

# MAINTAINING PROFESSIONAL RESILIENCE BY COPING EFFECTIVELY WITH GRIEF/LOSS IN HEALTHCARE PROFESSIONAL PRACTICE.

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“Life is inherently risky. There is only one big risk you should avoid at all costs, and that is the risk of doing nothing.”

Author Unknown

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## Objectives

- Define Resilience and how to achieve/maintain this.
- Differentiate between grief/mourning/bereavement
- Describe the biology of grief
- Identify grief response and qualifiers that make it unique to HCW
- Define Hope and resources for pts/families
- Establish effective communications for difficult conversations
- Distinguish between Active and Avoidant Coping
- Identify Secondary Trauma signs and risk factors.
- Incorporate appropriate coping skills for the grief process and STS.

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## RESILIENCE

- ability to absorb or avoid damage without suffering complete failure
- objective of design, maintenance and restoration for buildings and infrastructure, as well as communities.**
- ability to respond, absorb, and adapt to, as well as recover in a disruptive event

Innate or Learned?

- Hard wired OR
- Acquire and enhance both physically and psychologically

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## NURSES



Better understanding of bereavement  
+ Support systems: individual and group nurses & pt/families

= Reducing care fatigue & retention of experienced oncology nurses

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## Epidemiology of Grief

CDC: 2017

- USA: 2, 813,503 registered deaths
  - If each of these deaths affects just 5 people, almost 11 million people are affected by loss.
- Cancer was 2<sup>nd</sup> leading cause of death

National Center for Advancement of Health –Report on Grief and Bereavement

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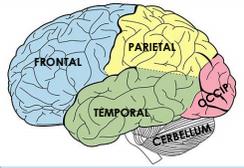
## Grief

- "departure from the state of health and well-being and need to return to state of equilibrium." George Engel, 1961
- cognitive process involving confrontation with & restructuring of thoughts about the loss experience (accepted, changed world in which the bereaved must now live). Stroebe, 1992.

<p><b>Grief</b></p> <ul style="list-style-type: none"> <li>❖ Experience of one who has lost a loved one to death</li> <li>❖ Applied to other losses</li> </ul>	<p><b>Mourning</b></p> <ul style="list-style-type: none"> <li>❖ Process that one goes through in adapting to death of that person// significant loss</li> </ul>	<p><b>Bereavement</b></p> <ul style="list-style-type: none"> <li>❖ Loss in which the person is trying to adapt without the deceased/loss in their ongoing environment.</li> </ul>
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## BIOLOGY OF GRIEF/LOSS




**LIMBIC SYSTEM**

- HIPPOCAMPUS** – plays an important role in emotions, learning and memory.
- AMYGDALA** – plays a role in aggression, eating, drinking and sexual behaviors.
- HYPOTHALAMUS** – monitors blood levels of glucose, salt, blood pressure and hormones.

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## Expressions of Grief

<p><b>NORMAL</b></p> <ul style="list-style-type: none"> <li>Sadness (most common)</li> <li>Anger (most confusing)</li> <li>Guilt and self-reproach</li> <li>Anxiety</li> <li>Loneliness</li> <li>Fatigue</li> <li>Helplessness</li> <li>Shock</li> <li>Yearning</li> <li>Emancipation</li> <li>Relief</li> <li>Numbness</li> </ul>	<p><b>INDIVIDUAL</b></p> <ul style="list-style-type: none"> <li>Phenomenon                     <ul style="list-style-type: none"> <li>Interpersonal variability</li> <li>Strong individual differences:                             <ul style="list-style-type: none"> <li>intensity of affective reactions</li> <li>degree of impairment</li> <li>length of time a person experiences painful aspect of loss.</li> </ul> </li> </ul> </li> <li>Internal Factors                     <ul style="list-style-type: none"> <li>Makes us aware of our own losses                             <ul style="list-style-type: none"> <li>is less fresh</li> <li>Unresolved losses</li> </ul> </li> </ul> </li> <li>External factors</li> </ul>
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## SYMBOLIC LOSSES (HCP & Pt/Family)

