



Continuing Professional Development Unit
Birmingham City University



Bereavement Counselling

Day THREE

Course Facilitator : David Forrest

davidforrest@gestaltuk.com www.gestaltuk.com davidforrest@uktherapist.net

Self Care for Engaging in Bereavement Counselling



Learn about your own reactions.

Anticipate that you may well experience emotional reactions.

Have someone to share some of the responsibility with.

Remember you cannot carry away the individual's/family's grief.

Remember that to be of any use, we need to take good care of ourself.





Bad News



The impact of distressing information cannot be softened
no matter how it is broken.

However,
if done badly,
the information can be distressing for both receiver and
bearer,
and impede the patient's long-term adjustment.



Bad News



Emotional Impact

It is vital to be aware of the importance of the information that is being
given, and its impact on the patient

Carers need not be afraid of showing their own feelings for the patient
may fear professional disinterest

Ask how the patient feels - for some people will not volunteer this
information

The patient may (will) react with varied emotions

Breaking the bad news



1992 Code of Professional Conduct states:

- ✓ Always act in such a manner as to promote and safeguard the interests and well-being of patients and clients
- ✓ Ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients
- ✓ Work in an open and co-operative manner with patients, clients and their families, foster their independence and recognise and respect their involvement in the planning and delivery of care.

Should – v - When



It has been advocated that the most important questions a professional should ask themselves is not 'should the patient be told', but:

- When should a patient be told?
- Where should a patient be told?
- Who should break the bad news and to whom?
- How should a patient be told?



Where and Who Tells the bad news



Where?

- ✓ a quiet, comfortable and private room
- ✓ a 'do not disturb sign' on the door
- ✓ phone disabled
- ✓ chairs comfortable and at same level, no barriers
- ✓ preparation is made for upset - tissues at the ready



Who?

Communication should be a team approach involving:

- ✓ the patient
- ✓ a nurse from the team caring for the patient, or
- ✓ the named nurse, to provide support and a familiar face
- ✓ a doctor with whom the patient has a good trusting relationship
- ✓ a friend or relative of the patient's choice if they so wish



- **team members must plan to decide who says what**
- **If the patient is told first** problems that may emerge if the family is told first can be avoided.

When to Tell the bad news



- The patient should be prepared for bad news when investigations begin.
- Making sure of all possible outcomes, including serious ones, ensures informed consent and prepares for the possibility of bad news.
- Distressing information can be communicated once all necessary tests have been completed, the results have been seen by a senior doctor and the diagnosis has been confirmed.
- This ensures that the patient can get clear answers to questions.
- Professionals should be prepared to answer any questions. They should also liaise with the MDT to help to answer queries of which they are unsure or about plans or action for the future.
- Information must be conveyed in a manner that the patient understands.
- Thus feelings, ability to understand and level of comprehension must be established.
- If the patient shows no interest in a meeting or puts up blocks to any news, this could indicate that he is not ready for discussion



How to Give the bad news



- ✓ establish the identities of the people present.
- ✓ go over the reasons for the meeting.
- ✓ check the patient's current knowledge to ensure that the discussion starts at a point which is appropriate to the patient.



- give the information clearly - avoid generalisations and jargon.
- even simple words like 'stomach' can mean different things to patient and doctor or nurse.
- thus it may be necessary to check the patient's understanding of words.
- try to use open questions and allow time for a response.
- silence should be respected and non-verbal cues acknowledged.

Dealing with Uncomfortable Questions



The patient may ask questions that are difficult or impossible to answer. e.g.



- How long have I got?
- How will I die?
- Will I have to suffer?
- Will it be frightening?
- Are you just trying to keep me alive?



