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Eastern Traditions versus Western Beliefs as Related to the Grief Process Regarding End-of-Life

Care in the Neonatal Intensive Care Unit

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Abstract

The field of neonatology continues to grow through research and technological advances that have allowed for the survival of the sickest or most premature baby. Despite the progression of neonatal abilities, death in the neonatal intensive care unit (NICU) continues to be a daily reality for parents and healthcare workers. Most Westernized NICUs have created specific bereavement protocols for the death of an infant aimed at assisting the parents of the deceased infant with successfully completing the grieving process. With the recent increase of immigrants from Eastern cultures, a controversy in neonatal care has arisen regarding how best to support and respect these Eastern cultures during end-of-life care without forcing Western ideals upon them. This paper explores the Hindu, Jewish, Buddhist, and Muslim cultures as related to how best to revere their rituals and traditions when death occurs in the hospital setting. By having a good working knowledge of these traditions, NICU healthcare workers can hopefully prevent the harmful complications associated with unresolved grief.

Description of the Issue to be Analyzed

Over the past fifty years, the field of neonatology has advanced from the continued growth of both knowledge and technology. Once upon a time, very few premature babies or infants born with congenital diseases were viable outside the womb. Now, from the smallest babies weighing in at nearly a pound to the babies born with severe heart defects have a chance of survival. Unfortunately, death remains part of the culture of even the best, most advanced neonatal intensive care units (NICU). NICUs have developed bereavement policies and procedures to guide end-of-life care of the infant to assist the family after death, but most are steeped in Western, Christian beliefs. A common problem for NICU staff arises when a baby of a different cultural background passes away, and it is unclear how to properly adapt the bereavement plan to meet the cultural needs of the family.

The problem with meeting cultural needs during and after the death of an infant occurs in hospitals worldwide. While this paper addresses the problem as it occurs in the setting of NICUs, the problem actually affects patients of all ages, in all settings of the hospital. This could be a NICU, cardiovascular intensive care unit, emergency department, or hospice facility. The United States is a melting pot of cultures, and there has been a recent influx of Eastern cultures, which brings controversy between Eastern and Western ideas on proper bereavement procedures. Some of these Eastern cultures include Hindu, Jewish, Buddhist, and Muslim cultures.

The death of a child has a significant impact on society. In any culture, the children are seen as the future. The death of a child, especially an infant, is a devastating event for the parents, family, friends, and the community they live in. The way a child leaves this world can have a drastic effect on

the grieving process and eventual healing of those involved. If an infant dies in the NICU setting and the cultural customs and rituals of the family are acknowledged and respected, the grieving process has the possibility to be healthier and more effective. However, if a family's rights and wishes concerning their cultural needs are not met, it can have long lasting negative effects on all parts of the grieving process, beginning with the acceptance phase of death. Unresolved grief can lead to both physical and emotional distress which can burden society and the healthcare industry financially. Even more severe, in some Eastern cultures there are specific customs and rituals that are imperative to the death process. If these customs are not followed in these cultures, the family can be shunned from the community as punishment. There are also beliefs that it hinders the deceased from properly entering Heaven or their respective form of the afterlife. For example, it is a common practice in the NICU to make hand and/or foot molds of the baby following death as a memento for the family. In the Muslim faith however, these molds are considered an aggravation of grief and are prohibited (Lundquist, Nilstun, & Dykes, 2003).

Providing culturally competent care in the NICU benefits the healthcare system. Proper care will benefit the patient and family, as well as the nursing staff involved in the process of bereavement care. As healthcare workers, the role of a nurse is to advocate for whichever is best for the patient and their family. This is important in death as it is in life. Assisting in the grieving process by utilizing cultural awareness helps the family grieve appropriately. Additionally, this allows a sense of closure for the nursing staff involved in the process. Currently there is controversy as well as a need for change because the NICU cares for babies of all cultures. Most NICUs, however, have only one type of bereavement care consisting of creating memories and mementos of the baby's life and death for the family that is based on Western traditions. These accepted Western traditions include the making of mementos such as three dimensional hand and foot molds, foot prints, and taking photographs. It has become apparent that there is a need for multiple types of bereavement care to properly meet the cultural needs of all the families who experience the loss of an infant while in the NICU.

