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Research paper

The nature of death, coping response and intensity of bereavement following death in the critical care environment

Thomas Buckley RN, PhD[a,b,*],
Monica Spinaze RN, MN[a],
Roger Bartrop MBBS, MD[a,b],
Sharon McKinley RN, PhD[a],
Victoria Whitfield BSW[a],
Jennifer Havyatt B Soc Stud[a],
Diane Roche RN, MA[a,b],
Judith Fethney BA, BTeach[b],
Geoffrey Tofler MBBS, MD[a,b]

[a] Royal North Shore Hospital, Sydney, Australia
[b] University of Sydney, Australia

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ABSTRACT

Introduction: Bereavement, defined as the situation of having recently lost a significant other, is recognised as one of life's greatest stressors and may lead to decrements in health status, psychological morbidity and excess risk of mortality.
Aim: The aim of this study was firstly to describe the relationships between the nature of death and bereavement intensity following death in the adult critical care environment and secondly to examine the modifying effects of coping responses on intensity of bereavement reaction.
Method: Prospective evaluation of the impact of the nature of death and coping responses on bereavement intensity. 78 participants completed a nature of death questionnaire within 2 weeks of bereavement and at 3 and 6 months completed the Core Bereavement Items Questionnaire (CBI-17) and Brief COPE Inventory.
Results: At 6 months, univariate variables significantly associated with bereavement intensity were: being unprepared for the death ($p < 0.001$), a drawn out death ($p < 0.001$), a violent death ($p = 0.007$) and if the deceased appeared to suffer more than expected ($p = 0.03$). Multivariate analysis revealed being unprepared for the death appears to account for these relationships. Regarding coping, there were significant increases from 3 to 6 months in both acceptance scales ($p = 0.01$) and planning ($p = 0.02$) on The Brief COPE Inventory. Greater use of emotional support ($p = 0.02$), self-blame (0.003) and denial ($p < 0.001$) were multivariate variables associated with higher bereavement intensity at 6 months.
Conclusion: The results from this evaluation provide insight into the impact of bereavement after death in the critical care environment and inform potential preventative approaches at the time of death to reduce bereavement intensity.

1. Introduction

The death of a loved one is recognised as one of life's greatest stressors.[1] While bereavement, defined as the situation of having recently lost a significant other through death[2] can be viewed as a normal human experience, the grief response in bereavement is a unique psychological stress, associated with decrements in health

* Corresponding author at: MO2, University of Sydney, NSW 2006, Australia. Tel.: +61 2 9114 4043.
E-mail address: tom.buckley@sydney.edu.au (T. Buckley).

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status and excess risk of mortality in surviving relatives.[3–7] For the surviving spouse/partner of deceased, bereavement can be particularly devastating, requiring intense readjustment[3] due to having to cope with the simultaneous disruption to living arrangements, financial security and social status. The death of a child has also been associated particularly with significant psychological stress.[8] For this reason, the health and wellbeing of relatives following bereavement is a concern, not only for preventative care[3] but for all clinicians involved in end of life care in the critical care environment.

Empirical research into the course of bereavement response suggests that disbelief, yearning, anger and depression are frequent responses in grief, which peak within the first 6 months.[1] Following death in the intensive care environment, risk of psychological morbidity may be higher than expected in bereavement with incidence of complicated grief, also known as unresolved or protracted grief, reported as high as 23% in one study.[9] Interventions around the time of death may potentially reduce the impact of death, both psychologically and physically on surviving family members, but the development of evidenced based practice in end of life care related to this is hampered by lack of evidenced based knowledge.[10]

Following death from normal causes, a high degree of acceptance has been reported as a dominant grief coping indicator.[1] Acceptance following death of a loved one is a clinically important coping indicator in bereavement with lower levels associated with higher risk of complicated grief disorder.[11] Additionally, lower prognostic awareness has been associated with lower levels of acceptance[1] suggesting acceptance at the time of death may be amenable to intervention.

