Document #6

ASSUMPTIONS AND PRINCIPLES REGARDING BEREAVEMENT

Introduction

We are all vulnerable to the profound feelings that accompany loss, whether that be our own impending death or loss of health; the death or loss of health of someone we love; the loss of relationships, of function, of dreams; the loss of possessions.

Loss can result in a wide range of emotional, physical, intellectual, social, familial, economic, and spiritual disruptions.

Grief and bereavement are normal and can be resolved with one's already existing resources. However, depending on a number of factors and circumstances, bereaved people may require the assistance of appropriately trained persons to provide a climate of support and acceptance.

Terms

The highly personal response to loss is known as GRIEF.

BEREAVEMENT is the state of deprivation following the loss of something held to be significant, whether positive or negative.

GRIEF WORK is the process in which people engage to resolve the disruptions caused by bereavement.

CAREGIVERS are those professional and nonprofessional individuals who presume to offer support, acceptance, and guidance to the bereaved.

BEREAVEMENT CARE is used to denote approaches, methods, and/or programs of treatment, support, and assistance directed specifically toward those who are grieving a recent and significant loss.

An axiom is a statement accepted as true without proof, self-evident. An assumption is a statement supposed to be true, but not proven. As used here, it refers to problems that people face. A principle is our presumed approach to solution of the problem asserted in the assumption.

The following assumptions and principles are offered to aid in the development of care programs to assist the grieving and bereaved.

GENERAL

Assumptions	Principles
120. Grief is normal and is often resolved with one's existing resources.	Since many grieving persons do not require professional intervention, caregivers may be helpful by simply acknowledging and affirming the normalcy of the process.
121. Grief is experienced in varying combinations of intensity and duration.	At any time in the grieving process, care may be needed and should be accessible.
122. The problems of the bereaved vary greatly. Grief may be accompanied by serious physical, social, emotional, intellectual, spiritual, and economic disruption.	Grieving and bereaved persons may benefit from the assistance of appropriately trained persons, professional or nonprofessional, skilled in bereavement work, and well informed concerning other resources that may be helpful in grief work.
123. Persons experiencing acute grief frequently have difficulty coping with a range of practical, psychosocial, economic, and religious matters which may influence their functioning.	Persons experiencing acute grief may benefit from assistance in contacting and accepting support from specialized services dealing with legal, religious, vocational, economic, sexual, and social problems.
124. Grief can accompany or follow a wide variety of losses, including loss of health, death, divorce, separation, and amputation.	Bereavement care should be considered for a variety of losses.
125. The experience and expression of grief and the needs that emerge may vary widely from individual to individual. They are subject to many variables, including past experiences, cultural expectations, personal beliefs, and relationships.	When bereavement care is needed, there is no single approach or method that routinely assists the bereaved. Care may include a number of formal and informal methods such as one-to-one or group counseling, discussion groups, practical help, intensive therapy, self-help groups, and the use of the arts such as music, art, and drama.

126.	Despite the fact that loss is painful, it can be a stimulus for growth.	In addition to support, bereavement care includes facilitation of personal, psychological, social, and spiritual growth.
127.	Bereaved persons may be particularly vulnerable.	Caregivers seek to recognize this vulnerability and assist in protecting the bereaved, helping them to utilize their own personal strengths and support systems.
128.	Bereaved persons have differing personal philosophies as well as moral and religious values.	Care for the bereaved respects the individuality of those being supported and incorporates variations in accordance with differing belief systems.
129.	Bereaved persons are often unaware of, or unable to reach out to, community resources which might meet their needs.	Caregivers should seek to provide continuing opportunities for the bereaved to "make connection." Outreach methods should be included in early bereavement follow-up.
130.	The bereaved may become overreliant on caregivers.	Caregivers should minimize the development of undue dependency.
131.	The bereaved may not accept the offer of relationships with individual caregivers.	Caregivers must be nonintrusive and sensitive to the individual desires of the bereaved.

132.	Some of the difficulties that arise in bereavement may be predicted prior to, or at the time of, loss.	Care for the bereaved should make use of available predictors.
133.	Rituals and ceremonies of leave taking (e.g. funerals) allow a loss to be acknowledged in a symbolic and formal way. They provide an opportunity for the expression of feelings and personal, spiritual, social, ethnic, and family belief systems in an appropriate setting.	Bereavement care should be compatible with the personal spirituality, religious rituals, and social customs of the bereaved.
134.	Bereaved persons often receive fragmented care which may complicate and disrupt the resolution of grief.	Continuity of program planning and communication among caregivers is important.
135.	Care of the bereaved is usually assigned a low priority in health care planning.	Caregivers must seek concrete ways to develop bereavement care as an integral component of health care through planning, education, training, and implementation.
136.	Caregivers can distance themselves from the bereaved by categorizing them.	Caregivers must avoid the tendency to be judgmental and the use of terms that imply mental illness or abberation.

