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Family Nurse Practitioners' Perceptions Of Bereavement Care

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FAMILY NURSE PRACTITIONERS' PERCEPTIONS OF BEREAVEMENT CARE

by

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Abstract

Studies have shown that long-term effects of bereavement increase health problems among many individuals. There is an increased need for bereavement care among family nurse practitioners to lessen physical and mental anguish among those who have experienced a loss. The purpose of this study was to describe and explore family nurse practitioners' perceptions of bereavement care. This study's importance was to find out what is being done to address patients' bereavement issues by the family nurse practitioner. Orlando's Nursing Process Theory was the theoretical framework that guided this study. The research question for this study was as follows: What are family nurse practitioners' perceptions of bereavement care? The sample (N = 143) consisted of family nurse practitioners practicing in a rural state in the southeastern United States. Perceptions of family nurse practitioners were assessed using a modified survey developed by Lemkau et al. (2000) entitled Family Physicians and Grieving Patients. Data were analyzed using measures of central tendency including means, percentages, and frequencies to summarize and describe the findings. Respondents in

general viewed that identifying and treating bereaved patients was a necessary role of the family nurse practitioner. All respondents had strong beliefs that grief contributed to health problems. Family nurse practitioners expressed a need for further education and training on the topic of bereavement. Based on the findings from the study, several nursing practice recommendations were made. The nurse practitioner should recognize the importance of bereavement care. Thus, a plan of care could be implemented for the bereaved patient. Through interventions and an appropriate plan of care for the bereaved patient, the nurse practitioner could decrease negative effects that bereavement can have on individuals. Recommendations for future research include replication of this study with a larger sample and investigation of grieving patients' perceptions of what is expected from their health care provider after a loss.

Blessed are they that mourn,

for they shall be comforted.

Matthew 5:4

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Table of Contents

List of Tables

Chapter I

The Research Problem

The loss of a loved one can be a traumatic life experience, and survivors may have difficulty coping. The death of a spouse, child, or family member can put extreme stress on the survivor. The stress of the loved one's death can produce negative effects on the survivor's health. In order to decrease negative effects on health, family nurse practitioners can assist those bereaved individuals through the grieving process. The purpose of this study was to describe and explore family nurse practitioners' perception of bereavement care.

Establishment of the Problem

In 1998 a survey questionnaire was published in *Nursing98* to investigate nurses' opinions on end-of-life care. Out of 300 responses from the publication survey and from an additional survey of 5,000 oncology nurses, a total of 2,333 responses was obtained. Thirty-three percent of the surveys were returned from nurse practitioners or clinical nurse specialists. Respondents

were asked several questions regarding end-of-life care. In addition, the respondents were asked to rate effectiveness of grief and bereavement support in their work setting. It is important to note that less than 35% of the respondents stated that grief and bereavement support was effective in their work setting (Ferrell, 2000).

In the year 2000 the National Vital Statistics report indicated that there were 2,414,000 deaths in the United States (Centers for Disease Control and Prevention, 2001). These statistics affirm that many individuals had to face death in the recent past. Death of a spouse, child, parent, or other significant other can be traumatic to the person experiencing the loss.

Health care providers are frequently faced with death in their practice, whether it is a patient or a patient's family member. Bereavement is a topic some health care providers ignore and most are rarely ready to discuss it. The *Merriam-Webster New Riverside Dictionary* (1999) defines bereavement as "the state or fact of being bereaved, especially the loss of a loved one by death." Another source defines bereavement as the period of time that the person is experiencing emotional and psychological stress due to the absence of the deceased (Potter, 2001). Therefore, bereavement care can be defined

as care that is focused on helping the person who is experiencing emotional and psychological stress from a loss.

Bereavement varies among gender, cultures, and races. Not only does bereavement vary among groups, but it can also vary due to the type of death experienced. Complicated bereavement can occur with the loss of a child or an unexpected death. It is reported that up to a third of those who have suffered from a death of a child or spouse will experience significant effects on their physical and or mental health (Parkes, 1998). Many factors may contribute to poor grief resolution. Those factors include circumstances surrounding the death (suicide, sudden traumatic deaths, or socially unacceptable, such as death from AIDS), the survivor's coping mechanism (alcoholism, drug abuse, or psychological problems), the survivor's support system (no family or family living at a distance), and the relationship with the deceased (over-dependence) (Zisook & Shuchter, 1985). All of these can contribute to poor outcomes of the bereaved patient.

Most professionals believe bereavement is longer among those who have experienced a sudden or traumatic loss. High risk deaths or traumatic deaths may not be an indicator for specific grieving time periods. In fact, whether the death is sudden or expected, every person is

different in the grieving process and the time it takes to grieve. The grieving process is individualized.

Sheldon (1998) reported, "Bereavement is a universal human experience and potentially dangerous to health. It is associated with a high mortality and up to a third of bereaved people develop a depressive illness" (p. 456). Sheldon also discusses factors of the bereaved person that contribute to poor outcomes. These include predisposing factors, such as low self-esteem, dependent or dysfunctional relationships, or previous mental disorders. Other indications of poor outcomes include sudden death, stigmatized deaths (e.g., HIV and suicides), lack of social support, or caring for the deceased greater than 6 months (Sheldon, 1998).

Lemkau et al. (2000) reported that bereavement has been associated with negative health effects, such as ischemic heart disease, hypertension, depression, anxiety disorders, and posttraumatic stress disorder. These researchers also reported that those who experienced high-risk deaths, such as death of a child or a spouse, usually have negative health outcomes (Lemkau et al., 2000). A major study of traumatic grief as a risk factor for mental and physical morbidity found that bereaved patients who exhibit symptoms existing 6 months after the death may be at high risk for poor health outcomes, such as cancer,

heart complications, and suicidal ideation (Prigerson et al., 1997).

A study by Reich and Rogers (1988) reported that not all grief is complicated, yet even the normal grieving process can take up to a year and the loss is usually never fully accepted. If the grief process is dysfunctional, the authors point out that treatment and interventions should be implemented. Bereaved persons may exhibit acute physical symptoms, which include insomnia, bad dreams, anxiety episodes, and depression. Many also exhibit psychosomatic symptoms, such as headaches, chest pain, increased or decreased appetite, and frequent infections. These symptoms could perhaps be lessened if health care professionals were more aware of the losses experienced by their patients. This can only be accomplished by open communication between the health care professional and the patient (Potter, 2001).

While it is true that not all patients will present with complaints related to bereavement issues, it is the responsibility of the health care professional to do a complete history and physical to help identify the etiology of the presenting symptoms. The most important part of bereavement is social support. The involvement of the health care professional can provide a positive

support system focusing on the strengths of the bereaved individual (Charlton & Dolman, 1995).

The main purpose in providing bereavement care is to decrease negative health consequences of the bereaved patient. This care can be strengthened by educating health care professionals regarding this important concept of bereavement care and by documenting through research what education is needed. It is essential for the nurse practitioner to perform a self-examination of views on bereavement care and be familiar with all aspects that may influence the effects on the bereaved's health. This researcher described and explored health care professionals' perceptions of bereavement care.

Significance to Nursing

Health care professionals will be faced with some aspect of bereavement care in practice. Research on this important topic is gaining more attention in the health care system. A large amount of money is spent each year on illnesses related to bereavement issues (Parkes, 1998). By implementing a plan specific for bereavement care, the nurse practitioner can reduce cost and perhaps reduce complicated health problems among those experiencing bereavement. Therefore, it is the responsibility of the nurse practitioner to provide complete and comprehensive

care. This standard includes that care associated with the bereaved patient.

Family nurse practitioners are the primary care providers for many bereaved patients. Bereavement care is a vital component in the practice of health care professionals. Bereavement care involves identification and various treatment interventions with the bereaved patient. The main purpose of the family nurse practitioner in providing bereavement care is to decrease the negative health consequences. It is essential that the nurse practitioner examine his or her beliefs and attitudes regarding death and dying to understand bereavement care. The nurse practitioner should become familiar with cultural variations related to grief and bereavement issues among his or her patient population. With self-examination and knowledge of the grieving process, the nurse practitioner can begin to recognize grief reactions. With this early recognition, interventions and goals can be established by the nurse practitioner to assist the bereaved patient. Through interventions and education, the nurse practitioner can perhaps improve outcomes of bereaved patients.

Education regarding these issues of death and dying, grief, and bereavement should be promoted among all health care professionals. Courses on these topics and their

effects on the health of the survivors should be implemented in every health-related college curriculum. Continuing education hours on topics of grief and bereavement can provide valuable information and can add to the body of knowledge of the health care professional. The family nurse practitioner or any health professional should always be in tune to the needs of the bereaved population which can be accomplished through education.

Through this research and other research studies on bereavement care, the body of knowledge in this area is broadened and becomes a basis for future research. Empirical examination of family nurse practitioners' perceptions regarding bereavement care practices is an essential element in understanding the adequacy and appropriateness of patient treatment and referral to existing support systems. Orlando's (1961) theoretical framework provides a framework for the current study which focuses on the nurse practitioners' perceptions to the bereaved patient.

Theoretical Framework

Orlando's (1961) Nursing Process Theory was the framework that guided this study. Orlando's major concept states, "Nursing is a process of interaction with an ill individual to meet an immediate need" (Chinn & Kramer,

1999, p. 39). According to Orlando, "The nursing situation consists of (a) the person's behavior, (b) the nurse's reaction, and (c) the nursing action appropriate to the person's need" (Chinn & Kramer, 1999, p. 39). The task of the professional nurse is to obtain new knowledge or an understanding of general principles and meanings implied by the patient in the nurse-patient reaction. Orlando (1961) states the professional nurse can accomplish this by the knowledge gained from education endeavors or by past experiences with people. Orlando points out that patients become distressed when their coping mechanisms are threatened and their needs go unmet. This can occur when a patient experiences a "(1) physical limitation, (2) adverse reaction to the setting, and (3) experiences which prevent the patient from communicating his needs" (Orlando, 1961, p. 11).

The Nursing Process Theory is an excellent foundation to explore the research of how family nurse practitioners perceive bereavement care. In applying Orlando's nursing situations in this study to family nurse practitioners' perceptions of bereavement care, the nurse practitioner's reaction was the focus. The researcher hoped to establish an understanding of how the nurse practitioner perceives the bereaved patient. The patient is experiencing distress related to a loss, therefore, the

behavior of bereavement were addressed. Findings may contribute to a better understanding of the third component, therapeutic actions, that will benefit the bereaved patient. These actions might include identifying high-risk patients, referring to a counselor or to other community assistance programs, educating the patient about the grief process, and lastly, prescribing medicines if necessary. Orlando reported that it is imperative for the professional nurse to clarify perceptions, thoughts, and feelings in order to determine whether the patient is in need of help (Fisher, Marriner-Tomey, Mills, & Sauter, 1994, p. 344). Therefore, it is the family nurse practitioner's responsibility to clarify his or her perceptions, thoughts, and feelings of bereavement care to meet the unmet needs of the bereaved patient.

Assumptions

For the purpose of this study, the following assumptions were made:

1. Perceptions of bereavement care are reflections of a person's view of the care and are based on the person's past experiences and educational background.

