

Grief and Loss Among Veterans With Spinal Cord Injury: A Qualitative Study

Lisa Burkhart^{1,2}, PhD, RN, ANEF, Ibuola O. Kale¹, MPH & Sherri L. LaVela^{1,3}, PhD, MPH, MBA

Abstract

Purpose: The objective of this study was to understand veteran perspectives of grief/loss associated with their spinal cord injury (SCI).

Design/Methods: Qualitative descriptive design using semistructured interviews with veterans with SCI ($n = 15$) was performed using interview questions informed by the literature. Analysis was conducted using a deductive/inductive approach.

Results: The 15 participants' mean age was 64 years; six had paraplegia, eight had tetraplegia, one had unknown level of injury, six were ambulatory, and nine were not ambulatory. The grief/loss experience was individual and constant, consisting of seven phases: experiencing shock, releasing emotion, withdrawing, focusing on losses, problem solving, realizing strength and motivation, and accepting a new life. Veteran coping strategies used in each phase of the grief experience were also identified, as well as triggers that increased or decreased the grief/loss experience.

Conclusions/Clinical Relevance: A better understanding of veterans living with SCI grief experience, coping strategies, and triggering events can help healthcare providers support veterans with SCI.

Keywords: Grief; loss; spinal cord injury; veteran; coping.

Spinal cord injury (SCI) is a permanent condition that can be caused by nontraumatic etiology or a traumatic incident that can occur anywhere along the spine, leading to complete or incomplete paraplegia or tetraplegia. According to the World Health Organization, 250,000–500,000 individuals experience an SCI each year. The Veterans Health Administration (VA) cares for 26% of the SCI population in the United States (National Spinal Cord Injury Statistical Center, 2015). Persons with SCI experience loss from several sources, including altered or complete loss of sensation, impaired mobility, neurogenic bowel and bladder dysfunction, sexual dysfunction, and/or chronic pain (Martinez et al., 2016; Masri & Keller, 2012). Subsequent grieving from losses because of SCI is associated with depression (Bombardier et al., 2016), lower satisfaction with life

(LaVela et al., 2019), pain interference (Etingen et al., 2018), and decreased participation in social roles (Locatelli et al., 2017).

Grief/loss theories have guided practice and provide a structure to conceptualize grief/loss that are grounded in different philosophies (Supiano, 2019). Although current literature and textbooks have moved away from the Kubler-Ross Stages Model of Death and Dying (Kubler-Ross, 1969), many providers frequently apply the universal constructs of shock/denial, anger, bargaining, depression, and acceptance to address the grief/loss experience when caring for individuals living with SCI (Bracken & Shepard, 1980; Corr, 2020; Maciejewski et al., 2007). Newer theories and research have supported postpositive multitrajectory theories of grief/loss experience (Bonanno et al., 2012; Klyce et al., 2015). Multitrajectories follow patterns. For example, chronic distress impairs normal functioning for over a year, delayed reactions affect normal functioning for about a year, recovery trajectory begins with a severe effect on normal functioning and resolves after a year, and resilience trajectory has a mild effect at the traumatic event and resolves after a year (Bonanno, 2004; Bonanno et al., 2011). Current grief/loss theoretical approaches and research differentiates depression and grief as discrete constructs, with grief being a normal process post loss and depression as a pathological progression requiring diverse mental health interventions (Bombardier et al., 2016). Stroebe and Schut (1999)

Correspondence: Lisa Burkhart, Center of Innovation for Complex Chronic Healthcare, Building 1-C219B, Edward Hines Jr. VA Hospital, 5000 5th Avenue, Hines, IL 60141. E-mail: Elizabeth.burkhart@va.gov

¹ Center of Innovation for Complex Chronic Healthcare, Edward Hines Jr. VA Hospital, Hines, IL, USA

² Marcella Niehoff School of Nursing, Loyola University Chicago, Chicago, IL, USA

³ Department of Physical Medicine and Rehabilitation, Feinberg School of Medicine, Northwestern University, Chicago, IL, USA

Copyright © 2020 Association of Rehabilitation Nurses.

Cite this article as:

Burkhart, L., Kale, I. O., & LaVela, S. L. (2021). Grief and loss among veterans with spinal cord injury: A qualitative study. *Rehabilitation Nursing*, 46(5), 270–278. doi: 10.1097/rnj.0000000000000303

present a cognitive stress coping theory that describes grieving as a dual process, oscillating between loss-oriented and restoration-oriented perspectives. Many grieve using effective coping strategies, without psychopathology, indicating the importance of such mechanisms to facilitate patient coping (Pollard & Kennedy, 2007). Jackson and Hough (2005) described various patterns of adjustment postinjury, identifying limited, moderate, and complicated grief behaviors contingent on medical, psychological, social, and environmental factors that affect recovery and adaptation. Meaning reconstruction theory (Neimeyer, 2019) provides a constructivist approach in grief work to find meaning in the loss. Clifton's (2014) autoethnography supports the complexity of grief loss in that grieving trajectories differ from a linear-stages model and depression symptoms through resiliency toward posttraumatic growth, well-being, and meaning making.

