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Developing a nursing caregiver bereavement resource package

By Deborah Mings

Abstract

We are all aware of the changing health care system and the many stresses and strains that face oncology nursing caregivers. Dealing with death and dying in a constructive manner is one of the many challenges facing oncology nursing. This paper will outline how the nursing worklife issues committee of our hospital developed one approach to assisting staff nurses in exploring their feelings around this issue. We used the concept of critical incident stress as our framework for this project. Critical incident stress is described as "any significant emotional event that has power, because of the circumstances in which it occurs, to cause unusual psychological distress in healthy normal people". We identified that dealing with dying patients, families and death on an ongoing basis can result in circumstances in which critical incidents can occur. In developing this resource package, the purpose was twofold: To acknowledge the emotional impact of working with oncology patients and to provide resources that the nurse can use to effectively work through the emotions associated with repeated patient losses. The resource package consists of a booklet that the committee developed, articles, cartoons, poems, thought-provoking ideas and an outline on how to debrief after a critical incident has occurred. People have used the resource package and consulted with the committee members according to their needs. The resources we developed and the theoretical background will be explored in this paper.

Introduction

On behalf of the members of the nursing worklife issues committee and myself, I am pleased to have the opportunity to present the work the committee developed, our nursing caregiver bereavement resource package. I will lead you through some of the theoretical concepts we used to construct our package and give you

some practical suggestions. By the end of this presentation I hope you will have enough information to go back to your respective hospitals and develop a resource package that meets the needs of the group of nurses with which you work.

I am assuming that no one today has been untouched by all the changes that have been occurring in health care. There are many stresses and strains that face oncology nursing caregivers. Dealing with death and dying in a constructive manner, particularly with all that is going on around us, is one of the many challenges currently facing oncology nursing.

The nursing worklife issues committee at Princess Margaret Hospital was formed to identify and develop strategies to address nursing worklife issues as they relate to oncology nursing. The committee is made up of staff nurse representatives, a clinical educator, two clinical nurse specialists, a chaplain and a human resource specialist.

One of the priority issues identified by the group (particularly by the front-line staff nurses) was the need to develop an intervention to assist oncology nurses in dealing with the feelings associated with dying and the death of patients. We considered a variety of approaches to this

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MISE AU POINT D'UNE TROUSSE DE RESSOURCES POUR SOULAGER LE DEUIL DES SOIGNANTS

ABRÉGÉ

Nous sommes toutes conscientes des bouleversements que vit le système des soins de santé et des nombreuses pressions et tensions que connaissent les infirmières praticiennes en oncologie. Travailler aux côtés de mourants et côtoyer la mort sont deux des défis que doivent relever les infirmières en oncologie. Cette présentation souligne comment le comité des questions relatives de la vie au travail des infirmières de notre hôpital a mis sur pied l'approche qui a aidé les infirmières de chevet à explorer ce qu'elles ressentaient à ce sujet. Nous avons utilisé le concept de "stress dû à un incident critique" comme cadre pour notre projet. Ce stress dû à un incident critique est décrit comme étant tout événement émotionnel significatif qui peut, du fait des circonstances dans lesquelles il se produit, déclencher une détresse psychologique inhabituelle chez des sujets sains et normaux. Nous avons conclu que le fait de soigner des patients à l'approche de la mort, d'aider leurs familles et de côtoyer la mort de façon régulière peut donner naissance aux circonstances dans lesquelles des incidents critiques peuvent se manifester. Nous avions deux objectifs en tête lorsque nous avons élaboré la trousse: premièrement, reconnaître l'impact émotionnel du travail en milieu oncologique; et deuxièmement, fournir aux infirmières des ressources qu'elles pourraient utiliser pour gérer les émotions qui accompagnent la perte répétée de patients. La trousse de ressources comprend un livret préparé par le comité, des articles, des bandes dessinées, des poèmes, des idées qui portent à réflexion et la voie à suivre pour se reprendre en mains après un incident critique. Les infirmières ont utilisé la trousse et ont consulté les membres du comité selon leurs besoins. Cette communication examine les ressources mises au point ainsi que les fondements théoriques.

The 1995 Schering Lecturer, Deborah Mings, left, is introduced by Barbara Warren, CANO past-president.

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problem, and after much debate about timing, cost and resources, we decided to develop a resource package, the focus of the package being a booklet that the committee developed. We were fortunate to have a graphics department (and some money) to produce a booklet that we felt would provide "food for thought" on this issue.

