Module 7: Loss, Grief, Bereavement
Supplemental Teaching Materials/Training Session Activities Contents

Table 1	Types of Grief	M7-46
Table 2	Normal Grief Reactions	M7-50
Table 3	Stages and Tasks of Grief	M7-51
Table 4	Unhelpful & Helpful Comments in Speaking with the Bereaved	M7-52
Table 5	Coping with Professional Anxiety in Terminal Illness	M7-53
Table 6	Inventory of Complicated Grief	M7-54
Table 7	Helping Children Cope with Grief: Remember the CHILD	M7-56
Table 8	Interventions for Grieving Children	M7-57
Table 9	Spiritual Assessment: Mnemonics for Interviewing	M7-58
Table 10	Bereavement Considerations for Veterans and Their Families	M7-59
Figure 1	Personal Loss History	M7-61
Figure 2	Loss Exercise	M7-62
Figure 3	Opportunities for Reminiscing	M7-65
Figure 4	Self-Care Assessment	M7-66
Figure 5	Mindfulness and Self-Care	M7-68
Figure 6	Self-Care Strategies for Nurses	M7-69
Figure 7	Exercise & Spiritual Practice for Stress Reduction, Health, & Well Being	M7-74
Figure 8	Fast Fact and Concept #043: Is it Grief or Depression	M7-76
Figure 9	RELIEVER	M7-78
Figure 10	Differences between Preparatory Grief and Depression	M7-79

Hospice Education Network © 2010

Module 7: Loss, Grief, Bereavement
Supplemental Teaching Materials/Training Session Activities

Module 7
Table 1: Types of Grief

Type of Grief	Definition	Characteristics
Anticipatory Grief (Rando, 2000)	Anticipated and real losses associated with diagnosis, acute and chronic illnesses and terminal illness. Experiencing anticipatory grief may provide time for preparation of loss, acceptance of loss, finish unfinished business, life review, resolve conflicts. For survivor, anticipatory grief provides time for preparing for life without deceased including preparation for role change, mastering life skills such as paying bills and learning how to manage a checkbook.	With acute illness, chronic illness, accidents and other changes in health, a patient may experience loss of general health, loss of functionality, loss of independence, loss of role in the family (breadwinner, caretaker) and loss of lifestyle as a result of dietary or activity restrictions. Loss of a limb or body part (breast, uterus) may cause loss of self-confidence, changes in perception about body image. Family members, significant others will also experience losses when patient is ill, including loss of role in the family, loss of relationship, loss of finances, loss of security, loss of companionship, loss of relationship, etc. AIDS can cause multiple losses over short periods of time, such as loss of a job, material possessions, body image due to changes in physical appearance, functionality, privacy (the secret is out), friends, partners, and social acceptance. With diagnosis of terminal illness, additional losses may include loss of control (choice), loss of physical and/or mental function, loss of relationships, loss of body image, loss of future, loss of dignity, loss of life.
Normal Grief	Also known as uncomplicated grief. Normal feelings, reactions and behaviors to a loss; grief reactions can be physical, psychological, cognitive, behavioral. (Doka, 1989; Parkes & Prigerson, 2009; Worden 2009).	Reactions to loss can be physical, psychological and cognitive.
Complicated grief includes: Chronic Grief Delayed Grief	 Normal grief reactions that do not subside and continue over very long periods of time. Normal grief reactions that are suppressed or postponed. The survivor consciously or unconsciously avoids	Those at risk for any of the four types of complicated grief may have experienced loss associated with: • traumatic death • sudden, unexpected death such as heart attacks, accidents • suicide • homicide • dependent relationship with deceased

Hospice Education Network © 2010

Type of Grief	Definition	Characteristics
Exaggerated Grief Masked Grief (Brown-Saltzman, 2006; Corless, 2010; Loney, 1998; Parkes & Priegerson, 2009; Worden, 2009)	the pain of the loss. Survivor resorts to self-destructive behaviors such as suicide. The survivor is not aware that behaviors that interfere with normal functioning are a result of the loss.	• mature person or those with chronic illnesses (survivor may have difficulty believing death actually occurred after years of remissions and exacerbations) • death of a child • multiple losses • unresolved grief from prior losses • concurrent stressor (the loss plus other stresses in life such as divorce, a move, children leaving home, other ill family members, financial issues, etc.). • history of mental illness or substance abuse • patient's dying process was difficult including poor pain and symptom management, psychosocial and/or spiritual suffering • poor or few support systems • no faith system, cultural traditions, religious beliefs Complicated grief reactions can include any of the normal grief reactions, but the reactions may be intensified, prolonged, last more than a year and/or interfere with the person's psychological, social, and physiological functioning. Other complicated grief reactions may include: • severe isolation • violent behavior • suicidal ideation • workaholic behavior • severe deterioration of functional status • symptoms of post traumatic stress disorder • denial beyond normal expectation • severe or prolonged depression • loss of interest in health and/or personal care • severe impairment in communication, thought or motor skills • ongoing inability to eat or sleep • replacing loss and relationship quickly • social withdrawal • searching and calling out for deceased • avoidance of reminders of the deceased • imitating the deceased Survivors experiencing complicated grief should be referred to a grief and bereavement specialist/counselor.
Disenfranchised Grief (Doka, 1989)	The grief encountered when a loss is experienced and cannot be openly acknowledged, socially sanctioned or publicly shared. Usually survivor experiencing	Those at risk for experiencing disenfranchised grief include partners of HIV/AIDS patients, ex-spouses, ex-partners, fiancés, friends, lovers, mistresses, co-workers, children who experience the death of a step-parent and others persons close to the patient but not biological family members.

Hospice Education Network © 2010

Type of Grief	Definition	Characteristics
	disenfranchised grief is not recognized by employers for time off for funeral/memorial service, grief. May not be recognized by biological family members and excluded from rites, rituals and traditions for loss.	The mother of a stillborn delivery may also experience disenfranchised grief, as society may not acknowledge a relationship between the mother and a child who experienced death prior to birth.
Children's Grief	Children mourn, grieve based on their developmental level.	Symptoms of grief in younger children: • Nervousness • Uncontrollable rages • Frequent sickness • Accident proneness • Antisocial behavior • Rebellious behavior • Hyperactivity • Nightmares • Depression • Compulsive behavior • Memories fading in and out • Excessive anger • Excessive dependency on remaining parent • Recurring dreams...wish-filling, denial, disguised Symptoms of grief in older children: • Difficulty in concentrating • Forgetfulness • Poor schoolwork • Insomnia or sleeping too much • Reclusiveness or social withdrawal • Antisocial behavior • Resentment of authority • Overdependence, regression • Resistance to discipline • Talk of or attempted suicide • Nightmares, symbolic dreams • Frequent sickness • Accident proneness • Overeating or undereating • Truancy • Experimentation with alcohol/drugs • Depression • Secretiveness • Sexual promiscuity • Staying away or running away from home • Compulsive behavior

Hospice Education Network © 2010

References:

Brown-Saltzman, K. (2006). Transforming the grief process. In R. Carroll-Johnson, L. Gorman, & N. J. Bush, *Psychosocial nursing care: Along the cancer continuum*, 2nd edition. Pittsburgh, PA: Oncology Nursing Press, Inc.

Corless, I. B. (2010). Bereavement. In B. R. Ferrell, & N. Coyle (Eds.), *Oxford textbook of palliative nursing, 3rd edition*, (Chapter 30). New York, NY: Oxford University Press.

Doka, K. (1989). *Disenfranchised grief: Recognizing hidden sorrow*. New York, NY: Lexington Books.

Loney, M. (1998). Death, dying, and grief in the face of cancer. In C. C. Burke (Ed.), *Psychosocial dimensions of oncology nursing care*. Pittsburgh, PA: Oncology Nursing Press, Inc.