There are several barriers to establishing a change in the current bereavement process. Many NICU nurses have been performing bereavement care the same way for years and are resistant to the idea of having to learn multiple ways of doing end-of-life care. The financial cost of developing committees to create new policies and procedures of bereavement care, followed by the cost of training a large staff to utilize these new policies and procedures, is another concern for many hospitals. In addition, another barrier is the cost of new supplies needed to properly create specialized bereavement packets. Convincing hospital administration of the need for these supplies when there may only be one to two Muslim patients in the NICU pass away in a certain period of time is an additional barrier.

A change in current status of bereavement care would benefit patients, families, and the community by positively assisting in the grieving process. By beginning the process of grief with

activities that are within their specific culture, the family may be able to remember the death experience in a positive way by having constructive memories to associate with it.

#### Pathophysiology of Unresolved Grief

The reasons for the death of an infant in the NICU are almost as various as the numbers of patients cared for each year. The demise of these neonates is most likely related to multiple complications of some varying degree of prematurity, surgical emergency, or severe heart disease. The parental grief, however, that can follow the death of an infant can result in long-lasting emotional, mental, and physical effects which can be especially problematic if this grief goes unresolved and becomes classified as complicated grief.

Grief is defined as the "...emotional and /or psychological reaction to any loss, not limited to death" (Hensley & Clayton, 2008, p. 650). The outward view of grief and/or bereavement is described by the word mourning and varies depending upon one's cultural preferences (Hensley & Clayton, 2008). It has been postulated and observed that this grief and mourning response is often more intense for mothers. This could potentially be problematic when planning for and dealing with a culturally responsible bereavement program. In many Eastern cultures, women are not allowed to make decisions surrounding end-of-life care, and therefore must rely on male members of their society.

In a 2008 randomized, controlled trial, Shear & Mulhare describe the phenomenon of complicated grief as the initial grief response which continues for an undetermined amount of time and there is not a sense of restructuring one's thoughts regarding the deceased. They also found two overwhelming symptoms that initiate a diagnosis of complicated grief. Those were the ideas of rumination and avoidance (Shear & Mulhare, 2008). Rumination stems from anger and resentment regarding the passing of their loved one. There can also be a feeling of guilt over how the person passed away. Overall, the person experiencing rumination follows the belief that if they stop grieving, then the deceased will be lost to them forever (Shear & Mulhare, 2008). The idea of avoidance centers on removing themselves from places and activities that might trigger memories of the deceased. This can eventually lead to total social isolation, difficulty with normal daily activities, and an inability to rejoin life (Shear & Mulhare, 2008).

These researchers suggest a modified interpersonal psychotherapy treatment in tandem with serotonin-active medications (Shear & Mulhare, 2008). This modified interpersonal psychotherapy is directly based on the attachment theory, Bowlby's ideas on grief, and practices used to treat other trauma related syndromes (Shear & Mulhare, 2008). Shear & Mulhare state that this modified treatment revolves around a cycle of confronting and avoiding the loss, building supportive relationships, and redefining life plans without the deceased (2008). Serotonin-active medication was found to be only moderately helpful as an adjunctive treatment approach when compared to its use in major depressive disorder. This finding

triggered the researchers to contemplate if a new class of drugs might be necessary for treatment of complicated grief (Shear & Mulhare, 2008). Complicated grief can also manifest in healthcare workers, which can affect their job performance and satisfaction. It can also have detrimental outcomes on their abilities to care for future patients, work well with other staff members, as well as trouble their personal relationships outside of the workplace.

Another worrisome problem surrounding this unresolved grief can hinder the parenting process of other children in the family after a neonatal loss. This could include siblings of the deceased child or future pregnancies. When the deceased infant is one of multiples, there can be difficulties of parental attachment or overprotection to the remaining siblings. Subsequent pregnancies can be difficult and complicated for the entire family due to being riddled with fear of another loss. If this future pregnancy occurs soon after the demise of the NICU infant, it can be perceived as an attempt to replace that child, which can manifest in unreasonable expectations for the new child. However, if the grief process over the loss of an infant is handled properly, the parents' fear regarding future pregnancies can be eased.