2. Bereavement care is a phenomenon that has the potential to create positive or negative health outcomes.

3. A nurse and patient can have a dynamic interpersonal relationship that ultimately leads to alleviation of the patient's distress (Orlando, 1961).

Statement of the Problem

Studies have shown that the long-term effects of bereavement may increase health problems. Researchers have studied the effects of bereavement, but few have examined the health care provider's perceptions of bereavement. There is an increased need for bereavement care among family nurse practitioners to lessen physical and mental anguish among those who have experienced a loss. Therefore, this study's purpose was to address the family nurse practitioner's perception of bereavement care.

Research Question

One research question was generated for this study: What are family nurse practitioners' perceptions of bereavement care?

Definition of Terms

For the purpose of this study, the following terms were defined:

1. *Family nurse practitioner*

Theoretical: one who is certified in the area of family practice and who administers care by diagnosing, treating, and evaluating patient care.

Operational: a male or female who is certified in the specialty of family nurse practitioner and who diagnoses, treats and evaluates the care of individuals.

2. *Perceptions*

Theoretical: the insight or understanding of a particular subject (*American Heritage Dictionary,* 1989).

Operational: the insight or understanding of the family nurse practitioner in bereavement care as scored by the results of the questionnaire, *Family Nurse Practitioners' Perceptions of Bereavement* Care, a modified version of the questionnaire, *Family P*hysicians *and Grieving Patients*.

3. *Bereavement Care*

Theoretical: care focused on one who is experiencing physical and mental stress from a loss (Potter, 2001).

Operational: care focused on one who is experiencing physical and mental stress from a loss and is examined by *Family Nurse Practitioners' Perceptions of Bereavement Care*, the modified version of the questionnaire, *Family Physicians and Grieving Patients,* in the areas of

attitudes, beliefs, identification, prescriptive practices, and barriers to care.

Summary

Death, whether it is of a spouse, child, parent, or a significant other, affects millions of individuals each year. Loss of a loved one can be a traumatic life experience and produce negative effects on the health of the bereaved person. Family nurse practitioners can assist those bereaved individuals through the grieving process in order to minimize negative effects on the health of the bereaved. Bereavement care, when implemented by the nurse practitioner, can provide the patient with support and assistance through these difficult times. Orlando's (1961) Nursing Process Theory is a framework that can guide the nurse practitioner in managing interactions with bereaved patients. The nurse practitioner should perform a self-examination on views regarding death and dying to better understand the bereaved individual. Assessing bereavement care through the instrument, *Family Nurse Practitioners' Perceptions of Bereavement Care,* modified version of the *Family Physicians and Grieving Patients* questionnaire, can accomplish this self-examination and assist other health professionals in the management of bereaved patients.

Chapter II

Review of the Literature

Family nurse practitioners provide primary care for many bereaved patients. Bereavement care is a vital component in the practice of all health care professionals. In order to provide this necessary component of health promotion, the nurse practitioner should first examine his or her views regarding bereavement care. In the past few years, the concept of bereavement care has been recognized as an important part of health promotion in the primary care setting. Although bereavement care is usually a team approach by all health care professionals, no studies were identified that specifically examined the perspective of the nurse practitioner. The emphasis of this review of literature is to examine research studies which identify those negative effects on health among the bereaved population and to describe perceptions of bereavement care among health care professionals.

Research has suggested that bereavement can produce negative effects on the health of the bereaved. In a study

by Zisook and Shuchter (1985), 300 widows and widowers were surveyed to describe the symptoms, syndromes, and behaviors seen during the course of bereavement. The subjects ranged in age from 20 to 76 years with a mean age of 53 years. The sample consisted of mostly females (91%), and the length of bereavement ranged from one month to 19 years. Respondents reported the death of the spouse was either terminal (47%), accidental (12%), or by suicide (1%).

A total of 1,400 questionnaires were sent to widows and widowers who were members of the chapters of the widow-to-widow programs in several large cities on the West Coast. A total of 300 questionnaires were returned, thus a return rate of 21%. A control group of 30 married individuals were used. The control group was obtained from local churches and synagogues and were matched with the respondents according to age and sex.

The questionnaire was developed to cover a variety of aspects of grief: mental and physical symptoms, adjustment, anxiety, depression, past medical problems, and addictions. The questionnaire used a variety of instruments combined including the Holmes Rahe Social Adjustment Scale, Beck Depression Inventory, and a revised *Hopkins Symptom Checklist*.

The results revealed there were no statistically significant change after the death of a spouse in the widows or widowers. These changes included activities such as "church attendance, number of social activities or confidants, mental disorders, physician visits, hospitalizations, medications, alcohol, or cigarette use" (Zisook & Shuchter, 1985, p. 96). The results did, however, reveal that there was a rise in the number of persons who desired counseling (16% vs. 28%), χ^2 (1, N = 300) 9.82, p = .002, after the death of the spouse.

Zisook and Shuchter (1985) formed a table consisting of five groups. The subjects were divided out by years since the death: Group 1 (0 to 1 year), Group 2 (1 to 2 years), Group 3 (2 to 4 years), Group 4 (4+ years), and Group 5 (control). The data revealed that symptoms (e.g., tension, irritability, apathy) were greatest in the first year after the loss, but in some persons symptoms may have continued up to four years after the loss. Three findings regarding symptoms did change significantly over time: preoccupation, χ^2 (3, N = 300) = 10.9, p = .012, tearfulness, χ^2 (3, N = 300) = 13.8, p = .003, and awakening at night, χ^2 (3, N = 300) = 12.9, p = .005. Analysis of the Hopkins Symptom Checklist data revealed statistically significant differences between groups on both the depression and anxiety factor. This was

calculated using the statistical method of analysis of variance.

Nursing implications obtained from this study indicated that the nurse practitioner should provide a comprehensive approach in caring for all patients. Underlying problems, such as long-term bereavement, may play a role in illnesses of the patient. The nurse practitioner should not assume that the grieving period has been completed, even though a patient experienced a loss one or 2 years ago. It should be noted that grief is different for every individual.

Zisook and Shuchter's (1985) landmark research demonstrated that the grieving period for most widows and widowers was longer than the normal expected time to grieve. The physical and emotional symptoms were, as expected, greater during the first year of bereavement, but did continue up to 4 years. The researchers concluded that, "death appears to leave a permanent mark on surviving widows/widowers" (Zisook & Shuchter, 1985, p. 99). Although some widows and widowers are able to pick up the pieces and live a normal life, others may have great difficulty and may need help. Therefore, continued research is needed to explore the grieving process and the multiple problems that may follow.

In another study regarding negative effects of bereavement, Prigerson et al. (1997) analyzed traumatic grief as a risk factor for mental and physical morbidity. The purpose of the study was to validate and expand the authors' former work suggesting that manifestations of traumatic grief are indicators of impending adverse physical and mental health outcomes.

Prior research conducted by Prigerson et al. (1997) revealed symptoms for traumatic grief were well-defined from the bereavement-related depression or anxiety in late life. The researchers found in previous work that bereavement with traumatic grief had unstable emotions and distress. These individuals were also found to have a mental and physical decline in health.

The subjects were taken from two local hospitals. The researchers identified 1,483 potential subjects. Out of these potential subjects, 1,111 (75%) agreed to participate. The subjects were interviewed initially after the researchers obtained written informed consent. The participants were spouses of a patient presently being cared for in one of the two hospitals. The criteria for being a subject in the study were as follows: (a) must be between the ages of 40 to 80 years and (b) the spouse's significant other or the patient have a grave illness. After an initial interview, 494 participants agreed to an

in-depth, face-to-face interview. The other 617 participants agreed to a telephone interview. The goal of Prigerson et al. (1997) was to interview these participants at 6 weeks, 6 months, 13 months, and 25 months after hospitalization of the significant other.

One-hundred fifty bereaved participants were included in the final analysis at the 6-month interview. The participants consisted of 61% women and 39% men. The mean age of the participants was 62.4 years. The 150 participants were compared to the overall group, and there were no differences in age, race, sex, depression, or anxiety.

The dependent variables which were measured at the 13- and 25-month assessments were mental and physical outcomes. The interviewer completed blood pressure checks and history of physician diagnoses for major illnesses. In the mental health investigation, the interviewer obtained history of the level of grief, depression, anxiety, and suicidal ideation. Any changes in behaviors were noted, such as nutritional changes, sleep pattern changes, use of alcohol, tobacco, or drugs, and physical activity.

The independent variable measured at the 6-month assessments was primarily traumatic grief. The researchers point out that overall the 6-month assessment of traumatic grief was the best indicator of time for exhibiting

symptoms of traumatic grief. Studies have shown that the majority of bereaved individuals are usually functioning better at the 6-month period after the loss (Clayton, 1990). Therefore, these individuals assessed were primarily the bereaved subjects who would be most at risk for negative health outcomes.

The independent variable, traumatic grief, was measured using the Grief Measurement Scale. The scale was revised by the authors. The authors included only those items in the Inventory of Complicated Grief. This deleted items such as depression and anxiety-related questions. The purpose of these deletions was to focus solely on symptoms of traumatic grief. This instrument had high internal consistency (range: 0.95 at 6 months). The symptoms of traumatic grief have already proven to have face validity, but Prigerson et al.'s (1997) intent in this study was to further establish validity of traumatic grief.

The control variables were identified as depression, anxiety, age, and sex. Depression and anxiety were evaluated at all five interviews. Depression was measured using the CES-D Scale. Cronbach's alpha for the CES-D Scale at the 6-month assessment was 0.65. Anxiety was measured using the PERI anxiety scale. The Cronbach alpha for this scale at the 6-month assessment was 0.74.

Prigerson et al. (1997) used several data analysis methods to examine the data. The researchers analyzed three themes which were as follows: changes in psychiatric symptoms over time, prediction of health outcomes with survival and regression analyses, and incidence of health difficulties between the 6th- and 25th-month assessments.

Changes in psychiatric symptoms over time was analyzed using those participants who scored high on the revised Grief Measurement Scale (> 32) and the PERI anxiety scale (> 13). Using the ANOVA, the researchers computed the effect of time on changes in mean symptom levels of traumatic grief, depression, and anxiety. The subjects who were bereaved at the second month assessment (n = 96) were used in this analysis.

The second analysis completed was the prediction of health outcomes with survival and regression analyses. Prigerson et al. used subjects who had been diagnosed with cancer during bereavement (N = 4), but who had no prior history of cancer. Using the Mantel-Cox test, survival function between the subjects with high and low levels of traumatic grief was examined. Survival curves were made for this analysis. In reviewing the long-term health outcomes of traumatic grief, the researchers used the scores of the 6th-month assessment to predict the outcomes 13 and 25 months after the loss. Multiple regression was

used to evaluate continuous outcomes. These continuous outcomes included suicide ideation, smoking and alcohol use, sleep pattern disturbances, self-rated health, and the interviewer's assessment of the subject's grief. These continuous outcomes were regressed while the dependent variables (depression, anxiety, and age) were controlled. Those variables which were either one or two values were evaluated using the logistic regression procedure. Some examples of these are as follows: heart trouble, hypertension, cancer, changes in appetite, headaches, and chest pain. The subjects used in this analysis had no prior history of any of these health problems.

