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Prolonged Emotional Distress among ICU Nurses Following Repeated Involvement in Family Centered Decisions about Terminal Extubation

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ABSTRACT

This study aimed to examine the severity and drivers of prolonged emotional distress among intensive care unit nurses repeatedly involved in family-centered terminal extubation decisions, identifying key ethical and interpersonal stressors to inform targeted institutional support interventions. A qualitative descriptive phenomenological design was conducted across four high-volume tertiary intensive care units in Central Punjab over a five-month period. Purposive sampling was utilized to recruit 36 registered nurses with extensive bedside withdrawal experience until theoretical data saturation was established. Data were collected via in-depth, semi-structured interviews and analyzed using Braun and Clarke reflexive thematic analysis supported by NVivo software. Analysis revealed three overarching themes: (1) the visceral burden of hands-on death withdrawal, encompassing the sensory choreography of airway removal and witnessing distressing agonal transitions; (2) relational friction and moral injury in surrogate decision-making, driven by absorbing family ambivalence, navigating acute guilt, and confronting medically perceived futility among unprepared relatives; and (3) cumulative psychological residue and behavioral adaptation, characterized by progressive unprocessed grief, profound emotional exhaustion, and defensive emotional blunting. Prolonged distress originates from acute sensory exposure, perceived clinical futility, and surrogate friction, progressively eroding empathetic capacity and prompting defensive disengagement. Healthcare organizations must transition toward structured, immediate post-extubation multidisciplinary debriefings and dedicated psychological support frameworks to preserve clinician retention and compassionate bedside care.

I. INTRODUCTION

The intensive care unit operates at the fragile intersection between aggressive technological intervention and biological limitation, where the imperative to preserve life routinely confronts the inevitability of death (Yazdan et al., 2023). Within this high-acuity environment, the shift from curative treatment to comfort-oriented end-of-life care presents clinicians with some of the most emotionally demanding challenges in modern medicine. Among these transitions, terminal extubation—the intentional removal of mechanical ventilation when continued life support offers no therapeutic benefit—stands out as an acutely impactful clinical event (Esplen, Wong, Vachon, Leung, & Bakirci, 2021). Over the past two decades, critical care has largely replaced paternalistic decision-making models with family-centered care, actively involving surrogate decision-makers in end-of-life deliberations to honor patient values and provide closure. While this philosophy respects autonomy, it fundamentally alters bedside dynamics, placing critical care nurses at the epicenter of complex relational and ethical tensions. Rather than serving as detached clinical operators adjusting ventilator parameters, nurses provide continuous, uninterrupted care, bearing direct witness to the profound grief, ambivalence, and distress that accompany every stage of life withdrawal (Voultsos, 2021).

Due to their around-the-clock physical presence, critical care nurses inevitably carry the emotional weight of mediating family-centered transitions. They frequently step into the vulnerable space between clinical teams and grieving families, explaining the physiological realities of dying, calming acute panics, and absorbing the guilt or reluctance expressed by relatives facing surrogate decision-making (Rabow, Huang, White-Hammond, Tucker, & management, 2021). The tactile reality of terminal extubation further intensifies this burden. It is the nurse who silences the cardiac monitors, suctions secretions, withdraws the artificial airway, titrates palliative sedatives, and prepares the patient's physical body so family members can hold their loved one without intervening plastic tubing. When agonal breathing or rapid physiological deterioration occurs, nurses must soothe terrified relatives while maintaining absolute professional composure (Callis, 2020). When such encounters are infrequent, clinicians can often lean on interpersonal coping mechanisms to restore psychological equilibrium. However, in busy critical care environments, nurses frequently navigate several terminal extubations within a single week or month. This constant turnover of grief prevents emotional recovery, allowing acute distress to accumulate into prolonged, unresolved psychological turmoil (SM & Skills, 2024).

