Peer support helps oncology nurses deal with dying patients

By Dawn Cruchet

Abstract

Benoliel (1967) found that nurses tend to avoid the pain of working with dying patients by controlling feelings and developing professional detachment that helps them to withdraw emotionally from the patient.

A pilot project was developed on the haematology/oncology unit of a large metropolitan hospital. This study, which consisted of three one-hour sessions, gave the nurses the opportunity to discuss how they coped with dying patients, individually and as team members. The results of these sessions were positive for the nurses who felt that they were able to share their experiences with co-workers. In addition, there was the opportunity to validate the relationship with the patient who had died and to bring a sense of closure to the experience.

Introduction

Nurses' encounters with the dying create stress and grief associated with professional and personal losses. In order to cope with this, Benoliel (1967) found that nurses maintained social distance from their dying patients. Lockard (1989) recognized that health care professionals must face their own mortality each time they interact with a dying patient, and that this constant identification leads to increased anxiety.

The intent of a death education program is to heighten the participants' awareness of their feelings about death and dying, provide an opportunity to explore these feelings, thoughts and reactions, and offer information about issues relating to death and dying, thereby decreasing the anxiety level and enabling the participant to more effectively care for and meet the many needs of a dying patient.

In a seminal study in 1967, Jeanne Quint Benoliel identified the need for systematic death education for nurses. She found that as a result of the anxiety created by dying patients, nurses tend to avoid pain by controlling feelings and developing professional detachment that helps them to withdraw emotionally from the patient.

Peer support groups for nurses provide a venue to deal with work-related issues, especially the sharing of thoughts, feelings and reactions to dying patients and their families. Larson (1992) pointed out that sharing distressing experiences helps to normalize difficult experiences and improves both self-esteem and a sense of efficacy by identifying alternative coping responses.

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There is a special challenge to oncology nursing because nurses share so much with their patients and families. At diagnosis, they share the hope of a quick remission. During active treatment, they share the hope of minimal side effects and relative comfort. During remission, they share the joy of being disease free. During relapse, they share the disappointment, anger, frustration and despair. And during terminal illness, they share the dying process and hope for eventual peace.

All this sharing and caring is not without consequences. Nurses experience a wide range of emotions. Mandel (1981) reported that nurses identified such feelings as anger, guilt, anxiety, depression, sadness, confusion, regret, hope, understanding and helplessness when caring for cancer patients. Since feelings are not right or wrong, but simply are, it is of paramount importance that nurses are able to share and explore these feelings. These feelings cannot be eliminated, nor should they be. Instead, means must be developed to allow and enable nurses to ventilate these emotions in a positive and supportive atmosphere. Peer support is the ideal way for nurses to help each other. Nurses need to focus on their coping mechanisms, both individually and as team members, in order to identify how they cope with dying patients and their families.

Death anxiety

Stephen Levine (1982) writes in his book **Who Dies?**:

Who is prepared to die? Who has lived so fully that they are not threatened by imagining their non-existence? For it is only the idea of death that frightens us. It is the unknown that we pull back from (p.5).

He writes that in our society which denies death, the confrontation with death "tunes us deeply to life" and helps us to become more fully alive.

Becker (1973) in his Pulitzer Prize winning book, **The Denial of Death**, writes that "the idea of death, the fear of it, haunts the human animal like nothing else" (p.ix). In Victor Frankl's remarkable book **Man's Search For Meaning** (1959), the author discusses how man's primary motivational force is his search for meaning, the one thing that gives quality to our lives. Death education programs should recognize this and include ways to help participants find their personal meanings in death-related issues. Momeyer (1985)

LE SOUTIEN DE L'ENTOURAGE AIDE LES INFIRMIÈRES EN ONCOLOGIE QUI TRAITENT DES PATIENTS MOURANTS

ABRÉGÉ

Benoliel (1967) a trouvé que les infirmières tendent à éviter la douleur associée au traitement des patients mourants en contrôlant leurs sentiments et en développant un détachement professionnel qui permet le retrait émotif par rapport au patient.

Un projet-pilote a été mené au Service d'hématologie/oncologie d'un grand hôpital métropolitain. Cette étude, qui consistait en trois séances d'une heure chacune, donnait aux infirmières l'occasion de discuter leur attitude face aux patients mourants, individuellement et comme membres d'une équipe. Les résultats de ces séances ont été positifs pour les infirmières, qui sentaient qu'elles pouvaient partager leur expérience avec des collègues. De plus, elles avaient l'occasion de valider leur relation avec le patient défunt et d'apporter un sens de clôture psychologique à cette expérience.