We had several criteria we felt were important in the development of the booklet. We designed the booklet so that it would fit into a lab coat pocket. That way if someone wanted to take it home with her, or carry it around, it was easily done. We wanted the colours and the graphics to be light, inviting and soothing.

We carefully chose the content of the booklet to reflect the theoretical concepts we had discovered in our reading and review of the literature. These concepts included critical incident stress and grief frameworks. Therefore, exercises in exploring and acknowledging the grief process and exercises in identifying physical, cognitive and emotional events related to critical incident stress were specifically chosen for the booklet. To complement this, poetry, suggestions for relaxation, humour and music were also included. The entire resource package contained the booklet, five articles and a bibliography.

To launch the bereavement resource package, we introduced the topic at nursing grand rounds during Nurses Week 1994. We then distributed the package to the various nursing units in the hospital. The package included enough copies of the caregiver bereavement resource guide for all staff members to have one, a copy of each article and a detailed bibliography. Response to the package has varied. Some units used the booklets and the debriefing format described in the article. Others did not. However, on many units all copies of the booklet have disappeared. In keeping with our committee philosophy that the use and impact of the resource package was to be based on the private needs of the individual and the nursing units, we did not undertake a formal evaluation. Coupled with this, shortly after the resource package was introduced, re-engineering resulted in an upheaval of the culture, climate and organization of the hospital, staff and nursing units. It is our committee's intent to re-introduce the package and its concepts once the move to our new hospital building has occurred in November 1995. We want to make discussions about death and dying and debriefing sessions a part of the organization's culture.

A word of caution and advice: If your committee decides to embrace a project such as this, you as an individual will also be embracing it for yourself. What initially started as an academic exercise to help nursing staff, became a catalyst for individual committee members' own self-exploration. You cannot read, discuss, dissect, review and ponder issues around nursing grief and bereavement without considering your own thoughts, feelings, attitudes and past events.

In this paper, it is not my intention to take you on an emotional trip through bereavement issues, nor is it my intent to take you on a solely academic ride through the literature. Instead, my intent is to present a balanced approach by bringing the two together. However, you may find yourself engrossed in personal thoughts and feelings about the material and you may find yourself a bit surprised by your own responses. Talk to supportive friends, family and colleagues. Bring issues around nursing grief and bereavement to the forefront. Create a supportive environment in which discussions around these issues is a part of the hospital culture and a unit norm. In oncology nursing there is no better area in which to bring together our thoughts, feelings and skills both for our own personal growth, but also for the benefit of our patients and families.

Part One

Literature review, critical incident stress

Stress, coping, burn-out, overwork, bereavement and job satisfaction are all related concepts that have generated an extensive body of literature within the field of nursing and have been the subject of much discussion in the popular literature. Any or all of these concepts would have provided us with a thorough and well-researched frame of reference for our project and we recognized that these concepts all had a relationship to nursing bereavement. However, we opted not to use these concepts directly and chose the concept of critical incident stress as one of our theoretical underpinnings.

We based our decision on the fact that there are many critical incidents that occur in the daily life of oncology nurses. Our committee was able to identify a number of critical incidents that had occurred amongst our group, mainly related to a particular patient's death but also related to the circumstances in which the death occurred. We also identified particular sites and units of the hospital where, because of the circumstances, the potential for critical incidents was particularly high. It is the aftermath of a critical incident that concerned our committee and led us to develop our resource package.

Critical incident stress is described as "an event that is extraordinary and produces significant reactions for the intervening ESP (emergency service personnel) or other helping professionals. Critical incident stress is the natural reaction of a normal person to an extremely abnormal situation" (Mitchell, 1989). Another definition of critical incident stress is "any event that evokes an intense emotional reaction - one that has the potential to interfere with a staff member's ability to cope" (Martin, 1993). Usual coping skills are ineffective in these situations and following the event the health care provider may exhibit psychologic and physiologic symptoms that may be experienced almost immediately or days to weeks after the event.

The first article on critical incident stress was published in January 1983 and stirred a nationwide and worldwide trend among emergency service organizations to develop programs to lessen the impact of distressing critical incidents and accelerate recovery from those incidents. The critical incident stress process is one of those concepts that has evolved over time and finds its major influences in military experiences, police psychology, emergency medical services, and disasters.