Parkes, C. M. & Prigerson, H. (2009). *Bereavement: Studies of grief in adult life*. (4th ed.) Oxon, UK: Routledge.

Rando, T. (Ed.). (2000). *Clinical dimensions of anticipatory mourning*. Champaign, IL: Research Press.

Worden, J. W. (2009). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (4th ed.). New York, NY: Springer Press.

Hospice Education Network © 2010

Module 7
Table 2: Normal Grief Reactions

Physical	Emotional	Cognitive	Behavioral
• hollowness in stomach • tightness in chest • heart palpitations • sensitivity to noise • breathlessness • weakness • tension • lack of energy • dry mouth • gastrointestinal disturbances • loss of libido • increase in appetite, loss of appetite • weight gain or loss • exhaustion • tight throat • vulnerable to illness • restlessness • headaches • dizziness • muscle aches • sexual dysfunction • insomnia • tremors, shakes	• numbness • relief • emancipation • sadness • yearning • anxiety • fear • anger • guilt and self-reproach • shame • loneliness • helplessness • hopelessness • abandonment • loss of control • emptiness • despair • ambivalence • loss of ability for pleasure • shock	• disbelief state of depersonalization • confusion • inability to concentrate • idealization of the deceased • preoccupation with thoughts or image of the deceased • dreams of the deceased • sense of presence of deceased • fleeting, tactile, olfactory, visual and auditory hallucinatory experiences • search for meaning in life and death	• impaired work performance • crying • withdrawal • avoiding reminders of the deceased • seeking or carrying reminders of the deceased • over-reactivity • changed relationships

References:

Doka, K. (1989). *Disenfranchised grief: Recognizing hidden sorrow*. New York, NY: Lexington Books.

Parkes, C. M. & Prigerson H. (2009). *Bereavement: Studies of grief in adult life*. (4th ed.) Oxon, UK: Routledge.

Worden, J. W. (2009). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (4th ed.). New York, NY: Springer Press.

Hospice Education Network © 2010

Module 7
Table 3: Stages and Tasks of Grief

Stage of Grief	Tasks	Characteristics
Stage 1: Notification and shock	Share acknowledgement of the reality of the loss by assessing the loss, recognizing the loss.	• Assists the survivor in coping with the initial impact of the death • Survivor may have feelings of numbness, difficulties with decision making, poor daily functioning, emotional outbursts, denial, isolation, avoidance • Feelings should eventually decrease and subside as the survivor moves onto the next stage
Stage 2: Experience the loss emotionally and cognitively	Share in the process of working through the pain by reacting to, expressing and experiencing the pain of separation/grief	• Confrontation, anger, bargaining, depression • Survivor may be angry at loved one who has died, "abandoned them," "left them behind"; anger may be directed at physician, nurse, other health care professionals, family members, friends • Survivor may feel guilt based on perceptions that he/she or others did not do enough to prevent the death, he/she did not take good enough care of the deceased • Survivor may ask questions, "What if....," "If only..." • Survivor may experience sadness, loneliness, emptiness, lack of interest in daily life, insomnia, loss of or increase in appetite, apathy, disorganization
Stage 3: Reintegration	Reorganize and restructure family systems and relationships and reinvest in other relationships and life pursuits by adjusting to an environment without the deceased; relinquishing old attachments; forming new identity without deceased, adapting to new role while retaining memories	• Survivor may begin to reorganize their life, find hope in the future, feel more energetic, participate in social events, acceptance

References:

Corless, I. B. (2010). Bereavement. In B. R. Ferrell, & N. Coyle (Eds.), *Oxford textbook of palliative nursing care,* 3rd edition, (Chapter 30). New York, NY: Oxford University Press.

Corr, C. A., & Doka, K. J. (1994). Current models of death, dying and bereavement. *Critical Care Nursing Clinic of North America, 6*(3), 545-552.

Kubler-Ross, E. (1969). *On death and dying*. New York, NY: MacMillan.

Rando, T. A. (1984). *Grief, dying and death: Clinical interventions for caregivers*. Champaign, IL: Research Press Co.

Worden, J. W. (2009). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (4th ed.). New York, NY: Springer Press.

Hospice Education Network © 2010

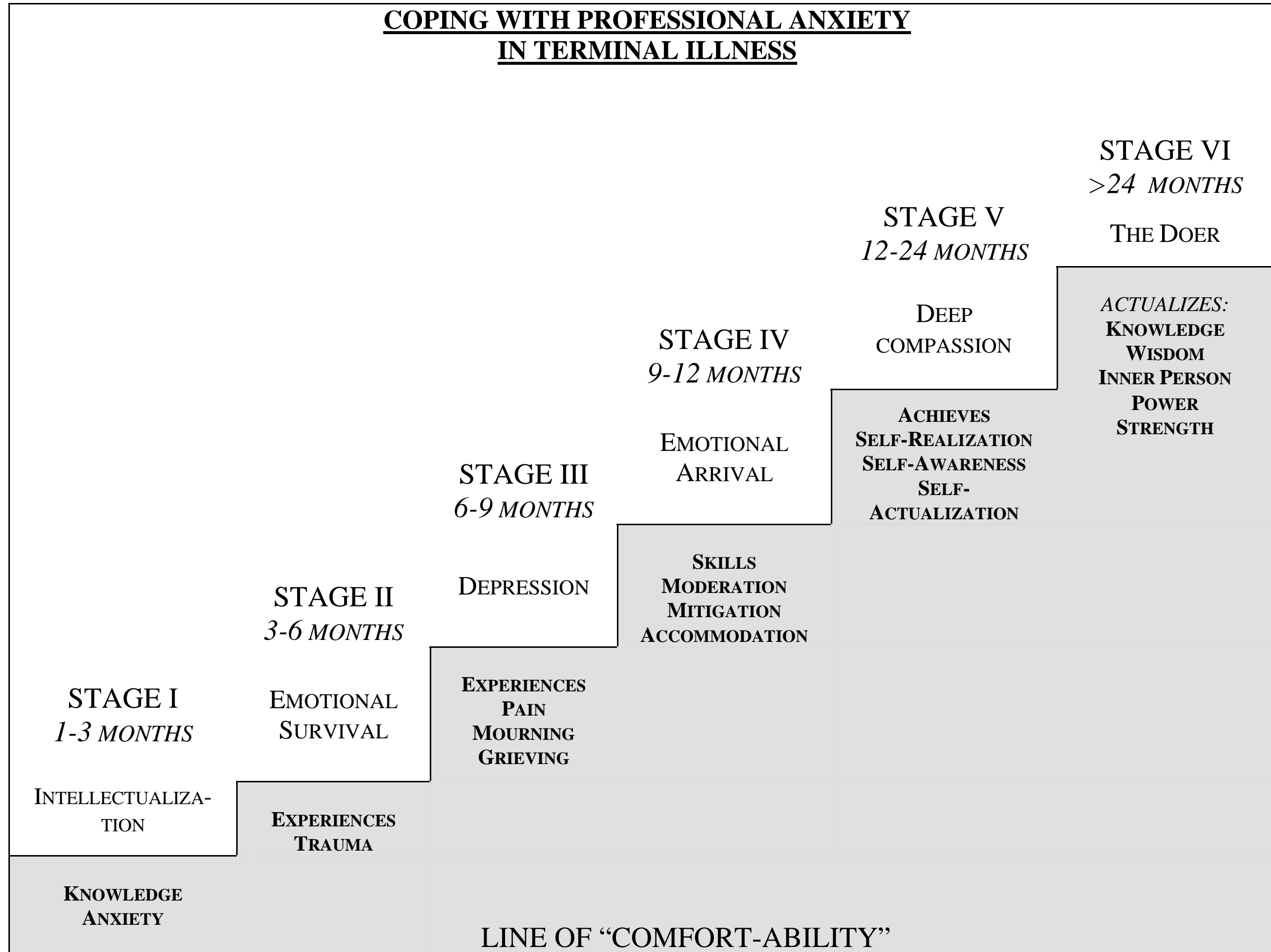
Module 7
Table 4: Unhelpful & Helpful Comments in Speaking with the Bereaved

Unhelpful Comments	Helpful Comments
I know exactly how you're feeling.	I am sorry that you are going through this painful process.
I can imagine how you are feeling.	It must be hard to accept that this has happened.
I understand how you are feeling.	It's OK to grieve and be really angry with God and anyone else.
I'm always here for you, call me if you need anything.	I can bring dinner over either Tuesday or Friday. Which will be better for you?
You should be over it by now. It's time you moved on.	Grieving takes time. Don't feel pushed to hurry through it.
You had so many years together. You are so lucky.	I did not know __________, will you tell me about him? What was your relationship like?
At least you have your children.	It's not your fault. You did everything you could do.
You're young, you'll meet someone else.	What's the most scary part about facing the future alone without __________?
At least her suffering is over. She is in a better place now.	You will never forget __________, will you?
He lived a really long and full life.	It's not easy for you, is it? What about your relationship will you miss the most?
How old was he?	He meant a lot to you.

