

# GriefMatters

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#### COVER

*Wheeler's Hill resident Lilli Hatch, who will celebrate her 106th birthday on the 06/03, pictured in Melbourne, Victoria  
with nurse Alison Lingard, who has been a friend and carer for Lili for 10 years.*

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# Editorial

With a combined total of 283,087 registered and enrolled nurses in Australia, nurses comprise the largest occupational group in the health workforce in the country (Australian Institute of Health and Welfare, 2010). As a cornerstone of the nation's health care industry, the nursing workforce is diverse, with nurses undertaking the provision of nursing care, health promotion, patient and public education on the prevention of illness and injury, participating in rehabilitation and social and emotional support. Most nurses will confront death while performing their daily duties and they play a pivotal role in the provision of grief and bereavement care, both within general and palliative care nursing roles. Few workplaces, other than palliative care settings, provide additional training and support to help nurses cope with caring for dying patients and the bereaved. Patient death can result in suffering for the caregiver and burnout. The provision of skills training, education and professional and personal support requires both individuals and organisational resources.

This edition of *Grief Matters: The Australian Journal of Grief and Bereavement* takes as its theme the work of the nurse and their interface with grief and bereavement. Papers explore the impact of these experiences on the nurses' professional role and personal wellbeing.

The first paper, by Kain, considers the exposure of nurses to death and dying within their clinical practice. Consideration is given to how patient death impacts upon the nurse and to what extent to these experiences contribute to professional burnout. It considers the question of to what extent is this experience of loss recognised by the nurse, colleagues and administrators. Examining these questions through the lens of disenfranchised grief, Kain provides an overview to the literature and addresses issues such as the need to control emotions and to "remain strong" in the face of family and colleagues; the impact of patient death upon the "good order" of the workplace and a work culture which does not encourage shared narratives and meanings about the impact of loss. The paper concludes with a discussion of the implications for practice and research.

In her paper *Reflections on the grief of nurses*, Vachon considers the nature of compassionate care – for the dying, the bereaved and for oneself. Engagement with life-threatening illnesses and bereavement is considered as whole-person care, in that the whole person of both the client and caregiver is involved. Compassion involves a recognition that all beings suffer and the human desire to alleviate that suffering. This involves non-attachment to outcome and the recognition that no matter how hard the nurse works there will be suffering, death and grief. Organisations have a responsibility to help nurses who are experiencing grief in response to their work; however, nurses also have a responsibility to care for themselves through mentorship; supervision;

individual and group social support; education and training; opportunities to attend funerals; and to receive external counselling and psychotherapy.

The final paper by Allison draws upon 40 years of nursing experience and provides a personal reflection on grief and loss in the workplace. Beginning with the first death of a patient and the powerful impact of a nursing supervisor who showed skill, empathy and compassion, to later experiences that were characterised by the empathic failure of colleagues, and others' experiences where the patient was the teacher. Allison reminds us that nurses are a diverse population with varied skills and capacity for self-awareness and compassionate connection. The paper concludes with a discussion of how health settings can provide support to enable the development of resiliency and optimism.

This edition of *Grief Matters* will further our understanding of the particular challenges that confront nurses in the provision of care to patients and to themselves. The task-oriented and time-poor culture in which nurses' work can often make the provision of grief and bereavement care problematic. These papers articulate a common view that organisations need to develop approaches to help nurses learn to cope with the deaths they experience in their workplace while at the same time recognising the diverse ways that nurses grieve. Of central importance is access to mentorship and supervision, opportunities for social support, and enhancing awareness of the impact of supporting patients, families and themselves in the wake of loss.

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# An Exploration of Grief in Contemporary Nursing

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## Abstract

In many areas of contemporary clinical practice, nurses are exposed to death and dying, which may contribute to professional burnout. However, little is known about whether nurses who care for the dying patient and their family experience their own grief when patients die. This paper presents a review of the literature to discuss the definitions of this aspect of nursing practice, and examines the concept of grief and its juxtaposition with contemporary nursing. There is a dearth of research examining grief in nursing practice; it is hypothesised that nurses may not feel they can express their grief and become self-disenfranchised due to the assumption that society expects them to remain strong in the face of death, and the expression of grief may give the appearance of vulnerability.

## Background: Locating Grief in Contemporary Nursing

Since Freudenberger (1974) first defined the effects of continual exposure to death and dying as contributors to professional burnout, there has been growing interest regarding the emotional toll on those caring for dying patients and their bereaved families. While the literature is replete with evidence informing nursing practice about how best to care for dying patients and bereaved families, there is limited emphasis on whether nurses who care for the dying patient and their family experience their own grief when patients die (Benoliel, 1974; Gerow et al., 2010; Papadatou, 2000) and, if so, whether this grief is disenfranchised (Lev, 1989).

Disenfranchised grief refers to the grief a person experiences that is not acknowledged, socially validated or publicly mourned, and there is no social recognition that the individual has a right to grieve or need for social support and sympathy (Doka, 1989; Stroebe, Hansson, Schut, & Stroebe, 2008).

Whether or not disenfranchised grief affects the work lives of nurses and their working relationships, however, is a question that has received little research attention. This paper presents a review of the literature to discuss the definitions of this aspect of caregiver suffering, and examines the concept of disenfranchised grief and its juxtaposition with contemporary nursing.

## Method

A search strategy was employed to identify published studies relevant to the literature review. Included studies were written in English; reported disenfranchised grief in a variety of settings; and were not limited to publication year cut-offs. Abstracts were reviewed by the author to assess their eligibility for inclusion. The reference lists of included studies were checked for further relevant literature. Databases included PsycINFO, PsyArticles, ProQuest and Google Scholar. The primary search terms used were (a) *disenfranchised grief*, and (b) *nurses/nursing*. As a result of the preliminary search, secondary search terms included (c) *anticipatory grief*, and (d) *ambiguous loss*.

## Findings

### Anticipatory grief and ambiguous loss

While this paper will focus on disenfranchised grief, it is important to note that ambiguous loss and anticipatory grief were found to be closely framed around disenfranchised grief as factors that can contribute to this type of grief (Frank, 2008; Sobel & Cowan, 2003).

Frank (2008) describes anticipatory grief as the emotions felt by caregivers when the care recipient is still alive; for example, when a family member tests positive to a given disease, families grieve for what is expected and then grieve again upon physical death (Sobel & Cowan, 2003). Given that nurses can experience a succession of losses when working with patients with life-threatening illnesses and their families, nurses are at risk of experiencing anticipatory grief before the death of a patient. Not only can the patient death be painful for the nurse, but when exposed to death frequently, they may not have time to resolve the grief from one patient before another patient dies (Matzo et al., 2003).

Ambiguous loss is a component of anticipatory grief and has two aspects, (a) where the person is physically present but has lost the persona they once had, for example, in the case of dementia, or the loss of a family member who is physically present but psychologically absent (Kean, 2010); and (b) where the person is physically absent but their persona is intact, e.g. a soldier missing in action (Frank, 2008).

### Disenfranchised grief

Disenfranchised grief can present with symptoms including: anxiety, depression, insomnia, substance abuse, relationship breakdown, posttraumatic stress disorder, delay or inability to proceed through the grief process to recovery, withdrawal from society and low self-esteem (Dyer, 2005; Frank, 2008; Hazen, 2003; Selby et al., 2007; Thupayagale-Tshweneagae, 2008).

Disenfranchised grief can be imposed by family, friends, society, or even self-imposed (Selby et al., 2007). The accounts of disenfranchised grief outside of nursing are numerous and varied; the literature reveals the most prominent areas for an individual to experience disenfranchised grief include, but are not limited to: cross-cultural workers re-entering their own country, parents who suffer through miscarriages, mothers who relinquish their babies for adoption, family members of death row inmates (Aloi, 2009; Beck & Jones, 2007; Brier, 2008; Hazen, 2003; McCreight, 2004; Selby et al., 2009) and is suggested as a possible issue for nurses working in critical care or end-of-life settings (Anderson & Gaugler, 2006; Austin, Kelecevic, Goble, & Mekechuk, 2009; Doka, 2005; Hanna & Romana, 2007; Lee & Dupree, 2008; Macpherson, 2008; Moss, Moss, Rubinstein, & Black, 2003).