The concept has continued to evolve over time. It is now well-recognized that other health professionals who are involved in the care of injured, sick and dying patients also experience critical incident stress (CIS). This has resulted in the acknowledgement of CIS in nursing, particularly in high stress, high volume, high acuity areas such as intensive care units (McKerron, 1991, Small, Engler & Rushton, 1991), the operating room (Gerber & Workman, 1995), emergency rooms (Spencer, 1994) and oncology nursing (Cohen & Sarter, 1992).

There are a number of circumstances that can precipitate a critical incident stress situation. This list is from the general critical incident stress literature. These include:

Situations that commonly precipitate critical incident stress

- death or injury of a health team member
 - injury or death of a child or children
 - death resulting from human violence
 - death after a lengthy resuscitation
 - any threat to the belief that childhood death is not supposed to happen
 - any situation in which sights, sounds or smells are distressing or unusual
 - any situation that attracts unusual media coverage
 - any situation in which parental grief must be witnessed
 - any situation in which blame is placed on the health care team for poor patient outcome
 - cumulative exposure to traumatic events
- (From Back, 1992)

Our committee believed that much of the stress oncology nurses experience occurs as a result of cumulative exposure to traumatic events. On some nursing units and in particular cancer sites, there is no time to grieve the loss of one patient before another dies. Another key issue noted by our committee involved the stress that was created when the patient did not die a "good death". Disagreement between the physician and nurses concerning ethical issues around continuation of a patient's treatment, patients who died in intractable pain, and situations in which errors may have contributed to the patient's death, all add to circumstances that could trigger a critical incident.

There are common reactions to critical incident stress. These include physical signs and symptoms such as nausea, tremors, upset stomach, sweating, diarrhea, rapid heart rate, dry mouth and sleep disturbance. Emotional reactions can include grief, anger, anxiety, fear, depression, worry and feeling overwhelmed. Behavioural reactions to critical incidents can include withdrawal, suspiciousness, increased or

decreased appetite, increased smoking, drug or alcohol use, excessive use of humour, prolonged silence or unusual behaviour.

Not all incidents that are stressful will produce a critical incident stress reaction. However, an accumulation of stressful events can create the emotional environment for a critical incident to occur.

Determining the critical incidents, stresses and worklife issues of oncology nurses was the focus of a phenomenological study by Cohen and Sarter (1992). In this case critical incidents were defined as "any incident in which a difference in patient outcomes occurred. It includes something that went well or not as planned, something typical, something particularly demanding and something that captures the essence of what nursing is all about." This definition of critical incidents reflects an attempt to piece together the overall pictures of the workworld of the oncology nurse, the stresses and scenarios that make up that world.

A number of themes emerged regarding critical incidents in oncology nursing. Not surprisingly, the critical incidents most often mentioned by the nurses involved the handling of acute physiologic emergencies. In fact when considering critical incidents, most nurses in this study described an acute physiological emergency with vivid recall and their role in that scenario. The nurses also talked about incidents that evoked unresolved feelings and provoked anxiety, i.e. the errors they had made, often years earlier, that still bothered them. Interestingly enough, many of the nurses noted that this was the first time that they had openly discussed experiences, fears, feelings and errors.

The role of "being there" for patients was noted to be important, and a source of critical incidents for oncology nurses. Participation in the personal lives and experiences of patients and their families involves entering into the experiences of patients by being present in their lives. As one nurse put it: "You do a good job with every patient; you do a great job with a few people who touch you in some special way..." (Steeves, Cohen & Wise, 1994).

Other critical incidents occur when the nurse empathizes with patients and relates what is happening to the patient to their own lives. This represents the nurse's attempt to find "meaning" in the situations they confront every day. One cannot care for a patient and attend to their needs and not experience some connection or meaning to that patient.

Some of the difficulties and challenges of reported critical incidents were experienced as a result of human interactions and relationships. These difficulties included conflict with patient and families, peers and physicians, poor staffing and unexpected crises.

"It's difficult dealing with doctors who don't particularly like or respect nurses. You get a lot of negative feedback from them. They don't like anything you do, no matter how hard you try." (Cohen & Sarter, 1992)

"It's unusual, but a stressful day would be one that you worked short-staffed; or you have a staff of registry people that you don't feel that comfortable with; or when you have lots of admits; or, for some nurses, when a patient dies, it's a pretty stressful day." (Cohen & Sarter, 1992)

Nurses indicated that caring for dying patients and their families is one of the most difficult and challenging aspects of oncology nursing. One nurse commented:

"You've got someone [who] you've grown to know, and like and love and have a lot of respect for [who] dies. And, then you also have the family that you got to know and love. You feel their loss, too." (Haberman, Germino, Maliski, Stafford-Fox, Rice, 1994)

Nurses also note that in addition to being appreciative, patients and families also vent their emotions. While the nurses understood why this occurred, they remembered how difficult it was when families and patients yelled at them or vented their anxiety, anger or anguish.

