



Coping styles of Guyanese nurses in the face of patients' deaths: A cross-sectional study*


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Objective: to investigate nurses' strategies to cope with patients' deaths and to explore potential influences of cultural aspects on this phenomenon. **Methodology:** this is a cross-sectional study. The participants were 85 Registered Nurses from a Guyanese regional hospital. Data collection was carried out using a sociodemographic questionnaire and the Coping Strategies Inventory by Lazarus and Folkman. Descriptive statistics and the Spearman's correlation test, Student's t-test and Kruskal-Wallis test were performed to explore the data obtained. **Results:** most of the participants were women (85.9%) of African descent (56.5%). The mean age was 29.63 years old (SD=8.98), varying from 20 to 55 years old. Nurses have adopted the Planful problem-solving, Self-controlling and Positive reappraisal coping strategies to deal with patients' deaths, and religion exerted an influence on the coping style they mentioned. Years as a Registered Nurse had positive correlations between the Planned problem-solving, Positive reappraisal, Seeking social support and Distancing coping styles related to patients' deaths. Nurses professing the Hindu religion presented higher scores related to the Escape-avoidance coping style. **Conclusion:** even without specific training in coping with death, Guyanese nurses have adopted adequate coping strategies to deal with this phenomenon. Cultural beliefs, such as religions of different philosophical and spiritual frameworks, may influence nurses' coping strategies in the face of patients' deaths.

Descriptors: Attitude to Death; Adaptation, Psychological; Mental Health; Nurses.

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Estilos de enfrentamento de enfermeiros guianeses diante da morte do paciente: um estudo transversal

Objetivo: investigar as estratégias dos enfermeiros para lidar com a morte do paciente e explorar as possíveis influências de aspectos culturais sobre esse fenômeno. **Metodologia:** estudo transversal. Os participantes foram 85 Enfermeiros Registrados de um hospital regional guianês. A coleta de dados foi realizada por meio de questionário sociodemográfico e do Inventário de Estratégias de *Coping* de Lazarus e Folkman. Estatística descritiva, teste de correlação de Spearman, teste t de Student e teste de Kruskal-Wallis foram empreendidos para explorar os dados obtidos. **Resultados:** a maioria dos participantes eram mulheres (85,9%) e afrodescendentes (56,5%). A média de idade foi de 29,63 anos (DP=8,98) e variou de 20 a 55 anos. Os enfermeiros adotaram estratégias de enfrentamento de resolução de problemas, autocontrole e reavaliação positiva para lidar com a morte de pacientes, e a religião teve influência no estilo de enfrentamento mencionado por eles. Houve correlação positiva entre os anos como enfermeiro registrado e os estilos de enfrentamento de resolução de problemas, reavaliação positiva, suporte social e afastamento relacionado à morte do paciente. Enfermeiros da religião hindu apresentaram maiores escores relacionados ao estilo de enfrentamento de fuga-esquiva. **Conclusão:** mesmo sem treinamento específico para o enfrentamento da morte, os enfermeiros guianeses adotaram estratégias de enfrentamento adequadas para lidar com esse fenômeno. Crenças culturais, como religiões de diferentes referenciais filosóficos e espirituais, podem influenciar a estratégia de enfrentamento dos enfermeiros diante da morte do paciente.

Descritores: Atitude Frente a Morte; Adaptação Psicológica; Saúde Mental; Enfermeiras e Enfermeiros.

Estilos de afrontamiento de enfermeros guyaneses ante el fallecimiento de pacientes: un estudio transversal