If an individual's loss is not acknowledged, emotional support is automatically withheld. In the case of family members of death row inmates, for example, society does not acknowledge the loss for the family members (because the death may be supported) and their grief goes unrecognised often without support from the community, leading to disenfranchisement (Beck & Jones, 2007; Jones & Beck, 2006). In research by Murray (2001), expressions of grief in this context may be seen as a social taboo.

### **Is grief disenfranchised in nursing?**

There is a growing body of research that informs doctors, nurses and therapists on the affect disenfranchised grief can have upon families with loved ones in palliative care settings (Brier, 2008; Doka, 2005; Dyer, 2005; Smith, 1999). Moral distress – the experience of uncomfortable, painful emotions that arise when the nurse is prevented from performing tasks that are deemed necessary and appropriate (Jameton, 1984) – is another example of caregiver suffering that can occur in many nursing disciplines. However, a study by Lee and Dupree (2008) to describe the experiences of paediatric intensive care unit (PICU) staff caring for a child who dies, found that moral distress was seen infrequently; a much larger problem was staff not feeling adequately supported in dealing with their grief.

Nursing staff facing disenfranchised grief in their career is a situation gaining momentum and nurses can experience this in a number of end-of-life settings. Residential aged care is one area where close bonds and attachments are made between the residents and the staff, and studies have shown that when a resident dies the grief does not stop with the family but is often felt by the nurses (Moss et al., 2003). The nurses' grief may not be recognised by the family or the facility, resulting in limited support and the possibility of disenfranchised grief. Anderson and Gaugler's (2006) study of certified nursing assistants in nursing homes also supports findings of disenfranchised grief in this group and states that when disenfranchised grief is experienced, poorer personal growth is experienced, defined by intolerance, and lack of compassion, forgiveness and hope.

Paediatric palliative care is another area where nurses may face disenfranchised grief. Successive, multiple deaths of children are part of the working environment, where nurses not only have to process the loss of the child but also witness the grief of family members (Fillion et al., 2007; Lee & Dupree, 2008). Liben, Papadatou and Wolfe (2008) presented a comprehensive review of the challenges facing paediatric palliative care; a major concern of the review was the need to acknowledge and support the emotional responses of the caregivers to help lessen compassion fatigue and burnout. Numerous studies support the need for debriefing after a critical incident or storytelling (of death experiences) between nurses to help make meaning out of the deaths and facilitate a supportive work environment (Doka, 2005; Hanna & Romana, 2007; Lee & Dupree, 2008; Liben et al., 2008; Macpherson, 2008), but these resources may not be available to assist nurses in dealing with their grief.

### **Discussion**

Nurses may not feel they can express their grief and become self-disenfranchised due to the assumption that society expects them to remain strong in the face of death and the expression of grief may give the appearance of vulnerability. This vulnerability and

fear of "losing face" may result in nurses developing ineffective ways of coping with grief, where the grief is compartmentalised, leading to emotional problems later (Brunelli, 2005). Within residential aged-care facilities, ageism and power differentials are also barriers to the expression of grief (Liben et al., 2008; Moss et al., 2003). Furthering the disenfranchisement of nurses' grief is the fact that facilities dealing with end-of-life care are structured so death has a minimum impact on ongoing patterns of work and relationships in the facility (Moss et al., 2003).

Doka (1989) hypothesises that individuals whose grief is disenfranchised are ostracised from social supports. Given this, if the nurse has few opportunities to express and resolve grief, it is possible that nurses who care for dying patients may feel alienated from their colleagues and workplaces, and may tend to hold onto their grief more tenaciously than they might if their grief was recognised and acknowledged. According to (Bowlby, 1973), holding onto grief in this way can lead to serious issues that may impact upon work performance and working relationships. Bowlby's grief theory of 1973 describes a series of phases through which the grieving person will experience grief reactions and, in time, reach recovery. During the first phase, the individual experiencing grief will engage in a period of numbness and shock, and may exhibit outbursts of extremely intense distress and/or anger. This is seen as a protective defense mechanism to blunt the emotions experienced. This has implications for attrition of nurses from clinical areas that expose them to death – such as palliative care, intensive care and other acute care settings – as well as other staffing issues. For example, disenfranchised grief may potentially create problems with bereavement leave in the workplace if the nurse experiences grief and feels the need to take leave to recover.

Disenfranchised grief may present as both physical and mental health problems (Selby et al., 2007). Attig (2004) hypothesises that when grief is disenfranchised, there is a failure to respect suffering and this violates the mourner's right to grieve. Furthermore, disenfranchisement of grief is considered a matter of denying a human right, and an ethical failure in that it fails to respect the bereaved both in their suffering and in their efforts to overcome it (Attig, 2004).

### **Implications for Practice and Future Research**

It is timely to move research beyond describing disenfranchised grief in nursing to measuring its impact upon our profession. While the significance of the existing literature on disenfranchisement of grief is valuable, most of the research examining this component of nursing practice is dated, and/or fails to contextualise the origins of caregiver grief. It is appropriate to recognise the important contributions of the literature within its limited focus; however, little is known of this aspect of caregiver suffering in contemporary nursing practice.

Further research is necessary to explore the extent of disenfranchised grief as a component of caregiver suffering in nursing. By recognising, validating and appropriately managing disenfranchised grief, policies can be developed that will prevent complications of grief, and offer significant support to those caring for dying patients and their families in the clinical and community environment.

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# LOSS & DISCOVERY

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# Reflections on the Grief of Nurses

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## Abstract

Working with those with life-threatening illnesses and bereavement is whole-person care, in that the whole person of both the client and caregiver is often involved. Our role as nurses involves caring and service. Part of service is compassion, recognising that all beings suffer and desiring to alleviate that suffering. True compassion involves non-attachment to outcome, recognising that no matter how hard we work there will be suffering, death and grief. Effectively caring for others involves self-compassion, self-awareness and self-care.

Organisations have a responsibility to help nurses and other team members who are experiencing grief in response to our work, but we also have a responsibility to care for ourselves.

## Background

Barnard, Towers, Boston, and Lambrinidou (2000) wrote that palliative care is whole-person care, not only in the sense that the whole person of the patient (body, mind and spirit) is the object of care, but also in that the whole person of the caregiver is involved as well. Palliative care is, par excellence, care that is given through the medium of a human relationship. Nursing is also work that is done through the medium of the human relationship. In work with those with life-threatening illness, palliative care and bereavement care, nurses ideally engage in whole-person care. Furman (2006) notes that in a holistic model of care, three levels of presence govern our relationships and tasks with patients: (a) physical presence or “being there” for the patient, which includes routine nursing interventions and tasks; (b) psychological presence or “being with” the patient, conveyed through communicating, assessing, caring and accepting them; (c) therapeutic presence, which includes connection with patients on a human level, using all resources of your body, mind and spirit.

**Table 1**  
Harper’s Stages of Adjusting to Work in Oncology (1994).

Stage I	1–3 months	Intellectualisation	Knowledge and anxiety.
Stage II	3–6 months	Emotional Survival	Experiences trauma.
Stage III	6–9 months	Depression	Experiences pain, mourning and grief.
Stage IV	9–12 months	Emotional Arrival	Skills, moderation, mitigation and accommodation.
Stage V	12–24 months	Deep Compassion	Achieves: self-realisation, self-awareness and self-actualisation.
Stage VI	8–10 years	The Doer	Inner knowledge and wisdom, inner power and strength.

