



# Life Review in Critical Care: Possibilities at the End of Life

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*We are lonesome animals. We spend all our life trying to be less lonesome. One of our ancient methods is to tell a story begging the listener to say—and to feel—Yes, that’s the way it is, or at least that’s the way I feel it. You’re not as alone as you thought.*

John Steinbeck<sup>1</sup>

## PRIME POINTS

- Life review may be used to provide emotional and spiritual support to dying critical care patients and their families.
- The therapeutic use of life review provides nurses with a framework for clinical interactions.
- The death of a loved one is clearly a major life stressor. Despite that loss, survivors who participate in life review retain or regain hope for the future and a passion for life.

It was a short but memorable clinical encounter, initiated with the eldest of 3 living sons. The men’s mother, an 87-year-old frail, Chinese-born woman, had just been terminally

extubated. A palliative care nurse was facilitating the woman’s life review with the sons, who were recounting harrowing tales of their mother’s life in Hong Kong during World War II: how people commonly ate animals off the street and weeds growing in the cracks of buildings to survive. Prompted to share their “gifts of the heart”—what their mother taught them about life and living that would resonate in their hearts—the sons spent the next hour in soft-spoken reflection at the bedside. As time progressed, a healing space was created, echoing the words of Curtis and Eldridge<sup>2(pp38-40)</sup>:

The deepest convictions of our heart are formed in stories and reside there in the images and emotions of story. . . . Life is not a list of propositions; it is a series of dramatic scenes . . . if we’re going to find the answer to the riddle of the earth—and of our own existence—we’ll find it in story.

## CE Continuing Education

This article has been designated for CE credit. A closed-book, multiple-choice examination follows this article, which tests your knowledge of the following objectives:

1. Recognize that life review is grounded in concepts of the therapeutic relationship
2. Understand the 3 interconnected components of life review
3. Describe how life review can be used to provide emotional and spiritual support to dying critical care patients and their families

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Using the palliative care consultation service of Lakeland Regional Medical Center, Lakeland, Florida, as a model, we offer clinical nurses an opportunity to extend practice beyond the physical care of patients at the end of life. When a patient's goals of care clearly shift from cure to comfort, life review provides an evidence-based approach for interaction with the patient's family. Using the theory and techniques we describe, practitioners can alleviate suffering, for the concern of nursing is "broader than the organ system that is affected, as we turn our attention to the emotional, physical and spiritual health of the whole patient."<sup>3(p17)</sup>

In her book *Kitchen Table Wisdom: Stories That Heal*,<sup>4(ppxxvi-xxvii)</sup> Remen speaks of being deeply moved by her patients' stories, "by the people and the meaning they found in their problems, by the unsuspected strengths, the depths of love and devotion. . . . Everybody is a story. . . . Everyone's story matters."

## Overview

Referring to a progressive return of the memories of past experience in search of meaning and in striving for emotional resolution, life review is a formal concept that has its roots in life-span developmental psychology.<sup>5</sup> As defined by the theories of

Butler<sup>5</sup> and Erikson,<sup>6</sup> development is shaped by countless factors throughout the entire life span: the historical time in which one lives, the economics and culture, and the positive and negative life circumstances.<sup>5-9</sup> In his 1963 article,<sup>5(p66)</sup> Butler theorized that life review was a

. . . naturally occurring, universal mental process characterized by the progressive return of consciousness of past experiences, and, particularly, the resurgence of unresolved conflicts. . . .

Presumably this process is prompted by the realization of approaching dissolution and death and the inability to maintain one's sense of personal invulnerability.

Life review has applications in varied situations, such as cultural transmission, anthropological field work, and career planning and vocational guidance.<sup>8</sup> However, its therapeutic use provides nurses a framework for clinical interactions.

Life review has been described as a recasting of the past in the context of the present<sup>10</sup>: the chance to reexamine one's life and solve old problems, the chance to make amends and restore harmony,<sup>11</sup> and the chance to "find new meaning in the face of impending death."<sup>12(p120)</sup>

Widely practiced in gerontology,<sup>6,11,12</sup> life review is thought to be a useful method for understanding both self and others.<sup>13</sup> In gerontology, multiple and consecutive weekly sessions are used to analyze, evaluate, and synthesize life events.<sup>14,15</sup> Investigators<sup>16,17</sup> have addressed adaptations of life review with terminally ill patients, situations in which time with patients and patients' families was often limited because of the severity of the illness. Additionally, we (M.J., P.A.) have had countless single clinical encounters in which the therapeutic use of life review has been used, supporting the counsel of Byock<sup>18</sup> to "create a space where healing can happen" and to "use a few moments to go deep—even when time is really short."

