
Chapter 6

DEATH NOTIFICATIONS

The Most Difficult Task

Three Stages of Grief: Impact, Recoil, and Recovery

1st Stage: IMPACT - Understanding grief and grief response

The initial reaction to death is that of the Impact stage. This phase is characterized by numbed, stunned and shocked feelings. The person is unable to come to grips with what has happened; he feels suspended from life. Usually the bereaved experience a restricted field of attention and are indifferent to their immediate needs. Often there is denial and a refusal to believe that the deceased is gone. Generally the person is not in touch with his own emotions. There is often somatic distress such as choking, shortness of breath, sighing, weakness and poor digestion.

The impact stage has often been described as feeling like you have just been slugged in the stomach. It is a period of maximum stress, where normal coping mechanisms don't seem to work. Our bodies and minds often attempt to deal with this overwhelming event by shutting down. It is almost as if our mind creates a wall or a cushion to allow time to deal with the blow. The time orientation of the bereaved is the immediate present. The victim is temporarily cut off from both his past and his future and can only deal with the present. This stage varies in length from a few minutes to a few hours. On rare occasions, this stage may last a month or even 6 months or more.

2nd Stage: RECOIL – Anger, protest, bitterness, feelings of guilt

One thing that marks the beginning of the Recoil Stage is an acceptance of the fact that the person is gone. Whereas during the Impact Stage the victim often will express denial, during the Recoil Stage, their language will change. They will begin talking about their loved one in a past tense rather than a present tense (i.e., they will say such things as “Johnny used to love...”, or “Mary would talk about...” instead of “Johnny love to...” or “Mary talks about...”).

When the initial shock and numbness of the impact phase begins to lift, the person experiences the first awareness of what has happened. Now the loss is felt most acutely and the bereaved feels restless, tense, and in turmoil. Now the first overt expression of emotion occurs. Anger, protest, restless irritability, irrational feelings, sometimes bitterness both toward others and at one's self. Guilt may also be expressed. There is usually also a need to talk and ventilate. During this stage there will be acute periods of loneliness and often times a childlike attitude of dependency, wanting to be cared for and looked after.

This is the time when there is an intense yearning and urges to recover the deceased. This manifests itself in many ways: preoccupation with thoughts of the deceased, a clear visual memory of the deceased, a sense of the presence of the deceased, calling and crying for the lost person, and even a conscious recognition of this urge to search for the deceased by going to his/her grave or places where he/she had been. Usually during this phase the bereaved will need to be with others and to have a stable, supporting environment. However, they are reluctant to request other's help. Therefore, the initiative to have people near them will usually have to be on the part of others. It is very easy to remain at the recoil stage, to become fixated here. Furthermore, this is a

very crucial period and the response of other persons is of critical significance for the bereaved person's future.

The time orientation or perspective now includes the past, present and future. This phase usually begins a month to a year after the death, and can last for the remainder of the bereaved person's life. It is not uncommon for the Recovery State to start as late as five years after a loss. It is helpful for the Chaplain to share with the victim that they will never get back to the same as before the death of their loved one. They will eventually get a "new normal". You can also share that there is no time limit on grieving. Just because there is a funeral, this does not mean they now have closure; they are not "just over it" Remember, grieving is a process.

Indicators of the Recoil Stage:

- If I could, I would
- Loneliness
- How will I go on?
- Assist survivor with a need to go on
- They will have a yearning for deceased not to be dead
- You cannot recover from grief until you are in a past tense process: called closure: He was; instead of he is.
- Could be preoccupation of the person calling the deceased
- Searching for deceased will happen
- Desire to be with others, relatives, friends, neighbors
- How we react is how the survivor will react!
- Be positive, in a negative response
- Shift from present tense to past tense

3rd Stage: RECOVERY – I have to go on!

This phase of the grief response entails getting back to normal in so far as that is possible. The person begins to feel the stress is passed and has come to face the matters of everyday living in the new environment without the deceased. The permanence and fact of the loss are accepted, and the attempts to recover the deceased are given up. The bereaved now has to develop a new set of functioning roles which involves letting go of the past and the building of a new life.

Some of the tasks included in building this new life are as follows:

- A. Learning to be alone.
- B. Finding a meaningful social and emotional life.
- C. Being the head of the household, breadwinner, both mother and father to the children and learning the role of the single parent.
- D. Facing the issue of remarriage.

Often times the bereaved will be in need of both vocational counseling and advice as to financial management. There may also be feelings of temporary anxiety, fatigue, and or depressive reactions.

The time orientation or perspective now includes the past, present and future. This phase may begin within three months to a year after the death, and last for the remainder of the bereaved person's life.

Indicators or Statements of someone in the Recovery Stage:

- I now must develop a new set of functioning rolls
- Realizes that life will go on
- Set up new social life

- Be both father & mother
- Facing issues that I am going to be alone the rest of my life
- May need: counseling- psychological, financial, and spiritual
- Anxiety; fatigue; stress
- Pulling together the past, present, and future
- No more denial is evident

Death

Death is the end of life, but death cannot sever the bond established between the living and the dead. Love still exists. Precious memories and cherished experiences can never be taken from us. Ask the grieving what the deceased meant to them, or ask them to share some memories they have of the deceased. Whether the deceased is a long-time friend or a recent acquaintance, the emotions are the same.

Loss

Experiencing death is a realization that there is something beyond yourself and your own life. We experience loss, and loss hurts. Because people tend to want to “fix” things or “make things better”, they say things that are more hurtful than helpful. Don’t ever say, “I know how you feel.” Even if you have experienced death, you don’t know EXACTLY how they feel. If you don’t know their feelings, don’t say you do. We can empathize with their pain – we can say we know pain and pain hurts.

Ask them to share their feelings with you. Emptiness and loneliness can overwhelm someone who loses a close friend or family member. That loss may invoke feelings of fear or fright. The relationship is gone, it is over. The loss in death is permanent.

Grief / Mourning

Grief is the pain of loss. It can be overwhelming. It cannot be contained and can tear us apart. Grief is a collection of emotions which include anger, disbelief, sadness, and loss. Grief is the single most powerful emotion we will ever face.

Grief shared is grief relief. When grief is bottled up, it can cause ulcers or other stress-related conditions. Grief is also the realization that we all will die. Refusing to accept what is inevitable is not uncommon for someone who is grieving

Crying helps us mend and caring for someone or something else helps us mend. There is a close connection for people who have pets and the healing process. The life expectancy of a pet is often short and this loss can help someone work through death.

Mourning is a process of healing. It lasts until you get your sense back about yourself. It cannot be rushed, healing takes time and mourning helps sooth the pain.

Everyone who dies has a relationship with someone that affects someone else. Those who make death notifications will be affected.

The Psychological Autopsy (What do we do with it? Where do we file it?)

All deaths fit into one of four categories: Natural, Accident, Suicide, and Homicide.

Imputed Lethality

How much of a role did the deceased have in his own death?

High Lethality:	He planned it.
Moderate Lethality:	He was in a position to die. (Motorcycle going to fast, jumping on a train, driving a car too fast without seat belts, careless and risky.)
Low Lethality:	Forgot safety factors. A mistake, stupid, caused his own death.
Absent Lethality:	Person really wanted to live. Failure on inside that caused his death. Failure on the outside that caused his death.
Additional factors:	Age, Sex, Family Status. Example: 79 year old smoker, kids live across Town, natural death, Coroners case, 911 <i>Versus</i> 11 year old girl, assaulted and murdered, 911. We have different feelings for the girl than we did for the old man. (Natural vs. Homicide) Absent Lethality

Example: 21 year old man/boy, motorcycle 130 mph, crash into car, 911. We deal differently with this type of death. (Accidental) Moderate Lethality

Example: 19 year old girl takes pills after loss of boyfriend. (Suicide) High Lethality

We pigeon hole death notifications. By performing a psychological autopsy we file it away and react to the death differently based on the level of lethality.

Transference

Scenario: 33 year old dead female. Who is the woman?

Scenario: 18 month old dead baby. Who is the baby?

Transference makes the scenario belong to the Chaplain. They (Chaplain) take ownership of the emotions and grief. The victim's loss becomes the Chaplain's loss. Without a support system that allows the Chaplain to defuse or debrief after a death notification, transference becomes more likely. Purging the scenario through defusing or debriefing lowers the impact of transference on the Chaplain. Without an outlet to defuse/debrief, the impact of transference on a Chaplain, just like an officer, will lead the person down the path towards cynicism. Cynicism can be the result of a career involving too much transference.

Impact on Survivors

Is anyone ready? Never!

The impact of a death on the survivors can be influenced by several contributing factors. These include how the notification was handled, what kind of support system is in place for the family member, and what information was made available at the time of notification. However, even in the "best" of scenarios where there is little lethality, the notification is handled "picture perfect" and the survivor is surrounded with caring support – none of this can truly prepare someone for the loss of a loved one. As a Chaplain, how we feel, think, and act can help or hinder the survivor's reaction.

As a Chaplain, be on the lookout for the signs of Acute Critical Incident Stress. This might be things like: agitation, denial, feeling numb, repetitive or intrusive thoughts, sleep disturbance (can't go to sleep, wake up in the middle of the night, violent nightmares), graphic remembrances of the event, emotional flat line, fear of losing control, guilt, quick to anger, compulsive behavior, etc. Acute Critical Incident Stress (ACIS) if not adequately handled will often lead to Post Traumatic Stress Disorder (PTSD).

MOST COMMON REACTIONS

Reactions fall into one of three areas, Cognitive, Emotional, or Physical. A person can react in any one of these areas or a combination of them. Common reactions include:

- Having trouble concentrating or making decisions
- Confusion
- Anger
- Hostility
- Feeling alone: uncomfortable in social places
- Flash backs: intrusive thoughts
- Fearing familiar things
- Wondering, how will I survive?
- Numbness: a lack of interest to go on
- Guilty: I wish I had...
- No one understands
- Lowered energy: causing a slow down
- Irritated, annoyed
- Tense, keyed-up
- Easily hurt
- Over Imagining
- Closure, understanding it is real, reality settles in
- Mind racing, repeating and thinking that same thought
- Emotionally empty, going through the motions
- Wishing others would take care of you
- Sleeplessness
- A feeling of being taken advantage of
- Vulnerable
- Over thinking decisions
- Transference: anniversaries, birthdays, holidays – It is a well known fact that anniversaries, birthdays, holidays, etc. bring back the loss in vivid detail. This is especially true of the first and second years after a death (often times the second year is actually worse than the first year). Transference can refer to the emotions that are attached to each of these anniversaries or holidays, so for example, they can no longer enjoy Christmas because it reminds them of their loss.
- Angry for not accomplishing more, why didn't I do...
- Displacement

Three Rules to Live By

- A. If you can't improve on silence, don't!
- B. If you can't improve the conditions in the home when you get there, then don't go in. (If you cannot bring peace and comfort to a chaotic situation because you are emotionally charged up, you will make the situation worse. We have often seen where we have a situation calmed down and an emotional person arrives – and blows everything up.)
- C. Use soft words in your vocabulary: splendid, lovely, wonderful, beautiful. Soft words can draw a person into seeing things differently. Especially when working with officers who see the negatives of society; they don't tend to see the beauty in things because they are often looking for the negative.