Katz (2006) speaks of countertransference as the alchemical reaction that occurs when two individuals engage together at the most vulnerable time in human existence – the end of life. Alchemy is “that space” that takes its own place in the poignant relationship between helper and patient. Both can be transformed through the experience. Fifteen years ago, when I was diagnosed with stage IV Non-Hodgkin’s lymphoma, the experience of the reciprocity and alchemy involved in this whole-person care, both with my palliative care patients and the bereaved with whom I worked, came to have a new meaning. The experience is discussed in more detail elsewhere (Vachon, 2007) but the bottom line is that I had experiences that took me outside of my paradigm, led to my realisation of how connected we are with one another, and that the work we do does not go unrecognised.

## Compassion, Wisdom and Service

Harper (1994) observed the processes that new social workers went through in the experience of adjusting to work in oncology. She describes the stages as seen in Table 1. The latter stages of “Deep Compassion” and “The Doer” can perhaps help us to understand what happens when nurses have been working in a field involving life-threatening illness, palliative care and/or bereavement for many years. After a period of a year or two, the caregiver can become capable of Deep Compassion and after about 8–10 years the caregiver can become The Doer. In the stage of Deep Compassion, the clinician achieves self-realisation, self-awareness and self-actualisation. In The Doer stage, the caregiver achieves inner knowledge and wisdom as well as inner power and strength.

A Buddhist definition of compassion is to “want others to be free from suffering” (Rinpoche, 2010). To generate genuine compassion, one needs to realise that one’s self is suffering, that an end to suffering is possible and that other beings similarly want to be free from suffering.



Remen (2000) writes of service as being the role of the health care professional: "Basically service is about taking life personally, letting the lives that touch yours touch you" (p. 197). She contends that service is a relationship between equals. When you serve, the work itself keeps you from burnout.

Gonzalez (2012) notes that the role of the leader is to be of service and defines a leader as anyone who is in a position to influence others; so health care professionals are, by the nature of our work, leaders who serve. Gonzalez says that the mindful leader has nine characteristics. They are: present, aware, calm, focused, clear, equanimous, positive, compassionate and impeccable (pp. 6–7).

According to Gonzalez (2012), true compassion is deep caring without attachment. "This is not the same as deep caring with detachment, which would imply an arm's-length relationship that does not touch you, where you could not feel the pain or get hurt in the process of caring" (p. 164). This compassion is caring deeply but without being attached to the outcome. True compassion with non-attachment to outcome builds resilience and prevents burnout. She describes mindful leaders as doing their best each and every moment of the day, under the circumstances. They understand the importance and value of self-compassion, because they know that without taking care of themselves, their ability to serve and to perform at a high level is not sustainable (p. 7). Being compassionate requires self-awareness, which can be developed in part through mindfulness meditation.

The combination of self-awareness and self-compassion leads us to being aware of when a work situation involves the need to take extra time for ourselves to reflect and grieve. Self-awareness and self-compassion also involve our recognising that, in order to continue to be involved in this type of service, we need to be aware of our own ongoing needs for self-care. Shanafelt et al. (2005) found that medical residents who were sufficiently attentive to their own needs to engage in self-care activities (including "relationships, work attitudes, religious/spiritual practice, personal philosophies, and strategies related to job-life balance", p. 560) are able to care for their patients in a sustainable way with greater compassion, sensitivity, effectiveness, and empathy. Neuroscience research has shown that part of the brain that is connected to our ability to connect to our own physical processes (the insula cortex) is associated with the ability to be attuned to the somatic and affective processes of other. So, by paying attention and caring for our own needs, we are better able to care for the needs of others.

The compassionate care of the dying and bereaved requires the ability to give of oneself without being destroyed in the process. Learning how to do this takes time and requires the caregiver come to know oneself intimately, knowing what may trigger a sense of loss and grief and how to best care for oneself in order to grieve appropriately and move on with caring for others (Vachon, 2007). The subtitle of the Kearney et al. (2009) article on self-care for physicians in end-of-life care is "Being connected ... A key to my survival". As caregivers it is crucial that we are "connected" to ourselves, others in our personal lives, our patients and, perhaps, the transcendent, if we are going to be able to survive and thrive in our work with the dying and bereaved. Organisations have a role to help nurses with the grief that accumulates as a result of their work, but we also have a responsibility to care for ourselves

## Loss and Grief in Nurses and Integration with Grief Theories

Many years ago I interviewed about 600 caregivers from across the world about the stress they experienced in the care of the critically ill, dying and bereaved (Vachon, 1987). Feelings of depression, grief and guilt were the greatest manifestation of stress across all groups of professionals and specialties. These feelings did not come only from the deaths of clients. They came also from the loss of self-esteem and the loss of support from significant others, including team members. Early work by Papadatou (2000) and Papadatou, Martinson, and Chung (2001) validated these observations and noted that the losses nurses experienced may extend beyond the deaths of patients. These losses include:

- loss of a close relationship with a particular patient
- loss due to the professional's identification with the pain of family members
- loss of one's unmet goals and expectations
- losses related to one's personal system of beliefs and assumptions about self, life, and death
- past unresolved losses or anticipated future losses
- the death of self

Constant exposure to death and loss may leave staff with grief overload and considerable distress. However, being involved during the deaths of some patients may result in staff having intense positive experiences that promote professional development (Saunders & Valente, 1994). Greater exposure to patients' deaths has been linked to higher reports of stress and burnout in nurses (Payne, 2001). Constant confrontation with the death of others causes caregivers to repeatedly re-evaluate their own mortality and to re-examine the meaning of life and death (Mount, 1986). Wakefield (2000) notes that grief is like a powder keg. Caregivers may not be aware that they have been challenged by grief, but the effects of grief can be explosive and cause problems at any time. Despite this, caregivers are expected to carry on as "normal" once a patient has died.

Saunders and Valente (1994) found nurses felt that they handled their grief effectively if they helped the patient die a "good death", which involved the following:

- The nurse relieved the patient's distress and symptoms to the extent allowed by current knowledge and technology.
- Patients had the chance to complete tasks related to their important relationships.
- The nurse believed she had delivered the best possible care to the patient.
- The patient's death did not violate the natural order.
- The death was contextually appropriate (e.g. natural deaths in oncology).
- Although grief took longer than many nurses anticipated, they were proud of managing symptoms and facilitating family communication and this comforted them in their own grief.

In an international study (Papadatou et al., 2001) of grief in paediatric nurses in Greece ( $n=39$  oncology and ICU nurses) and Hong Kong ( $n=24$  nurses working on the general paediatric ward, Paediatric Intensive Care Unit or Neonatal Intensive Care Unit), 93% of the nurses reported they were grieving in view or after

the death of a patient. Only three reported avoiding involvement with patients to protect themselves from being affected by their death. These nurses remained emotionally detached and distant when children died and did not grieve. The nurses who allowed themselves to experience grief described it as being a continuous, ongoing fluctuation between focusing on the loss and pain and avoiding or repressing it. Responses that put them in touch with their loss and pain included sadness, depression and despair; recurring thoughts about the deceased and the dying conditions; the experience of guilt feelings; a need to cry, to pray, to temporarily withdraw from daily activities; and to share their experiences with colleagues or loved ones or attend the child's funeral to bring closure to the relationship. Responses that helped them to repress or avoid their feelings involved a systematic control of their feelings; becoming involved with clinical duties and activities and/or distancing themselves from the actual dying or death scene. Depersonalisation of dying children was used to counteract intense emotions (e.g. *"I see them as dolls, rather than humans"*, p. 408).

