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Exploring Traumatic Stress, Hope, Happiness, Resilience Among Palliative/Terminal Care & Neonate/Paediatric Care Nurses

Dushyant Kumawat, Samir Khan

Abstract: ***The present study was conducted to examine different psychological variables of female nurses working in Palliative and Neonatal care units across Government and Private hospitals in Delhi NCR, Karnataka, West Bengal, and Rajasthan states in India. The objective of the study to address significant gaps in the research by exploring the differences in experiences and psychological well-being amongst these healthcare professionals. The study compared the levels of traumatic stress, coping with grief, happiness, hope, and resilience between two groups of nurses, Palliative Care and Neonate Care. The results of the Independent-Samples Mann-Whitney U Test showed that there was no significant difference between the two groups in terms of their scores on any of the variables. Hope and resilience had a strong positive correlation with each other. However, most of the correlations were not statistically significant, indicating that there is no significant relationship between the dependent variables in this study. Overall, the results suggest that there is no significant difference between the perceptions of Palliative Care and Neonate Care nurses in terms of their coping with grief, hope, happiness, resilience, and traumatic stress, and there is no significant relationship between these variables. The findings of this study may provide crucial insights into the unique challenges that nurses working in specialized care settings face, including exposure to traumatic events and death and how their individual resources are allowing to deal with it. This knowledge can inform targeted interventions and support strategies to enhance their resilience and overall well-being. Ultimately, understanding the psychological well-being of these healthcare professionals is critical in ensuring they receive the necessary support and resources to cope with the demands of their job.***

Keywords: ***Hope, Coping with Grief, Resilience, Happiness, Palliative Nurses, Neonate Nurses, Traumatic Stress***

I. INTRODUCTION

A. Mental Health

Maintaining a state of mental well-being is a critical aspect of overall health and essential to realizing one's abilities, success in work and learning, and contribution to society. It is an integral component of general health and well-being that supports individual and collective decision-making, relationship building, and positive socio-economic development. As a fundamental human right, mental health is crucial to personal, community, and socio-economic development. (World, 2022) Mental health is a multifaceted construct that extends beyond the mere absence of mental disorders. It is a spectrum subjectively experienced by individuals, each with unique degrees of difficulty and distress and with varying clinical and social outcomes. Mental health conditions encompass a broad range of mental disorders, psychosocial disabilities, and other psychological states that cause significant distress, impair functioning, or pose a risk of self-harm. While individuals with mental health conditions are often at a greater risk for lower levels of mental well-being, it is important to recognize that this is not always the case. While the terms "poor mental health" and "mental illness" are often used interchangeably, it is essential to note that they are not synonymous. One can experience poor mental health without a formal diagnosis, whereas individuals with a mental illness may experience periods of physical, mental, and social wellness. Within the healthcare industry, nurses are critical in providing compassionate care and medical attention to patients in various settings, including hospitals, long-term care facilities, and medical practices. Palliative nurses, in particular, are certified healthcare professionals who specialize in offering specialized care to terminally ill patients. By exploring this branch of nursing, individuals can gain insight into their compatibility with this area of expertise (Felman, 2022) [4]

B. Palliative Care Nurse

Palliative care is widely regarded as a field where the provision of 'care' is of utmost importance (Bradshaw, 1996). The original philosophy of palliative care, as conceived by Cicely Saunders, underscored the integration of compassion and medical science. Palliative care demands that healthcare providers establish grounded relationships with dying patients and their families based on shared mutual understanding rather than a self-conscious use of psychosocial skills and techniques. In this way, palliative care is defined as a moral practice based on hope and acceptance, which offers individual patients a sense of freedom and space (Bradshaw, 1996). Palliative nurses may operate in a hospital or hospice centre or provide in-home care services for the patient. They are proficient in evaluating the physical, psychological, and spiritual needs of the patient and their family and provide Relief from pain and suffering through symptom management. Palliative

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*Correspondence Author(s)

Dushyant Kumawat*, Department of Psychology, School of Allied Healthcare and Science, Jain (Deemed-to-be-University), Bangalore (Karnataka), India. Email ID: maildushyantkumawat@gmail.com

Mr. Samir Khan, Department of Psychology, School of Allied Healthcare and Science, Jain (Deemed-to-be-University), Bangalore (Karnataka), India. Email ID: Samirkhan@jainunivertcity.ac.in

nurses also play a vital role in educating families on the dying process and extending support and comfort to them during this emotionally challenging time.

C. Works Of Palliative Care Nurses

The provision of palliative care nursing involves a comprehensive evaluation, disease diagnosis, and targeted management of the emotional and physical reactions of individuals to actual or potentially life-restricting illnesses. This necessitates a dynamic, compassionate interplay between the healthcare practitioner, patient, and family to curtail distress. As such, palliative nursing has emerged as a specialized field in the nursing profession that is perpetually advancing to encompass the amalgamation of scientific innovations and the artistry of nursing. (Bradley EH, Cherlin E, McCorkle R, Fried TR, Kasl SV, Cicchetti DV, et Al. Nurses' Use of Palliative Care Practices in the Acute Care Setting. J Prof Nurs. [PubMed] [Google Scholar] - (Google Search, 2018)

Palliative care nurses have many more duties while caring for terminal patients. Some typical responsibilities include (Google Scholar)

- Provide primary medical care: Nursing professionals are responsible for administering essential medical care, encompassing an array of duties such as monitoring and documenting vital signs, ensuring patient cleanliness and hygiene, offering support with daily activities such as dressing and nourishment, and communicating pertinent information to the designated primary care provider.
- Complete and file medical paperwork: Palliative care nurses collaborate with the patient's family members to ensure they receive regular updates about any patient's health status adjustments. These professionals also provide valuable insight to families regarding patient care, symptom management, and end-of-life procedures.
- Administer medication: It is the nurses' responsibility to administer specific drugs to patients by the directives of a physician. This crucial task necessitates extensive comprehension of the precise dosages and appropriate delivery methods, ranging from syringes to oral medication. Such knowledge is essential to ensure the safety and well-being of patients.
- Attempt pain relief: Palliative care nurses diligently oversee patients' pain levels approaching the end of their lives, persistently seeking out viable solutions to address their physical discomfort. This may include administering pharmaceuticals, implementing various therapies such as oxygen, and exploring non-conventional methods of relief, such as the soothing power of music or massage. Furthermore, they remain acutely aware of the significance of mitigating other distressing symptoms, such as nausea, anxiety, and the development of bed sores, to provide optimal end-of-life care.
- Counsel patients: Hospice nurses are instrumental in facilitating patients' emotional journeys towards the end of their lives while offering dedicated support without family members. These healthcare professionals provide invaluable psychological and spiritual resources to help patients navigate the complexities of bidding farewell.

D. Work Environment

Palliative care nurses are predominantly employed full-time within healthcare settings, such as hospice centres or hospitals. However, some nurses choose to provide direct care to terminally ill patients who opt to remain in their homes. This particular type of care can be physically demanding, requiring prolonged periods of standing or walking. The duration of full-time shifts can vary from eight to 12 hours, contingent upon the specific duties of the nurse and the setting in which they are employed.

Medical equipment, including blood pressure monitors, IVs, syringes, and pulse oximeters, are commonly utilized by palliative care nurses. These healthcare professionals take great care to adhere to safety protocols designed to mitigate biological hazards posed by bodily fluids. This includes the secure disposal of "sharps," such as syringes, which necessitate special handling to minimize the risk of injury. To safeguard against biological hazards and prevent the spread of illness, palliative care nurses wear personal protective equipment, including medical masks.

E. Neonate Nursing

The nursing profession encompasses several specializations, one of which is paediatric nursing. This area of expertise is focused on providing medical care for children from infancy to adolescence. The distinct nature of paediatric health is characterized by the rapid growth and development that occurs during childhood. Although not mandatory, obtaining certification as a paediatric nurse can significantly enhance one's professional qualifications and job prospects. Nurses who have a genuine passion for caring for children are strongly encouraged to pursue specialized knowledge and training in this field Datta, Parul (2007).

F. Works of Neonate Nurses

Paediatric nursing necessitates collaborative teamwork with diverse healthcare professionals to deliver optimal medical care to children. These nurses are instrumental in monitoring the health of young patients and providing continued care and support throughout the course of treatment.