- Intangible losses
- Loss of relationships
- Intact systems
- Future dreams
- Health related loss
- Stillbirths
- miscarriages

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## Attachments



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## ATTACHMENT

- ▶ Bowlby's Attachment theory
  - Tendency in human beings to create strong affectional bonds with others and a way to understand the strong emotional reaction that occurs when those bonds are threatened or broken.
- ▶ Situations that endanger this bond give rise to certain very specific reactions.
  - May see pts through lengthy treatment element until death
  - More intimate the bond, the stronger the reaction when bond is broken
- ▶ How we connect with patients and families:
  - How we respond to suffering of others
  - Emotions: yours/pts
  - Empathy
    - Intimacy\*
- ▶ Intensity to HCW + Pt/Family
  - Pts/families are here at a vulnerable time
  - Pts/families see us as part of a "team" that brings on a new sense of hope.

\*increase in empathy + desire to help = stronger potential for professional stress

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## Grief/Loss Process/Resolution

- Practice "active grieving"
- ▶ When there is an attachment, there will be a loss
  - ▶ Attend funeral, funeral home visitation; closure
  - ▶ Send sympathy card
  - ▶ Understand you will grieve differently for each death-don't pile on the guilt
  - ▶ Reach out for help/support
    - HCW may be at a loss or unable to negotiate for this help.
- Roadblocks to achieving "active grieving"
- ▶ Avoidant coping
  - ▶ Messages:
    - "part of what happens here"
    - "have to be strong"
    - "could I have done something different to prevent the death"
    - Too much work to do
  - ▶ Lack of collegial support (peer or supervisory)

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## Mourning Process

- ▶ Process that occurs following a loss and how we adapt to that loss
- ▶ Discussed in Stages, phases or tasks
- ▶ Worden views Task element most realistic:
  - Mourner takes action to move through the process
    - **Accept reality of the loss**
    - **Process Pain of Grief**
    - Adjust to a world without the deceased
    - Find an enduring connection with the deceased in midst of embarking on a new life

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## Different Faces of Hope

- Active Treatment
- ▶ Engaging pt/family in protocol process
  - ▶ Monitoring response, side effect profiles
  - ▶ DOCUMENTATION
  - ▶ Frequent visits (attachment)
  - ▶ Social interactions
  - ▶ Clinical trial no longer effective vs. failure
- Attentive Treatment
- ▶ Aware, conscientious, respectful, accommodating, courteous, gracious, heedful, thoughtful, devoted
  - ▶ Disease progression
  - ▶ Redefining Hope:
    - SOC
    - Possible Hospice
- Outside Resources: Create reference manual: online resources, community resources, support groups-in person or online. Utilize social worker to refer to community resources

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## Effective Communication

- ▶ NCI named cancer communication as "extra ordinary" opportunity (1999)
- ▶ ASCO named communication as key clinician skill
- ▶ IOM identified communication as one of six fundamental clinician skills in improving supportive and palliative care for those with cancer.

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## Fundamental Communication Skills

- Behaviors to Avoid
- ▶ Blocking
  - ▶ Lecturing
  - ▶ Collusion
  - ▶ Premature Reassurance
- Behaviors to Cultivate
- ▶ Ask-Tell-Ask
  - ▶ Tell Me More
  - ▶ Respond to Emotion
    - Naming
    - Understanding
    - Respecting
    - Supporting
    - Exploring

Dr. Anthony Back, 2005

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### Effective Communication in Difficult Conversations

- Use Active Empathic Listening
- Be factual and specific
- Acknowledge and validate feelings
- Find common ground: shared interest or goal
- Discuss all options
- Express respect/appreciation
- Trouble shooting
- Attentive body Language
- Identifying cultural specifics/limitations

SPIKES

- S=Set-up
- P=Perception
- I=Invitation
- K=Knowledge
- E=Empathize
- S=Summarize and strategize

Following up after death

- Should I/Shouldn't I?
- What do I say?