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postulates that the very reality of our finiteness contributes to the development of the psychological phenomenon of death anxiety and that the impact on patient care is profound. Holman (1990) concluded that frequent exposure to death renders health professionals vulnerable to severe anxiety, which they may try to avoid through death denial, leaving them psychologically unable to support dying patients.

Death education

Morgan (1977) noted that:

Death education relates not only to death itself but to our feelings about ourselves and nature and the universe we live in. It has to do with our values and ideals, the way we relate to one another and the kind of world we are building. Thoughtfully pursued, it can deepen the quality of our lives and of our relationships (p.396).

The leaders in the death-awareness movement have defined three goals of death education: Information sharing, values clarification and coping behaviours (Knott, 1979). He views the first goal as the dissemination of relevant data in the field of thanatology. The second goal includes the examination and clarification of one's personal values regarding death-related issues. The third goal, coping behaviours, includes a series of skills aimed at solving problems for and giving help to oneself and others. These goals are especially applicable for nurses because they are a way for nurses to keep up-to-date on thanatological knowledge, explore personal values and reactions, and develop coping strategies for caring for dying patients and families.

Benoliel's landmark study in 1967 showed that nursing students were not being adequately prepared to assume responsibility for meeting the needs of dying patients. Degner and Gow (1988) reviewed current approaches to death education for nurses and found that nurse educators preferred an integrated or elective course approach without systematic assignment of students to care for the dying. Nursing literature recommends that all death education for nurses include a component of direct experience. The current discrepancy between education and practice contributes to inconsistencies in the preparation of nurses to care for dying patients.

Peer support

Humphrey (1986) recommends that caregivers, including nurses, develop support networks among their peers to share the responsibilities and reactions to dying patients and their families. Tschudin (1991) states that "before anyone can support another person, he or she needs to be supported" (p.13). She goes on to discuss how nurses talk easily with patients about issues that are taboo for most people such as death, illness and AIDS. These discussions involve much emotional giving, because the topics may be outside conventionally accepted boundaries. Tschudin writes that "seeing that others have the same needs and problems is invaluable, and this cannot be learnt in isolation" (p.14).

Gilmore (1973) stresses the importance of how increased self-understanding increases one's capacity to help. What we don't know about ourselves we tend not to acknowledge in others. This is critical for nurses who share intense, special and very private moments with their patients, especially during times of life-threatening illness and death. Self-awareness is strengthening and leads to greater self security and more satisfaction.

The intent of using peer support as a form of death education is to give nurses the opportunity to share thoughts, feelings and reactions to their work with seriously ill patients who die. A nurse who can acknowledge his or her emotional response to distress is able to deal with it rather than be controlled by it (Cathcart, 1989). Sharing distressing experiences normalizes the difficult situations and improves self-esteem by identifying alternative coping responses (Larson, 1992).

Pilot project

A pilot project was undertaken with the nurses on a busy oncology/haematology unit of a large, metropolitan hospital. Two questions were addressed: 1) Does participation in a peer support group decrease death anxiety of oncology nurses? 2) Does participation in one, two or three one-hour peer support group sessions affect the death anxiety of oncology nurses?

Methodology

A series of three one-hour sessions were offered to each of two teams of nurses on the same oncology/haematology unit whereby they were asked to discuss how they coped, individually and as a team, with dying patients and their families. All nurses were given Templer's Death Anxiety Scale (DAS) (Figure One) as a pre-test and as a post-test to determine if there was a decrease in death anxiety as a result of sharing thoughts, feelings and reactions to the deaths of their patients. They were also given a questionnaire with demographic data (Figure Two) to complete. The post-test was given to all the nurses at the same time two weeks after the completion of the third peer support group session.

Templar's Death Anxiety Scale is a pencil-and-paper scale consisting of 15 keyed true/false statements that reflect a wide range of personal death experiences: Death concerns, fear of the dying process, and fear of corpses. Lockard (1989) found that test-retest reliability of the DAS with nursing students was .81 over a one-week interval. Internal validity was also established by Templer by checking for excessive inter-item redundancy.

Demographic data

Twenty nurses participated in this pilot project (n=20). All of the nurses were between 20 and 40 years old. Sixty per cent of the nurses had been practising nursing less than five years since graduation, while 40 per cent had been practising for more than five years. Seventy-five per cent of the nurses had been working on this unit for less than four years and 25 per cent had been working on this unit for more than four years. Eighty-five per cent of the nurses had experienced the death of a family member or close friend, while 15 per cent had not. All the respondents who had experienced this close death had encountered it in the last five years. Forty per cent of the nurses had encountered a situation where they seriously thought they might die, while 60 per cent had never felt this way.