When any form of life review is undertaken, a life is examined, and questions such as the following<sup>19</sup> are asked: Who am I? How did I do? How did I live my life? Thus, an important difference between reminiscence and review must be addressed. Life review is "not a random sharing of pleasurable past events, but rather a structured process containing a component of self-evaluation."<sup>14(p9)</sup> Life review can be used with both patients and patients' families; the outcomes include increased life satisfaction and accomplishment, promotion of peaceful feelings, and a state of integrity.<sup>20</sup> Furthermore, Garland and Garland<sup>8</sup> contend that life review has a distinct purpose in end-of-life care by upholding the unique value of each person's life. These themes are consistent with Erikson's theories of development<sup>6</sup>: the final task is ego integrity versus ego despair.

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Ego integrity<sup>6</sup> involves acceptance of the course of one's life, acceptance of one's place in history, absence of death-anxiety, and satisfaction with life. In contrast, ego despair echoes in the words of the poet Robert Frost<sup>21</sup>: ". . . nothing to look backward to with pride, and nothing to look forward to with hope, so now and never any different."

## Improving Outcomes at the End of Life

Each health care provider can be inspired by the Institute of Medicine report *Approaching Death: Improving Care at the End of Life*<sup>22</sup>:

A humane care system . . . honors and protects those who are dying, conveys by word and action that dignity resides in people—not physical attributes—and helps people preserve their integrity while coping with unavoidable physical insults and losses. Such reliably excellent and respectful care at the end of life is an attainable goal.

Byock<sup>23(p36)</sup> builds on this vision, contending that a solely physiological approach with the terminally ill is "two-dimensional, and without the color, tone, or texture of life." Additionally, Volker and Limerick<sup>24</sup> explored the concept of dignified dying. In their interviews with advanced practice nurses in oncology, the theme of "going in peace" emerged, which referred to "the importance of connecting with loved ones; conveying final messages; dying in a quiet, nonchaotic environment; not suffering from physical or existential distress; and meeting spiritual needs."<sup>24(p244)</sup>

Irrespective of the clinical setting, the grief that is expressed at any bedside represents a "developmental crisis that becomes interwoven with family history."<sup>25(p17)</sup>

Although Butler's concept of life review<sup>5</sup> traditionally involves a patient and a health care practitioner, life review in critical care usually involves a patient's family members, who become survivors if the patient dies. Compared with those who do not engage in life review, survivors who purposefully recount the events of their loved one's life and death maintain a higher level of emotional function, such as moving appropriately through the grieving process and retaining the ability to perform activities of daily living. In support of this approach, many authors<sup>8,26-28</sup> have articulated that the physical effects of internal stress are reduced by the outward expression of emotion. According to Pennebaker,<sup>27</sup> the continuous inhibition of traumatic memory is a physical stressor that adversely affects the immune system. The death of a loved one is clearly a major life stressor. Despite that loss, survivors who participate in life review have the following desired outcome: they retain or regain hope for the future and a passion for life.

## Components

The 3 interconnected components of life review are recontextualizing, forgiving, and reclaiming un-lived life.<sup>29</sup>

### Recontextualizing

Recontextualizing is using an expanded vision of maturity, referring to the wisdom that comes with age and experience. Recontextualizing

is used to reframe self-defined mistakes and failures. First, past negative life events and situations must be reexamined or reframed in such a way that they can be perceived as positive. A person must be willing to view the past differently, even when reliving unpleasant or painful experiences. In contrast to viewing oneself as the "victim" of past negative events and experiences, recontextualizing offers the realization that one is often in control of life experiences and has the opportunity to change memories based on perception of the experiences. Recontextualizing allows a reflection on the past, thus repairing relationships and events. Changing the perception changes the memory, from one of failure to one of success.<sup>5,8,10,29</sup> Recontextualizing involves the "search for the deeper, sometimes more elusive, patterns that may be operating beneath the surface of everyday events."<sup>29(p117)</sup>

Present during the life review of a man who was dying were the man's wife of 59 years, 2 adult daughters, and 1 granddaughter. Between numerous tears, the younger daughter reluctantly and slowly spoke of childhood memories: when her father was always adamant that she fulfill her academic duties. Deeply resentful as a child and adolescent, she was able to trace her current value of responsibility, as well as her national stature in her field, to her father's expectations when she was a child. Without this purposeful revisiting of past events, the daughter's memory might have focused on that resentment. Remen<sup>26(p29)</sup> remarks:

Over time, meaning heals many things that are beyond a cure. Finding meaning does

not require us to live differently; it requires us to see our lives differently. . . . Meaning may change the way we see ourselves and the world.