Later, Papadatou, Bellali, Papazoglou, and Petraki (2002) explored the grief responses of Greek paediatric oncology nurses and physicians caring for children dying of cancer and again found that grief responses fluctuated between experiencing and avoiding grief. This observation is similar to that of Garfield (1995) who wrote of caregivers alternating between numbness and experiencing grief while caring for people dying of AIDS. These experiences can be compared with the Dual Process Model of grief (Stroebe & Schut, 1999) in which there are two alternating dimensions of experiencing grief: (a) loss orientation with a focus on the past, and (b) restoration orientation with a focus on the present and the future. Oscillation is the movement between these two approaches. Oscillation also describes the process of moving between confronting and avoiding these dimensions of loss.

Caregivers may grieve for the child who has just died and remember her, while also moving on to care for the next child. This is not always a problem. There is also the possibility that the caregivers do not all experience grief in the same way.

Resilience is a concept that is gaining attention in both the bereavement (Bonanno, 2004; 2009) and palliative care literature (Ablett & Jones, 2007; Monroe & Oliviere, 2007). Resilience is a "universal capacity which [sic] allows a person, group or community to prevent, minimise or overcome damaging effects of adversity". It is not just about reforming, but about the possibility of growth" (Newman, 2004, in Monroe & Oliviere, 2007, p. 1). "The promotion of resilience does not lie in an avoidance of stress, but rather in encountering stress at a time and in a way that allows self-confidence and social competence to increase through mastery and appropriate responsibility" (Rutter, 1985, in Ablett & Jones, 2007, p. 608). Recent research shows that resilience can best be understood as the interplay between particular genes and the environment (Bazelon, 2007).

Professional caregivers have been found to have a higher than normal level of deprivation in their childhoods (Raphael, 1983). Given the recent work on resilience, genetics, and social support, it is conceivable that some caregivers are more sensitive

to the availability of social support within the work environment than others. Current research on resilience is also looking at issues of attachment. Hawkins, Howard, and Oyeboode (2007) studied adult attachment style in 84 nurses recruited from five UK hospices. Attachment styles were characterised as follows:

**Table 2**  
Attachment Styles (Hawkins, Howard, & Oyeboode, 2007).

Attachment Style	Characterised by
Secure	Comfortable using others as a source of support when needed.
Preoccupied	Having a positive model of others, but a negative model of self, leading to becoming preoccupied with their attachment needs, actively attempting to get their needs for acceptance and approval met in close relationships.
Fearful	Having a negative model of self and a negative model of others.
Dismissing	Having a positive model of self but a negative model of others.

Hospice nurses with a fearful or dismissing attachment style were found to be less likely to seek emotional social support as a means of coping with stress than hospice nurses with a secure or preoccupied attachment style.

### Coping with Grief in the Work Setting

#### A model for the grieving process of professionals

Papadatou (2009) proposes a model for the professional's grieving process that draws on her research and the literature on bereavement, much of which is discussed above. See Table 3 for a breakdown of the model's propositions.

**Table 3**  
Model for the professional's grieving process (Papadatou, 2009).

Proposition 1	Professionals who experience the death of a person as a personal loss are likely to grieve.
Proposition 2	Grieving involves a fluctuation between experiencing and avoiding loss and grief.
Proposition 3	Through grieving, meanings are attributed to death, dying and caregiving.
Proposition 4	Personal meanings are affected by meanings that are shared by co-workers and vice versa.
Proposition 5	Grief overload and grief complications occur when there is no fluctuation between experiencing and avoiding loss and grief.
Proposition 6	Grief offers opportunity for personal growth.
Proposition 7	The professional's grieving process is affected by several interacting variables.

## Approaches to coping with grief in the organisational setting

When caregivers begin to work in a setting where they will have regular exposure to dying persons, they should receive mentoring to help them to deal with their grief in a manner that is congruent with their personality and previous exposure to grief. Different types of support may need to be available for caregivers with different personality profiles. Redinbaugh, Schuerger, Weiss, Brufsky, and Arnold (2001) note, for example, that physicians and nurses may have different personality structures and prefer different coping strategies, which may lead to differences in response to patient deaths. Individuals have natural propensities and aversions for minimising grief reactions. Some caregivers would be likely to talk about their grief. Others would attempt to understand their grief through its depiction in literature and the arts. Some might dampen their grief with alcohol or drugs and others would use personal faith to resolve their grief. There is no "one size fits all" approach to grieving professionals any more than there is one for grieving family members.

Appropriate forms of intervention need to consider the needs of varying team members. Since attachment styles have been associated with bereavement outcomes (Prigerson et al., 2009; Parkes, 2011) it is logical that the early experiences of nurses may leave some people more vulnerable to issues of attachment and loss. More research is needed to determine the best approach for dealing with the needs of staff with different needs for bereavement intervention in the clinical situation.

Caregivers may be helped to recognise the feelings associated with grief that they experience when a patient dies, identify the source of these feelings and be offered the opportunity to share their feelings with a caring team, or reflect on their own. The caregiver might ask themselves the following questions and may find the suggested approaches helpful (adapted from Vachon, 2007).

*Are these normal, straightforward feelings of grief because the caregiver was close to the person and will miss the person? If so:*

- talking with colleagues about what was gained in the relationship with the person and what is lost with the person's death
- recognising what made the relationship with that person so special
- journaling about the experience with the person
- attending the person's wake, funeral or memorial service
- writing a card or letter to the bereaved relatives
- taking the time to acknowledge whatever emotions are being experienced and reflecting on how the experience with that person will affect your future care of other patients?

*Are these feelings caused by identification or over-identification with the person who died? If so:*

- The caregiver may need to speak with a more experienced colleague or engage in a supervisory process in which the caregiver can look at whether this identification with the patient is reflective of unresolved grief for a person in the caregiver's past who has died. If so, the caregiver might wish to take the time to deal with that grief with a therapist or grief counsellor.

- Is the grief due to recognising one's own mortality through identification with the patient? If so, the caregiver might find it helpful to speak with a trusted colleague, or friend about her ideas about her personal mortality. What would it mean to be dying in the way this person has just died, or is dying?
- Does the caregiver seem to frequently experience more than the anticipated amount of grief when patients die, or does the caregiver never seem to really "connect" with patients enough to experience any grief?
- Does the caregiver have unresolved grief from the past that is unrecognised? If so it might be helpful to either seek therapy, or attend a workshop dealing with grief issues.
- Consistent experiences with more than the usual amount of grief may also be reflective of a problem with boundary setting, or not having enough of a life outside of the professional setting, thereby trying to receive all of one's satisfactions through work. The caregiver needs to find interests and relationships outside of the work situation that also give satisfaction.

*Are the feelings caused by the fact that this was not a "good death" or is the caregiver experiencing feelings of guilt about something that happened in the relationship or in the patient's care? If so:*

- The team might schedule a meeting to discuss the person's death, discussing what lessons might be learned to improve the care of patients to follow.
- The caregiver might speak with colleagues, a manager, or a therapist about specific concerns about the care given, either letting go of unnecessary guilt, or recognising the mistakes one made and vowing not to make them again.

## Conclusions

Nurses will experience grief in a variety of ways and from a variety of sources in our work with those with life-threatening illness and bereavement. If we can bring true compassion to our care of ourselves and our patients (e.g. working to develop non-attachment to outcome through meditation and other reflective practices, engaging in self-awareness and self-care practices, seeking help as needed and having a rich life outside of work), we may be less traumatised by the experiences of loss and grief in our professional lives. That does not mean that we will be immune to suffering but that we may have an increased resilience to the multiple losses we experience.

Organisations need to develop approaches to help nurses learn to cope with the deaths we experience in our work, recognising that grief is a natural expression in response to loss. These approaches will need to recognise that people will grieve in different ways depending on their personality and previous experiences with attachment, resilience and grief. Programs involving mentorship and supervision; opportunities for social support individually and in groups in the workplace; intellectual input through lectures and workshops; creative ways to deal with grief through art or organisational memorial services; having opportunities to attend funerals; and having outside counselling and psychotherapy available to nurses are approaches that may facilitate the natural expression of grief and allow nurses to function in a healthier way in the work environment.