Dr. Back, 2005

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### Oncology Nursing Benefits and Challenges

- Personal Growth
- More resilient
- Prioritized life events
  - "don't sweat the small stuff"
- Perspective on life now more +
- Helping people
- WHAT KEEPS YOU HERE?

- Global Nursing shortage
  - Suboptimal staff support
  - Retention
- Occupational Factors
  - High work demands
  - Witnessing pain of pts/families
  - Challenges with clinical trials
  - detachment
  - Lack of personal accomplishment

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### Oncology Nursing

- Negating Self-Care:
  - Suppress our feelings
  - Receive little mentoring, debriefing or counseling after (first) death experience
  - Lack of resources
  - Psychological distress
  - Suicide risk

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### Suicide Risk...domino effect

National Suicide Prevention Hotline 1-800-273-8255.

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### Trauma Self-Reported

- Exposure to Traumas?
  - What kind
- Has individual/group experienced:
  - Helplessness
  - Shame/embarrassment
  - Denial/"it will go away"
  - Anger/hostility
  - Sorrow
  - restlessness

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### TRAUMA

- NOUN, Greek-"wound"
- a deeply distressing or disturbing experience.
  - "a personal trauma like the death of a child"
  - synonyms:
    - lament · agony · suffering · pain · anguish · misery · distress · heartbreak · affliction · watchfulness · woe · hell · purgatory · exorcism
- emotional shock following a stressful event or a physical injury.
  - "the event is relived with all the accompanying trauma"
  - synonyms:
    - shock · upheaval · distress · stress · strain · pain · anguish · suffering · upset · agony · misery · sorrow · grief · heartache · heartbreak · torture · disturbance · disorder · jolt · ordeal · trial · tribulation · trouble · worry · anxiety · burden · adversity · hardship · nightmare

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## FACES OF STRESS

**PTSD**

- Exposure to actual or threatened death, serious injury, or sexual violence (many ways)
- Intrusion sx associated with the traumatic event
- Persistent avoidance of stimuli associated with trauma (after trauma occurred)
- Negative alterations in cognitions & mood associated w/trauma; beginning or worsening after trauma occurred
- Marked alterations in arousal/reactivity associated w/trauma; beginning or worsening after
- Duration of disturbance (Criteria B,C,D, E) >1 month
- Disturbance causes clinically significant distress or impairment in social, occupational, other important areas of functioning
- Disturbance not attributed to physiological effects of substance or medical condition

**ACUTE STRESS DISORDER**

- Exposure to actual or threatened death, serious injury or sexual violation:
- Presence of nine+ of following sx from any of 5 categories: intrusion, negative mood, dissociation, avoidance, arousal; beginning or worsening after trauma
- Duration of the disturbance (see in Criteria B) is 3d-1 month after trauma exposure
- Disturbance causes clinically significant distress or impairment in social, occupational or important areas of function.
- Disturbance is not attributable to physiological effects or medical condition, not explained by brief psychotic disorder.

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## FACES OF STRESS

**Compassion Fatigue**

- situations where nurses had either turned off their own feelings or experienced helplessness and anger in response to the stress they feel watching patients go through devastating illnesses or trauma (Johnson, 1992)
- "cost of caring" (Figley, 1995)
- often linked with the study of burnout,
- arises from a rescue-caretaking response
  - one cannot rescue or save the individual from harm and results in guilt and distress
- appears suddenly and subsides more quickly (Valant, 2002; Stamm, 2002; Stamm, 2005)

**Burnout**

- arises and declines more slowly (Figley, 1995)
- Prolonged job stress due to emotional exhaustion, depersonalization and reduced personal accomplishment (Quinal et al., 2009)
- Breakdown in adaptation (Quinal et al., 2009)
- Gradually emerges (Quinal et al., 2009)
- from an assertiveness-goal achievement response
  - one cannot achieve his or her goals and results in "frustration, a sense of loss of control, increased willful efforts, and diminishing morale" (Valant, 2002)

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## Secondary Traumatic Stress (STS)

- Individuals experience when working with clients who are repeatedly exposed to trauma and **LOSS**.
- Researchers suggest that upsetting work experiences may lead to secondary traumatic stress (M.H. Komachi, K. Kamibeppu, D. Nishi, Y. Matsuoka, 2012)
- Stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1995)
- Among oncology nurses, 38% experienced moderate secondary traumatic stress (Quinal et al., 2009).