Nurses also obtain a lot of personal satisfaction from caring for dying patients and reported that although rewards were primarily from success stories when patients became disease-free, rewards also come from meaningful interactions and from patients' gratitude for emotional support.

"I enjoy taking care of patients who are dying from the

standpoint that I feel like I can comfort them and make it an easier transition. Even when somebody dies, it is fulfilling because before they die, you can contract for what you're doing for them, whether it's giving them an hour alone with the door locked with their husband or keeping them alive until their husband flies in or helping them write a letter to their grandchildren. These are important things." (Haberman, Germino, Maliski, Stafford-Fox, Rice, 1994)

Nurses in oncology fully live and embrace the cancer experience through their patients' triumphs and heartaches. McDonnell and Ferrell (1992) note that oncology nurses are "privileged to care for patients and families facing cancer, will celebrate the joyful rewards that come from helping others confront mortality...However, the nurse will experience the deep sorrows born of the struggle, pain, suffering and loss".

Oncology nurses encounter many stressors, both negative and positive that contribute to the course of their working day. For nurses to most effectively meet the needs of the patients and their families, they must first meet their own needs. Relationships of mutual growth and development and the experience of understanding the meaning of cancer require nurses to have reserves of both physical, psychosocial and spiritual energy from which they can draw and provide comprehensive care. These concepts of critical incidents, stress, meaning, understanding and growth led us into the development of our resource package, the nursing bereavement resource guide. The development process for the resource package is described next.

Part Two The creation of the Nursing Caregiver Bereavement Resource Guide

This section of this presentation deals specifically with the nursing worklife issues committee's preparation of the booklet, the "Nursing Caregiver Bereavement Resource Guide". The guide focuses on those areas we thought important to address, both from the literature review and from our own personal and professional experiences. We gathered our information from many sources - articles, popular culture and books, videotapes, music and discussion. Surprisingly, we found that funeral homes have a rich source of written resources related to bereavement. We also found that very few resources are actually directed at caregivers, more were from the perspective of individuals who have experienced grief. It requires imagination and creativity to take resources and make them applicable to the nursing caregiver situation. I will now take you through specific sections of the resource guide booklet. The booklet begins with an analogy entitled the "Spaghetti Dinner".

The Spaghetti Dinner

Suppose you have had a group of friends over for a spaghetti dinner. It's been a delightful evening, but now your guests have gone home. You walk into your kitchen, and there sit the dishes. Those tomato-sauce-turned-to-glue-covered dishes are one of the truly ugly sights of the world!

You're tired and in the mood for anything but washing dishes. You now have two basic choices: You can leave the mess until morning, or, you can wash the dishes now regardless of how you feel.

If you leave them, the present moment is certainly more pleasant. In fact, the balance of the evening can be delightful and your night's rest refreshing. But come daylight...there they are! Now those dishes are uglier than ever as they stare at you with mute disdain.

Now the task is even more difficult. The pleasantness of the dinner party is gone and forgotten as you face the same decision again: Do you wash them now, or put off the gruesome task until some other time, or hope the tooth fairy will come along and wash them for you?

If you choose to wash the dishes immediately after dinner, your guests just might help you - if you're lucky. But come morning, the task is finished. You can go into the new day basking in the warmth of a good evening and the knowledge

that you did good work with a difficult task.

Grief work is much like that image. There is work that must be done at a time when you feel like doing nothing at all. Grief work can be put off. You can feel better for awhile by avoiding some feelings and not talking about some things. But there will be a day when you awaken to see that your feelings are still there and things still need to be talked about with someone who understands and cares.

Like the spaghetti dinner, the longer you wait, the more difficult and unpleasant grief work becomes. Grief is not an illness. But if you try to avoid grief work, you may well become ill.

Deits, Bob (1988). *"Life After Loss, a Personal Guide to Dealing with Death, Divorce, Job Change and Relocation."* Fisher Books, Tucson, Arizona, pg 45-50.