Although not the same, the disease of major depressive disorder and post traumatic stress disorder can closely resemble, or be superimposed, on complicated grief. While the specific pathophysiology of depression is not yet well understood, most researchers agree it is a result of a defect in serotonin activity along with abnormal function of the neurotransmitters norepinephrine and dopamine in the brain. Post traumatic stress disorder is classified as a type of anxiety disorder by psychiatric professionals. It has been found to be the result of a recurring traumatic event or stressor that produces dysfunction in the networks of both the central and peripheral nervous systems. The discrepancies and commonalities between complicated grief, depression, and post traumatic stress disorder are listed in table 1 extracted from the article *Treatment of Complicated Grief* (Shear, Frank, Houck, & Reynolds, 2005, p. 2603).

**Table 1.** Similarities and Differences Between Complicated Grief and *DSM-IV* Disorders

Similarities Between Complicated Grief and <i>DSM-IV</i> Disorders	
Major Depression	Posttraumatic Stress Disorder
Sadness, loss of interest	Triggered by traumatic event
Loss of self-esteem	Sense of shock, helplessness
Guilt	Intrusive images
	Avoidance behavior
Differences Between Complicated Grief and <i>DSM-IV</i> Disorders	
Major Depression	Complicated Grief
Pervasive sad mood	Sadness related to missing the deceased
Loss of interest or pleasure	Interest in memories of the deceased maintained; longing and yearning for contact; pleasurable reveries
Pervasive sense of guilt	Guilt focused on interactions with the deceased
Rumination about past failures or misdeeds	Preoccupation with positive thoughts of the deceased
	Intrusive images of the person dying
	Avoidance of situations and people related to reminders of the loss
Posttraumatic Stress Disorder	Complicated Grief
Triggered by physical threat	Triggered by loss
Primary emotion is fear	Primary emotion is sadness
Nightmares are very common	Nightmares are rare
Painful reminders linked to the traumatic event; usually specific to the event	Painful reminders more pervasive and unexpected
	Yearning and longing for the person who died
	Pleasurable reveries

Abbreviation: *DSM-IV*, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*.

### Synthesis of Knowledge

Among Western and Eastern cultures there are many similarities and differences involving end-of-life decision making and care as well as bereavement practices. As healthcare workers, it is imperative to have a good knowledge of these variances. To explore the Hindu culture, the descriptive exploratory design study with a sample size of forty-five by Doorenbos & Nies was assessed (2003). Within the Hindu culture, there is a strong belief in karma, destiny, and reincarnation. Because of the belief in karma, the Hindus desire to have all aspects of their life in order prior to death, which is congruent with the Western culture (Doorenbos & Nies, 2003). The ideas of karma and destiny may lead the dying patient or family of the dying infant to refuse comfort care, because time of death is determined by destiny and suffering is a major aspect of dying (Doorenbos & Nies, 2003). The preference in this culture would be to die at home, however, in the case of NICU patient, this is often impossible. In contrast with Western thinking of focusing on the individual's preferences, the Hindu culture makes end-of-life decisions as a family, which makes the phenomena of a living will null and void (Doorenbos & Nies, 2003). Regarding withdrawal of care, the Hindus reason that the physician is the instrument of karma, and he or she will determine the fated destiny of the patient (Doorenbos & Nies, 2003). Once death has occurred, Doorenbos & Nies report the involvement of several rituals such as: the need for the deceased's head to face East with a lamp near their head, a large presence of family members, and the desire for cremation of the body (2003). The body of the deceased Hindu is also not supposed to be handled and/or washed by anyone but a family member of the same sex (Doorenbos & Nies, 2003). This would be vast contrast to the NICU bereavement protocol which includes bathing assisted by staff members and the creation of mementoes. Failure to perform these rituals properly would not only affect the deceased person's ability to be reincarnated but can have negative effects on the entire family (Doorenbos & Nies, 2003).