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# GriefMatters

The Australian Journal of Grief and Bereavement

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*Grief Matters: The Australian Journal of Grief and Bereavement* is looking for articles relating to grief, loss, and bereavement around the following themes:

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# Grief, Bereavement and Self-Care in Nursing

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## Abstract

Nurses witness pain, suffering and loss as part of their normal professional experience. They therefore confront grief – not only that of their patients but also their own personal grief. This article draws on grief response insights I have gained from my interactions with, and observations of, patients and nurses. Vignettes are used to illustrate these experiences and observations. The experience of grief, if combined with self-awareness, professional development and support, can enhance resilience and optimism and be a positive professional experience.

## Reflections on the Impact of Nurses' Experience of Grief

A common misconception becoming more pervasive in our society is that we should avoid negative situations. This is a utopian notion that nurses understand is an unrealistic one. Nurses are confronted with suffering and must learn to navigate the emotions and potential trauma associated with witnessing pain and distress. With support and reflection they can learn to develop the skills of resilience, optimism and the confidence to tackle stresses and become effective, supportive and therapeutic clinicians. Anderson and Ewen's (2011) study of nurses in a nursing home found nurses that grew personally and professionally from the experience of grief reported significantly lower levels of burnout, higher levels of psychological and physical wellbeing and higher levels of job satisfaction. They surmised that these findings could indicate that grief may be a determinant of wellbeing.

This is my fortieth year of nursing. I have worked in many, and various, areas of health care. This is a reflection of the impact on nurses from caring for patients and families experiencing illness, pain, loss and death. During my nursing career I have witnessed changes in health care, nurse education and expectations of society – all have affected how we respond to grief and loss. The care of the dying has changed over the years I have worked. Medicine has become more focused on cure as technology has opened up new therapeutic options. Advancements in medical science have led to often unrealistic community expectations of what medicine can achieve. The medical and nursing professions can regard death as failure (Kellehear, 2009). This results from an overestimation of modern medicine's power to prolong life, increased life expectancy (usually secondary to simple public health measures) and an increasingly urban lifestyle that has left the natural world, and death, behind us.

Throughout my nursing career I have witnessed the "not for resuscitation" policies develop – a response to our attempts at resuscitating patients with resultant poor outcomes. We followed this policy with "medical emergency team responses" to try to improve outcomes

and now we have policies for "responding to the deteriorating patient" to reduce the need for medical emergencies. All legitimate policies but the emphasis is on a clinically, morally and, perhaps, legally responsible need to treat with curative intent no matter how poor the chances of a favourable outcome (Kellehear, 2009). Milliken, Clements, and Tillman (2007) identify that, with the expansion of clinical knowledge and technology, there is less time to provide patient care. Patients are "sicker" and the pressure to improve "productivity" increases the strain and stress related to achieving efficient and effective care. We have, at times, not recognised the important contribution medicine and nursing have to make to the dying patient and their family, friends and community.

The first death of a patient in my care was a man who bled to death from tongue cancer. He had been an inpatient for several weeks. I had only been on the wards for a short time after six weeks of preliminary training and every handover comment was made on the expectation that he would "bleed out". I was petrified of this occurring on my shift. And so, one afternoon, I answered his call bell and found him expectorating large amounts of blood. I raced to get the nurse supervising me. She responded and immediately came to the room, calm and competent. She spoke reassuringly to the patient, cleaned him and put him on his side. *"It won't be long, I will be with you."* She stayed with him, talking gently and calmly while he exsanguinated. I have no memory of what I did. He became unconscious and died. That nurse calmly said, *"I will ring his sister, then we will lay him out,"* and did so using very skilled, empathic communication skills. She guided me through preparing his body for transfer to the morgue. *"He worked in Africa, you know. He was a diamond miner. I imagine him in Africa with a helmet on, smoking a pipe! We'll miss him on the ward."* She talked to him and guided me in the procedure of laying out (quite a procedure in those days). I was in awe of her calmness, competence but, more importantly, her care – of the person that was her patient and, of me, her apprentice. We took the patient to the morgue and then went back to our other patients.

Do not get me wrong, our "training" did not allow for reflection, recognition of self-care, peer support or counselling. *"A nurse may grieve, but must do so silently, because others depend on her to be strong,"* was the unstated message. This is the conundrum. We need to be "caring", which means we need to be empathetic but we need to be "strong", which means we need to be resilient. From Moore (2002), empathy means "fully identifying oneself mentally with another" (p. 260); resilient means "readily recovering from a shock, illness etc., buoyant" (p. 705); and grief means "intense sorrow" (p. 260). The nurse that cared for the

first patient I witnessed die showed empathy – she knew his history, his losses and his fear but showed resilience by being calm and competent. She knew others needed her skills.

Many years later I sat in on a handover. Mrs M. was handed over as a 70 year old, day two, post mastectomy. She was described as “difficult”; she wouldn’t get up for a shower or bed making, not talking, generally non-compliant. She was allocated to me to care for. When I went to her she was lying in bed and did not interact. I asked her how she was. “OK,” was the response and nothing more. I noticed a photo of a little girl on her bed-side cupboard. “*She’s cute,*” was all I could think of saying. And she cried. I was paralysed (again) with my lack of confidence to explore this response. Luckily she took it up. “*She’s my granddaughter – her mother died of breast cancer two years ago and I am her mother now, and now I am going to die.*” I was completely out of my depth. I cannot remember exactly what I said but I had enough empathy to, at least, listen to her. I remember thinking, “*I won’t take her temperature because she will think I am stopping her from telling her story*”, so I listened and felt sad. Not long afterwards, the surgeon did his round. There was no 10 am temperature recorded and I was asked to “please explain”. I was told that was not an adequate explanation. I was angry – a response that came, both from my empathy for the patient, but, also, from the questioning of my clinical assessment (the patient was not unwell or showing any signs of infection – wound clean and no signs of being febrile). I resigned from that hospital. Pereira, Fonesca, and Carvalho (2011) discuss burnout as the consequence of emotional tensions. In health care settings, intense relationships with other human beings are often marked by patients’ suffering. They found that “health care settings do not offer the possibility for professionals to share their feelings or to cope with their emotions in a healthier way” (p. 323).

I did not leave nursing; instead I decided community nursing would best suit me. After a short while in this position I was asked to do an urgent visit to a young woman in respiratory distress with lung cancer. She was 30 years old, sitting in bed struggling for breath with her three-year-old son sitting on her bed. Her sister was her carer. I was a young mother and, of course, felt tremendous empathy. She refused to go to hospital and I administered subcutaneous morphine and hoped I had not killed her. She, in fact, settled and went to the football the following Saturday. I was subsequently her primary nurse. She died after several weeks and we were notified of her funeral. The culture of this community service was that nurses would, or could, go to the funeral. I went, more from my impression that this was an expectation, than from my need to “say goodbye” in a ritualised way. I am, however, very glad I went to that funeral.

It was very sad. A family had lost a mother, a daughter, a sister; a community of people had lost a friend, companion ... and, from all accounts, quite a fun-loving woman. I sat at the funeral and observed the full chapel. I realised I had been just a small part of her life. We had nursed her well – her symptoms were well controlled, her sister had enough support and equipment to care for her at home – she was desperate not to die in hospital. She had written letters to her little boy that he will read as he grows up. She had courageously handed the care

of her son over to her sister and brother-in-law: “*now he will have brothers and sisters*”. While the nursing team had helped with her symptoms, listened and helped to facilitate her leaving of her son, I had not lost a sister or a friend; a patient I had cared for well had died. I have never felt the need to go to a funeral again.

This patient taught me a lot. When she was told her disease was progressing and her prognosis poor, I had said “*I am sorry*” and she had said, in a sincere way, “*Don’t be, you didn’t give me the cancer, I need you to help me stay at home*”. My supervisor was supportive and encouraging. She didn’t forget to say: “*You did a great job there*”. The members of the team were competent and good communicators so we could discuss cases and collectively solve problems. It was a healthy work environment. We shared the vicarious stress.