The last analysis used by Prigerson et al. (1997) was the Fisher's exact test. This test was used to compare the subjects who exhibited the negative variables listed above in the 6th- and 25th-month assessments with those subjects who did not exhibit these negative effects.

The results in the changes in psychiatric symptoms over time revealed that traumatic grief made a large decline (57%) at 2 months, 6% at 13 weeks, and then surprisingly increased to 7% at 25 months. Those subjects who were determined depressed by the CES-D declined from the original score consistently from 75% to 33% in the 25 months. Those subjects who were considered anxious by the PERI anxiety score remained at about 20% through the 25

months. The mean scores from the ANOVAs revealed the following for traumatic grief (F = 111.87, p < .0001), depression (F = 46.35, p < .0001), and anxiety (F = 3.32, p < .05). In conclusion, regarding the ANOVA, traumatic grief and depression mean scores declined over the 25th-month period, but the anxiety mean scores declined at a much slower pace, almost the same throughout the 25th-month period.

According to Prigerson et al. (1997), the survival analyses for incidence of cancer revealed an increased incidence for those who had high levels of traumatic grief (df = 1, p < .0001). The four individuals who were diagnosed with cancer during the 6^{th}- and 25^{th}-month assessments exhibited high levels of traumatic grief.

The prediction of mental and physical health outcomes revealed that the bereaved individual was 1.11 times more likely to develop high blood pressure at 13 months, and persons scoring 32 were 35.5 times greater to develop high blood pressure at 13 months than a subject whose score was zero. The analysis revealed greater incidences on all negative outcomes (i.e., tobacco use, heart disease, increased blood pressure, heart complications, change in appetite, suicidal ideation) ranging from 1.15 to 534 times more likely to develop a negative outcome. Overall, the results revealed that the level of traumatic grief at

6 months was a much greater indicator of negative health consequences than all other time frames used.

The incidence of health outcomes for subjects with high and low levels of traumatic grief was compared at the 6th- and 25th-month assessments. These findings revealed those subjects with high levels of traumatic grief had a greater incidence of heart trouble ($p < .05$) and cancer ($p < .001$), among other negative health outcomes compared to those who scored low on traumatic grief.

In conclusion, the results of Prigerson et al. (1997) reveal that traumatic grief symptoms may have long-term effects of bereavement. The results also disclose that the symptoms of traumatic grief may extend further than one year of bereavement, even up to 2 years into the bereavement period. The results of Prigerson et al. suggest that psychiatric sequelae, primarily traumatic grief, may have a major impact on the bereaved individuals future health.

Prigerson et al. (1997) has relevance to the current study in that the nurse practitioner should assess for these psychiatric sequelae, especially traumatic grief. This study adds to the body of evidence that the topic of bereavement must gain attention by the nurse practitioner. It is imperative that the nurse practitioner assess those individuals at risk for traumatic grief to prevent

negative health outcomes. Education regarding the grief process and active listening can be just a few of the ways the nurse practitioner can utilize bereavement care. This study by Prigerson et al. (1997) should gain the attention of all health care providers who want to promote positive health behaviors and outcomes.

In order to provide comprehensive bereavement care, it is important to review the perceptions of other health care professionals. Studies were scarce when investigating the perceptions on the topic of bereavement. A recent study by Lemkau et al. (2000) examined family practice physicians' perceptions of bereavement care. The researchers determined through a review of studies that bereavement issues can cause various health problems in patients (e.g., heart disease, hypertension, depression, anxiety, etc.). These effects are especially prominent among those who have experienced a sudden loss or loss of a child.

The purpose of the study by Lemkau et al. was to explore and describe how family practice physicians perceive their role in bereavement care, how they identify and treat bereaved patients, and what they believe about the effects of bereavement. The researchers also explored physician beliefs, attitudes, and behaviors in relation to

demographic, training, practice, and personal characteristics (Lemkau et al., 2000).

Lemkau et al. (2000) developed a questionnaire entitled, Family Physicians and Grieving Patients, which was pilot-tested. The questionnaire consisted of close-ended items in the form of Likert scales and multiple-choice answers. The variables under investigation were demographics, background, attitudinal, behavioral, and knowledge.

For this exploratory survey study, Lemkau et al. (2000) randomly selected 400 family practice physicians from a list of family physicians as the prospective sample. The researchers sent a packet which consisted of a cover letter, the developed questionnaire, a pre-stamped return envelope, an incentive (bumper sticker), and a pre-stamped postcard that the recipient was to return to confirm they had completed and mailed the survey. After one month, the authors attempted to contact nonrespondents. A second packet was mailed after 3 to 6 weeks to those whose location was correctly identified.

After two mailings, 113 questionnaires were returned, a response rate of 36%. The majority (73.5%) of the sample were men. The median age was 43 years (29 to 80 years). Ninety-two percent of the respondents were certified in family medicine and had a range of 3 to 54 years of

practice, with a median of 15. Most respondents (85.8%) stated their location was an outpatient clinic. Half of the respondents reported their location of practice was in a city of 25,000 or more people.

Lemkau et al. (2000) analyzed data with descriptive statistics and χ^2 to note similarities and differences of the sample to demographic statistics. Lemkau et al. found that family practice physicians believe bereavement care is an important part of their practice, but factors such as time (86.7%), lack of education (19.5%), reimbursement issues (22.1%), and the patient's time factor (28.3%) all play a role in involvement of bereavement care. Two questions regarding grief recovery time yielded surprising results. Physicians reported that recovery time from a sudden death of a child would take 2 years or less (58.1%), and 75.9% reported it would take 2 years or less to recover from death of a spouse. Physicians (83.2%) reported evaluating grieving patients and referral was made with complex cases. Many physicians did report taking an active role in bereavement care, such as inquiring about death in their patient's family or by providing counseling, making referrals, or prescribing medications if needed. When asked about psychosocial issues in the treatment of grieving patients, respondents reported expressing sympathy (88.5%), instructing patients to find

social support like friends or family (84.1%), many reported touching the patient (83.2%), and scheduling follow-up appointments (65.5%). Respondents (62.5%) reported prescribing antidepressants, and benzodiazepines were prescribed for sedation or anxiety by 42.9% of the respondents. All respondents agreed there needed to be more education on the topic of bereavement, this can also be determined by the underestimation of the grief recovery time that is required for a loss of a child or spouse.

The researchers concluded that bereavement care is a very important issue for health care professionals to address in their practice. Bereavement education should be geared toward treatment options appropriate in the primary care setting, the utilization of interdisciplinary teams and indications for these teams. Lemkau et al. also determined that physicians believe special losses, such as sudden deaths, death of a child or spouse, may need distinct treatment. Lemkau et al. believe that physicians may need help in certain areas in responding to grieving patients such as with crying patients, which could be improved with mentoring by mental health professionals or other experienced professionals.

The current study was based upon Lemkau et al. It is evident that more research needs to be implemented to explore and describe health care professionals'

perceptions of bereavement care to give the professional a better understanding on bereavement management.

A similar study by Saunderson and Ridsdale (1999) examined the views of general practitioners in regard to death and in assisting patients with the grieving process. Saunderson and Ridsdale document that bereavement has significant morbidity and mortality. Saunderson and Ridsdale report that studies have shown a need for bereavement care among family doctors to reduce the risk of depression, prolonged distress, and persistent or chronic grief. Therefore, this study was conducted to search the perceptions of general practitioners when a death has occurred, to explore experiences in working with grieving patients, and to explore the personal interest of general practitioners in managing themselves and bereaved patients.

The researchers used a design of semi-structured interviews followed by qualitative content analysis. This design was used to increase the depth of exploration of attitudes and beliefs regarding bereavement issues with the general practitioner. A pilot study conducted in 1996 with general practitioners gave way to the importance of bereavement care issues.

The setting for the study was a London borough of Redbridge. The sample was obtained from a list of a family

health services authority. The list contained 118 names of general practitioners. Invitations were sent out to 45 general practitioners to participate in the study. Twenty-five (56%) responded positively and were considered the sample. The total sample compared to the population of general practitioners in Redbridge consisted of more women (36%) than men (31%). Doctors who agreed to be participants in the study were then visited in their home or in the clinic and interviewed using a semi-structured questionnaire. These interviews were tape-recorded, which was later transcribed for analysis. The interviews were examined using the grounded theory approach. The aim of this approach was to describe and understand the key social psychological and structural processes that occur in real-world observations.

Saunderson and Ridsdale identified five major themes. In describing the first theme, 22 of the doctors interviewed expressed guilt or fear of making a mistake causing negative outcomes. Secondly, 20 of the doctors stated that there was a difference in general practice and hospital medicine. They described the hospital practice as dealing with serious acute conditions, whereas the general practitioner deals with minor acute problems or long-term medical conditions. Most agreed that there is a stronger relationship with the patient in general practice. Next,

22 of the doctors expressed that their experiences with bereavement issues were from personal beliefs or attitudes rather than from vocational training. Only three reported that vocational training had influenced their care in bereavement issues. Most doctors felt as if they were cheated out of this vitally important issue in medical school, because death is sometimes related to failure on the doctor's part. The fourth theme identified was the approaches in contacting bereaved patients. Seventeen out of the 25 described situations in which they had participated in the area of contacting the bereaved individuals. All agreed that this contact was an important part of the doctor-patient relationship. Lastly, some doctors reported that they themselves feel a sense of loss with the death of patients.

In conclusion, Saunderson and Ridsdale (1999) determined general practitioners felt a high degree of expectation not to make mistakes and to be diagnostically correct. These expectations sustain the feeling of guilt they experience after the death of a patient. They also reported that there was a significant difference in hospital and in general practice. The general practitioners expressed that there should be more educational materials or programs available to manage and inform the bereaved patients. General practitioners

reported that it was their own personal experiences in which they relied on to guide their care in bereavement practices due to the lack of teaching materials on this issue.

The review of the literature revealed effects of bereavement on survivors especially those who have suffered loss of a spouse and examined family physicians' perceptions of bereavement care which included beliefs and attitudes, identification, and treatment of bereavement issues. Grieving times were established as different for every individual and the length of time may even be years. For this reason and others, health care providers' involvement is essential to lessen physical, mental, and emotional needs of the bereaved individual. The review of literature led the researcher to conclude that further research describing the perceptions of family nurse practitioners regarding bereavement care is needed, to perhaps lessen the physical and mental anguish among those who have experienced a loss.

Continued research strengthens the need for bereavement care as a practice among health care professionals. Harris and Kendrick (1998) conducted a descriptive, exploratory study to examine perceptions of general practitioners in the area of patient death notification by hospitals and hospices and to describe

practice policies related to bereavement care and support. Harris and Kendrick introduced the study by stating that interventions geared toward bereavement care may have a positive impact on decreasing negative outcomes associated with bereavement care.

