Bystander Bereavement - Beyond Burnout

by

Penelope L. Nesbitt, BSW (Univ. of New South Wales)

When a community is shattered by a major disaster or tragedy, much attention is given nowadays not only to the care of victims, but increasingly to the "innocent bystanders" and the rescue workers. Trauma debriefing teams are being utilised to deal with the psychological needs of these people, as, for example, occurred after the Queen Street massacre in Melbourne, Australia, in 1987. Eleven people were shot dead in the Australia Post Building whilst terrified colleagues hid, wondering if they were to be killed next. Within days, debriefing teams were set up, business ceased for the day and skilled bereavement counsellors helped the Australia Post employees to begin to come to terms with this gruesome event.

But what of those workers who deal with death and tragedy on a daily basis? Hospital staff working in Accident and Emergency departments and Intensive Care units are in the front line of a constant onslaught, inescapably subject to confrontation with loss.

Hospital administrators appear to be unaware of, or unsympathetic to, the specific needs of staff in areas where there are multiple deaths. Inappropriate interventions, or stress management contingencies if any exist at all, clearly do not serve the needs of staff who are struggling with their own bystander bereavement.

The very nature of hospital work demands of its employees what can at times best be described as working above and beyond the call of duty. Staff are frequently working with life and death situations where there is no "downing tools" if the load gets too much, or if it is time to go home.

From discussions with staff after a tragedy had occurred, it became clear that these people were often deeply affected both in the short and long term. Doyle[1], Price[2] and Raphael[3] made similar observations in their discussions on the casualties amongst those designated as helpers, or workers.

For those who work in them, Accident and Emergency and Intensive Care Units are fraught with their own inherent job stresses. This is acknowledged by Brunt[4] and Orlowski[5], while Selye's research addresses the central issues of modern-day work stress[6].

Concern, therefore, must be expressed about the long-term effects of the combination of these factors, which include the effect on physical and mental health of staff, the inevitable attrition of teams through the loss of highly trained people, and individual difficulties with unresolved losses.

The most glaring inadequacies were found to be in the areas of preparation for, and education about, death; post-crisis debriefing; and the administrative arrangements to implement strategies for the management of stress. Intervention in all these areas is imperative if hospital staff are to be cared for in the same manner as that which is demanded from them in the care of patients and their relatives.

Working in A & E and Intensive Care Units

In January, 1987, I commenced work at the Royal North Shore Hospital in Sydney, Australia. I was employed to provide a social work service to the Accident and Emergency and Intensive Care Units, and to work on an on-call, 24-hour crisis roster. Thus began my "baptism of fire", and, like most of my colleagues, my rude awakening to the facts of death.

The hospital accepts patients from a large geographical area, is well equipped with medical technology, and boasts a number of highly skilled specialist teams such as the neurosurgical and spinal injuries units. As a result the Accident and Emergency and Intensive Care Units are busy and the environment can at times be devastating in the extreme. For staff to have time to deal with the myriad of reactions to the death of a patient is unfortunately a luxury, and as yet there is no formalised system of debriefing staff post-trauma.

The teams with whom I work consist of doctors, nurses, social workers and physiotherapists; all ordinary men and women possessing special skills and dealing with extraordinary situations, at times seeing sights so gruesome as to be unimaginable. Contrary to the opinion of some who believe "you must be used to it" or "you can cope because it's your job", it became apparent that in the aftermath of death and destruction there were many staff affected and grieved by these incidents.

Reactions to Stress

From observation and discussion, it emerged that people involved with care of dead or dying patients, frequently with horrific injuries, denied or subjugated the normal stress, or fight or flee, reaction. The power of a uniform, or hospital identity badge, is immense; somehow, once donned, it affords people abilities previously unknown. Doctors, nurses and social workers were no longer mere mortals, but people whom others marvelled at, awestruck by the apparently cool, capable, rational manner in which they conducted themselves, unaware of the inner turmoil being suffered, and which often took its toll later on.

After a crisis had passed and the patient had died and the family had left, many staff, myself included, revealed later that at various times throughout the preceding few hours they had had both physical and psychological signs and syptoms of what would correctly be called a normal shock reaction. These included nausea, faintness, dizziness, shaking and palpitations, excessive perspiration, wanting to walk away, cry or scream, and anger (often directed at the person who had, say, caused the accident, or sometimes, in cases of suicide, at the patient). As well as this, many people reported feeling a sort of mania, as if they could keep going until they dropped; they even had difficulty leaving work to go home. Recently while assisting the relatives of a brain-dead patient one evening, I returned to find a colleague standing by the bedside looking somewhat bewildered and agitated. Although throughout the previous two days she had dealt with the brain deaths of three young patients, the subsequent organ donations and the distress of the nursing staff, she felt guilty at going home and leaving me to deal with the situation, despite my having experienced a somewhat less traumatic 48 hours. After several attempts to coerce her to go home, she eventually had to be led to her office, have her

belongings collected, her pager turned off, and be accompanied to her car.