Individuals living with SCI face considerable psychological stressors (Craig et al., 2015). Furthermore, veterans with SCI may have additional stressors and posttraumatic stress disorder because of military experiences and combat that can exacerbate and intensify the grief experience (Kaplow et al., 2013). This may affect how they face grieving because of their injury and may lead to using distinctive coping strategies. To date, no research has explored veteran perspectives of grieving because of losses associated with incurring and living with SCI. Therefore, the objective of this study was to understand veteran perspectives of grief/loss associated with their SCI.

Methods

A qualitative descriptive design (Sandelowski, 2010; Sandelowski & Leeman, 2012) using semistructured interviews was used to reveal experiences of grief and loss because of SCI as perceived by veterans with SCI ($n = 15$). This study was approved by the local VA Institutional Review Board and Research and Development Committee to ensure the protection of human rights, and participants provided verbal consent. Participants were recruited from October 2017 to January 2018 using convenience sampling by posting flyers in an SCI clinic and mailing invitation letters to randomly selected veterans with International Classification of Diseases-Ninth Revision, Clinical Modification (ICD-9-CM) SCI diagnoses who received care at the midwestern SCI facility. Inclusion criterion was being a veteran with an SCI (across injury types, levels, duration). Exclusion criterion was having a preexisting relationship with the researchers. The primary author, with expertise in patient interviewing and qualitative methodology, conducted the interviews face-to-face in a private office or by

telephone, each lasting about an hour. Field notes were documented during and after interviews. Interview questions were informed by the literature associated with grief/loss and reviewed by the authors (Table 1). Interviews were audiotaped, transcribed verbatim, and verified for accuracy. Data were analyzed beginning with a deductive approach using content analysis; however, the data revealed a process of the grief experience that required inductive analysis (Saldana, 2016). Rigor was addressed in terms of credibility in that the interview questions revealed the grief experience in the participants' stories and reflected the social reality of the participants. Dependability and confirmability were supported by maintaining an audit trail for the categories using a codebook, coding rules, and NVivo (QSR International, Version 12 NVivo, 2018, Doncaster, Victoria, Australia) that aligned the categories with the data. Analysis was conducted by two experienced qualitative researchers individually using content analysis to establish initial codes documented in a codebook and then collectively using a deductive-inductive approach to refine the seven categories describing the grief/loss experience and the 11 coping strategies from the veteran's perspective. A third experienced qualitative researcher reviewed categories for conceptual congruity and refinement. Data were analyzed using constant comparison methods until saturation was reached, which occurred at 14 participants. Transferability was supported by an expert panel of currently practicing interprofessional SCI providers and veterans with SCI by reviewing and agreeing that the categories apply to their practice or lives, respectively. Key categories were identified and are presented along with illustrative quotes. Participant identification is listed by number in parentheses after each quote.

Results

The 15 participants were male, and average age was 64 years (range: 33–82 years); six had paraplegia, eight had tetraplegia, and one did not know the level of injury. Six

Table 1 Qualitative Interview Questions Used in Veteran Interviews

1. Tell me your story of the SCI injury.
2. How would you describe grief/loss associated with SCI?
3. Describe when grief was better or worse for you.
4. What factors increase your feelings of grief/loss associated with SCI?
5. What factors decrease your feelings of grief/loss associated with SCI?
6. What do you do to cope with grief/loss associated with your SCI?
7. What else ideally could help you cope with grief/loss associated with SCI?

Note. SCI = spinal cord injury.

were ambulatory (Table 2). No participants refused or withdrew from the study.

Participants with SCI openly discussed their experiences with grief because of their SCI as constant and individualized with highs and lows that followed a nonlinear pattern of seven categorical phases. Veterans engaged in coping strategies throughout the grief experience, identifying several that were particularly useful during specific grief phases. Contextual factors were identified that may increase or decrease feelings of grief because of SCI.

Veteran Grief/Loss Experience: Phases and Coping Strategies

Participants agreed that the grief experience associated with SCI was individualized and constant with highs and lows: “This is our life now. So, we are dealing with that grief every day. It does not go away” (#14). There were “peaks and valleys. I’m either at the top of the hill or I’m down in the valley” (#6). The grief experience changes over time. It was “worst at the beginning because everything I did was a struggle” (#4). Although grief is constant, it is experienced in different ways that follow a nonlinear process of peaks and valleys. Participants expressed phases of experiences, which are described below.