Their responsibilities may include administering childhood vaccinations or immunizations, ensuring compliance with vaccination schedules, and communicating essential health information and treatment phases to children and their families.

Furthermore, they may contribute to the dissemination of children's health education to the public or other healthcare professionals, as well as participate in clinical research related to common paediatric health conditions and their appropriate therapeutic interventions.

Some paediatric nurses opt to specialize in specific areas of children's health, such as anaesthetics, oncology, or neurology, in pursuit of advanced knowledge and expertise.

The nursing profession is renowned for its rewarding nature, but it is also characterized by its significant emotional and physical demands. Nurses working in palliative care and neonate care units face unique challenges that can significantly affect their mental

well-being. (News-Medical, 2016). The aim of the study is to look for the factors that impact the psychological health of these nurses and provide possible solutions to alleviate these issues (Google Scholar, 2023) [1].

1. The Emotional Demands of Care Provision:

Palliative care nurses provide critical support to terminally ill patients and their families. Their role often entails managing the emotional distress and physical pain of those nearing the end of their lives.

2. Exposure to death and grief:

The psychological well-being of nurses can be adversely impacted by frequent exposure to death, loss, and grief. In the context of palliative care, nurses bear witness to the gradual decline and ultimate passing of their patients, while in neonate care, the loss of a fragile newborn can be a devastating experience. Such constant exposure to death can manifest in the form of compassion fatigue, burnout, and grief-related stress.

3. Shift work and long hours

Furthermore, nurses are often subject to long work hours and rotating shifts, which can disrupt their sleep patterns and intensify the fatigue associated with physically and mentally demanding tasks. The stress of handling emotionally taxing situations in palliative and neonate care settings can be exacerbated by this exhaustion.

4. Lack of resources and support

Moreover, nurses may face additional stressors stemming from a lack of resources and support. Inadequate staffing, insufficient equipment, and limited training can heighten the stress experienced by nurses. Furthermore, a lack of emotional support from supervisors, colleagues, and family members can complicate their psychological distress.

The year 2019 bore witness to the untimely demise of 6.2 million young ones under the age of five, of which 2.4 million were newborns, experiencing this fate on a global scale. The neonatal period poses the most significant threat of mortality for paediatric patients. (First 28 days after birth). The prevalence of elevated mortality rates poses a significant challenge for healthcare practitioners worldwide as they frequently encounter infants who are unlikely to be cured. Consequently, healthcare providers have shifted their focus towards enhancing the quality of life for both infants and their families, seeking to alleviate the burden of illness and promote well-being.

In recent years, the significance of palliative care for neonates has been gaining momentum and has become an essential component of modern neonatal nursing practice. The garnering of attention from caregivers and families of patients has been a notable occurrence. The progression of exploration and development has advanced significantly, particularly in prominent regions such as the United States, Canada, Australia, and Europe.

The notion of end-of-life care within neonatal intensive care units (NICUs) has gained the endorsement of the World Health Organization, which has further advocated for a bespoke care model that strives to mitigate pain and optimize the provision of optimal well-being for neonates as a critical aspect of healthcare. Palliative care for children entails the provision of comprehensive care that caters to the physical, emotional, and spiritual needs of infants while also offering support to their families. It is an active approach to care that prioritizes the comfort and dignity of neonates with complex medical needs.

The inability of neonates to convey their physical distress through verbal communication mandates the implementation of proficient care to alleviate their discomfort. The management of neonatal pain is fundamentally reliant on the significant contribution of nurses, who are equipped with both general and specific knowledge pertaining to the infants' health status under their care.

The comprehension of fundamental principles of neonatal palliative care, which prioritize the provision of ethical and humane care to facilitate a peaceful end-of-life experience, is not inherently complex. Nevertheless, healthcare providers encounter several impediments in the actual delivery of palliative care. Scholars have proposed that nurses' perspectives on neonatal palliative care may be influenced by attitudinal, educational, and institutional factors. Kain et al. (2009) undertook a comprehensive analysis of the barriers and facilitators associated with neonatal palliative care delivery in nursing. They developed, pilot-tested and administered the Neonatal Palliative Care Attitude Scale, an instrument designed to gauge the obstacles and enablers that would be utilized in subsequent investigations in this domain.

The year 2019 witnessed the unfortunate demise of as many as 6.2 million children, all under the age of 5, with a staggering 2.4 million of them being newborns, on a global scale. The neonatal period, which lasts for the first 28 days following birth, holds the maximum risk of mortality for these children. This alarming trend of high mortality rates has put healthcare providers around the world in a challenging position, where they come across a large number of critically ill infants for whom complete recovery may be unlikely. Therefore, healthcare providers are now increasingly emphasizing improving the quality of life for these young infants and their families.

In recent years, emphasis on integrating palliative care into contemporary neonatal nursing practice. This development has captured the attention of both healthcare providers and families of neonates. Notably, considerable exploration and advancement of palliative care has taken place in the United States, Canada, Australia, and Europe, reflecting the increasing importance of this aspect of neonatal care.

The World Health Organization espouses the notion of providing end-of-life care to neonates in neonatal intensive care units (NICUs) and has advocated a care model that prioritizes pain management and optimal quality of life for these vulnerable infants. This care model, known as palliative care for children, involves a comprehensive approach that encompasses neonates' physical, mental, and spiritual well-being, as well as providing critical support to their families.

In light of the language barriers faced by neonates in expressing their discomfort, the provision of specialized care becomes an integral measure of their relief. The management of neonatal pain is a crucial responsibility bestowed upon nurses, who hold a pivotal role in this regard, drawing upon their extensive knowledge of infantile conditions and personalized expertise catered to each individual under their watchful care. The maintenance of the

primacy of palliative care while providing ethical and compassionate support for a "good death" in neonatal patients is a fundamental principle of care. However, the actual provision of palliative care poses multiple challenges for healthcare providers. A study postulated that attitudinal, educational, and institutional factors may influence nurses' attitudes toward neonatal palliative care. To address this, Kain and colleagues 2009 developed and pilot-tested the Neonatal Palliative Care Attitude Scale, an instrument designed to measure the barriers and facilitators to neonatal palliative care delivery. This approach provides a comprehensive understanding of the factors that impact the provision of palliative care to neonates, which can be useful in future investigations in this field.

II. REVIEW OF LITERATURE

Reviews of previous studies related to the topic and establishes a relationship between the previous studies and present research. The factors affecting the psychological health of nurses in palliative care and neonate care.

A. Greif and Stress Among Palliative Care and Neonate Care Nurses

Recently, two studies have delved into the perceptions and experiences of healthcare professionals in nursing who work with patients approaching the end of life. With a focus on specialized hospital departments in Poland, Kostka et al. (2021) conducted a pilot study encompassing 160 nurses. The method employed was questionnaires, which aimed to evaluate the emotional reactions of the nurses to patient mortality, as well as their coping mechanisms. The results disclosed that nurses frequently experienced emotions such as compassion, sadness, and helplessness when faced with patient death, with over half reporting high levels of stress. Anxiety levels were found to be significantly higher among nurses in internal medicine compared to intensive care or emergency departments. In light of these findings, the authors emphasize the need for effective coping strategies to be implemented for nurses working in challenging end-of-life care situations.

In 2019, Temelli and Cerit delved into the perceptions of death and palliative care practices among 23 Turkish palliative care nurses through qualitative interviews. Their research brought to light three key themes concerning the perception of death, including the recognition of death as an inevitable and natural occurrence and the gradual desensitization of nurses with increased professional experience. Additionally, the authors identified three principal themes that were associated with palliative care practices, namely symptom management, effective communication, and spiritual care. These ground-breaking findings emphasize the paramountcy of comprehending the perspectives of nurses towards death and their approach to palliative care practices in order to facilitate optimal end-of-life care. The present literature review centres on the firsthand accounts of nurses who attend to neonates in neonatal intensive care units (NICUs), as well as their families, with a particular focus on end-of-life care and work-related stressors. This review encompasses three distinct studies, of which two adopt a qualitative approach, and one employs a mixed-methods methodology. In a recent research conducted by Favrod et al. (2018), an analysis of the mental health symptoms and work-related stressors of hospital midwives and NICU nurses in two Swiss university hospitals was carried out. The findings suggest that NICU nurses exhibit elevated levels of secondary traumatic stress and fewer symptoms of anxiety when compared to their hospital midwife counterparts. The identified work-related stressors were grouped into five themes, with nearly half, i.e., 46% of them, classified as traumatic stressors. Moreover, NICU nurses appear to experience more traumatic stressors in their working environment as compared to hospital midwives.