All too often the same members of staff who had just dealt with the crisis returned to duty as expected, maintaining the professional façade. On occasions the crises are continuous, and the same team may have to deal with several tragedies during their shifts—things are rarely quiet in the Accident and Emergency or Intensive Care Unit. These people are frequently being confronted with the awesome reality of death in its many, often horrific forms, and in effect with their own mortality and the inevitable mortality of those they love. And what of the effects such confrontation has, not only on physical well-being, but on one's sense of self, of living, of loving and, importantly, on one's own, often unresolved, losses?

Others felt the need to cry, often grieving the death of the patient and the unfairness of death, often saying they felt voyeurs of other people's grief, and guilty and confused as to the reasons for their bereft feelings. Sometimes there were similarities with loved ones who had died, or of those living who would inevitably be lost through death. For male colleagues, overt demonstrations of distress were even more difficult to come to terms with, because of the sex role stereotype that "big boys (or men) don't cry". Certainly this was apparent with many colleagues, but more noticeably so with male members of staff.

Informal Debriefing

Sometimes, if time allowed, informal debriefing would take place in the form of a chat over coffee. A commonly felt post-crisis need was wanting to talk with someone. This was usually with other staff who had been involved, because of a feeling that friends and family would not understand, or should not be burdened with the description of such horror. It was viewed as a sort of play-back, with people needing to go over in full detail, and often more than once, everything that they had seen, heard, felt, smelt and so on—the assault to one's senses appeared to present the most pertinent need for catharsis.

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Painful memories and feelings were often blocked, at the earlier stage of needing to cope during the crisis. After assisting the family of a patient with fatal burns, the use of my hair dryer that evening unexpectedly brought on many of the physical reactions, and the tears which I had controlled throughout the ordeal. Another colleague found a solution to dealing with pent-up emotion: she would take home videos of the saddest movies she knew of, using this as a stimulus for the tears which she knew needed to come.

Cumulative Effects of Stress

Another question which became of concern was the cumulative effect of these reactions, suppressed or otherwise, over time. How was this affecting people? In discussions with staff, common themes again emerged such as people being concerned with the manner in which they would die. Others spoke of having a skewed view of life and death, seeing maiming, death and horror lurking everywhere, and wanting, for example, to become over-protective of their children. After being over-exposed to death, an overwhelming sense of the futility of living pervaded the thoughts of some members of staff.

Many people spoke of feeling utterly helpless, frequently using derogatory words about themselves such as being useless, hopeless or inadequate because they had been unable to save these lives. Others directed anger at equipment, or the emergency room, or the ward set-up, feeling that the perceived inadequacies or inefficiencies of these in some way contributed to their inability to prevent the person from dying.

A somewhat overwhelming picture emerges of grief, frustration and despair, particularly taking into account the intrinsic stressors which are part of any job. Staff in Accident and Emergency and Intensive Care Units work in an unpredictable environment. There is no indication, other than perhaps a radio call from an ambulance, of what sort of horror is going to emerge next through the emergency-room doors. At the same time, of course, there is the expectation that staff will at all times deliver a highly skilled, professional, calm service to severely injured and sick patients.

It is being increasingly acknowledged, as David Price and Patricia Murphy point out[2], that the effects of multiple stressors can be more detrimental than the stress associated with one major disaster. Many readers may be familiar with the stress rating scale drawn up in 1972 by Holmes and Masuda[7]. They were able to demonstrate that the amount of stress to which people are exposed can affect their health, even to the point of producing physical symptoms over an extended period of time. Selye, in research on stress, made the observation that one apparent stressor was a perceived lack of control of one's environment[6]. He also suggested that the human stress response may now be maladaptive, being a primitive response aimed at removing or protecting the person from physical harm, or threat.

Distancing and Dehumanisation

With regard to the needs of staff dealing with tremendous losses, Beverley Raphael writes that the individual ". . . needs, in short, care and consolation from others to bear the enormity of much of the pain and loss and death he helps others encompass. If this is not available for him, he may develop defensive pathology in the form of dehumanisation, distancing of personal relationships, or isolation of affect, so that cold mechanical relating and care is all that he can give."[3]. Other maladaptive consoling behaviours observed were those such as overeating, drinking to excess or "acting out" in personal relationships.