Experiencing Shock

Participants described their initial response to incurring an SCI as shock: “It hits you like a hammer” (#6). “It was very traumatic” (#2). “Because it was sudden onset...there was no foreshadowing...you are fine one minute and then the next you are not. So, deer in the headlights” (#13). It was “kind of surreal...one day I was walking and the next day I wasn’t” (#8). Participants agreed that the initial response to the SCI was shock of an immediate change.

Releasing Emotion

Participants described “a mixture of emotions that erupt without rhyme or reason anytime” (#14). This included

anger: “I was angry the majority of the time” (#5) and “I was pissed off at the world” (#15). They described feeling “just sadness” (#7) and “My emotion will get me. I cry...Why am I like this? You know, why does this kind of thing happen?” (#11). Veteran participants also expressed fear, “a lot of fear involved, unknown kind of stuff” (#3), particularly from the point of view of others: “I was mostly scared and nervous and just did not want people to look at me weird or just I did not want to go out and just being embarrassed by the way I looked, being in a chair” (#15). Participants agreed that they experienced various emotions, most commonly anger.

Coping strategy: Anger as a motivator

Participants used anger as a motivator to work harder: “I really pushed myself a lot because of that and I think the anger helped...doing the therapy, getting better” (#3) and “Do the best you can, and you do the best you can. That’s all you have to do” (#1). Challenging the emotion toward working hard motivated participants to engage in their recovery and face grief.

Coping strategy: Talk to chosen individuals

Participants also recognized the need to talk to people who could help with their emotions: “I’m feeling bad I just call for them [providers]...all I got to do is talk to them. You know, I do not have no problems” (#1). “I have some conversations with my [provider], when I come for depression. I will discuss some parts of it but not all” (#10). “I think you have to have...somebody that you can open, open up to. And, you know, maybe it’s your spouse, girlfriend, boyfriend. Maybe it’s your psychiatrist, maybe it’s your clergy, family” (#13). Participants cope by reaching out to healthcare professionals or trusted friends/family to talk.

Withdrawing

Participants described another phase of grieving as a need to both physically and emotionally withdraw. They described maintaining physical distance from others by “staying in my room” (#4, #5) or “staying at home” (#13). Emotionally, they were “locked up in [my]self” (#4) and “you are just slumped down and everything and you are not really doing nothing or thinking about nothing” (#7), “I did not want to do anything” (#15). Some described suicidal thoughts: “I was hoping that I would not wake up in the morning” (#4), “I thought of suicide constantly” (#5), and “I was praying to die at night” (#7). Participants experienced a need to withdraw from others and life.

Coping strategy: Reflection

Withdrawing can be a time for reflection. Participants found there were times when they needed to be physically

Table 2 Sample Characteristics (N = 15)

Sample Characteristic	n	Percent
Degree of injury		
Tetraplegia	8	57
Paraplegia	6	43
Ambulatory	6	40
Not ambulatory	9	60
Gender		
Male	15	100
Female	0	0
	n	Mean (Range)
Age	15	62 (33–82)
Time since injury	15	21 years (27 days to 37 years)

alone to rest and reflect. “You just kind of retreat. You back yourself off until you know that you are in the right state of mind to reemerge as a positive person” (#6). “I said this one weekend I do not want anybody here. I said I just want to deal with it. So just let me” (#14). Withdrawing allows the patient the space and time to reflect.

Coping strategy: Hold emotions in

Holding emotions in may occur while withdrawing. Participants described times when they needed to hold emotions in: “I kept to myself, I kept most of it all to myself” (#7). Participants described being stoic and not sharing their emotions: “I usually just blow it off. Say nothing, you know, it’s all right...I do not open up a lot...I do not wear it on my sleeve” (#3). “I’m more apt to withhold my actual physical feelings from others” (#12). “I’m a pretty good emotion hider...I’m not one of those people who wears their heart on their sleeve” (#13). Most participants described holding emotions in as a coping strategy.

Coping strategy: Get out

Participants also described a need to get out to overcome the withdrawal phase of their grief. “The best thing to do is get out and about and do exercises and talk to a lot of people” (#11). “I like to just get out and even if it’s just riding around; I look at the trees, the cars, the people” (#14). “My body just got in the [wheel]chair and I’m like, I felt free as bird. I went flying. I took off probably about lunch time, and I do not think I came back until about 12 o’clock that evening” (#5). Most participants described engaging in adaptive sports. Participants recognized that there was a time to move past withdrawing by getting out into the world.