"In the study conducted by Almeida et al. (2016)," the experiences of nine nurses working in a neonatal intensive care unit (NICU) in São Paulo, Brazil, caring for dying newborns and their families were explored. The study revealed the emotionally challenging nature of caring for dying newborns and their families, prompting nurses to seek coping strategies. Furthermore, the study indicated that nurses expressed feelings of accomplishment before the newborn's passing.

Bloomer et al. (2015) conducted a study examining how nurses care for families before and after the death of a child/infant in pediatric and neonatal intensive care units in Australia. The study revealed that nurses experience discomfort and frustration when continuing to provide aggressive treatment to a dying child/infant while caring for the family. Delaying death to allow families to prepare is a common practice among nurses. However, there remains room for improvement in providing anticipatory guidance. In aggregate, overall investigations underscore the emotional hurdles confronting nursing personnel in the neonatal intensive care unit (NICU) context vis-à-vis neonatal patient care and familial involvement, especially during end-of-life scenarios. Furthermore, these inquiries reveal sources of occupational anxieties and highlight the necessity for adaptive coping mechanisms, such as cognitive restructuring techniques and opportunities for recuperation between recurrent work-induced traumatic stressors. These inquiries further advocate for enhancing the psychological well-being of healthcare professionals, which may serve to mitigate absenteeism and enhance patient care standards. The extant literature offers valuable insights into the experiences of healthcare professionals, particularly those serving in hospice and neonatal intensive care units (NICUs). These studies underscore the detrimental effects of stress, burnout, and compassion fatigue on the mental well-being of healthcare workers, as well as their capacity to deliver optimal patient care.

Whitebird et al. (2013) [11] conducted a cross-sectional survey of 547 hospice workers in Minnesota to explore the overall mental health of staff, including their levels of stress, burnout, and compassion fatigue, and the coping strategies they employ [12]. The results of the study revealed high levels of stress among hospice staff, with a considerable proportion of respondents reporting moderate to severe symptoms of depression, anxiety, compassion fatigue, and burnout. Staff members reported managing their stress through physical activity and social support, and they recommended more

opportunities for colleague interaction and exercise to mitigate the incidence of staff burnout.

In Braithwaite's (2008) investigation, the impact of nurse burnout and stress on neonatal intensive care units (NICUs) was examined. The study revealed that high levels of absenteeism, low morale, mental fatigue, and exhaustion could lead to adverse effects on neonatal care. Burnout, which is a response to workplace stress resulting in emotional and mental exhaustion, depersonalization, and decreased sense of personal accomplishment, can be prevented by ensuring job satisfaction, emotional support, and self-care. The study emphasizes the need for both individual nurses and administrative leaders to take necessary measures to prevent nurse burnout. Additionally, it highlights the importance of addressing issues related to low morale, increased absenteeism, and high-stress levels in the NICU. Yam et al. (2001) [2] undertook a pioneering examination of the experiences of ten registered nurses employed at a neonatal intensive care unit in Hong Kong [9]. The objective of the paper was to know their perceptions of palliative care, the challenges they encountered whilst providing care for dying infants, and the factors that influenced their approach to care. The findings indicated that the nurses experienced disbelief and feelings of ambivalence and helplessness while safeguarding their emotional well-being by delivering optimal physical care to the infants and emotional support to the parents. The literature review underscores the necessity for addressing the difficulties that healthcare providers confront in delivering quality patient care while coping with stress, exhaustion, and burnout. The studies suggest that various strategies such as physical exercise, social backing, job satisfaction, emotional support, and self-care could help prevent burnout, enhance the mental health and well-being of healthcare professionals, and ultimately increase the quality of care provided to patients.

B. Happiness, Well-Being & Hope among Neonate Care Nurses

Upon initial observation, neonatal intensive care units (NICUs) may not appear to be uplifting environments. In both North America and Western Europe, premature birth is currently the primary cause of permanent disability or fatality among infants (Baron & Rey-Casserly, 2010; Dani, Poggi, Romagnoli & Bertini, 2009; Greene, 2002; Hack, 2006) [6]. Although survival rates are gradually increasing, the likelihood of complications and disability remains elevated, particularly for infants with a very low gestational age. However, accurately predicting the probability of future morbidity and severity of disability poses a challenge (Ambalavanan et al., 2006; Bharti & Bharti, 2005; Johnson et al., 2009) [18]. The standards for assessing health-related quality of life (HRQoL) remain unclear and warrant further investigation (Mottram & Holt, 2010) [3].

Einarsdóttir J. conducted a study (2012) [5] on Happiness in the neonatal intensive care unit: merits of ethnographic fieldwork. A body of research has been dedicated to examining the deleterious impact of distress on professionals working in ethically complex wards, most notably neonatal intensive units (NICUs) [7]. This study aims to explore the experiences of health professionals, including nurses, paediatricians, and assistant nurses, working in such a ward in Iceland. To gain the insight into how health professionals, who operate under stressful conditions in an ethically sensitive environment, can mitigate the negative effects of their work to such an extent that they derive a sense of Happiness from it. This research was conducted through ethnographic fieldwork, utilizing participant observation and semi-structured interviews were their to collect the data. The participants evaluated their overall well-being based on conventional definitions of Happiness. Notably, the opportunity to work with children, the ability to help others, engage in social relations, and experience professional pride were cited as significant factors contributing to the participants' Happiness at work [10]. This study sheds light on the potential strategies health professionals can employ. However, the arduous encounters were not disregarded by the professionals. Instead, they approached these situations by engaging in meaningful negotiations that allowed for the exploration of various interpretations, goals, and priorities. The outcomes of this approach were in contrast to those of prevalent survey-based research, as these professionals assigned a positive significance to stress and advocated that favourable experiences served to counterbalance unfavourable ones. For the advancement of happiness research, a comprehensive approach that incorporates diverse methods and theories is essential. In this regard, ethnography, with its capacity to embrace unforeseeable, debatable, contradictory, and ambiguous aspects of human existence, can offer remarkable contributions to happiness research and investigations into job satisfaction.

C. Facilitators and Barriers Affecting Implementation of Neonatal & Palliative Care

In recent times, neonatal nursing practice has included the integration of palliative care for neonates as a vital component. Caregivers and families of patients have shown significant interest in this aspect, leading to its growing recognition. This has been particularly evident in the progress made in its exploration and development across the United States, Canada, Australia, and Europe.

Zhong, Y., Black, B. P., Kain, V. J., & Song, Y. (2022) [19] conducted a study on Facilitators and Barriers Affecting the Implementation of Neonatal Palliative Care by Nurses in Mainland China. Frontiers in paediatrics [20]. The delivery of palliative care to neonates remains a formidable challenge for neonatal nurses in mainland China [21]. As such, the objective of this inquiry was to investigate the factors that impede or enable neonatal nurses' disposition towards palliative care for neonates in mainland China. A survey was conducted utilizing a simplified Chinese version of the Neonatal Palliative Care Attitude Scale, which was administered, piloted, and analysed via survey methods [22]. Neonatal nurses from intensive care units across mainland China, irrespective of their experience in the field, were invited to participate [22]. Over the course of five months in 2019, they surveyed neonatal nurses from 40 hospitals in five provinces of China. The response rate was an impressive 92.5% (N = 550). This study identified eight facilitators and four barriers to neonatal palliative care implementation. A recent

investigation has delineated eight factors that act as facilitators and four that act as barriers to the successful implementation of neonatal palliative care. The eight facilitators are as follows: first and foremost, the support of neonatal palliative care in healthcare institutions; secondly, the provision of social support for families to participate in healthcare decisions; thirdly, the opportunity for individuals to express their opinions, values, and beliefs; fourthly, the endorsement of the significance of neonatal palliative care; fifthly, the recognition of pain relief as a central tenet of palliative care; sixthly, the inclusion of palliative care in neonatal education at universities; seventhly, the provision of specialized training in hospitals; and finally, the availability of professional counselling and the ability to discuss concerns with other healthcare professionals. Conversely, the four barriers to neonatal palliative care implementation include a lack of clinicians, time constraints, limited clinical skills, and a lack of systematic education. Furthermore, the findings revealed that younger and older nurses held positive attitudes towards providing palliative care, while middle-aged nurses were less enthusiastic. Neonatal palliative care, with a specific focus on pain management, was deemed equally significant as curative treatment by the participants of this study. Nurses proactively involved parents in decision-making and were found to have access to professional counselling and opportunities to discuss concerns with other healthcare professionals. However, the study identified unique challenges to the implementation of neonatal palliative care in mainland China, including a scarcity of clinicians, adequate time, clinical expertise, formal education, experience with neonatal palliative care, and social acceptance. Further research is recommended to address these barriers and improve the provision of neonatal palliative care in China. As we have established, neonatal nursing practice has included the integration of palliative care for neonates as a vital component; this study is an attempt to understand that the younger and older nurses demonstrated a favourable outlook towards administering palliative care, whereas their middle-aged counterparts displayed comparatively subdued responses.