Objetivo: investigar las estrategias de los enfermeros para lidiar con el fallecimiento de pacientes y explorar las posibles influencias de los aspectos culturales en este fenómeno. **Metodología:** estudio transversal. Los participantes fueron 85 Enfermeros Certificados de un hospital regional de Guyana. La recolección de datos se realizó mediante un cuestionario sociodemográfico y el Inventario de Estrategias de Afrontamiento de Lazarus y Folkman. Se realizaron estadísticas descriptivas, prueba de correlación de Spearman, prueba t de Student y prueba de Kruskal-Wallis para explorar los datos obtenidos. **Resultados:** la mayoría de los participantes eran mujeres (85,9%) y afrodescendientes (56,5%). La media de edad fue 29,63 años (DE=8,98) y osciló entre 20 y 55 años. Los enfermeros adoptaron estrategias de afrontamiento de resolución de problemas, autocontrol y reevaluación positiva para hacer frente al fallecimiento de los pacientes, y la religión influyó en el estilo de afrontamiento que mencionaron. Hubo una correlación positiva entre los años como Enfermero Certificado tuvieron y los estilos de afrontamiento de resolución de problemas, la reevaluación positiva, el apoyo social y el distanciamiento relacionado con el fallecimiento de los pacientes. Los enfermeros de religión hindú presentaron puntuaciones más altas relacionadas con el estilo de afrontamiento de escape-evitación. **Conclusión:** incluso sin formación específica para afrontar la muerte, los enfermeros guyaneses adoptaron estrategias adecuadas para hacer frente a este fenómeno. Las creencias culturales, como ser religiones de distintos marcos filosóficos y espirituales, pueden influir en la estrategia de afrontamiento de los enfermeros ante el fallecimiento de los pacientes.

Descriptores: Actitud Frente a la Muerte; Adaptación Psicológica; Salud Mental; Enfermeras y Enfermeros.

Introduction

Nurses are health professionals exposed to extensive contact with patients, often resulting in a greater emotional bond with hospitalized individuals and their families⁽¹⁻²⁾. When a patient dies, such professionals often experience high stress levels, and this loss is one of the most stressful situations they can experience in their work routines⁽³⁻⁴⁾. In addition to stress, emotions such as compassion, sadness, helplessness, anger, fear and guilt may also arise, as well as psychological processes such as denial and distancing⁽⁴⁻⁶⁾.

It must be considered that care continues even after the death of a hospitalized person, since actions such as preparing the body, psychological support to family members and providing practical guidance on the next steps are actions commonly performed by nurses⁽⁷⁾. Such processes can be emotionally challenging for these professionals, who, in addition to dealing with the death of a patient will still have to continue with their other duties of the workday. When nurses are not emotionally and professionally prepared for this challenge, the care provided to patients and families may be impaired^(3,8). Thus, it is understood that mentally fit nurses are more capable of dealing with the challenges of the profession, especially in the face of patients' deaths^(5,9-10).

In the COVID-19 pandemic context, the influence of nurses' mental health and the coping strategies they used to endure the tough work routine during the health crisis proved even more pressing with regard both to their general health status and to the quality of patient care⁽¹¹⁾. In addition to the stress related to increased workload and frequent exposure to patients' deaths, emotional distress was heightened due to the contagious nature of SARS-CoV-2, which added to concerns about safety of the work environment and of family members and colleagues⁽¹²⁾. It is noteworthy that a systematic review found that female nurses and Nursing staff suffered the greatest psychological impact among health workers in the first line of care during the pandemic⁽¹³⁾.

In the face of the pandemic battlefield, a scoping review study on COVID-19-related stress coping resources among nurses identified that professional responsibility attitude, workplace safety and team spirit benefited such professionals in stress management. The relevance of social support represented by colleagues, family members and society itself was also observed, in addition to activities aimed at relaxation and distraction, such as deep breathing, physical exercises and reading. Religiousness/Spirituality (R/S) coping was also especially relevant, such as engagement in prayer⁽¹²⁾.

Regarding R/S, beyond the pandemic context there is evidence that involvement in religiousness/spirituality is a coping mechanism often used by nurses to deal with

stress and overload, providing senses and meanings in the face of professional challenges, including the death of a patient^(6,14-16). As examples, a New Zealand study conducted with Nursing professionals facing the death of a patient observed lower burnout levels among those with some religious affiliation and who indicated greater influence of spiritual/religious beliefs on their attitudes towards death and dying⁽¹⁷⁾, while a survey of Indonesian Muslim nurses, also facing the death of a patient, identified religious coping in the form of engagement in prayer, search for religious statements about death, and the belief that death was the fulfilment of divine will⁽¹⁸⁾.