Figure One
Templer's Death Anxiety Scale

1. I am very much afraid to die.	T F
2. The thought of death seldom enters my mind.	T F
3. It doesn't make me nervous when people talk about death.	T F
4. I dread to think about having to have an operation.	T F
5. I am not at all afraid to die.	T F
6. I am not particularly afraid of getting cancer.	T F
7. The thought of death never bothers me.	T F
8. I am often distressed by the way time flies so very rapidly.	T F
9. I fear dying a fearful death.	T F
10. The subject of life after death troubles me greatly.	T F
11. I am really scared of having a heart attack.	T F
12. I often think about how short life really is.	T F
13. I shudder when I hear people talking about a World War III.	T F
14. The sight of a dead body is horrifying to me.	T F
15. I feel that the future holds nothing for me to fear.	T F

Journal of General Psychology, 82, 165-177, 1970.

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Findings

The nurses who participated in this pilot project demonstrated a notable decrease in measured death anxiety between pre-test and post-test using Templer's Death Anxiety Scale (Figure One). The mean change was .95 (Table One).

A regression analysis showed there was no significant effect, i.e. no decrease in death anxiety relative to participation in one, two or three peer support group sessions. Table Two indicates that 15 per cent of the sample (n=20) attended no peer support group session. Sixty per cent were present at one or two sessions, while 15 per cent took part in three peer support group sessions. Ten per cent of the respondents did not indicate how many sessions they had attended.

Discussion

The nurses found the peer support group sessions to be helpful and positive. They felt the sessions gave them a chance to share their thoughts and feelings and validate the relationships they had had with their patients who had died.

Sharing thoughts

One nurse, who had had a difficult experience several years previously when she had become too involved with a patient and family, was careful to "distance" herself now. This in turn caused her conflict because she then felt that she was at times "cold" with her patients and families. Another nurse said she found it helpful to clarify her own feelings about death and dying before working in oncology. After an especially distressing experience with a dying patient whose mother became hysterical at the time of death, one nurse expressed how helpful it was to have the opportunity to review the situation and share her reactions a few days later in a peer support group session. Nurses also felt that they were affected differently by the deaths of their patients.

Personal coping methods

Several of the nurses felt it was important to set personal limits in terms of dealing with dying patients and families. These would vary from individual to individual. One nurse felt that attending the funeral of a patient with whom she had developed a special relationship helped her to acknowledge the death and terminate the relationship. Another nurse found that she needed to consciously separate her "work life" and her "home life" and concentrate wholly on one or the other. One nurse liked to call the family of the patient who had died in three or four months to see how they were managing. Another nurse found it helpful for him to review the situation in his mind afterwards when the patient he was caring for died.

Table One
Mean scores of Templer's Death Anxiety Scale

	Pre-test	Post-test
N	20	20
Mean	7.80	6.85
SD	2.09	2.41

Table Two

Peer support group sessions attended	n=20	%
0	3	15
1	6	30
2	6	30
3	3	15
Did not respond	2	10

Team coping methods

The way nurses coped as team members with the deaths of patients and their families was also highly individual. While one nurse did not like to be alone with the body after death and would ask a colleague to accompany her, another preferred to be alone with the body because she felt it was a good opportunity for her to say a quiet goodbye. One nurse recalled an especially difficult situation when a patient was admitted to the unit and died within four hours. The nurses discussed how one of them had stayed with the family while another remained with the patient. In this way, they were able to help each other out and, at the same time, provide support for both the patient and family.

The nurses acknowledged how much more stressful it was for them to care for a patient and family at the time of death when they did not know and had not previously cared for this patient. They felt the establishment of rapport was very important when caring for a dying patient and family. The nurses discussed how they also supported each other informally throughout the day, sharing thoughts and reactions over lunch and coffee. However, they felt that this type of peer support was sporadic because of time constraints.