### *Forgiving*

Offering forgiveness to another and oneself often has an important result for patients facing the end of life. Anger and resentment, previously concentrated in a negative effort, can now be redirected toward positive thoughts and attitudes.<sup>29</sup> Byock<sup>30</sup> recounts numerous clinical cases involving forgiveness and cautions about a frequent misconception. Forgiveness is not about absolving someone else's responsibility. Yet, when a relationship is completed, the story of the fractured relationship is totally reframed: everything that happened before is a prologue to the healing.<sup>18</sup> The repair of life review never eliminates the pain, but forgiveness work helps in coming to terms with the painful feelings.<sup>29</sup>

These thoughts are duplicated by Archbishop Desmond Tutu, who won the Nobel Peace Prize in 1984 for his healing work in South Africa after apartheid. Tutu asserts as follows<sup>31(pp270-271,279)</sup>:

Forgiving and being reconciled are not about pretending that things are other than they are. It is not patting another on the back and turning a blind eye to the wrong. True reconciliation exposes the awfulness, the abuse, the pain, the degradation, the truth. . . . It means taking what happened seriously and not minimizing it, drawing out the sting in the memory that threatens to

poison our entire existence. . . . True forgiveness deals with the past, all of the past, to make the future possible.

The following highlights the concept of forgiveness. A 72-year-old man was unresponsive and had been intubated after an extensive myocardial infarction and unknown downtime before resuscitation. His family assembled to spend time with him, but this gathering was no simple feat; the family did not regard their father as a model parent. As a result, the 5 middle-aged adult children were living separate and rather chaotic lives. Some lived in other states, those who lived in the local area rarely talked, and none knew the whereabouts of their mother. Because of the exceptional and harsh nature of the stories (marked by family chaos and alcohol abuse by both parents), it was critical for the facilitators who were listening to maintain a nonjudgmental and therapeutic stance, to build trust and rapport.

When talking about their childhood experiences, the adult siblings began to relate the stories that they had heard, as well as those they had experienced. Life review became an opportunity to place their own stories beside the stories of their father's life. Painful moments, which could not be denied, could at least be placed in the context of the patient's troubled life. The entire family was willing to reflect on and laugh about the joys that had been a part of their life together, especially holiday memories. More importantly, they found parts of their lives that they could treasure beyond the earlier pain and the current grief. When life support was discontinued, the many years of

separation softened as the siblings began to find a sense of forgiveness for their father and each other. The family discovered that their shared stories were allowing them to reconnect, for they had lived through challenging childhoods. Because of the chaotic nature of this family's life, the reconnection might not be sustainable, but for one moment, the grieving siblings found a sense of grace, appreciation, and gratitude in their shared life review.

### *Reclaiming an Unlived Life*

Reclaiming an unlived life involves reflecting on an opportunity earlier in life that was never used.<sup>29</sup> Regret is a common theme in such reflections and is a topic of growing interest to cognitive researchers. Common life regrets involve education (how misgivings about attending school affected other life decisions), career (lack of success or choice of career), romance (long-lost loves and unsuccessful relationships), family (doubts over parenting or estrangements from parents/siblings), and the self (disappointments in abilities, attitudes, and behaviors).<sup>32</sup> In expanding on the classic poem of Robert Frost, Beazley<sup>33(pp9)</sup> addresses the concept of *The Road Not Taken* as

. . . the source of all regrets.

It seduces us with its fantasies of what might have been, limitless possibilities that would have unfolded for us "if only" . . . When we are unhappy, we explore these roads through rich and varied fantasies, creating a world of regret around our hopes and dreams that never came true. In our "if only" daydreams, the roads not

taken entice us with their infinite possibilities, poisoning the road we did take or were forced to take and the present in which we live.

Such reflection transpired during the extensive life review of a dying patient by his adult daughter. Years ago, an irreparable breach had been created between the patient and his sister; the 2 of them took the specific details of the rift to their graves. However, the patient's daughter had the courage to examine the lost opportunity of a life with her cousins. Deciding to end the division, she contacted her cousins and invited them to join her at her father's deathbed. One local cousin responded to her invitation. Among many tears and hugs, the cousins pledged to reunite the family, thus reclaiming a lost heritage.

Schachter-Shalomi and Miller<sup>29(p93)</sup> relate the 3 components of life review to the concept of time:

What frees us from the tyranny of the past is the understanding that time is *stretchable*, not linear, so we can reframe and reshape it using contemplative techniques. If we think that time is linear, an event happens only once, the outcome is irreversible, and there is no way to reenter it with awareness for the purpose of repairing it. But spiritual insight reveals that time is multidirectional. Because it interpenetrates past, present, and future, we can reach back into the past and repair events and relationships that we perceive as failures or disappointments.