Focus on Losses

Participants described focusing on losses during low points: “I used to always cry about what I could not do” (#10). This included losses related to mobility: “loss of my legs, the feeling” (#7). Participants also described losses associated with independence and self-care, particularly bowel and bladder control: “It’s very hard, hard to accept the reality of being dependent upon somebody else” (#6) and “you go from being totally independent to being totally dependent. And that’s part of the grieving of that emotion...I want to sleep in but my attendant’s going to be here. I just want to sleep in tonight, I got to do my bowel program” (#14). Losses also related to family and friend relationships, including being with a lover, “I feel empty...I’m not able to be a man, and to me, I’m not able to make contact with my wife anymore because I’m not [physically] working” (#10); playing with children, “To not go out and be able to sit up, stay out, a

birthday party for one of the grandkids and then participate in it” (#9); and participating in social events with friends, “the guys used to go hunting...you know you cannot do that anymore either” (#7). Participants also expressed career losses: “Miss my job, miss what I was doing. So, I grieve my career loss” (#8). Focusing on losses and inabilities were low points in the grieving process.

Coping strategy: Feel no pity

When participants focused on losses or were reminded of losses, they would not allow themselves to feel pity: “I do not feel sorry for myself. You know it happened; it was an accident” (#2). “You start pitying yourself and you cannot do that...because you’ll go downhill with that too” (#7). “I’m not going to let this put me through a lot of grief. I’m going to try and, you know, get away from that, you know. And not feel sorry for myself because feeling sorry for yourself is just going to make you more miserable” (#11). Participants described not feeling pity helped them cope with grief.

Coping strategy: Do not allow others to express pity

Similarly, participants would not allow their friends or family to express pity: “I do not want nobody to feel, nobody to feel sorry for me” (#1). “I did not want to be pitied in anyway. So that was it. I just left that behind” (#7). “I did not want people to feel sorry or pity party” (#15). Akin to not feeling self-pity, participants did not endorse pity from others.

Coping strategy: Do not think about it

Several participants described ignoring the losses and/or redirecting thoughts as a coping mechanism: “I do not think about how my loss...if you think about loss you cannot adjust” (#1). “I do not spend a lot of time in that area [grief/loss space]...I try to stay away from those areas as much as possible” (#3). “I do not know if I do cope with it. I try to, I try to ignore it” (#12). “Kind of try and forget the stuff a lot” (#14). Most participants believed that thinking about grief and loss associated with SCI was something to avoid.

Problem Solving

Participants experienced a phase of questioning and problem-solving: “Is this the way I’m going to be the rest of my life, you know? Sitting in this chair and, you know, well it is but, you know, doing nothing?” (#4). “I have no job and what can I do? And so those are really hard questions that you have to wrap your head around” (#13). Participants described a moment of decision-making about one’s future: “I think I needed that at that moment, at that time, to make up my mind. Am I going to let this take me down or am I going to move on? And I decided to move on” (#8). Part of the grieving phase includes a

time of contemplating one's future and problem solving toward living as an individual with SCI.

Coping strategy: Learn about the injury and opportunities

Participants described wanting to learn about the injury to help cope: "I would say normal [grieving] is talking about your injury, researching your injury...asking people questions that you are not sure of.... Just getting to know your limitations and, you know, what you can and what you cannot do and what is" (#2). "While I try to take a positive attitude toward that and learn a different style of playing to minimize the effect of the spinal cord injury" (#12). Participants agreed that they sought out information while problem solving.

Realizing Strength and Motivation

At a point in the grief process, many participants made a conscious decision to direct their focus toward strength and motivation to maximize independence: "I did not know how strong I was until I got hurt...I had to realize that I had to be strong if I did not want to end up in a nursing home. So, I had to be strong for myself. I had to learn how to do things all myself" (#1). There was a motivation to change destructive behavior: "The drinking wasn't doing anything for me. So, I stopped, I think I felt better with myself at that time" (#12). "It dawned on me that I had to live this life in the manner which I was, and so I did" (#5). This phase was a time of gaining strength and motivation to use positive coping mechanisms to reduce feelings of grief.

Coping strategy: Focus on the future

Participants described plans for the future. This included educational goals: "go[ing] to school...I had to learn all this stuff if I wanted to be independent" (#7), "taking those courses" (#13), and "go[ing] to college. To dare to go out beyond my door, my house and into the world" (#5), as well as going to work: "you still go to work and maybe you are not 100% but I was, you know, going back to work helped me a lot mentally" (#2). Others described "I've got a bucket list" (#4), "I used to be a musician...one of my goals is to eventually play out again" (#3), or "being around them [kids and grandkids] gives me that goal to push on" (#14). Participants expressed that creating future plans helped them cope.

Accepting New Life

Participants described reaching a place of acceptance and beginning a new life as an individual with SCI. "I realized that my 100% is not what the 100% was before. And accepting that, I think, helped a lot" (#3) and "I realized life does not end because you are traumatized. If anything, it's a new life. A new beginning" (#5). As part of this process, there was a recognition of a new beginning:

"No, it's not over. It's just the beginning. A different beginning, but a beginning. So, some people, once you accept it, one of the best things you can ever do" (#11). Several participants described feeling lucky at this new beginning: "I realized how lucky because I got used to adjusting [because the injury happened when he was younger]" (#1) and "I get to live life over again. I get to restart it and live, I get to live life over" (#15). This phase of the grief experience was described as accepting a new life and was transformative toward a new beginning.

