

## COMMUNITY NURSES, SPIRITUALITY AND BEREAVEMENT CARE.

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*Abstract: The study aimed to explore the perceptions of community nurses (health visitors and district nurses) in delivering a bereavement service to older people. It also aimed to gain an understanding of how bereaved older clients perceived bereavement visiting by community nurses. Qualitative semi-structured interviews were carried out with ten bereaved older people and twenty community nurses. Analysis of the interviews identified key concepts. A quantitative survey was carried out by questionnaire to two hundred and fourteen community nurses and achieved a return rate of one hundred and forty-three (66.8%). Community nurses interviewed stressed the importance of continuity of care, using intuition, and the importance of a client led service within the nurse/client relationship. They also identified, as helpful, having had a personal experience of grief. Bereaved older people interviewed identified key concepts of continuity, friendship and rapport within the client/nurse relationship. They had mixed perceptions regarding their own abilities to cope with grief as well as the impact of visits received from community nurses. Some bereaved older people perceived community nurses as skilled assessors of their grief. Community nurses surveyed by postal questionnaire demonstrated variations both in practice and in the administration of practice related to bereavement care. Friendship and rapport with the client group was found to be important as was spirituality, community nurse educational preparation and the role of voluntary organisations. Professional dichotomies in bereavement care were found to be present.*

*Key words: Bereaved older people, bereavement, community nurses, education, spirituality*

### Introduction

The research activity and associated findings have a wide scope, however, for the purpose of this paper a very focussed approach will explore the perceptions of community nurses regarding 'spirituality' and 'educational preparation' for delivering a bereavement service to older people. In order to progress the discourse the paper will highlight literature around spirituality and contrast it with survey findings of community nurses obtained by interview and questionnaire.

### Rationale for the study

Bereavement is an issue for nurses who may be in contact with spouses and other family members before, during and after the death of an older person. Little research has been carried out on bereavement visiting by community nurses.

Scrutton (1995) points out that, in order to view their future in a positive framework, bereaved older people require to work through their grief and, in doing this, they have to overcome the combination of being old and of experiencing a significant loss. The Scottish Office Home and Health Department (1991) recognised the need for health professionals to understand grief, to recognise the skills for effectively helping the bereaved and to develop an awareness of statutory and voluntary organisations involved in this process. This 'marriage' of ideas in both Scrutton's and The Scottish Office literature appears to be a common sense approach when viewed through the eyes of community nurses. According to Fischer & Hegge (2000) the community nurses's role includes actively visiting older people who have been bereaved and one can surmise that it

is important to explore this service from the users' perspective. It was therefore considered appropriate to attempt to explore the perceptions of community nurses in delivering a bereavement service to older people. Hopefully, gaining an understanding of how bereaved older people perceive bereavement visiting by community nurses would provide the users' perspectives.

Due to the apparent absence of policies, guidelines and protocols, opportunities to demonstrate examples of evidence based practice would be provided within the study. Parkes (1995) maintains that it remains unethical to introduce services for the bereaved that are not well founded and evaluated. Informal discussions with community nurses revealed that they often had no reliable method of hearing about a death in their practice, let alone an evidence base from which to draw. The necessity for evidence based practice to link into practice within the NHS may, to some, appear obvious. Logue however, questions this perceived wisdom:

*'it is my contention that the activity of nursing research, particularly nursing research in institutions of higher education is often done for the wrong reasons.'* (Logue 1996 p 63-64).

Increasing funding, recognition and academic snobbery are cited by Logue as being some of the wrong reasons for carrying out research and he challenges the profession to: *'remember to value intuition, experience and practical ability as much as intellectual ability.'* (Logue 1996 p 69).

## The study methodology

The retrieval of data was perceived to require great tact given the sensitivity of the research topic. Telephone interviews were not employed as they were not considered complementary to the sensitive nature of the research topic. They may also have effectively excluded research subjects with a hearing impairment. Focus groups were not used after advice was sought from Age Concern on their possibility. This consultation resulted in Age Concern counselling against focus groups in favour of face to face interviews with consenting individuals in order to engender a personal, sensitive approach. Postal surveys were also rejected as they were felt to be the least likely method of dealing with such a sensitive matter. The final method of choice was underscored by the present researcher's considerable experience

in practice of interviewing bereaved older people. Therefore semi-structured interviews were felt to be more appropriate for this type of data collection. MacPherson, Hunter and McKeganey (1988) identified the added value of using semi-structured interviews to generate rich data on a complex issue, especially when dealing with sensitive topics. However, these authors maintain that a valid consumer view is available when sensitivity is used throughout the exercise. Qualitative data collection via semi-structured interviews was also considered to be appropriate for community nurses in order to enrich the data gathering process and assist in the formation of a larger quantitative survey by postal questionnaire.