Adapted:
Klein, S. (1998). *Heavenly hurts: Surviving AIDS-related deaths and losses*. New York, NY: Baywood Publishing Company. Reprinted with permission.

Hospice Education Network © 2010

Module 7
Table 5: Coping with Professional Anxiety in Terminal Illness



Source:
Harper, B. C. (1994). *Death: The coping mechanism of the health professional*. Greenville, SC: Southeastern University Press. Reprinted with permission.

Hospice Education Network © 2010

Module 7
Table 6: Inventory of Complicated Grief

PLEASE fill in the circle next to the answer which best describes how you feel right now:

1. I think about this person so much that it's hard for me to do the things I normally do…
   ○ never ○ rarely ○ sometimes ○ often ○ always

2. Memories of the person who died upset me…
   ○ never ○ rarely ○ sometimes ○ often ○ always

3. I cannot accept the death of the person who died…
   ○ never ○ rarely ○ sometimes ○ often ○ always

4. I feel myself longing for the person who died…
   ○ never ○ rarely ○ sometimes ○ often ○ always

5. I feel drawn to places and things associated with the person who died…
   ○ never ○ rarely ○ sometimes ○ often ○ always

6. I can't help feeling angry about his/her death…
   ○ never ○ rarely ○ sometimes ○ often ○ always

7. I feel disbelief over what happened…
   ○ never ○ rarely ○ sometimes ○ often ○ always

8. I feel stunned or dazed over what happened…
   ○ never ○ rarely ○ sometimes ○ often ○ always

9. Ever since s/he died it is hard for me to trust people…
   ○ never ○ rarely ○ sometimes ○ often ○ always

10. Ever since s/he died I feel like I have lost the ability to care about other people or I feel distant from people I care about…
    ○ never ○ rarely ○ sometimes ○ often ○ always

11. I have pain in the same area of my body or have some of the same symptoms as the person who died…
    ○ never ○ rarely ○ sometimes ○ often ○ always

12. I go out of my way to avoid reminders of the person who died…
    ○ never ○ rarely ○ sometimes ○ often ○ always

13. I feel that life is empty without the person who died…
    ○ never ○ rarely ○ sometimes ○ often ○ always

Hospice Education Network © 2010

14. I hear the voice of the person who died speak to me…
○ never ○ rarely ○ sometimes ○ often ○ always

15. I see the person who died stand before me…
○ never ○ rarely ○ sometimes ○ often ○ always

16. I feel that it is unfair that I should live when this person died…
○ never ○ rarely ○ sometimes ○ often ○ always

17. I feel bitter over this person's death…
○ never ○ rarely ○ sometimes ○ often ○ always

18. I feel envious of others who have not lost someone close…
○ never ○ rarely ○ sometimes ○ often ○ always

19. I feel lonely a great deal of the time ever since s/he died…
○ never ○ rarely ○ sometimes ○ often ○ always

Source:
Prigerson, H. G., Shear, M. K., Frank, E., Beey, L. C., Silberman, R., Prigerson, J., et al. (1997). Traumatic grief: A case of loss-induced trauma. *American Journal of Psychiatry, 154*(7), 1003-1009. Reprinted with permission from the American Journal of Psychiatry, Copyright 1997, American Psychiatric Association.

Hospice Education Network © 2010

Module 7
Table 7: Helping Children Cope with Grief: Remember the CHILD.

Helping Children Cope with Grief: Remember the **CHILD**	
C-Consider	• Unique situation of the child • His/her developmental capacity to understand • His/her concerns, thoughts, feelings, and relationship to his/her sibling
H-Honesty	• Use the "d" words: death, die, dying • Realize that it is all right to not have all the answers • Avoid euphemisms • Avoid words such as gone away or went on a trip • Do not explain to a child that the dead person is sleeping
I-Involve	• Let the child know what is happening; if possible, before the death occurs • Give the child factual knowledge about the cause of death – especially the school-age child • Involve the child in saying good-bye to the dying and deceased – allow the child the choice to participate in the funeral to the level at which he/she is comfortable
L-Listen	• Concentrate on discussing the stumbling block of the moment • Let the child talk through what is on his/her mind • Let the child know that it is all right to not want to talk to anyone anymore about the death for a while • Give the child outlets for expressing his/her grief – art, drawing, play, writing letters, poetry, stories, hammering • Be aware of thoughts and fantasies children may have of being reunited with the person who has died • Careful attention to any suggestion of suicidal risk, no matter what the age of the child • Clarify that death is NOT the result of the child's action or thoughts; be attuned to magical thinking involved in the child's explanation of the death and correct it to avoid guilt and inappropriate grief reactions
D-Do it over and over again	• Appropriately share your grief; realize that children cannot do grief work without permission and role models • Children need to see an honest expression of emotions from adults • Keep in mind the developmental capacities of the child and his/her age-related concerns and needs

Adapted from:

Davies, B., & Orloff, S. (2010). Bereavement issues and staff support. In G. Hanks, N. I. Cherny, N.A. Christakis, M. Fallon, S. Kassa, & R.K. Portenoy (Eds.). *Oxford textbook of palliative medicine* (4th ed., p. 1370). Oxford, UK: Oxford University Press. Reprinted with permission of Oxford University Press in the format Copy via Copyright Clearance Center.

Hospice Education Network © 2010

Module 7
Table 8: Interventions for Grieving Children

Explanation of Death

- Silence about death (which indicates that the subject is taboo) does not help children deal with loss. When discussing death with a child, the explanation should be kept as simple and direct as possible. Each child needs to be told the truth with as much detail as can be comprehended at his or her age and stage of development. Questions should be addressed honestly and directly. Children need to be reassured about their own security (they frequently worry that they will also die, or that their surviving parent will go away). Children's questions should be answered, making sure that the child processes the information.

Correct language

- Although it is a difficult conversation to initiate with children, any discussion about death must include proper words (e.g., "cancer," "died," "death"). Euphemisms (e.g., "passed away," "he is sleeping," "we lost him") should never be used because they can confuse children and lead to misinterpretations.

Planning Rituals

- After a death occurs, children can and should be included in the planning and participation of mourning rituals. As with bereaved adults, these rituals help children to memorialize loved ones. Although children should never be forced to attend or participate in mourning rituals, their participation should be encouraged. Children can be encouraged to participate in those aspects of funeral or memorial services with which they feel comfortable. If the child wants to attend the funeral (wake, memorial service, etc.) it is important that a full explanation of what to expect is given in advance. This preparation should include the layout of the room, who might be present (e.g., friends and family members), what the child will see (e.g., a casket, people crying), and what will happen. The surviving parent may be too involved in his or her own grief to give their child the attention needed, therefore, it is often helpful to identify a familiar adult friend or family member who will be assigned to care for the grieving child during the funeral.