To determine the needs of the Jewish family during death in the NICU, the qualitative methodology study with sixteen participants by Bonura, Fender, Roesler, & Pacquiao from 2001 was reviewed. In vast contrast with the Western consideration of quality of life when assessing the need to withdraw care, the Jewish tradition is to respect all life, no matter the outcome (Bonura, et al., 2001). This respect is seen community wide and grieving is experienced by the entire family and community as a whole. The Jewish community, therefore, comes to support and care for the dying patient and their family (Bonura, et al., 2001). This idea of caring for the ill or dying patient in the community is seen as a way to prevent pain, suffering, and loneliness upon one's own demise. A person of the Jewish faith that is expected to die within three days is referred to as a "goses." When caring for this type of patient, Jewish tradition forbids anything, even movement of the person that might speed up the death process

(Bonura, et al., 2001). It would be disrespectful for healthcare workers to speak to the parents of a dying infant concerning autopsy or disposition of the body prior to the actual death of the baby.

It is best for a Rabbi to be present at the bedside to perform rituals for the dying patient, and healthcare workers should always encourage family involvement. The Jewish consider palliative care acceptable, and deathbed confessions and rituals are often a tradition, just as in Western society (Bonura, et al., 2001). After death occurs, however, the infant's eyes need to be closed, preferably by a Jewish family member, but this is not mandated (Bonura, et al., 2001). It was also reported that it is best if a family member of the Jewish faith remain with the deceased until burial, but it is acceptable for a person of non-Jewish faith to handle the body (Bonura, et al., 2001). This would be important knowledge regarding current Western NICU bereavement traditions. Autopsy is done only if required by civil law, but no organs can be removed or donated without permission from a Rabbi (Bonura et al., 2001). Burial without embalment should take place within twenty-four hours of death if at all possible, and cremation and viewing of the body at a funeral home are strictly prohibited (Bonura, et al., 2001). In most Western societies of today, the bereaving person is expected to return to society and work within three days of the death of a loved one. The Jewish tradition, on the other hand, allows for prescribed periods of staged mourning processes (Bonura et al., 2001).

In the 2007 article regarding end-of-life decision making needs of the Buddhist, Chinese, American, Hsiung & Ferrrans give insight into the practices surrounding Buddhism. Much like the Hindu culture, Buddhism centers on the idea of certain death as related to karma as well as the phenomena of reincarnation. The family as a unit is the most important concept regarding Buddhism. In fact, Buddhists are expected to consider the family before themselves and often even "...share the shame, guilt, and humiliation of other family members" (Hsiung & Ferrrans, 2007, p.136). The utmost importance of family is seen during the hospitalization of a critically ill loved one. The family is designated to make all healthcare decisions. Communicating in any other fashion could be perceived as rude by the family (Hsiung & Ferrrans, 2007). The reasoning behind communicating with the family about their loved one's condition relates back to the idea of karma. Because Buddhists feel that by talking about death, ominous diagnoses, and end-of-life decision making in front of the patient will only speed up the process of death (Hsiung & Ferrrans, 2007). This may be taken to the extreme because the family unit may choose to lie to the patient about his or her condition, which would be frowned upon in Western cultures (Hsiung & Ferrrans, 2007). In a 2006 study, researchers found that open communication between the family, patient, and healthcare team regarding prognosis, treatment, and possibilities of end-of-life care did not in fact speed up the death process. Ultimately, the ability to plan for the inevitable death made the process more positive (Chow, Chan, Ho, Tse, Suen, & Yuen, 2006).

There is also a paternal hierarchy for decision making among the Buddhist faith, which consists of grandfather, father, and then eldest son, and this male hierarchy even overrides the husband-wife bond (Hsiung & Ferrans, 2007). Within this hierarchy, women are not allowed to make decisions, but are expected to care for the dying patient (Hsiung & Ferrans, 2007). This can be problematic when dealing with grief because the grief process has been shown to be more intense for females than males. They are unable to consider advanced directives due to the karma factor, and generally rely on aggressive life support because Buddhism teaches that if one can survive an adverse event, they will be blessed in life to reach the next adversity (Hsiung & Ferrans, 2007). Buddhist patients may refuse comfort measures out of respect for their family and authority figures. They generally prefer a quiet place for the death experience, which would be almost impossible in a NICU (Hsiung & Ferrans, 2007). Jenko & Moffitt (2006) described that Buddhist families would generally be opposed to withdrawal of life support because this would interfere with karma. Additionally, they believe that only dying with favorable karma can lead to a positive reincarnation experience in their next life.