This organisation also had robust education courses. It was through the palliative care course I completed during my employment with this community agency that I began to recognise how important self-awareness is in coping with life’s roller-coaster. We spent one afternoon examining our past and the significant people and events that had affected us, and then confronted our own deaths – where were we, who was there, and what had we left unsaid or undone? The impact of that afternoon still stays with me and I go back there when I lose perspective and resolve.

The acute sector remained an enticement and I returned, this time as a unit manager. Firstly of an acute medical ward and, following that, an oncology unit with inpatient oncology beds, palliative care suites and a day oncology unit. We cared for our patients from diagnosis to death. I felt very responsible for the wellbeing of the nurses. How would we manage the potential stress of being so constantly exposed to, and empathising with, such intense emotional and physical stress?

The nurses who were skilled, competent nurses, able to effectively care for and advocate for their patients, not surprisingly, continued to give excellent care and retained their sense of humour (much appreciated by their patients). The nurses who were less skilled and less able to advocate for their patients, started to take on the mantle of martyrs. Theirs was always the busiest shift with the most dramatic events. Discussions were difficult because most lacked self-awareness. They affected the rest of the team. They were “special” and, when a death occurred, it would be they who rushed to console the relatives. They would want to go to the funerals. Recognising that the nursing team could fracture, I instigated a collaborative approach to try to manage the situation. We developed communication strategies and other patient management tools and made available support for education and development and tried to facilitate reflection and discussion. The skilled nurses – those who understood the science, the disease process and had self-awareness and empathy, functioned, in the main, as a very able, efficient, effective team. They were resilient and supported each other with practical help – “*I’ll do that wash*”, “*let’s do that together*” and collegiate support, “*that son’s just angry because he’s grieving, you didn’t do anything wrong*”. Those who were less knowledgeable and skilled wanted the “quick fix” – practising Reiki (there is no scientific evidence for this therapy), displaying a moonstone (to create a peaceful environment) or

conducting a seance (to cleanse the room) – continued to think they were “special” and expressed the impact of the stresses they were exposed to. If I suggested working in another area of nursing, they would consider this a “lesser” option, often perceiving they were well suited to caring for dying patients because of their empathy: “*the patients love me*”. They often requested debriefings but then derailed them by not attending, or by dominating them with their own experience rather than the team’s experience. Without self-awareness, all other methods of self-care – a healthy lifestyle, time between work and home to “file” the day’s events and friends and colleagues to talk to – are not appropriately utilised. It is difficult to put grief into perspective if the nurse’s role in patients’ and their family’s lives and the illness “journey” is not appropriately understood.

My present position is as a clinical nurse consultant in palliative care. It is as if I am watching the hospital from “Google Earth”. I work in most wards, am well known, on committees and give lectures to everyone from interns and nurses to volunteers. It is a large, busy, acute hospital trying to balance standards of care and efficiencies within fiscal limits. A large proportion of this work is achieved by young, inexperienced clinicians and they do a great job. It is, however, a rare day that I don’t have a clinical, ethical or personal dilemma discussed. We have very skilled, competent managers and medical consultants. However, medicine practised by the novice can mechanistically focus on symptoms and physical signs, resulting in a clinical diagnostic process where results are shortlisted to a differential diagnosis, with further tests and investigations to pinpoint the cause, which is treated. Thus, it is the *disease* we are treating, not the patient. The diseased patient may be elderly, sometimes demented and subjected to uncomfortable, sometimes painful procedures – intravenous therapy, nasogastric tube feeding, scans, monitoring devices, oxygen saturation measurements, blood tests. Young doctors order these investigations and young nurses lack confidence and knowledge to question and advocate for their patients. The “not for resuscitation” form, including the medical emergency team response parameters are completed. The “falls risk” forms and “early discharge via transit lounge by 10 am” are “initiatives” that take precedence over rational, clinical judgement. Pereira, Foneseca, and Carvalho (2012) note that time pressures, excessive bureaucracy and insufficient education were the main risk factors for emotional exhaustion in hospice nurses. Having time to spend with patients and families and effective communication were protective factors.

It is important that consensus around the direction of medical treatment between staff, the patients’ families, and the patient themselves is developed. Nurses generally want to maximise patient comfort in order to avoid “torturing” the patient (Badger, 2005). Consider the eighty-six-year-old farmer from a distant country town, who has had a subdural haemorrhage drained and requires shackles to prevent him from removing his nasogastric tube, despite, reportedly having expressed wishes not to be kept alive if he is unable to return to his farm. This is unlikely to be a rewarding nursing experience.

How can health settings provide the support to enable development of the resilience and optimism

so necessary for healthy coping? Pereira, Foneseca, and Carvalho (2012), following a systematic review, identified that:

being affected by another human being’s suffering may in turn cause suffering for the professionals themselves. This suffering is commonly endured in silence. Health care settings do not offer the possibility for professionals to share their feelings or to cope with their emotions in a healthier way. (p. 323)

McGrath (2011) found that nurses may not acknowledge the personal impact of a patient’s death or accumulation of deaths; others have reported fatigue, anxiety, insomnia, and mood swings.

We must start by acknowledging death. A good start would be to use the word “died” rather than euphemisms, such as “passed away”. Does “losing the battle with cancer” mean that we are the army that have failed the patient? If we can openly discuss death and acknowledge its impact, we can develop strategies to assist self-care following a patient’s death. These include recognising that it is normal to feel loss and grief and each individual will express this according to their cultural norm. It is alright for nurses to acknowledge their emotions, sometimes it is appropriate to cry with families but it is important that support should be available for sharing these emotions with colleagues. This may be in the form of debriefing, discussions at handover, availability of formal counselling or some other way of acknowledging that nurses care. Nurses should be encouraged to identify a role model, to interact with a mentor to reflect on patient/family relationships, and to help foster self-awareness and professional development. Nurses need to feel part of a team and supported by that team. We need to be able to be able to recognise nurses when they are affected by a patient’s death or an accumulation of deaths. These nurses need support and encouragement and open acceptance of the need for professional counselling when appropriate (McGrath, 2011).

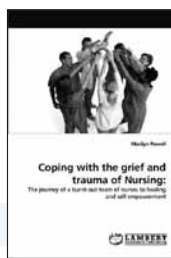
Being affected by another human being’s suffering and loss may cause grief for the nurse caring for that person. On reflection of my many years of nursing, I have observed that witnessing and supporting patients and their families who are suffering pain can be enriching and rewarding. Encouraging personal and professional growth requires support, positive role modelling, continued education, positive interpersonal team relationships and a realistic approach to loss, suffering and death as a normal part of life. Acknowledging that death can be accompanied with sorrow, loss, fear and regret, which, in turn, can impact personally on nurses, allows for individual and team strategies that can result in professional growth, resilience and optimism. With these ingredients we allow nurses to gain self-awareness and emotional maturity. The contribution nurses give in supporting patients and their families when they are suffering or dying can lead to greater professional and personal satisfaction.



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# Book Reviews



## **Coping With the Grief and Trauma of Nursing: The Journey of a Burnt-out Team of Nurses to Healing and Self Empowerment**

Marilyn Powell (2011)  
104pp. ISBN: 9783844315523  
Saarbrücken, Germany: LAP  
Lambert Academic Publishing  
US \$67.00

From a 1997 study with nine nurses, this book is a précis of the participatory research that aimed to explore the almost unfathomable world of nurses' grief. This "collaborative enquiry" involved the researcher, also a nurse, becoming embedded with the participants – ordinarily a conflict but Powell makes a meaningful case for the suitability of the method.

