

## After death 1: caring for bereaved relatives and being aware of cultural differences

Nurses are ideally placed to perform last offices for patients who are deceased and care for their bereaved relatives. Cultural awareness and sensitivity is vital

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This first in a two part unit on bereavement and last offices discusses relatives' grief reactions and caring for deceased patients, taking into account spiritual and cultural differences.

### INTRODUCTION

Caring for deceased patients and their relatives can be demanding, complex and emotionally exhausting but it is also a privileged experience for nurses.

Care typically involves performing rituals associated with last offices and providing cultural and spiritual support for relatives. Other aspects include health and safety issues and legal requirements (Pattison, 2007). In addition, care should be extended to supporting newly bereaved relatives by showing genuine concern and empathy (Hills and Albarran, 2009).

Recently, a more active approach to promoting dignity, respect, and dignified and compassionate care from nurses has been encouraged (Maben et al, 2010; Meyer, 2010). Arguably, the relationships that nurses have with patients should mean they are ideally placed to provide effective care for the deceased and to manage relatives' needs and grief reactions sensitively. However, the Healthcare Commission (2007) suggested that more than 8,000 complaints from acute hospitals focused on end of life care, after death care and care of the newly bereaved.

A number of policies have been developed to respond to the unique needs of families that are distressed and grieving. The End of

Life Care Strategy (Department of Health, 2008) offers a framework for improving end of life care for patients and families from the point of diagnosis through the dying process, after death and into bereavement.

### UNDERSTANDING GRIEF REACTIONS

Understanding and managing family members who have experienced the loss of a relative is determined to an extent by whether death was sudden or anticipated:

- Sudden death: as this is unexpected family and close friends may be extremely distressed and shocked on hearing the news;
- Anticipated death: as in the case of patients who are terminally ill and whose symptoms and complete care are managed by palliation. Preparing for the final moments, managing and controlling symptoms, involving patients and families in decision making, respecting their wishes and affording them dignity and privacy are all embraced in the concept of a "good death" (Pattison, 2008; Powis et al, 2004).

Typical displays of grief may include despair, disbelief, denial, anger, shock, tearfulness, helplessness, guilt, sorrow and deep sadness. Fainting, vomiting, shortness of breath, hyperventilation and cardiac chest pain are examples of possible physical responses (Pattison, 2008).

Cultural factors may also have an impact on relatives' grieving behaviours, such as inconsolable wailing or tearing of their own clothing.

Even when family members have been involved in caring and supporting a relative in their final days, they are still likely to experience grief reactions; these may not resolve immediately or mean their adjustment with bereavement will occur earlier than if the death was not expected.

Many theories explain expressions of grief and bereavement, although no single one

### LEARNING OBJECTIVES

- To understand the range of physical and emotional grief reactions among people who are newly bereaved.
- To be aware of different spiritual and cultural needs after death.

explains the complexity of emotions. While the depth and range of reactions can be affected by cultural, social and environmental factors, there is a consensus that emotional support in the early stages can prevent long term ill health associated with bereavement (Murray Parkes, 1998). The way in which

nurses convey empathy, compassion and emotional concern may be critical in mediating acute and long term responses and adjustment to grief.

### EXPLORING GRIEF THEORY

For most people, the death of a close family member stimulates a range of emotions that may be difficult to control.

Murray Parkes (1972) argued that grief is an evolutionary and instinctual behaviour aimed at re-establishing a relationship with the person who has died. Walters (1999) believed the purpose of mourning is to integrate and embed the character and life of the deceased into the ongoing lives of the bereaved.

Kübler-Ross' (1973) influential work on the process of dying suggested that coping mechanisms can be characterised by five stages:

- Shock/denial;
- Anger;
- Bargaining;
- Depression;
- Acceptance.

These responses do not follow an orderly sequence however, and some people move back and forth between the different elements. Kübler-Ross' work is often used to explain the grief responses of family members following death. Recognising the mourning process allows nurses to understand and accept that newly bereaved relatives' responses can be diverse and changeable.