Coping strategy: Volunteer

Participants described wanting to share this experience with others as part of their own growth process. Some participants volunteered through peer counseling: "I talk to some of the veterans in the hospital...peer counseling" (#1); "I did a lot of volunteer work...and that gave me the, encouraged me to realize what life was all about" (#11); and "I've been helping other people with disabilities, other veterans, other groups, I've been on all kinds of committees, councils, advisory. So, helping others kind of gives me a help because I can, I know what they are going through" (#14). "I begin to laugh, have joy. I thought more making people happy than I did myself. I felt if I brought joy to them, it's the best thing possible that I could do. And, also mentally made me alive, much more alive. To the point that I became a peer counselor" (#5). Volunteering not only helped others, but the act of reciprocity helped the veteran accept their new life.

Contextual Factors That Increase or Decrease Grief

Throughout this process, participants described factors that increased or decreased feelings of grief that contributed to the ups and downs of the grief experience.

Factors That Increase Grief

Participants described events or barriers that increased grief. Several factors reminded them of losses associated with the SCI.

Environmental/accessibility barriers

Participants described public access barriers that limited their ability to perform basic care: "You are out and you have to use the bathroom. You cannot get to the bathroom, the bathroom's too small. Bathroom's not accessible" (#2). Participants also described barriers to participating in social events: "There was times you were not invited because they were going out to eat somewhere but see, it has steps and everything. A lot of steps and they cannot carry you up all those steps" (#7) and "I got brothers and sisters-in-laws. They live in apartment that has second and third stories. They do not have elevators. I cannot get to them because I cannot get there. Because I

cannot climb that many stairs. Can you imagine how that feels?” (#9). Losses (e.g., continence, mobility) may be direct consequences of environmental barriers, which may cause or trigger a grief experience.

Life events as reminders of losses

Participants described times when they experienced events that reminded them of loss and triggered a grief experience. These memories included sports/outdoor activities: “When people are going places or doing things that I used to be able to do, like I used to love to go out to the woods, climbing. They have adaptive chairs now, track chairs or something, but it’s not the same. You’re still in a chair or you cannot do it at all. That’s kind of when it rears its ugly head” (#14). Memories also related to experiences with loved ones: “Walking down the street with my girlfriend...and trying to hold hands while walking. You know, that’s, first you get pissed off about I wish I could do that, or I wish I could do this. But you cannot” (#15). Experiences also related to family roles: “there were times when I used to go to the window, just look out at the grounds and I see a playground below me. And I’d be looking, and my sister just had children... playing on the playground and everything. And I kept thinking to myself, gee, I’m not going to be able to do that my, her kids, you know. You know, the uncle, I will not be able to play around, run around with them” (#7). Events can trigger focusing on losses.

Worsening health

Participants described health changes causing more losses, which triggered the grief experience: “things have progressively deteriorated both my physical well-being... it has started to have a negative impact on me emotionally, mentally” (#12). These changes could be due to aging or physical complications “when you have a condition that exacerbates it or brings that emotion to the top then it spotlights the part that you cannot do more...I want to go out but my shoulders are hurting...I do not get the exercise I should or the cardio which that leads to more health problems. So, it’s like the grief, you know, they go hand in hand so to speak” (#14). Complications can lead to hospitalization, which limits independence and triggers a grief experience: “he was supposed to go to a family reunion out of state, and he did not have, he got this sore, they would not let him go. And he was so bad, he was really depressed. Didn’t talk to nobody” (4). Worsening health attributes can lead to additional losses, which triggers the grief experience.

Factors That Decreased Grief

Participants described contextual factors that decreased the grief they experience.

Having a social network

Participants consistently described a network of family and friends that provided a supportive environment that facilitated dealing with grief: “I’ve had a pretty [good] support network that’s around me. And I think that, when you are going through that phase and there’s a certain, this level of uncertainty, that’s really, really critical to have” (#13) and “family who are very supportive and very helpful. I think that’s, that’s about the best thing that helps” (#12). “Sometimes I have friends come over, we play cards. You know, sometimes I go over to their houses and maybe we play cards, or we play dominos” (#9). These individuals create a positive atmosphere: “I been surrounded by nothing but positive people. I’ve just been, I do not know. I just do not like being around negative people” (#2). Friends provide “companionship and the camaraderie” (#7) and opportunities to enjoy activities “with friends, we go play bags or horseshoes...with friends, it’s nice and loose. And we are playing, competing, but not cutthroat competing kind of stuff” (#3). The existence of a social network of family and friends helps to decrease the grief experience.