References:

Fitzgerald, H. (1992). *The grieving child: A parent's guide*. New York, NY: Fireside.

Kastenbaum, R. (2008). *Death, society, and human experience* (10th ed.). Boston, MA: Allyn and Bacon.

Hospice Education Network © 2010

Module 7
Table 9: Spiritual Assessment

SPIRITUAL ASSESSMENT: MNEMONICS FOR INTERVIEWING		
AUTHOR	COMPONENTS (MNEMONIC)	ILLUSTRATIVE QUESTIONS
Maugens	**S** (spiritual belief system)	What is your formal religious affiliation?
	P (personal spirituality)	Describe the beliefs and practices of your religion or spiritual system that you personally accept. What is the importance of your spirituality/religion in daily life?
	I (integration with a spiritual community)	Do you belong to any spiritual or religious group or community? What importance does this group have to you? Does or could this group provide help in dealing with health issues?
	R (ritualized practices and restrictions)	Are there specific elements of medical care that you forbid on the basis of religious/spiritual grounds?
	I (implications for medical care)	What aspects of your religion/spirituality would you like me to keep in mind as I care for you? Are there any barriers to our relationship based on religious or spiritual issues?
	T (terminal evens planning)	As we plan for your care near the end of life, how does your faith impact on your decisions?
Anandarajah & Hight	**H** (sources of hope)	What or who is it that gives you hope?
	O (organized religion)	Are you a part of an organized faith group? What does this group do for you as a person?
	P (personal spirituality or spiritual practices)	What personal spiritual practices, like prayer or meditation, help you?
	E (effects on medical care and/or end-of-life issues)	Do you have any beliefs that may affect how the health care team cares for you?
Puchalski	**F** (faith)	Do you have a faith belief? What is it that gives your life meaning?
	I (importance or influence)	What importance does your faith have in your life? How does your faith belief influence your life?
	C (community)	Are you a member of a faith community? How does this support you?
	A (address)	How would you like for me to integrate or address these issues in your care?

Adapted from:
Taylor, E.J. (2010). Spiritual assessment. In B. R. Ferrell, & N. Coyle (Eds.), *Oxford textbook of palliative nursing* 3rd edition, (Chapter 33, p. 651). New York, NY: Oxford University Press. Reprinted with permission.

Hospice Education Network © 2010

Module 7
Table 10: Bereavement Considerations for Veterans and Their Families

Bereavement Issues for Family Members

- If the veteran was "career military," the family may have lived in numerous places for short periods of time. This situation can have different effects on bereavement. Because they have not established roots, there may not be a network of support that facilitates effective grieving. On the other hand, because of their frequent moving, families of veterans may readily reach out for support because they have learned how to ask for help and form new bonds quickly.

- In one way or another, the soldier changes after war and their relationships with others can never be the same. Much of a family's suffering surrounds grieving the loss these changes cause. Helping families come to peace with their changed loved one usually involves helping them grieve so they can let go of how their prewar family member was and open up to a new relationship that includes the changes that their relationship incurs. It means letting go of old expectations and exploring ways to birth new expectations within relationships.

- If the veteran had PTSD, especially if it became exacerbated during their dying process, the family caregivers may be exhausted and not have the energy required for grieving. They may have become so consumed with caregiving that they lost their own life or sense of self, which makes recovery from grief more difficult.

- If PTSD is identified for the first time as a veteran is dying, the impact on family needs to be factored into their bereavement needs. Some feel relief saying, "I'm so glad to know it has a name. I knew something was wrong, but I didn't know what. Now this makes sense." Others might feel guilty. "I wish I would have realized this sooner, I would have _______(listened more carefully—sought help for him/her, been more patient and understanding, etc.)"

- Family members may need help in understanding that a veteran's inability to grieve someone's death might be due to their fear of unresolved grief from comrades who died in combat. This fear can sometimes cause the veteran to detach from his grief.

- Family members might have anger or bitterness about their veteran not getting a medal, service-connection disability, pension, etc. These feelings can interfere with effective grieving.

- Family members, who are receiving a military-related pension that ceases upon the veteran's death, may seek to keep the veteran alive for financial gain, seeking futile treatments that interfere with peaceful dying and effective bereavement processes.

- Some community hospices have started partnering with the VA in their communities and the *Vet Centers* to provide bereavement care for families of veterans returning from Iraq and Afghanistan.

Bereavement Issues for Veterans

- Stoicism sometimes interferes with veterans' willingness to receive bereavement services. They might fear being a "cry baby," losing control, or becoming vulnerable. Bereavement groups are sometimes viewed as a "pity party," something they did not want.

Hospice Education Network © 2010

- In combat, there was no time to mourn the death of comrades; soldiers had to keep moving or they would be killed. With grief on hold, their bereavement needs may stagnate, but facing their own death decades later or the death of a loved one can trigger PTSD or activate grief from the many past losses during combat, deaths that were often mutilating or guilt-laden.

- Veterans may be aware that they have unresolved grief. This awareness can cause a fear of grieving when a member of their own family dies. "If I start crying, I may not be able to stop."

- For veterans who have served in dangerous assignments, their past experiences with death might have been violent and mutilating. They bring this experience with them whenever they encounter death or grief.

- It's often helpful to place two veterans together in the same room when they are receiving hospice or palliative care. There is great camaraderie as they care for each other. Grief can also be facilitated as staff can support them as they grieve their roommate's death.

- If the veteran has PTSD, he/she probably does not trust easily or is reticent to reach out to strangers trying to provide bereavement care. They might cope with grief by isolating or "bunkering down," which is often counterproductive. Initial approaches by others may need to be modified and should focus on gaining trust.

- On the other hand, the brother/sisterhood that saw veterans through dangerous times is often called into action when their buddy is dying. They come to bedside to care for their falling comrade. Afterward, they often check on their fallen comrade's family to make sure their needs are being met.
- Stoicism, PTSD, or alcohol abuse might create multiple families, estrangements, or forgiveness issues. Any of these can complicate peaceful dying and effective grieving.

- Exacerbation of mental illness can occur when there is a death in the family. Bereavement programs need to be an integral part of psychiatric programs for veterans.

- Veterans might feel angry or bitter about medals they didn't receive, service-connected disabilities they didn't get, pensions they didn't receive, or agent orange damage that went unacknowledged. This situation sometimes shields them from effectively encountering their need for grieving.

- Veterans, who are receiving a pension that ends with their death, might fight hard to stay alive for financial purposes. Concern about their spouse's welfare might cause them to want futile medical treatments. This focus sometimes interferes with anticipatory grieving for their own life, and it prevents essential dialogue with family members, which subsequently complicates their bereavement.

- Military funerals include presenting an American flag to a family member. If there are disputes within families or if there has been divorce with multiple blended families, issues surrounding "Who gets the flag?" might arise. The resulting anger can complicate bereavement.

- Veterans are eligible for free burial at a national cemetery, as well as their spouses. This sometimes eases financial burdens, facilitating "good grief."

Reference:
Grassman, D.L. (2009). *Peace at last: Stories of hope and healing for veterans and their families.* St. Petersburg, Florida: Vandamere Press. Reprinted with permission from the publisher.

Hospice Education Network © 2010

Module 7
Figure 1: Personal Loss History

1. The first death I can remember was the death of:
2. I was age:
3. The feelings I remember I had at the time were:
4. The first funeral (wake or other ritual service) I ever attended was for:
5. I was age:
6. The thing I most remember about that experience is:
7. My most recent loss by death was (person, time, circumstances):
8. I cope with this loss by:
9. The most difficult death for me was the death of:
10. It was difficult because:
11. Of the important people in my life who are now living, the most difficult death for me would be the death of:
12. It would be the most difficult because:
13. My primary style of coping with loss is:
14. I know my own grief is resolved when:
15. It is appropriate for me to share my own experiences of grief with a client/patient when:

Source:
Worden, J. W. (2009). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (4th ed., pp. 136-137). New York, NY: Springer Publishing Company, Inc. Used by permission.