Although these studies have shown the implications of the spiritual/religious experience on nurses' coping with the death of a patient, the literature on how cultural and religious aspects relate to this phenomenon in this population group is still scarce^(3,6,18). Thus, new research studies are necessary in order to ground more holistic care strategies for nurses' mental health, without losing sensitivity to the specific cultural context in which they are inserted.

In this sense, one of the five content areas presented by Cultural Formulation in Diagnosis and Cultural concepts of distress described by DSM-V corresponds to cultural factors related to psychosocial environments and the different levels at which it works. In this item, it is considered that social stressors, availability of social supporters, disabilities and functioning are culturally interpreted, and that religion, as well as family, play an important role in shaping the ways to cope with stressors⁽¹⁹⁾.

Therefore, this study aimed at investigating nurses' strategies to cope with patients' deaths and at exploring potential influences of cultural aspects on this phenomenon. The hypothesis is that nurses have difficulties to deal with this phenomenon and that the educational background, ethnicity and religion exert an influence on the coping style adopted to deal with patients' deaths.

As for the conceptual framework, this research was based on the "Lazarus Theory of Stress, Coping and Adaptation", which basically focuses on how individuals cope with stressful situations, both emotionally and physically⁽²⁰⁾. For this study, the death of a patient can be considered a stimulus factor, which may develop into a stressor that causes emotional distress to nurses.

Methodology

Study design, locus and sample size

This cross-sectional study was conducted at a hospital in New Amsterdam, East Berbice-Corentyne, Guyana. The health care system in Guyana has five

different health care levels and the research locus is a regional hospital that welcomes patients from all these levels⁽²¹⁾. It has twelve male and female medical and surgical units, gynaecological unit, intensive care unit, paediatric and neonatal intensive care units, outpatient department, emergency unit, operating theatre, and maternity/labour unit. It is the referral hospital for Region 6, one of the ten administrative regions of the country, and all intensive procedures, laboratory and other diagnostic tests are done there, along with the only operating theatre in the region. Consequently, this health service was chosen as data collection setting because it was considered that the nurses working in it have more chances of having experienced patients' deaths due to the critical characteristics of most of the hospitalized individuals.

The population of nurses in this hospital was 95. All of them were invited to participate in this research through posters. The inclusion criteria for this study were nurses that are licensed to practice in Guyana and have been employed in the hospital for at least two months. The exclusion criteria included nurses who were on annual leave/vacation during data collection. The purposive sample adopted in this study comprised 85 nurses (89.5%) who accepted to participate in the study.

Data collection

Data collection was carried out between 2019 and 2020 and was conducted using a social and demographic questionnaire that was prepared by the researcher, including questions about the participants' professional status and educational background. The cultural aspects were also explored, specifically based on item five from the Spiritual, religion and moral tradition supplementary module to the Core Cultural Formulation Interview from DSM-V⁽¹⁹⁾.

There are three main religions in Guyana: Christianity, Islamism and Hinduism⁽²²⁾. There is religious freedom in the country and everyone is free to practice their own religious belief. None of the hospitals has a chaplain or other religious symbols. When a patient is dying, the relatives are free to call their religious leader to perform the last rights. Considering the diverse evidence that religious characteristics may interfere with the coping process of the nurses who deal with patients' deaths⁽¹⁷⁻¹⁸⁾, in this study religion was considered as an especially important variable to analyse.

Additionally, the Coping Strategies Inventory created by Lazarus and Folkman was used⁽²⁰⁾. It consists of 66 items that measure eight domains of coping strategies, namely: Confrontive coping, which refers to aggressive efforts to change the situation; Distancing is where the stress around is distanced and it prevents the person from affecting their action; Self-controlling

looks at how the person controls their emotions and actions in different situations; Seeking social support looks at how a person can relate and talk to others when facing difficult times; Accepting responsibility looks at acceptance of one's own role in adapting to stressful and adverse situations; Escape-avoidance looks at when a person denies and seeks to escape the extent of stress as a coping response; Planful problem-solving happens when a person implements specific solution-focused strategies to get through the tough time and redirect their actions; and Positive reappraisal looks at when a person seek to find the answers when problems arrive, and to grow from these situations⁽²⁰⁾.