Accomplishments

Participants described experiences of accomplishments, particularly in physical and occupational therapy sessions, as gratifying and helpful to experience less grief because of the injury. “I can move around the gym...maybe I will walk again...I feel better. Accomplished something” (#4). “There’s a certain part that’s also somewhat gratifying but simple things, for example, just taking my leg and moving it out straight and bending it back...you use kind of a motivational crutch when you can see little bits and pieces of progress” (#13). “I just think about the stuff I did, the stuff I did, or the stuff I do now that people will look at me and be like, holy cow, you are in a chair and you can do this or stuff that gives me a good feeling” (#15). Accomplishments provide a sense of feeling good and are helpful factors to decrease feelings of grief.

Discussion

Participants described seven phases of grief post-SCI, as well as coping strategies used during the grieving process as nonlinear and individual. Several of the phases are consistent with the stages model of death and dying (Bracken & Shepard, 1980; Kubler-Ross, 1969; Maciejewski et al., 2007), including experiencing shock, releasing emotions (anger), withdrawing, and accepting new life. However, the stages model is related to bereavement and the ability to overcome a loss because of death. Loss associated with SCI differs from bereavement, in that SCI is an ever-present reminder, particularly when confronted with

environmental barriers, worsening health, and common life milestones, including marriage, parenting, and career building. The phases described in this study were not universal stages that ended in a resolution. Participants viewed grief as something to continually cope with while avoiding the factors that trigger grief experiences and integrating factors that decrease feelings of grief. This continual experience of highs and lows is consistent with multitrajectory and stress coping theories describing oscillating experiences affected by coping strategies (Clifton, 2014; Jackson & Hough, 2005; Stroebe & Schut, 1999).

Although the literature differentiates grief from depression (Bombardier et al., 2016; Bonanno et al., 2012; Klyce et al., 2015), veterans consistently described feeling depressed as “a low point” or “the bad place” when experiencing grief. Participants did not describe depression as a medical diagnosis because their frame of reference was life experience and not a medical model. Veterans often avoided talking about grief and emphasized moving beyond the injury, coping with low points and moving toward positive coping and building a new life.

Nurses are in a unique position of journeying alongside patients during acute care, rehabilitation, and return to the community. Noting patient behavior, environmental context, social interactions, and conversations provide valuable insights as to what grief phase the veteran is experiencing. For example, early postinjury, individuals with SCI may express experiencing *shock*, *releasing emotion*, *withdrawing*, and *focusing on losses* phases. Nurses can foster healthy coping by avoiding pity, respecting time for reflection, providing information, supporting conversations with important people, allowing the patient to go outside or another area, inspiring hope, and translating negative emotions productively toward therapy. It is also important to recognize the moments when suicidal ideation requires mental health expertise and collaboration with the interprofessional team for a mental health referral. Results also indicate that experiencing an SCI can be transformative, consistent with meaning reconstruction theory (Neimeyer, 2019), exemplified as *problem solving*, *realizing strength and motivation*, and *accepting their new life*. Several participants cited nurses as key individuals who helped them feel whole again by encouraging participation in community and adaptive sports activities and finding meaning in volunteering, employment, or hobbies.

Some participants described life experiences that further complicated their own injury-related grief process, such as chronic pain or the death of a loved one. This phenomenon is consistent with the work of Jackson and Hough's (2005) describing how grieving behaviors are affected by medical factors, in this case, chronic pain, and

psychological and social factors, in this case, loss of a family member. Therefore, it is important for nurses to holistically assess for and recognize the effect of pain and family dynamics on grief/loss. Variations in veteran experiences because of positive and negative contextual factors support individualized trajectories and subsequent care in how grief integrates into the ebb and flow of life.

Results revealed grieving phases and coping strategies common to veterans with SCI. Veterans with SCI have unique life experiences because of experiencing military culture and combat that promote problem solving, stoicism, camaraderie, and peer mentoring when coping with adverse conditions (Burkhart & Hogan, 2015; Chemtob et al., 2018). These were expressed in phases and coping strategies related to *problem solving*, *avoiding pity behaviors*, *holding emotions in*, *learning about the injury*, and *volunteering*.

Limitations

All participants were male, which limits insight to only men with SCI. Women with SCI may experience grief differently, use different coping strategies, and identify different grief triggers. In addition, the interviews were conducted with veterans from one VA facility, and the findings may represent beliefs only of the veteran sample from one mid-western locale, although the sample mimics the demographics of the larger cohort of veterans with SCI (mostly men, half with tetraplegia and half paraplegia). Additional research is needed to determine the generalizability of these results, including race/ethnicity data, which we did not collect in the current study. Also, more research is needed to determine how factors (e.g., chronic pain and bereavement) affect grief associated with SCI.