Pearson (1997) maintains that using data analysis from qualitative and quantitative methodologies can enhance the overall findings of research. Qualitative analysis pays greater attention to the perceptions and meanings placed on events by subjects while quantitative analysis is essentially deductive. Integrating the two approaches is not without problems. However, the justification for using this method was that one type of analysis (the qualitative interviews) would inform the setting up of the next stage of the research (the quantitative survey by questionnaire). Morgan (1998) discusses the practical strategies for combining qualitative and quantitative methods and applying them to health research. While it remains tempting to believe research projects that combine the strengths of two or more methods will produce more than those same methods could offer in isolation, there is a greater appeal according to Morgan. This combination maximises the ability to bring different strengths together in the same research project. The practical strategy of utilising two research methods in sequence, so that what was learned from one was added to another, was adopted into the design.

Gibson (1996) highlighted the intrusive threat of sensitive research into a person's private life with particular reference to bereavement. It was therefore felt to be unacceptable to retrieve sensitive qualitative data from bereaved older people by using postal or telephone questionnaires. Quantitative data gathering via postal questionnaire was, however, considered to be an appropriate method to employ with community nurses as it required participants chiefly to tick boxes on a scale rather than share sensitive information during an interview.

### **Summary of findings from community nurse interviews**

The key findings from the community nurse interviews were, continuity in the relationship between the community nurses and their clients is valued. Using intuition during interactions with clients helps community nurses to understand clients' experiences. The importance of having a client led service rather than a service reacting to normative needs was a frustration for some community nurses but is the preferred method. Having a personal experience of grief can be seen to have advantages for community nurses when delivering a bereavement service to older people.

### **Summary of findings from bereaved older people interviews**

The key findings from the bereaved older people interviews were continuity, friendship and rapport, bereaved older people's perceptions of their coping abilities and the impact of bereavement visits from community nurses. Most of the bereaved older people valued continuity with their community nurse in their journey of care prior to and post the death of their spouse. Community nurses were often perceived simultaneously as friends and professionals. This did not appear to cause any conflict in creating a good rapport. Bereaved older people were found to have insights into how they were coping with their grief and they perceived community nurses to be skilled at assessing how people cope with their grief. The feelings, plans, relationships and behaviours of bereaved older people were found to be affected in a variety of ways by community nurses visiting after spousal bereavement. While some were adamant that community nurses played no part in these areas of their lives others could point to examples where they had a direct impact.

### **Summary of findings from the survey of community nurses by postal questionnaire**

The key findings from the survey of community nurses were; variations exist in community nurse practice regarding bereaved older people visiting. Variations also exist in the administration of primary care practice linked to bereaved older people visiting. Friendship and rapport are important concepts within the nurse-client relationship. There are pro-

fessional dichotomies in practice for community nurses involved in bereaved older person care. Spirituality is an element of bereaved older person care which community nurses recognise as important but are not always confident of their ability to deliver. The educational preparation of community nurses for this type of work is limited while preparation via personal experience of bereavement is rated more highly. Voluntary organisations were found to have an important role in preparing and supporting some community nurses for this type of work.

## **Discussion of findings**

### **Spirituality**

Family health prior to, and after, the death of a family member, as discussed by Denham (1999), included some bereaved older people in the sample where the age of subjects ranged from 54-71 years. This study examined ecological influences on family health and found that most family members valued faith and viewed spirituality as important. They used faith and spirituality to help them to make sense of, and find answers to, the ontological questions generated by terminal illness and death. According to Balk (1999), grief presents a spiritual challenge but not all bereavements trigger spiritual change. Spiritual change occurs when grievers make sense of, and construe meaning from, their experience and need not necessarily include a reliance on religious beliefs.

The Community Nurse questionnaire (Table 2) asked respondents to indicate how important it was for their client to have a personal faith. The table clearly demonstrates the emphasis community nurses place upon the value of clients/patients having a personal faith in order to facilitate their grief.

While indicating that faith has a significant role for clients in the grief process, community nurses perceived their professional ability to deliver spiritual care to be low in comparison to their ability to deliver physical, psychological and social care.

The Community Nurse Questionnaire (Table 3) asked respondents to indicate where they perceived their professional abilities to be in respect of caring for bereaved older client's physical, psychological, social and spiritual needs.

Table 2: Clients having a personal faith.

	Very important	Important	Not important	Totals
Community Nurses	53	63	7	123
%	43.08	51.21	5.69	100

Table 3: Community nurses' perceptions regarding their professional abilities.

	High ability	Fair ability	Low ability	Totals
Physical needs	72 59.50%	40 33.05%	9 7.43%	121 100%
Psychological needs	50 41.66%	67 55.83%	3 2.47%	120 100%
Social needs	57 47.10%	58 47.93%	6 4.95%	121 100%
Spiritual needs	13 10.92%	66 55.46%	40 33.61%	119 100%

This finding challenges the received wisdom that nurses deliver holistic care to their patients/clients. Anderson & Dimond (1995) do, however, point out that relying on religious beliefs is a potential coping mechanism for bereaved spouses and that these can be a source of comfort with increasing frequency as time passes. Parkes (1997) refers to older people in particular receiving comfort from a religious faith that allows them to believe in an afterlife. In identifying the coping strategies of senior and elderly widows Hegge & Fischer (2000) included having a faith as a potential coping strategy.