Each item is rated on a four-point scale (1 - Not used, 2 - Somewhat used, 3 - Used quite a bit, and 4 - Used a great deal). The total score for each of the eight domains is obtained by adding up the scale answers given by the individual. Higher scores indicate that a particular coping mechanism was used more often and *vice versa*⁽²⁰⁾. As it evaluates eight different factors, it allows for a wider analysis of the various possibilities of behaviours to cope with the stressors.

All questionnaires were answered by the participants through individual and face-to-face interviews, held at a convenient time for nurses and in a private room, for approximately 30 minutes.

Data processing and analysis

The data gathered were double-typed into a Microsoft Excel spreadsheet. The researcher checked for errors comparing the two different spreadsheets. Subsequently, the database was transferred to the IBM SPSS software, version 20.

Descriptive statistics were performed to calculate common patterns of sociodemographic, cultural and professional characteristics, as well as the frequency of each coping style used by nurses. The Spearman Correlation Test was used considering the scores from each coping style and professional characteristic, and the Student's t-test was employed to calculate and compare the mean of the Coping Style Inventory scores between nurses who participated in and those that did not attend any workshops about patients' deaths. The Kruskal-Wallis test was performed to identify the median difference of coping style scores. Results with p-values ≤ 0.05 were considered statistically significant.

Ethical aspects

This proposal was reviewed by the Ethics Board of the Guyana government to ensure that all ethical requirements were met. Permission was granted. Participation was voluntary and withdrawal from this study was allowed.

The consent form was presented in two copies, one for the participant and the other form of records for the research. By agreeing to take part in this research, the participants gave the main researcher and co-researchers permission to use or disclose health information.

Use of the Coping Strategies Inventory by Richard Lazarus and Susan Folkman was allowed by Susan Folkman through an email message. The data collection procedure was conducted at a time convenient to the participants.

Results

Most of the participants were women (85.9%) of African descent (56.5%). The mean age was 29.63 years old (SD=8.98) and ranged from 20 to 55. The prevalence of nurses who experienced patients' deaths during their career was 88.2% and 40.0% mentioned that the dead patients were adults. Most of the participants (85.9%) did not attend any workshop or training session on how to cope with patients' deaths.

Table 2 - Correlation among the years as a Registered Nurse, years working in the hospital and coping styles from the Lazarus and Folkman inventory (n=85). Guyana, 2019-2020

Variables	1	2	3	4	5	6	7	8	9	10
1. Confrontive coping	-									
2. Distancing	0.380*	-								
3. Self-controlling	0.496*	0.464*	-							
4. Seeking social support	0.437*	0.204	0.262†	-						
5. Accepting responsibility	0.579*	0.391*	0.491*	0.354*	-					
6. Escape-avoidance	0.530*	0.385*	0.344*	0.262†	0.528*	-				
7. Planful problem-solving	0.321*	0.342*	0.361*	0.530*	0.264†	0.129	-			
8. Positive reappraisal	0.322*	0.312*	0.369*	0.501*	0.265†	0.215†	0.597*	-		
9. Years as an RN‡	0.048	0.220†	0.037	0.242†	0.090	0.158	0.238†	0.221†	-	
10. Years working in the hospital	-0.092	-0.097	-0.132	0.075	-0.187	-0.179	0.200	0.195	0.315*	-

*The correlation is significant at the 0.01 level (2-tailed); †The correlation is significant at the 0.05 level (2-tailed); ‡RN = Registered Nurse

There was no significant difference between the mean coping style scores obtained by nurses who participated in and did not attend any workshops about patients' deaths (Table 3).

The results suggested that the nurses' schooling levels, the patients' life stage or the nurses' work department exert no influence on the coping styles

The mean score obtained by the participants in each coping style from the Coping Strategies Inventory⁽²⁰⁾ are presented in Table 1.