In the booklet, we ask our readers to take a few minutes to reflect on the story. We remind nurses that grief work can be left, but sooner or later, feelings and issues must be addressed. Because they must be dealt with, we include an exercise in our booklet to encourage the review of life events. We want the reader to take the opportunity to review events, feelings and issues that may have been left unaddressed. This exercise helps nurses to identify experiences both negative and positive, feelings and changes that may be affecting happiness today. It is important to identify loss experiences that may have seemed insignificant at the time but may be causing distress. We cannot always separate life and work stresses and did not attempt to separate the two when asking nurses to review their life events.

The life review exercise includes:

- List the most significant changes in your life during the past year. Include both positive and negative experiences.
- Diagram your moods over the past year.
- What physical problems have you had over the last year?
- Describe your outlook on life right now in terms of: a colour, a taste, a smell, a touch, a sound.
- If you could change things in your life right now, what things would they be?

After completing the survey, look back on your answers and examine the responses:

- impact
- feelings
- physical problems
- images

Is a change possible or necessary? What do you need to do to make the change?

The follow-up instructions include:

- To get the most benefit from the survey, first go through it carefully by yourself and then share your feelings with a trusted friend, spouse, family member, counsellor or spiritual leader. The simple act of talking about your feelings is an important step.
- It is important for you to pay particular attention to any correlations between your physical problems and a time of loss. You can spend a great deal of time and money treating physical symptoms and never get to the root cause if loss and grief are factors of your illness.

Deits, Bob (1988). *"Life After Loss, a Personal Guide to Dealing with Death, Divorce, Job Change and Relocation."* Fisher Books, Tucson, Arizona, pg 79-81.

It is important to develop an emotional "grief muscle". This means actually reviewing your thoughts and feelings around your grief. Like all muscles, the "grief muscle" must be exercised. We include an exercise in our booklet to do just that. This exercise can be done after a particularly difficult death or when a patient dies who you have been close to. Of course, all of these exercises also apply to personal tragedy that requires exploration and expression of feelings.

Communicating your grief

The task here is to communicate with your grief as though it had a personality of its own. You talk to your grief, and you will listen to what your grief has to tell you.

You are going to write two letters: Before you write, ask yourself: If I could tell my grief what I am thinking and

feeling, what would I say? What do I want my grief to know about its impact on my life? Be as frank as you can. Write the letter and sign it.

As close to 24 hours later as possible, write the second letter. This one will be from your grief to you. What does grief want from me? What do I think my grief is telling me?

Then as frankly as possible, write yourself on behalf of your grief.

Put the letters aside for a day or two, then read them both out loud to yourself.

What do the letters reveal about your attitude toward the experience of grief? What new thing can you learn about yourself from the letters?

Find someone with whom you can share the letters and talk about your discoveries.

Deits, Bob (1988). *"Life After Loss, a Personal Guide to Dealing with Death, Divorce, Job Change and Relocation."* Fisher Books, Tucson, Arizona, pg 79-81.

Some other exercises that were not included in this booklet, but will be included in the next edition, also provide a good outline for thought and discussion. These exercises are suggested in Valente and Sanders (1994), and can be done alone or as a group activity.

Personal Inventory:

- What type of patients give you the most distress when they die?
- How do I typically express grief?
- What type of assistance is most acceptable to me when I grieve over a patient's death?

Supportive response to colleagues:

- What clues do I tend to notice from others?
- How do I extend my offer to help?
- What type of assistance do others on the team seek and give?
- What are my personal stressors that intrude into work?

To prove that others find it beneficial to ponder their feelings around death and grief as a way of enhancing life, I have taken this excerpt from the book *"From Beginning to End: The Ritual of Our Lives"* written by Robert Fulghum, the author of *"All I Really Need To Know I Learned In Kindergarten"*.

A caption from this photograph: "a man sitting in a chair in a cemetery, as a light rain fell and the sun shone at the same time, on the fourth day of June in 1994"

If you were there, standing close by, you would notice that the sod beneath his chair was laid down in small square sections, suggesting it had been removed and carefully replaced.

The man owns the property upon which he sits. He has paid for the site, paid to have the ground dug up, to have the cement vault installed, and to have the ground restored. He is sitting on his own grave. Not because his death is imminent - he's in pretty good shape, actually. And not because he was in a morbid state of mind - he was in a fine mood when the picture was taken. In fact, he has had one of the most affirmative afternoons of his life.

Sitting for an afternoon on his own grave, he has had one of those potent experiences when the large pattern of his life has been unexpectedly reviewed. The past, birth, childhood, adolescence, marriage, career, the present and the future. He has confronted finitude - the limits of life. The fact of his own death lies before him and beneath him - raising the questions of the when and the where and the how of it. What shall he do with his life between now and then?"