It would appear, then, that the end result of an over-exposure to death and loss, coupled with the stress inherent in the job, often leads to a conglomerate of symptoms both physical and psychological. What commonly seems to occur is that the person becomes classified as "burnt out" and may leave the job, unhappy, confused and unwell. The cost is felt at all levels—for the individual, the team and the organisation.

To avoid this undesirable result the solution is threefold, dealing with the periods before and after the crisis, as well as stress management.

1. Before the Crisis—Education/ Preparation

If we are truly to assist bereaved people, then we must feel unafraid in the presence of the strong emotions which invariably accompany hearing the news of the death of a loved one. This news may take only a few seconds to relate, but these moments and the ensuing period will remain etched in the memory of the bereaved. The manner in which people are treated at this time may have much to do with the difference between a healthy or complicated outcome of their bereavement, and, at the worst, the morbidity or mortality of the bereaved. Education and preparation of staff appear to be the best tools at our disposal.

Luis F. Martorell, a writer on social work practice, speaks of the lack of preparation of students for dealing with death, and one's own mortality[8]. Medical, nursing and other paramedical training also appears to suffer from the same lack of personal preparation for loss and death.

At the Bereavement Care Centre in Sydney, Malcolm and Diane McKissock run experiential and skills training workshops, with much emphasis on the experiential. Part of the course involves preparing the participants for viewing a body at a funeral home, which they then go on to do. All the didactic material in the world does little to engender the feelings evoked by one's first viewing of a dead body. The honest and often painful discussions which follow lead many to a far greater appreciation of their own needs, and the needs of others, at a time of loss.

Such a programme of education and preparation would be a worthy addition to the training of all people proposing to work in areas where death and loss occur. At Royal North Shore Hospital, all social work staff wanting to work on the crisis roster undergo training, part of which involves being taken through the steps of viewing a body. Staff are treated with the same care that it is expected they will show to relatives of deceased people, being given the opportunity to debrief after the viewing.

People who are struggling with their own fear and unresolved losses will inevitably find that this hinders their ability to help the bereaved. Price and Murphy suggest that working in the presence of death and loss, continually abrading one's own unhealed emotional wounds, invariably contributes to worker stress and burn out, and poorer care of patients and relatives[2].

2. Debriefing

The second area of need is for staff to be provided with some form of trauma debriefing along the lines of Jeffrey Mitchell's Critical Incident Stress Debriefing Process[9]. Mitchell postulates four types of debriefing — on-scene, or near-scene; initial defusing; formal critical incident stress debriefing; and a follow up debriefing session. The overall goal is clear—"to protect and support personnel and to minimise the development of abnormal stress response syndromes which may cause lost time and effectiveness at work, and problems within the family".

The profession of the debriefing facilitator is not relevant, but he or she needs to be a skilled professional, trained in group work and bereavement skills, and familiar with all aspects of the normal shock syndrome. A person who is respected by, and acceptable to all staff, and who was not directly involved with the disaster, would be the most suitable. That the debriefing should take place at the work-place appears to be important for a number of reasons. Many people feel that only other staff will be able to cope with a detailed discussion of the trauma or crisis. Secondly, many of the staff spoke of the need to "come down" or normalise prior to going home. The debriefing session acts as a buffer or safety zone, bridging the gap between work and home. We are always careful about not allowing distressed relatives to drive home, yet all too often deeply shocked and upset staff not only may drive home, but may be called upon to make clear, rational decisions about patients.

Discussion earlier centred on the difficulty some workers experience in "decelerating" after being wound up during a crisis. Raphael, Singh and Bradbury[10], in their paper on disaster workers, note that many have difficulty in ceasing work, and handing over to other competent workers. Such a situation is clearly dangerous for all concerned and begs the intervention of an on-scene or near-scene debriefing facilitator.

Many writers express concerns for those people who attempt to use family members as the prime source of emotional support after crises at work. Those not involved in such a working environment are typically at a loss to know how best to help, leaving the worker frustrated, and emotionally blocked.

The use of post-crisis debriefing may very well reduce absenteeism and help avoid low morale among teams. Such intangibles as workers' stress levels and the effectiveness of debriefing are difficult to measure objectively. However, any doubts about the cost-benefit of debriefing, would, I am sure, be removed if the costs in terms of absenteeism, loss of workers and individual difficulties with loss are taken into account. Raphael comments that "it is clear that bereavement may act as a precipitant or vulnerability factor in the development of morbidity"[3].