Despite the recognized intensity of this bedside work, current scholarly literature provides an incomplete understanding of how nurses process repeated exposure to these events. The majority of existing research has approached end-of-life stress through quantitative frameworks, relying on standardized survey scales to measure general moral distress, compassion fatigue, or burnout (Smart, Glubrecht, Brooks, & Graves, 2024). While these inquiries confirm high baseline exhaustion among critical care personnel, they aggregate disparate clinical stressors and treat palliative transitions as uniform occurrences. By flattening these experiences into numerical scores, existing studies obscure the granular ethical dilemmas, relational friction, and moral injuries distinctive to family-mediated terminal extubation (CPXP, FAAN, & CPXP, 2021). Very little scholarly attention has explored why certain withdrawals leave lasting emotional residue while others do not, nor has research captured how nurses' professional identities and empathetic boundaries evolve across years of repeated bedside losses. The qualitative nuances—particularly the friction between a nurse's clinical perception of futility and a family's protracted struggle to let go—remain under-theorized and under-examined (Beres et al., 2022).

This gap in understanding leaves healthcare organizations ill-equipped to support bedside staff with meaningful, tailored interventions. Current institutional responses typically lean on generic wellness programs, such as brief mindfulness modules or passive employee assistance hotlines, which overlook the systemic and existential nature of extubation-related trauma (Doolittle, 2015). To design sustainable remedies, research must articulate the specific questions critical care nurses grapple with: How does repeated involvement in family-directed withdrawal alter a nurse's emotional well-being over time, and what specific interpersonal and ethical ruptures transform acute bedside sadness into enduring distress? Uncovering these lived perspectives is essential for protecting the nursing workforce from attrition and preserving compassionate clinical care at the bedside (Cacciatore, Thieleman, Killian, & Tavasolli, 2015). Grounded in this urgent need, this qualitative study aims to examine the severity and

drivers of prolonged emotional distress among ICU nurses repeatedly involved in family-centered terminal extubation decisions, identifying key ethical and interpersonal stressors to inform targeted institutional support interventions (Zhang et al., 2022).

II. METHOD

Participants

To capture the nuanced reality of clinicians' internal conflicts, this study utilized a qualitative descriptive phenomenological design, an approach uniquely suited to examining complex, emotionally charged phenomena through the lived experiences of frontline practitioners. Empirical fieldwork was conducted over a five-month timeframe across four high-volume tertiary care intensive care units in Central Punjab (Roberts, Rickard, Rajbhandari, & Reynolds, 2007). This regional setting was purposefully selected because Central Punjab houses the province's most congested referral hospitals, treating complex trauma, surgical, and medical cases drawn from both dense urban centers and surrounding agricultural districts. In these intensive care units, critical care clinicians routinely navigate multifaceted sociocultural dynamics, as terminal weaning decisions frequently intersect with large extended-family hierarchies, differing religious interpretations regarding the withdrawal of life support, and heightened surrogate anxieties, creating a clinical environment where end-of-life dilemmas and moral distress manifest with distinctive intensity.

Participants were recruited through purposive sampling supplemented by institutional snowball sampling to identify nurses with substantial, direct exposure to end-of-life transitions. Inclusion criteria required participants to be registered nurses holding full-time adult intensive care appointments, possess a minimum of two years of continuous critical care bedside experience, and have participated directly in at least three family-mediated terminal extubation procedures within the preceding twelve months (Mooney, Fitzsimons, & Richardson, 2007). Nurses on clinical probation, temporary agency staff, and those practicing within pediatric or neonatal units were excluded, as proxy decision-making and parental dynamics in those populations introduce fundamentally distinct psychosocial and ethical considerations. Participant recruitment proceeded until theoretical data saturation was established, defined as the point where consecutive interviews yielded conceptual redundancy without generating new codes or relational properties. Saturation was attained after thirty-six participants, a cohort size consistent with qualitative standards in critical care and palliative nursing research.

Data collection was executed through in-depth, semi-structured individual interviews guided by a pre-tested, multidisciplinary protocol. The interview guide was developed through iterative consultations among critical care clinicians, palliative care specialists, and medical ethicists, after which it was pilot-tested with three intensive care nurses whose data were excluded from the final analysis (He, Yu, Sun, Lin, & Zeng, 2025). The instrument focused on core thematic domains, including the lived emotional experience during the physical extubation process, interpersonal communication barriers encountered with grieving surrogates, perceptions of interprofessional support, and subsequent behavioral adaptations or psychological residue. All interviews were conducted in private conference rooms adjacent to the units during non-shift hours to prevent cognitive fatigue and guarantee psychological safety. Each dialogue lasted between forty-five and seventy-five minutes, was recorded using high-definition digital voice recorders, and was supplemented with detailed reflexive field notes documenting non-verbal cues, emotional pauses, and clinical affect.