The researchers surveyed general practitioners practicing in fund-holding practices (43.9%), training practices (29.2%), and in practices with as many general practitioners as 1 (21.3%), 2 to 4 (52.4%), 5 to 7 (23.2%), and 8 or more (3.1%). The majority of the respondents (68%) described an urban practice setting. Some respondents reported that 39% of the patient population was greater than 65 years of age.

A total of 500 questionnaires were sent to senior partners of general practices in the South Thames Region. A total of 353 (71%) questionnaires were returned. Prior to implementation, a pilot study was conducted on 30 South Thames general practitioners to examine clarity of the questionnaire. The questionnaire was developed to cover a variety of areas related to bereavement care practices. These included discussion of death, identification of bereaved patients, support for the bereaved, and services offered to bereaved patients. The questionnaire also explored the general practitioners' experience with death

notification from hospitals and hospices and experience with death registers.

Harris and Kendrick (1998) analyzed data using simple frequencies and chi square with Yates' correction for 2 x 2 tables. Using the sign test, Stata, combined data of general practitioners' perceptions of death notification by hospital and hospices were compared.

The results of each topic covered on the questionnaire were categorized by the researchers. The topic related to information on patient deaths from hospitals and hospices revealed hospitals were thought by the general practitioner to have a much slower reporting time than hospices. General practitioners reported a problem in receiving information regarding a patient's death from hospitals (45%) compared to hospices (8.7%). The researchers inquired on practice activity related to patient deaths. It was found that 56% of the practices kept death registers. The majority of these were of an urban practice setting. Results revealed that 65% of the respondents discussed deaths of patients within the practice. These discussions were mainly among other general practitioners (70%). Out of the 353 respondents, 142 reported a practice policy for identifying newly bereaved relatives, but only if approached by the relative. Some respondents (18%) revealed variations among

partners with the bereaved individual, and 5% reported that none of the above interventions were provided. The general practitioners who did offer contact for the bereaved relative were asked to explain. The most common practice was a home visit to the bereaved relative. When asked about bereavement referrals, 37% of respondents revealed that someone in the practice offered bereavement counseling, and, of these, 74% had training in bereavement counseling. Referrals outside the clinic to support groups, church groups, and to mental health teams were made by 62% of the respondents. Remarks were made by 61 respondents which included topics such as the importance of bereavement care and personal care, time restraints in working with the bereaved, the perplexity of whether to provide routine care or selective care, and the danger of over medicalizing the grief process.

Harris and Kendrick (1998) reported that bereavement care is a team approach in the primary care setting, and although this study explored general practitioners' perceptions, other health care professionals may differ in opinions. The researchers also stated that further research should be completed looking at bereavement care from a patient's point of view.

Although this study and others reviewed the general practitioner's perception of bereavement care, it is

important for the nurse practitioner to look at other disciplines' perceptions and practices of bereavement care. Harris and Kendrick (1998) point out that bereaved individuals suffer increased rates of physical and mental ill health. These researchers also discussed the importance of bereavement in health promotion and prevention. Thus, the nurse practitioner can apply information gathered in this study to establish bereavement support programs in the clinic setting. The nurse practitioner can be an advocate for bereavement care among the other disciplines within this setting.

Summary

A review of the literature revealed several studies relating to morbidity and mortality in bereaved individuals, but few studies regarding the perceptions of health care professionals regarding bereavement care. The first two studies introduced in the review of literature are the foundation in which the nurse practitioner can use in recognizing the importance of bereavement care. Studies such as the one by Zisook and Shuchter (1985) can educate the nurse practitioner on specific areas of the grieving process. Prigerson et al. (1997) give the nurse practitioner informative statistics that lead one to believe that bereaved individuals can have negative health

outcomes. These two studies give the nurse practitioner the justification in providing bereavement care. The studies related to perceptions were primarily based on physicians' perceptions of bereavement care. There were no studies identified in the review of the literature related to nurse practitioners' perceptions on bereavement care. It is important for the nurse practitioner to review other disciplines' perceptions as well as a self-examination. Bereavement care is at times a team approach involving many disciplines and health care professionals; therefore, it is necessary for the nurse practitioner to review other perspectives on bereavement care. All researchers agreed that bereavement care should be studied more in depth to perhaps lessen negative effects on the health of the bereaved.

Chapter III

The Method

The purpose of this study was to assess the perceptions of family nurse practitioners in regard to bereavement care. Research has affirmed that bereavement care can support those who are grieving and promote a healthier grieving process. Nurse practitioners need to be mindful to the needs of the bereaved population. It is the nurse practitioner who may determine, by assessment findings, if there are deeper problems that may require further interventions. To establish an understanding of bereavement care, the need for self-evaluation is important in establishing an effective bereavement plan of care for the nurse practitioner.

Design of the Study

This study utilized research methods to describe and explore how family nurse practitioners perceive their role with bereaved patients. A descriptive design is one in which the main objective is to precisely depict the characteristics of individuals or groups and the frequency

with which particular phenomena occur (Polit & Hungler, 1999).

The descriptive design was used in this study to describe family nurse practitioners' perception of working with bereaved patients. An exploratory design is one in which many facets of a phenomena are examined (Polit & Hungler, 1999). The exploratory design was used in order to explore family nurse practitioners' identification, response, and management of bereaved patients. Furthermore, this design was used to explore family nurse practitioners' beliefs and attitudes, past clinical and personal experience with grief, and educational background. These designs were appropriate because no manipulation of variables existed and no causation among variables was implied.

Research Question

In this study, the following research question was evaluated: What are family nurse practitioners' perceptions of bereavement care?

Limitations

The limitations of this study were as follows:

1. The convenience sample may not adequately represent the entire population of family nurse practitioners' perceptions on the topic of bereavement

care preventing generalization of the findings to other populations and settings.

3. Mailed questionnaires such as those utilized in this study have low response rates.

4. The time span for data collection eliminated those nurse practitioners who did not return their survey in a timely manner.

Setting, Population, and Sample

The setting for this study was a rural state in the southeastern United States. The population was comprised of nurse practitioners certified in the specialty of family nurse practitioner. Using the fish-bowl method, a randomized sample was taken from a list of family nurse practitioners. The list was obtained from a board of nursing in a rural state in the southeastern United States. Three hundred family nurse practitioners were randomly selected. The target sample (N = 100) were those who returned the survey and met the criteria of a family nurse practitioner. The final sample consisted of 143 family nurse practitioners.

Methods of Data Collection

Instrumentation. The instrument used to collect data for this study was the questionnaire, *Family Nurse Practitioners' Perceptions of Bereavement* Care, a modified

version of Family *Physicians and Grieving Patients* questionnaire developed by Lemkau et al. (2000) (see Appendix A). Demographic questions were included in the questionnaire. Although validity and reliability were not established by Lemkau et al., the instrument had face validity as assessed by a pilot-test administered to a panel of experts not directly involved in the study. The questionnaire was modified by the author of this study to address family nurse practitioners. The consent to modify was given by Lemkau et al. (2000). As did the authors of the instrument, face validity was assessed by a panel of expert researchers for this study. Any changes or recommendations were considered.

The survey covered demographic, background, attitudinal, behavioral, and knowledge variables. The survey consisted of 34 close-ended items and should have been completed in approximately 15 to 20 minutes. The use of a 1-5 Likert rating scale was used for seven questions. These questions related to family nurse practitioners' role in identifying and assessing grieving patients, to what extent grief contributes to health problems, and how comfortable the family nurse practitioner is with a crying patient. Other questions that used the Likert Scale were related to how comfortable a patient was in discussing the grief, satisfaction of the family nurse practitioner in

working with the grieving patient, and personal losses or experiences of the family nurse practitioner. The remaining questions were a multiple-choice format with either forced choice or multiple-endorsement options. Questions of this type inquired about style in working with grieving patients, how the family nurse practitioner found out about a death and response taken, barriers and procedures in caring for the grieving patient, prescriptive practices, and the length of time expected to return to a normal state of health. Demographic data included personal and clinical experiences of the family nurse practitioner with grief issues, type of educational background, and clinic setting.

Procedures

Prior to implementation of this study, permission was obtained from the Mississippi University for Women Committee on Use of Human Subjects in Experimentation (see Appendix B). Permission was also obtained to use and modify the instrument, *Family Physicians and Grieving Patients* (see Appendices C and D).

A pilot study was implemented to determine any problems with the methodology and to establish face validity. Three local family nurse practitioners were selected to review the cover letter-consent form and to

complete the questionnaire. From this pilot test, modification was made to the question about personal experience with death. The selection of death of a spouse was added to the list of answers. A list of family nurse practitioners was then obtained from a board of nursing in the southeastern United States. Three hundred names were randomly selected using the fish-bowl method. The researcher mailed the questionnaire to each potential subject. A cover letter-consent form was attached to the questionnaires explaining the purpose and nature of the study and directions for the use of the questionnaire (see Appendix E). The cover letter explained that informed consent would be assumed with the return of the survey. Each research packet contained a cover/consent letter, instructions for completing the questionnaire, the questionnaire, and a self-addressed, stamped envelope. Subjects were asked to return the completed questionnaires within 2 weeks. Participation in the study was voluntary, and the participant remained anonymous unless he or she requested a copy of the results. If the participant requested these results, the survey and the name were separated at the time of receiving the envelope. After 2 weeks, a reminder postcard was sent to those subjects who did not return the questionnaire (see Appendix F). As the completed questionnaires were returned, the researcher

placed them in a large envelope which was placed in a locked filing cabinet until data analysis.

Data Analysis

Data were analyzed using descriptive statistics. Scoring was documented with measures of central tendencies including means, percentages, and frequencies to summarize and describe the findings. Demographic data were analyzed by obtaining the mean and percent for each question. Frequencies were obtained for the number of responses in each category.

Summary

The purpose of this study was to provide descriptive and exploratory information on the perceptions of bereavement care among family nurse practitioners. Three hundred family nurse practitioners were randomly selected. The survey was a mailed survey, *Family Nurse Practitioners' Perceptions of Bereavement Care*, modified version of the *Family Physicians and Grieving Patients* instrument. Data were compiled from the survey and analyzed using descriptive statistics. The theoretical model that guided this study was Orlando's (1961) Nursing Process Theory.

Chapter IV

The Findings

The influence of bereavement interventions by health care professionals can aid the individual to a healthier state of living. Nurse practitioners and other health care professionals are challenged when working with bereaved patients. For a better understanding of the perceptions of nurse practitioners regarding bereavement care, data were gathered. A descriptive and exploratory study was conducted to assess the perceptions of nurse practitioners regarding their role in bereavement care. In using both descriptive and exploratory designs, the researcher described family nurse practitioners' perceptions in working with bereaved patients and explored family nurse practitioners' identification, response, and management of bereaved patients. A demographic portion was included to explore family nurse practitioners' beliefs and attitudes, past clinical and personal experiences with grief, and educational background. Data were collected utilizing a mailed survey developed by Lemkau et al. (2000). Frequency distributions, medians, and percentages were used to

analyze data. A description of the sample, results of data analysis, and additional findings of interest are presented in this chapter.