FAMILY (Traditional and non-traditional relationships)

Assumptions	Principles
137. As a patient approaches death, it may be difficult for family members to resolve unfinished business, express feelings, and participate in the provision of care. Such difficulties may add to the emotional burden of the bereaved.	Caregivers should facilitate the participation of family members in the care of the patient and nurture communication and contact between patient and family members.
138. At times, the needs and ambivalent feelings of individual family members will be in conflict with the needs and desires of others who are emotionally involved.	The patient, family, and others who are emotionally involved may require assistance if they are to recognize and allow their conflicting needs and ambivalent feelings.
139. The family system and its usual dynamics may be disrupted and changed by the loss of a family member and the ensuing grief.	The caregiver should, when necessary, be ready to assist grieving families as they adapt to the changes in organization and relationships related to the death of their loved one.
140. The expression of grief by individual family members is an added source of stress within the family and can be disruptive.	Families may need help to recognize and tolerate differing grieving patterns of members.

141. Loss of a key family member often results in change in social and/or community status, and thus deprives the person/family of support groups and networks to which they are accustomed.	Persons or families experiencing loss should have assistance available to make the transition to newly defined roles and to re-enter or develop needed support systems.
142. When adult family members are struggling with their own acute grief, they are often incapable of providing adequate support to grieving children.	Attention must be paid to meeting the needs of children in a grieving family when the surviving parent(s) is temporarily unable to provide the required support.
143. Latent or active family problems may surface, intensify, and/or continue and may be further complicated by the death of the family member.	Those caring for family members during bereavement need to have a basic understanding of human behavior, family dynamics, and the psychology of grief and bereavement in order to identify needs. (Also, see #150).

144.	Abrupt termination of important relationships with primary health care personnel after the death of a patient may subject bereaved family members to secondary losses.	Post-death follow-up by primary health care personnel is desirable to provide continuity, although they may not continue as central caregivers.

CAREGIVERS

	Assumptions	Principles
145.	All of us have experienced loss.	As caregivers we are responsible for attending to the continuing task of recognizing and integrating our personal losses.
146.	Working with the bereaved may reawaken feelings associated with former losses and may also engender new loss.	Caregivers must be sensitive to interrelationships between their personal lives and their work with the bereaved. Responsibility for perceiving and resolving loss belongs both to the individuals and to their work community.
147.	Ongoing involvement with the bereaved may lead to stress for caregivers and may result in burnout.	The issue of staff stress must be addressed with provisions made for emotional support and clinical supervision. This is a joint responsibility of the individual and organization.

148.	Loss and grief are universal experiences which may be manifested differently.	Multidisciplinary and cross-cultural interchange should be included in training.
149.	Not all bereaved persons require the services of professional caregivers.	The development of programs to select, train, and support lay caregivers is a responsibility of the professional.
150.	Caregivers have disparate levels of preparation and endurance, and different areas of prejudice.	Caregivers need to recognize their limitations and make referrals when the demands of caregiving exceed their expertise and resources.

COMMUNITY PROGRAM

	Assumptions	Principles
151.	Important supportive relationships for the bereaved already exist in family, religious, and social networks.	Professional caregivers are not lone helpers and need to see themselves as part of a larger group of lay and professional providers of support.
152.	In some communities, agencies exist which work capably with the bereaved.	Where effective care exists, services should not be duplicated.

153.	The community at large has limited education regarding bereavement.	Effective educational programs should be available to all persons in the community.
154.	Bereavement care can be financially expensive.	Bereavement care should be delivered as effectively and as economically as possible.
155.	Elements of duality, exclusion, ageism, sexism, and racism exist within our society.	Regardless of age, race, sex, socio-economic status, educational level, or chosen lifestyle, all persons should have bereavement support readily available.

RESEARCH

	Assumptions	Principles
156.	There is much to learn about grief and bereavement, the needs of those who grieve, and appropriate response.	There is a need to increase research, evaluation, analysis, and synthesis in this field.

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