- In general, be truthful and admit to not knowing all the answers
- Stress positive aspects - what can be done, rather than what cannot (e.g. pain relief, rehab, false limbs)
- Be aware that time limits on life expectancy can be highly inaccurate
- the patient and his family may gear themselves up to the wrong timespan, leading to stress and an inability to reach the goals that they have set



Patient Understanding and Denial



Patients can forget 40% of information given to them in a general interview:

- This percentage increases when the news is bad
- hearing a word like 'cancer' can make it impossible for the person to hear anymore information

Facts must be given at the patient's pace, with the nurse taking cues from the patient:

- ✓ understanding must be checked frequently
- ✓ unclear or forgotten points reinforced
- ✓ this process may take more than one meeting and many informal talks between family, patient and staff may be needed

Denial:

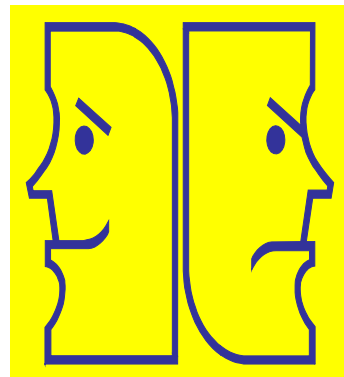
- ❖ when the truth is too hard to bear
- ❖ it may be better to leave denial unchallenged, if it causes no problem for the patient or family
- ❖ in some patients, initial denial gives way to other feelings
- ❖ thus further meetings may need to be arranged
- ❖ patient and family need to know that they can have some more of your time if they need it



Factors in grief reactions



- Who the person or object was
- The nature of the attachment
- The mode of death or loss
- The historical antecedents
- The bereaved's personality
- The social variables such as
 - ethnic culture
 - social culture
 - religious culture
 - supportive networks
- Concurrent stresses.



Bereaved Adjustments



- ❖ External Adjustments – How the death affect's one's everyday functioning in the world – roles and skills
- ❖ Internal adjustments – How the death affects one's sense of self: self-definition, self-esteem and sense of self-efficacy
- ❖ Spiritual adjustments – How the death affects one's beliefs, values and assmptions about the world: Loss of direction and meaning in life

Skills Component



- ❖ Draw on listening skills, including empathic listening, tolerating silences.
- ❖ Stay with the conversation and make yourself aware of verbal and non-verbal communication.
- ❖ Check out what the client/patient seems to be thinking and feeling about a matter.
- ❖ Reflect back what might be the meaning of seemingly
❖ denied or distorted feelings that do not seem to fit with a
❖ persons overall presentation.
- ❖ Resist offering praise that is sourced from your own
❖ frame of reference.

In Practice



The counselling attitudes can enable grievors to be less frightened and less condemning of the feelings they experience as part of their grief.

Counselling skills, with conscious usage and practice, become integrated more naturally into practice in a way that is responsive to the grieving person.

Reflective listening can enable grievors to find their

- ❖ own words to tell the story of their relationship with the dead person,
- ❖ to share the memories good and bad,
- ❖ and to express their feelings of loss.

More deeply empathic responses pick up feelings at the edge of awareness.

- ❖ The griever may have 'needed' to keep certain feelings out of full awareness.

The Accepting Process



It is the counsellor's task not to help the bereaved to give up their relationship with the deceased,
But to help them find an appropriate place for the dead
in their emotional lives –
a place that will enable them to go on living
effectively in the world.

This task is often hindered by
holding onto the past attachment
rather than going on and forming new ones.

Healthy Grief



Shock

denial anger bargaining

Experiencing and expressing all emotions and reactions to the loss.

Suffering & Disorganisation

anger, bargaining, depression

Completing and letting go of attachments both to the deceased and to the sorrow

Aftershocks & Reorganisation

anger, bargaining, acceptance

Recovering & reinvesting anew in one's own life

Unsuccessful Grief



- ✗ The lack of knowledge about experiencing and completing the mourning process.
- ✗ Exaggerating or prolonging our grief years beyond the actual loss.
- ✗ Misguided ideas of courage in our society
- ✗ Denial of grief
- ✗ Delayed grief
- ✗ Lack of supportive network



Complicated Grief can result due the following:

Problematic relationships with the deceased prior to loss.

Guilt feelings

Idealisation

Over-dependence

Unresolved differences

Existing unresolved grief & loss (from childhood)

No family support

Accumulated losses

Delayed grief

Loss due to Suicide



Remember

Counsellor awareness : Experiences of grief

Tasks of mourning: to place deceased in life and memory

Talk about death and dying

Use of Counselling skills: aid the process of grief

Self-care: enables you to care effectively for others