Objectives and posttest can be found on page 190.

Bereavement Debriefing Sessions: An Intervention to Support Health Care Professionals in Managing Their Grief After the Death of a Patient

Elizabeth A. Keene, Nancy Hutton, Barbara Hall, Cynda Rushton

Health care professionals experience grief when caring for children with life-threatening conditions. Harriet Lane Compassionate Care, the pediatric palliative care program of the Johns Hopkins Children's Center, created an action plan to support health care professionals; one intervention – the bereavement debriefing session – was specifically aimed at providing emotional support and increasing one's ability to manage grief. A structured format for conducting bereavement debriefing sessions was developed, and 113 sessions were held in a three-year period; data were collected to capture themes discussed. Bereavement debriefing sessions were conducted most frequently after unexpected deaths or deaths of long-term patients. Though attendance included all disciplines, nurses attended the sessions most often. Self-report evaluation forms revealed that health care professionals found the sessions helpful. Bereavement debriefing sessions can be one aspect of an effective approach to supporting health care professionals in managing their grief in caring for children with life-threatening conditions.

Caring for children with life-threatening conditions can have a profound effect on health care professionals. Without the ability to manage one's grief in response to the death of a patient, health care professionals may experience physical, emotional, cognitive, behavior, or spiritual distress, which could have implications for their professional practice (Behnke, Reiss, Neimeyer, & Bandstra, 1987; Davies, 1996; Papadatou, 2000).

As part of a quality improvement project to improve care of children with life-threatening conditions, the pediatric palliative care program of Johns Hopkins Children's Center, Harriet Lane Compassionate Care, created an action plan to support health care professionals in their care of dying children. The approach consisted of four interventions that are described elsewhere (Rushton et al., 2006); this article focuses on one intervention – bereavement debriefing sessions – which are specifically aimed at providing emotional support and increasing one's ability to manage grief. Although data collection started with the quality improvement project funded by the Education Development Center, bereavement debriefing sessions have continued as an on-going intervention to support health care professionals at Johns Hopkins Children's Center.

Review of Literature

The opportunity for health care professionals to process personal and professional responses to a patient's death seems to be important yet lacking (McCoyd & Walter, 2007; Serwint, 2004). One structured process developed from efforts to reduce post-traumatic stress symptoms for trauma workers: Critical Incident Stress Debriefing (CISD) sessions. There continues to be controversy around the efficacy of CISD sessions for supporting health care professionals, and this process was specifically designed around crisis situations for emergency responders rather than responses to patients' deaths in the hospital setting (Everly & Boyle, 1999; Mitchell, Sakraida, & Kameg, 2003; Raphael & Wooding, 2004); however, the idea of developing a process of support for health care professionals is important.

Recent studies illustrate the need for grieving health care professionals to be offered emotional support and opportunities to make meaning (Lee & Dupree, 2008; Macpherson, 2008). Papadatou (2000) proposed a model for how health care professionals grieve and identified six possible ways the loss of a patient could affect a health care professional when a child is dying: a) loss of relationship with patient, b) loss related to identification with pain experienced by parents, c) loss of assumptions about one's worldview, d) unresolved previous personal losses, e) loss related to facing personal mortality, and f) loss related to professional expectations. Papadatou (2000) suggested a multifaceted approach to supporting health care professionals, including informational, clinical, and emotional support, as well as opportunities for meaning-making. Davies (1996) found that the most common strategy for pediatric

Elizabeth A. Keene, MA, FT, *was a Bereavement Coordinator, Harriet Lane Compassionate Care, Johns Hopkins Children's Center, St. Mary's Health System, Lewiston, ME, at the time this article was written, and is Vice President for Mission Effectiveness, St. Mary's Health System, Lewiston, ME.*

Nancy Hutton, MD, *is an Associate Professor, Johns Hopkins School of Medicine, Baltimore, MD.*

Barbara Hall, RN, *is a Family Care Coordinator, Harriet Lane Compassionate Care, Johns Hopkins Children's Center, Baltimore, MD.*

Cynda Rushton, PhD, FAAN, *is an Associate Professor, Johns Hopkins School of Nursing, Baltimore, MD.*

Statement of Disclosure: *The authors reported no actual or potential conflict of interest in relation to this continuing nursing education article.*

nurses caring for dying children was to share their experiences with colleagues.