Duration of Distress

In the United States, we have a tendency to avoid topics like death and dying. This inability to talk about death in a “healthy” way increases the stress level of those around a survivor. The survivor’s level of *distress* and the amount of time the survivor feels distressed, is greatly reduced when they have contact with others close to them, whether they are family or close friends. This support system may include the survivor’s spouse, mother, father, sister, brother, grandparent, or other close relative. If a person does not have family or friends close by, it will be important for them to get connected with a local support group or bereavement group.

Be careful not to say, “You will heal in time”, or other sentiments. Time is NOT a healer, although it helps. Encourage the survivor to return to “pre-event” behavior, assisting them in doing things they did before the death.

Routines are helpful in establishing a sense of order or control in a situation which is completely out of their control. Examples of this include: Taking a daily nap (at the same time each day), or taking the dog out for a walk (could be every morning at 9:00 and every afternoon at 4:30).

SUPPORT THAT HELPS

When working with victims who show strong signs of “being in control”, several practices or support policies are often helpful. This is especially true if the loss is in a law enforcement family. These support practices include:

- Action Oriented Assistance: Officers tend to be action orientated. Is there something they can do to help? Give them tasks to do.
- “Need to Know” actually means, “Help me do what is next”.
- Psychological and emotional support assistance: CISM, Chaplain Service, professional counseling, etc.
- Conformation Information: Means giving everyone the same information. This is especially important in a line of duty death. There should be a phone tree to all off duty officers to make sure they have all the current information as to the death and what is going on.
- Command Level Contact: Means the Chief is in briefings, with the family, and generally showing his support. This is very important at such times as a line of duty death.
- Pastor, mortuary: Make sure those involved (Pastor, Mortuary, Caterer, etc.) know and understand the details with regards to services and upcoming “events”.

OVERCOMING GRIEF

- A. Take time to accept death, we can't deny it.
- B. Take time to let go: Letting go indicates that we are not in control of life.
- C. Take time to make decisions.
- D. Take time to share
 1. Loss of parents, grieve for our past.
 2. Loss of spouse, grieve for our present.
 3. Loss of a child, grieve for our future.
- E. Take time to believe: There is a difference between fact and faith. Faith works because it is totally illogical. (It is 28 – 0 in the last of the fourth quarter. Faith says “we can win”. Facts would say “it is impossible”).
- F. Take time to FORGIVE: Non-forgiveness is a bitterness. It traps people in their past. Forgiveness is not pardon but it helps in looking at things differently.
- G. Take time to feel good about your self.
- H. Take time to laugh: laughter in humor is medicine. A merry heart makes like a medicine.
- I. Take time to meet new friends.
- J. Take time to give your time, energy, or effort. Getting involved makes life go on.

DEATH NOTIFICATIONS (IN PERSON ONLY)

(Suggestions/Recommendations)

Pre-Notification

- Correct Information: Verify deceased and family information. Who, what, when, how it happened, Next of kin or family information. Make sure information is correct.
- Pre-event conditions of family (stability, if known): health, kids, neighbors/friends.
- Two person detail / Parking / Time of Day: Always go in with an officer to do the notification. NEVER go by yourself. The officer is your protection. Remember, no situation is “typical”. Park down the road or street, not right in front of the residence. Regardless of the time of day or night, never park right in front.
- Determine, before you go in the house, who will be giving the notification. If comfortable, offer to give the notification. If the officer would prefer to give it, be there as his/her support. It is their call – we are their support. If they are non-committal or ask you if you are willing – take the hint. They'd probably rather have you give the notification.

The Notification

- Knock and introduce yourself and the officer. Get in! Do not give notification at the door or outside. Access the room conditions.
- Get into a soft room: living room, family room, somewhere with soft chairs. Steer the person to a chair where their knees are above their hips – this prevents them from jumping up when the notification is given. It is not uncommon for a person to jump up and start swinging as a reaction to receiving very bad news.
- Ask if there are other people in the home – so you can tell everyone in the house at the same time.
- Use direct words that are understandable, dead, killed, died, etc. Do not use words like fatality, fatal accident, tragic accident – too much is left for interpretation and you don't want to explain yourself a second time. Say things like, “We are here to tell you that Phillip is dead”, or “Phillip was killed in an auto accident on Highway 65”.
- Expect the un-expectable – reactions are not predictable.

- Offer limited facts only. ABSOLUTELY NO OPINIONS. Avoid saying, “I don’t know”. Rather say, “I will find out” or “an investigation is taking place, they’ll know more later”. Absolute honesty is not always the best way to handle things. There are some things they just don’t need to know.
- Be Specific, but tactful. This is not the time for jargon. Use soft, simple, and clear language.
- Offer empathy (ability to share in their feelings), not sympathy (often perceived as pity when coming from a stranger). Unless you know them, people do not want sympathy from strangers.
- Do not give reason for false hopes – that is actually cruel.
- Help move them towards closure. “What did he/she like to do?” – help them think in past tense, but don’t force it.
- Quiet moment? Don’t try to fill the quiet moments. When you cannot improve on silence, don’t!

Next Steps

- Don’t be in a hurry to get out of there. If you have other commitments, ask the ECO DISPATCHER to send a back-up.
- Make phone calls, get someone else there to help. Don’t leave them alone – even if they request it.
- What types of support systems are available to them? (Pastor/Priest/ Rabbi, relative/children, neighbors)
- What else can you do?
- Have you shared with them the burial process? Do they know what the deceased would have wanted, burial or cremation?
- Inform them that they don’t have to make immediate decisions about the funeral, etc. It is usually best to make these decisions with the help of a close friend or relative. If no one is available, a Chaplain may be able to help with making arrangements, including going to the mortuary as a support person.

Epilogue Clichés – Things people despise hearing:

- Be strong for your children.
- You’ve got to get a hold of yourself.
- It’s nature’s way or God’s will.
- Buck up.
- You’re young; you’ll make a life for yourself.
- Time will heal all this.
- Look around you’re not the only one going through this.
- You need to stop reliving the past.
- Only the good die young.
- You need to count your blessings.
- Think of your precious memories.
- God needed Him more than you did.
- He’s happy now that he’s with God.
- I know how you feel.
- If there’s anything you need just call.
- What you don’t know won’t hurt you.
- Well you have 2 other children.
- You can have more children.

GRIEF INTERVENTIONS

The process of grief, as identified by Kubler-Ross, includes five stages: Denial, Anger, Bargaining, Depression and Acceptance. When dealing with those in grief, our intervention should include allowing the expression of feelings, responding with empathy, and prayer, if desired by griever(s). If prayer is desired, offer to pray with them at that moment. Be careful not to force yourself to be a theological “expert”.

Effective grief intervention is understanding there are a variety of reactions to grief and recognition of the importance of grief work (and it is work). If appropriate, arrange for follow-up with the person or refer them to resources that can assist them as they work through their grief. Most importantly, remember this is a ministry of presence.

Article~

Grief Knowledge

No amount of knowledge can prepare us for bereavement. Grief is the most intense and enduring emotion we can experience. No quick fix. No short cut. An ancient African saying is, “There is no way out of the desert except through it.” Knowledge of the grief process gives us a very generalized map of the terrain we have to cover. Each of us will take a different route. Each will choose his own landmarks. He will travel at his own unique speed and will navigate using the tools provided by his culture, experience, and faith. In the end, he will be forever changed by his journey.

Knowledge helps us avoid the major pitfalls of grief. A knowledge of what is known of grief assures us that we have not lost all sense of sanity. When we find ourselves feeling befuddled in a mist shrouded swamp we can say “It’s okay. This too is a part of my journey. Others have gone this way before me and I will survive. I am human”.

The following is an excerpt from an article by Reverend Howard R. Gorle, M.Div from Hospice.Net. Copyright 1996, National Hospice Organization, Arlington Virginia. All rights reserved. Used by permission. (www.hospicenet.org/htm/knowledge.html)

Article~

STRAIGHT TALK ABOUT GRIEF INTERVENTION
Suicide – Last year my father killed himself with a handgun.

When you spoke of how "invasive" your presence seems to a family, I remembered wanting to strike the officer who barred my way into my father's room. I immediately hated him, and resented his presence. One of my sisters used language (to an officer) I'd never heard come out of her mouth before! We actually laughed about it later, but at the time, the violent feelings brought on by fear and shock was over-whelming!

Not long after, I saw one of the officers at a restaurant. It may have been purely coincidence, but at the moment of recognition, it seemed he, either out of respect for my privacy or his (or in fear of my wrath!) moved to another area of the restaurant. I wanted to speak to him, but the lump in my throat prevented me from saying:

- ☞ Thank you for being there.*
- ☞ Thank you for doing your job professionally, sensitively, and with obvious care and concern.*
- ☞ In that long wait for Homicide to arrive, and then do their job, thank you for behaving in a respectful manner.*
- ☞ Thank you for refraining from "small talk" with each other about sports, or cracking jokes to offset your discomfort and awkwardness in the face of our pain.*
- ☞ Thank you for your honesty and patience in answering questions again, and again, and again.*
- ☞ Thank you for your gentleness in handling my father's body. I noticed.*
- ☞ Thank you for pausing to let me touch the wrapped and covered remains of what I knew for a lifetime as flesh of my flesh - my father.*
- ☞ Thank you for cleaning up as much as you could in Dad's room. We could tell that you had made a real effort to make things as easy on us as possible. (We are not allowed as chaplains to clean up blood or other body fluids)*
- ☞ Thank you for treating each of us with respect and concern.*
- ☞ Thank you for not avoiding eye contact with us.*
- ☞ Thank you for seeming to give us private moments as family members arrived, even though I knew you had to observe each one of us.*
- ☞ I remember the Homicide sergeant giving us his telephone number and offering to answer any ongoing questions. He respected my need for detailed answers, which others in my family didn't require. He was gentle and patient, and at the same time direct and painfully honest. He also told me clearly how to get a copy of the police report, how long it would take for the autopsy report to be prepared, and exactly what to expect and how to proceed.*

As I anticipate the "year-anniversary" of my dad's suicide, I can look back and remember the support I have personally received.

