Example nursing essay

Deathography Reflective Essay

In life nothing is more inevitable than death, it simply cannot be avoided. Despite advances in medical sciences and increased longevity in the Western world, human life remains fragile as death can occur at any age in a myriad of circumstances. Grief follows the death of a loved one, is often cited as being a ‘ universal’ response to loss (Davidson, 1988) and can be defined as ‘ intense sorrow’ (Oxford English Dictionary, 2013). Each bereaved person will experience and respond to grief in a unique way, underpinned by social, cultural and religious factors, further influenced by the individual’s personality and coping mechanisms. Grief reactions are widely acknowledged to vary in length and severity and to have physical, emotional, cognitive, behavioural and spiritual components (Rosenblatt, 1993: Archer, 1999: Parkes, 2001).

On the 18th September 1989 I gave birth to a beautiful, healthy baby girl weighing 8lbs and 11 ounces. As a parent I had such high hopes and expectations for the future but on 23rd February 2002, aged 12 years, her life was drastically cut short following a tragic accident. She was excited as she set off for her first ever sleep over at her best friend’s house, I was anxious as this was the first time she had been away from home without me.

On that cold, damp Saturday afternoon they had decided to go out for a bike ride (my daughter had borrowed an old bike belonging to her friend’s brother). Whilst out riding the chain came off, as she fell to the ground the bike landed on top of her abdomen causing her liver to rupture. My daughter died within minutes from a massive internal haemorrhage, in severe pain and all alone at the road side as her friend had gone to get help. Oblivious to

what had happened; I received a telephone call from her friend’s mother stating that Gemma had been in an accident and to meet her at the Birmingham Children’s Hospital. Assuming that she had experienced relatively minor injuries (I was told not to worry), I was ill prepared for the scene that unfolded before me as I entered the Multiple Injuries Unit in Accident and Emergency. Gemma lay motionless on a trolley, her body covered with a white sheet. The room was full of nurses and doctors who had attempted to resuscitate her, all of whom appeared shaken and emotional but no one was able to provide an explanation or answer my questions as there were no signs of injury or trauma to her body. It was only after the post mortem that the cause of her death was identified. I left the hospital that evening with a carrier bag containing her personal possessions and a leaflet explaining ‘ what to do when a child dies in hospital’, barely able to comprehend what had just happened or the magnitude of my loss.

The loss of a child is the most devastating loss of all. It defies the natural order of events as parents do not expect to mourn their children, causing heartbreak and trauma like no other. Parental grief is different from other losses in both intensity and length. Sudden death robs the bereaved of preparatory grief, is more common in young people and often occurs in clinical environments.

There is a well-established theory base relating to issues of loss. Early theories include Freud’s (1917) grief work perspective and Bowlby’s (1969) early attachment model. Freud’s work led to grief being conceptualised as both a pathological condition requiring psychological intervention and a linear process. The individual must ‘ work through’ it in order to detach the

memories and thoughts associated with the deceased love one. Both Bowlby (1980) and Parkes and Brown (1972) suggest that grief follows a predictable pattern. A well-known five stage grief model developed by Kübler-Ross (1969) depicts grief as passing through phases of shock and denial, anger, depression, bargaining and eventual resolution and acceptance. Terms such as ‘ normal’ and ‘ complicated’ grief (Engel, 1961) were developed as a way of distinguishing grief that had not resolved within a given time frame.

Recent years have seen the development of a number of new theories and approaches to loss and grief. Stroebe and Schut (1999) explain grief reactions in terms of two concurrent processes or ‘ orientations’ (also known as the dual process model). Loss orientation is described as a traditional grief reaction, characterised by despair, sadness and anger, whilst restoration orientation is characterised by attempting to rebuild one’s life and move on. Klass et al (1996) emphasises the importance not of letting go but of holding on even after the loss has occurred to maintain continuing bonds. Worden (1991) described four overlapping stages and tasks which the bereaved work through in order to relocate the deceased by redefining the relationship in the new context of the loss to invest in the future.

People who are suddenly bereaved often require more support and counselling than those who have the time to prepare for the death of a loved one. Without such support, unresolved grief reactions may occur along with a life time risk for psychiatric diagnosis (Keyes et al, 2014). Unexpected death is associated with Post Traumatic Stress Disorder (PTSD), panic disorder and depression regardless of when the death occurred in the life of the bereaved person. The incidence of generalised anxiety disorder, social

phobia, mania and alcohol abuse is greater if the death occurred after the age of 40 in the bereaved person’s life. Thus, whilst extreme sadness and despair are normal reactions to loss which usually dissipate over time, some grief reactions are so severe they give rise to psychiatric disorders requiring medical intervention (Worden, 2003).

