

Abstracts

Denise Brady

Librarian

St Christopher's Hospice

London

Bereavement support in an acute hospital: an Irish model

Walsh T, Foreman M, Curry P. *Death Studies* 32(8) 768–785

The End of Life Care Programme (2008), spearheaded by the Department of Health in the UK, emphasises a generic approach to end of life care. This article describes a similar approach to bereavement care operating in a large hospital in Dublin, Ireland. It comprises a literature review, the model of bereavement care used in the hospital, and the results of a survey of service users. The hospital offers long-term and accident and emergency care and serves both a local and national population, so the bereavement service supports people not only in the nearby community but also nationwide.

The literature review includes sources on the importance of normalising grief, as well as references to bereavement services in hospitals. There are also interesting references to a variety of research reports published in Ireland in the last few years.

The bereavement model is described using a pyramid. The base is bereavement skills training for all health care workers, with study days, peer support, evaluation and research. The next layer concerns bereavement outreach using death education in the community and an information pack on what to do after a death, including planning memorial services. Next is the bereavement support programme that involves care of the dying and the bereaved families. Approaching the top of the pyramid are parent support days, risk assessment and referral to community or specialist services. At the apex of the pyramid is individual family and group counselling.

For the survey, 335 out of 839 bereaved people (the next-of-kin of people who died over one year in the hospital) replied to a postal questionnaire. The survey requested demographic details, information on their relationship to the deceased and their opinion of the bereavement service. Of the respondents, 65% had found it a comfort to receive an initial letter from the bereavement service. Feedback was positive on the range of services offered, with the respondents

specifically mentioning peer support programmes, telephone and postal support, remembrance services and face-to-face counselling. There were varied opinions on many of the services, but the responses did indicate that, even if only one aspect of care was found wanting, the whole experience was infused with bitterness. At the same time, kindness and respect were warmly welcomed and remembered.

Limitations of the study are mentioned but the overall result is a cautious endorsement of the service. This is an ambitious project but one that provides a model that could offer a starting point for other hospital programmes. ■

End of Life Care Programme (2008). Available from: <http://www.endoflifecareforadults.nhs.uk/eolc/> [accessed 10 December 2008].

A case for inclusion of prolonged grief disorder in DSM-IV

Prigerson HG, Vanderwerker LC, Maciejewski PK. *Grief Matters* 11(1) 23–32

This article provides a compelling case for the inclusion of prolonged grief disorder (PGD) as a diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. The authors consider PGD should be a psychiatric diagnosis in order to benefit those people who suffer prolonged and distressing grief, estimated by them to be about 11% of bereaved people. They believe the condition meets the *DSM* definition of a mental disorder, further indicating that it has unique characteristics distinct from other psychiatric symptoms and therefore needs its own optimum treatment interventions. Prolonged grief disorder is the most recent name for this condition; in the context of this article, it can be viewed as a substitute for terms previously used, such as complicated grief, pathological grief, and traumatic grief.

The article is a history of the development of the concept. The authors use an amended form of the stages of grief model as a guide to normal grief and then provide key descriptive features of PGD. In the final analysis, they consider yearning as a key

symptom, together with nine other symptoms, five of which must be present over a six-month period in order to confirm a diagnosis.

The authors also detail efforts to build a consensus, including their recent research, further confirming their stance. This includes statistical and clinical analyses, comparisons with conditions already included in the *DSM* (eg. major depressive disorder) and brief information on the various groups they consulted. The research undertaken by these authors has been extensive; it is not easy to obtain consensus and they have made every effort to do so. Their object is to relieve suffering and the article has commitment and a sense of urgency. This is a seminal article setting out the case for including PGD in the next (fifth) edition of the manual, *DSM-V*. However, discussion is still warranted and this is the perfect springboard.

In a broader context it is useful to read 'Depression, bereavement and "understandable" intense sadness: should the *DSM-IV* approach be revised?' (Mai, 2008). This provides some reasons for and against the inclusion of bereavement in the *DSM*, including references that further inform the debate. In addition, see *Omega* 2006, 52(1) for a whole journal issue on the subject where the issues for and against inclusion are examined from all angles, with the final conclusion favouring inclusion. Alternatively you can read a brief overview of the *Omega* debate in *Bereavement Care* (Brady, 2007). ■

Brady D (2007). *Complicated grief. Bereavement Care* 26(1) 15–16.

Mai M (2008). Editorial. *American Journal of Psychiatry*. November. Available from: <http://ajp.psychiatryonline.org/cgi/content/full/165/11/1373> [accessed 12 December 2008].