Measures

Recorded dialogues were transcribed verbatim within forty-eight hours and imported into NVivo software to systematically manage the dataset alongside rigorous manual auditing. Analytical interpretation strictly followed the six-phase reflexive thematic analysis framework established by Braun and Clarke, progressing from repeated readings for data familiarization to open coding, code clustering, candidate theme development, and thematic refinement against the entire dataset (Teece & Baker, 2026). Both explicit semantic content and underlying latent moral distress were systematically categorized. Analytical rigor and trustworthiness were maintained through multiple verification mechanisms. Two qualitative researchers independently coded a randomly selected twenty-five percent sample of the interview transcripts, demonstrating strong inter-coder agreement, with interpretive divergences resolved through negotiated consensus with a third senior investigator. Furthermore, member

checking was performed with five participants to validate descriptive accuracy, while a comprehensive audit trail documented each coding decision and interpretive transition.

Procedure

Formal ethical authorization was granted by the Institutional Review Board of the University of Health Sciences Lahore under protocol approval reference UHS/IRB/2024-914. Prior to participation, all nurses received comprehensive oral and written explanations regarding the study's purpose, after which voluntary written informed consent was formally obtained. To guarantee complete confidentiality, each participant was assigned an alphanumeric identifier, and all institutional names, colleague details, and specific patient anecdotes were excised from transcript records (Akbar, Elahi, Mohammadi, & Khoshknab, 2017). Digital files were preserved on encrypted, password-protected institutional servers accessible solely to the primary research team. Recognizing that recounting distressing end-of-life encounters can evoke secondary trauma, the research protocol incorporated an immediate psychological support framework, providing voluntary debriefing and expedited referral to an independent clinical psychology service for any nurse experiencing acute emotional distress during or following the interview.

III. RESULTS

Analyses of the transcripts revealed three primary interconnected themes, shedding light on the intricate, cumulative psychological toll of family-centered terminal extubations on intensive care unit nurses, as mapped systematically in NVivo qualitative analysis software (image_1.png).

The first primary theme, **The Visceral Burden of Hands-On Death Withdrawal**, captured the immediate physical and sensory impact of the transition. Within this, the first subtheme, **Choreographing the Sensory Reality of Extubation**, highlighted how nurses bear the physical execution of withdrawal. One participant noted, "You pull the tube, and then you have to stand there, watching the agonal breathing... your hands are physically stopping the support while the family is screaming." Another recounted, "It is the sound, that rattle after you remove the airway, and you are the one holding their hand, wiping the mouth, trying to make it look peaceful when it feels so violent." The second subtheme, **The Emotional Toll of Witnessing Agonal Transitions**, illustrated the deep internal toll of this direct exposure. A nurse reflected, "Watching someone suffocate slowly while the family looks at you to do something is a burden that doesn't just leave when you clock out." Another stated, "There is this heavy silence right after the ventilator stops, a sudden weight that hits your chest every single time, especially when you have to do it multiple times a week."