From: Fulghum, Robert (1995). *"From Beginning to End: The Rituals of Our Lives"* Random House, New York, pg 31-32.

That man sitting on top of his grave and pondering his existence is Robert Fulghum. I am not suggesting that you go out, buy a grave plot and sit pondering your existence. I am, however, using this as an example of how reviewing issues around mortality and death can be a positive experience that enhances rather than detracts from experiencing life.

No book on grief and bereavement would be complete without including an exercise on how to relax. We included an exercise called the 8-8-8 Breather.

Relaxation - An exercise to relax tension

Sit comfortably in your chair with your feet on the floor and your hands laid loosely on your thighs, palms down.
Close your eyes.

1. Gently blow out all the air in your lungs.
2. Slowly inhale while counting to eight. Allow your abdomen to expand while you are breathing in. Count: One-and-two-and three-and four-and-five and six-and seven-and eight.
3. Hold your breath to the same count of eight.
4. Slowly exhale while counting to eight in the same manner. Relax your abdomen as you breathe out.
5. Breathe normally for one minute.
6. Repeat this sequence several times until you feel your tension subsiding.

This is a good way to relax and one you can do whenever you feel stressed and need to relax.

The committee also investigated music as a method of relaxing and dealing with stress. Our original intent was to have a tape of relaxation music included as a part of the relaxation package. We concluded that since everyone has somewhat different tastes in music, we would include some practical tips on what to look for when choosing music and encourage people to find their own "comfort" music.

What we discovered:

Music aids in the creation of an atmosphere conducive to the expression and release of feelings.

A universal form of communication, music speaks to everyone in a different way and at a different level.

Because it is such a personal choice, it would not benefit anyone to provide a random list of music to listen to. Instead, the following criteria are listed to assist you in the appropriate selection of music for relaxation and expression:

- music with a slow, steady rhythm
- low frequency tones
- repetitive
- instrumental is preferred to vocal
- less than 80 beats/min. (anything greater will accelerate the heart rate)

Two additional activities related to music (and hence relaxation and expression) include: Writing meaningful lyrics and drawing while listening to music.

Do not be alarmed if you find that certain musical pieces evoke strong emotions or even make you cry. It is not unusual for music to trigger the expression of pent-up emotions.

You may even want to plan to cry by playing music that is meaningful to you! You'll feel better afterwards!

(Thanks to David Loyst, Registered Music Therapist, Riverdale Hospital, Toronto)

Humour

Humour is another great way to release stress and pent-up emotions. George Bernard Shaw tells us:

"Life does not cease to be funny when people die any more than it ceases to be serious when people laugh"

We included some comics in the booklet that the committee found funny. Like music, humour is whatever appeals to the individual.

As nurses, we do not always feel comfortable, and it is sometimes difficult for us to know what to do in response to tears and crying of a patient, family member, friend or colleague. We included a section entitled "Tears - Suggestions for nurses on what to do when a family and friends are crying".

When someone is crying:

1. Move closer to the individual who is crying.
Moving closer may reduce the feeling of vulnerability. At the very least, do not move away.

2. Offer a tissue or handkerchief.
Providing a tissue achieves four things: It gives the individual permission to cry; it provides an opportunity for the individual to save face; it gives you something to do; and it brings you closer to the individual, accomplishing the first suggestion.

3. Touch the person who is crying, if you and the individual are comfortable with this approach.

This can be anything from a light touch on the shoulder to a full hug.

4. Try to identify the emotions causing the tears.

Note: Crying is not an emotion, it is a symptom that expresses a range of emotions, such as anger, happiness, distress, etc. When the cause of the emotion is obvious, then use it as an opportunity to give an appropriate empathic response.

If it is not obvious, use an open-ended question such as "Are you able to tell me what is making you cry at the moment?"

5. Stay with the individual until things are calmer.

If you are not able to stay, get someone else to stay.

From: Buckman, Robert (1992). *How to Break Bad News: A Guide for Health Care Professionals*. Johns Hopkins Press: Baltimore, pg 151-152.

"Letting go" is critical to adjusting to loss. To help nurses "let go" we included a mantra and an exercise in this section. The mantra goes like this:

Letting Go

I bless you

I release you

I set you free

I set me free

I let you be

I let me be

From: Bazarath, Alla, Renee (1990). *A Journey Through Grief: Gentle, Specific Help to Get You Through the Most Difficult Stages of Grieving*. CompCare Publishers, Minnesota, pg 38.