Kilcullen and Ireland (2017) [16] conducted an investigation to discern the impediments and catalysts affecting the provision of palliative care in neonatal units from the perspective of neonatal nurses [17]. The study employed a qualitative research methodology, and personalized interviews were administered to eight neonatal nurses at the regional tertiary neonatal unit located in the Townsville Hospital in Australia. The data collected were analyzed through the thematic analysis technique within the phenomenological framework. The study revealed the significance of a strengths-based approach to identify and tackle barriers while simultaneously enhancing the facilitators to ultimately enhance the delivery of palliative care in a comprehensive manner.

III. RATIONALE OF THE STUDY

Nurses hold a pivotal role in the healthcare system, particularly in specialized units such as Palliative and Neonatal care where patients require specific attention and care. However, the nature of their work makes them susceptible to emotional and psychological stress, which can significantly impact their mental health and overall well-being. Research indicates that nurses working in these units are at higher risk of experiencing traumatic stress, burnout, and other mental health issues. As a result, it is crucial to investigate the variations in perceptions of traumatic stress, coping with grief, happiness, hope, and resilience among female nurses working in these units in India to identify possible interventions aimed at managing and reducing stress while promoting overall well-being.

The shortage of nurses in India highlights the need to prioritize the mental health and well-being of nursing staff in these units. According to a report from the World Health Organization (WHO), Due to the ageing population and rising demand for healthcare services, India is facing a 2.4 million nurse shortfall, which is anticipated to deteriorate in the future years.

Additionally, nurses in India encounter several challenges such as inadequate resources, long working hours, and poor working conditions, making them more susceptible to stress and burnout, which can negatively affect their job satisfaction and performance, ultimately compromising the quality of care provided to patients.

Comprehending how nurses perceive and cope with traumatic stress is critical in developing effective interventions aimed at promoting their mental health and overall well-being. Traumatic stress is a complex concept influenced by various factors such as personal traits, work environment, and individual coping strategies. Therefore, this study aims to investigate the differences in perceptions of traumatic stress, coping with grief, happiness, hope, and resilience among female nurses working in Palliative and Neonatal care units in India.

In addition, by identifying effective coping strategies, healthcare organizations can tailor interventions aimed at managing and reducing stress while promoting overall well-being. The results of this study can help healthcare organizations provide sufficient training and support to nursing staff, especially those working in high-stress units like Palliative and Neonatal care. This training can focus on developing coping skills, boosting resilience, and identifying and managing secondary traumatic stress symptoms. By doing so, organizations can equip their staff with necessary coping skills, enabling them to handle the emotional demands of their work and ultimately improving the quality of care provided to patients.

Moreover, the findings of this study can inform the development of culturally appropriate interventions aimed at promoting the mental health and well-being of nursing staff in India. Due to India's diverse cultural norms and beliefs, developing interventions that are sensitive to these cultural differences is crucial. Future research could investigate potential cultural variations in the experience of traumatic stress and coping strategies among nurses working in different regions of India.

IV. METHODOLOGY

A. Aim

i. Exploring Traumatic

Stress, Hope, Happiness, Resilience Among Palliative/Terminal Care & Neonate/Paediatric Care Nurses

B. Hypothesis

i. Null hypothesis

1. There is no significant difference between palliative care nurses and neonate care nurses in terms of their traumatic stress.
2. There is no significant difference between palliative care nurses and neonate care nurses in terms of their hope.
3. There is no significant difference between palliative care nurses and neonate care nurses in terms of their happiness.
4. There is no significant difference between palliative care nurses and neonate care nurses in terms of their coping with grief.
5. There is no significant difference between palliative care nurses and neonate care nurses in terms of their Resilience.
6. There is no significant correlation among Coping with grief, Resilience, Hope, Happiness, Traumatic stress.

C. Variables

i. Independent Variables

Type of nurses –

1. Palliative care
2. Neonate Care

ii. Dependent Variables

1. Coping with Grief
2. Happiness
3. Hope
4. Resilience
5. Traumatic Stress

D. Tool Description

Mental health assessment tools are essential for clinicians, researchers, and other healthcare professionals to evaluate individuals' psychological well-being accurately. The use of standardized and validated tools ensures consistency, objectivity, and reliability of mental health assessments. This paper will describe and evaluate five different assessment tools used in the field of psychology, including the Secondary Traumatic Stress Scale, the Oxford Happiness Questionnaire, the Connor Davidson + Brief Resilience Scales, the Adult Hope Scale, and the Coping Assessment for Bereavement and Loss Experiences.

1. Secondary Traumatic Stress Scale

The Secondary Traumatic Stress Scale (STSS) was developed by Bride et al. in 2004 to assess secondary traumatic stress (STS) symptoms in healthcare professionals. Secondary traumatic stress is a type of psychological distress that results from exposure to the traumatic experiences of others, such as patients, clients, or witnesses. The STSS is a self-report questionnaire consisting of 17 items, rated on a five-point scale, ranging from 0 (not at all) to 4 (very often). The items cover three domains: intrusion (e.g., "I had nightmares about work"), avoidance (e.g., "I tried to avoid being reminded of my work"), and arousal (e.g., "I felt jittery and easily startled").

The STSS has been found to have good psychometric properties, including high internal consistency (α = .87), test-retest reliability (r = .84), and convergent validity with other measures of STS and post-traumatic stress disorder (PTSD) symptoms (Bride et al., 2004) [13]. The STSS has been used in various healthcare settings [14], including hospitals, clinics, and community-based organizations, to assess STS symptoms in nurses, social workers, counsellors, and other healthcare professionals [15].

2. Oxford Happiness Questionnaire

The Oxford Happiness Questionnaire (OHQ) is a self-report questionnaire that assesses subjective well-being or happiness. The OHQ was developed by Hills and Argyle in 2002 and consists of 29 items, rated on a six-point scale, ranging from 1 (strongly disagree) to 6 (strongly agree). The items cover six domains: life satisfaction (e.g., "In most ways, my life is close to my ideal"), positive affect (e.g., "I felt happy"), negative affect (e.g., "I felt anxious"), self-esteem (e.g., "I feel I have a number of good qualities"), optimism (e.g., "I feel optimistic about the future"), and social support (e.g., "I have people I can rely on").

The OHQ has been found to have good psychometric properties, including high internal consistency (α = .91), test-retest reliability (r = .84), and convergent validity with other measures of subjective well-being (Hills & Argyle, 2002). The OHQ has been used in various populations, including university students, adults, and older adults, to assess their subjective well-being.

3. Connor Davidson + Brief Resilience Scales

The Connor Davidson + Brief Resilience Scales (CD-RISC) were developed by Connor and Davidson in 2003 to assess resilience in adults. Resilience refers to the ability to adapt and cope with stress, adversity, or trauma. The CD-RISC is a self-report questionnaire consisting of 25 items, rated on a five-point scale, ranging from 0 (not true at all) to 4 (true nearly all the time). The items cover five domains: personal competence (e.g., "I am able to handle unpleasant or painful feelings"), high standards (e.g., "I strive for excellence in everything I do"), trust in one's instincts (e., "I trust my ability to handle difficult situations"), spiritual fulfilment (e.g., "I have a sense of direction and purpose in my life"), and positive future orientation (e.g., "I am optimistic about my future"). Each item is rated on an 8-point scale from 1 (definitely false) to 8 (definitely true). The scores on this scale range from 8 to 64, with higher scores indicating higher levels of hope.

i. Reliability and Validity

The internal consistency of CD-RISC has been established as satisfactory to excellent with Cronbach's alpha values ranging from 0.87 to 0.93 for the original 25-item version. Additionally, test-retest reliability has been reported as satisfactory. In terms of validity, CD-RISC has demonstrated good convergent and discriminant validity in various populations. Positive correlations have been found with measures of well-being, social support, and

positive coping strategies, while negative correlations have been found with measures of depression, anxiety, and stress. Furthermore, the scale has been validated in diverse populations, including military personnel, college students, and clinical samples.