On that fateful day in 2002, my whole life’s purpose changed and everything that I had lived for now ceased to be. Neimeyer (2000) maintained that major losses challenge a person’s sense of identity. In the immediate days and months that followed I strongly identified with the initial stages outlined by Kübler – Ross of shock and denial. As a mental health professional I was familiar with the model and knew the predicted pattern that my grief would likely follow. I would ask myself over and over again, how could my only child be dead? How can someone die falling off a bicycle?

Catapulted into the depths of despair, no longer a mother, all my hopes and plans for the future had become futile and irrelevant. A major task of grief requires refocusing one’s life story to rebuild and maintain a semblance of continuity between what has gone before and what lies ahead (Neimeyer, 2006). The foundations of my belief system had been called into question; why Lord did you have to take my daughter who had so much to live for when there is so much human suffering in the world. I was consumed with anger whilst having to support my husband, parents and other family members alongside coping with returning to work. My colleagues would avoid me in the corridor, not knowing how to approach me or what to say.

Barely able to function, I felt lost, alone, hopeless and worthless. Overwhelmed by guilt, I felt that I should be blamed for failing to protect my daughter as I had not fulfilled my duty as a mother. The months turned to years, my frustration grew as I waited for the time that I would achieve resolution and acceptance. I lost motivation and became anxious, living in fear that I would lose another family member in such sudden and dreadful circumstances. I experienced flashbacks and actively avoided seeing friends and family as their children reached major milestones such as learning to drive or graduation. Loss orientation and concurring loss restoration would have been incomprehensible for me at this time. Instead, I chose to keep her memory alive by raising money for the Birmingham Children's Hospital, publishing a diary of a bereaved mother, sponsoring an award in her name at the school she had previously attended, making frequent visits to her grave and commissioning a large portrait of her to hang in the lounge (continuing bonds).

Five years on, I was still unable to contemplate resolution and the trajectory of my grief wasn't following a staged or linear process but zig zagged erratically back and forth between stages. This was unsettling and uncomfortable and went against everything that I had been taught as a mental health professional. Not only had the prescriptive linear and staged models been unhelpful (Sheehy, 2013) but had led professionals to conclude that I experienced a complicated grief reaction as resolution didn't come within a given time frame. I gave up engaging with health care professions as I felt the template they were adhering to didn't fit my unique situation. I still felt the physical pain of losing her as I acknowledged that my loss had

pervaded every area of my life and completely changed my personality. Finally, I knew that it was up to me to find meaning in my life in order to have a future. That meaning came six years later when I became the mother of a baby boy in 2008.

The experience of losing Gemma was devastating and remains immensely painful but I now accept that the pain is an intrinsic part of me. I have simply learnt to live with it. The loss and trauma I have experienced has defined the person I am today, however, it must be stated that it has also positively influenced my attitudes and beliefs about life in many ways. Over the thirteen years, I have gained inner strength and I now appreciate just how precious life is. I take nothing for granted, knowing only too well how quickly a life can be taken away. I don’t plan for next year or too far into the future but I prefer to live in the moment and try to find something positive in each day. I am more tolerant and forgiving of others, whilst making a conscious effort to regularly remind relatives and friends how important they are to me and how much they are loved. If something is wrong in my life, I now have the courage to change it. I am not afraid of my own mortality, my faith has now been fully restored and I believe that one day I will be with her again when it is my turn to cross to the other side. Furthermore, the way in which I interact with bereaved people as a mental health professional has changed, shaped by my own experiences and the need to understand each individual in the context of their reality.

The hardest thing to do was to forgive myself and to realise that I am not to blame for her death. I have survived life’s cruellest blow and although life will never be the same, I am now able to experience happiness again.

Gemma will always have a presence in my life as she is spoken about lovingly and frequently as a household name, her portrait remains over the fire place as a reminder of her wonderful contribution to my life.

In conclusion, whilst models and theories offer helpful frameworks and insights into the grieving process an individual's unique response cannot be overstated. Many factors influence how an individual grieves, the dominance of linear or staged processes are too prescriptive. In supporting the bereaved, the task of the health care professional is not to favour or propose one model over another but to challenge assumptions and listen to the bereaved in order to facilitate an accurate reconstruction of the individual's inner self and outer world. Thus, adopting broad concepts facilitates a more holistic understanding of the needs of the individual. Failure to do so will result in a continued theory/practice gap and those bereaved individuals who do not come through may remain prone to a range of long lasting psychiatric disorders. Further research is required into bereavement related contextual factors and the development of effective interventions in helping the bereaved to cope and such an approach is relevant in a wide variety of situations.

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