Not every critical situation is a terminal one. Yet, life review is an important tool in placing the trauma of critical illness and associated aggressive medical treatment into the broader context of one's entire life. The following relates the case of an elderly woman with sudden onset of confusion and then paralysis. It was quickly obvious that a stroke had occurred, and a craniotomy was to be done in hope of decreasing the damage from the cerebral bleeding. The patient and her spouse had moved to the city after they retired, so none of their 3 children lived in the area. Because other sources of support were not available, the chaplain on call responded while the patient was taken to surgery. The initial likelihood of the patient's survival was slim, so her spouse was encouraged to reflect on her significant attributes, memories of time together, and the family that they had raised. Everyone expected that this life review would be the beginning of the mourning process. The spouse was careful to be "positive," because he was hopeful of a recovery. Nonetheless, the life review was part of acknowledging the value of the patient's life and offered a context for more complete and sensitive care. The life review was expanded as the patient's children arrived, as they gave consideration to questions about life's meaning and significance. The patient eventually recovered and was discharged to a skilled nursing facility for rehabilitation, but the family reported positive emotional benefit from the session of reflection.

### Relevance to Critical Care

Critical care poses unique challenges for dying patients and the

patients' loved ones, because "most of these deaths occur after what may have been a lengthy and failed attempt to cure, followed by a painful decision to withdraw support, frequently accompanied by intense emotion and often spiritual distress."<sup>34(p63)</sup> In the landmark Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT),<sup>35</sup> more than one-third of patients who died spent at least 10 days in a critical care unit, and 46% received mechanical ventilation within 3 days of death. Robley and Denton<sup>36(p288)</sup> assert that "dying in the environment of critical care is distinctly different technologically and sometimes emotionally than dying in other settings."

Baggs<sup>37</sup> reviewed the research findings on adult patients in critical care, concluding that positive outcomes for end-of-life care addressed communication and psychological support as well as improvements in relationships. Accomplishing this outcome requires that palliative measures, such as life review and fostering emotional resolution, are part of routine care. When life review is implemented in critical care, multiple and consecutive weekly sessions are not always possible. However, the approach can be adapted for the time constraints of critical care. As previously discussed, life review offers a theoretical framework to identify and alleviate suffering. Although many critical care patients survive, some do not, and critical care is a fragile time in a family's story. Family members experience the emotional trauma of ending a psychological attachment to the patient, permanently altering the family unit.

With regard to emotional resolution, Ferrell and Coyle<sup>34(p15)</sup> write of nurses identifying unnecessary sources of suffering (eg, shame or spiritual abandonment), diagnosing sources of suffering (those that can and should be relieved), and intervening through “presence, listening, and communication that enables patient expression. . . .” Hall<sup>3(p57)</sup> echoes these thoughts, stating that “the healing nurse searches for ways to convey to the patient an attitude of ‘I am in this battle with you.’” Hall further explains that “healing nursing requires that these skills and attitudes be formulated first in the nurse’s mind and then honed in practice.”<sup>3(p72)</sup>

Life review was used in the following case history, which involved the wife of a trauma patient with massive fractures and contused organs. The couple was from out of state and without their usual means of emotional support. In the single-visit review of her husband’s life, the wife had a persistent theme: “I can’t imagine where I would have been or what I would have been if I had not met him.” Using this latent content, the facilitator explored the wife’s gifts of the heart—intangibles the husband gave that would equip the wife to continue living. The patient died 31 hours after admission; the wife returned home. However, during the critical care stay, she expressed the benefits of the therapeutic presence.

Life review is appropriate for any family willing and able to engage in the emotional work of the process. Because of the acute nature of critical care nursing, life review encounters are short-term. However, for nurses who are more comfortable with the technological aspects of care, life

review offers a structured framework for emotionally engaging a patient’s family.

### How Life Review Begins

Nurses must always give primary consideration to the physical, mental, and emotional states of critical care patients and the patients’ families. Before life review is started, priority must be given to a patient’s pain and symptom management. Once the patient is physically comfortable, professional attention can be turned to the many factors involved with guiding life review.

During review activities, facilitators should be considerate of the family’s cultural, religious, or spiritual beliefs, for life review is grounded

in the concepts of the therapeutic relationship. Using open-ended questions is always preferable, thus minimizing the feeling of interrogation and maximizing respect for the narrator. Practitioners must also learn when not to speak, taking care not to interrupt a thought or discourage the narrator from continued review.