Another important aspect to point out in the Buddhist tradition is the concept of dying with a full stomach (Hsiung & Ferrans, 2007). The idea of a full stomach will aid them on their journey into their next life. Therefore, the healthcare team can expect persons of this faith to choose feeding as a palliative care option. Once death has occurred, the family is expected to stay with the deceased for at least eight hours, which entails a great need for privacy (Hsiung & Ferrans, 2007). Currently, NICUs as a whole do a good job of allowing the family to spend extended time with their deceased infant. However, nurses and other members of the healthcare team consistently check in on the family, which can be perceived as a sign that they are unwelcome there. The family is in charge of readying the body for burial. The focus of a Buddhist funeral service surrounds ritual traditions and remembering the loved one (Hsiung & Ferrans, 2007). Additionally, when a baby or young person dies in a Buddhist household, a white cloth is hung outside their home to signify their passing (Hsiung & Ferrans, 2007).

Several articles discussed the wishes of the Muslim patient and family regarding end-of-life care. The family and the Muslim community are of utmost importance, and decisions made by the community leaders or family supersede any individual desires (Johnstone & Kanitsaki, 2009). This again would make advanced directives undesirable. The Muslim family is seen as the protector of the dying person's soul when making decisions about withdrawal of care. In extreme cases, such as brain death where treatment is futile, it is acceptable to have a do not resuscitate order (Lawrence & Rozmus, 2001). Mothers of dying infants, however, who experienced withdrawal of care, stated they were unable to be in the room for the withdrawal process because it is perceived the physician was taking the baby's soul (Lundquist, et al., 2003). In general, the Muslim community frowns upon withdrawal of care because it is felt that a

person's time on earth is set by their respective God. They also see comfort care as interfering with the person's repentance of sin (Gebara & Tashjian, 2006).

During the dying process, expressions of pain should be done in private. The patient should be turned toward Mecca with their head facing right. Also during this time, a nurse may be asked to clean or bathe the patient several times per day, and this is because cleanliness is equated with a pure soul for death (Lawrence & Rozmus, 2001). Muslims repent for their sins and have ritual prayer upon their deathbed, as do many Western cultures. Dignity and modesty are revered in the Muslim community, and this is no different during the death and dying processes (Zafir al-Shahri, 2002). This modesty is seen after the death of a Muslim patient because non-Muslims should not touch the body. A Muslim selected by the family will be designated to wash and prepare the body (Lawrence & Rozmus, 2001). If this process must be done by nursing staff, the following procedures should be observed: gloves should be worn and they are to close the patient's eyes and mouth, turn the head toward Mecca, straighten the body, place the hands on the chest with the right hand over the left, wash the body if only of the same sex, and cover the entire body with a white sheet (Lawrence & Rozmus, 2001).

Following the death of an infant, mothers are not designated to wash and prepare the body. Most Muslim mothers did not want to view or spend extended time with the infant after death due to complications of the grieving process (Lundquist, et al., 2003). This would make the NICU bereavement protocol of involving the mother and other family members go against Muslim traditions and wishes. Autopsies are not allowed unless required by civil law, and Muslims much prefer to have all medical items and tubes removed from their loved one (Zafir al-Shahri, 2002). Organ donation is not prohibited but should only take place when absolutely necessary (Lawrence & Rozmus, 2001).

The use of music during the death process is not allowed in the Muslim faith. This is another area of education for the NICU staff since music is often used as a soothing and developmental tool (Zafir al-Shahri, 2002). Muslims believe that if a fetus is greater than one hundred and twenty days old, they should be treated just as an adult when death occurs (Lawrence & Rozmus, 2001). Funeral proceedings should take place as soon as possible following death, preferably within twenty-four hours. Additionally, the body should be buried in a Muslim cemetery (Lawrence & Rozmus, 2001).

Muslim men and women grieve and mourn the loss of a loved one separately, and the entire community and family are involved in this mourning process. Having a separate grieving process for men and women could result in additional cases of complicated grief. This could be due to the fact most researchers will agree that women's grief is felt more intensely as compared to men.