Hospice Education Network © 2010

Module 7
Figure 2: Loss Exercise

LIST YOUR...

5 Most prized possessions (material things)	5 Favorite activities	5 Most valuable body parts	5 Values that are most important to you	5 People you love the most

As I tell you this story, cross out as many items as I tell you.

Imagine: It is a lovely spring day - you know the kind, one of the first days when the snow has melted and the flowers are blooming up north or down here the temperatures are comfortable and the birds are singing.

You are young and successful and happy with your life.

You step in the shower anxious to get on with the day. While you soap yourself you discover a small lump on your neck and another in your breast.

CROSS OUT TWO ITEMS

Probably swollen glands from your recent cold (premenstrual changes) you think, and ignore it and go on with your life.

Two and one-half weeks later it is still there.

CROSS OUT TWO ITEMS

Probably cold returning - you've been busy, not resting, You've had cystic breasts, you rationalize and life goes on but something keeps nagging at you so you make an appointment to see your doctor.

CROSS OUT ONE ITEM

The doctor, after examining you and ordering a mammogram, she says, "I'm sure it's nothing but I'd like to biopsy it just in case, so we'll schedule you for surgery the end of the week."

Hospice Education Network © 2010

CROSS OUT THREE ITEMS

You decide to have a biopsy (frozen section) done, and to go ahead with a mastectomy if the lump is malignant, though everyone assures you that it is not.

CROSS OUT TWO ITEMS

You pull your way up through the fog in the recovery room and feel the mass of bandages on your chest. Your worst fears have been confirmed!

CROSS OUT FOUR ITEMS

You recover and have radiation treatment, just in case.

CROSS OUT TWO ITEMS

Slowly you recover your strength and life returns to normal - almost.

It is spring again, two years later. You have a cold. You ignore it as usual but it doesn't go away and one morning, to your surprise, you find it difficult to breathe.

CROSS OUT TWO ITEMS

Lung metastasis, you feel your world turn upside down again. That wonderful defense mechanism of denial must be let go. You begin chemotherapy and are very sick, weak and angry. You lash out at your family, doctors, friends. You want to live but you cannot eat.

CROSS OUT TWO ITEMS

One morning you do not have enough energy to sit in a chair and the doctor tells you the chemotherapy is not working and he wants to stop it.

CROSS OUT THREE ITEMS

It seems like life goes on around you in slow motion. Days and nights blur. How odd you think, staring at your bony hand, as your body deteriorates your spirit seems to be withdrawing also. You wonder if it's the pain medication or if it's the first taste of death but you do not have the energy to ask anyone.

CROSS OUT THE LAST TWO ITEMS

Source:

Fauser, M., Lo, K., & Kelly, R. (1996). *Trainer certification program* [Manual]. Largo, FL: The Hospice Institute of the Florida Suncoast. Reprinted with permission.

Hospice Education Network © 2010

DISCUSSION QUESTIONS FOR LOSS EXERCISE:

1. Break into groups.
2. Try to get in touch with your most predominant feelings during the exercise.
3. What was it like to have to select and cross off items?
4. What did you cross out first? Last?
5. Was it harder to cross out as you went or did you give up?

Hospice Education Network © 2010

Module 7
Figure 3: Opportunities for Reminiscing

Reminiscing

In addition to sharing pictures, items, and favorite stories about your loved one, the following questions offer an opportunity for personal reflections and sharing about the meaning and purpose of a loved one's life.

What will you never forget about _______________?

What did you like most about __________________?

What was unusual or out of character for _______________?

What was the favorite expression of _____________?

What was a favorite song or type of music of __________________?

What was ________________ favorite way of doing things?

What qualities of ________________ would you like to have?

What do you hope that others will always remember about _____________?

If ________________ were face to face with you now, what would you say or do?

How would you describe ________________ to a stranger?

Source:
Humphrey, G.M., & Zimpfer, D.G. (1996). *Counseling for grief and bereavement*. Thousand Oaks, CA: Sage Publications. Permission granted by Sage Publications Ltd. in the format of Copy via Copyright Clearance Center.

Module 7
Figure 4: Self-Care Assessment

Self-Care Assessment

Take a moment to consider the frequency with which you do the following acts of self-care. Rate using the scale below:

4 = Often
3 = Sometimes
2 = Rarely
1 = Are you kidding? It never even crossed my mind!

Physical Self-Care

__ Eat regularly (no skipping meals)
__ Eat healthfully
__ Exercise at least 30 minutes five times a week
__ Sleep 7–9 hours per night
__ Schedule regular preventative health-care appointments
__ Take time off when ill
__ Get massages or other body work
__ Do enjoyable physical work

Psychological Self-Care

__ Read a good novel or other nonwork-related literature
__ Write in a journal
__ Develop or maintain a hobby
__ Make time for self-reflection
__ Seek the services of a counselor or therapist
__ Spend time outdoors
__ Say "no" to extra responsibilities when stressed
__ Allow the gift of receiving (instead of just giving)

Emotional Self-Care

__ Stay in contact with important people
__ Spend time with the people whose company is most comfortable
__ Practice supportive self-talk; speak kindly in internal thoughts
__ Allow both tears and laughter to erupt spontaneously

Hospice Education Network © 2010

__ Play with children and animals
__ Identify comforting activities and seek them out
__ "Brag" to a trusted friend or family member; be proud of accomplishments
__ Express anger in a constructive way

Spiritual Self-Care

__ Make time for regular prayer, meditation, and reflection
__ Seek community among friends, neighbors, or other gatherings
__ Cherish optimism and hope
__ Contribute to or participate in meaningful activities of choice
__ Be open to inspiration
__ Use ritual to celebrate milestones and to memorialize loved ones
__ Be aware of the nontangibles of life
__ Listen to or create music

Workplace Self-Care

__ Take time to eat lunch
__ Make time to address both the physical and emotional needs of residents
__ Take time to chat and laugh with co-workers
__ Seek regular supervision and mentoring
__ Set limits with residents, families, and colleagues
__ Find a project or task that is exciting and rewarding in which to be involved
__ Decrease time spent comparing work performance to others
__ Seek a support group – even if it is only one other person

Results:

121-160 You're a self-care guru! Share the wisdom with everyone around you.

81-120 You're on the right track. Get creative in the areas of least scoring.

41-80 Uh-oh. There's some work to do. Hunker down and focus on yourself.

≤ 40 Are you still reading this? You're about to self-destruct. Call 911!

Hospice Education Network © 2010

Module 7
Figure 5: Mindfulness and Self-Care

Mindfulness and Self-Care

- When you awaken, express gratitude for your home…your work…your family or friends…your health or movement toward health
- Say "thank you" and "you're welcome" frequently
- When caught up in a stressful situation, ask yourself: "What is the most important thing right now?"
- Take mini-stretch breaks throughout the day
- Be willing to say, "I don't know"
- Ask for help and support when you need it
- Create a personal mission statement for your work
- Place a post-it at the nursing station or on your computer that says *BREATHE*
- Try substituting water or fruit juices for carbonated beverages. Monitor your intake of caffeine, alcohol, salt, and sugar
- Take a technology break—spend one day at home without answering the phone, email, or fax
- Take a media break—spend one day at home without listening to the radio news, watching TV, or reading the newspaper
- Place photos or pictures in your workplace of things or people who bring you joy
- For four hours, try and do one thing at a time; avoid multi-tasking
- Keep a humor file
- If you feel a little too busy…stop and take 5 conscious, deep, diaphragmatic breaths
- If you feel moderately busy…stop and take 10 conscious, deep, diaphragmatic breaths
- If you are excessively busy and feel overwhelmed…stop, sit down, close your eyes, take 10 conscious, deep, diaphragmatic breaths. Quiet your thoughts and gently remind yourself that you are capable of moving through this situation. Repeat. This will take < 5 minutes, and will help to restore your perspective and energy
- When you go to bed at night, express gratitude for the day you were given…for your home…your work…your family or friends…your health or movement toward health

Adapted from Kraybill, K. *Creating and maintaining a healthy work environment: A resource guide for staff retreats*. Available at http://www.nhchc.org/Clinicians/ResourceGuideforStaffRetreats.pdf (Last retrieved on May 21, 2010). Used with permission.