Offering bereavement debriefing sessions is just one intervention in part of a larger pediatric palliative care program at Johns Hopkins Children's Center focused on providing this multifaceted approach to support. Other supportive interventions include palliative care educational forums for information support, patient care conferences for clinical support, bereavement debriefing sessions for emotional support, and rituals of remembrance as opportunities for meaning-making (Rushton et al., 2006).

Bereavement Debriefing Sessions at Johns Hopkins

Bereavement debriefing sessions are offered after all patient deaths but are not mandatory. The session is usually initiated by the bereavement coordinator; e-mail and verbal invitations are extended to the key health care professionals involved in the care of the patient. The bereavement coordinator then schedules a session convenient to participants. Staff are notified by e-mail, and signs are posted in private areas on the clinical unit. There may be more than one bereavement debriefing session per patient death, especially if multiple units or services were involved.

The sessions are facilitated by the bereavement coordinator, and the structure for the sessions is based on CISD sessions with several important distinctions. One key difference between CISD and bereavement debriefing sessions is the "critical incident" category. CISD sessions focus on the details of the incident, and disruptions the traumatic event can cause physically and psychologically (Mitchell et al., 2003). Bereavement debriefing sessions focus on the emotional response of health care professionals, often in the wider context of a relationship with the patient and not simply the death event itself. Another way in which bereavement debriefing sessions differ from CISD sessions is the timing of the session; bereavement debriefing sessions are usually held within a week of the patient's death, often after the funeral (as opposed to CISD sessions, which are offered within hours of the incident). This affords people the opportunity to reflect on or hear about the patient's funeral, as well as discuss the effects of grief that they are experiencing.

Table 1.
Format and Structure of Bereavement Debriefing Sessions

Format	Structure
Welcome and Introductions	• Review purpose of bereavement debriefing sessions • Invite participants to give names and answer • "How were you involved in care for this patient and family?"
Factual Information	• Review time of death circumstances
Case Review	• "What was it like taking care of this patient?" • "What was the most distressing aspect of the case?" • "What was the most satisfying aspect of the case?"
Grief Responses	• "What have you experienced since the death?" (Elicit physical, emotional, behavioral, cognitive, or spiritual responses)
Emotional	• "What will you remember most about this patient/family?"
Strategies for Coping with Grief	• "How are you taking care of yourself so you can continue to provide care for other patients and families?" • Review grief coping strategies • Review available resources
Lessons Learned	• "What lessons did we learn from caring for this patient/family?"
Conclusion	• Acknowledge care provided • Review bereavement support available for families and staff

The format of bereavement debriefing sessions (see Table 1) includes a welcome from the facilitator to review the purpose of the session and an opportunity for introductions with the question, "How were you involved in care for this patient/family?" Responses may reveal who was present at the time of death or if this is someone's first experience of a patient's death. The next segment includes a review of the circumstances at the time of death. If key faculty and staff who cared for the patient were not present when the patient died, appropriate details about the patient's comfort level and how the family coped at the time of death and at the funeral can provide reassurance.

Several open-ended questions are then posed as a way to invite the participants to express their personal and professional responses to the death. "What was it like taking care of this patient?" can elicit responses about the experience of providing physical care or coping with emotional and spiritual stress. Inquiring about the most distressing and the most satisfying aspects of the case enables participants to review both positive and negative experiences in caring for the patient/family. "What have you experienced since the death?" provides an opening for participants to discuss any physical, emotional, behaviorial, or spiritual responses. The facilitator can normalize the responses are part of the grief process.

The next segment shifts the focus to the patient: "What will you remember most about this patient and family?" This is often the most emotionally vulnerable segment. After inviting memories to be shared, the facilitator shifts the conversation to a more cognitive level and inquires about coping strategies. This can illustrate the individual nature of coping with grief, and often elicits support and wisdom shared from those with more experience to newer staff. The final open-ended question is, "What lessons did we learn from caring for this patient and family?" Responses to this question can range from personal reflections on the particular patient to thoughts on death and comments on working as part of a health care team. Finally the facilitator acknowledges the care provided to the patient and family, and reviews the bereavement support that is available for both families and health care professionals.