Description of the Sample

The sample (N = 143) consisted of family nurse practitioners living in a rural state in the southeastern United States who completed and returned the modified questionnaire. A total of 300 questionnaires were mailed to family nurse practitioners. A list of family nurse practitioners in the state was obtained from the state's Board of Nursing. Of the 300 questionnaires mailed, 8 were returned undeliverable due to change of address and no forwarding address on file. A total of 143 (48.9%) individuals returned the questionnaires. Of the 143 questionnaires returned, all individuals reported that they were certified in the specialty of family nurse practitioner. Sixteen individuals reported that they were certified in other areas. Examples of these specialities were as follows: pediatric nurse practitioner (n = 3), adult nurse practitioner (n = 4), acute care/critical care nurse practitioner (n = 4), geriatric nurse practitioner (n = 5), psych/mental health nurse practitioner (n = 1), and Ob-Gyn/women's health nurse practitioner (n = 2). Only 5.6% of the respondents reported being faculty members in

a Master of Science in Nursing program with a family nurse practitioner specialty. All respondents except one reported receiving their graduate training in the United States.

The majority of the sample (88.7%, *n* = 125) were female; only 16 (11.3%) males responded to the survey. The median age was 43 years, with a range from 25 to 65 years. The median number of years as a nurse practitioner was 5, with a range from 1 to 26 years.

Practice sites of nurse practitioners included outpatient clinics (86.7%, *n* = 124), hospital-emergency department (7.7%, *n* = 11), nursing home (2.1%, *n* = 3), correctional facility (1.4%, *n* = 2), outpatient dialysis unit (0.7%, *n* = 1), psychiatric hospital (0.7%, *n* = 1), and public health (0.7%, *n* = 1). In describing the location of the practice setting, only 28 (20.3%) reported their practice was in, or very close to, a city of 25,000 or greater persons. Most respondents either practiced in a large town/small city of a population of 5,000 to 25,000 persons (42.8%) or in a rural area or village of less than 5,000 (40.5%).

Respondents were asked about patient care and the time involved with direct patient care. In the question, Which pattern best describes your practice?, 28.2%

(n = 142) of the respondents reported the patient always sees the same nurse practitioner. The majority of respondents (46.5%, n = 142) stated patients see the same nurse practitioner most of the time, and only 25.4% (n = 142) stated the patient sees the nurse practitioner or physician who is available.

Distribution of the sample for number of patients seen in a typical half a day is represented in Table 1.

Table 1

Number of Patients Seen by the Family Nurse Practitioners in Typical Half Day by Frequency and Percentages

No. of patients seen by FNP	*f*[a]	%
< 10	46	32.4
11 to 20	84	59.1
21 to 30	12	8.5
> 30	0	0.0

Note. Percentages were rounded to the nearest tenth.

[a]n = 142. One participant failed to answer this question.

Distribution of the sample for number of hours worked in a week providing direct patient care is represented in Table 2.

Table 2

Hours Worked by Family Nurse Practitioners in a Week Providing Direct Patient Care by Frequency and Percentages

Hours worked	*f*[a]	%
0 to 20	18	12.6
21 to 40	84	58.7
41 to 60	36	25.2
> 60	5	3.5

Note. Percentages were rounded to the nearest tenth.

[a]*N* = 143.

Results of Data Analysis

The study addressed the following question: What are family nurse practitioners' perceptions of bereavement care? Excluding demographic questions, the survey consisted of 22 questions related to bereavement care. The use of a 1 to 5 Likert rating scale was used for 7 of the 22 questions. These questions related to family nurse practitioners' role in identifying and assessing the grieving patient, to what extent grief contributes to health problems, and how comfortable the family nurse practitioner is with a crying patient. Other questions that used the Likert scale were related to how comfortable a patient was in discussing the grief, satisfaction of the

family nurse practitioner in working with the grieving patient, and personal losses or experiences of the family nurse practitioner. All questions were grouped according to the following categories and presented in tables: beliefs and attitudes, personal experiences with grief, identification of bereaved patients, psychosocial issues in the treatment of grieving patients, prescribing behavior, and lastly barriers and learning experiences in treatment of grieving patients.

Six questions related to family nurse practitioners' beliefs and attitudes regarding bereavement care. The respondent was to scale each question on a 1 to 5 Likert scale.

Out of 143 respondents, 44.8% agreed that grief contributed to health problems. These respondents indicated this by marking a 5 on the Likert scale. It is important to note that no respondents felt that grief had any effect on the health of bereaved persons.

Respondents also rated the importance of the family nurse practitioner in identifying and managing grieving patients. The majority (56.6%) felt that it was very important, while 33.6% rated this question a 4 on the 1 to 5 Likert scale.

Family nurse practitioners were asked about patients' interest in discussing their grief with them. Only 17.6%

reported that the patient was very interested (5 on 1 to 5 Likert scale) in discussing their grief with the family nurse practitioner. The majority of the respondents (43%) scaled patients' interest in discussing their grief with the family nurse practitioner as a 4 on a 1 to 5 Likert scale. A similar question was asked regarding the helpfulness of the bereaved patient in discussing their grief with the family nurse practitioner. Again, the major portion of respondents rated this as a 4 (43.3%) on a 1 to 5 Likert scale.

It was interesting to note that 41.9% of respondents felt that working with bereaved patients was only moderately satisfying (3 on 1 to 5 Likert scale). Few respondents (2.8%) stated that bereavement work was not at all satisfying, and 13.3% reported it was very satisfying.

The survey also addressed the family nurse practitioner's level of comfort in working with a crying patient. Most respondents scaled this question with 4 and 5. The individual percentages for these to ratings were equal (32.9%), producing a total of 65.8% reporting they felt comfortable to very comfortable in working with a crying patient. Table 3 summarizes the findings from six of the seven Likert scale questions which relate to family nurse practitioners' beliefs and attitudes regarding bereavement care.

Table 3

Family Nurse Practitioners' Beliefs and Attitudes Regarding Bereavement Care by Frequency and Percentages

Question	n	Response[a]	*f*	%
Based on your experience, to what extent does grief contribute to health problems?	143	1	0	0.0
		2	0	0.0
		3	19	13.3
		4	60	41.9
		5	64	44.8
How important is the family nurse practitioner's role in identifying and managing grieving patients?	143	1	0	0.0
		2	4	2.8
		3	10	7.0
		4	48	33.6
		5	81	56.6
Generally how interested are bereaved patients in discussing their grief with you?	142	1	0	0.0
		2	8	5.6
		3	48	33.8
		4	61	43.0
		5	25	17.6
Generally how helpful is it for bereaved patients to discuss their grief with you?	141	1	0	0.0
		2	3	2.1
		3	47	33.3
		4	61	43.3
		5	30	21.3
How satisfying is it for you to work with grieving patients?	143	1	4	2.8
		2	25	17.5
		3	60	41.9
		4	35	24.4
		5	19	13.3
How comfortable are you interacting with a patient who is crying?	143	1	3	2.1
		2	2	1.4
		3	44	30.7
		4	47	32.9
		5	47	32.9

Note. Percentages were rounded to the nearest tenth.

[a]Based on a Likert scale, with 1 indicating *least positive* and 5 *most positive*.

Personal experiences with grief can determine how one responds to a grieving individual. The survey assessed the family nurse practitioners' personal experiences with grief in two questions.

All respondents reported having some experience personally with the loss of a loved one. Most respondents (76.9%) reported having lost an important loved one, and 46.2% stated that they had lost a close friend. Parental loss was the third most reported death with 37.5% reporting loss of their father, and 26.6% reported having lost their mother. Table 4 summarizes the findings regarding family nurse practitioners' personal experiences with grief.

Table 4

Family Nurse Practitioners' Personal Experience With Grief by Frequency and Percentages

Question	*f*[a]	%
Which of the following have you personally experienced?		
Death of		
Mother		26.6
Father		37.8
Sibling		18.2
Child		4.9
Spouse		1.4
Close friend		46.2
Other important loved one		76.9

(*table continues*)

Table 4 (*continued*)

Question	*f*[a]	%
Have you ever experienced the sudden traumatic death of someone you loved?		
Yes	68	47.6
No	75	52.4

Note. Respondents were allowed to mark more than one response. Percentages were rounded to the nearest tenth.

[a]*N* = 143.

The remaining Likert scale question not discussed in Table 1 asked the respondent to rate on a 1 to 5 scale how helpful it was to talk with others about significant losses experienced. Two respondents did not answer this question (n = 141). Frequency of the family nurse practitioners' opinions regarding the helpfulness of discussing their own grief with others were as follows: Not at all helpful (4.3%, n = 6), 2 on a 1 to 5 scale (11.3%, n = 16), moderately helpful (24.1%, n = 34), 4 on a 1 to 5 scale (29.1%, n = 41), and 31.2% (n = 44) stated discussing their grief with others was very helpful (see Table 5).

Table 5

Frequency of Family Nurse Practitioners' Opinions Regarding the Helpfulness of Discussing Their Own Grief by Frequency and Percentages

Response to question	*f*[a]	%
1 (Not at all helpful)	6	4.3
2	16	11.3
3 (Moderately)	34	24.1
4	41	29.1
5 (Very helpful)	44	31.2

Note. Percentages were rounded to the nearest tenth.

[a]*n* = 141.

Family nurse practitioner respondents were asked to rate their professional training on the identification and management of grief. The respondents were allowed to mark poor, fair, good, excellent, or that they never had any formal training on the identification and management of grief. The results were as follows (N = 143): poor (11.9%), fair (39.2%), good (38.5%), and excellent (9.0%); 1.4% stated they had never had formal training on the subject of grief.

The survey sought to inquire about family nurse practitioners' style in regard to grieving patients. Some

family nurse practitioners (50.3%) reported they follow most grieving patients themselves and referred only complicated cases. Others (35.0%) stated they generally referred grieving patients to mental health professionals and clergy. A small portion (12.6%) stated they were minimally involved in identifying or following grieving patients, and only 2.1% stated they followed all grieving patients (N = 143).

The survey explored the family nurse practitioners' identification of bereaved patients. Several situations regarding inquiring about a death within a patient's family or social network were given in one question. The respondent was asked to mark one or more situations that described when this inquiry might occur. Three situations received the highest marks and are as follows: when physical symptoms do not add up (78.3%), when known from other source that the patient has experienced a loss (79.0%), and when the patient is depressed (86.7%).

Next in identification of the bereaved patient, the respondent was given specific conditions in which he or she might consider when deciding how to respond to a bereaved patient. The respondent was allowed to mark more than one condition. Four conditions received the highest responses and are as follows: whether the death was suicide (61.5%), whether the death was sudden (70.6%), the

nature of the patient's support system (85.3%), and the nature of the patient's relationship with the deceased (86.0%) (see Table 6).