Table 1 - Mean of scores obtained by the participants in the coping scale (n=85). Guyana, 2019-2020

Variables	Mean	SD*
Planful problem-solving	1.43	0.60
Self-controlling	1.42	0.53
Positive reappraisal	1.42	0.54
Seeking social support	1.36	0.55
Distancing	1.23	0.52
Accepting responsibility	1.14	0.66
Confrontive coping	1.10	0.58
Escape-avoidance	1.10	0.45

*SD = Standard Deviation

It was identified that the years as a Registered Nurse have significant and positive correlations between the Planful problem-solving, Positive reappraisal, Seeking social support and Distancing coping styles related to patients' deaths. There was no significant correlation among the years working in the hospital and any coping styles considering the phenomena under study (Table 2).

related to patients' deaths in the sample under study. There was only a statistically significant difference in the scores related to the Escape-avoidance coping style among the participants from different religious groups (Hindu: n=22, Mean rank=58.82; Christian: n=52, Mean rank=37.92; Other religions: n=10, Mean rank=30.40; p=0.001).

Table 3 - Mean coping style scores difference between nurses who participated in and did not attend any workshop about patients' deaths (n=85). Guyana, 2019-2020

Variables	Yes (n=9)		No (n=70)		T†	Sig.‡
	Mean	SD*	Mean	SD*		
Confrontive coping	1.30	0.60	1.09	0.59	0.978	0.331
Distancing	1.09	0.51	1.25	0.51	-0.864	0.390
Self-controlling	1.35	0.43	1.43	0.54	-0.414	0.680
Seeking social support	1.61	0.79	1.33	0.51	1.443	0.153
Accepting responsibility	1.00	0.47	1.13	0.64	-0.582	0.562
Escape-avoidance	1.13	0.46	1.11	0.45	0.101	0.920
Planful problem-solving	1.56	0.68	1.41	0.58	0.677	0.501
Positive reappraisal	1.59	0.70	1.41	0.53	0.903	0.370

*SD = Standard Deviation; †T = Student's t-test; ‡Sig. = Statistical Significance

These results showed a possible influence of religion on the coping style adopted by nurses in this situation. The nurses who mentioned belonging to the Hindu religion presented higher scores related to the Escape-avoidance coping style than those who professed other religions. The frequency of religious practice at worship places or at home does not seem to interfere with the coping styles adopted to deal with patients' deaths.

Discussion

The results showed that Planful problem-solving, Self-controlling and Positive reappraisal were the main coping styles used by Guyanese Registered Nurses on how to deal with patients' deaths. It is understood that these coping styles are essential in health care because they reflect important and positive attitudes of strength and adaptive values that are necessary to help deal with problems from the nurses' environment in an effective way⁽²³⁾.

However, it was not possible to compare these results in the light of the literature, as previous studies on how professionals deal with death mostly resorted to specific indicators such as self-efficacy in death⁽²⁴⁻²⁵⁾, attitude in relation to death⁽²⁶⁻²⁸⁾ or the origin of these resources, whether intrinsic or extrinsic⁽³⁾. Among nurses, many of the studies carried out recently have a qualitative design^(3,5-6). Thus, it is suggested that future studies use scales such as the Lazarus and Folkman Coping Strategies Inventory⁽²⁰⁾ – a well-established tool to assess coping styles in diverse populations – to assess the outcome of dealing with patients' deaths, making it possible to compare the results, especially across different cultural contexts.

Moreover, although the participants have reported adaptive skills that helped them react effectively and efficiently in relation to the death of a patient, previous studies have pointed out the importance of hospitals to offer mental counselling to their employees^(26-27,29). This strategy can help the professionals manage the emotional impact of this phenomenon in their personal life and, consequently, improve the care provided^(26-27,29). In this sense, it is understood that it is important that responsible bodies implement mental health promotion actions for Guyanese nurses, considering the guidelines indicated in a report by the World Health Organization regarding the strengthening of mental health care systems and the reshaping of environments that influence mental health all over the world⁽³⁰⁾.

There were positive correlations between the years as a Registered Nurse and the Seeking social support, Planful problem-solving and Positive reappraisal coping strategies. Previous studies have also verified positive correlations between service

time and positive attitudes in relation to death^(26,28). However, these surveys did not use the same scale as this research. These results were probably found because the experiences have contributed to better preparing nurses to deal with the different situations they may encounter in their clinical practice.