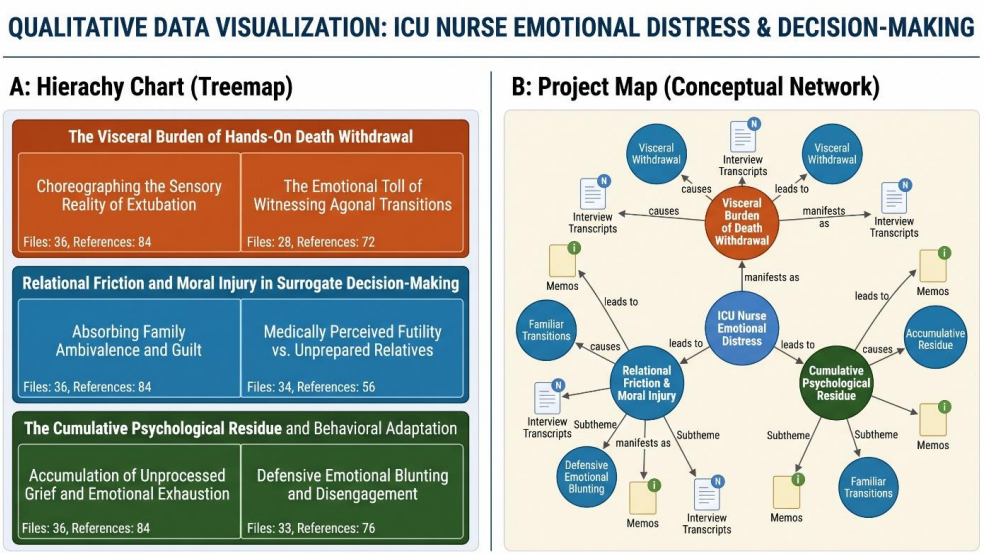
The second theme, **Relational Friction and Moral Injury in Surrogate Decision-Making**, explored the social and ethical complexities nurses negotiate with grieving families. The first subtheme, **Absorbing Family Ambivalence and Guilt**, described how nurses absorb families' emotional conflicts. A participant explained, "The family looks at you as if you are the executioner... they ask 'Are we sure?' over and over, and you carry their doubt home with you." Another observed, "I had a daughter begging me not to do it while the brother was nodding yes... we become the sponge for all their unresolved guilt and conflict." The second subtheme, **Medically Perceived Futility vs. Unprepared Relatives**, detailed the distress when nurses believe life-prolonging actions are futile. A respondent shared, "We know the patient is gone, but the family expects a miracle, so we are forced to participate in what feels like torturing a body before finally letting go." Another expressed, "The hardest part is when we prolong the suffering because the family isn't ready, making us feel like we are failing our primary duty to protect the patient from harm."

The third theme, **The Cumulative Psychological Residue and Behavioral Adaptation**, focused on the long-term emotional impact and subsequent coping mechanisms. The first subtheme, **Accumulation of Unprocessed Grief and Emotional Exhaustion**, outlined how repeated exposures erode psychological reserves. One nurse commented, "You can't just weep with one family and then go to the next bed to titrate pressors... you bury it, and then one day, you realize you have nothing left to give." Another added, "After the third or fourth one in a month, you feel like a ghost walking around... the grief just stacks up inside you until you feel entirely hollow." The second subtheme, **Defensive Emotional Blunting and Disengagement**, revealed how nurses protect themselves by

distancing from patients and families. A nurse remarked, "I started pulling back, focusing entirely on the monitor or the tubing just to keep from looking the family in the eyes." Another confessed, "You build these high emotional walls just to survive the shifts, but then you realize you've become cold, not just at work, but with your own family at home."

To help synthesize these experiential domains, a comprehensive NVivo 12 visual framework is presented below, contrasting a flat hierarchy chart against a multi-directional project map to analyze coding density and inter-theme relationships. Let's inspect the visualization:

Figure I: Qualitative Visualization



IV. DISCUSSION

The findings of this study illuminated how prolonged emotional distress among critical care nurses originated from a compounding convergence of sensory trauma during airway removal, ethical friction surrounding perceived therapeutic futility, and relational exhaustion from mediating surrogate ambivalence (Mazanec, Aslakson, Bodurtha, Smith, & Nursing, 2016). Rather than reflecting transient grief, the observed distress represented an enduring psychological and moral burden driven by the uninterrupted physical proximity of nurses to the dying process (Ip et al., 2025). These results established that the bedside clinician's psychological trajectory during terminal weaning was fundamentally distinct from that of other interprofessional team members, as nurses directly executed the physical withdrawal while simultaneously absorbing the immediate emotional crisis of the patient's family (Emami Zeydi, Ghazanfari, Suhonen, Adib-Hajbaghery, & Karkhah, 2022). The sensory immediacy articulated by particip ants demonstrated that treatment withdrawal in high-acuity environments-imposed challenges extending far beyond routine clinical sadness (Foltz-Ramos, 2017). The tactile and acoustic reality of terminal extubation—specifically suctioning secretions, observing agonal respirations, and silencing alarms—inflicted an acute sensory toll that persisted long after the patient died (Dartey et al., 2025). This physical choreography placed nurses in direct tension with families who frequently interpreted agonal respirations as active suffering (Dacar, Covell, & Papathanassoglou, 2019). Frontline clinicians bore the primary brunt of this reaction, feeling uniquely culpable for the apparent physical discomfort of the dying patient while attempting to reassure distraught relatives, creating an acute psychological double bind (Jepkosgei et al., 2026).