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## STS Symptoms

- increased negative arousal/jumpiness
- intrusive thoughts/images of patient situations**
- difficulty separating work from personal life
- lowered frustration tolerance
- increased outbursts of anger or rage/**irritability**
- dread of working with certain individuals
- depression
- ineffective and/or self destructive self soothing behaviors
- hypervigilance (sensory sensitivity)
- decreased feelings of work competence

- diminished sense of purpose/enjoyment with career
- lowered functioning in nonprofessional situations
- avoiding situations which remind the nurse of work with distressed patients
- loss of hope/**fore shortened future**
- isolation (from supporters)
- confusion
- helplessness
- difficulty sleeping**
- diminished activity level**

Gentry, Baranowsky, Dunning, 2002

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## Secondary Traumatic Stress

**RISK FACTORS**

- Empathy
- Personal experience of trauma (unresolved)
- Lack of social support
- Experience level of nursing staff
- Caring for younger pts
- Insufficient staffing

**PROTECTIVE FACTORS**

- Adequate social support
  - Personal
  - Collegial
- Use of effective strategies to ameliorate stress
- Formal process in place

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## Resolving STSS

### Personal strategies:

- Sleep
- regular exercise
- relaxation, and nutrition
- enjoying non-work-related activities
- managing a good work-family balance
- permitting personal time for grieving/losing pts
- developing coping skills
- Psychotherapy
- spiritual needs

### Professional Strategies:

- peer consultation
- setting boundaries/and personal limits
- diversifying types of patients regarding level of acuity
- identifying potential responses to difficult scenarios with patients
- focusing on positive components of one's own/pts' experiences
- meeting regularly with groups of respectful professionals who share common goals.

### Organizational Strategies:

- Breaking through the silence that often exists around secondary traumatic stress
- having comforting physical spaces for clinicians to meet
- having adequate resources regarding the job
- Encouraging an atmosphere of respect for the work done
- create a support team.

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## Emotional Coping In Grief/Loss

### ACTIVE

- Most effective
- Can include use of humor
- Reframe/redefine a difficult situation
- Use of emotional regulation skills
- Accept and use social support
- What can I control/how I respond
- Buddy system

### AVOIDANT

- Least effective
- Blame
- Distraction
- Denial
- Social withdrawal
- Substance abuse
- Can make you feel better in the short term, not effective in long term.

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## Grief Process/Coping Options

- "Best care is given if caregivers are cognizant, they have needs too."

(Mary Vlachon, 1979)

### Grief sharing procedure:

- After pt dies, attending nurse tape records the circumstances of death, who was present and their reactions, and an informal assessment of which family members might be at risk following the death. Nurse also shares personal feelings they are experiencing at the time.
- Later in the week others on the team listen to the tape during rounds set-up for the entire caregiving team to discuss deaths on the unit.
- Tape recording provides information to those not present at the death, but to also stimulate discussion about loss, share feelings and assess if anything could have been handled differently

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## Grief Process/Coping Options, cont'd

### 6 Rules to handle grief on the unit:

- #1. Health Professionals (HP) are expected to invest in and develop close relationships with seriously ill and dying children.
- #2. HP are expected to be affected & express their grief reactions in anticipation, at the moment of death or after it. The intensity & expression of their grief, however must be tempered and controlled.
- #3. Grief of HP must never be so intense as to impair clinical judgment or lead to an emotional breakdown.
- #4. Grief of HP must never exceed the grief of the family
- #5. Grief of HP never be apparent to other sick or dying children or their parents.
- #6. Team members are expected to support each other in their grief, sharing thoughts & feelings with colleagues.