Conclusions

Participation in peer support group sessions decreased the death anxiety in a group of oncology nurses. The number of sessions each nurse attended was not a significant factor. The nurses who participated in this pilot project found it was so helpful that they

Figure Two
Demographic data

- What is your age?

a. 20 to 25 years	35%
b. 26 to 30 years	35%
c. 31 to 40 years	30%
d. 41 to 50 years	0
e. 51 to 65 years	0
- How many years have you been practising nursing since graduation?

a. less than 2 years	35%	} - 60% <5 yr.
b. 2 to 4 years	25%	
c. 5 to 8 years	10%	} - 40% 5 yr. +
d. 9 to 12 years	25%	
e. more than 13 years	5%	
- How long have you been working on this unit?

a. less than 6 months	5%	} - 75% <4 yr.
b. 7 to 11 months	10%	
c. 1 to 3 years	60%	} - 25% 4 yr. +
d. 4 to 7 years	10%	
e. more than 8 years	15%	
- Have you ever experienced the death of a family member or close friend?

a. Yes	85%
b. No	15%
- If yes, when did you experience the death of this family member or close friend?

a. in the last week	6%
b. in the last 6 months	12%
c. in the last year	18%
d. in the last 5 years	65%
- Have you ever encountered a situation where you seriously thought that you might die?

a. Yes	40%
b. No	60%

requested that support group sessions be incorporated into the work week. As a result, the assistant head nurse of the unit now leads a peer support group one morning a week. In this way, each team has a session every second week.

The author believes there are a number of reasons why this pilot project was effective and worked for these oncology nurses. The head nurse was supportive of this project from its inception. Support was demonstrated during the project and in her covering the floor from 0730 to 0830 to allow the staff nurses time to participate in the peer support group sessions. It also showed that she recognized the need for the sessions. The assistant head nurse also endorsed and supported the project enthusiastically. The nurses on the unit had already developed a rapport and relationships with each other. Initially, the author co-led the sessions with the assistant head nurse, who later independently led the sessions for Team II. This participation was an important factor because staff were actively involved and felt they were part of the project. Since the author's role was not perceived as being especially prominent, it was easy for the nurses to incorporate the peer support group sessions into their work week since it met their needs and was helpful to them. The assistant head nurse felt that she gained valuable insight into staff behaviour and attitudes. These insights would be helpful in terms of staff assignments and needs that might otherwise not be addressed. Awareness was raised concerning interests and needs of the staff nurses. For example, the nurses recognized their use of highly technical skills in oncology nursing but felt they did not have too much experience with patients choosing to die on the unit. Many of the patients died during a crisis in the intensive care unit or were referred to the palliative care unit when active treatment was no longer an option. The nurses requested more information on the physiology of the dying process so they could be more helpful to families.

The peer support group sessions gave the nurses the opportunity to validate their feelings about dying patients and to bring a sense of closure to the relationship they had with the individual who had died. They also gave the nurses the chance to share thoughts and feelings with each other. It was generally acknowledged that nurses are affected differently by the deaths of patients and it was reassuring to discuss these differences.

Implications for future nursing practice

The findings of this pilot project the continuation of ongoing peer support group sessions. The inclusion of other members of the multidisciplinary team on the oncology/haematology unit, such as the social worker, dietician, nursing aides, rotating physicians and

medical students, would give other caregivers the opportunity to share their thoughts and reactions to oncology patients who die from their disease. Nurses in the oncology day centre of this hospital might also be included in these sessions because they, too, develop close relationships with the same cancer patients and families who attend as outpatients. Inclusion in the peer support group sessions would give oncology day centre nurses the opportunity to share their feelings and bring closure to the relationships they developed.

The value of peer support groups is not exclusive to oncology nurses. Since 70 to 80 per cent of individuals die in Canadian hospitals (van Bommel, 1992), most nurses will care for dying patients at some point, and some more frequently than others. All nurses can benefit by sharing the thoughts, feelings and reactions that occur when a patient dies, thereby normalizing their experiences and in so doing, energizing themselves.

Implications for nursing research

A future research consideration would be a more indepth qualitative study on the various coping mechanisms of nurses, individually and as team members. Research on attitude and behaviour change in nurses as the result of peer support group sessions is also worthy of investigation.

Another direction might be to determine the relationships of age, personal death experiences and nursing experiences on the pre-test anxiety scale. This pilot project could be replicated and a coding system developed to ascertain if these variables affect the DAS of individual scores. Follow-up post-tests at six months and one year would be beneficial in determining if the group of nurses continued to have a significantly lower death anxiety level over time.

Strong emotions are a natural part of helping people cope with life-threatening illness, grief and loss (Larson, 1992). Oncology nurses, and indeed all nurses, need to acknowledge these feelings and find a way to share and validate them. Peer support groups provide this venue and strengthen nurses' interconnectedness so that they are able to find the right balance between giving to themselves and giving to others.

Acknowledgements

The author would like to express her appreciation to Carol Burnett, Marika Swidzinski, Catherine Oliver and the participating nursing staff of the Royal Victoria Hospital, Montreal, for their help, support, encouragement and cooperation with the implementation of this pilot project.

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