4. The Coping Assessment for Bereavement and Loss Experiences:

The Coping Assessment for Bereavement and Loss Experiences (CALE) is a self-report measure designed to assess coping strategies used by individuals who have experienced the death of a loved one. The CALE was developed by Hansson, Stroebe, and Schut in 2007 and consists of 41 items, which are rated on a 5-point scale ranging from 1 (not at all) to 5 (very much). The items cover various coping strategies, such as emotional expression (e.g., "I cry when I am alone"), seeking social support (e.g., "I talk to friends or family about my loss"), avoidance (e.g., "I try not to think about what happened"), and positive thinking (e.g., "I try to see the positive side of things").

ii. Reliability and Validity

The CABLE has demonstrated good internal consistency, with a Cronbach's alpha coefficient of 0.87. It has also shown good test-retest reliability, with a coefficient of 0.74. The CALE has good convergent and discriminant validity, as it correlates positively with measures of emotional expression, seeking social support, and positive thinking, and negatively with measures of avoidance and rumination.

5. Adult Hope Scale (Ahs) –

The Adult Hope Scale (AHS) is designed to assess Snyder's cognitive model of hope, whereby hope is defined as a positive motivational state that is grounded in a dynamic interplay between successful agency (goal-directed energy) and pathways (planning to meet goals) (Snyder, Irving, & Anderson, 1991, p. 287). The AHS comprises a total of 12 items, of which four items are designed to measure pathways thinking, four items are designed to measure agency thinking, and four items serve as fillers. Participants are required to rate each item on an 8-point scale, ranging from definitely false to definitely true, and the entire assessment can be completed in just a few minutes.

iii. Reliability & Validity

The reliability and validity of the Adult Hope Scale (AHS) have been assessed across various populations, demonstrating its efficacy as a measure of hope. In a recent study, the AHS was evaluated in a sample of newly admitted nursing home residents (n=65) with a range of cognitive functioning. Results indicate that the AHS displayed good reliability (alpha = .85) and remained robust even in the subset of the sample with cognitive impairment on testing (alpha = .89). Furthermore, concurrent and divergent validity measures aligned with expectations, providing support for the AHS's validity as a measure of hope in older adults, regardless of their cognitive functioning levels.

E. Research Design

This study employed an ex-post facto comparative research design. An ex-post facto comparative research design is a type of research design that involves the analysis of data that has already been collected and the comparison of groups or conditions that were not manipulated or controlled by the researcher. In this type of design, the researcher does not have control over the independent variables, which are predetermined by the conditions or groups being compared. The research is conducted after the events have already taken place, and the data is analysed retrospectively to identify relationships or differences between the groups or conditions being compared. The term "ex-post facto" means "after the fact" in Latin, indicating that the research is conducted after the events have already occurred.

F. Sampling

This study used a purposive and snowball sampling technique, and the sample consisted exclusively of female nurses from Palliative and Neonatal units from both Government and Private Sector Hospitals (N=18 and N=37, respectively). The data was collected through online questionnaires distributed across the different states of the country (Rajasthan , West Bengal, Delhi NCR, Karnataka) to ensure a diverse representation of the population under study. The inclusion criteria for the participants were Indian nationals, proficient in the Indian language, and above 18 years of age with expertise in palliative and neonatal care. Male nurses and respondents from departments other than Palliative and Neonatal care were excluded.

- Inclusion Criteria: Nurses should be from palliative or neonate care department. . Good comprehension of the English Language and a resident of India. Rural or urban background Nurses of any socio-economic or cultural backgrounds
- Exclusion Criteria: Nurses of the other departments. NRI and non-Indian Nationals.

G. Ethical Consideration

- Informed consent was taken before the participants were assessed.
- The participants were informed of their rights to withdraw from the study at any point of the time during the course of the study if they so wish to.
- The data and responses of each participant were treated with confidentiality as informed to the participants.
- The responses and data provided were strictly only for the purpose of the research study

H. Procedure

The present study aims to investigate the reliability and validity of five widely used psychological assessment tools, namely the Secondary Traumatic Stress Scale (STSS), Coping Assessment for Bereavement and Loss Experiences (CABLE), Oxford Happiness Questionnaire, Adult Hope Scale (AHS), and Connor Davidson + Brief Resilience Scales (CD-RISC-10).

The STSS is a 17-item self-report scale that measures secondary traumatic stress, which is the emotional distress that results from indirect exposure to traumatic events. The STSS was developed by Bride et al. in 2004, and its reliability and validity have been extensively tested in various populations. The scale has been found to have good internal consistency, test-retest reliability, and construct validity.

The CABLE is a 30-item self-report questionnaire that assesses coping strategies in the context of bereavement and loss. The CABLE was developed by Neimeyer et al. in 2002 and has been used in various studies to assess the effectiveness of different coping strategies in dealing with grief. The scale has good internal consistency and has been found to have good construct validity.

The Oxford Happiness Questionnaire is a 29-item self-report questionnaire that measures subjective happiness. The questionnaire was developed by Hills and Argyle in 2002 and has been widely used in various populations. The scale has good internal consistency, test-retest reliability, and construct validity.

The AHS is a 12-item self-report scale that measures hope in adults. The scale was developed by Snyder et al. in 1991 and has been widely used to assess the relationship between hope and various outcomes, such as mental health and well-being. The scale has good internal consistency and construct validity.

The CD-RISC-10 is a 10-item self-report scale that measures resilience. The scale was developed by Connor and Davidson in 2003 and has been widely used to assess resilience in various populations [8]. The scale has good internal consistency, test-retest reliability, and construct validity.

In this study, participants were recruited through online platforms and were asked to complete an online questionnaire that included the five psychological assessment tools. The collected data were analyzed using SPSS, and statistical tests were performed to investigate the hypothesis. The participants in this study were required to give their informed consent before taking part in the study. Informed consent is an important ethical principle in research that requires the researcher to obtain the participant's voluntary and informed agreement to participate in the study. It ensures that the participant understands the nature of the study, the potential risks and benefits, and their right to withdraw at any time.

V. RESULTS

Table 1 Presents the results of the Independent-Samples Mann-Whitney U Test conducted to compare the distribution of the variables of interest between two types of nurses, Palliative Care and Neonate Care. The test compares whether there is a significant difference between the two groups.

Table 1: Comparison of Traumatic Stress between Palliative & Neonate Care Nurses

Test	Sig.	Decision
Independent-Samples Mann-Whitney U Test	0.180	Retain the null hypothesis

For the variable STSSTOTAL, the p-value is 0.180, which is greater than the significance level of 0.05, indicating that there is no significant difference between the two groups of nurses in terms of their scores on the Secondary Traumatic Stress Scale. Therefore, the null hypothesis is retained.

Table 2: Comparison of Resilience between Palliative & Neonate Care Nurses

Test	Sig.	Decision
Independent-Samples Mann-Whitney U Test	0.820	Retain the null hypothesis

For the variables RISCTOTAL, the p-values are all greater than 0.05, indicating that there is no significant difference between the two groups of nurses in terms of their scores on the respective scales. Therefore, the null hypothesis is retained for all variables.

Table 3: Comparison of Hope between Palliative & Neonate Care Nurses

Test	Sig.	Decision
Independent-Samples Mann-Whitney U Test	0.820	Retain the null hypothesis

For the variable HOPETOTAL, the p-values are all greater than 0.05, indicating that there is no significant difference between the two groups of nurses in terms of their scores on the respective scales. Therefore, the null hypothesis is retained for all variables.