Despite this, the years working in the hospital or attending any workshop about patients' deaths showed not to be relevant to the coping styles adopted in cases of patients' deaths. This result differs from other studies found in the literature, which point out that nurses who attend some course on the theme are more likely to reflect a positive attitude to deal with this phenomenon^(3,26). It is understood that addressing this theme from the first years of Nursing undergraduate courses is essential. In addition to the positive result for the professionals' mental health, it will also contribute to comprehensive and multidisciplinary assistance, ensuring quality in communication, comfort, safety and humanization towards the patient and their family^(16,31).

Additionally, the fact that the schooling levels have not shown any influence on the coping styles adopted by nurses may reflect that the curriculum emphasises more the technical aspects than the emotional ones. That is, Education and Nursing curriculum managers should pay attention to more sensitive and diverse strategies that could promote better professional choices related to coping with stressful situations.

Regarding the cultural aspects, in the current study it was identified that Hindu nurses presented higher scores related to Escape-avoidance coping than those who mentioned other religions, and this result suggests that cultural beliefs in fact can influence nurses' coping strategies in the face of patients' deaths, corroborating previous studies^(3,32-36).

According to some Hindu beliefs, life is a cycle, and suffering has a connection with karma related to personal choices made in current or previous lives. Thus, Hindus have a specific way to interpret suffering, transcending the purely physical dimension of pain and death⁽³²⁾. This cultural specificity may explain the difference in coping styles mentioned by the participants who profess this religion.

In the case of the current study, although the results indicate a possible influence of the professed religion on the coping styles adopted in the face of patients' deaths, the frequency of religious practice, either at home or going to a worship place, did not differentiate the sample in terms of such coping styles. This result might express that the philosophical and spiritual framework of each religion is more important in terms of influence on nurses' professional attitudes than frequency of the religious practice itself⁽³³⁻³⁶⁾.

Furthermore, it is strongly recommended to consider the possible effects of culture on events that require high emotional load, as different cultural contexts also imply different forms of expression and emotional regulation⁽³⁷⁾. It is noteworthy that an integrative review on R/S in the clinical practice in Psychology identified R/S as a fundamental characteristic of people's culture, which directly influences their relationship with peers, either from their own beliefs or from being inserted in a culture that, independently, has and promotes characteristics that are socially widespread⁽³⁸⁾.

It should be noted that R/S is also identified as a protective factor for coping with death in the clinical practice⁽³³⁻³⁶⁾. However, these terms present a profound complexity that was not considered in the current study, as the survey carried out was only of the religion professed by the participants and the frequency of their religious practice. In this sense, it is suggested to conduct additional studies that consider R/S aspects with a view to better exploring these possible relationships.

In addition, some previous studies⁽³⁹⁻⁴⁰⁾ suggested that terminally-ill patients and the elderly may demand more emotional and material resources from health professionals to face the death situations of these patients and suggested that nurses' reaction to coping is different, especially when they work at certain departments. However, in the current study, the nurses' work departments did not influence the coping strategies they used when a patient died. It is understood that this result stems from the fact that, in the hospital where the study was developed there was no specific department for Geriatrics or Palliative Care. That is, the presence of nurses from these specific areas in the sample could result in other outcomes.

The study had some limitations. Firstly, the convenience sample obtained only from a single hospital precludes generalising the results. Secondly, it was difficult to control confounding and other factors that could have contributed to the emotional impact experienced by the nurses after patients' deaths. The participants' recollection of their emotional response following the death of a patient might have been faulty due to forgetfulness, reluctance to report embarrassing behaviours, and the desire to report socially desirable behaviours.

Conclusion

This study showed that Guyanese nurses have adopted coping strategies considered adequate to deal with patients' deaths. Religious affiliations to different philosophical and spiritual frameworks may also be associated with different coping strategies in the face

of such challenge. That is, cultural aspects, such as religion, exert an influence on this phenomenon.

The results related to educational background suggest that more emphasis should be given to practical training in coping with death and dying for nurses, not only considering the theoretical aspects and technical procedures but also the emotional effects of death, as well as the cultural influences that permeate the perception of death and, consequently, influence the ways to professionally deal with this phenomenon. Based on this study, it is recommended that policy-makers and managers implement measures and systems for nurses to be counselled and well trained.

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