

# Bereavement Needs Assessment in Nurses

Subjects: Nursing

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The impossibility of anticipating the events, the numerous deaths, the excessive workload, the lack of personal health and the necessary means of protection made it difficult to regulate the impact and the elaboration of grief to the point of becoming, on many occasions, a traumatic grief whose physical and psychological manifestations are becoming more and more evident. a specific measurement instrument suitable is proposed to identify possible risk factors and a symptomatology of professional traumatic grief. It could be used to plan and take action aimed at preventing the long-term effects of this pathology, thereby mitigating the threat to personal identity, promoting coping resources for professionals, helping to minimize negative self-evaluation due to the loss and improving the quality of life and healthcare of this at-risk population. A scale for a group of symptoms based on professional traumatic grief was developed.

Keywords: nursing ; COVID-19 ; traumatic grief

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## 1. Phase I: Instrument Design

The instrument was developed through three successive steps that, in accordance with the recommendations established by Polit and Beck <sup>[1]</sup>, follow a qualitative methodology (phases a and b) and a quantitative methodology (phase c). These phases are summarized and grouped as follows: A. Systematic review; B. Focus group of “experts” and professionals experiencing grief; and C. Preliminary design of the inventory.

(A) Systematic review. As a first stage, an initial and exhaustive literature review was necessary. The empirical and theoretical literature is well-suited to providing insights into the phenomenon under study <sup>[2]</sup>. Systematic reviews, although designed to answer discrete questions using explicit methods, can further contribute to the delineation of the construct <sup>[3]</sup>. In this regard, the aim of first phase was to conduct a systematic review of the scientific literature to gather current knowledge about bereavement, complicated grief, bereavement in healthcare professionals and validated instruments in the literature for measuring it. The search strategy for the empirical review was designed to retrieve the largest number of references relevant to measuring professional traumatic grief. The review strategies were guided by standardized approaches, including the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) guidelines <sup>[4]</sup>. The search strategy was configured by combining the following descriptors: “professional bereavement”, “complicated bereavement”, “post-traumatic stress”, “scales”, “assessment”, “health professionals”, “nursing professionals”, “risk factors” and “coping with death”.

(B) Focus group of “experts” and professionals experiencing grief. To encompass a wide range of typologically relevant opinions and observations for the further development of the scale items, focus group sessions were conducted with two samples, namely the expert team and health professionals, with bereavement experiences. Theoretical purposive sampling was used to select participants. The group of experts and the group of professionals experiencing grief were identified by the research group through contacts at meetings with health professionals, membership in related professional organizations and existing professional contacts. An invitation was sent to all potential participants via e-mail. Those interested in participating were contacted by telephone to arrange an appointment, and a few days before the session, participation was confirmed with another telephone call. Participation was voluntary, with the confidentiality and privacy of their contributions ensured. The participants received the necessary information on the objectives, background and methods before providing a written consent form.

The team of experts consisted of professionals with knowledge of bereavement, while the second group consisted of professionals who experience grief (these professionals are nurses, doctors, healthcare assistants and other healthcare professionals who work in services where death is most present (ICU, emergency, oncology, pediatric oncology, etc.). Given the nature of the objectives, the formation of focus groups was considered the most relevant method for obtaining information and gaining a more in-depth understanding of the topic in order to construct a questionnaire aimed at a sample of individuals with professional traumatic grief. The focus group meetings were conducted by researchers from the

team trained in qualitative research and were held in a comfortable, quiet place to ensure quality communication and preserve confidentiality. The place chosen was the meeting room of the Salus Infirmorum University Nursing Center.

At the beginning of the session, all the participants were provided with a definition of the construct to be measured, i.e., professional traumatic grief, and were asked to express their opinions and perceptions regarding the subject matter, the characteristics of prolonged grief and its possible inclusion in a symptomatology scale. In the case of health professionals, their experiences of patient deaths were also discussed. Prior to the focus group meeting with the health professionals, the researcher ensured that the participants felt comfortable being interviewed and, after the interview, they were offered emotional support if needed. The discussion was facilitated by some open-ended questions to generate a voluntary debate on the different perspectives of the professionals about their experiences of patient deaths. The information obtained was audio-recorded so it could be transcribed verbatim and then analyzed as detailed by Krippendorff <sup>[5]</sup>, using conventional methods of qualitative content analysis. The moderators used a semi-structured approach and an interview guide. The interview guide was constructed to specifically explore concepts relevant to professional traumatic grief and its components. A field notebook was also used to collect nonverbal aspects of communication (gestures, expressions, postures, etc.) in order to obtain the results of what was expressed by the participants.

Data analysis: Focus group analysis was understood to be the process of the identification, codification and categorization of the main axes of meaning underlying the data. Qualitative data from the focus group were transcribed and processed.