For those new to life review, the prompts in Table 1 might be a useful beginning. Attempts are made to balance both the positive and the negative aspects of life. Practitioners can use any prompt to begin; no single “right” way to initiate a life review exists. Although a life review has no definitive end, a practitioner stops the facilitation when the family

**Table 1** Prompts for beginning a life review<sup>a</sup>

- Tell me about a tranquil time or place experienced or visited.
- Tell me about a chaotic time.
- What was the childhood like?
- What about the teenage/young adult years?
- Tell me about family members/close relationships.
- What about best friends? What do you have in common?
- Tell me about an obstacle overcome in life and about the skills used in overcoming it.
- What have been the most important things in life? What is important today?
- Do you have any thoughts about death and loss?
- What are life’s achievements?
- What are some of the most satisfying things in life?
- Has someone important ever gone away?
- Who have you admired, and why?
- Describe the kind of person you have been.
- What things have been most enjoyed in life?
- Tell me about your life’s work.
- What were the happiest moments of life?
- What would you like to leave your family?
- How would you like to be remembered by your family and friends?
- What was the deepest regret or disappointment as a child or young adult?  
As a middle-aged or older adult?

<sup>a</sup> Based on Garland and Garland<sup>6</sup> and Black and Haight.<sup>14</sup>

either feels emotionally satisfied or emotionally unable to tolerate the process. In some situations, life review might be inappropriate. Some patients and patients' families have no desire to recall the past; these individuals should never feel compelled to participate in a life review.<sup>8,28</sup> Facilitators should be attentive to both overt verbal responses (eg, I just don't feel like talking now, Why are you asking me this, or That is a personal question) and subtle nonverbal reactions (eg, looking uninterested, distressed, or annoyed). Enthusiastic practitioners should guard against pushing for a more intimate or emotionally laden relationship than a family can tolerate or desires.

Details of the therapeutic relationship are beyond the scope of this article, but a successful life review depends on the firm understanding of the key elements of such a relationship, as listed in Table 2. To be perceived as genuine, a nurse must understand that facilitating a life review involves "time, concentration, imagination, a sense of humor, and an attitude that place the patient as the hero of his or her own life story."<sup>41(pp3-4)</sup> Having an open, nonjudgmental approach is vital to establishing rapport; this approach can be a challenge even for seasoned practitioners. One facilitator interacted closely with the 24-year-old daughter of a dying patient. The daughter came to the family meeting in a baseball cap worn backward and a muscle shirt revealing large, unusual tattoos. As the life review proceeded, it was revealed that this amazing young woman had been her father's primary caregiver for more than 24

**Table 2** Elements of the therapeutic relationship<sup>a</sup>

Element	Comment
Ensure confidentiality and privacy.	Create visual and auditory barriers so that conversations cannot be overheard. Close doors and curtains.
Establish trust.	Respect the value of family stories by showing interest. Be nonjudgmental.
Have a unhurried attitude.	Arrange for assistance so alarms and time-sensitive care do not interrupt the conversation.
Be authentic.	Talk face to face without the distraction of other tasks.
Maintain professional boundaries,	Focus on listening instead of trying to fix long-standing family issues.
Differentiate between manifest content (surface meaning) and latent content (unconscious themes that can be discerned beneath the surface).	Listen for feelings of sadness, regret, and fear that may be manifested as uncertainty and anger.
Watch for nonverbal cues.	Pay close attention to facial expressions, tone of voice, and body language.
Use open-ended questions to minimize interrogation and maximize respect.	"What" and "how" elicit better responses than does "why." Ask families to tell you about a positive event or special time in their family life.
Use self-disclosure appropriately.	Limit self-disclosure to showing sensitivity to family issues. Avoid saying, "I know what you are going through."
Be considerate of the patient's and the family's religious or spiritual beliefs.	When someone is in crisis, challenging existing belief systems is rarely beneficial. Their beliefs may be supportive to them in a larger context. Consult the chaplain for additional assistance and support.
Know yourself before attempting to know others.	Self-care is always the first rule in providing emotional support. Use various resources to help with professional balance.
Convey a sense of compassion.	Express concern for the family's emotional, physical, and spiritual challenges during this time.

<sup>a</sup> Based on Hall,<sup>3</sup> Garland and Garland,<sup>6</sup> Pennebaker,<sup>27</sup> Kruse et al.,<sup>38</sup> Rogers,<sup>39</sup> and Watts.<sup>40</sup>

months. Knowing she would lose her father, she had had his right hand-print tattooed on her right shoulder and his "rosary" tattooed on her chest, so she would always have his guidance and direction in her life.