Table 4: Comparison of Happiness between Palliative & Neonate Care Nurses

Test	Sig.	Decision
Independent-Samples Mann-Whitney U Test	1.000	Retain the null hypothesis

For the variable HAPPINESS TOTAL, the p-values are all greater than 0.05, indicating that there is no significant difference between the two groups of nurses in terms of their scores on the respective scales. Therefore, the null hypothesis is retained for all variables.

Table 5: Comparison of Coping with Grief between Palliative & Neonate Care Nurses

Test	Sig.	Decision
Independent-Samples Mann-Whitney U Test	0.616	Retain the null hypothesis

For the variable COPINGTOTAL, the p-values are all greater than 0.05, indicating that there is no significant difference between the two groups of nurses in terms of their scores on the respective scales.

Therefore, the null hypothesis is retained for all variables. Overall, the results suggest that there is no significant difference between the perceptions of Palliative Care and Neonate Care nurses in terms of their coping with grief, hope, happiness, resilience, and traumatic stress.

Table 6: Intercorrelation of Dependent Variables

Spearman Rho	Traumatic Stress	Coping with Grief	Happiness	Hope	Resilience
Traumatic Stress		-0.087	0.022	0.414	0.412
		Sig. 0.732	Sig. 0.932	Sig. 0.088	Sig. 0.089
Coping with grief	-0.087		0.132	0.028	-0.055
	Sig. 0.732		Sig. 0.602	Sig. 0.912	Sig. 0.827
Happiness	0.022	0.132		0.456	0.422
	Sig. 0.932	Sig. 0.602		Sig. 0.057	Sig. 0.081
Hope	0.414	0.028	0.456		0.851**
	Sig. 0.088	Sig. 0.912	Sig. 0.057		Sig. 0.000
Resilience	0.412	-0.055	0.422	0.851**	
	Sig. 0.089	Sig. 0.827	Sig. 0.081	Sig. 0.000	

The values in the table represent the correlation coefficients between the pairs of variables, with the corresponding p-values in parentheses. A correlation coefficient ranges from -1 to 1, where -1 indicates a perfect negative correlation, 0 indicates no correlation, and 1 indicates a perfect positive correlation. The p-value indicates the significance level of the correlation coefficient. Looking at the table, we can see that Traumatic Stress has a weak negative correlation with Coping with grief and a weak positive correlation with Hope and Resilience. Coping with grief has a weak negative correlation with Happiness, while Happiness has a weak positive correlation with Hope. Hope and Resilience have a strong positive correlation with each other.

However, most of the p-values are greater than 0.05, which suggests that the correlations are not statistically significant. Therefore, we can conclude that there is no significant relationship between the dependent variables in this study.

VI. DISCUSSION

The study's findings provide valuable insights into the complex relationship between the dependent variables, which include Traumatic Stress, Coping with Grief, Happiness, Hope, and Resilience. The weak negative correlation between Traumatic Stress and Coping with Grief highlights the importance of providing adequate support and resources for nurses who experience high levels of stress and grief in their work. By addressing these challenges head-on, healthcare organizations can help their nurses better cope with the emotional toll of their work and reduce the risk of burnout.

At the same time, the positive correlations between Traumatic Stress and Hope and Resilience suggest that nurses who experience high levels of stress may also develop important strengths and coping mechanisms. These findings underscore the resilience and adaptability of healthcare professionals in the face of challenging circumstances. By recognizing and supporting these strengths, healthcare organizations can help their nurses not only survive but thrive in their demanding roles, ultimately improving patient outcomes and achieving better overall health outcomes for the communities they serve.

Secondly, Coping with Grief has a weak negative correlation with Happiness, suggesting that nurses who are more successful at coping with grief tend to be less happy. It is possible that coping with grief requires some degree of emotional detachment, which may reduce happiness. Thirdly, Happiness has a weak positive correlation with Hope, suggesting that nurses who are happier are also more likely to have hope. It is plausible that a positive mood may foster a more optimistic outlook, leading to greater hope. Finally, Hope and Resilience have a strong positive correlation with each other. This finding is consistent with previous research that suggests that hope and resilience are closely related constructs. People who have higher levels of hope are more likely to be resilient in the face of adversity.

The results of this study suggest that there is no significant relationship between the variables measured, as indicated by the majority of p-values being greater than 0.05. However, it is important to note that while statistical significance was not found, there may still be meaningful relationships between these variables that were not captured in this study. Future research could explore other potential factors that may influence these relationships.

Furthermore, the lack of significant differences between the coping strategies of Palliative Care and Neonate Care nurses highlights the importance of providing support and resources for all nurses facing similar challenges in their work. It is crucial for healthcare organizations to prioritize the mental and emotional well-being of their staff, as this can ultimately impact patient care. Further research could also examine the effectiveness of different coping strategies and interventions for nurses in high-stress environments. Overall, these findings contribute to the growing body of literature on nurse well-being and highlight the need for continued attention and resources in this area.

VII. CONCLUSION AND SUMMARY

A. Conclusion

The present study sought to explore the variations in perceptions of traumatic stress, coping with grief, happiness, hope, and resilience among female nurses employed in Palliative and Neonatal care units in India. The sampling technique utilized for selecting The study participants involved purposive and snowball methods, and data

was collected through online questionnaires. An ex-post facto comparative research design was employed, and statistical analysis was performed using SPSS.

The results indicated that there were no significant differences between the two groups of nurses in terms of coping with grief, hope, happiness, resilience, and traumatic stress, which is consistent with the null hypothesis. Thus, the study inferred that female nurses in both units encounter similar levels of traumatic stress and use comparable coping mechanisms. The intercorrelation analysis between the dependent variables indicated weak and insignificant correlations between them, suggesting that no significant relationship exists between traumatic stress, coping with grief, happiness, hope, and resilience among female nurses working in these units.

The study's findings have important implications for the healthcare sector, specifically in India, where there is a dearth of nurses, and the available ones work in strenuous and demanding settings. Therefore, interventions that aim to manage and alleviate stress and promote well-being can be implemented similarly in both units. The study suggests that promoting hope and resilience can be beneficial in helping nurses cope with stressful situations, irrespective of the unit they work in. However, the study's limitations include a small sample size, cross-sectional design, and exclusive focus on female nurses. Future studies should attempt to replicate the findings with a larger and more diverse sample of healthcare professionals working in the same units.

B. Summary

The study compared the levels of traumatic stress, coping with grief, happiness, hope, and resilience between two groups of nurses, Palliative Care and Neonate Care. The results of the Independent-Samples Mann-Whitney U Test showed that there was no significant difference between the two groups in terms of their scores on any of the scales. The intercorrelation analysis showed that there was a weak negative correlation between traumatic stress and coping with grief, and a weak positive correlation between traumatic stress and hope and resilience. There was also a weak negative correlation between coping with grief and happiness and a weak positive correlation between happiness and hope. Hope and resilience had a strong positive correlation with each other. However, most of the correlations were not statistically significant, indicating that there is no significant relationship between the dependent variables in this study. Overall, the results suggest that there is no significant difference between the perceptions of Palliative Care and Neonate Care nurses in terms of their coping with grief, hope, happiness, resilience, and traumatic stress, and there is no significant relationship between these variables.

C. Future Recommendations

The present study's findings suggest several recommendations for future research and healthcare organizations. Healthcare organizations should prioritize their nursing staff's training and support, particularly for those working in high-stress units like Palliative and Neonatal care. This training should focus on enhancing coping skills, resilience, and identifying and managing secondary traumatic stress symptoms. By doing so, organizations can improve the quality of care provided to patients by ensuring their staff is equipped with the necessary skills to cope with the emotional demands of their work.

Future research should explore the factors that contribute to secondary traumatic stress in nurses and investigate effective interventions to mitigate its effects. Longitudinal studies could be conducted to identify the long-term impact of secondary traumatic stress on the mental health and well-being of nursing staff and potential protective factors that could buffer against its effects. To enhance the generalizability of findings, future research should be conducted with a larger and more diverse sample of nursing staff, including participants from different regions of India and other countries to explore potential cultural differences in the experience of secondary traumatic stress and coping strategies.

Healthcare organizations should implement strategies to promote the mental health and well-being of their staff. This could include providing counseling services, mindfulness programs, and other wellness initiatives aimed at reducing stress and promoting resilience. By prioritizing their staff's mental health and well-being, healthcare organizations can create a supportive and positive work environment that ultimately benefits both patients and staff.