It has been suggested that the manner and forewarning of the death may affect a person's ability to process or cope with grief.[1,12] Bereavement following deaths from unexpected and therefore unprepared causes (e.g. motor vehicle accidents or suicide), is more likely to be associated with high degrees of disbelief and anger, and lower levels of acceptance.[12] Additionally, evidence suggests ability to cope following death of a child may be influenced by factors such as information given by staff concerning the child's illness and death.[13] As such, an understanding of the circumstance surrounding death, such as preparedness for the death, is important to provide evidenced based care to reduce the effect of bereavement on immediate surviving relatives.

The aim of this study was to describe relationships between the nature of death and bereavement intensity at 3 and 6 months following death in the adult critical care environment. We hypothesised that the nature of the death, including level of preparation for the death, would be a determinant of bereavement intensity. An additional aim was to examine the modifying effects of coping responses on intensity of bereavement reaction to identify potentially modifiable coping responses.

2. Methods

2.1. Study design

Bereaved participants were recruited from the critical care units of five hospitals in the Sydney metropolitan area participating in the Cardiovascular Health in Bereavement (CARBER) study. The CARBER study was prospective evaluation of cardiovascular risk factors in recently bereaved spouses/partner or parents of deceased.[14–16] The study reported here is an analysis of coping at 3 and 6 months following bereavement in this sample. The study protocol was approved by the Human Research Ethics Committee for the Area Health Service and conformed to the principles outlined in the Declaration of Helsinki.

2.2. Study participants

Between 2005 and 2008, bereaved participants were enrolled into the CARBER study, across 5 study sites (1 tertiary referral and 4 district hospitals in Northern Sydney). Participants were enrolled within 2 weeks of the death of their partner or child and completed questionnaires on coping at 3 and 6 months following the death of their relative. Potential bereaved participants were excluded if they had cognitive impairment, psychotic illness, were residents in nursing homes or unable to speak or read English.

All identified bereaved spouses or parents of deceased patients who met eligibility criteria at the participating institutions were contacted by a social worker or study investigator in person at the hospital or by telephone within the first 72 h following bereavement. Interested participants received a study information sheet and an appointment was made to conduct initial data collection within 2 weeks of bereavement in participants' homes. Follow-up assessments were at 3 months by mailed questionnaire and 6 months in participants homes following death of participants' relatives. Of those who met study inclusion criteria ($n = 133$), 60% agreed to participate and completed initial assessments (within 2 weeks of the death).

Seventy-eight participants enrolled in the CARBER study completed data on nature of death, coping and bereavement intensity and formed the sample for analysis presented here. Three bereaved (4%) withdrew from the study before the 3 month assessment and one bereaved died from multiorgan failure prior to the final assessment (although 3 month assessment was completed for these participants). Six (8%) participants did not three month psychological assessments, although they did complete the 6 month assessment. Substitution of missing data was not performed as the decision to not complete the questionnaire was unlikely to be random.

2.3. Data collection

On entry to the study (within 2 weeks of bereavement), participants completed a sociodemographic and clinical history questionnaire, including details of the nature of their relatives' death.

2.4. Nature of death questionnaire

Participants completed 6 questions relating to the nature of their relatives' death. Four questions relating to preparedness, how drawn out the death seemed, the extent of suffering and how violent the death seemed were based on a previously published questionnaire.[17] Participants were asked: Q1. "How prepared did you feel for your partner/child's death?" with potential responses recorded on a Likert scale of 1–7 with 1 = totally unprepared and 7 = well prepared; Q2. "How drawn out did the dying process seem to you?" with potential responses on a Likert scale of 1–7 with 1 = over very quickly and 7 = well extremely prolonged; Q3. "How violent did your partner/child's death seem to you?" with potential responses on a Likert scale of 1–7 with 1 = peaceful and 7 = violent; and Q4. "To what extent do you think your partner/child suffered in dying?" with potential responses recorded on a Likert scale of 1–7 with 1 = minimally and 7 = extremely. Two additional questions were administered as follows: Q5. "How much did your partner/child suffer compared to what you expected?" with potential responses measured on a Likert scale of 1–7 with 1 = much less and 7 = much more; and Q6. "Did you feel you had the opportunity to say "good-bye" to your partner/child just before s/he died? With potential responses: yes or no. Each question was analysed separately in statistical analyses.