The ethical friction between clinical assessments of futility and family reluctance to withdraw life-sustaining therapy served as a primary driver of moral injury (King & Gazecki, 2021). Moral distress manifested acutely when institutional or relational dynamics forced clinicians to maintain aggressive, non-beneficial interventions that they perceived as inflicting unnecessary physical harm (Etland & Management, 2013). In regional critical care settings characterized by extended familial decision-making hierarchies and complex religious expectations, the trajectory of dying was frequently protracted (Kakhki, Daneshfar, NamaeiQasemnia, Yousefnezhad, & Kazemi, 2026). This

dynamic introduced a pronounced ethical dissonance between the nursing obligation to prevent harm and the clinical imperative to respect surrogate autonomy, leaving bedside staff feeling complicit in prolonging physiological agony (Ali & Shaban, 2025). Over time, repeated involvement in these procedures without adequate psychological recovery precipitated cumulative emotional exhaustion and maladaptive coping mechanisms. Repetitive exposure to unresolved ethical challenges generated an enduring moral residue, leading to progressive emotional depletion. In response to recurring bereavement, nurses adopted behavioral adaptations characterized by defensive emotional blunting and cognitive detachment from subsequent families. Although psychological detachment served as an instinctive self-protective buffer against acute distress, prolonged disengagement ultimately diminished clinicians' professional satisfaction and empathetic capacity, fostering profound feelings of alienation that undermined clinical retention and workforce sustainability.

This study possessed notable methodological strengths, including an empirical qualitative design that captured granular, under-the- theorized emotional nuances rather than reducing clinical distress to quantitative questionnaire metrics (Chatmon, Richoux, & Sweeney, 2023). The purposeful recruitment of seasoned critical care nurses across multiple high-volume tertiary centers provided authentic insight into real-world bedside realities in public healthcare settings. Nevertheless, several limitations warrant consideration. The geographic restriction to tertiary institutions in Central Punjab reflected specific regional socio-cultural and administrative dynamics that might not fully mirror critical care environments with different nurse-to-patient staffing ratios or dedicated palliative care teams (McNamara, 2019). Additionally, the retrospective nature of qualitative interviews introduced potential recall bias, as participants may have prioritized their most traumatic extubation encounters over more routine end-of-life transitions. These findings carry critical implications for critical care administration and clinical practice. Healthcare institutions must transition away from generic wellness programs toward structured, immediate post-extubation multidisciplinary debriefings and peer-led psychological support (Gurney, MacPhee, Howard, & Rodney, 2020). Furthermore, clarifying communication pathways during family conferences could mitigate the moral dissonance experienced by nurses when navigating surrogate denial. Ongoing professional debate centers on whether routine palliative consultation models or dedicated nurse-led ethics rounds provide superior protection against cumulative moral trauma. Future research should implement longitudinal designs to evaluate prospective emotional trajectories across sequential end-of-life care encounters and evaluate structured psychological interventions designed to preserve compassionate nursing care without accelerating workforce attrition (Purdy et al., 2017).

V. CONCLUSION

This study demonstrates that prolonged ICU nurse distress stems from the visceral burden of hands-on death withdrawal, marked by choreographing the sensory reality of extubation and the emotional toll of witnessing agonal transitions. Clinicians navigate relational friction and moral injury in surrogate decision-making through absorbing family ambivalence and guilt alongside medically perceived futility versus unprepared relatives. Over time, the cumulative psychological residue and behavioral adaptation leads to the accumulation of unprocessed grief and emotional exhaustion, culminating in defensive emotional blunting and disengagement. Targeted institutional debriefings are vital to preserve nurse retention and bedside empathy.

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