Table 6

Identification of Bereaved Patients by Frequency and Percentages

Question	%
In which of the following situations would you usually inquire about deaths within a patient's family or social network?[a]	
When I know from other source that the patient has experienced a loss	79.0
When patient is depressed	86.7
When physical symptoms do not add up	78.3
Appointment for checkup or annual physical for established patient	25.2
Initial office visit	41.3
Follow-up appointment	23.1

(table continues)

Table 6 (*continued*)

Question	%
Which of the following do you usually consider in deciding how to respond to a bereaved patient?[b]	
The nature of the patient's relationship with the deceased	86.0
The nature of the patient's support system	85.3
Whether the death was sudden	70.6
Whether the death was a suicide	61.5
Whether I knew the patient well	32.2
Whether the deceased was my patient	21.0
Whether the patient is a man or a woman	14.0
Other	14.7

Note. Respondents were allowed to mark more than one response. Percentages were rounded to the nearest tenth.

[a]*N* = 143. [b]*N* = 143.

In addition to identification of bereaved patients, the survey explored the family nurse practitioners' perception of grief recovery time. The respondents were given two situations in which they were to give their opinion of how long it might take to recover from the situation. The first situation related to a sudden and traumatic death of a child who was still living at home.

The highest frequency was 2 to 10 years (32.8%, *n* = 47) for a parent to return to their previous state of social and psychological functioning after the above situation.

The next situation related to grief recovery time after the death of a spouse who had been seriously ill. The response that gained the highest frequency was 1 year but less than 2 years (37.8%, *n* = 54) for the spouse to recover from the death (see Table 7).

Table 7

Family Nurse Practitioners' Perceptions of Grief Periods by Frequency and Percentages

Response	*f*[a]	%
How long would you expect a parent to return to their previous state of social and psychological functioning after the sudden and traumatic death of a child who was still at home?		
< 6 months	1	0.7
6 months but < 1 year	26	18.2
1 year but < 2 years	42	29.4
2 to 10 years	47	32.8
> 10 years	3	2.1
Never	24	16.8

(*table continues*)

Table 7 (*continued*)

Response	*f*[a]	%
How long would you expect it to take an older person to return to their previous state of social and psychological functioning after the death of a spouse who has been seriously ill?		
< 6 months	3	2.1
6 months but < 1 year	29	20.2
1 year but < 2 years	54	37.8
2 to 10 years	46	32.2
> 10 years	1	0.7
Never	10	7.0

Note. Percentages were rounded to the nearest tenth.

[a]*N* = 143.

Psychosocial issues were addressed in the survey. These issues were examined to provide information regarding how the family nurse practitioner provided psychosocial interventions to the bereaved patient.

The first psychosocial issue addressed was related to the action the family nurse practitioner would take with the grieving patient. Respondents were allowed to mark more than one action. Several actions rendered high frequencies. The most selected action (88.8%) was the action of encouraging the patient to express their feelings to the family nurse practitioner.

Spiritual and religious concerns of grieving patients were the second psychosocial issues addressed. The respondents were given specific actions in which they might approach religious/spiritual concerns of the grieving patient. Two actions received the majority of responses and are summarized as follows: Ask about patient's spiritual beliefs (51.0%) and if patient raises them, I discuss spiritual concerns (67.8%). Table 8 lists the questions and responses and summarizes the findings.

Table 8

Psychosocial Issues in the Treatment of Grieving Patients by Percentages

Action	%
What do you usually do with grieving patients?[a]	
Express my condolences	85.3
Touch the patient	83.9
Ask about circumstances of the loss	76.9
Encourage patient to express his or her feelings with me	88.8
Share something of my own experiences of loss	35.7
Offer anticipatory guidance about the grieving process	53.1

(*table continues*)

Table 8 (*continued*)

Action	%
Encourage the patient to talk with family/friends about their loss	83.2
Arrange for more frequent appointments	32.2
Other	21.0
How do you usually approach the religious and spiritual concerns of grieving patients?[b]	
Ask about patient's spiritual beliefs	51.0
If patient raises them, I discuss spiritual concerns	67.8
I offer to pray with the patient	29.4
I refer the patient to the appropriate clergy	31.5
I choose not to approach the private spiritual beliefs of my patients	2.8

Note. Respondents were allowed to mark more than one response. Percentages were rounded to the nearest tenth.

[a]$N = 143$. [b]$N = 143$.

The family nurse practitioners' prescribing behaviors were addressed in two questions. The first question asked the respondent, "Under what conditions do you usually prescribe psychotropic medications to the grieving patient?" Six conditions were presented and the family nurse practitioners were allowed to mark more than one

condition. The majority of the respondents (65%) revealed that they do prescribe psychotropic medications if the patient is clinically depressed. Only 22.4% of the sample denied prescribing medications to the grieving patient. Those respondents (n = 111) who stated they did prescribe medications for the bereaved patient were asked to go to the next question. This question asked the type of medication usually prescribed to the grieving patient. Most (91.9%) reported prescribing antidepressants at dosages appropriate for depression. Questions and responses are listed in Table 9.

Table 9

Family Nurse Practitioners' Prescribing Behavior by Percentages

Condition	%
Under what conditions do you usually prescribe psychotropic medications to grieving patients?[a]	
For a short time period to newly bereaved patients	42.7
If patient's behavior upsets other family members	4.2
For sleep difficulties	57.3
If patient is clinically depressed	65.0

(table continues)

Table 9 (*Continued*)

Condition	%
I do not prescribe psychotropic drugs to bereaved patients.	22.4
Note. The above respondents skipped the next question.	
What do you usually prescribe for grieving patients?[b]	
Antidepressants at dosages appropriate for depression	91.9
Low dose antidepressants for sedation only	27.9
Antihistamines for sedative purposes	51.4
Other	7.2

Note. Respondents were allowed to mark more than one response. Percentages were rounded to the nearest tenth.

[a]N = 143. [b]n = 111.

It was important to determine the barriers and learning experiences of the family nurse practitioners' regarding working with grieving patients. Two questions inquired about these topics.

Time constraints of the family nurse practitioner (77.6%) proved to be the major barrier in the treatment of grieving patients. Also, 44.8% reported that a lack of expertise in the area of bereavement was a barrier.

In learning about grief and bereavement, 85.3% of the respondents stated the source of information on grief and bereavement was their experiences with their patients. Others (73.4%) reported experiences within their family/social network had added to their knowledge about grief and bereavement. Table 10 lists the questions and responses and summarizes the results.

Table 10

Barriers and Learning Experiences in Treatment of Grieving Patients by Frequency and Percentage

Barrier	%
Which of the following are significant barriers to the treatment of grieving patients?[a]	
Patient time constraints	42.0
My time constraints	77.6
Lack of adequate reimbursement	12.6
My lack of expertise in this area	44.8
Other	14.0
How have you learned about grief and bereavement?[b]	
Course in college	49.7
Graduate program	51.7

(*table continues*)

Table 10 (*continued*)

Barrier	%
CEU	35.7
Personal reading	63.6
Contact with mental health professionals	39.9
Experience with patients	85.3
Experience within my family/social network	73.4

Note. Respondents were allowed to mark more than one response. Percentages were rounded to the nearest tenth.

[a]*N* = 143. [b]*N* = 143.

In addition to learning experiences, respondents were asked if they would be interested in a continuing education unit on the topic of bereavement. Most respondents (79%) stated they would be interested in a continuing education unit, and 21% of the respondents stated they would not be interested.

Summary

The purpose of the study was to describe and explore family nurse practitioners' perceptions of bereavement care. All certified family nurse practitioners who returned the survey were chosen as the sample. A total of

143 surveys were obtained. The survey consisted of a demographic portion which was used in describing the population surveyed. The *Family Nurse Practitioners' Perceptions of Bereavement Care*, a modified version of the survey, *Family Physicians and Grieving Patients*, developed by Lemkau et al. (2000), was the instrument used to obtain data. Data were analyzed using descriptive statistics. Scoring was documented with means, percentages, and frequencies to summarize and describe the findings. Data reported will be discussed in the next chapter.

Chapter V

The Outcomes

For years researchers have documented that grief may contribute to negative effects on health in the bereaved individual. Primary care providers are recognizing this as a potential health need. Nurse practitioners are in a unique position to assist patients in optimizing health and well-being by demonstrating a supportive, holistic approach and providing bereavement care. The purpose of this study was to describe and explore family nurse practitioners' perceptions regarding bereavement care. Certified family nurse practitioners who were listed with a board of nursing in the southeastern United States were selected as the target population. The sample consisted of all certified family nurse practitioners who returned the mailed survey. The *Family Nurse Practitioners' Perceptions of Bereavement Care*, a modified version of the questionnaire developed by Lemkau et al. (2000) entitled *Family Physicians and Grieving Patients*, was used in this study to address family nurse practitioners' perceptions of bereavement care. Demographic data were included in the

survey. Data were analyzed using descriptive statistics. In this chapter, the outcomes of the study are presented. In addition, conclusions are drawn, implications for nursing examined, and recommendations which evolved from the study are identified.

Summary and Discussion the Findings

A total of 143 family nurse practitioners from a rural state in the southeastern United States were surveyed using the *Family Nurse Practitioners' Perceptions of Bereavement Care* questionnaire. The research question was as follows: What are the perceptions of family nurse practitioners regarding bereavement care? The results were considered to be representative of the perceptions of family nurse practitioners regarding bereavement care in the rural state because of the high response rate. Data were obtained through a mailed survey of certified family nurse practitioners who were listed with a board of nursing in a rural state in the southeastern United States.

An analysis of the survey of *Family Nurse Practitioners' Perceptions of Bereavement Care* revealed strong beliefs related to family nurse practitioners' role in bereavement care. The survey consisted of mostly females (88.7%) working in an outpatient clinic setting

(86.7%). The majority of practice settings were located in a large town/small city with a population of 5,000 to 25,000 persons (42.8%) and 40.5% in a rural village of less than 5,000 persons. Most family nurse practitioners reported a typical patient load in a half day to be 11 to 20 patients (59.1%).

In response to the importance of family nurse practitioners' role in identifying and treating bereaved patients, the majority (97.2%) felt it was important to very important. Based on past experiences, all respondents believed that grief contributed to health problems. These results are similar to the results obtained in the study by Lemkau et al. (2000). In comparing results on identification and treating bereaved patients, physicians also reported identification of bereaved patients of utmost importance. Physicians also believed grief did contribute to health problems, and the responsibility of identifying and treating grieving patients was the role of the health care provider (Lemkau et al., 2000).

In assessing family nurse practitioners' level of satisfaction in working with grieving patients, this survey revealed most family nurse practitioners rated the work satisfying to very satisfying (79.7%). Overall, family nurse practitioners (96.5%) were comfortable interacting with a patient who was crying. In comparison

to the study of family physicians' perceptions of bereavement care, Lemkau et al. found that physicians may need help in responding to crying patients, which could be improved with mentoring by experienced professionals. Family nurse practitioners could assist other health professionals, such as physicians, in increasing their comfort level in working with crying patients.

Out of all family nurse practitioners surveyed, all reported having some experience with death. The majority reported they had experienced the death of a close friend or another important loved one. Approximately half of the respondents reported having experienced a traumatic death of a loved one. Numerous studies have been conducted on the effects of traumatic grief on the bereaved individual. The survey also touched on traumatic grief in another question. The family nurse practitioner was presented several conditions in which he or she might decide how to respond to a bereaved patient. A large majority of respondents stated they would definitely inquire or respond to a bereaved patient if the death experienced was a suicide (61.5%) or a sudden death (70.6%). These results along with others can conclude that traumatic grief can have long-term effects on the health of the individual. It can also be concluded that the nurse practitioner is concerned with those bereaved patients who have

experienced traumatic grief. It is very important for the nurse practitioner to consider his or her own experience with traumatic grief, as well as assessing the type of loss the bereaved individual has experienced. Individuals who have experienced traumatic grief may need a multi-disciplinary approach.