Article~

HANDLING DIFFICULT GRIEF CRISES

Earl Grollman

Each death is different. When a parent dies, one loses the past. When a spouse dies, one loses the present. When a child dies, one loses the future. Even though grief is a common human experience, it is as individual as fingerprints-it shows itself in widely differing ways.

The following are some guidelines for the sorts of death experience that are encountered infrequently-where information may be scant. To be effective as clergy persons, we must be aware of all kinds of loss, the frequent as well as the less common incidences of death: loss of a newborn, sudden infant death, a death that was unanticipated, suicide, and the special feelings of the clergy person-so well acquainted with grief-when a loved one of his own has died. There are sources of help to assist the bereaved in coping with grief and loneliness and provide for continuing reassurance and understanding. People differ more widely in their reactions to death than they do to any other human experience. There is no magical procedure that will comfort all people, either at the time of death or during the period that follows.

The problem is not that the clergy person will not always succeed in grief counseling. The tragedy is that the clergy person may not be well-informed and at least attempt to do his or her best to help people in times of crisis. As Mark Twain said: "It's not what people know that gets them into trouble; but it's what they know that isn't so."

People differ more widely in their reaction to death than they do to any other human experience.

While bereavement and grief are the most universal of all human experience and the most human - they are also the most painful. Information is not adequate if it remains with the clergy person alone. Those insights must be shared in a non-threatening way to help make the agonizing period less stressful and less frightening. Then survivors will not be caught unaware and unprepared for their often bizarre but rarely spoken of sensations, thoughts, and behavioral changes. They need to understand that these changes are normal in the face of the very unusual and traumatic death in their family. And don't forget: just being with the bereaved is often more important than what you say.

LIVING WITH NEWBORN DEATH

How often do newborns die?

Within the first 28 days of life, approximately 35,000 newborn infants die in this country every year. In addition, 33,000 fetal deaths or stillbirths occur after the 20th week of pregnancy. Taken together, these 68,000 deaths add up to one death every seven minutes. The cold statistic translates into an enormous collection of human suffering for surviving parents, siblings, and the greater circle of family and friends. A child's death is no longer in the ordinary order of events. We expect older people to die-but not young babies. It doesn't seem fair before they have had a chance to live.

What about stillbirths?

Stillbirths occur in about one in 80 deliveries. After the birth and death, there is usually a conspiracy of silence. Parents are rarely encouraged to see and touch the dead body. Frequently, the baby is not given a name and the mother is quickly discharged - as if nothing had occurred. Rituals and rite of passage are seldom offered. The funeral (if there is one) is open private, without the mother and sometimes without the father being present. Most health professionals do little or no follow-up. Still birth is a non-event. It is as if the mother never carried her child. As if the father had no hopes and aspirations. There is no communication about the misery, the guilt, the shame, the failure.

What can the clergy person do in this tragic climate?

First, help the family to face reality. The child is dead. And no matter how brief the life, there are deep emotional attachments. The parents desperately need to cope and respond to their loss. How hard it is to grieve the death of a dream! Help the family make their baby-and their loss-more real with something tangible to hold on to-a hospital bracelet, a lock of hair, photographs, birth and death notices. These reminders dramatize the fact that a profound event indeed touched their lives, ever so swiftly. Let parents mourn a reality, not an illusion.

If the parents desire, let them view and touch their dead child. Too often, the infant is rushed from the mother to a special (care) unit, never to be seen again. Many parents who have had the opportunity to hold their child have remarked how therapeutic this touching had been. "Now I know my child lived. I am better able to accept that he died." This is true even when the infant is physically deformed. Beauty is in the eyes of the beholder.

As options are offered to the family, describe in advance the child's appearance, explain that the body is cold. We may offer our support by saying: "If you want, I'll stay with you. Tell me what's best for you." Understand that funerals are not solely for people who have lived a long while. The importance of funeral rituals for infant deaths has been emphasized by Dr. D. Gary Benfield, Director of the Regional Neonatal Intensive Care Unit, Children's Hospital Medical Center of Akron and Jane A. Nichols, Bereavement Consultant. They afford both closure and relief.

SUDDEN INFANT DEATH SYNDROME (CRIB DEATH)

Is there a typical history?

There is no classical case. Both rich and poor, white, black, and yellow are the victims. SIDS is not preventable no predictable. The infant is usually put to bed after a feeding without any suspicion that something is out of the ordinary. Sometime later, a few minutes, several hours or the following morning, whenever the parents next check on the baby, the infant is found lifeless. There is no outcry, no struggle. The infant may be lying face up or face down in the crib. Occasionally, there is a pinkish froth coming from the nose, or a spot of blood on the bed. The face and remainder of the body may bear bluish-purple discolorations which may appear to be bruises. These are normal post-mortem changes and should not be mistaken for injuries.

"What did I do wrong?" "Was it my fault?" "Why didn't I detect that there was something wrong with my child?"

Lola Redford, wife of actor Robert Redford, tells how guilty they both felt after their first born died in his crib. "I had this notion that when you come from strong Mormon stock, you just don't have children who die." She also spoke of not being willing to hire a babysitter for her two subsequent children, of spending all her energy "guarding" them. For almost nine years, I gave those children my undivided 100% neurotic attention. I was so afraid they would die."

Some parents believe that they accidentally killed their child by allowing the infant to suffocate in the bedclothes or choke on regurgitated milk. There is no basis to believe this is true.

How about the grandparents?

Grandparents are often unaware of the mysterious, sudden, unexpected death called SIDS. They may believe that the tragedy could have been averted by some action of their children such as a more proper diet or closer observation during a virus. Worst of all, they may believe the baby died because of some omission or neglect. Grand parents need continual reassurances that the cause of the disease remains unknown and that the parents did not cause nor could they have prevented this crashing, bitter disappointment.

Grandparents often take charge of the funeral arrangements. After all, they are older and more experienced in the sad preparations for death. The clergy person might have well to say: "I know that you, too, are going through an ordeal. But you know of course, that your children are the ones who feel the loss most keenly. Perhaps it would be better for your children to come to their own decisions about what is best for them!"

What can the clergy person do to help the family?

Tell them that SIDS occurs in apparently healthy, normal, thriving babies who have received the most skillful and loving care. The death does not reflect in any way on the ability of the parents to care for their children SIDS is not suffocation or pneumonia. They did nothing to cause death

Should there be an autopsy?

Usually the examination reveals no disease sufficient to account for death. In approximately fifteen percent of the cases, however, post-mortem examination exposes a previously unsuspected abnormality or rapidly fatal infectious disease. This is one of the reasons autopsy on these infants is so important.

Did my child suffer?

Explain to the family that evidence underscores the point that the infant was not in pain. In most cases, death is sudden, almost instantaneous. There are examples when the child "just stopped breathing" in the arms of the parent. The adults report a sense of peacefulness and quietude.

SIDS Questionnaire

In California there is an extensive multi-page questionnaire that the law enforcement officer must complete by talking with the family. You as chaplain will find it helpful to let the family know that the officer needs their help with this task. The extensive questions are not to cast blame on the parents or family but rather to aide in future research to prevent SIDS in the future.

DEATH BY SUICIDEWhat is the incidence of suicide?

Once every minute, someone attempts to kill himself or herself with conscious intent. Sixty or seventy times a day these attempts succeed. In America, the problem has reached somewhere between twenty-two and twenty-five thousand annually or one suicide every twenty-six minutes.

Who would dare destroy something so precious as life?

Almost everybody at one time or another contemplates suicide. Death is one of the choices open to human beings. Suicide has been known in all times and committed by all manner of people, from Saul, Sappho, and Seneca to Virginia Woolf, James Forrestall, Marilyn Monroe, and Ernest Hemingway. Every person is a potential suicide.

How is suicide different from other death?

Of course, natural death has its share of emotional overtones: Loneliness, disbelief, heartache, and torment. With self-inflicted death, the emotions are intensified to unbelievable and unbearable proportions. Those left behind experience not only pain of separation but aggravated feelings of guilt, shame, and self-blame.

The act of self-destruction raises the obvious questions, "Why?" and "What could I have done to prevent it?" Suicide is an irrational act and often we cannot understand or find out WHY. Anxious and grief-stricken, the survivors ask, "How can I face my friends? What will they think of me?" Death by suicide is the greatest of all affronts to those who remain. Special counseling skills are needed to cope with the runaway emotions of the bereaved. Suicide stigmatizes not only the victim but the survivors as well.

As a clergy person, can I suggest a public funeral? Wouldn't this run contrary to religious beliefs? Not Necessarily!

Suicide is taboo. Theology and customs are changing. Suicide is an irrational act. Suicide victims were not in there right mind. A loving God loves us unconditionally no matter what we have done. Our Lord offers us his "Amazing Grace" and healing power. Funerals and services of worship are not for the dead, but rather for those who are

grieving and who remain. It is still appropriate to celebrate the life of the suicide victim and to affirm our faith in the future.

Shouldn't the funeral be private?

It is understandable that when the survivors hear the shocking news their first impulse is to hold the funeral as quickly as possible. After all, there is an aura of shame and dishonor. As a result, a private service may be contemplated for the immediate family only.

However, no matter how great the humiliation the relatives cannot hide from the bitter truth. No one can run away from pain. A private funeral seems to say that because the family is unable to bear the disgrace they want to keep it "secret." The mourners overlook one important fact: When given the opportunity, friends can be of inestimable value. The funeral, where no one is invited but all may attend, affords a sharing occasion for supportive love at a time when it is so desperately needed. One person is no person. The solitary heart must throb with the caring heart of others.

Many people who themselves have experienced the death of a loved one have developed tremendous gifts of insight. They understand the value of sharing. They may help the bereaved to reach out of their isolation to an important support system. Fellow sufferers often become second families to each other. Some helpful organizations include:

- ☞ Candelighters, 123 c Street, Southeast, Washington, D.C. 20003. This is an international organization of parents whose children have cancer or died from this disease.*
- ☞ Compassionate Friends, P.O. Box 1347, Oak Brook, Illinois 60521. A support group for bereaved parents who "need not walk alone."*
- ☞ Sudden Infant Death Syndrome Foundation, 8240 Professional Place, Landover, MD 20785. The group intervenes on behalf of stricken parents of SIDS or "crib death" with professional counseling services for adults and children.*
- ☞ Widowed-to-Widowed Program. Begun at the Laboratory of Community Psychiatry, Harvard Medical School, 58 Feinwood Rd., Massachusetts 02115. There are hundreds of these organizations throughout the United States. They bring together the widow and widower in fellowship and help them find a new way of life.*
- ☞ Parents without Partners, 7910 Woodmont Avenue, Washington, D.C. 20014. A nonsectarian organization with a membership of a hundred thousand in over 700 chapters concerned with the welfare of single parents and their children. It assures them that they are not alone. Their motto is "Sharing by Caring." If such an organization does not exist in your area, the clergy person could be instrumental in its formation.*

SUDDEN INFANT DEATH SYNDROME

A call involving a death especially that of a child will be one of the most difficult calls a First Responder may be expected to handle. Completing this task in an efficient and caring manner may save the family from the additional trauma of repeated interviews. ALL suspicious deaths should be treated/ handled as a homicide until proven otherwise. The goal of this section is to point out the difference between SIDS (Sudden Infant Death Syndrome) deaths and those of child abuse and homicides.