Conclusion

Rehabilitation nurses embrace holistic care within an interprofessional team (Association of Rehabilitation Nurses, 2014). Results from this study provide evidence to integrate grief/loss care for veterans living with SCI. Nurses also advocate at the individual, family, community, and population levels (American Nurses Association, 2015). Results support interventions that reduce grief/loss triggers, including providing anticipatory guidance and education, supporting family involvement, and advocating for environmental access. This study can help nurses, the interprofessional team, and veterans with SCI better understand the grief/loss process associated with the injury so that providers and veterans can better anticipate the experience and facilitate healthy coping toward a more meaningful, positive life.

Key Practice Points

- Nurses need to assess for grief/loss phases associated with SCI to better understand patient emotional responses and to provide holistic nursing care.
- Nurses need to assess whether patients are veterans so they can support healthy coping strategies unique to veteran experiences.
- Nurses need to assess for contextual factors that can trigger grief/loss or support healthy coping.

Conflict of Interest

The authors declare no conflicts of interest.

Funding

This work was supported by the Paralyzed Veterans of America Education Foundation, Grant #821 Developing a Curriculum on Grief/Loss Due to SCI for Health Providers (PI: Sherri L. LaVela).

References

- American Nurses Association. (2015). *Nursing: Scope and standards of practice*. Author.
- Association of Rehabilitation Nurses. (2014). *Standards and scope of rehabilitation nursing practice* (6th ed.). Author.
- Bombardier, C. H., Adams, L. M., Fann, J. R., & Hoffman, J. M. (2016). Depression trajectories during the first year after spinal cord injury. *Archives of Physical Medicine and Rehabilitation*, 97, 196–203. 10.1016/j.apmr.2015.10.083
- Bonanno, G. A. (2004). Loss, trauma and human resilience: Have we underestimated the human compacity to thrive after extremely adverse events? *American Psychologist*, 59(1), 20–28. 10.1037/0003-066X.59.1.20
- Bonanno, G. A., Galatzer-Levy, I. R., Kennedy, P., Lude, P., & Elfstrom, M. L. (2012). Trajectories of resilience, depression, and anxiety following spinal cord injury. *Rehabilitation Psychology*, 57(3), 236–247.
- Bonanno, G. A., Westfall, M., & Mancini, A. D. (2011). Resilience to loss and potential trauma. *Annual Review of Clinical Psychology*, 7, 511–535. 10.1146/annurev-clinpsy-032210-104526
- Bracken, M. B., & Shepard, M. J. (1980). Coping and adaptation following acute spinal cord injury: A theoretical analysis. *Paraplegia*, 18, 74–85.
- Burkhart, L., & Hogan, N. (2015). Being a female veteran: A grounded theory of coping with transitions. *Social Work in Mental Health*, 13(2), 108–127.
- Chemtob, K., Caron, J. G., Fortier, M. S., Latimer-Cheung, A. E., Zelaya, W., & Sweet, S. N. (2018). Exploring the peer mentorship experiences of adults with spinal cord injury. *Rehabilitation Psychology*, 63(4), 542–552. 10.1037/rep0000228
- Clifton, S. (2014). Grieving my broken body: An autoethnographic account of spinal cord injury as an experience of grief. *Disability and Rehabilitation*, 36(21), 1823–1829. 10.3109/09638288.2013.872202
- Corr, C. A. (2020). Elisabeth Kübler-Ross and the “five stages” model in a sampling of recent American textbooks. *Omega (Westport)*, 82(2), 294–322. 10.1177/0030222818809766
- Craig, A., Perry, K. N., Guest, R., Tran, Y., Dezarnaulds, A., Hales, A., Ephraums, C., & Middleton, J. (2015). Prospective study of the occurrence of psychological disorders and comorbidities after spinal cord injury. *Archives of Physical Medicine and Rehabilitation*, 96(8), 1426–1434.
- Etingen, B., Miskevics, S., & LaVela, S. L. (2018). The relationship between pain interference and psychosocial well-being among veterans with spinal cord injuries/disorders. *The Journal of Neuroscience Nursing*, 50(1), 48–55. 10.1097/JNN.0000000000000341
- Jackson, S. A., & Hough, S. (2005). Adjustment to the process of grief following a spinal cord injury/dysfunction. *SCI Nursing*, 22(1), 15–19.
- Kaplow, J. B., Layne, C. M., Saltzman, W. R., Cozza, S. J., & Pynoos, R. S. (2013). Using multidimensional grief theory to explore the effects of deployment, reintegration, and death on military youth and families. *Clinical Child and Family Psychology Review*, 16(3), 322–340. 10.1007/s10567-013-0143-1
- Klyce, D. W., Bombardier, C. H., Davis, T. J., Hartoonian, N., Hoffman, J. M., Fann, J. R., & Kalpakjian, C. Z. (2015). Distinguishing grief from depression during acute recovery from spinal cord injury. *Archives of Physical Medicine and Rehabilitation*, 96, 1419–1425.
- Kubler-Ross, E. (1969). *On death and dying: What the dying have to teach doctors, nurses, clergy and their own families*. McMillan.
- LaVela, S. L., Etingen, B., Miskevics, S., & Heinemann, A. W. (2019). What determines low satisfaction with life in individuals with spinal cord injury? *The Journal of Spinal Cord Medicine*, 42(2), 236–244. 10.1080/10790268.2018.1466480
- Locatelli, S. M., Etingen, B., Miskevics, S., & LaVela, S. L. (2017). Effect of the environment on participation in spinal cord injuries/disorders: The mediating impact of resilience, grief, and self-efficacy. *Rehabilitation Psychology*, 62(3), 334–344. 10.1037/rep0000153
- Maciejewski, P. K., Zhang, B., Block, S. D., & Prigerson, H. G. (2007). An empirical examination of the stage theory of grief. *JAMA*, 297, 716–723.
- Martinez, L., Neshatian, L., & Khavari, R. (2016). Neurogenic bowel dysfunction in patients with neurogenic bladder. *Current Bladder Dysfunction Reports*, 11(4), 334–340. 10.1007/s11884-016-0390-3
- Masri, R., & Keller, A. (2012). Chronic pain following spinal cord injury. *Advances in Experimental Medicine and Biology*, 760, 74–88.
- National Spinal Cord Injury Statistical Center. (2015). *Facts and figures at a glance*. University of Alabama at Birmingham.
- Neimeyer, R. A. (2019). Meaning reconstruction in bereavement: Development of a research program. *Death Studies*, 43(2), 79–91. 10.1080/07481187.2018.1456620
- Pollard, C., & Kennedy, P. (2007). A longitudinal analysis of emotional impact, coping strategies and post-traumatic psychological growth following spinal cord injury: A 10-year review. *British Journal of Health Psychology*, 12, 347–362. 10.1348/135910707X197046
- Saldana, J. (2016). *The coding manual for qualitative researchers*. Sage.
- Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing and Health*, 33(1), 77–84. 10.1002/nur.20362
- Sandelowski, M., & Leeman, J. (2012). Writing usable qualitative health research findings. *Qualitative Health Research*, 22(10), 1404–1413. 10.1177/1049732312450368
- Stroebe, M., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies*, 23(3), 197–224.
- Supiano, K. P. (2019). The role of theory in understanding grief. *Death Studies*, 43(2), 75–78. 10.1080/07481187.2018.1456678