Developed by psychologist Dana Papadou, 2000, pediatric unit in Athens, Greece

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## Grief Process/Coping Options, cont'd

### The "Pause"

- Initiated more than a decade ago in trauma ER
- Reactivated by Jonathan Bartels, RN now palliative care liaison RN @ UVMC
- JCAHO recognized as 15 best new practices (Cleveland Clinic) this year.
- Built into clinical protocols
- Especially useful in time of COVID19

- "Could we take a moment just to Pause and honor this person. This was someone who was alive and now has passed away. They were someone who loved and was loved. They were someone's friend and family member. In our own way and in silence let us take a moment to honor the life that's been lived and honor our own efforts that were made on their behalf."

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## Oncology Nurse Support Group

### Study by Wittenberg-Lyles, Goldsmith and Reno, 2014

- 10 oncology nurses
- 27-58 yrs of age
- Oncology practitioner 4.5-34 years
- Educations: BSN & AA
- Averaged 7 support grp mtgs/yr
  - Support group started 2009 and time of article continued to meet
- Exclusion Criteria:
  - Management complaints
  - Personal staff conflicts
  - Workload challenges

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### Barriers to ONSG

- Scheduling conflicts
- Disagreements over times to meet
  - After hours
  - Compensation
  - Day off
- Outside leader
- Inner circle leader
  - More responsibility outside of normal job duties



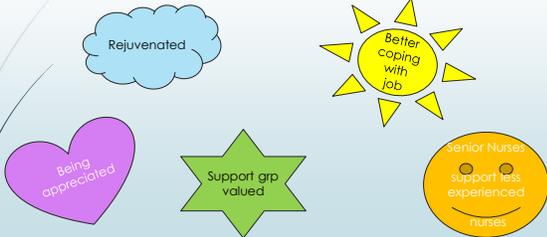
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### ONSG Benefits/Expected Outcomes



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### Peer Support Group Participants



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### Tools to Maintain Professional and Workplace Resilience

- Talking about this death/loss
  - Individually, unit groups, support groups
  - can help prevent excessive stress (secondary trauma)
  - Facilitates process of grief and mourning
- Journaling-Therapeutic
- Self-examination of Personal Inventory: "Positive reflection"
- Creative outlets
  - Music
  - Dance
  - Art
- Exercise
- Pets
- Social connections
- Mindfulness
- Gratitude Journal
- Reflection-present and past
- Support groups
- Online MH apps?

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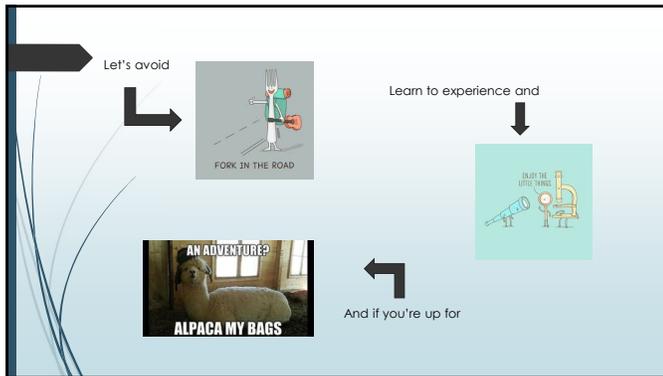


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“ Our greatest wounds, integrated, become our greatest strengths. ”

Anna Freud

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## Explore Future Directions

- ONSG
  - Eligibility Criteria
  - Baseline Criteria
- Identifying Loss Characteristics
- Incorporating Resilience and Compassion
- Practicing detailed/difficult communications
- Emotional Recharge-Define this individually
- Debrief/STSS assessment
- Caregiver's survey

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