This section has taken into account information from the California Penal Code 13519.3, which mandates instruction of this material. (Revised January 1996)

SIDS Legislation in California

- Senate Bill 1067 – Training First Responders
- Senate Bill 1068 – Training Public Health Nurses
- Senate Bill 1069 – Standardizing Autopsy Protocol
- Senate Bill 1070 – State SIDS Advisory Council

Definition of Sudden Infant Death Syndrome

The sudden and unexpected death of an apparently healthy child or infant which is unexpected by medical history and which a thorough postmortem examination and Death Scene investigation fail to reveal an adequate cause of death.

SIDS babies generally have no history of serious illness. However, two distinguishing factors are related to SIDS: the age of the baby at the time of death, and the baby dies while sleeping.

Autopsies provide no definite cause of death, as there are negative findings in an autopsy, thus making SIDS an exclusionary diagnosis.

SIDS has been studied for years and many theories have been tested. Unfortunately, we come to the same conclusions – there no definite cause is found even though there are only two pathways to death in this situation: respiratory and cardiac.

In continued attempts to find a cause, and thus possibly preventive measures, recent theories have focused on sleep pattern disorders, nervous system disorders, heart irregularities, chemical imbalances, and the responsiveness to acetylcholine chemical or the inability to respond to high levels of carbon dioxide.

Description of the typical baby that Dies of SIDS

Babies tend to be between the age of two weeks and one year with the most common occurrences happening between two and four months. 90% of the deaths caused by SIDS happen before the baby reaches the age of six months. Rarely do we find a toddler (after the age of two) to have died of SIDS.

The loss of a child is difficult even if there is an explanation for the death. However, with SIDS the added stress that parents put themselves through is wondering what they might have done something, anything differently. But in SIDS, typically there is no recent history of an illness so there was no reason to suspect the child would die. It almost always occurs during sleep, and there is no warning to the parent or child care provider. The only fact we do know is that SIDS is more common (3:2 margin) in boys than in girls. But that margin is not great enough to take any comfort in.

Risks and Non-Risk Factors of SIDS

Studies have discovered several common factors that may contribute to an increased possibility of a SIDS-related death. These include: smoking and/or drug abuse by the

mother during pregnancy, multiple births (one of a twin or more), premature birth, and low birth weight.

What we also know is that infant immunizations like DPT and polio vaccines have no correlation to SIDS. Even if a family had a child die of SIDS, the risk factor is no higher for a second child to be more prone to die of SIDS. Race is not an issue nor are periods of apnea.

Physical Signs of SIDS

Facts Surrounding the Incident

When a first responder or law enforcement officer is called to an infant death, they will immediately look for signs of foul play – it is their job. In a SIDS case, however, there are no physical signs to observe, there is no evidence of trauma, the child appears well nourished, and, there is no swelling (edema). There may be blood tinged sputum, they may have had a bowel/bladder movement as part of the terminal event, there may be frothy drainage from the mouth, and diaper rash looks more severe.

Generally, due to the size of the infant, the cooling (rigor mortis) takes place quickly (3 hours) – post mortem lividity. Lastly, first responders and law enforcement will meet with other siblings to ensure they appear normal and healthy. Again, this is routine in an investigation of SIDS.

Differentiating SIDS from Child Abuse or Neglect

SIDS	CHILD ABUSE / NEGLECT
7,000 – 10,000 deaths annually	1,000 – 4,000 deaths annually
Highest between 2-4 months of age	300 deaths per year in infants
More prevalent in winter (Nov-Mar)	No Seasonal differences
Physical appearance (see above)	Physical appearance – there are distinguishable and visible signs of injury like: Broken bones, bruises, burns, cuts, head trauma, scars, welts, may show signs of obvious malnutrition (thin). Other siblings may show signs/ patterns of injuries commonly seen in child abuse and neglect
Initially suspect SIDS if all the above characteristics are present and the parents state the child was well and healthy when put to bed.	May initially suspect child abuse/neglect if all of the above characteristics and the parent’s (child care provider) story does not or cannot account for all the injuries to the infant.

The Grieving Process for SIDS – related deaths

Shock/ Disbelief

- No known reason to suspect death.

- No known cause of death.
- Reactions of parents at the time of death may vary according to each person's coping or managing severe, acute, stressful situations based on prior history and social/cultural norms.
- Most parents' feel there must have been some way to prevent the event from occurring.

Numbness

- Goes through motions of daily living.
- Cannot distract parent from hurt.
- Fear for safety of other family members.

Psychosomatic symptoms of illness may develop with other signs of prolonged stress.

Release of grief and guilt

- May not give into the need to release anger and guilt (through crying, etc.) for weeks or months.
- Parent at this point needs to talk it out.
- Men and women often grieve differently which can lead/cause communication breakdowns between couples.

Dealing with reality and fantasy

- Begin to accept death as being unchangeable.
- Realize only they can pull themselves out of the pit of despair.
- Begin to think about subsequent children, job outside home, or perhaps work with local S.I.D.S. parent group(s).

Dealing with memories

- About a year later, relief periods of not thinking about baby begin to grow longer.
- More able to talk objectively about their personal grief and death of infant.
- Will be moments of relapse.

Becoming a new person

- Suffering strengthens and changes a person.
- Hopefully change is not crippling.
- Not how fast, but how well person mends.

WHEN SIDS HAPPENS

- Baby found non-responsive, not breathing
- Call to 911 by responsible party
- EMS, fire and /or police respond
- Decision is made to institute or continue basic life support resuscitation efforts in accordance with local EMS agency policies.
- Death Scene Investigation
- Decision is made about transporting baby (hospital)
- Baby is pronounced dead by Physician
- Family informed of death
- Chaplain Notified
- Coroner is notified / responds to the hospital

SUPPORT OF PARENTS/CAREGIVERS – COMMUNICATION TECHNIQUES

- Use a calm and directive voice

- Be clear in instructions to those present
- Provide explanations to the parents or caregivers about treatment and transport
- Reassure parents or caregivers that there was nothing they could have done
- Allow a parent or caregiver to accompany the baby, if the situation permits (get approval from deputy/coroner before offering the option)
- Be Sincere
- Be supportive
- Be open minded
- Do not interrogate
- Be a good listener
- Be a good observer
- Allow family to talk
- Do not be afraid to show emotion

FACTS SURROUNDING INCIDENT

The deputy will elicit a brief history at scene, if time permits. The Chaplain should be aware of the procedure but would not be asking questions. When you do have an opportunity to interact with the family, refrain from asking judgmental questions. Focus on non-leading and open-ended questions, which include:

- What happened?
- Who found the infant and where?
- What did he or she do?
- Had the infant been moved?
- What time was the infant last seen alive?
- How was the infant that day?
- Had the infant been sick?

Perform an environmental check and document findings:

- Observe the location of the infant upon arrival, in the crib or bed, floor, etc.
- Observe for the presence of objects in the original area in which the infant was found.
- Observe any unusual conditions such as high room temperature or odors in the environment.
- Observe presence of medications (take all medications to the hospital, if possible).

Document all findings completely and accurately on the patient care record.

Failure to accurately document findings could result in unnecessary investigations or significant emotional stress to the parents or caregiver or emergency medical responders.

Identify Potential Parent/Caregiver Responses to an Infant Death.

- Responses of parents/caregivers to the sudden and unexpected death of an infant are not predictable. The responses may vary and could include: denial, anger, hysteria, withdrawal, intense guilt, or no visible response.
- The parent/caregiver may or may not accept that the infant is dead.
- The parent/caregiver may make demands of the emergency medical responder which could include:
 - ♦ Repetitive questions.
 - ♦ Request to not initiate care or terminate resuscitation efforts.

- ♦ Request to be alone with the infant.
- ♦ Request for the cause of apparent death.
- ♦ The parent/caregiver may even interfere with appropriate care.

Identify Potential Responses of the Emergency Medical Responder to an Infant Death.

- Response of the emergency medical responder to the sudden and unexpected death of an infant may include the following:
 - ♦ Anger, blame and identification with the parent.
 - ♦ Withdrawal, avoidance of parent/caregiver.
 - ♦ Self-doubt, if the baby does not recover.
 - ♦ Sadness and depression.
- The emergency medical responder may have expectations of how the parent/caregiver should behave and respond:
 - ♦ Expecting tearful and hysterical responses and unable to believe that not every parent/caregiver will initiate CPR.
 - ♦ Unable to accept a parent who has decided the infant is dead and does not want CPR started.
 - ♦ Unfamiliar with the mourning and grief behaviors of different cultures or religious belief.

Identify Ways the Emergency Medical Responders May Prevent, Reduce, or Stop the Critical Incident Stress.

- Acknowledge that stress is an integral part of the job of the emergency medical responder.
- Identify signs and symptoms of stress which may include:
 - ♦ Recurring dreams.
 - ♦ Anger.
 - ♦ Physical illness.
 - ♦ Depression.
 - ♦ Changes in eating and sleeping patterns.
 - ♦ Mood changes.
 - ♦ Inability to concentrate.
 - ♦ Withdrawal.
- Identify strategies for decreasing the impact of stress. These may include:
 - ♦ Exercise, plan leisure time and limit overtime hours.
 - ♦ Get feedback from SIDS parent groups.
 - ♦ Request tape reviews and become educated about stress management and SIDS.
 - ♦ Talk to field supervisors, get adequate rest, eat a balanced diet, write a personal journal and obtain professional, religious or peer counseling.
- Request professional assistance if the particular incident produces a profound emotional reaction. Request Critical Incident Stress Debriefing (CISD), if available.

NOTE: The determination of whether the child is or is not a SIDS victim is the responsibility of the medical examiner or medical coroner. It is NOT the responsibility of the Emergency Medical technician.

The responsibilities of the Coroner and the Local Health Department are noted on the following:

Coroner's Responsibilities

- Performs autopsy
- Death Scene Investigation
- Notifies Local Health Department
- Notifies State SIDS program
- Notifies parents of cause of death
- Signs Death Certificate

Local Health Dept Responsibilities

- Provides information and counseling
- Referral information for peer support.
- Provides information to state program.
- Periodic follow-up.
- Community education with peer group.