The therapeutic relationship must also embody compassion. Remen<sup>26(p205)</sup> indicates the following:

Compassion begins with the acceptance of what is most

human in ourselves, what is most capable of suffering. In attending to our own capacity to suffer, we can uncover a simple and profound connection between our own vulnerability and the vulnerability in all others. Experiencing this allows us to find an instinctive kindness toward life which is the foundation

of all compassion and genuine service.

Ferrell and Coyle<sup>34</sup> refer to the work of theologian William Reich, who wrote on the concepts of suffering and compassion. Reich identified 3 phases of compassion: (1) silent empathy/silent compassion (in which the caregiver is silent in witnessing the suffering of another), (2) expressive compassion (in which the caregiver helps by listening to stories and converting the experience into comprehensible words), and (3) compassionate voice of one's own (in which the caregiver is also transformed by both the suffering and the efforts to relieve that suffering). This element is crucial, because witnessing suffering is the everyday work of nurses. In every setting, across diseases, and in people of all ages, suffering is a part of being human and is often intensified when being human also involves being ill.<sup>34(p23)</sup>

Within the framework of the therapeutic relationship, documentation of a life review is completed with a strong sense of ethical responsibility. As indicated by the code of ethics for nurses of the American Nurses Association,<sup>42</sup> entries in the medical record must be respectful of human dignity, honoring privacy and confidentiality. Although it is important for the health care team to be informed about a patient's condition, facilitation of life review often brings forth painful, private, and delicate topics that do not need to be broadcast in a "tabloid" format. For example, difficult family encounters might include information on

incest and substantial substance abuse; documentation of these situations should reflect broad sweeps (eg, patient has incarcerated son), rather than gritty detail (eg, patient's son is in the state prison for rape). The therapeutic intent of life review should be kept in the forefront, and the practitioner-patient relationship should always be honored.

One must know oneself before attempting to know others. Garland and Garland<sup>8(p97)</sup> state, [It] is advisable to know oneself by narrating one's own story clearly and fully before venturing into reviewing others' lives. Without doing so, it is difficult to appreciate the obstacles that can emerge in the process, and to understand how to negotiate them.

Friedman<sup>43(pD5)</sup> reinforces this thought:

In therapy, the relationship is the very instrument of the treatment. . . . therapists, just like their patients, bring their own life experiences into treatment, which influence their feelings about their patients—a process called countertransference.

The resources reviewed in Table 3 are suggestions for beginning one's own life review. As Kubler-Ross<sup>45(p285)</sup> stated in her memoir, "You cannot heal the world without healing yourself first."

Because of the amount of time some families require for closure and the intensity of their grief, some situations may create chaos in critical care units, such as intense wailing at

the time of death.<sup>6</sup> Also, because of complex family dynamics, more than a single therapeutic presence is often required. These times are ideal to involve the expertise of the interdisciplinary team, especially pastoral care. For example, an 85-year-old man who was dying participated in a life review. The man's second wife and his adult son strongly disliked each other. Each insisted on time with the patient without the presence of the other. While a chaplain was supporting the son at the patient's bedside, a palliative care nurse was supporting the wife in the waiting room. The 2 groups then changed places, allowing both the wife and the son equal time with the patient. With 2 clinical practitioners, life review could proceed with each grieving family member without neglect of the other family member.

Life review may also result in psychopathological outcomes, such as obsessive preoccupation with the past, marked anxiety, and severe guilt and despair. In the following case study, the wife of a patient who had just been extubated, whispered, "I do not want him to be alone. . . . my children have each other. . . . I do not want him to be alone." In the preceding days of interaction, the wife had expressed marked despair, so she was gently but directly confronted about possible suicidal ideation upon her husband's death. Her response led to an evaluation by the mental health department's intake social worker. Possibly, outcomes such as these cannot be prevented, because of a family's underlying psychological issues, but recognizing the issues and intervening appropriately are vital.

**Table 3** Resources for self-discovery

*I am that stranger who has nothing to give you and who is telling you to look inside.  
Not inside any box . . . but somewhere even closer: inside yourself.*

Eckhart Tolle<sup>44(p9)</sup>

**Sreenan M. *Spirit Dances: The Best of Life*. Ouray, CO: Sreenan Human Resources; 2004.**

This book is designed to aid the reader in unfolding the best of life's dances, or "spirit dances." Lessons in courage, creativity, persistence, power, and truth are introduced. Dr. Sreenan states, "When you are clear about your needs and your values and begin to live by them, you are living with integrity. . . . You are knowing and accepting all parts of your self." Such integrity permeates your life in subtle, yet powerful ways. In dealing with "fears and past ghosts," personal energy can be freed to invest in creating health and powerful relationships, building character, and making one's wildest dreams come alive. Each concept is fully developed in a self-contained chapter; each chapter concludes with reflective questions and an extensive bibliography for additional reading.