Hospice Education Network © 2010

Module 7
Figure 6: Self-Care Strategies for Nurses

Self-Care Strategies for Nurses

The goal of this session is to increase awareness of the impact of chronic stress on health care professionals and to give a brief overview of interventions or self care behaviors that can reduce stress. Much of the following information and exercises are taken from *Self Care Strategies for Healthcare Professionals* section of The Nursing Wellness Program developed in the Department of Nursing Research and Education, City of Hope, Duarte, CA.

Nursing care of geriatric patients and patients at the end-of-life can be complex and requires nurses to use professional interventions and personal coping strategies in order to be effective. Professional self-care is a skills set that can be learned, and is just as important as all other nursing skills sets. This exercise is to assist nurses to think about personal coping strategies that support a healthy life style and to offer education on self care to fellow nurses and staff such as nursing assistants and others.

"When we attend to ourselves with compassion and mercy, more healing is made available for others."
--Wayne Muller

Significance of Self-Care

Nurses are excellent at nurturing their patients and taking care of others. Even when nurses are experiencing burnout symptoms, they do not lose empathy for their patients (Kash, et. al., 2000). Recently, the term "compassion fatigue" has been used (Figley, 2002) to describe physical, spiritual, and emotional exhaustion in healthcare and others such as firemen, rescue workers, and other deeply caring individuals. However, nurses are not always as good at nurturing themselves, and can become physically and emotionally exhausted. Nurses often deal with stressors in the work environment at the expense of their own health. For example, there is a high frequency of smoking among nurses and nurses are at risk for obesity. Nurses are also at risk for low back pain, depression, suicide, alcohol and drug abuse (Sarna, 2004).

It is ideal to have nurses and others practice healthy, ongoing self-care while successfully continuing to care for others. Self care that leads healing begins by employing such simple practices as regular exercise, healthy eating habits, enjoyable social activities, journaling, and restful sleep. You can find more information at http://www.compassionfatigue.org/ Last accessed July 19, 2010.

Stressors and Nurses:
Nursing practice exposes the nurse to many different stressors. French et al (2000) identified 9 workplace stressors that seem to affect nurses. These include:

- Conflict with physicians
- Inadequate preparation
- Problems with peers
- Difficulty with supervisors

Hospice Education Network © 2010

- Discrimination, workload
- Uncertainty concerning treatment
- Dealing with death and dying
- Patients and their families

These potential stressors exist within the workplace and do not begin to describe the stressors that may exist for an individual outside the workplace and in the home. The consequences of prolonged and/or unmitigated stress include the development of burnout, deterioration in over all health as well as the use of coping mechanisms destructive to the individual (i.e., smoking and overeating).

The nursing profession attracts individuals who are interested in caring for others and helping people in times of great stress. Nurses find themselves attached to patients and, when those patients become terminally ill, often find it difficult to manage the physical and emotional impact. These physical and emotional consequences can lead to compassion fatigue or burnout (Kash et.al., 2000). Nurses frequently deal with this stress at the expense of their own health, as illustrated by the frequency of smoking found in the working nursing population (Sarna, 2005). Nothing in the usual curriculum in nursing schools or orientation programs in hospitals is directed toward helping nurse's deal with job-related stress. Burnout is described as a state of profound physical, emotional, and mental exhaustion. There are three principle symptoms of burnout identified by Maslach and Jackson (1996). They are emotional exhaustion, depersonalization and decreased feelings of personal accomplishment.

The literature suggests that programs that use the personal approach to wellness may be more successful than those that attempt to modify environmental factors (Kash et al., 2000). By facilitating the individual's preparation of a wellness strategy, the impact of stressful professional circumstances can be mitigated.

Proactive Choices for Well Being

It is important to identify your own wellness strategies and think about how to maximize your well being to prevent the debilitating effects of chronic stress. Chronic stress leads to burnout, which includes physical and emotional exhaustion, decreased empathy, decreased sense of accomplishment and staff turnover (Kash et al., 2000). Waiting until you are already on the verge of burnout can lead to health problems, resignation, or disability. High stress leading to burnout is also contributes to staff turnover.

Interventions Daily Stress Diary:

Self-monitoring helps change behavior. Awareness, which is increased with self-monitoring, leads to change and growth. Keeping a "stress diary" can help with self-monitoring and planning for changes to promote self-care.

Stress Diary

Keeping a stress diary for a week or two can help you identify the types of situations that are stressful for you and your responses to them. You may identify a pattern of behavior that you want to change.

Hospice Education Network © 2010

Example:

Time	Stressful Event	Symptoms
8:30	Rushing, late to work	frustrated
9:30	Change in schedule	mild headache
11:00	Difficult patient	anger; neck tense
3:00	Traffic; accident on freeway	moderate headache
6:00	neck & shoulder pain	anger
7:00	Child not doing homework	frustration, depressed

Daily Stress Response Diary

Fill in the stress diary below for one week. Complete one row for each stressful situation you experience daily. You may want to make copies of this form for additional diary entries.

NOTE: The Root Cause column may be somewhat difficult at first. This piece of data is to capture your learning history that contributes to the current situation. For example, if you are feeling anxious talking to your boss (the stressor), the root cause of this anxiety may be anxious feelings you have had in the past with authority figures such as a parent or teacher. If you can't think of a root cause, skip this column and go on to complete the rest of the worksheet. You can always go back and fill this in if you have an insight.

Date	**Symptom of the Stress** (How it was felt in your body)	**Stressor** (Cause or Situation)	**Root cause** (Underlying Reason)	**Action** (What you did to make the situation better)	**Past Behavior** (What did you do in the past?)	**Options** (What will you do differently in the future?)

Girdano, D.A., Everly, G.S., & Dusek, D.E. (2008). *Controlling stress and tension* (10th Ed.). Boston, MA: Allyn and Bacon.

The Wellness Plan

Learning about your unique stress patterns can help you create a **plan of care**. This care plan – your wellness plan – is a **living document** that will change as you change. It is a **tool** that you will modify as you learn what works and doesn't work for you over time.

Hospice Education Network © 2010

Start thinking today about how you can create a personalized wellness plan that you can adhere to over time. Applying your strategies **consistently** is key to preventing stress overload and resulting burnout. Now is the time to make a firm commitment to take good care of you!

You might think about how you answered your self-care history form. What has worked for you in the past? Wellness strategies can include:

- Exercise/sports
- Deep breathing and relaxation skills
- Art therapy techniques
- Classical music
- Social support
- Meditation/prayer
- Hobbies
- Humor
- Positive self-talk and reframing
- Church and community activities
- Family fun time
- Learning something new of interest
- Massage
- Yoga
- Playing with children/pet

It is helpful to think of strategies that will work for you in these **5 domains**:

The Five Domains of Wellness

- Physical (e.g., walking, swimming, dancing)
- Mental (e.g., learning something new; positive self-talk)
- Emotional (e.g., expressing feelings through art or journal)
- Social (e.g., connecting with family, friends regularly)
- Spiritual (e.g., prayer/meditation; being in nature)

On the next page is a poem about self-care. You are invited to read this poem, and then write a self-reflection on how the poem applies to you.