We suggest that if you have had an attachment to a patient and he or she has died, this particular mantra may help in letting the patient go. Rituals are extremely important in our lives. We have rituals for every important milestone and passage. Having some sort of a ritual - be it this mantra, a poem or a ceremony that marks the passage of a patient - may provide the health care provider with a sense of closure to the emotions associated with a patient death.

Our committee wanted to acknowledge that, for some nurses, a bereavement package may not be enough. Cumulative critical incidents and life stresses may have resulted in the need to seek expert counselling and support. Our booklet concludes with a section on seeking help. This section encourages the nurse who is experiencing difficulties to seek assistance and counselling from someone they trust. It includes a list of suggestions and alternatives, i.e. employee assistance program, spiritual leader, trusted friend or an established counselling service.

This provides you with an overall outline of the content we included in our booklet. Your group or committee may decide to include content similar to this, or based on the needs and feedback of the nursing staff, include other content that has added meaning for them. Whatever you choose, remember the booklet will touch different people in different ways. Some people will look at the contents of the package and decide they do not want anything to do with it. Some people will do the exercises, some will read the poetry, others will laugh at the comics. Our package was designed to meet the needs of the nurse in her own time and space. Keep these ideas in mind as you are constructing your booklet.

Part Three

Further suggestions for development

Finally, I will review some important information that we included in the rest of our package. We reviewed many resources, and chose five of the best articles, along with a bibliography to be included as part of the resource package.

The articles included in the package:

1. "Love and Work: Oncology Nurses' View of the Meaning of Their Work", Marlene Zichi Cohen and Barbara Sarter. *Oncology Nursing Forum*, Vol 19, No. 10, 1992. We chose this article because it accurately describes the meaning of oncology nursing, and the critical incidents that impact on our lives. To augment this, you may want to review the *Results of the Life Cycle Research Project* published by ONS.

2. "Nurses Cry, Too", Susan J. Stowers, *Nursing Management*, April 1983. This article presents the human side of grief and how it can impact on a nurse. It also demonstrates how grief can be turned into growth.
3. "Nurses' grief", Judith M. Saunders and Sharon M. Valente, *Cancer Nursing*, Vol 17, No. 4, 1994. This article is one of the few nursing articles that really delves into the whole concept of nursing bereavement, particularly from the oncology nurse perspective. It provided us with an excellent theoretical framework for our booklet and a model from which to do future work.
4. "Suggestions for Medical Personnel for Helping Grieving People", Adapted from *Hope for the Bereaved: Understanding, Coping and Growing Through Grief*, by Therese S. Schoenbeck, Syracuse, NY, pages 48-49. We included this article to address the practical needs of the nurse working with bereaved individuals.
5. "To Cope With The Stress", Kathleen R. Martin, *Nursing '93*, May. This article provides an excellent outline for debriefing after a critical incident has occurred.

I would like to conclude this paper by discussing some of the key issues and ideas from the articles we included as a part of the bereavement package. Our committee's intent was that the bereavement package was the first part of a series of interventions to address the issue of "nursing bereavement". Our next step is to develop a program to address this issue in a more comprehensive manner. The ideas presented below can help you develop a nursing bereavement program that suits the needs of your nurses.

Good death vs bad death

Saunders and Valente (1994) have conducted bereavement workshops with over 300 oncology and hospice nurses. These nurses completed questionnaires and interviews about personal and professional bereavement as part of the workshop experience. Most nurses report that they handle their grief effectively if they helped a patient die a "good death". A good death included: Relieving the patient's distress and symptoms to the extent that is allowed by current knowledge and technology; knowing that the patient had a chance to complete tasks related to their important relationships; the nurse believing that they had delivered the best quality of care possible; and the patient's death did not violate the natural order and was contextually appropriate. It was particularly distressing for the nurses when they were not able to help a patient have a "good death" or if they were off duty when a patient who was important to them died. This created grief that was more difficult, complicated, painful and distressing. As oncology nurses, we have an opportunity to recognize and be aware of situations that can result in distressing situations for ourselves and our colleagues. These situations provide an opportunity to conduct critical incident debriefing sessions.

As I mentioned, included in the bereavement package was an article entitled "To Cope With Stress" by Kathleen R. Martin that appeared in the May issue of *Nursing '93*. This article gives an outline of steps and methodology in conducting a critical incident stress debriefing session.