#### Discussion of Analysis and Recommendations for Further Study

The analysis of the research concerning the topic of culturally sensitive bereavement care formulated the emergence of several commonalities that are in direct contrast with the Westernized way

of thinking about death and dying. In the Western culture, the idea of individualism and autonomy to make decisions is viewed as empowering and has come to be respected. This makes the idea of advanced directives, living wills, and do not resuscitate orders popular documents. However, in the Eastern traditions of Hinduism, Judaism, Buddhism, and Muslim cultures, autonomy is seen as isolating and burdening upon the potentially sick or dying person. The school of thought for these cultures is generally that the family and/or community will make end-of-life decisions. Therefore, there is no need for any type of advanced directives. In fact, sometimes just mentioning the idea of an advanced directive can create mistrust for the healthcare worker. This would include the prospect of withdrawal of care, which is generally considered taboo among these cultures for several reasons.

In Hinduism and Buddhism, there is strong belief in the idea of karma, destiny, and reincarnation. This means that nothing should be done to increase the process of dying because time of death has been predetermined by their God and would interfere with karma and successful reincarnation. The Jewish faith gives no merit to the Western concept of quality of life, but rather respects all life. They would, therefore, also do nothing to speed up the death of a loved one. Muslims generally view the idea of withdrawal of support equated with taking that person's soul. Since it is the family's priority to see that person die with a pure soul, withdrawal of care most likely not be done.

Muslims, Hindus, and Buddhists are opposed to comfort care measures because it interferes with karma or the repentance of sins. All of these cultures, including the Westernized cultures, have specific death rituals to be performed. All have a great desire for these practices to be respected and followed as closely as possible even when death takes place in a hospital setting. All Eastern cultures discussed value that the washing and preparation of the body be done by a same sex person of their same beliefs. This is an important factor to take into consideration if an infant of another culture dies suddenly in the NICU, since it is common practice for the bedside nurse to perform bathing and dressing of the body.

The Hindu, Buddhist, and Jewish cultures all expressed desires to have a designee remain with the deceased for extended time periods after death. The Muslim community, however, do not prefer to see nor stay with the patient after death. They also do not wish to receive any type of memento from deceased, because all of these things tend to worsen their grief experience. This is important for healthcare workers to understand, because it is a vast change in bereavement practices in the NICU and could potentially cause complicated grief. Several of these Eastern cultures expressed the desire to pass away at home, but this is often not possible in the NICU setting.

Both Eastern and Western cultures are appreciative of early, open communication among the healthcare team, patient, family, and sometimes community leaders. These differing cultures also shared the need to repent and confess their sins to their religious leader of choice on their deathbed. This is commonly seen in Western society as well. Generally, the Eastern cultures were opposed to the process

of an autopsy and desired to have all medical devices removed from their baby. This can sometimes cause conflict between the physician in the NICU and the family members depending upon the cause of death. Most of them had strong beliefs that burial or cremation should take place within twenty-four hours of death to prevent complications in the afterlife, no matter what the preferred disposition for the body.

Another common theme among these Eastern societies was long periods of mourning involving the entire family and community, which is a direct contrast to Western ideas of bereavement. In the Buddhist and Muslim communities, there are observed male and female role differences regarding end-of-life decision making and grieving processes. These variances can lead to issues with successful grieving due to the fact that men and women experience differing degrees of grief.

Based on the discovered body of knowledge, findings note that no matter the culture, race, or religious beliefs, there are several common desires for the bereavement process. Respect for the dying, the wishes of the family, and their religious practices were found to be of utmost importance to many of the cultures studied. The need to receive information regarding diagnosis and outcome was deemed paramount to make informed decisions throughout the cultures surveyed. All of the cultures researched go through the grief process in some fashion. They each expressed the need for support from healthcare workers, friends, family, and their religious community leaders. Overall, there are many ways in which healthcare providers can assist in creating a culturally sensitive bereavement environment. This process may take more time and effort to discern the wishes of the family due to cultural barriers present. Healthcare workers should never assume that all cultures can be treated the same.

To foster healthy grieving and to provide proper support for bereaving families, every NICU should create a bereavement program. It is apparent from the synthesis of this research that some type of culturally sensitive training should be a part of bereavement training. Interpreters should be readily available for these instances. There is also a need to have easier access to various religious leaders. In the field of nursing, each new graduate should be oriented to the bereavement process, and they should utilize a check list to ease their own discomfort and become more familiar with the process.