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DECLARATION STATEMENT

After aggregating input from all authors, I must verify the accuracy of the following information as the article's author.

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- **Funding Support:** This article has not been sponsored or funded by any organization or

agency. The independence of this research is a crucial factor in affirming its impartiality, as it has been conducted without any external sway.

- **Ethical Approval and Consent to Participate:** The data provided in this article is exempt from the requirement for ethical approval or participant consent.
- **Data Access Statement and Material Availability:** The adequate resources of this article are publicly accessible.
- **Authors Contributions:** The authorship of this article is contributed equally to all participating individuals.

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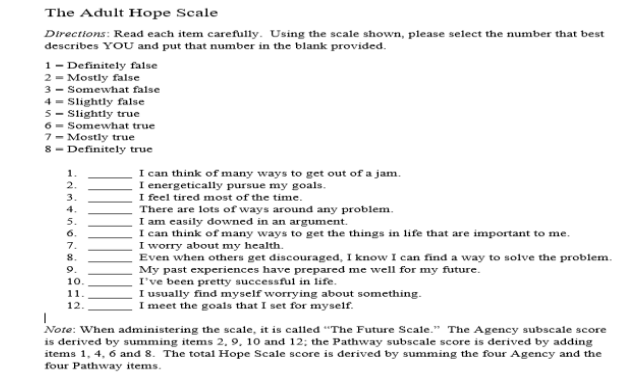
APPENDIX

The data was collected using the Adult hope scale, The Coping Assessment for Bereavement and Loss Experiences, The Connor-Davidson Resilience Scale-10, Oxford Happiness Questionnaire and Secondary traumatic stress scale.

The scale is as follows:



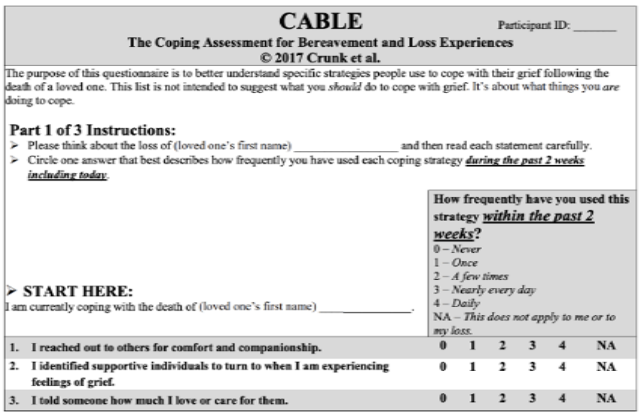
The Adult Hope Scale

Directions: Read each item carefully. Using the scale shown, please select the number that best describes YOU and put that number in the blank provided.

1 = Definitely false
2 = Mostly false
3 = Somewhat false
4 = Slightly false
5 = Slightly true
6 = Somewhat true
7 = Mostly true
8 = Definitely true

1. _____ I can think of many ways to get out of a jam.
2. _____ I energetically pursue my goals.
3. _____ I feel tired most of the time.
4. _____ There are lots of ways around any problem.
5. _____ I am easily downed in an argument.
6. _____ I can think of many ways to get the things in life that are important to me.
7. _____ I worry about my health.
8. _____ Even when others get discouraged, I know I can find a way to solve the problem.
9. _____ My past experiences have prepared me well for my future.
10. _____ I've been pretty successful in life.
11. _____ I usually find myself worrying about something.
12. _____ I meet the goals that I set for myself.

Note: When administering the scale, it is called "The Future Scale." The Agency subscale score is derived by summing items 2, 9, 10 and 12; the Pathway subscale score is derived by adding items 1, 4, 6 and 8. The total Hope Scale score is derived by summing the four Agency and the four Pathway items.



CABLE Participant ID: _____

The Coping Assessment for Bereavement and Loss Experiences
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The purpose of this questionnaire is to better understand specific strategies people use to cope with their grief following the death of a loved one. This list is not intended to suggest what you *should* do to cope with grief. It's about what things you *are* doing to cope.

Part 1 of 3 Instructions:

- Please think about the loss of (loved one's first name) _____ and then read each statement carefully.
- Circle one answer that best describes how frequently you have used each coping strategy ***during the past 2 weeks including today***.

START HERE:
I am currently coping with the death of (loved one's first name) _____.

	How frequently have you used this strategy ***within the past 2 weeks***? 0 – *Never* 1 – *Once* 2 – *A few times* 3 – *Nearly every day* 4 – *Daily* NA – *This does not apply to me or to my loss.*					
1. I reached out to others for comfort and companionship.	0	1	2	3	4	NA
2. I identified supportive individuals to turn to when I am experiencing feelings of grief.	0	1	2	3	4	NA
3. I told someone how much I love or care for them.	0	1	2	3	4	NA

➢ As you complete this questionnaire, please keep in mind that this list is not intended to suggest what you *should* be doing to cope with your grief, but rather to identify what you already do.	**How frequently have you used this strategy *within the past 2 weeks*?** 0 – *Never* 1 – *Once* 2 – *A few times* 3 – *Nearly every day* 4 – *Daily* NA – *This does not apply to me or to my loss.*					
4. I engaged in an act of kindness toward someone.	**0**	**1**	**2**	**3**	**4**	**NA**
5. I cared for or nurtured others.	**0**	**1**	**2**	**3**	**4**	**NA**
6. I turned to my spirituality or religion for comfort (for example, prayer or scripture reading).	**0**	**1**	**2**	**3**	**4**	**NA**
7. I attended a meeting or service related to my faith (for example, synagogue or church service).	**0**	**1**	**2**	**3**	**4**	**NA**
8. I sought help from organized bereavement support groups.	**0**	**1**	**2**	**3**	**4**	**NA**
9. I attended grief therapy sessions from a mental health professional.	**0**	**1**	**2**	**3**	**4**	**NA**
10. I read self-help books about the grieving process or coping with grief.	**0**	**1**	**2**	**3**	**4**	**NA**
11. I consulted professional resources (for example, internet websites) to help me cope.	**0**	**1**	**2**	**3**	**4**	**NA**
12. I visited websites that focus on the grieving process.	**0**	**1**	**2**	**3**	**4**	**NA**
13. I reminded myself of the things that I am thankful for.	**0**	**1**	**2**	**3**	**4**	**NA**

➢ As you complete this questionnaire, please keep in mind that this list is not intended to suggest what you *should* be doing to cope with your grief, but rather to identify what you already do.	**How frequently have you used this strategy *within the past 2 weeks*?** 0 – *Never* 1 – *Once* 2 – *A few times* 3 – *Nearly every day* 4 – *Daily* NA – *This does not apply to me or to my loss.*					
14. I talked to my loved one in my mind or out loud.	**0**	**1**	**2**	**3**	**4**	**NA**
15. I regularly set aside time by myself to express my grief and to remember my loved one.	**0**	**1**	**2**	**3**	**4**	**NA**
16. I focused on the things I am doing to get better, rather than on how bad things are.	**0**	**1**	**2**	**3**	**4**	**NA**
17. I reminded myself of my strengths.	**0**	**1**	**2**	**3**	**4**	**NA**
18. I posted reminders of how to cope during difficult times in visible locations to look at when I am struggling.	**0**	**1**	**2**	**3**	**4**	**NA**
19. I made notes of how well I am doing.	**0**	**1**	**2**	**3**	**4**	**NA**
20. I took steps to regain my sense of hope, such as creating goals for the future.	**0**	**1**	**2**	**3**	**4**	**NA**
21. I took some steps toward a "new me" by coming up with some new goals or plans for my life.	**0**	**1**	**2**	**3**	**4**	**NA**
22. I reviewed photos or videos of my loved one.	**0**	**1**	**2**	**3**	**4**	**NA**
23. I sought comfort in a keepsake or object that reminds me of my loved one.	**0**	**1**	**2**	**3**	**4**	**NA**

