



Review Article

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Application of Caring Theory to Psychological Distress in the COVID-19 Crisis

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This paper will discuss Jean Watson's caring theory, caritas process® number one in relation to psychological distress experienced by intensive care unit nurses in the care of patients with Novel Coronavirus, or COVID-19, and those under suspicion for the illness. Two case scenarios are provided, one of a patient with COVID-19 and his interventions during the crisis compared to a patient under suspicion for COVID-19, undergoing multiple procedures to intervene for his diagnosis. The first aspect of the caritas process®, loving-kindness, is discussed as an overview and represents as a sign of self-care. Loving-kindness is applied in the two patient cases and examples are given to overcome psychological distress.

Clinical Nursing Situations during the COVID-19 Crisis

After working through most of my first year as a COVID-19 ICU nurse, an overwhelming fear of the patients' survival surfaces often. At the beginning of every shift, I and most nurses on the units check the patients' charts to see if the patients are negative for SARS-CoV-2. When the charts say "positive" or "pending," a quiver of anxiety runs through me, but I hope for the best for the patient and the team members. During the crisis, I took care of multiple patients, some for several weeks. I came into work for my 12½ hour shift, donned my personal protective equipment (PPE) of a surgical hat, a reused N95 mask, a face shield, and a contact gown, and stepped into the ICU, hoping for the relatively young patients to survive. Back home, I reflected on my day's work and tried to distract myself by praying for a solution. I then woke up in the middle of my night from nightmares recalling the traumatic events of the day. Like many of the other nurses caring for COVID-19 patients, it is possible I was experiencing psychological distress.

Psychological distress is prevalent in the intensive care units. In the recent COVID-19 crisis, psychological distress has been an overwhelming problem due to the repeated admissions, codes, and deaths. Morely, et al. [1] describe psychological distress as an umbrella term for negative emotions of frustration, anger, guilt, regret, powerlessness, and feelings associated with depression and anxiety. The stress of this emotional and physical depletion impacts nurses. I experienced death anxiety, fear of contamination and spread to my family, social isolation, and frustrations over the lack of

supplies and public compliance [2]. A mild situation involved a patient who will be referred to as Ben, a 40-year-old, chocolate factory worker, who came in with severe hemoptysis, and history of sarcoidosis and asthma. He was swabbed for COVID-19, but the results would not have been back until 8 a.m. the next morning. He was admitted into the Medical ICU for immediate bronchoscopy and intubation. A father, a husband, a son, and a business owner, Ben always helped others out before himself, according to his mother. He walked into the Emergency Room, coughing up to a liter of blood, and we needed to find the source.

Using this as our motivation, the medical ICU team, which included me, and the anesthesiologist, prepared the patient to be placed in our hands. The anesthesiologist successfully administered anesthetic medications, and placed the endotracheal tube (ETT), the attending used the bronchoscope to find the source of the bleed in the patient's lungs, and my role was to manage the medications and document. I hoped for the best patient outcome, while hoping for the COVID-19 test to be negative. After the patient was sedated and intubated, the team wanted him to be paralyzed, to relax the workload of his lungs and prevent hemoptysis. Ben was fortunate to be COVID negative, unlike John, a 56-year-old male, who I took care of for several weeks during the crisis. John had a history of obesity, hypertension, hyperlipidemia, atrial fibrillation, and diabetes. The COVID-19 interventions for John were highly intense in contrast to Ben's of management of drip medications and train-of-four tests to monitor adequate paralyzation. John had a central line for vesicant medications, an endotracheal tube for many weeks which required him to have a tracheostomy, tube feeds by OG tube, intermittent low wall suction when the tube feeds were not tolerable, and frequent ABGs, and he was placed him in prone position every six hours, and monitored for hemodynamic instability

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continuously. He was on multiple sedative medications at the highest dosage, but was still able to shake his head vigorously. When the resident lowered his FiO_2 on the ventilator and decreased his sedative dosage, he would immediately start to desaturate. They would then tell me to increase feeds and flushes, not understanding that he was aspirating. During the crisis, I felt powerless and in distress, working outside of hospital policy and our scope of practice to implement the providers' orders. I personally advocated for my patients and told certain residents that John could not tolerate these interventions. During the peak, the dearth of support and providers, often times I had to do what was right for my patients to make them feel comfortable, and evidently to keep them alive. Compassion and determination are essential parts of being a nurse; however, extensive stress hinders our self-care and balance in life.