**Ditzler JS. *Your Best Year Yet! Ten Questions for Making the Next Twelve Months Your Most Successful Ever*. New York, NY: Warner Books; 1994.**

In a 3-hour process of self-discovery, Ditzler has "shaped and simplified the annual life review and planning process" to foster a "new level of consciousness and awareness in the way we live and direct our own lives." Ditzler states that people often set goals without preparing the personal environment for those goals to succeed, noting that most people are motivated by their personal values and beliefs rather than by material success or recognition. By acknowledging both accomplishments and disappointments, readers are guided into setting goals that are responsible and proactive. The outcome is "a flow to our lives and a sense of fulfillment in our hearts and minds."

**Beazley H. *No Regrets: A Ten-Step Program for Living in the Present and Leaving the Past Behind*. Hoboken, NJ: John Wiley & Sons Inc; 2004.**

Using Robert Frost's famous poem *The Road Not Taken*, Beazley cautions that dwelling on past mistakes, failed expectations, or missed opportunities consumes one's ability to enjoy the present, stealing hope for new possibilities. His book, based on psychotherapeutic and spiritual principles, offers insights into toxic thought patterns that create and support regrets, as well as myths about forgiveness. In addition to inspiring stories of other people, Beazley's structured program offers the reader tools on meditation, journaling, and creative visualization to create a rich and rewarding life in the present.

**Roese N. *If Only: How to Turn Regret Into Opportunity*. New York, NY: Broadway Books; 2005.**

Roese has spent a decade in the scientific study of counterfactual thought: the thought of "what might have been, of what could have happened had some detail, or action, or outcome been different in the past." Regret is described as an emotion built from counterfactual thoughts. Old patterns of thinking (which act as an impediment to sound reasoning and wise decision making) and new patterns of thinking (which play a vital role in learning, insight, and the recognition of possibilities) are explained with numerous examples. Roese provides a guide for harnessing regret to new action rather than suppressing the emotion.

## Life Review and Spirituality

Many regrets voiced during life review involve spiritual dimensions. In order to avoid clinical practice that is "technically and scientifically rich, yet spiritually poor,"<sup>38(p303)</sup> facilitators of review activities should be considerate of the religious or spiritual beliefs of a patient and the patient's family. Known for her pioneering work with spirituality in medicine, Puchalski declared that spirituality is "the source of life's meaning" and is "the lifeline that sustains people through stress and challenging times."<sup>46(p30)</sup> Reportedly found in all cultures and societies, spirituality conveys our universal humanity, how all people relate to each other. "Defined broadly as that part of

people that seeks meaning," states Puchalski,<sup>47(p38)</sup> spirituality is considered "essential to healthcare." Spirituality is manifested both in negative themes, including lack of purpose, despair, anger, abandonment, and need for reconciliation and forgiveness,<sup>48</sup> and in positive themes, including love, harmony, and a feeling of connectedness.<sup>49</sup>

Distinguishing between religion and spirituality is important. Religion includes belief systems often associated with an organized institution and centers on shared rituals and practices. Spirituality is more universal and inclusive, revolving around the meaning of life and faith rather than around a set of rules and customs. Spirituality involves a

relationship to the self and to others and may or may not involve a relationship with a higher being.<sup>49(p33)</sup> Patients and their families bring all their prehospitalization issues and concerns with them; the "challenge for all people is finding meaning and purpose even in the midst of failed jobs, bad relationships, missed accomplishments, and unattained successes."<sup>48(p152)</sup> Imagine compounding this challenge with a life-threatening illness.

Themes of spirituality are reflected through the previously discussed components of life review: recontextualizing, forgiveness, and reclaiming the un-lived life. Both spirituality and life review are concerned with common personal

themes of forgiveness and reconciliation; relationships, love, and the interconnectedness of all humanity; and the search for the purpose and meaning of life. For example, Avery<sup>50</sup> recounted the intense distress of an elderly man whose insomnia could not be adequately managed pharmacologically. Because a deeper issue was suspected, a life review was facilitated, and a harrowing incident was revealed for the first time. During the patient's active duty in World War II, a squad of enemy soldiers came over a hill bearing the white flag of surrender. The patient, then a young man filled with fear, killed all 8 men with a machine gun. With the use of recontextualizing, the patient was guided to admit his tremendous 50-year emotional burden to his family. In the end, the patient's family offered forgiveness on behalf of the murdered men's families, and the spiritual distress was relieved. Through life review, patients can acknowledge and accept those past life situations that cannot now be changed or fixed.

