup> Qualitative research demonstrated that when patients were suffering from respiratory distress, and the nurses were unable to do anything for them, this had a huge negative impact on the nurses' spirits.<sup>20</sup> This negative impact can lead to thoughts regarding continuing to work in the care of COVID-19 patients in the ICU.

The fourth central theme identified in our research was the impact of patient death on nurses' emotional state. The nurses felt helpless, death broke through all their boundaries. There were quite a few situations where they cried and felt suffocated. When they tried to describe the specific situations in which they had the most emotional difficulty, they described wrapping bodies and a thunderous silence following the patient's death. Similar to the results of our study, participants reported emotional challenges and providing end-of-life care during the pandemic. A qualitative interview with sixteen health and social care professionals showed that nurses were a major factor in the relationships between patients at the end of life and their families.<sup>34</sup> Another qualitative phenomenology study demonstrated that nurses were emotionally affected by patient suffering under the critical conditions caused by COVID-19 and the sense of waiting to die.<sup>16</sup> Research concludes that self-awareness, as well as acknowledgment of personal constraints, constitute essential equipment for healing in a genuine meet with people in need.<sup>35</sup>

The large number of daily deaths due to the pandemic has had negative emotional and professional consequences for nurses, who have and recalculate their professional course. A research found that psychological problems related to nurses' work might negatively affect their strength and their intention to leave the profession.<sup>36</sup> However, dissimilarly to our results, another mixed methods study with 105 nurses found that the vast majority had no wish of leaving the COVID-19 unit, described their working environment as great. This may have resulted from adequate education, clear and accountable leadership, responsibilities during the transition in the COVID-19 unit, thus, helping to cope with devastating anxiety.<sup>18</sup>

## Conclusions

The main research aim was to explore the experiences of ICU nursing staff caring for COVID-19 patients who died during the two first pandemic waves. The nurses' experiences described in this study show that they faced a psychological challenge while caring for patients with COVID-19. The foundations of this distress were related to the unexpected death rates of the second wave as compared to the first, patients' deaths, and being unable to help patients with COVID-19, a pre-determined chronicle of COVID-19 patient death, and caregivers' emotional coping with patient death. During outbreaks of diseases or natural disasters, nurses vigorously provide health care services for patients from the beginning of the crisis.

## Implications to Practice, Policy, and Research

1. There is a need to develop a plan in advance, providing the essential practice and skills for nurses to be able to manage such situations, characterized by sudden and extreme demands of caring for patients in COVID-19 departments.
2. To enhance nurses' mental status, there is a need for policy makers and governments to create a support system during and after such events. Moreover, governments and health organizations should minimize nurses' mental load by providing psychological counseling, as well as information and educational support.
3. Based on study findings, qualitative research is needed to examine those themes for generalization, in order to prepare nurses for new epidemic in the unexpected future.

## Limitations and Future Research

One limitation the sample is small and drawn from the center of the country, therefore no generalizations can be made to other areas contexts in Israel or internationally. Therefore, it required to evaluate ICCU nursing staff experience of COVID-19 patient deaths in a large sample and in different countries.

Another limitation is the use of one tool, interviews, in this study. Therefore, future studies should focus on and use various tools, as observations or questionnaires, which might be useful for detecting more complex and deeper in-sights to the phenomena.

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