References:

Figley, C. (2002) *Helping traumatized families*. New York, NY:Brummer-Routledge.
Figley, C. (1998). *Burnout in families: The systemic costs of caring*. Boca Raton, FL: CRC Press LLC.
French, S.E., Lenton, R., Walters, V., & Eyles, J. (2000). An empirical evaluation of an expanded Nursing Stress Scale. *Journal of Nursing Meaurements, 8*(2), 161-178.
Girdano, D.A., Everly, G.S., & Dusek, D.E. (2008). *Controlling stress and tension* (8th Ed.). Boston, MA: Allyn and Bacon.
Kash, K.M., Holland, J.C., Breitbart, W., Berenson, S., Dougherty, J., Ouellette-Kobasa, S. et al. (2000). Stress and burnout in oncology. *Oncology (Williston Park), 14*(11), 1621-1633; discussion 1633-1624, 1636-1627.
Maslach, C., Jackson, S.E., & Leiter, M.P. (1996). *Maslach Burnout Inventory. 3rd ed.* Palo Alto, CA: Consulting Psychologists Press.
Sarna, L., Bialous, S.A., Wewers, M.E., Froelicher, E.S., & Danao, L. (2005). Nurses, smoking, and the workplace. *Research in Nursing & Health, 28*(1), 79-90.

Hospice Education Network © 2010

Grace

Give me the **grace**
To care
Without neglecting my needs,
The **humility**
To assist
Without rescuing,
The **kindness**
To be clear
Without being cold,
The **mercy**
To be angry
Without rejecting,
The **prudence**
To disclose
Without disrespecting my privacy,
The **humor**
To admit human failings
Without experiencing shame,
The **compassion**
To give freely
Without giving myself away
--Source unknown

Self-Care Exercises to use with the poem, *Grace*:

Written Self-Reflection Exercise:
After reading the poem "*Grace*" write about the parts of the poem that apply to you.
OR
Art Reflection Exercise:
Using any media of your choice, create an art reflection that expresses your response/emotions to the poem *"Grace."*

Remember these KEYS TO SUCCESS:

- Self-monitoring creates awareness. Awareness plus a plan of action leads to behavior change.
- The *Wellness Plan* is a living document that will change as you learn about yourself.
- The *Five Domains of Wellness* is a key feature of the *Wellness Plan* to help you create a balanced approach to wellness.
- Journaling (written reflections) and art reflections are both excellent ways to help you gain insight into your needs.

This resource "Self-Care Strategies for Nurses" was adapted from City of Hope, *Self Care Strategies for Healthcare Professionals,* Department of Nursing Research and Education, Kate Kravits, RN MA, Principal Investigator. Supported by a grant from the UniHealth Foundation.

Hospice Education Network © 2010

Module 7
Figure 7: Exercise & Spiritual Practice for Stress Reduction, Health and Well Being

Exercise:
When you are in a stressed "fight or flight" state, exercise is a natural outlet to help restore your body to its normal state. "Good" chemicals, such as endorphins are released.

Aerobic exercise, such as walking, biking, dancing and swimming:
- Strengthens your cardiovascular system
- Increases your stamina
- Helps regulate blood pressure
- Helps regulate blood sugar
- Helps you work off "emotional steam"
- Relieves chronic tension
- Decreases feelings of depression and anxiety
- Helps you sleep better (caution: aerobic exercise should not be done 2 hours before bedtime; exercise in the morning, afternoon or early evening)

Stretching exercise, such as yoga, tai chi, palates, or general stretching routine:
- Helps you relax
- Relieves chronic tension
- Decreases feelings of depression and anxiety
- Improves your circulation
- Increases your muscle strength and tone
- Helps with joint mobility
- Helps you sleep better if done before bedtime

Creating time to exercise:
- Set up a schedule of at least 3 times per week.
- Decide what days and times are best.
- Use music to help motivate you.
- Exercise with a friend if you need support.

Familiar excuses:
- I'm too tired.
- Exercise is boring.
- I walk a lot at work.

Spirituality and Well Being:
Spirituality means feeling centered, connected with a higher power or feeling that life has meaning and purpose. It may include religious practices or rituals. It usually includes some type of quiet time. We all have a need to express ourselves spiritually. However, the manner in which we do so is very individual.

Think about what is important to you and how you may already be experiencing meaning and purpose. Think about what would be helpful to you in expressing your spirituality consistently.

Hospice Education Network © 2010

Examples of Spiritual Practice:
- Meditation
- Prayer
- Quiet reflection time in nature
- Spiritual or inspirational reading
- Meditative walking
- Going to worship services
- Looking at an icon
- Creating a home altar
- Bible study group
- Singing/chanting
- Drumming
- Spiritual Dance
- Yoga

Serenity Prayer:
The Serenity Prayer, a very old prayer adopted by Alcoholics Anonymous, is a helpful prayer for everyone:

God grant me the serenity to
Accept the things I cannot change
Change the things I can
And the wisdom to know the difference.

Adapted from:
Self Care Strategies for Healthcare Professionals, Department of Nursing Research and Education, City of Hope, Kate Kravits, RN MA, Principal Investigator and supported by a grant from the UniHealth Foundation.

Hospice Education Network © 2010

Module 7
Figure 8: Fast Fact and Concept #043: Is it Grief or Depression, 2nd Edition
Author(s): VJ Periyakoil

Distinguishing between a dying patient's normal grief and a major depression is a part of routine care for patients near the end-of-life. This Fast Fact will review the definitions and clinical features that distinguish these conditions.

DEFINITIONS

Preparatory (aka anticipatory) grief is the grief, "that the terminally ill patient has to undergo in order to prepare himself for his final separation from this world" 1. Features include rumination about the past, withdrawal from family/friends and periods of sadness, crying or anxiety. *Preparatory Grief is a normal, not pathological, life cycle event.*

Depression: Clinically significant depression among a population of dying patients may be somewhat more common (25-77%) 2 than in the general population. However, depression is not an inevitable part of the dying experience and is very treatable. Somatic symptoms (anorexia, weight changes, constipation etc) are often present as a part of the normal dying process and may not help to distinguish between preparatory grief and depression (See Fast Fact #7).Feelings of guilt, hopelessness, worthlessness, and suicidal ideation are the key factors that differentiate grief from depression; when in doubt, treat for depression. The following additional points are offered to help the clinician distinguish between preparatory grief and depression

DISTINGUISHING PREPARATORY GRIEF vs. DEPRESSION

Temporal Variation

A temporal variation of mood is normal in preparatory grief—a mixture of "good and bad days". In contrast, persistent flat affect or dysphoria is characteristic of depression. Depression is a pathological state; patients may *'get stuck'* in this state without treatment.

Self-Image

A disturbed self-esteem is not typically seen in grief while this is a common feature of depression; overwhelming and persistent feelings of worthlessness to others and of being a burden are common in depression. Distressing guilt in usually generalized to all facets of life in depression, while in grief, the guilt is focused around specific issues (e.g. not being able to attend a child's wedding).

Hope

A grieving patient's hope shifts, but is not lost. (Hope may shift from a hope for cure to hope for life prolongation to hope for dying well). In contrast, the depressed patient will comment on feelings of hopelessness and helplessness.

Anhedonia

The ability to feel pleasure is not lost in preparatory grief. Note: grieving patients often need social interaction to help them through the grief process. Anhedonia is an important clue to underlying depression.

Hospice Education Network © 2010

Response to Support
Social support helps provide the acceptance and assistance necessary for completion of grief work 3. While social interaction may be helpful in some depressed patients, it will typically not provide the assistance necessary to resolve depression.

Active Desire for an Early Death
An *active* desire for an early death is not typical of preparatory grief.A *persistent, active desire* for an early death in a patient, whose symptomatic and social needs have been reasonably met, is suggestive of clinical depression.