Spousal bereavement assessment: a review of bereavement – specific measures

Minton ME, Barron CR. *Journal of Gerontological Nursing* 34(8) 34–48

This provides an interesting review of articles that have used a variety of bereavement assessment tools to

research spousal bereavement, displaying the details of about 40 articles in a long table. Included in the table are, for each study, the researchers, the sample, the design, the research focus, the assessment tool used and its validity. The review authors then detail each of the 12 assessment tools used and state the differing focus of each tool. They suggest three that would be most useful for nurses in their routine work with patients: the continuing bonds in coping (CB coping) tool, the self-regard questionnaire (SRQ), and 10-mile mourning bridge (10MMB).

The CB coping tool describes the ways people maintain links with the deceased, while the SRQ assesses current experience of the self over time following a bereavement. The 10MMB measures progress through the bereavement process, the zero mile being the time of the death and the tenth mile reflecting the time when a person feels a recovering of emotional energy beyond the grieving process. The authors consider that knowledge of these tools will provide nurses with guidance on how to assist people through the bereavement process.

The article is useful in that it reviews a range of assessment tools. The literature search itself leaves room for improvement as, for instance, the authors used widowhood as a heading. If this had been truncated to widow, then references to widow, widows, widower and widowers would have been included. This also leaves out other relevant measures that pertain to groups other than bereaved spouses, one example being the recent guidance from Help the Hospices (Relf, Machin & Archer, 2008). ■

Relf M, Machin L, Archer N (2008). *Guidance for bereavement needs assessment in palliative care*. London: Help the Hospices.

Service and science in times of crisis: developing, planning, and implementing a clinical research program for children traumatically bereaved after 9/11

Goodman RF, Brown EJ. *Death Studies* 32(2) 154–180

This article provides information and discussion on the development of a programme to help the

bereaved children of emergency workers who died in the attack on the New York Twin Towers in 2001. The authors outline the initial planning of a specialised service and describe the details of the programme that encompassed support, psycho-education, psychological assessment and interventions.

This initiative included a research project that was envisaged would provide unique data on trauma and its aftermath. A counselling service for active emergency workers was already in place, but the authors suggest that this did not have sufficient resources to cope with the aftermath of 9/11, and that the research element had greatly assisted in obtaining additional funding to meet the new needs.

The leaders of the programme liaised with the pre-existing counselling service, recruited collaborators who were experts in trauma, sought to understand the tight community of emergency workers, obtained funding, and recruited staff. Considerable time was spent in identifying and contacting relevant families; 515 children were eligible for an intervention and 70 were treated. Support and psycho-education, rather than pathology or research, was emphasised.

The many challenges and tensions in setting up a clinical service combined with a research project are described in some detail. The authors briefly outline the intervention and research methods, which involved a randomised control trial of CBT and client-focused therapy, as well as a longitudinal study. However, although they report that those who participated were generally satisfied with the service, they do not provide any results in terms of psychological tests. One would hope these will be detailed in a subsequent paper. ■

An inner struggle for hope: insights from the diaries of bereaved family caregivers

Holtslander L, Duggleby W. *International Journal of Palliative Nursing* 14(10) 478–484

Thirteen women between the ages of 60 and 79 were the focus of this research. It explored the experience

and processes of hope in adjusting to partner/spousal bereavement after a death from cancer. The study took place in Canada and all the participants had contact with a local palliative care service. A diagram describes the demographics of the group. All the participants were interviewed at least twice and, at the end of the first interview, were asked to complete a daily 'hope' diary at the start or end of each day for a period of two weeks.

The interviews and diaries were examined initially as one study but this article describes the secondary analyses of the diaries alone. These revealed that hope meant that they wanted to cope with loss of their spouse, to regain confidence and to be able to reach out to others. This hope was also for their families. Hindrances to hope were multiples losses, loneliness and their own physical health concerns. Fostering hope involved positive thoughts, connections (to other people, to God, to nature) and taking care of their own physical needs: eg. being able to sleep well, to go for a walk. The act of keeping the diary was also regarded as therapeutic (one participant taped her diary instead of writing it) and extracts from them revealed that this activity enabled people to reflect on the ups and downs of their days. The authors conclude that nurses have a role in promoting hope interventions for bereaved older people. ■

The 'forgotten bereaved'

Harvard Mental Health Letter 2008 (Sept) 6

This short, unattributed article provides a snapshot of some issues that affect bereaved adult siblings. The article suggests this is often an unacknowledged loss. It quotes some insensitive remarks and suggests some challenges in sibling loss-issues around mortality, guilt, issues of identity and delayed grief. Some advice on coping strategies is provided and also a reference to a book on the subject (Wray, 2003). ■

Wray TJ (2003). *Surviving the death of a sibling*. New York: Three Rivers Press.