The historical, political and cultural imperatives that have defined the nursing role are explored as Powell discusses methodologies and philosophical dimensions influencing nursing. These include feminist, political and embedded perceptions of nurses and nursing – powerlessness and lack of voice; attitudes to each other; and continuing mismatch between the hierarchy in health care professions, all of which provide scant space for grief expression. The absence of support for emotional labour is highlighted, especially regarding caring for dying patients.

Powell explores participants' grief journeys to acknowledgment and empowerment in finally addressing grief – seldom the object of study but an area where serious reflection is due – and is dense with discussion for the exploration of grief with nurses, even midwives. The nurse's narrative provides those who specialise in grief and counselling many grounds for discussion. Participant comments provide interesting insights, often unspoken viewpoints (e.g. "coping regardless", a concept endemic in nursing) and intrinsically link disenfranchised grief with nursing practice.

Powell articulates expressions of grief, beginning with what participants originally considered as coping to how they would deal with grief in the future, providing some understanding of the isolation nurses experience and the "conspiracy" of silence accompanying the stigma of "not coping". Nurses risk themselves in developing meaningful relationships with their patients and become enveloped in the family's grief.

Management is not identified as supportive; effective nurses are expected to be proficient, cost effective and non-complaining – reinforcing cultural pressure to just "get on with the job". The study's recommendation is a strategy for structured debriefs every fortnight with management participation.

This is not a book that could be necessarily utilised by management to address the issue of grief experienced by nurses; however, nurses could make use of it as a guide to develop means to address their grief. While a small study, much benefit would come from its replication. It would be interesting to know if the strategy of fortnightly debriefing continued fifteen years on.



## **Grief Support for Nurses: An Assessment of Needs**

Christina G. Shinbara (2008)  
114pp. ISBN: 9781243576453  
Ann Arbor, MI: ProQuest LLC,  
UMI Dissertation Publishing  
US \$69.00

This research assessed the grief support needs of nurses, starting with a broad literature review exploring the definition and literature on nurses' psychological and physical responses to death and grief. Nurses are expected to be present with patients – to develop interpersonal relationships, not only with the patient but also the family and friends, contributing to, and influencing, nurses' grief responses. Models of grief are discussed, including Kübler-Ross, Kavanagh, and Doka's disenfranchised grief.

A web-based study was conducted with 62 respondents, using a snowball technique and a Needs Assessment Questionnaire. Respondents were aged over 18, held a nursing degree and practicing.

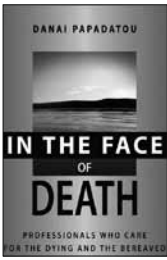
The survey articulates the impact of patient loss and nurses' experience of grief. Contemporary health services give minimal support; nurses receive little in the way of training, debriefing or meetings, and often lack training to know when they need help. Nurses' need for support is verified and the outcomes of the lack of support are myriad – most respondents acknowledged grief had affected performance.

It makes for an interesting read. Can the grief experienced by nurses be unacknowledged because society considers the relationship insignificant or because "it is their job"? Shinbara discusses "emotional tension", which surfaced throughout the study, supporting emerging research into the "emotional labour" of nursing.

The importance of coping effectively is highlighted, including acknowledging grief, seeking or receiving support (e.g. facilitating active listening, debriefing and engaging in narrative), and giving voice to grief among colleagues. Recommended interventions include formal training in grief and bereavement, support using participative programs, and improving institutional and collegiate support.

Despite limitations, the study provides insight. Similar research undertaken internationally would be valuable and stimulate discussion about what can and should be done about grief and nurses.

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Melbourne, Australia.*



**In the Face of Death:  
Professionals Who Care for the  
Dying and the Bereaved**

Danai Papadatou (2009)  
360pp. ISBN: 978-082610256-0  
New York: Springer Publishing  
Company  
AUD \$73.95 (incl. GST)

This is no ordinary academic textbook. It is nothing short of a masterpiece in which Papadatou provides the field of death, dying and bereavement with invaluable and constructive insights into the world of caring for the dying and the bereaved. Not only does the author draw on her strong clinical, teaching and research background in the field of paediatric oncology and palliative care, she also uses Greek myths and legends to illuminate present-day dilemmas for society in general and health care in particular.

In arguing the case for a “relationship-centered approach to care” Papadatou demonstrates a full understanding of the realities of caring for the sick and the dying on both an individual and team basis. Poignant vignettes are used to highlight both the suffering of helping professionals and the rewards of caring. Papadatou’s discussion of compassion fatigue, countertransference, burnout and vicarious traumatisation is meticulous in its detail and provides a helpful analysis of these complex and interrelated issues. More importantly, she provides constructive strategies for minimising “psychological absenteeism” and “depersonalisation” in helping professionals, behaviour that often adds to the suffering and isolation of patients and families.

The book is broadly divided into three sections: (a) “The caring relationship”, (b) “The care provider in death situations”, and (c) “The team in the face of death”. The concept of the “Good Enough Team”, with astute observations about leadership, supervision and the role of consultants skilled in organisational analysis should be essential reading for anyone working in a health care team. The principles and propositions that Papadatou offers are firmly based on research and scientific evidence and yet never lose sight of the art of caring. Indeed, in the epilogue she once again calls on the myths of Pandora and Prometheus to discuss the relationship between hope, healing and transformation.

In her own words, “May this book open up avenues for reflection; opportunities for debate; and an increased awareness of what we, the professionals, bring into our relationships with the people we serve, and what we receive in return that enriches our personal and professional lives”.

*Irene Renzenbrink  
Board Member  
International Work Group on Death  
Dying and Bereavement  
Melbourne, Australia.*

# Abstracts

Brunelli, T. (2005).

## **A Concept Analysis: The Grieving Process for Nurses**

*Nursing Forum*, 40(4), 123–128.

This article examines how nurses grieve following the death of a patient. The author begins with a concept analysis, conducts a literature review, examines a case study, and makes recommendations for practice and further discussion.

The concept analysis examined the concept of grief and the grieving process. Theories of grief are examined (Reece, Kübler-Ross, Kübler-Ross & Stephenson, and Pessagno) and commonalities between them are discussed. A review of the literature follows, which searched the content of the medical and nursing databases for research relating to the grieving process. Tellingly, most articles relate only to the nursing role as facilitating the grief process of patients, and one noted nurses' special training to handle the grief process and "teach" it to "lay persons", a claim the author disputes. Very few studies related to nurses' own grief. Four studies were found to be of use. The first identified burnout as a result of a compromised grieving process; the second discussed physical and emotional symptoms of the unresolved grief of nurses being a result of repressed grief; the third discussed a support program where nurses were supported from patient diagnosis to postdeath; and the fourth examined a Grief Care Plan developed specifically for nurses.

A case study is then discussed, exploring the grief responses of three nurses around one patient loss, a 15-year-old cancer patient. Between them, the three nurses present a model case (the author), a borderline case and a contrary case. The case studies examined each nurse's relationship with patient, their feelings and their behaviour, from admission through diagnosis and treatment, finally to death and coping (from incorporating lessons learned into their practice, to avoiding patient closeness, or to quitting nursing altogether).

Memorial services are recommended as a form of staff support. Resolution of grief is important to enable nurses to be fully present for their patients. Therefore, consequences of unresolved grief are bigger than just the individual nurse's response – they exist on a patient, hospital and even national level.

Anderson, K. A., & Gaugler, J. E. (2007).

## **The Grief Experience of Certified Nursing Assistants: Personal Growth and Complicated Grief**

*Omega*, 54(4), 301–318.

This article focuses on the grief of CNAs (certified nursing assistants) in nursing homes, a professional group that is particularly susceptible to grief. Despite their high contact with death and grief, scant training in relation to grief is provided to CNAs.