REFERRAL AGENCIES

California SIDS Program
(800) 369-SIDS

National SIDS Foundation and Guilds for Infant Survival
GIS (800) 221
SIDS (800) 247-4370

National SIDS Foundation
Two Metro Plaza, Suite 205
8240 Professional Place
Landover, MD. 20785

National SIDS Foundation
10500 Little Patuxent Parkway, Suite #240
Columbia, Maryland 21044
(800) 221-SIDS
(800) 369-SIDS

Guild for Infant Survival, Inc. (Orange County)
P.O. Box 17432
Irvine, California 92713-7432
(714) 474-SIDS

California Association of Public Health Nurses
3701 Branch Center Road
Sacramento, California 95827
(916) 366-2345

Bereavement Network Resources of Sacramento
P.O. Box 660365
Sacramento, California, 95866
(916) 363-3092

Valley-Sierra Chapter the SIDS Alliance
564 La Sierra Drive, Box 78
Sacramento, California 95864

(916) 368-SIDS

Placer County Law Enforcement Chaplaincy
 P.O Box 1111
 Newcastle, CA 95658
 (916) 663-2427

Reference Resources

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LINE-OF-DUTY DEATHS

Article~

Survivor and Department Responses

Frances A. Stillman, Ed.D., Research Director,
 Concerns of Police Survivors
*Introductory comment by James K. Stewart,
 Director of the National Institute of Justice*

Introduction: Officer Brummett was performing a routine traffic stop when a passing car struck and killed him.. For the first 6 months after the incident, his widow refused to accept the fact that her husband had died. After 6 months, she accepted his death but felt emotionally numb and unable to grieve. She said she needed to be "strong" so she would not upset others.

More than 2 years after the accident, Mrs. Brummett remained distressed by her loss. Plagued by nightmares of her husband, she had trouble controlling her thoughts about his death and her consequent problems. She could not concentrate at work and began to drink heavily. She felt alienated from most of her friends and family.

The National Institute of Justice is proud of its efforts in "protecting the protectors" - reducing the risks police officers face on the job. The most dramatic example is the Institute's role in developing lightweight police body armor, which has been credited with saving the lives of more than 700 police officers nationwide.¹

But despite these and other efforts, far too many police officers still are killed in carrying out their sworn duty to protect citizens from criminal attack. Line-of-duty deaths, whether felonious or accidental, are a sad and frequent reminder of the danger inherent in police work. While the loss to the department and the community is serious, each police death leaves family, friends, and coworkers with the emotional trauma of a devastating loss.

There is a bond joining those in the "police family" that is formed by the shared experiences they have faced. A police death hits hard within that family, as others are reminded of their own vulnerability.

Many mistakenly believe that the spouses, children, and parents who survive police deaths are somehow more prepared for their losses than are other people. But knowing that the job can be dangerous does not prepare an individual for the actual experience of losing a loved one. Police survivors often endure prolonged psychological stress because they do not seek help. They are hurt by the misconception that, because they are part of the police community, they should somehow be stronger emotionally and better prepared for such a tragedy.

¹ Updated statistic: Between 1975 and 1999, 1,800 law enforcement officers have been killed in the line of duty. Since that same time, 2,400 officer's lives have been saved due to the use of police body armor. That is an average of 72 law enforcement officers killed annually and 96 saved due solely to the use of body armor. Statistic taken from Video entitled, *Surviving a Shooting, Your Guide to Personal Body Armor*. Justice Technology Information Network, National Law Enforcement and Corrections Technology Center. National Institute of Justice. <http://www.justnet.org/videos/justnet.html#surviving..>

To learn more about the problems faced by survivors of police deaths, and how police departments can help, the National Institute of Justice sponsored this study by Concerns of police survivors. The findings presented in this Research in Brief clearly show the magnitude of distress survivors face.

Too often, when police survivors do seek help, it isn't available. As this Research in Brief indicates, police departments can do much more to help survivors cope with their loss. Many departments have no formal procedures for completing required paperwork and assisting family members with funeral plans and requests for benefits. Most departments do not consider the emotional and psychological needs of survivors to be a part of their responsibility.

When police departments establish systematic policies for dealing with a departmental death, they are better able to respond to the needs of survivors. Effective procedures allow a police department to respond in a prompt, organized manner and remain sensitive to the profound human emotions they must confront. The immediate and continuing response of police departments when an officer is killed has a definite impact on the well being of survivors.

Departments with no formalized policies can learn from those that have developed clear and caring procedures for dealing with line-of-duty deaths. The information from this study can help departments begin to meet this great unfulfilled need.

To some, Mrs. Brummett's reaction to her husband's death may seem extreme. It is not. In fact, it is typical of the intense, long-lasting reactions experienced by the majority of adult police "survivors" - that is, the spouses, parents, siblings, friends, and coworkers of police officers killed in the course of their work. (While children also are survivors, their reactions were not studied in the research on which this report is based.)

Reactions of police survivors are often so profound as to be diagnosed as Post-Traumatic Stress Disorder (PTSD), a psychological disorder associated with traumatic events that are generally outside the range of usual human experience. Common PTSD symptoms include recurring recollections of the traumatic event, feelings of detachment or estrangement from others, hyper alertness, sleep disturbances, guilt about surviving, memory impairment, and difficulty with concentrating.

Many people and police departments are unaware of the devastating impact of an officer's death on survivors. Many mistakenly believe that police survivors are somehow more prepared for their losses than civilian survivors.

In fact, surviving family members of public safety officers may be more at risk than other survivors after their loss. Relatives of slain police officers often endure psychological distress for long periods of time and do not seek help or discuss their problems because they feel embarrassed or wish to avoid seeming weak. They may refuse existing community services because they believe that only other members of the "police culture" can understand their problems.

A survivor's level of distress is affected by the police department's response to the tragedy. Elements of the department's response that should be considered include:

- *The way survivors are notified of the death.*
- *The emotional support provided by the department.*
- *The information the department gives concerning insurance and benefits.*

How these elements are handled has an influence on whether or not the survivor will develop a clinical psychological disorder such as PTSD.

However, most police departments lack formal policies for handling the aftermath when an officer is killed on duty. Some departments have provided policies concerning only felonious on-duty deaths, thus excluding accidental deaths, thus excluding accidental deaths. Others deal only with such tangible issues as notification procedures and funeral arrangements but neglect important intangibles such as counseling and emotional support.

To learn more about the impact of a law enforcement officer's death on adult survivors and on the steps a police department can take to help survivor, the National Institute of Justice sponsored a study on the psychological, emotional, financial, and practical problems faced by survivors of police deaths.

The study was conducted by Concerns of Police Survivors (COPS), a nonprofit organization that offers emotional and moral support to spouses, parents, children, siblings, other family members, and others who are affected by police line-of-duty deaths. The study examined the reactions of 126 survivors to their losses and the ways that 188 police departments responded to their problems.

This report discusses the study findings and provides recommendations that will assist police departments in developing workable, sensitive policies that help bereaved spouses and families.

Methodology of the Study

Data for this project were gathered from two main sources: Surviving adult family members of police officers killed in the line of duty; and Police departments that had lost an officer feloniously or accidentally.

The sample of spouses and of police departments for this research was drawn primarily from the U.S. Department of Justice, Public Safety Office, and Benefits Office data base. The office which provides financial benefits to eligible survivors, maintains records on officers killed in the line of duty whose departments file an application for the death benefit.

Most of the spouses included in the study were survivors of officers who died between November 1982 and February 1986 and whose applications for benefits had been received by the Office. Police departments surveyed were those that had submitted a claim for Federal death benefits through the Office between 1983 and 1985.

Participating survivors responded to a questionnaire; some also participated in personal interviews. Police departments responded to a mailed questionnaire. Responding departments, located throughout the Nation, ranged in size from less than 10 sworn officers to more than 5,000 and represented Federal, State, and local jurisdictions.

Impact of the Loss on Survivors

This study found that when police officers die in action, surviving spouses, parents, and siblings are not more prepared for the death just because they are part of a law enforcement family. Knowing that the job could be dangerous does not prepare an individual for the actual experience of having a loved one die.

According to the COPS study, the following are common police survivors' reactions to their loss:

- *Having difficulty concentrating and making decisions, feeling confused, having one's mind go blank.*
- *Feeling hostile.*
- *Feeling different from others, feeling alone, being uncomfortable in social situations.*
- *Fearing people, places, and things, and being anxious of one's ability to survive.*
- *Re-experiencing the traumatic incident through flashbacks, dreams, or thoughts.*
- *Feeling emotionally numb, having less interest in previously enjoyed activities, or being unable to return to prior employment.*
- *Having less ability to express positive and negative emotions.*
- *Feeling guilty about the way one acted toward the deceased or as if one could have prevented the death.*

These reactions are indicated by specific symptoms. Table 1 presents the most prevalent and acute symptoms identified by survivors as occurring at levels that clinically indicate serious distress.

The study also found that 59 percent of the surviving spouses of police officers killed in the line of duty met the criteria for having PTSD. This psychological disorder is common among victims of physical assault, rape, and natural disasters, prisoners of war, and persons taken hostage.

Factors that were found to intensify distress reactions among spouses include the way they are notified of the death and the length of time they had been married. Spouses who are not notified in person experience additional trauma, as evidenced by increased levels of hostility and guilt. Younger women, especially if married for 10 years or less, were found to have a ;more severe reaction to the death of a spouse than older women married for a longer period of time.

Duration of Distress

It has commonly been assumed that survivor grief reactions are "acute, time-limited phenomena." Survivors are often encouraged and even pressured to return to pre-trauma behaviors and activities. For some, this is an impossibility. For others, it is possible only after an extended period of healing.

- *This study confirmed recent research that indicates that the grief response after an accidental traumatic loss may add to long-term emotional distress.*
- *Survivors were found to have clinical levels of psycho-pathology in a number of areas and evidence of PTSD even 2 years after the traumatic death occurred.*

Most Prevalent and Acute Symptoms Identified by Survivors	
Reported Symptom	Percent
Feeling Lonely	75.2%
Feeling Unhappy or Sad	70.4%
Feeling low in energy or slowed down	68.3%
Feeling easily annoyed or irritated	67.5%
Feeling tense or keyed up	66.7%

Easily hurt feelings	64.3%
Trouble concentrating	56.3
Repeated images that won't leave your mind	53.9%
Thinking about the same thing repeatedly	52.8%
Trouble remembering things	52.4%
Feeling emotionally numb or empty	52.4%
Feeling angry	51.6%
Wishing others would care for you	51.2%
Difficulty falling asleep	50.8
Feeling uncomfortable in social situations	50.8%
Feeling people will take advantage of you	50.8%
Difficulty making decisions	47.6%
Having to think carefully to make correct decisions	46.8%
Being angry at yourself for not accomplishing more	49.6%

Table 1

The assumption that time heals all wounds is not valid in the case of police survivors since people who hold this assumption may be deterred from providing the support and intervention that survivors need to recover emotionally and psychologically from a personal crisis and to return to a pre-trauma level of functioning.