Worden (1991) suggested there are four tasks for mourning that occur over time:

- Coming to terms with the fact that the death of a loved one has happened;
- Feeling the pain of grief both physically and emotionally;
- Adjusting to life without the deceased;
- Relocating and reinvesting in personal lives.

In contrast, Stroebe and Schut (1999) proposed that bereaved people cope with the stressors of grief by engaging in adaptive behaviours that move back and forth. This typically includes confrontational tasks, such as expressing grief and feelings of loss, while avoidance tasks involve denial, blocking memories and seeking relief in activities that keep the mind occupied. It is through these oscillating patterns of grief that resolution and emotional adjustment eventually take place.

## Supporting grieving relatives

Once the death has been communicated to the family, it is important to allow them time to comprehend the news and express their grief. Breaking bad news may be difficult if nurses have not previously met the family, so establishing and building a rapport early is vital. Nurses must be supportive and provide honest, compassionate and individualised information (Haas, 2003).

In community settings, in particular, it is important that family members have regular contact with nurses caring for their relative. This is useful if patients deteriorate or die unexpectedly, as having a nurse to provide emotional support and advice about the next steps is invaluable to those who are bereaved.

Culture, gender and other factors may

affect how grief is felt; relatives may become silent and withdrawn, deny the information given or become aggressive.

Nurses' ability to manage these extremes and support families rely on interpersonal skills. Research suggests this can be achieved by the following:

- A comfortable non-denominational venue to ensure privacy;
- Tailored emotional support and honest information (oral and written) relevant to families' needs;
- Providing opportunities for families to verbalise emotions and have questions answered sensitively, simply, clearly and informatively;
- Providing access to spiritual care, especially when based on religious faith;
- Offering relatives opportunities to view the deceased.

Viewing the deceased should be optional; for those who choose to do so, their experience can help with grief adjustment by enabling them to bid farewell to a life shared. Regardless of the patient's physical state, the appearance of the deceased and how families are treated during such occasions may affect how they cope with their bereavement in the long term.

Overall, nurses' communication skills are pivotal throughout the end of life care and bereavement process.

## AWARENESS OF DIFFERENT RELIGIOUS/CULTURAL NEEDS

All major religions have beliefs and customs that are central to their faith and relate to

death and the afterlife (Kwan, 2002). In many faiths, last offices are steeped in religious beliefs and traditions that can be traced back through centuries.

Death is also seen as a social experience where involving family members is common to all religions. The value of being with the person at the point of dying and afterwards is of symbolic importance (Kwan, 2002).

Ensuring the deceased and family are managed in a dignified manner and religious requirements are respected can alleviate the pain of the experience for the bereaved. Bereaved people can recall in detail all aspects of their relative's death and the last time they saw them.

Having written documentation of patients' faith and preferences for last offices should help ensure their wishes are respected. As society is culturally diverse, it is important that nurses have some knowledge of practices and rituals for the main religions in their communities. Access to information on specific religious rituals relating to death should be available so nurses can ensure the practices of groups are adhered to and sensitively addressed. For example, these might include positioning the patient facing towards Mecca, allowing family members to recite prayers before and after death, or opening a window. In some instances, ceremonial rituals may only be performed by spiritual leaders, while in others family members are expected to prepare the body for the afterlife (Pattison, 2007).

Irrespective of faith or culture, it is dangerous to make assumptions. In some faiths giving bad news is discouraged and viewed as impolite, harmful and disrespectful (Høye and Severinsson, 2010). This study illustrated how, despite the gravity of their situation, family members sought to adhere to cultural traditions, which could include filtering out or modifying information given to hospitalised relatives to reduce their anxiety and stress. To avoid potential problems, nurses should always consult patients and families about arrangements.

Part 2 of this series, to be published next week, examines nurses' role in last offices

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