References

- Kubler-Ross E. (1997).*On death and dying*. Pp 123-124. New York, NY: Simon and Schuster.
- EPEC Project Module 6 (1996). Anxiety, delirium, depression. In: Emanuel LL, von Gunten CF, Ferris FF, eds. *The EPEC Curriculum: Education for Physicians on End-of-life Care.* Chicago, IL: The EPEC Project. http://www.EPEC.net.
- Education on Palliative and End-of-Life Care. (1999). http://www.epec.net.
- Rando TA. (1984). *Grief, dying, and death. Clinical interventions for the caregiver.* Champaign, IL: Research Press Company.
- Chochinov HM, Wilson, KG, Enno, M, Mowchun, N, Lander, S, Levitt, M, & Clinch, JJ (1995). Desire for death in the terminally ill. *Am J of Psychiatry*, 152(8), 1185-91.
- Billings JA & Block SD. (1995). Depression. *J Pall Care*, 11(1) 48-54.
- Block SD, for the ACP-ASIM End-of-Life Care Consensus Panel (2000). Assessing and managing depression in the terminally ill patient. *Annals Intern Med*, 132(3), 209-218.
- Block SD. (2001). Psychological considerations, growth, and transcendence at the end of life: the art of the possible. *JAMA*, 285(22) 2898-2905.

Periyakoil, VJ (2005). Fast Facts and Concepts #43: Is it grief or depression?, 2nd ed. Retrieved July 5, 2010 from http://www.mcw.edu/fastFact/ff_043.htm

Copyright/Referencing Information: Users are free to download and distribute Fast Facts for educational purposes only. Periyakoil VJ. Is It Grief or Depression? 2nd Edition. Fast Facts and Concepts. August 2005; 43. Available at: http://www.eperc.mcw.edu/fastfact/ff_043.htm.

Disclaimer: Fast Facts and Concepts provide educational information. This information is not medical advice. Health care providers should exercise their own independent clinical judgment. Some Fast Facts cite the use of a product in a dosage, for an indication, or in a manner other than that recommended in the product labeling. Accordingly, the official prescribing information should be consulted before any such product is used.

Hospice Education Network © 2010

Module 7
Figure 9: RELIEVER

The acronym RELIEVER can assist in supportive interventions that can facilitate preparatory grief.

Reflect: Mirror the emotions of the patient.
Example: A patient says, "Why do I have this terrible disease?" You may respond, "I can see that you are angry."

Empathize: Make every effort to make a personal connection with the patient.
Example: You may say to a patient, "I can only imagine how disappointment this all must be to you. It must be hard to get up everyday and try to move forward. What can I do to assist you?"

Lead: Ask guided questions in order to understand coping strategies of the patient in the past. Using those strategies can be helpful if those strategies were useful for them previously.
Example: "When you have gone through difficult situations in the past, how did you handle those?"

Improvise: Emotional boundaries must be respected and support must be offered within those boundaries. Care must be individualized. Some patients prefer to be quiet and listen to instructions. Others want to be involved. Some patients may want us to just be quiet and be present with them. Some may withdraw and others may want to continue with everyday routines.

Educate: Remind patients and their families that grief often comes in waves and that everyone grieves in their own unique ways. Anger is expected to—at self, situation, and others and all is common and normal. Patients and their families need to identify, validate, and channel constructive outlets for anger.

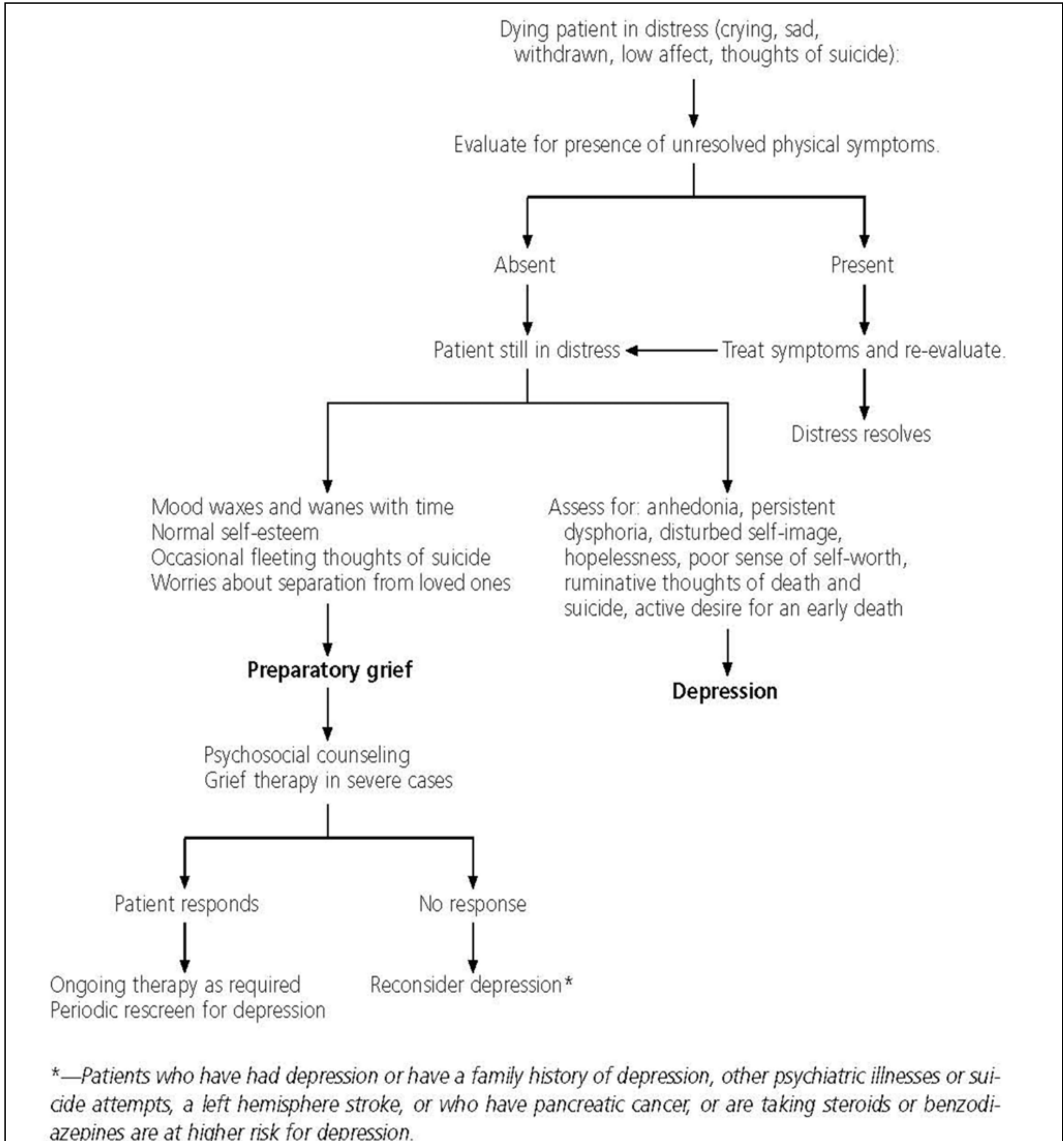
Validate the Experience: Relate to the patient that what they are experiencing is normal.
Example: "It is okay to be angry. It's a normal response to this very difficult situation."

Recall: Reminiscing and recalling one's life experiences is important. Healthcare providers can encourage this by asking patients about their accomplishments, legacies, etc.

Reference:
Periyakoil, V.S. & Hallenbeck, J. (2002). Identifying and managing preparatory grief and depression at the end of life. *American Family Physician, (65)*5, 883-890. Reprint permission granted by *American Family Physisican (AFP).*

Hospice Education Network © 2010

Module 7
Figure 10: Differences between Preparatory Grief and Depression



Reference:
Periyakoil, V.S., & Hallenbeck, J. (2002). Identifying and managing preparatory grief and depression at the end of life. *American Family Physician, (65)*5, 883-890. Reprint permission granted by *American Family Physisican (AFP).*

Hospice Education Network © 2010