Simsen (1986), in a study of how patients cope spiritually, refers to the work of Frankl (1963) who has written extensively on clients finding 'meaning' through their spiritual selves. Simsen cites the 'making sense of experience' as something that enables patients to move on, perhaps in a series of concurrent or sequential tasks.

Table 3 demonstrates that either a dichotomy exists between community nurses perceptions regarding the important role played by 'faith' in the grieving process and their ability to deliver spiritual care, or they may simply not perceive this to be their role. The area of spiritual health care is, by nature, a very

nebulous domain. It sits alongside intuitive practice and, according to Table 3 continues to exercise a degree of discomfort for community nurses. Whilst acknowledging the holistic needs of bereaved older clients, community nurses show themselves to be much more comfortable with the idea of meeting physical, psychological and social needs. A significantly low number of respondents perceived themselves to have a high ability to deliver spiritual care. These findings ask questions of practitioners and educators especially with respect to the preparation of nurses for practice. The teaching of spiritual care need not be narrowed to issues around faith, but may incorporate patients' and clients' views on the meaning of life, art, music, contentment and, not least, a pain free existence.

**Educational preparation for practice**

The present research suggests a gap in the basic educational programme that nurses consider relevant to their practice. Ross (1996) reminds us that it remains unclear how spirituality is taught to nurses and, if it is taught, how effective such teaching is in preparing nurses to provide spiritual care. Ameling & Povilonis (2001) were unable to find any studies in American literature about nursing training and spirituality and, remarkably, also failed to find any

mental health studies incorporating such literature. Given the paucity of literature both in the United Kingdom and The United States of America, it appears reasonable to accept this as contributory to the explanation for community nurses in the present study indicating their lack of ability to meet bereaved older people's spiritual needs. It might also partially explain the subsequent need for the involvement of groups out with the NHS in supporting bereaved older people.

At a legislative level social and spiritual issues have been highlighted the Scottish Executive in an effort to improve the quality of services available to patients and their families. In 2002, Scottish Executive issued HDL 2002 (76) Spiritual Care in NHSScotland. This asked each Health Board to write and implement a policy which took into account both the needs of the local community and national initiatives and national policy drivers such as 'Partnership for Care' and 'Fair for All'. As further response to this circular, a Scoping Study Group was established by NHS QIS to identify the key issues within the provision of spiritual care in NHSScotland, and recommend where NHS Quality Improvement Scotland could best support quality improvement within this service.

## Conclusions and recommendations

This study has explored the perceptions of community nurses in delivering a bereavement service to older people. It has also gained an understanding of how bereaved older people perceived bereavement visiting by community nurses. The study has demonstrated that bereavement is a major concern for members of the nursing profession who may be in contact with spouses and other family members before, during and after the death of an older person. A critical review of the literature has emphasised the paucity of focused material available and has utilised literature of an analogous nature to illuminate the topic. This has included literature both from traditional and contemporary sources which informs and challenges beliefs and practices around the bereavement experience. The research methodology has employed a phenomenological approach in order to obtain data from qualitative and quantitative sources. This complementary approach has provided added value to the research findings and the subsequent discourse. Key findings from community nurse interviews, bereaved older people interviews

and a survey of community nurses by postal questionnaire were presented in the findings. In common with the literature review, discussion of these findings questioned and challenged practices and beliefs associated with bereaved older people visiting. The discussion highlighted both areas of agreement and disagreement between the perceived experiences of community nurses and bereaved older people. Three main recommendations can be made from the study, these are now presented.

Further research is recommended to ascertain if the spouses of bereaved older people perceive themselves to experience a significant amount of unmet need prior to, during and post bereavement. The public health issue of the often unarticulated needs of carers in particular, is well documented by Dowrick (1993) & Jones & Martinson (1992). This recommendation should be considered by service and educational providers as a potential area for collaborative work.

The educational providers of nurse education are recommended to address the issue of bereavement at both pre-registration and post-registration levels. Curriculum planners should consider collaborating with voluntary organisations and self-help group specialists working with bereaved people. Aspects such the delivery of spiritual care, the use of intuition and the potential roles of community groups with bereaved older people should be included in a wider preparation for practice.

Primary health care systems are recommended to develop robust systems of support for bereaved older people that communicate effectively within and out with primary care teams. An ad hoc approach is not recommended to meet the needs of bereaved older people. Rather, systems that enable the targeting of high risk groups within primary care practices and facilitate community nurses to evaluate their interventions with these individuals and groups are recommended as worthy.

## Dissemination of the Findings

Microsoft Excel was employed specifically to produce easily read and understood results which have been sent to community nurses and senior nurse managers. Personnel from Age Concern and CRUSE Bereavement Care had previously contributed to the research by agreeing to be interviewed. These inter-

views recorded their perceptions of bereaved older people's needs and how community nurses could help to identify and meet these needs. The results were also circulated to Age Concern and CRUSE Bereavement Care.

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