For their correct analysis, the steps of Giorgi's phenomenological method <sup>[6]</sup> were followed:

- (1) Collect and describe the phenomenological data. Specifically, each researcher listened to the recordings several times
- (2) Read the description of the data set. to obtain a comprehensive understanding of the phenomenon
- (3) Divide the descriptions into units of meaning. under study. After transcription and subsequent reading, the units of
- (4) Transform the units of meaning. meaning (words, constructs and/or concepts) related to the
- (5) Identify the essential structure of the phenomenon. construct were labeled with a code. Similar codes representing
- (6) Integrate the characteristics into the essential structure of the phenomenon. similar concepts were classified into subcategories and then converted into a category. Data collected from health professionals' focus group and from experts' focus group were analyzed and reported separately and refined and reduced until mutual agreement between the researchers was reached.

(C) Preliminary Instrument Design. In this phase, a first version of the instrument was developed, consisting of 28 items reflecting the symptomatology of professional traumatic grief. The questionnaire items were designed based on the symptoms of prolonged grief most frequently reported in the scientific literature <sup>[7][8][9][10][11]</sup> on published instruments of grief <sup>[10][11][12]</sup> and on the information obtained from the focus groups. In addition, it was considered appropriate to include among the symptoms the defining characteristics that obtained high scores in the article by Gilart et al. <sup>[13]</sup>.

The research team named the scale Inventory of Symptoms of Professional Traumatic Grief, or ISDUTYP.

A 7-point Likert-type response scale was chosen, where 1 indicates never, 2 hardly ever, 3 seldom, 4 sometimes, 5 often, 6 usually and 7 always. In addition, the experts agreed that with respect to the wording of the instrument, the participants had to indicate the frequency with which they felt the symptoms during the last six months.

## **2. Phase II: Validation of the Content of the Instrument**

Content validity is defined as the degree to which the items of an assessment instrument are relevant and representative of the entity to be measured. This method is characterized by having a number of experts who either propose the items or dimensions that should make up the construct of interest or evaluate the different items according to their clarity, coherence and relevance, based on a Likert-type scale, and make judgments on the elements and contents to be evaluated <sup>[14]</sup>. Evaluating the content validity of a scale is an essential step in the development of an instrument, since doing so allows the appropriate items for the scale to measure to be selected. The procedure recommended by Polit and Beck <sup>[1]</sup> to ensure the content validity of an instrument is based on expert judgment of the relevance of the items to the construct they are intended to measure. The main objective of the second phase was to submit the indicators of the version elaborated in the previous phase to the judgment of a group of experts who would analyze the clarity, coherence and relevance of each item, taking as a reference the classic criteria established by Angleitner, John and Löhr <sup>[15]</sup>. These criteria include: level of clarity (the item is well-understood and its syntax and semantics are adequate); coherence (the item has a logical relationship with the scale of professional traumatic grief); relevance (the item is important and should be included in the scale). In addition, at the end of the questionnaire, there was a text box where it was possible for the judges to write the comments and suggestions they considered pertinent.

### 3. Evaluation of the Clarity, Consistency and Relevance of the Symptomatology Scale by a Panel of Experts

For the selection of experts, there is no consensus to define what constitutes an expert, but it is important that they have knowledge in the area under investigation and that they work on an academic and/or professional level and, in turn, have knowledge of complementary areas <sup>[16]</sup>. The number of experts selected was determined according to recommendations for obtaining useful estimates, the ideal number being between 7 and 30 experts <sup>[17][18]</sup>.

The hyperlink that was generated to evaluate the instrument was sent by e-mail to:

-College of Nursing in the province of Cadiz;

-Experts on the subject, who were accessed through: direct contact; bereavement research groups; nursing faculties in the province of Cadiz. To conduct this phase, the QuestionPro platform was used to prepare and digitize a document that included;

-Data about sociodemographic characteristics: sex, age, years of experience, position held (nurse, doctor, psychologist, teacher, researcher, other), unit/service where they worked (hospital, primary care, university, emergency services, other);

The evaluation focused on assessing the clarity, consistency and relevance of each of the symptoms included in the questionnaire. A four-point ordinal scale (1 = not clear, 2 = somewhat clear, 3 = quite clear and 4 = very clear) was used to assess the clarity of each of the symptoms, and a four-point ordinal scale (1 = not coherent (or relevant), 2 = somewhat coherent (or relevant), 3 = quite coherent (or relevant) and 4 = very coherent (or relevant)) was used to assess the coherence and relevance of each of the symptoms. Finally, for each of the sections to be evaluated by the experts, a space for open answers was added for new suggestions or reformulating symptoms that were difficult to understand.

The statistical analysis of the data generated from the experts' responses included a descriptive analysis of the sociodemographic variables and the calculation of item- and scale-level content validity indices (I-CVI and S-CVI, respectively). For each item, the I-CVI was calculated, defined as the proportion of experts who rated the content as valid (representativeness/clarity rating of 3 or 4) <sup>[19]</sup>. Items were rated as excellent when the I-CVI value was greater than 0.78 <sup>[20]</sup>. For full validation of the scale, all I-CVI values were averaged to calculate the S-CVI, for which a value above 0.90 was considered excellent <sup>[19]</sup>. The sociodemographic data were analyzed with SPSS for Windows version 23 (IBM, Armonk, NY, USA) and the I-CVI and S-CVI with Microsoft Office Excel, 2016 (Microsoft Corporation, Redmond, WA, USA).

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