A literature review is discussed. Research identifies that nurses have the greatest physical and social contact with patients of all health care professionals. Nurses also have significant grief reactions to patient deaths and, in high-mortality settings, experience: (a) overwhelming and lasting guilt and sadness, (b) helplessness and moral distress, (c) low morale and loss of efficacy in their work, (d) unacknowledged and disenfranchised grief, (e) chronic and compounded grief from accumulated losses, (f) compassion fatigue, and (g) stress and burnout. CNAs are found to rely on mutual support and internal coping more than any formal support from employers.

The authors conducted a quantitative study to investigate CNAs' grief responses following patient loss, with the aim to identify and evaluate the factors that exacerbate and mediate grief. A total of 136 CNAs from 12 nursing homes in the US participated in the study, using self-administered surveys. Four factors of predictor variables for grief used in the study: (a) attitude toward death, (b) coping efficacy, (c) social support, (d) perceptions of disenfranchised grief. The "quality" of grief was assessed with two outcome variables: positive outcome (resultant personal growth) and negative outcome (resultant complicated grief).

CNAs with lower levels of disenfranchised grief had higher levels of personal growth, while those CNAs with less experience with death on the job and a greater fear of death had higher levels of complicated grief. Suggestions are given for the direction of future research, with the aim to enfranchise the grief of certified nursing assistants.

Gerow, L., Conejo, P., Alonzo, A., Davis, N., Rodgers, S., & Williams Domian, E. (2010).

### **Creating a Curtain of Protection: Nurses' Experiences of Grief Following Patient Death.**

*Journal of Nursing Scholarship*, 42(2), 122–129.

The authors of this paper conducted a qualitative study with 11 registered nurses in the US, using semi-structured interviews (for consistency between the five interviewers) with a phenomenological approach. They aimed to examine the lived experiences of nurses' grief following patient death and to develop understanding of nurses' feelings, emotions, grief reactions and coping mechanisms.

The authors first conduct a literature review, identifying that little research has been done into the grief of nurses. Some research has identified that grief of nurses over patient death is different to bereavement grief as typically experienced. Characteristic coping mechanisms in order to continue with patient care involve avoidance or compartmentalisation.

The study used purposive sampling with a small number of participants (consistent with other studies of this kind). Participants were all women aged between 29 and 61, with three to 43 years' experience as a registered nurse across various specialities. Interviews were conducted at participants' locations for the best outcome. Responses were analysed using Heideggerian hermeneutical analysis and Van Manen's progression of reflection, description, writing and rewriting.

Four phenomenological themes were noted in the participants' responses: (a) the "reciprocal relationship transcends [the] professional relationship", (b) "initial patient death events are formative", (c) "nurses' coping responses incorporate spiritual worldviews and caring rituals", and (d) "remaining 'professional' requires compartmentalising of experience".

The relationship between nurse and patient is considered reciprocal as the nurse benefits from the relationship – the personal growth experienced in the acknowledgement of need that the nurse could address through knowledge, skill and quality of care. This acknowledgement comes in the form of thanks from the patient and/or family for the nurse's care. Nurses are often struggling with competing and conflicting beliefs – grieving is a natural response to a positive relationship, yet as professional caregivers they are expected to keep an emotional distance. Nurses create a "curtain of protection" to ease the burden of grief and to continue in their work.

# Programs and Services

The Australian Centre for Grief and Bereavement is located at McCulloch House, Monash Medical Centre, 246 Clayton Road, Clayton, Victoria. The Centre provides a range of programs and services to both individuals and organisations. These include:

## Consultation and Advice

Centre staff are available for consultation on grief and bereavement issues. These may include advice on program development, staff training, client issues and evaluation. A flexible fee structure has been developed for consultation, which takes the type of organisation into account.

## Clinical Supervision

Clinical supervision for those who work in bereavement support is essential. Centre staff are available to take on a limited number of supervisees on a regular basis. Both individual and small group supervision is available for a moderate cost.

## Bereavement Counselling and Support Service

The Australian Centre for Grief and Bereavement has a confidential bereavement counselling service which is available to people who have been bereaved through any cause. This service is provided by experienced counsellors participating in advanced training in bereavement counselling. These counsellors are closely supervised by experienced accredited grief and bereavement practitioners.

Counselling appointments can be made by telephone and should be made directly by the bereaved person.

Contact the Bereavement Counselling and Support Service on +61 3 9265 2111. The service is located at McCulloch House, Monash Medical Centre, Clayton, Victoria.

## Referral

The Australian Centre for Grief and Bereavement has a referral database and can put agencies and individuals in touch with private bereavement educators and counsellors. This referral database is comprised of professional educators and counsellors who specialise in grief and bereavement. For referrals to private grief counsellors phone the Centre's Bereavement Counselling and Support Service on +61 3 9265 2111.

## Education and Training Programs

The Australian Centre for Grief and Bereavement offers quality education and training opportunities for health professionals, interns, students, volunteers and any other individual or agency wanting to incorporate counselling, therapy, support and education into their current work practice.

## Membership

Membership of the Australian Centre for Grief and Bereavement offers a range of benefits including *Grief Matters: The Australian Journal of Grief and Bereavement* (issued three times per year), special discount member rate for ACGB seminars, workshops and ACGB products, access to ACGB library for research purposes, free member functions and voting rights at the Annual General Meeting. Membership rates and details are as follows:

### 2012 Fees

<b>Individual Membership</b>	<b>\$110.00</b>
<b>Organisational Membership</b>	<b>\$275.00</b>
<b>Student &amp; Concessional Membership</b>	<b>\$85.00</b>

*The above prices include GST – Australia only*

## Reciprocal Membership of the Association for Death Education and Counseling (ADEC)

The Australian Centre for Grief and Bereavement now offers an enhanced level of membership, which includes reciprocal membership with the largest interdisciplinary organisation in the field of dying, death and bereavement, the Association for Death Education and Counseling (ADEC).

The US-based association is one of the oldest interdisciplinary organisations in the field of dying, death and bereavement. Its nearly 2,000 members include a wide array of bereavement practitioners, mental and medical health personnel, educators, clergy, funeral directors and volunteers. Further details on the organisation can be viewed at the ADEC website: [www.adec.org](http://www.adec.org).

In addition to the current benefits of ACGB membership, joint ACGB–ADEC membership will offer substantial benefits.

For full details, please refer to our website, [www.grief.org.au](http://www.grief.org.au) or contact the Centre.

### 2012 Fees

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<b>Organisational Membership</b>	<b>\$519.00</b>
<b>Student &amp; Concessional Membership</b>	<b>\$135.00</b>

Further information on the Australian Centre for Grief and Bereavement can be obtained by:

<b>Telephone</b>	+61 3 9265 2100
<b>Freecall</b>	1800 642 066
<b>Facsimile</b>	+61 3 9265 2150
<b>Email</b>	<a href="mailto:info@grief.org.au">info@grief.org.au</a>
<b>Website</b>	<a href="http://www.grief.org.au">www.grief.org.au</a>

## ACGB Online



### ACGB Website

The Australian Centre for Grief and Bereavement has developed a home page for access on the internet, and includes information about the Centre's activities, resources and a range of grief and bereavement information. Entries include information about education activities offered during the current semester, an order form for resource materials available for purchase, details about the Bereavement Counselling and Support Service and information from Bereavement Support Services in Victoria (a list of agencies and organisations which provide free or low cost bereavement counselling, support and services). Direct access is also available from the home page to other grief and loss sites.

The website is located at: [www.grief.org.au](http://www.grief.org.au)

### Support ACGB

The Australian Centre for Grief and Bereavement is an independent, not-for-profit organisation offering a range of education, counselling, research and clinical services in the field of grief and bereavement.

Donations over \$2 are tax deductible within Australia and allow ACGB to continue to provide services, including bereavement counselling, support groups, outreach, newsletters, events and education and training.

To make a donation, visit:  
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It is a condition of publication that papers have not previously been published, nor are currently under consideration for publication elsewhere.

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In preparing manuscripts, contributors should follow the rules set forth in the *Publication Manual of the American Psychological Association* (6th ed.).

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