Felonious vs. Accidental Death

Responding police departments reported a total of 298 line-of-duty deaths during the time period studied. Of these, 158 resulted from accidental causes and 140 from felonious causes.

Deaths due to homicide traditionally have been perceived by society as more serious and threatening events than deaths due to accidents. Thus, it was believed that surviving family members of an officer who died feloniously experienced a more severe reaction than survivors of one killed accidentally.

This study indicates this assumption is not valid for surviving spouses. Spouses of officers killed accidentally and spouses of homicide victims experience the same level of distress.

Significant differences were noted, however, between parents of officers killed accidentally and parents of officers killed feloniously. The latter were found to be more traumatized, hostile, and depressed after the death.

Survivors reported that the type of death makes a difference in the response they receive from the police department, with homicides receiving more or preferential attention than accidents. The difference in police department response can add considerable pain to an already traumatized family - especially when the family expected a different type of treatment.

In addition, if the suspect accused of killing the officer is apprehended, the survivors may experience additional trauma as a result of the trial.

Benefits and Compensation

Ninety-one percent of the police departments surveyed reported that they provide explanations of their health benefits to officers and 89 percent said they provide explanations of death benefits. However, the departments were not questioned about how the explanations were carried out and whether the officers actually understood or were aware of the importance of the information. Some departments indicated this instruction was accomplished in a brief description, or by handing officers a booklet to read. Very few departments fully explain all benefits, options, and compensation and their implications for the officer and family.

Survivors may be excluded from the police department's group medical coverage within days of the officer's death. In such cases, a letter informing survivors of this separation is sent in the mail, forcing the survivor - still in a state of shock - to find health coverage for the family. In such cases, departments seem to fail to differentiate between a planned termination from police service and an unexpected line-of-duty death.

While survivors generally reported satisfaction with the treatment they received from police departments, they did report certain specific problems regarding compensation and benefits. Most survivors are not prepared for the delays that occur in processing benefit and compensation requests. Some survivors found that departments are uninformed about benefits.

Psychological Counseling

Of the police departments surveyed, 58 percent have a psychological unit but only 31 percent offer access to a staff psychologist. Only 5.4 percent of the departments offer peer counseling and police-family response services; 43 percent make counseling referrals; and 19 percent pay for outside counseling.

Survivors reported a lack of psychological counseling for family members. In addition, most believed that if such services were needed as a result of the death, the police department should pay for them.

Survivors also reported they felt abandoned by the police departments. The spouses wanted some type of formal and informal contact to continue. Most reported that contact ended soon after the funeral.

Police Department Policy

In addition to its impact on the family, the death of an officer can be a tremendous shock for members of the police department. For smaller departments that lack financial and personnel resources, the loss of an officer creates significant disruption. And, for police officers in departments of all sizes, the death of an officer can be a demoralizing reminder of their own vulnerability.

Yet 67 percent of departments surveyed lack formal policies concerning the death of an officer. Often no one is designated or prepared to deal with the legal and financial paperwork and to assist the surviving family members in planning for the funeral, with requesting benefits, or in preparing for the emotional and financial strain that may accompany the death.

In addition, most existing policies reflect an action-oriented, task-oriented, time-limited philosophy toward survivors. Most departments tend not to consider the emotional or psychological needs of survivors to be part of their responsibility.

Notification. Notification practices varied greatly among departments. Of the policy statements submitted to COPS (60 percent of the departments with formal policies submitted them), 50 percent dealt with notification. Some dealt only with chain-of-command notification procedures, but most specified the need to notify the family quickly.

Most departments do not have designated officers or teams for notification. Often any available officer or a group of officers is asked to notify survivors.

Maintenance of records. Accurate records of next of kin are essential to notification procedures. Yet records - in cases where they are kept - are not consistently verified and updated by most police agencies.

While almost 80 percent of the police agencies surveyed keep records of spouses, more than two-thirds lack records on parents of officers. Some 40 percent of the agencies update spouses' records periodically, about 27 percent never do, and another 23 percent do so only on change of duty. Agencies that maintain records on parents of officers update them infrequently.

Action-oriented assistance. Funeral and burial procedures appeared in 53 percent of the policies COPS received; information on amount of compensation varied greatly among departments. In 67 percent of the departments surveyed, the family pays for funeral and burial expenses.

Information and emotional services provided. Of the departments surveyed, 5.3 percent provide information on will preparation; 44 percent offer instruction on stress management; 92 percent provide transportation to the hospital after the incident; 92 percent provide assistance with the media; 97 percent provide assistance with benefits; and 32 percent provide financial counseling.

Policy suggestions for police departments. The results of this study suggest that more than half of the surviving spouses of police officers killed in the line of duty may need support and assistance from the police department. Recovery from such trauma may be a very long, involved process quite different from the recovery process after a death due to a terminal illness or other anticipated event.

Police departments can help family members, as well as their own officers, to cope with the loss of an officer by establishing and implementing both general and specific policies on how to proceed in the event of a death. By designing clear-cut policies concerning notification procedures, psychological services, emotional support, and benefits and compensation for survivors, police departments will be better prepared to respond to survivors in an organized and humane fashion.

However, being organized is not enough. Survivors and police personnel need to be aware that the death of a loved one of a good friend, of a partner, or of a coworker, is a stressor of the highest magnitude. Avoiding discussion of the possibility of injury or death, of possible plans of action, and of prescribing policies protects no one from death. But it means that if death does occur, the crisis management skills needed to help survivors will not have been planned and thus will not be readily available.

NOTIFICATIONS DEALING WITH TRAUMA

The following information is taken from an article by C.A.J. McLauchlan entitled, *Handling Distressed Relatives and Breaking Bad News*". *Publication and Date Unknown*

Common problems associated with breaking bad news in cases of trauma stem from the fact that death or severe injury is sudden and unexpected. Often the victim is young and the prognosis is unsure. First Responders, Emergency Personnel and Hospital staff are often very busy causing the notification to the family to be done in an unskilled manner. Lastly, when alcohol intoxication is suspected as being a contributing factor – this raises another series of questions and concerns.

Coping with major trauma is stressful for both staff and the relatives. Handling distressed relatives is an under emphasized part of the work, and medical staff may have had no training and little experience of it. It is a time that the relative will always remember and, if handled badly, will leave lasting scars.

Major trauma does not always end in death. Other various outcomes of major trauma include: serious head injury, multiple injuries, spinal injury, major burns, loss of limb, and loss of sight.

Giving bad news is never easy, but it can be especially difficult in cases of major trauma. The nature of the patient's problem and the bad news can be very varied. The management of the relatives may begin before they arrive at hospital and carry on until well after death or discharge of the patient. The principles of management apply to the accident and emergency department as well as the intensive treatment unit or admitting

ward. Providing genuine understanding and support for relatives is the key to their management.

Initial contact

When a victim of major trauma arrives in the emergency room the priority is immediate resuscitation. Once the victim has been identified the closest relatives or friends should be notified.

Handling the initial contact with relatives

It may be preferable for a police officer and law enforcement Chaplain to make contact in person. Information on the telephone should be given by an experienced nurse or doctor. Relatives should not drive to hospital alone

The full severity of injuries or death may be best explained at the hospital

Communication with the emergency services is very important. The ambulance crew and police, as well as giving information on the incident, may have already seen the relatives or know their whereabouts. It is usually better for a sympathetic law enforcement chaplain and police officer to make the initial contact in person rather than for a telephone call to be made from the hospital. The police may also be able to help with transport.

If the telephone is used, information should be given by an experienced nurse or doctor and a lone relative advised strongly against driving to hospital alone. Mentioning that the victim is unconscious often helps to impart a certain severity to the lay person, although the full severity or death is usually best explained in person at the hospital. If relatives are not told of the victim's death, however, they may blame themselves for not arriving at the hospital in time to be with their loved one at death. It is important to dispel any self recrimination by giving the relatives the exact information, including the time of death. If the relatives have to travel great distances or from overseas the full details, including death, may have to be explained over the telephone. Find out if the relative is alone and, if so, suggest that he or she seeks support locally. Offer to telephone for support.

Anxious relatives should be met by a nurse and not be kept waiting around at reception for the department's or ward's communications to be established. Therefore, it is important that the nursing sister coordinates the information so that the staff, in particular those at reception, know that potentially distressed relatives are expected. They should be welcomed and not made to feel in the way. Staff should remember that it is not only the victim's relatives who may be distressed; in some instances close friends may be severely distressed and should be handled in the same way as the relatives.

There should be a private room or office where relatives and friends can wait and be seen. Ideally this room should be solely for relatives and friends and be suitably furnished.

Breaking the news

When setting up the relative's room for notification of the trauma, you will want to make sure the room is private, has a telephone, hand basin and mirror, cups and water, tissues and advice/information leaflets. The informational leaflets should be kept out of sight and brought out when appropriate. Make sure the décor and furniture is appropriate – soft furniture and low lighting is helpful.

Remember to ask relatives for the medical history of the patient. This history may be vital if the patient is receiving certain drugs such as steroids or anticoagulants, and an idea of the quality of life may be useful in elderly victims or those with disease. Providing a history can also make relatives feel less helpless and that they are doing something.

During attempted resuscitation relatives should at least be given early warning if the condition is critical. Regular updates by the same person (usually a nurse) are also appreciated and may help to break the bad news in stages. It also allows relationships to form, which will help in providing the support that may be needed later.

The contact nurse should introduce a doctor, preferably a senior one to the relatives as soon as possible to provide further information. Relatives expect to see a doctor for medical information and an idea of the prognosis: "Will he be all right, doctor?"