Caring Theory and Caritas Process® One

Jean Watson's caring theory is a philosophical foundation to the discipline of nursing. Caring theory is the perspective that caring for humanity is undivided [3]. Watson's theory of human caring begins with love, and this is how we are connected to all mankind [3]. Watson's caring theory encompasses three components, the caritas process®, the transpersonal caring relationship, and the caring moment/occasion. The caritas processes® or carative factors were created as a guide for nursing in comparison to medicine's curative factors [4]. There are ten caritas processes®: Loving-kindness, faith-hope, transpersonal, relationship, forgive, creative self, learning, caritas field, humanity, and infinity [5].

According to the loving-kindness aspect of the process, nurses are to center themselves in self-care in order to be altruistic towards others [5]. This aspect of the process was important to me in the care of patients during the COVID-19 pandemic. Watson explains caritas process® one as cultivating a spirit of loving-kindness, and equanimity which is a state of mental composure, within ourselves and others to function as our initial conscious care act [3]. Nurses should take care of their spirits and be kind towards themselves. When we practice self-love, it translates as inspiration for all we do. Once a nurse is able to stimulate loving kindness, their hearts are overjoyed with compassion and this spreads to their life experiences [6]. Young (2006) emphasizes that the first caritas would not work if loving kindness is used as a façade to conceal one's feelings of frustration, hurt, anger, worry, and despair [6]. The nurse must be able to navigate through this pain, and allow it to be released and absorbed by the space of energy. Once these feelings are dispersed and carried by the flow, a deeper true charity or caritas radiates within oneself to others [6].

Application of Caritas Process® One to the Clinical Nursing Situations

Psychological distress during the COVID-19 crisis is arduous; loving-kindness, the first caritas process®, teaches one to release these negative emotions into the flow of energy. In Ben's case, who was emergently admitted as a person under suspicion for COVID-19, the team was fearful of this droplet

and contact spread virus because he kept coughing up blood. He also needed a bronchoscopy and to be ventilated via the endotracheal tube, which can contribute to the potential spread of COVID-19. I expressed altruistic characteristics by gathering all the information about Ben, including his workplace and how it could contribute to Sarcoidosis, collecting supplies and medications for the procedures, and preparing the room for a warm welcome.

I was able to apply self-love, by talking about my fears of the unknown to my coworkers. They were able to actively listen to my concerns and helped me get resources to complete my task. Once I was able to see the patient, I was at peace and felt calm. I built a transpersonal relationship and became grounded in the care for my patient Ben, by centering myself and listening to his concerns. The face-paced moments of interactions with Ben prior to the procedure instilled confidence within me to reassure Ben. We discussed what to expect with the procedure and after-care, and I assured him that I would keep in contact with his wife.

John's COVID-19 case was complex, and my interactions with the ICU team involved in his care were frustrating. I came into my shifts knowing that I would be paired with John for several weeks. I held conversations with him because hearing is the last system to leave and sedated patients can still hear us. Although verbal communication was not possible, our energies were in sync. I care for John with compassion but, we both needed equanimity. When I completed my daily assessments, I could tell he was miserable. His head was shaking and he sweating and crying at times, unable to do much. Shaking one's head while being highly sedated and connected to a ventilator is not comfortable. I titrated up on his medications and increased his oxygenation. I heard a gurgling sound around his breathing tube and held his tube feeds. To prevent aspiration due to copious secretions, I connected him to low wall suction. Time was essential to us but was fleeting during the peak of the crisis. Staffing was low, and we had to take more shifts to cover the shortage. Communication as a team was extremely limited because of the overwhelming number of COVID-19 cases. Nevertheless, I advocated and took action when necessary to care for my patients. However, joy and gratitude were not felt spiritually by John and me.

Costello [7] provided examples of self-care for nursing students inspired by Watson's first caritas. Costello's student subjects reported a decrease in stress, after implementing yoga, writing in a journal, praying, mediating, listening to music, and writing or reading poetry. Therefore, to practice self-care, I need to take time for the things that bring me happiness. As a child, I liked to draw and paint and create things for my family. Even as an adult, I crochet, and craft art pieces but I need to do this more often. To produce a more balanced life, I am learning to express love through my creative outlets. In times of stress during nursing school, I documented about my days in a journal. The process of writing became therapeutic to me, and I was able to reflect on my feelings and memories. I hope to rely on these tools of self-care in times of distress.

Conclusion

I learned that Watson's caring theory and the caritas pro-

cess® emphasizes self-care to alleviate psychological distress. The loving-kindness caritas is imperative for nurses to practice in order to care for themselves and to share that with their patients. Throughout this process of learning about Watson's caring theory, I have been able to reflect on the two different cases of Ben and John. I have learned that placing a veil over our emotions is not beneficial for our equilibrium. It is important for nurses to learn to allow time to release this energy and love themselves in order to deliver and share a unifying caring experience.

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