Methods

The Harriet Lane Compassionate Care (HLCC) Team developed a form for the facilitator to note demographic elements of the session and themes that arose from the structured questions. The bereavement coordinator recorded the data for all bereavement debriefing sessions. If multiple themes arose at a bereavement debriefing session, all themes were captured on the form for that particular session.

Two instruments were used to evaluate the sessions. In the initial 13 months, data collection of bereavement debriefing sessions included evaluation forms as a way to assess the sessions as a quality improvement intervention. Forms were distributed at the end of each bereavement debriefing session, and participants completed them before leaving the room. Participants were asked to rate how helpful, informative, and meaningful they found the bereavement debriefing session.

In addition, an IRB-exempt, anonymous, voluntary, cross-sectional survey was administered to staff pre- and post-intervention (in 1999 and again in 2003) in conjunction with a quality improvement project through the Education Development Center. In 2003, seven additional questions (27 response items) were added related to the HLCC program outcomes of interest. Using a 5-point Likert response scale, these questions assessed participation in HLCC program activities and the self-reported impact of participation in HLCC. The association of participation in HLCC activities with self-reported professional attributes was examined using ANOVA. Respondents were asked to rate how much participation in bereavement debriefing sessions impacted their ability to manage their grief and helped them maintain/restore their professional integrity.

Data Analysis

From February 2002 through December 2005, 113 bereavement debriefing sessions were held at Johns Hopkins Children's Center. Attendance reflected good interdisciplinary representation, with a prevalence of nurses (374 [54%] of the 676 health care professionals who attended). Physicians (15%), child life specialists (8%), and social workers (5%) also attended sessions regularly, but all disciplines were represented, including chaplains, nutritionists, clerical associates, allied health therapists, the librarian, and foreign language interpreters.

Sessions were requested most often by the oncology service (45% of sessions). Sessions were held every time there was a death on a medical-surgical floor or for a primary clinic patient who died outside the hospital (25% of sessions).

One theme noted was the reason for requesting the bereavement debriefing session. The most frequent reason cited was professional distress (cited in 97 of the 113 bereavement debriefing sessions). Most often, it was related to the relationship with the patient and/or the family, although it was sometimes related to the circumstances of the death (if the staff felt the patient died in pain). The theme reported next was a sudden or unexpected death (39 citations) (see Table 2).

In response to inquiring about the most distressing aspect of case, the most frequent themes were related to emotional and physical aspects of care (see Table 3). A long-term relationship with the patient/family occurred most often (81 occurrences); the emotional impact of the death of the patient and witnessing the parents' pain was significant for participants, along with the emotional impact of sudden, unexpected deaths (23 occurrences). Another aspect cited often was providing aggressive treatment while the patient was dying (34 occurrences). This theme declined in frequency during the three years.

Responses to the most satisfying aspects of the case included elements related to team collaboration, end-of-life care, and the relationship with the family (see Table 4.)

Results from the 184 evaluation forms returned indicate that participants found the bereavement debriefing session helpful (98.4%), informative (97.8%), and meaningful (97.8%). Fifty-seven percent of respondents reported that they had attended previous debriefing sessions (71 respondents reported they had attended two or more bereavement debriefing sessions). Many evaluations noted how helpful it was to hear how other disciplines viewed what happened from their perspective. In response to a narrative question about how the session would change one's practice, examples included, "I see the importance of taking care of myself as

Table 2.
Reason for Requesting Bereavement Debriefing Sessions

Reason	Number of Occurrences
Professional distress	97
Sudden/unexpected death	39
Multiple units involved in care	8
Long-term relationship with patient	6
Multiples deaths in a short period	5
Critical incident	2
Team conflict	1

Table 3.
Most Distressing Aspect of the Case

Theme	Number of Occurrences
Long-term relationship with patient/family	81
Provided aggressive treatment while patient was dying	34
Unexpected death	23
Conflict with family	21
Different cultural values/practices	12
No discussion with patient/family about end-of-life	12
Did not know patient/family well	11
Did not know enough	9

Table 4.
Most Satisfying Aspect of the Case

Theme	Number of Occurrences
Working as a team	51
Being instrumental in helping patient die respectfully	47
Felt a sense of closure	36
Good relationship with family	18
Good relationship with patient	6
Joy from caring for patient	2

a provider," and "I will change how I interact with nurses on other units from seeing how this affected them."