It was interesting to note the family nurse practitioners' response to grief recovery times. The majority of family nurse practitioners felt that a parent would return to a previous state of social and psychological functioning after death of a child still at home within 2 to 10 years (32.8%) or one year but less than 2 years (29.4%). Only 16.8% viewed a parent would never return to their previous state after the death of a child. In another situation regarding grief recovery, family nurse practitioners were questioned about the loss of a spouse who had been seriously ill. Many (37.8%) viewed grief recovery time after this type of loss to be one year but less than 2 years, and 32.2% reported a recovery time of 2 to 10 years. Study findings from Zisook and Shuchter's (1985) landmark study suggested that grieving periods for widows and widowers were longer than the normal expected time to grieve. As demonstrated in the study's findings, the nurse practitioner should not assume that the grieving period has been completed, even though a

patient experienced a loss one, two, or even more years. It should be recognized by all health care providers that grief is different for every individual.

The majority of family nurse practitioners viewed their experience and training in the areas of grief and bereavement to be either fair or good. Most experiences in grief work were from either personal experiences or with patient care. Family nurse practitioners did express an interest in some type of continuing education on the topic of bereavement care. Lemkau et al. (2000) in their study on family physicians' perceptions of bereavement care found that health care professionals need more training geared toward bereavement management. This study concluded with these same findings. Bereavement education should be geared toward proper assessment techniques and treatment options appropriate in the clinic setting, as well as other areas in health care. In another study by Saunderson and Ridsdale (1999), similar findings were also discovered. The authors of this study found that general practitioners relied on their own experiences of death and bereavement to guide their care in bereavement practices due to the lack of teaching materials on this issue.

Numerous family nurse practitioners stated they followed grieving patients themselves, and only referred complicated cases. In relation to bereavement referrals, a

study conducted by Harris and Kendrick (1998) found that 37% of general practitioners offered bereavement counseling either personally or had someone in the practice who was experienced in bereavement counseling. Most referrals in the study by Harris and Kendrick were outside the clinic to support groups, church groups, and mental health teams. The respondents (35%) of this study reported referring grieving patients to mental health professionals and or to clergy. The author of this research study agrees with Harris and Kendrick in that bereavement care should be a team approach. Bereavement care could also be improved with more research from the patient's perspective of what is really expected from the health care provider.

In inquiring about a loss within a patient's family or social network, the respondents reported the following situations as most important: When the patient was depressed, when physical symptoms did not add up, or if it was known that the patient had experienced a loss. In deciding how to respond to the grieving patient, the family nurse practitioners reported they considered the patient's support system, the relationship the patient had with the deceased, and or if the death was a suicide. Sheldon (1998) in a clinical review reported predisposing factors that could indicate poor outcomes for the bereaved

patient. These factors included sudden death, stigmatized deaths (HIV, suicides), lack of social support, or caring for the deceased greater than 6 months. The findings of this study compare to the clinical review by Sheldon (1998). The family nurse practitioner should always inquire about the death within a patient's family or social network to prevent these poor outcomes in the bereaved patient.

In expressing condolences to the grieving patient, various answers were selected. The majority of family nurse practitioners expressed condolences by touching the patient, encouraging the patient to express his or her feelings to them or to family and friends regarding the loss. The most important part of bereavement care is social support. The involvement of the health care professional can provide a positive support system focusing on the strengths of the bereaved individual (Charlton & Dolman, 1995).

In regard to addressing psychosocial issues, most family nurse practitioners reported they discuss spiritual concerns of the grieving patient if the patient raises the issue or at times they would ask the grieving patient about spiritual beliefs. Spirituality or religion can assist the grieving patient in coping with the loss more effectively. If comfortable with his or her spirituality,

the family nurse practitioner can and should discuss spiritual concerns of the bereaved patient. The family nurse practitioner always has the option of making a referral to a clergy member.

In the management of grieving patients, family nurse practitioners (n = 111) reported prescribing psychotropic medications for depression, sleep difficulties, or only for short periods to the newly bereaved patient. Most (91.9%) prescribed antidepressants at dosages appropriate for depression. This percentage for prescribing antidepressants was higher than the findings by Lemkau et al. (2000). Family physicians in this study reported prescribing antidepressants (62.5%) for depression and benzodiazepines (42.9%) for sedation or anxiety. The total number of respondents who prescribed psychotropic medications in the current study and the study by Lemkau et al. (2000) were strikingly the same (n = 111 vs. n = 112).

Barriers of bereavement care were identified by family nurse practitioners. The major barriers identified were time constraints and lack of expertise in the area of bereavement. These barriers have been a recurrent theme throughout the reviews of literature in this study.

Conclusion

Bereavement care is an important element for the nurse practitioner to consider when providing holistic care to clients. Based on the results of this study, several conclusions can be drawn. Findings suggest that family nurse practitioners recognize the importance of providing bereavement care. A general consensus among nurse practitioners surveyed revealed that the nurse practitioners' role in identifying and managing grieving patients was very important. All respondents rated that grief was either moderately or very contributory to health problems in the grieving patient. Some differences existed among family nurse practitioners in relation to knowledge about bereavement and recovery times of grieving patients. Many nurse practitioners were interested in a continuing education unit on the topic of bereavement care. More research studies need to focus on the outcomes of family nurse practitioners in implementing interventions with bereaved patients.

Implications to Nursing

The results of this study had many implications for nursing. Implications were suggested for theory, practice, education, and research.

Orlando's theory was found to be valuable in this study. Orlando's Nursing Process Theory may be used as an integral part of nursing research and practice in delivering care to the bereaved population. A clarification of perceptions, beliefs, and attitudes by the nurse practitioner regarding bereavement care can provide a more holistic approach in caring for the bereaved patient. Orlando (1961) stated the professional nurse can accomplish an effective nurse-patient reaction by gaining new knowledge through education and or by experiences with people. In order to expand knowledge and provide a more holistic approach, bereavement issues should be addressed. This can be done best by an understanding of nurse practitioners' perceptions of bereavement care.

Additional implications involved nursing practice. If nurse practitioners consider the importance of bereavement care, interventions can be implemented to assist these patients. These interventions can perhaps decrease future negative effects on health of the bereaved patient. This idea was strengthened by Lemkau et al. (2000) who examined family physicians' perceptions on bereavement care. If nurse practitioners were more knowledgeable regarding the needs of bereaved patients, the plan of care for the bereaved patient might be more effective.

Bereavement care is a topic that seems to be ignored or pushed aside in most health professionals' educational curricula. Beginning nursing and medical students, as well as advanced nursing professionals, should be educated regarding the effects of bereavement on patients and interventions in supporting these patients. Novices and experts should evaluate their own perspectives on death and grief in order to provide a balanced approach to the bereaved patient. An understanding of bereavement care from a provider's stance is essential in building knowledge for further education.

A final implication of this study was directed toward further research regarding perceptions of nurse practitioners on bereavement care. Although there is an extensive amount of research on grief issues, studies directed to enhance knowledge of bereavement care for nurse practitioners were lacking. Research on nurse practitioners' perceptions of bereavement care is necessary to provide further knowledge to enhance the plan of care for the bereaved patient.

Recommendations

The following recommendations were made for future research as a result of the study:

1. Replication of this study with a larger sample of family nurse practitioners throughout the United States.

2. Conduction of a study to compare perceptions of family nurse practitioners and family physicians regarding bereavement care.

3. Dissemination of study statistics to participants who requested results by indicating return addresses on surveys.

4. Conduction of a longitudinal study to determine if family nurse practitioners' perceptions change with experience.

5. Conduction of a study to explore the grieving patients' perceptions of what is expected from their health care provider after a loss.

6. Dissemination of the study's findings through publication or formal presentations.

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APPENDIX A

FAMILY NURSE PRACTITIONERS' PERCEPTIONS OF BEREAVEMENT CARE

Family Nurse Practitioners' Perceptions of Bereavement Care

This survey was developed by Lemkau et al. which surveyed family physicians. It is entitled Family Physicians and Grieving Patients and has been modified for this study with the permission of the author.

1. How important is the family nurse practitioner's role in identifying and managing grieving patients? (Circle one)

1	2	3	4	5
Not at all important		**Moderately**		**Very important**

2. Based on your experience, to what extent does grief contribute to health problems? (Circle one)

1	2	3	4	5
Not at all contributory		**Moderately**		**Very contributory**

3. Which description best fits your style in regard to grieving patients? (Check one)

   ❑ a. I am minimally involved in identifying or following grieving patients.
   ❑ b. I generally refer grieving patients to mental health professionals and or clergy.
   ❑ c. I follow most grieving patients myself and refer only complicated cases.
   ❑ d. I follow all grieving patients myself.

4. In which of the following situations would you usually inquire about deaths within a patient's family or social network? (Check any/all that apply)
   ❑ a. Initial office visit
   ❑ b. Follow-up appointment
   ❑ c. Appointment for checkup or annual physical for established patient
   ❑ d. When patient is depressed
   ❑ e. When physical findings for symptoms don't add up
   ❑ f. When I know from other sources that the patient has experienced a loss

5. Which of the following do you usually consider in deciding how to respond to a bereaved patient? (Check any/all that apply)
   - ❑ a. The nature of the patient's relationship with the deceased
   - ❑ b. Whether or not the death was sudden
   - ❑ c. Whether or not the death was a suicide
   - ❑ d. The nature of the patient's support system
   - ❑ e. Whether I know the patient well
   - ❑ f. Whether the deceased was my patient
   - ❑ g. Whether the patient is a man or a woman
   - ❑ h. Other (please specify):_____

6. Which of the following are significant barriers to the management of grieving patients in your practice? (Check any/all that apply)
   - ❑ a. Patient time constraints
   - ❑ b. My time constraints
   - ❑ c. Lack of adequate reimbursement
   - ❑ d. My lack of expertise in this area
   - ❑ e. Other (please specify):_____

7. What do you usually do with grieving patients? (Check any/all that apply)
   - ❑ a. Express my condolences
   - ❑ b. Touch the patient
   - ❑ c. Ask about the circumstances of the loss
   - ❑ d. Encourage the patient to express their feelings with me
   - ❑ e. Share something of my own experiences of loss
   - ❑ f. Offer anticipatory guidance about the grieving process
   - ❑ g. Encourage the patient to talk with family/friends about their loss
   - ❑ h. Arrange for more frequent appointments
   - ❑ i. Other (please specify):_____

8. How do you usually approach the religious and spiritual concerns of grieving patients? (Check any/all that apply)
   - ❑ a. I ask about the patient's spiritual beliefs.
   - ❑ b. If the patient raises them, I discuss spiritual concerns.
   - ❑ c. I offer to pray with the patient.
   - ❑ d. I refer the patient to the appropriate clergy.
   - ❑ e. I choose not to approach the private spiritual beliefs of my patients.