Advice for the doctor

Breaking bad news has to be tailored to the situation and the particular relatives, but the following principles generally apply:

- On leaving the resuscitation area or theater you may be stressed, so take a moment to compose yourself and think about what you are going to say. Also remove evidence of blood stains, etc., so that you are physically and mentally prepared.
- Take an experienced nurse with you. A nurse can be a great support and can carry on where you leave off.
- Confirm that you have the correct relatives and who's who. Ascertain what information they already have.
- Enter the relatives' room, introduce yourself, and sit down near the patient's closest relative. Do not stand holding the door handle like a bus conductor ready to jump out. Giving the impression that you have time to talk and listen is important.
- In general look at who you are talking to, be honest and direct, and keep it simple. Be prepared to emphasize the main points. Avoid too much technical information at this stage (although with patients with multiple injuries there may be much going on). If death is probable say so; do not beat about the bush.
- After breaking bad news allow time and some moments of silence while the facts sink in.
- Be prepared for a variety of emotional responses or reactions. Some people may stick at one reaction whereas others go through several reactions.
- Allow and encourage reactions such as crying. Provide tissues and facilities for relatives to make themselves presentable to the world again.
- Although it is upsetting, close relatives appreciate the truth and your honest empathy.
- At this stage there is no substitute for genuine understanding and support. A sensitive nurse is a great asset.
- During the interview it is a helpful and natural comfort for staff to touch or hold the hand of the relative. Various social and cultural factors may influence the appropriateness of touching, but generally if it comes naturally then it is probably right.
- Likewise, during the interview it may be natural for the staff to have sad feelings, and these need not be completely hidden. Some sign of emotion may help distressed or bereaved people to release that the staff do have some understanding and it is not just another case.
- Avoid platitudes - for example, after a death comments such as "you've still got your other son, etc.," which are not helpful as it is the dead person whom the relatives want back. Also avoid false sympathy as in "I know what it's like," but rather

- empathize, as in: "It must be hard for you...." or "It must feel very unreal..." etc., reflecting back their emotions.
- Encourage and be prepared for questions to be asked during the interview. These may disclose any misunderstandings and present a chance to re-emphasize the message. The question of pain and suffering is common and should be discussed routinely, with reassurance as appropriate. The prognosis may be unknown initially, and you should say so. If death or serious disability is possible, however, then it is only fair to be honest and warn the relatives. It will be worse shock later if they have been protected from this knowledge. Do not be afraid to answer that you do not know the answers to medical or philosophical questions such as "Why me?" Other difficult questions may arise from feelings of guilt or when a relative was involved in but not injured in the same accident. Special problems may arise if the relative feels responsible directly - for example, as the driver in an accident. Other complications may include a recent squabble before the accident with subsequent self-recrimination. The "If only..." rumination can be a type of guilt response that is fruitless and should be understood but discouraged at the outset.

If death has already occurred the same principles as discussed above apply. It is important to use the word "death" or "dead" early and avoid euphemisms such as "passes on." The news is usually hard to accept and so it must be as clear as possible, abrupt as it may seem. People usually need an explanation to the cause of death of a loved one. It may be helpful to explain the inevitability in the light of known injuries and that "everything possible was done." Worries about their own first aid at the scene of the accident may need talking through.

Children should not be excluded from the proceedings in the mistaken belief that they need protection. They will be afraid and may have fantasies and feelings of guilt and need information.

Management of Relatives

Seeing the patient

Depending on urgency of further treatment it should usually be possible for close relatives briefly to see the patient before he or she is rushed off to the theater, the intensive treatment unit, or even another hospital. Although distressing, reality is usually preferable to fantasy. Also, sometimes this may be the last time that they will see their lives one alive. In addition, this contact may be beneficial to the conscious patient. Relatives may ask to enter or remain in the resuscitation area during emergency treatment, especially of infants and children. This is not yet generally accepted, but it seems that it can be beneficial provided that they are supported by an advocate such as a sensitive member of staff. Hospital staff may, however, be apprehensive about the presence of relatives, and their feelings must be considered.

Seeing the body after death

The opportunity to see the body after death should always be offered and gently encouraged if there is any doubt. Well-meaning friends may try and discourage this act, which is an important part of accepting reality.

The imagination is usually far worse than reality, and cruel fantasies about the victim being disfigured or squashed flat can be dispelled. The actions and words of staff when relatives are with the body should give "permission" for relatives to touch, hold, kiss, or

say good-bye to the loved one. Nurses will often carefully prepare a body before viewing in the clinical are or chapel. The relative may also like to be left alone with the body.

Checklist of actions in the event of death

- Notify the general practitioner, other relatives and friends, and the coroner's officer
- Ensure that the minister or chaplain has been called if the relatives wish
- Give an information or help leaflet to the relatives
- Notify the social worker if he or she is available
- Give useful telephone numbers and contact addresses to the relatives (including your number)

Other actions

Although they are stunned by events, it is often the small touches of care that relatives appreciate and remember, such as being given a lock of hair from their dead child by a thoughtful nurse.

Always ask if there is anyone else whom the relatives would like to be contacted - for example, a close friend or minister. The hospital chaplains can be a source of great support to both relatives and busy staff.

If a mechanism of counseling and follow up exists locally consider borrowing their expertise in appropriate cases of trauma.

Follow up

Long term management and bereavement counseling is not within the scope of this article, but arrangements for follow up may need initiating on day one. If the nurse or doctor concerned in the emergency department feels able they can offer to see the relative again. Some departments have a social worker who can provide some practical help as well as coordinate follow up. If death occurs it is helpful to have a routine checklist.

An up to date leaflet explaining official procedures slipped into a relative's pocket is useful for later perusal. Participation by the coroner's officer, who may be a policeman, should be explained. Warning relatives of the possibility of them developing symptoms of post-traumatic stress disorder is appropriate in certain cases. (An explanatory leaflet that includes ways to get help would be useful in busy departments.) Such symptoms include depression, anxiety, and flashbacks, with a wide range of severity. Also, it may be necessary in follow up to warn them of possible avoiding or unhelpful actions by neighbors. Details of any local organizations, from which help and practical advice can be obtained from trained counselors, should also be given.

Staff's reaction

Lastly, do not forget the caregivers. There are many different reactions, the commonest of which are sadness, anger, and guilt. Staff may identify with particular people or situations. For example, a child being killed will be particularly upsetting, especially for staff with children of the same age. Part of the debriefing on major trauma must include an opportunity for members of staff to express their feelings. Hiding behind a defense of excessive concern with composure or tasks should be avoided.

Because of its suddenness and severity major trauma is especially difficult for relatives and staff to cope with. However bad the news is relatives need direct, honest information along with genuine understanding and support. Many doctors find this important part of their work difficult. Reasons have been suggested for this. Awareness may help the situation and lead to a greater emphasis in training.

In short, the principles of dealing with the distressed relative can be remembered as follows:

- Empathize. Sit and listen to and reflect back relatives' reactions rather than make assumptions or categorize them.
- Enable relatives to accept reality and to experience the pain.
- Encourage, as in "you will be able to cope" (with help if needed)

- Encounter your own feelings and express them later, perhaps as part of a debriefing.

GIVE TO THE FUTURE: SUPPORT ORGAN DONATION

The Clergy's Role

In the course of performing clerical duties in a hospital setting, you may be requested to offer spiritual counsel to families who are considering donation of the organs of a loved one. This is a sensitive role for a counselor, whether you have had one or one hundred experiences with such a call.

The Uniform Anatomical Gift Act governs organ donation in the United States. This Act allows individuals to will their organs. Also, relatives of the deceased can make the donation as long as there is no indication of the decedent's wishes to the contrary. Advances in medical science have made it possible to transplant as many as 25 human tissues and organs including the kidneys, corneas, heart, liver, pancreas, skin, and bone. While it is recognized that all are important, this brochure specifically addresses kidney donation and transplantation.

Kidney Failure and Treatment Options

Irreversible kidney failure affects many lives. There are now more than 60,000 Americans suffering from permanent kidney failure. When the normal function of both kidneys stops and cannot be restored, medical intervention is necessary to prevent death. Persons with end stage renal disease (ESRD) have two life-saving treatments available to them: dialysis and transplantation.

Dialysis

Dialysis is an expensive process of removing toxic materials from a patient's bloodstream. Patients on dialysis must devote many hours per week to this therapy. This schedule alone places great demands on patients and their families. Also, the dialysis process, while life-saving, rarely allows patients to feel as vigorous or healthy as they did prior to their illness.

Transplantation

Patients suffering from irreversible kidney failure often prefer kidney transplantation because of the less restricted life-style that is possible. Also, success rates for kidney transplants are impressive and are improving. Even though a cure for this disease has yet to be discovered, a kidney transplant offers the possibility for return to work and daily activities.

Kidneys for transplantation come from two sources: living related donors and cadaveric donor. For a number of reasons, it is not always possible for a family member to donate a kidney. The majority (nearly 75%) of transplants are made possible by cadaveric donations. If a sufficient number of cadaveric kidneys were donated, many more patients could receive kidney transplants. Although about 9,000 kidney transplants are performed in the United States each year, another 13,500 Americans remain on waiting lists because not enough kidneys are available. Obviously, donated kidneys are desperately needed.

The Option of Donation

When a family is faced with the loss of a loved one, the suggestion of organ donation can be overwhelming. The decision may not be an easy one, especially if the family has never discussed the issue. Your role, then, is one of offering support and answering questions as objectively as possible.

Working as a Team

While experienced health care professionals will already be on hand to respond to the physical, medical, and some psychological aspects, you have a fundamental role in offering support and religious guidance. Although you may not be the person who first presents the option of organ donation to the family (usually the request is made by a medical team member), you are often one of the key individuals to whom a family will turn to help with the decision. Good communications with health care team members is imperative to effective counseling. Two requests for donation may be as disconcerting to a family as no request at all, and family denials must be respected. In the event that family consent is given, all future arrangements for the organ donation are the responsibility of the health care team, but communications should be maintained if on-going pastoral counseling is taking place.

Frequently Asked Questions

The specific questions family members ask are as varied as the individuals themselves. The concerns listed below are among those most frequently expressed about organ donation.

Is there any possible conflict between saving life and using organs for transplantation?

Many safeguards exist to prohibit such conflict. Organ donation occurs only after all efforts to save life have been exhausted and death is legally certified. The doctor who certifies death is not the one who removes the organs.

How are the donated organs used?

Sophisticated, modern communications can rapidly locate those patients with kidney failure who are waiting for compatible kidneys. Usually, donation of kidneys allows two patients the opportunity for transplantation, since a person can function adequately with one kidney.

What happens after the organs are removed?

The body becomes the responsibility of the family or next of kin. There is nothing involved in organ donation that should alter funeral arrangements.

Will the identities of the donor and recipient be kept confidential?

Because of respect for the privacy of both donors and recipients, names are considered confidential information and are rarely released to either party.

Why must this decision be made immediately?

A request for a decision in this hour of grief may seem insensitive, yet timely kidney removal is necessary in order to give life to others. This immediacy does not change the fact that the decision should be carefully considered and acceptable to family members.

Are there financial considerations?

There is no cost to the donor family for organ donation. These costs are wholly the responsibility of the organ acquisition facility. Costs for funeral arrangements, burial, etc., remain the responsibility of the family whether or not an organ donation has been made.

Is it a sin to desecrate the body? Will donation affect salvation?

Just as there are a wide variety of religious practices in our society, so are there many views on death and salvation. Common themes of sacrificial giving, sharing, and healing are found in numerous religious writings. Such themes represent the universality of the highest humanitarian and spiritual ideals.