Results from the post-intervention survey indicate that by self-report, the greater the level of participation in bereavement debriefing sessions, the greater the score for how well health care professionals believed they managed their grief (Reder, Rushton, Hutton, & Hall, 2005). Staff who reported no participation in bereavement debriefing sessions scored from a low of 1.4/5 for their ability to manage grief, while those who participated in bereavement debriefing sessions scored up to 3.2/5 ($p = 0.003$). Staff who participated in bereavement debriefing sessions also scored higher in their ability to maintain their professional integrity (3.1/5) as opposed to non-participants (1.5/5, $p = 0.005$).

Discussion

Learning to manage grief responses to patient deaths is a crucial yet underemphasized skill for health care professionals. Without the ability to manage one's grief in healthy ways, a health care professional may find his or her personal and professional life affected, resulting in less-than-optimal care for patients and families (International Work Group on Death, Dying and Bereavement, 2006). Some may fear the emotional response evoked by a patient's death. In turn, this could lead to avoidance of a particular patient/ family or even lead to hesitation for working with critically ill patients in the future (Davies, 1996).

Several results from this study validate conclusions from Papadatou (2002) and other researchers in identifying emotional support as one effective intervention in learning to manage grief. (Davies, 1996; International Work Group on Death, Dying and Bereavement, 2006; Rashotte, Fothergill-Bourbonnais, & Chamberlain, 1997). The top two reasons for requesting a bereavement debriefing session were professional distress and an unexpected death; both reasons are related to the emotional impact of the death (such as grief from the long-term relationship with the patient and family, and shock from an unexpected death) (Papadatou, 2002), which coincide with the primary purpose of a bereavement debriefing session – to allow health care professionals to express their personal and professional responses to the death. The converse is also true; although sessions are offered after every death, they are not held for every death (113 sessions were held for the 494 deaths from 2002-2005), and when health care professionals decline a session, the two main reasons are "we did not know the patient" or "this was an expected death, and everything went well."

Most participants in the bereavement debriefing session were female nurses. Although not explored in this study, the elements of gender and role (physician vs. nurse) are also being explored as potential factors in managing grief. While several studies have found that female physicians report more psychological distress than male physicians (Behnke et al., 1987, Redinbaugh et al., 2003), Papadatou (2002) compared Greek physicians and nurses and found that physicians grieved privately, related their grief to the loss of their unmet professional goals (to cure the patient), and rarely sought emotional support. Nurses described their experience of grief as related to the loss of the relationship with the patient/family and did seek support among colleagues (Papadatou, 2002). It is unclear whether this is specifically related to professional role or gender although one study of physicians concluded that female doctors reported more symptoms of grief, used more coping strategies, and needed more emotional support (Redinbaugh et al., 2003). The fact that nurses seek emotional support more than physicians is affirmed by the attendance at the bereavement debriefing sessions in this study; significantly more nurses than physicians participated in the sessions focused on providing emotional support.

Threats to the loss of professional integrity and expectations appeared less frequently as a theme as the number of patient care conferences (another intervention initiated by the HLCC program) increased (Rushton et al., 2006). It may be that the ability to articulate concerns, clarify goals of care, and learn reasons for parents' decisions – all elements of patient care conferences – diminish the threat of loss of professional integrity.

One important aspect of the bereavement debriefing session is the experience of the facilitator. It is important that the person leading the session has training in group process and grief and loss to recognize potential complications of grief or help foster healthy therapeutic relationships. If the facilitator can offer a quality of presence that creates a safe and trustworthy environment, the staff will have a level of comfort that allows them to participate fully and honestly in vulnerable conversations.

Support from nursing leadership is essential for the success of this type of intervention. At Johns Hopkins Children's Center, the director of nursing and key nurse managers demonstrated their support by identifying occasions for bereavement debriefing sessions, giving staff release time to attend, and providing some overall funding to support the program. In addition to the philosophical aspect of this intervention related to the integration of palliative care, the director of nursing also perceived this as part of a strategy to address staff retention and satisfaction. Other institutions have also reported that provision of opportunities for nurses to share or reduce emotional distress have led to decreases in staff turnover (Huff, 2006).