Bedside staff have a distinct opportunity to make a difference. According to Kruse et al,<sup>38(pp302-303)</sup> "It is possible to be at the end of life physically and yet continue to develop and nurture life spiritually." Furthermore, Puchalski<sup>51</sup> has indicated that spirituality implies

... time for listening and caring. If we are tense and nervous, we may convey this

discomfort about the unknown of illness. We must, in the midst of that uncertainty, create an atmosphere of comfort and trust. If we can sit in silence, part of the journey may be working through the unknown together.

Kruse et al<sup>38(p298)</sup> summarized this concept: "If we do not address the spiritual needs . . . , we neglect caring for the person as a whole."

## Conclusion

Beardslee and Vaillant<sup>9(p171)</sup> claim that "at some point in life, there are suddenly more yesterdays than tomorrows." This claim is certainly true for dying patients in critical care who have lost the ability to fulfill the roles and responsibilities of life. Profound listening work offers the chance to recapture a patient's personhood. Most likely, this recapturing occurs via the stories of loved ones, for as Kiernan<sup>52</sup> stated, "We convey meaning through stories." Health care professionals have a definitive opportunity to foster a good death, to promote the completion of final developmental tasks. Such is the essence of life review. **CCN**

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To learn more about end-of-life care, read "Providing a 'Good Death': Critical Care Nurses' Suggestions for Improving End-of-Life Care," by Beckstrand et al in the *American Journal of Critical Care*, 2006;15:38-45. Available at [www.ajconline.org](http://www.ajconline.org).

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**CE Test** Test ID C101: Life Review in Critical Care: Possibilities at the End of Life

**Learning objectives:** 1. Recognize that life review is grounded in concepts of the therapeutic relationship 2. Understand the 3 interconnected components of life review 3. Describe how life review can be used to provide emotional and spiritual support to dying critical care patients and their families

1. Which component of life review is used to reframe self-defined mistakes and failures?
  - a. Recontextualizing
  - b. Forgiving
  - c. Reclaiming an un-lived life
  - d. Time as stretchable
2. What percentage of patients received mechanical ventilation within 3 days of death in the landmark Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT)?
  - a. 6%
  - b. 16%
  - c. 26%
  - d. 46%
3. Which of the following must be given priority before life review is started?
  - a. Pain and symptom management
  - b. Cultural beliefs
  - c. Religious beliefs
  - d. Spiritual beliefs
4. Which of the following statements is correct about life review?
  - a. Life review is a random sharing of pleasurable past events.
  - b. A life review has no definitive end.
  - c. Life reviews are appropriate in all situations.
  - d. Closed-ended questions are preferable in initiating a life review.
5. In which phase of compassion does the caregiver help by listening to stories and converting the experience into comprehensible words?
  - a. Silent empathy
  - b. Compassionate voice of one's own
  - c. Silent compassion
  - d. Expressive compassion
6. Who is known for pioneering work with spirituality in medicine?
  - a. Haight
  - b. Garland
  - c. Puchalski
  - d. Coyle
7. What differentiates religion from spirituality?
  - a. Religion conveys our universal humanity.
  - b. Religion is more universal and inclusive.
  - c. Religion centers on shared rituals and practices.
  - d. Religion revolves around the meaning of life and faith.
8. Which of the following actions supports a therapeutic relationship?
  - a. Challenging existing belief systems when someone is in crisis.
  - b. Paying close attention to body language.
  - c. Focusing on trying to fix long-standing family issues.
  - d. Stating, "I know what you are going through."
9. Which of the following terms best describes unconscious themes that can be discerned beneath the surface?
  - a. Latent content
  - b. Surface meaning
  - c. Manifest content
  - d. Self-disclosure
10. Which of the following elements of the therapeutic relationship involves talking face-to-face without the distraction of other tasks?
  - a. Ensuring confidentiality and privacy
  - b. Establishing trust
  - c. Having an unhurried attitude
  - d. Being authentic
11. Which of the following authors provides a guide for harnessing regret to new action rather than suppressing the emotion?
  - a. Beazley
  - b. Roesse
  - c. Ditzler
  - d. Sreenan
12. Which of the following resources offers insights into toxic thought patterns that create and support regrets, as well as myths about forgiveness?
  - a. Spirit Dances: The Best of Life
  - b. Your Best Year Yet! Ten Questions for Making the Next Twelve Months Your Most Successful Ever
  - c. No Regrets: A Ten-Step Program for Living in the Present and Leaving the Past Behind
  - d. If Only: How to Turn Regret Into Opportunity

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