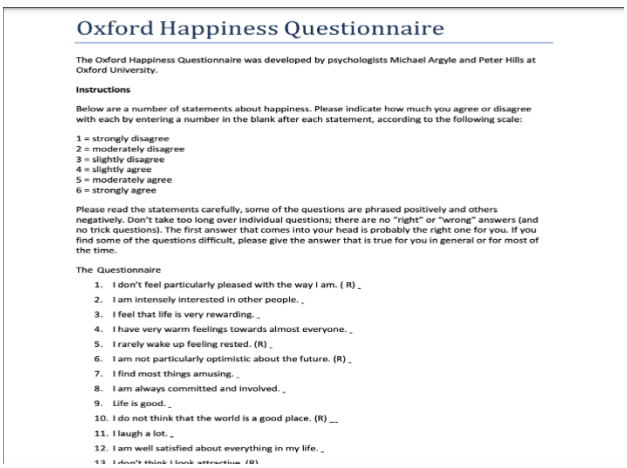
24. I turned to my spirituality in order to experience hopefulness or peace.	**0**	**1**	**2**	**3**	**4**	**NA**
25. I set aside time to talk with my Higher Power about my grief.	**0**	**1**	**2**	**3**	**4**	**NA**
26. I looked for companionship by exploring new friendships.	**0**	**1**	**2**	**3**	**4**	**NA**
27. I turned to others for positive feedback or praise.	**0**	**1**	**2**	**3**	**4**	**NA**
28. I did things or went places that once held special meaning for my loved one and me.	**0**	**1**	**2**	**3**	**4**	**NA**

CD-RISC-10

The 10-item scale is comprised of ten of the original 25 items from the CD-RISC-10 scale. A respondent's total score can range from 0-40.

The following represent items for the 10-item Connor-Davidson Resilience Scale – noting that the items listed here are *not a complete representation of the scale*:

1. I am able to adapt when changes occur.
2. I can deal with whatever comes my way.
3. I try to see the humorous side of things when I am faced with problems.
4. Having to cope with stress can make me stronger.
5. I tend to bounce back after illness, injury or other hardships.
6. I believe I can achieve my goals, even if there are obstacles.
7. Under pressure, I stay focused and think clearly.
8. I am not easily discouraged by failure.
9. I think of myself as a strong person when dealing with life's challenges and difficulties.
10. I am able to handle unpleasant or painful feelings like sadness, fear, and anger.



Oxford Happiness Questionnaire

The Oxford Happiness Questionnaire was developed by psychologists Michael Argyle and Peter Hills at Oxford University.

Instructions

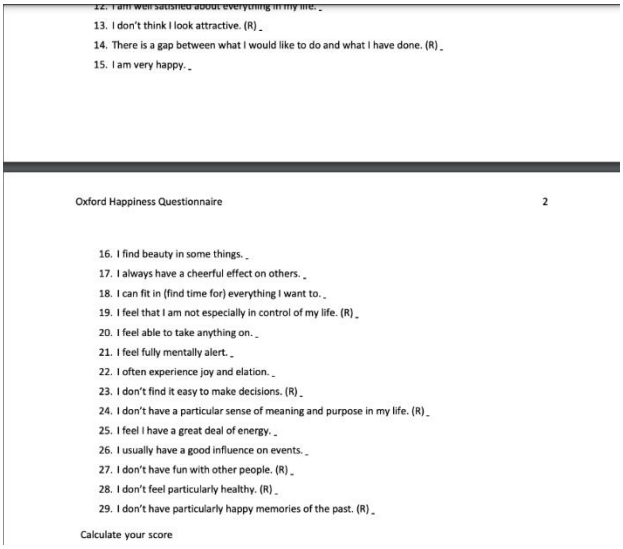
Below are a number of statements about happiness. Please indicate how much you agree or disagree with each by entering a number in the blank after each statement, according to the following scale:

1 = strongly disagree
2 = moderately disagree
3 = slightly disagree
4 = slightly agree
5 = moderately agree
6 = strongly agree

Please read the statements carefully, some of the questions are phrased positively and others negatively. Don't take too long over individual questions; there are no "right" or "wrong" answers (and no trick questions). The first answer that comes into your head is probably the right one for you. If you find some of the questions difficult, please give the answer that is true for you in general or for most of the time.

The Questionnaire

1. I don't feel particularly pleased with the way I am. (R) _
2. I am intensely interested in other people. _
3. I feel that life is very rewarding. _
4. I have very warm feelings towards almost everyone. _
5. I rarely wake up feeling rested. (R) _
6. I am not particularly optimistic about the future. (R) _
7. I find most things amusing. _
8. I am always committed and involved. _
9. Life is good. _
10. I do not think that the world is a good place. (R) __
11. I laugh a lot. _
12. I am well satisfied about everything in my life. _
13. I don't think I look attractive. (R) _

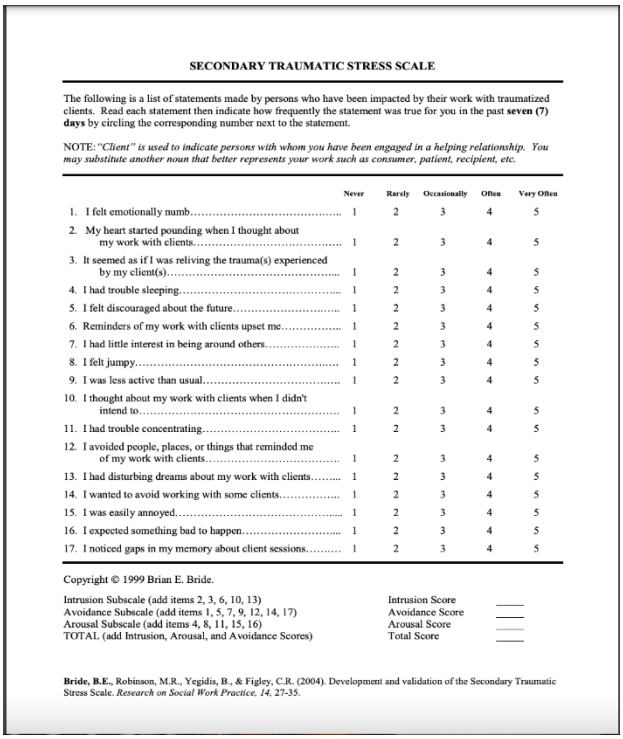


12. I am well satisfied about everything in my life. _
13. I don't think I look attractive. (R) _
14. There is a gap between what I would like to do and what I have done. (R) _
15. I am very happy. _

Oxford Happiness Questionnaire 2

16. I find beauty in some things. _
17. I always have a cheerful effect on others. _
18. I can fit in (find time for) everything I want to. _
19. I feel that I am not especially in control of my life. (R) _
20. I feel able to take anything on. _
21. I feel fully mentally alert. _
22. I often experience joy and elation. _
23. I don't find it easy to make decisions. (R) _
24. I don't have a particular sense of meaning and purpose in my life. (R) _
25. I feel I have a great deal of energy. _
26. I usually have a good influence on events. _
27. I don't have fun with other people. (R) _
28. I don't feel particularly healthy. (R) _
29. I don't have particularly happy memories of the past. (R) _

Calculate your score



SECONDARY TRAUMATIC STRESS SCALE

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past **seven (7) days** by circling the corresponding number next to the statement.

NOTE: *"Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.*

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s)	1	2	3	4	5
4. I had trouble sleeping	1	2	3	4	5
5. I felt discouraged about the future	1	2	3	4	5
6. Reminders of my work with clients upset me	1	2	3	4	5
7. I had little interest in being around others	1	2	3	4	5
8. I felt jumpy	1	2	3	4	5
9. I was less active than usual	1	2	3	4	5
10. I thought about my work with clients when I didn't intend to	1	2	3	4	5
11. I had trouble concentrating	1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with clients	1	2	3	4	5
13. I had disturbing dreams about my work with clients	1	2	3	4	5
14. I wanted to avoid working with some clients	1	2	3	4	5
15. I was easily annoyed	1	2	3	4	5
16. I expected something bad to happen	1	2	3	4	5
17. I noticed gaps in my memory about client sessions	1	2	3	4	5

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Intrusion Subscale (add items 2, 3, 6, 10, 13)	Intrusion Score ____
Avoidance Subscale (add items 1, 5, 7, 9, 12, 14, 17)	Avoidance Score ____
Arousal Subscale (add items 4, 8, 11, 15, 16)	Arousal Score ____
TOTAL (add Intrusion, Arousal, and Avoidance Scores)	Total Score ____

Bride, B.E., Robinson, M.R., Yegidis, B., & Figley, C.R. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice, 14,* 27-35.