There are several limitations to this intervention that should be considered. While the same person completed the bereavement debriefing session forms capturing the themes from each session, there may be bias in identifying the themes accurately. The evaluation forms were all done by participant self-report, which has the benefit of individualized comments but not statistical significance. All sessions were held at one institution, and therefore, cannot be generalized. Further study incorporating more objective data is warranted.

Conclusion

Health care professionals experience grief in caring for children with life-threatening conditions. As palliative care continues to evolve, the ability of health care professionals who care for these patients and families to manage their individual grief responses in the face of multiple losses is crucial. Offering bereavement debriefing sessions is one example of support that an institution can provide as part of a multifaceted approach in support of its staff. At Johns Hopkins Children's Center, staff have learned that these sessions can be most effective when the patient/family was known to staff over a long period of time or when a death occurs unexpectedly. The opportunity to express one's grief and reflect on the experience of caring for a particular patient and family allows health care professionals to learn to manage their own grief experience to continue to serve the many families who need their expertise and care.

References

Behnke, M.L., Reiss, J., Neimeyer, G., & Bandstra, E.S. (1987). Grief responses of pediatric house officers to a patient's death. *Death Studies, 11*, 169-176.

Davies, B. (1996). Caring for dying children: Nurses' experiences. *Pediatric Nursing, 22*, 500-507.

Everly, G.S., Jr., & Boyle, S.H. (1999). Critical incident stress debriefing (CISD): A meta-analysis. *International Journal of Emergency Mental Health, 1*(3), 165-168.

Huff, C. (2006). *Emotional debriefing.* Retrieved from http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/PubsNewsArticle/data/2006August/0608HHN_FEA_ClinSupport&domain=HHNMAG

International Work Group on Death, Dying, and Bereavement. (2006). Caregivers in death, dying and bereavement situations. *Death Studies, 30*, 649-663.

Lee, K.J., & Dupree, C.Y. (2008). Staff experiences with end-of-life care in the pediatric intensive care unit. *Journal of Palliative Medicine, 11*(7), 986-990.

Macpherson, C.F. (2008). Peer-supported storytelling for grieving pediatric oncology nurses. *Journal of Pediatric Oncology Nursing, 25*(3), 148-163.

McCoyd, J.L., & Walter, C. (2007). A different kind of holding environment: A case study of group work with pediatric staff. *Journal of Social Work in End-of-Life & Palliative Care, 3*(3), 5-23.

Mitchell, A.M., Sakraida, T.J., & Kameg, K. (2003). Critical incident stress debriefing: Implications for best practice. *Disaster Management & Response, 1*(2), 46-51.

Papadatou, D. (2000). A proposed model of health professionals' grieving process. *Omega, 41*, 59-77.

Papadatou, D. (2002). Greek nurse and physician grief as a result of caring for children dying of cancer. *Pediatric Nursing, 28*, 345-353.

Raphael, B., & Wooding, S. (2004). Debriefing: its evolution and current status. *Psychiatric Clinics of North America, 27*(3), 407-423.

Rashotte, J., Fothergill-Bourbonnais, F., & Chamberlain, M. (1997). Pediatric intensive care nurses and their grief experiences: A phenomenological study. *Heart and Lung, 26*, 372-386.

Reder, E.K., Rushton, C.H., Hutton, N., & Hall, B. (2005). Compassionate care for health care professionals: An action plan to improve pediatric palliative care [Abstract]. *Journal of Palliative Medicine, 7*, 165.

Redinbaugh, E.M., Sullivan, A.M., Block, S.D., Gadmer, N.M., Lakoma, M., Mitchell, A.M., ... Arnold R.M. (2003). Doctors' emotional reactions to recent death of a patient: Cross sectional study of hospital doctors. *British Medical Journal, 327*, 185-191.

Rushton, C.H., Reder, E., Hall, B., Comello, K., Sellers, D.E., & Hutton, N. (2006). Interdisciplinary interventions to improve pediatric palliative care and reduce health care professional suffering. *Journal of Palliative Medicine, 9*, 922-933.

Serwint, J. (2004). One method of coping: Resident debriefing after the death of a patient. *The Journal of Pediatrics, 145*, 229-234.

Additional Readings

Hinds, P.S., Pritchard, M., & Harper, J. (2004). End-of-life research as a priority for pediatric oncology. *Journal of Pediatric Oncology Nursing, 21*(3), 175-179.