9. Generally how interested are bereaved patients in discussing their grief with you? (Circle number)

1	2	3	4	5
Not at all interested		**Moderately**		**Very interested**

10. Generally, how helpful is it for bereaved patients to discuss their grief with you? (Circle number)

1	2	3	4	5
Not at all helpful		**Moderately**		**Very helpful**

11. Under what conditions do you usually prescribe psychotropic medications to grieving patients? (Check any/all that apply)
    - ❑ a. For a short period of time to newly bereaved patients
    - ❑ b. If patient's behavior upsets other family members
    - ❑ c. For sleep difficulties
    - ❑ d. If patient is clinically depressed
    - ❑ e. I do not prescribe psychotropic drugs to bereaved patients (skip to #13)

12. What do you usually prescribe for grieving patients? (Check any/all that apply)
    - ❑ a. Antidepressants at dosages appropriate for depression
    - ❑ b. Low dose antidepressants for sedation only
    - ❑ c. Antihistamines for sedative purposes
    - ❑ d. Other. Please specify:_____

13. How long would you expect it to take a parent to return to their previous state of social and psychological functioning after the sudden and traumatic death of a child who was still at home?
    - ❑ a. Less than 6 months
    - ❑ b. At least 6 months, but less than a year
    - ❑ c. At least 1 year, but less than 2 years
    - ❑ d. 2 to 10 years
    - ❑ e. More than 10 years
    - ❑ f. Never

14. How long would you expect it to take an older person to return to their previous state of social and psychological functioning after the death of a spouse who has been seriously ill?
    - ❑ a. Less than 6 months
    - ❑ b. At least 6 months, but less than a year
    - ❑ c. At least 1 year, but less than 2 years
    - ❑ d. 2 to 10 years
    - ❑ e. More than 10 years
    - ❑ f. Never

15. How satisfying is it for you to work with grieving patients? (Circle number)

1	2	3	4	5
Not at all satisfying		**Moderately**		**Very satisfying**

16. How comfortable are you interacting with a patient who is crying?

1	2	3	4	5
Not at all comfortable		**Moderately**		**Very comfortable**

17. How would you rate your professional training about the identification and management of grief? (Check one)
    - ❑ a. Poor
    - ❑ b. Fair
    - ❑ c. Good
    - ❑ d. Excellent
    - ❑ e. I've had no formal training.

18. How have you learned about grief and bereavement? (Check any/all that apply)
    - ❑ a. Course in college
    - ❑ b. Graduate program
    - ❑ c. CEU
    - ❑ d. Personal reading
    - ❑ e. Contact with mental health professionals
    - ❑ f. Experiences with patients
    - ❑ g. Experiences within my family/social network

19. Would you be interested in pursuing a CEU on this topic?
    - ❑ a. No
    - ❑ b. Yes

20. Which of the following have you personally experienced? (Check any/all that apply)
    - ❑ a. Death of my mother
    - ❑ b. Death of my father
    - ❑ c. Death of a sibling
    - ❑ d. Death of a child
    - ❑ e. Death of a close friend
    - ❑ f. Death of a spouse
    - ❑ g. Death of other important loved one

21. Have you ever experienced the sudden and traumatic death of someone you loved?
    - ❑ a. No
    - ❑ b. Yes

22. In general, how helpful is it for you to talk with others about significant losses you have experienced? (Circle number)

1	2	3	4	5
Not at all helpful		**Moderately**		**Very helpful**

23. Which pattern best describes your practice?
    - ❑ a. Patients always see the same nurse practitioner.
    - ❑ b. Patients see the same nurse practitioner most of the time.
    - ❑ c. Patients see whichever nurse practitioner or physician is available.

24. How many hours a week do you typically devote to direct patient care?
    - ❑ a. 0 to 20 hours per week
    - ❑ e. 21 to 40 hours per week
    - ❑ f. 41 to 60 hours per week
    - ❑ g. More than 60 hours per week

25. How many patients do you see in a typical half day of patient care?
    - ❑ a. Less than 10
    - ❑ b. 11 to 20
    - ❑ c. 21 to 30
    - ❑ d. More than 30

26. What is your gender?
    - ❑ a. Male
    - ❑ b. Female

27. What year were you born? 19___

28. Are you certified as a family nurse practitioner?
    - ❑ a. Yes
    - ❑ b. No

29. Are you certified in another specialty besides FNP?
    - ❑ a. Yes
    - ❑ b. No

    If so, please specify:_____

30. In what year did you receive your certification for family nurse practitioner? 19____

31. Did you graduate from a graduate school in the U.S.?
    - ❑ a. Yes
    - ❑ b. No

32. What is your main practice setting?
    - ❑ a. Outpatient office/clinic
    - ❑ b. Other. Please specify:_____

33. Where is your main practice?
    - ❑ a. Rural area or village (less than 5,000 people)
    - ❑ b. Large town/small city (5,000 to 25,000)
    - ❑ c. Suburban/urban (in or very close to a city of 25,000 or more)

34. Are you a faculty member in a Master of Science in Nursing program with a family nurse practitioner specialty?
    - ❑ a. Yes
    - ❑ b. No

Thank you for your participation!

Please mail your survey in the enclosed self-addressed, stamped envelope to Joy Loden, RN, BSN, P. O. Box 430, Mantachie, MS 38855. If you have any questions, please call (662) 282-4468.

Source: Lemkau et al. (2000)

APPENDIX B

APPROVAL OF MISSISSIPPI UNIVERSITY FOR WOMEN'S COMMITTEE ON USE OF HUMAN SUBJECTS IN EXPERIMENTATION

MISSISSIPPI UNIVERSITY FOR WOMEN

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December 19, 2001

Ms. Joy Young Loden
c/o Graduate Nursing Program
P. O. Box W-910
Campus

Dear Ms. Loden:

I am pleased to inform you that the members of the Committee on Human Subjects in Experimentation have approved your proposed research as submitted.

The committee reminds you that the results of any questionnaire or survey must be kept under lock and key to ensure confidentiality and be kept for a sufficient length of time to protect the participant and the researcher.

I wish you much success in your research.

Sincerely,

Vagn K. Hansen, Ph.D.
Provost and Vice President
for Academic Affairs

VH:wr

cc: Mr. Jim Davidson
Ms. Terri Hamill
Dr. Sheila Adams

APPENDIX C

LETTER REQUESTING PERMISSION TO USE TOOL

3681 Walton Cemetery Road
Mantachie, MS 38855
(662) 282-4468
E-mail: cjw@ayrix.net

October 23, 2001

Dear Dr. Lemkau,

I recently read your article in *Archives of Family Medicine* on family practice physicians' perceptions of bereavement care. As a graduate student at Mississippi University for Women in Columbus, Mississippi, I was highly impressed by your work. My background is in hospice care, so I realize the importance of bereavement care among physicians and health care professionals. For this reason, I would like, with your permission, to replicate your study. I would also ask your permission to use the questionnaire that was developed for your study.

My study will sample family nurse practitioners working in primary care settings, as this will be my specialty area upon graduation. The goal of this research study will be to gain a better insight into how family nurse practitioners perceive their role in bereavement care and to ultimately increase knowledge concerning this essential part of practice.

I can be reached during working hours at (662) 841-3612 or after 6:00 p.m. at my home (662) 282-4468. My address and e-mail are listed above.

Sincerely,

Joy Loden, RN, BSN
Graduate Student

APPENDIX D

PERMISSION TO MODIFY TOOL

cjw

From: cjw <cjw@ayrix.net>
To: <jeanne.lemkau@wright.edu>
Cc: <cjw@ayrix.net>
Sent: Tuesday, November 27, 2001 1:04 PM
Subject: modification of questionnaire "Family Physicians and Grieving Patients"

Dr Lemkau,

I received the questionnaire, "Family Physicians and Grieving Patients" that you sent. Again, thank you for allowing me to use
this questionnaire with my study. After reviewing the questionnaire, I noticed several questions that was specific for the physician (e.g. questions 1,19,28-32,35). I would like to ask your permission to modify the questionnaire for my study so it is specific for family nurse practitioners, since this will be my population. Again, thank you for your time and be assured all information will be referenced appropriately.

Sincerely,

Joy Loden RN, BSN
Mississippi University for Women Graduate Student

cjw

From: <jeanne.lemkau@wright.edu>
To: <jeanne.lemkau@wright.edu>; <cjw@ayrix.net>
Sent: Wednesday, November 28, 2001 1:11 PM
Subject: RE: modification of questionnaire"Family Physicians and Grieving Patients"

you are kind to ask but, in fact, you don't even need to. i think as long as you are clear about what you do in any presentation or publication you are on ethically firm ground. good luck with the study

>===== Original Message From cjw <cjw@ayrix.net> =====
>Dr Lemkau,
>
>I received the questionnaire, "Family Physicians and Grieving Patients" that you sent. Again, thank you for allowing me to use
>this questionnaire with my study. After reviewing the questionnaire, I noticed several questions that was specific for the physician (e.g. questions 1,19,28-32,35). I would like to ask your permission to modify the questionnaire for my study so it is specific for family nurse practitioners, since this will be my population. Again, thank you for your time and be assured all information will be referenced appropriately.
>
>
>Sincerely,
>
>Joy Loden RN, BSN
>Mississippi University for Women Graduate Student

Jeanne Lemkau,PhD
Depts of Family Medicine and Community Health
(On Leave, 2000-2001/ available electronically or by phone 937 767 7026)

APPENDIX E

CONSENT/COVER LETTER TO PARTICIPANTS

P.O. Box 430
Mantachie, MS 38855

Dear Nurse Practitioner,

My name is Joy Loden. I am a family nurse practitioner student at Mississippi University for Women. I am investigating bereavement care from a family nurse practitioner's perspective. The study is entitled Family Nurse Practitioners' Perceptions of Bereavement Care. I am asking you to please take a few minutes to fill out the enclosed questionnaire for my research.

While there is no immediate benefit to patients from this study, an awareness of family nurse practitioners perceptions of bereavement care may influence bereavement care assessments. The study of bereavement care issues are limited to other health care professionals. The advanced nurse practitioner's perceptions have not yet been considered.

Please send your response back to me in the enclosed self-addressed, stamped envelope. Your completed response will act as a consent form. Since you do not place your name on the questionnaire or return envelope, your response will remain anonymous.

If you would like me to send you a copy of the results, place your name and address on the outside of your return envelope. By doing this, you may have the potential to lose you anonymity, but the information and your name will be kept separate as soon as the researcher obtains the envelope.

I appreciate your time and thank you in advance for your participation.

Sincerely,

Joy Loden, RN, BSN

APPENDIX F

REMINDER POSTCARD

REMINDER POSTCARD

This is a reminder to please complete and mail the questionnaire related to the study of Family Nurse Practitioners' Perceptions of Bereavement Care within the next 2 days.

If you have already mailed this information, please disregard this notice.

Thank you for your participation.

Joy Loden, RN, BSN