People working in areas where there are multiple deaths or crises are exposed to higher than normal stress levels, often leaving them depleted and needing time out. Preparation, debriefing and measures for stress management are all needed.

Certainly undue stress is implicated in many studies on stress, and morbidity and mortality.

3. Stress Management

Responsibility for the management of stress rests with the individual as well as the organisation. Educating staff about sensible diet, regular exercise and sleep, and engaging in relaxing non-work activities, leaves the onus on people to heed this advice and be active in self-care.

At an administrative level some innovative techniques are called for in order to give back to staff some of what is required of them in their work. People working in areas where there are multiple deaths or crises are exposed to higher than normal stress levels, often leaving them depleted, and needing time out. Whilst employed as director of nursing at a palliative care unit in Sydney, Malcolm McKissock instigated some novel ideas for staff care and stress management. Podiatry and hairdressing services available at the hospital were expected to be used by staff for at least one hour of work time, once per fortnight, by each member of staff. This was felt to be one small way to care for staff from whom so much was demanded. I have frequently heard hospital staff say that what they needed was a good massage at the end of a busy day.

Within the Social Work Depart-

ment at Royal North Shore Hospital, debriefing has been included on monthly statistics forms, ratifying this as an approved use of work time.

People need to be rotated in order to give some relief from the constant exposure to death. Time to "regroup", and to recoup one's strength, is required in order to work effectively. Empathy, compassion and care are finite entities and people possessing these qualities can run low. Regular "topping up" is a must.

Polly Doyle[1] refers to the black humour of the film and television programmes "MASH", where doctors and nurses use humour to ameliorate some of the pain of the tremendous loss with which they deal. Humour does much to improve morale, and light-hearted skylarking during quieter periods, or staff get-togethers after work, are important prescriptions for good staff cohesion, morale and mental health.

Conclusion

These are merely a few suggestions, not an exhaustive list, but certainly attention must be drawn to the needs of hospital staff as the frequently forgotten casualties of disaster.

As Truswell, Blyth, Kendall and Shipway[11] point out, hospital workers are "in the frontline of so much distress, grief, frustration and anger". The constant reminders of one's mortality and vulnerability cannot be mentally filed away as experiences which one may never have: death comes to us all.

Most people are aware of the need to come to a certain level of understanding and acceptance of one's own death, and of the need to work through other losses suffered in life. Life will undoubtedly be richer and fuller without the encumbrance of such unfinished business. To be confronted with death, however, virtually on a daily basis, does not appear to augur well for such a resolution of one's fear, and for the healing of the emotional scars of loss. I would venture that it is often a brutal and terrifying assault, opening a gaping wound in the precious fiction of our immortality.

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Further Reading

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Supplement to the International Conference on Grief and Bereavement in Contemporary Society, London 1988

Cruse will be publishing, later this year, a Supplement to the International Conference. The Supplement is expected to include the Plenary Addresses by Dr. Colin Murray Parkes, Professor Peter Marris on Adult Grief and Bereavement, Professor Robert Pynoos on Children and Bereavement, and the First Professor Shamai Davidson Memorial Lecture delivered by Professor Gerald Caplan on Loss, Stress and Mental Health.

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Helping Children in Crisis. Cornwall. Friday, 26th May, 1989, 10 a.m.-4 p.m. First Annual Day Conference of Cruse in Cornwall. To be held at the Post-Graduate Centre, Treliske Hospital, Truro, Cornwall. Speakers: Dr. Dora Black, Consultant Child and Adolescent Psychiatrist, Royal Free Hospital and Vice-Chairman of Cruse; and Joan Sloan, Social Work Consultant, Cornwall Social Services Department. Programme also includes video presentation and discussion in small groups. Cost: £25 inc. refreshments. Application forms from Cruse Conference Secretary, Cruse Office, 2 Walsingham Place, Truro, Cornwall TR2 1RP.

International Conference on Children and Death. Athens, Greece. 30th October-3rd November, 1989. Sponsored by the University of Athens, The Association for Death Education and Counselling (USA) and the National Drug Organisation (Greece). For professionals involved in educating children on death and loss, those involved in the care of chronically and seriously ill children and their families, and professionals counselling bereaved families. Further details from Dr. Danai Papadatou, Messogion 8, Athens 115 27, Greece (Tel. (301) 7777 545).