Does organ donation conflict with religious beliefs of the family?

Religious leaders all over the world support organ donation which is essential to the lives of others. Specifically, some religious denominations have expressed their attitudes in the following faith statements.

A Lutheran tradition: "The decisions concerning replacement therapy have to be made in a responsiveness and responsibility to the whole web of mankind." "By such a donation the very fact of death may be changed from a total physical loss for one to a second chance of a better life for another.

A Catholic tradition: "The public must be educated. It must be explained with intelligence and respect that to consent explicitly or tacitly to serious damage to the integrity of the corpse in the interest of those who are suffering, is no violation of the reverence due to the dead.

A Jewish tradition: "...there can be no greater Kevod Hamet [honor to the dead] than to bring healing to the living."

What good comes from organ donation"

Organ donation is an opportunity to make a positive, valuable contribution out of a tragic death. It is a considerable comfort for families to realize that they have helped others to live and to lead healthier, happier lives.

Summary

It is sincerely hoped that you, as the spiritual counselor, may share in the values of organ donation and transplantation. By supporting the concept of organ donation, you can offer those you counsel an opportunity to feel that something valuable was salvaged from their misfortune. Also, you can join in the concerted effort to enrich life for thousands of persons suffering from irreversible kidney failure.

Article~

" HOW DO I ASK?"

*Requesting Tissue or Organ Donations From Bereaved Families
By Sheila Howard, RN, BSN*

Brian was pale and out of breath as he ran into the private lounge where his parents and I were waiting for him. The grief on his parents' faces told him what he least wanted to hear. I reached out to grab him as he fell into a nearby chair; his body shook with retching sobs.

No words were needed: Brian had just lost his bride of 4 months. A driver with a suspended license had run a red light, plowing into Claire's car and killing her instantly. She was 25 years old.

You could feel the pain and outrage in the room. WHY? WHY? WHY?

I had no answer. Who could?

As a transplant coordinator for a tissue bank, however, I did know of one possible thread of consolation. These tragedies are, in fact, the very basis of my job. If the patient meets the eligibility criteria, I approach the grieving family members, console them, and offer them the option of tissue or organ donation.

You might be taking on this responsibility, too: A federal law passed in 1986 requires hospitals to set up protocols to encourage donations for tissue or organ transplants. The hope is that from the devastating sorrow of people like Brian, some good may come for others.

How then, should you ask? How do you talk to families about donation when they've just had their lives turned upside down? And when? To do it immediately doesn't seem right. Yet that's when the donation is usually needed.

Though approaching a family about donation is never easy, two common barriers make it harder. Both our own anxiety and helplessness in dealing with the grieving family or a scanty knowledge of the donation process can stop us.

In-service education can bridge the information gap. But getting ourselves to feel more comfortable about asking is more difficult. My advice is to first acknowledge your feelings

of inadequacy. Examining some of the fears, myths, and misconceptions that surround donation can also help.

Overwhelmingly accepted

One common myth is that asking for a donation as quickly as we must is insensitive to the family's grief, even offensive, because most people don't want to donate anyway. That simply isn't true.

Nationwide, the concept of tissue or organ donation is overwhelmingly accepted. In recent Gallup polls, for instance, up to 85% of the people surveyed said they'd be willing to donate the tissues and organs of their loved ones.

If so, then why aren't more donating? Well, acceptance of the concept apparently becomes more tentative when the reality hits home. People don't dislike donation; they dislike thinking about their own mortality.

Another reason is that many families who might donate aren't being offered the option at the time of loss.

If someone wanted to donate, you might ask, wouldn't he carry a donor card? Not necessarily. Best estimates show that perhaps on 2% or 3% of the adult population carry donor cards. Again, people are reluctant to plan for death, even though donor cards can ease the burden of the donation decision for their families.

Donor cards don't lift that burden entirely, however; the family still must approve the donation. Although donor cards are legal in all 50 states, most hospitals also obtain consent from the legal next of kin. Enforcing the legality of the donor card over the family members' objections would only intensify their grief, so their right to refuse is typically respected.

As you approach the family, remember that most people are willing to at least consider donation. Their right to refuse ensures that you won't in any way override their feelings.

Talking to the family

Before you discuss donation with the family members, be sure, of course, that they've been informed of the death and that the patient is an appropriate candidate.

Your next step is to assess whether the family members are calm enough to discuss donation. Have they truly accepted the death or, in the case of brain death, do they understand that their loved one is dead - and that the ventilation support is to maintain the vital organs only?

One of the public's misconceptions, by the way, is that a potential donor's care will have been compromised for the sake of the donation. Your thorough explanation of the donation process can reassure the family members on this point; you might also let them know that the patient's doctor is in no way involved with the tissue or organ procurement.

Then, try to find out whether the patient had a donor card or whether anyone in the family has mentioned donation. Knowing that before hand can help the discussion go more smoothly.

To properly ask for consent, you'll need to identify the legal next of kin and his relationship to the patient. This is usually the spouse; if there's no spouse, an adult son or daughter (over age 18); if there are no adult children, either parent of the patient; and son on. But bear in mind that usually one family member or close friend - not necessarily the legal next of kin - is the main support person and decision maker. Failure to include this person in the consent process may spell failure to get the family's permission.

As you talk to the family members about donation, remember first of all why you're there: to comfort, help, and support them - and to offer them an option that's now available through your hospital.

If they do react with tears or screams of protest, try not to take it personally. This, too, could be part of their grieving, and not necessarily a rejection of your request or even a sign that they think of it as an "intrusion."

Perhaps the best way to demonstrate how donation can help console bereaved families is to tell you how I approached Brian, the young man whose wife was killed in a car accident.

As Brian moved his hands away from his face, he softly moaned, "Claire, Claire," I placed my hand on his shoulder and stooped down so he could see me clearly. "Brian, my name is Sheila Howard. I'm the transplant coordinator here. I'm so sorry about Claire.... Can I do anything for you? Would you like something to drink - coffee? A soda? Water?"

Maintaining eye contact with Brian (without invading his space) helped calm him. Besides trying to give him something to focus on. I wanted him to know that I cared. Even the few minutes I spent getting Brian and his family sodas helped them regain some control of their emotions. They could then start thinking about the necessary calls and arrangements.

You may not always be sure of the exact moment to ask for the donation. Just remember, your first priority is to care for the family members during their bereavement. And the option you're offering can give them some comfort.

"Brian, would you like me to call someone for you? Can I answer any questions for you?" His eyes, flooded with tears, never left mine. I added, "Would you like to talk about Claire?"

Yes, he would: "How did this happen?" "Where?" And then, the hardest question: "Did she suffer?"

These questions are universal. Sometimes simply letting the family members talk about their loved one will open the door for more communication. The family needs to know who, why, how, could the death have been prevented? As part of their normal grieving, later, they'll probably want to review the death to see if they could have done anything to prevent it.

Most likely, despite your assurances that there was nothing they could have done, they'll feel anger, guilt, and sadness. Yet the answers you give them now can help them resolve some of these feelings afterward.

I answered Brian's questions as truthfully and completely as I could, avoiding clichés such as, "It must have been God's will," "There must be a reason," or "at least she didn't suffer." When I was sure I'd answered all his questions about the accident, I explained my role.

"Brian, losing Claire must be terrible for you. I'm very sorry: I'd like to be able to help. When facing a tragedy like this, many people get a lot of comfort from donating tissue or organs. Our hospital can provide this option for you. Did you know that Claire carried a donor card?"

He nodded. "Yes - anything you can use. Claire and I talked about this once. It's what we both wanted."

What if Claire hadn't carried a donor card? Knowing that the concept of donation is widely accepted, I would have gone on to ask Brian if he'd like to consider the option. He probably wouldn't have thought about it unless someone mentioned it to him.

I'd never start the discussion by asking if the patient carried a donor card. In most cases, the reply would be no, and I wouldn't want to have the door closed on the subject before I could start.

Although Brian had given a resounding yes, I couldn't simply get his signed consent and leave. I had to give him the specific information he needed, such as which organs or tissues could be donated, which blood tests would be needed beforehand, when and how the surgery would be done and who would perform it, how long it would take, what effect the donation process would have on Claire's body and on the funeral arrangements, and what costs would be involved and who would pay them. (The costs of evaluating donor eligibility and the entire donation process are covered by the procurement agency involved.)

I also explained the potential benefits of transplantation. Success wasn't guaranteed, I told him, but important research would progress even if an organ or tissue proved unacceptable for transplantation.

Most important, I made sure Brian realized that he had the right to refuse donation and that his decision wouldn't be held against him in any way.

Only after I'd finished this explanation did I ask Brian to sign the consent form.

As I stood up to leave, I said, "Brian, I know this is hard for you, but many families say it helps to receive some information later about their donation. Would you like to know how many people Claire was able to help? I can't tell you their names, of course, but I'll be able to tell you how she helped them." He smiled slightly.

"Yes, I'd like to know. Yes. It's a way for Claire to live on, isn't it?"

The Who, What, and How of Donation

A recently deceased person can donate either tissue or organs, sometimes both. The two types of donation have important differences.

Organ donation includes vital organs such as the heart, lungs, liver, kidneys, and pancreas. These organs can be donated only by those who have suffered brain-death

and whose vital functions have been maintained by a life-support system. The age limit for donating vital organs is 60 or under - for heart donations, much younger.

Once brain-death has been documented and the family's consent for donation obtained, the patient is usually placed on ventilator support to ensure maximum viability of the organs until the actual procurement occurs. Vital organs must be transplanted relatively quickly after being removed from the donor: heart and lung, within 2 hours; heart, within 3 to 4 hours; liver, within 8 to 12 hours; pancreas, within 24 hours; and kidney, within 72 hours.

Tissue donation includes the long bones of the arms and legs, the iliac crests, vertebrae, ribs, facial lata, dura mater, arteries, veins, heart valves, cartilage and ligaments, skin, and corneas.

Tissue donation can be accepted up to 24 hours after the cessation of circulation. Because the patient needn't have been sustained on a life-support system and the maximum age limits aren't as strict, more deceased patients can donate tissue than organs.

Every year in the United States, more than 500,000 operations require bone products for transplantation. Bone is perhaps the most versatile tissue transplanted because it can be cut and shaped as needed.

Some common uses of bone? Reinforcement for areas where bone tumors and cysts have been removed, spinal fusions, and reconstructive surgery. Advantages to the recipient include faster healing, shorter hospital stays, reduced costs, and less discomfort.

In bone and soft tissue donation, a surgical team removes the tissue, which is then sent to a tissue bank to be either freeze-dried or fresh frozen. The tissue may be stored up to 5 years for later transplantation.