For more than 128 additional continuing professional development articles related to Psychosocial/Psychiatric topics, go to www.NursingCenter.com/ce.

**TEST INSTRUCTIONS**

- Read the article. The test for this nursing continuing professional development (NCPD) activity is to be taken online at www.nursingcenter.com/CE/RNJ. Tests can no longer be mailed or faxed.
- You'll need to create an account (it's free!) and log in to access My Planner before taking online tests. Your planner will keep track of all your Lippincott Professional Development online NCPD activities for you.
- There's only one correct answer for each question. A passing score for this test is 7 correct answers. If you pass, you can print your certificate of earned contact hours and access the answer key. If you fail, you have the option of taking the test again at no additional cost.
- For questions, contact Lippincott Professional Development: 1-800-787-8985.
- Registration deadline is September 6, 2024

PROVIDER ACCREDITATION

Lippincott Professional Development will award 2.5 contact hours for this nursing continuing professional development activity.

Lippincott Professional Development is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.



Nursing Continuing
Professional Development

This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749 for 2.5 contact hours. Lippincott Professional Development is also an approved provider of continuing nursing education by the District of Columbia, Georgia, and Florida, CE Broker #50-1223. Your certificate is valid in all states.

Payment: The registration fee for this test is free for members through November 30, 2021 and \$10.00 after November 30, and \$12.50 for nonmembers.

1. ARN members can access the discount by logging into the secure "Members Only" area of <http://www.rehabnurse.org>.
2. Select the Education tab on the navigation menu.
3. Select Continuing Education.
4. Select the Rehabilitation Nursing Journal article of your choice
5. You will appear at nursing.CEConnection.com.
6. Log in using your Association of Rehabilitation Nursing username and password. The first time you log in, you will have to complete your user profile.
7. Confirm the title of the CE activity you would like to purchase
8. Click start to view the article or select take test (if you have previously read the article.)
9. After passing the posttest, select + Cart to add the CE activity to your cart.
10. Select check out and pay for your CE activity. A copy of the receipt will be emailed.