The cost benefit analysis of orienting all nurses to the process of culturally sensitive bereavement care far outweighs the loss of work hours for the nurse that was unable to obtain closure due to a difficult bereavement experience. The decreased cost of treating the parents for symptoms of unresolved, complicated grief also outweighs the cost of creating and maintaining a culturally competent bereavement program. The cost of creating this program could be contained by utilizing various types of education materials, such as posters, pamphlets, short in-services during shift change, and power points viewable online. A culturally specific reference guide could also be created to place with bereavement materials. Due to the fact that bereavement affects all members of the healthcare team, this education should be

considered for doctors, nurses, respiratory therapists, and social workers. Another low cost option to enhance cultural knowledge would be to follow up with families of other cultures that have experience a loss to assess strengths and weaknesses of their bereavement experience.

Based on the weaknesses, limitations, and gaps in the body of knowledge, additional research needs to be done on certain cultures in the field of neonatology. The question of how to make end of life care successful should be asked for each culture. How the hospital staff could make the bereavement more culturally sensitive should also be asked. This would include which deciphering which rituals and practices are most important for each culture. All members of the healthcare team need to be included in this research, because they are all involved in and affected by the death of a patient. Each member of the healthcare team has the potential to positively or negatively affect the bereavement process for these families through their words or actions. For the Nashville area, populations such as Kurdish, Hispanic, and African American are largely represented. It would, therefore, be beneficial to further study these cultures. Specifically among these cultures, the areas of pediatrics and neonatology should be closely studied due to the vulnerability of patients. In addition, the death of a child is often times more traumatic than the death of an adult, and the healthcare staff should do as much as possible to lessen this burden. There may be varying religious practices based on the age of the patient.

Due to the descriptive nature of this topic of interest, a qualitative design method would render the most expressive data. This is an extremely vulnerable population to be studied because it deals with the subject of death, and specifically the death of a child. Immigrants to the United States are also at a disadvantage due to language barriers. The researcher must insure that informed consent is obtained in their native language, and all aspects of the study procedures are completely understood by the participants. The recruitment of subjects for a future study could present a barrier due to language and custom differences, and these barriers might create an atmosphere of distrust and prevent honest responses. The fear of deportation could limit the enrollment of some illegal immigrants. Many aspects of cultural competence must be considered prior to planning a research study of this type.

Within the body of knowledge concerning bereavement care, there are several strengths. First, there is a vast amount of research regarding the topic, and many cultures have been studied. The simple fact that so many researchers have investigated the topic of bereavement care in different cultures is a notable strength. Second, emerging themes were identified that were common throughout different cultures. For example, regardless of culture, grief and coping are experienced similarly, and the risk of complicated grief is a potential danger for all cultures. Also, all cultures expressed the desire to be involved in decision making and wanted to be given medical information. Third, most researchers of this topic use a qualitative method, which is appropriate based on the nature of the subject.

While the body of knowledge displays many strong points, there are also several weaknesses to discuss. One significant weakness found within the body of knowledge is the thought that other cultures should conform to the Westernized view of bereavement since they are living in the United States. For example, in the NICU this equates to expecting culturally diverse parents to accept bereavement mementos made by the nursing staff, when in reality these mementos may insult or even go against their religious or cultural beliefs. Another weakness in the body of knowledge is the lack of NICU specific research due to the relative newness of the field of neonatology. While some research can be generalized to the NICU population, neonatology is a highly specialized area and therefore requires its own research in many situations.

The most evident limitation in the body of knowledge is the language barrier that exists when researching diverse cultures. Also, the small sample sizes for the studies limit the generalizability as well as the amount of knowledge that can be gathered. Gaps exist within the research of other cultures. There are many cultures that are not represented or under represented in the literature. For example, despite the rapid increase of the Hispanic population living within the United States, there is little research found regarding their bereavement practices.

#### Summary

The United States is extremely culturally diverse, and each of these various cultures has their own specific traditions and rituals associated with death. Despite the vast differences between cultures, the one common thread is the need for respect. During the bereavement process, respect should be given to the patient, the family, and their cultural practices. It is also crucial to inform the family of all medical facts available and support them as they cope with their grief. By providing culturally competent bereavement care at the end-of-life, the difficulty associated with the loss of a loved one can be eased, and the family can begin the process of successful grieving.

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