Critical incident debriefing sessions

A critical incident stress debriefing session should occur when:

- many individuals within a group appear distressed
- the signals of distress appear quite severe
- personnel demonstrate numerous behavioural changes
- personnel request a time to talk about the event
- the event was extraordinary
- signals of distress continue beyond three weeks post-event.

From Mitchell, J., Gray, C. In *Emergency Services Stress*. Englewood Cliffs, N.J. Prentice Hall, 1990. pg. 143.

Critical incident stress debriefing team

The ideal situation involves the development of a critical incident stress debriefing team. This team is trained to respond to critical incidents that occur in the hospital setting, provide support and counselling and educate staff on the concepts of critical incident stress. The goals of a critical incident stress program would be to: Provide pre-critical incident stress education, to prevent and reduce the long-term effects of critical incident stress, to provide the caregiver with the skills needed to reduce the intensity and frequency of critical incident stress and to manage it if it occurs.

Critical incident stress debriefing process

Whether or not a critical incident stress debriefing team actually exists in your hospital, a debriefing process can occur as a natural part of the closure process in difficult patient deaths. This can be a part of the culture of the unit. The actual debriefing session involves a skilled facilitator (i.e. a clinical nurse specialist or social worker) who assists to move the group through a series of phases. The goal is to reduce the probability of long-term problems by conducting mandatory sessions 48-72 hours after an incident. The debriefing should include the staff directly involved in the occurrence. The facilitator's goal is to cognitively restructure the event to emphasize the success of the employee in dealing with the traumatic event. Essential to the success of the debriefing is the assurance that no repercussions will follow disclosure of feelings and symptoms and that expressions of emotions will have no effect on the employees' performance evaluation, respectability or assignments.

Peer support

Another idea from the literature we reviewed involves the development of a peer support network. In this instance, peer supporters are chosen or volunteer from the nursing staff to serve as a part of the critical incident stress management team. The peer supporter is required to be friendly, compassionate and have a genuine interest in her fellow employees. She functions as a listener, and is trained to act as an observer to identify potentially stressful incidents.

Saunders and Valente (1994) propose a bereavement task model that provides a useful perspective for explaining nurses' bereavement. This model can be used in discussions and as a method of making nurses aware of issues and tasks associated with bereavement. These tasks include: Finding meaning; restoring and maintaining integrity; managing affect; and realigning relationship. The intensity of the work required to complete the task depends upon: The circumstances of the death; the difficulty of the death and the occurrence of multiple deaths at the same time.

Finding meaning

Regardless of the circumstances of the death, the initial task involved in working towards grief resolution includes making sense of the death and finding meaning. Finding meaning is an emotional and cognitive processing task that involves understanding the experience of death.

Making sense of a "good death" is not as difficult as making sense of a "bad death".

Restoring and maintaining integrity

This task involves continuing the sense of a nurse's professional integrity, personal wholeness and self-esteem. This is an important task to complete in the event of a particularly difficult death when a re-examination of values, roles and professional obligations occurs. A nurse's values and sense of integrity may be threatened when a conflict exists between the treatment course and the wishes of the patient or family member to discontinue treatment.

Managing affect

Affect varies for each individual but includes such emotional responses as crying, sadness, anger and anxiety, all emotions linked to grief. Staff conflict over managing affect may cause some nurses to establish professional boundaries and avoid sharing feelings. Confusion arises when some professionals expect everyone to grieve in a standard fashion.

Re-aligning

This task involves re-affirming relationships that may have been influenced by the patient's death, particularly when it was difficult and involved a conflict with family members or other health care professionals. Disputes may lead to team dysfunction, communication problems, mistrust and alienation.

The individual members of a team and the team as a whole are susceptible to cumulative effects of loss and "bereavement overload". Overload occurs after significant or multiple deaths happen or when

there is not enough time between death to cognitively appraise, or give meaning to the death.

Stress is a normal part of life, but burn-out is not. It is important to read, take steps/courses to alleviate stress associated with bereavement. Support each other as you work with the dying and their bereaved families.

It is important that nurses take the opportunity to review their feelings and thoughts associated with patients' deaths. In the profession of oncology nursing, patient deaths constitute an occupational hazard.

We need to encourage personal and professional growth through the recognition of situations that can precipitate critical incidents, and the provision of opportunities for discussion and review of feelings. Look after yourself, take the time to ponder life, relax, support each other and deal positively with feelings and emotions.

There is no better area of reflection in which oncology nurses can bring together their feelings, thoughts and skills to the betterment of themselves and for the quality of care and life of their patients. ♥

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