Long Term Care
Intensive Train-The-Trainer Series

Grief, Loss & Bereavement

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Grief, Loss & Bereavement (Slide 1)

Module Overview: (Slide 2)
Loss, grief and bereavement affect resident, family and staff. Each survivor and health care professional experience grief in their own way, with his/her own coping skills, in accordance with his/her own cultural norms, belief systems, faith systems and life experiences.

The American society is a death-denying society. As such, Americans often deny the need to express grief and feel the pain that accompanies a loss, which both are beneficial to healing and loss.

Definition of Terms (Slide 3)
Grief Work – Series or stages the survivor moves through
Loss – Absence of possession or future possession
Mourning – Social express of a loss
Grief – Emotional response to loss
Bereavement – Inner feelings and outward reactions of the survivor, including grief and mourning.
Anticipatory Grief – Grief before the loss
Normal Grief – Normal feelings, behavior and reactions to loss
Complicated Grief – Grief other than normal
Death Anxiety – Loss and fear related to one's own death and mortality

Objectives: (Slide 4)

1. Differentiate between grief, loss, mourning and bereavement.
2. Identify types of grief according to characteristics and signs and symptoms.
3. Examine three stages of grief, based on task and characteristics.
4. Identify interventions appropriate for dealing with various grief stages.
5. Identify effects of death anxiety, and cumulative loss and grief on Long Term Care staff.
6. Describe method for assessing agency support systems.
7. Describe various support systems agencies can employ to help staff.

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Grief, Loss, Bereavement

Teaching Cues	Content	Resources
Use with professional trained staff only	1.0 THE GRIEF PROCESS	Slide 5
	1.1 Grief is a process. The healthcare provider's role includes facilitating the grief process by assessing grief and assisting the survivor to feel the loss, express the loss and complete the tasks of the grief process. Grief begins before the death for the resident and survivor as they anticipate and experience loss. Grief continues for the survivor with the loss of the resident. Grief affects survivors physically, psychologically, socially and spiritually.	
	1.2 The grief process is not always orderly and predictable. Usually the grief process includes a series of stages and/or tasks that the survivor moves through to help resolve grief. This is sometimes referred to as "grief work" .	
	1.3 No one really "gets over" a loss, but he/she can heal and learn to live with a loss and/or live without the deceased.	
Emphasize difference between terms	2.0 Loss, mourning, grief and bereavement	
	2.1 Loss is defined as the absence of a possession or future possession. The value of the possession is determined by and unique to the individual experiencing the loss. Losses are experienced in daily life such as through divorce or children leaving home.	
	2.2 Losses may also occur before the death for the resident and significant others as they anticipate and experience loss of health, changes in relationships and roles and loss of life. After a death, the survivor experiences loss of the loved one.	
	2.3 Most losses will trigger mourning and grief and accompanying feelings, behaviors and reactions to the loss. Residents, family members and survivors experience loss.	

Teaching Cues	Content	Resources
Definition & Examples	3.0 Mourning is the outward, social expression of a loss	
	3.1 How one outwardly expresses a loss may be dictated by cultural norms, customs, practices including rituals and traditions. Some cultures may be very emotional and verbal in their expression of loss, some may show little reaction to loss, others may wail or cry loudly, and some may appear stoic and businesslike. Religious and cultural beliefs may also dictate how long one mou rns and how the survivor "should" act during the bereavement period.	
	3.2 In addition, outward expression of loss may be influenced by the individual's personality and life experiences	
Definition & Examples	4.0 Grief is the emotional response to a loss.	Slide 6 Use with advanced clinical staff
	4.1 Grief is the individualized and personalized feelings and responses that an individual makes to real, perceived, or anticipated loss.	
	4.2 Grief can be experienced by residents, families, and survivors	
	4.3 The feelings associated with grief cannot directly be felt by others, but the reactions to the grief and associated behaviors may be assessed by the clinician. These feelings can include anger, frustration, loneliness, sadness, guilt, regret, peace and an array of other feelings.	
Definition	5.0 Bereavement includes grief and mourning - the inner feelings and outward reactions of the survivor.	
	5.1 It is often said that the survivor has a "bereavement period." This may be the time it takes for the survivor to feel the pain of loss, mourn, grieve and adjust to a world without the physical, psychological and social presence of the deceased.	

Use according to audience	6.0 Types of grief	Slide 7 Handout I
	6.1 The clinician should identify the type of grief based on characteristics, signs/symptoms of grief to be able to implement appropriate bereavement interventions.	

Define & Examples	7.0 Anticipatory grief:	
	7.1 Grief before loss associated with diagnosis, acute and chronic illness and terminal illness experienced by resident, family and health care provider.	
	7.2 Examples: actual or fear of potential loss of health, loss of independence, loss of body part, loss of financial stability, loss of choice, loss of mental function.	
Define Components	8.0 Normal grief (uncomplicated grief)	Slide 8 Handout II
	8.1 Normal feelings, behaviors and reactions to a loss	
	8.2 Normal grief reactions to a loss can be physical, emotional, cognitive and behavioral.	
Detailed and Complex work- Refer to a professional. Lecture purpose is awareness and exposure to terms.	9.0 Complicated grief Four types of complicated grief	Slide 9 Refer to grief counselor
	9.1 Chronic grief is characterized by normal grief reactions that do not subside and continue over very long periods of time.	
	9.2 Delayed grief is characterized by normal grief reactions that are suppressed or postponed and the survivor consciously or unconsciously avoids the pain of the loss.	
	9.3 Exaggerated grief - The survivor resorts to self-destructive behaviors such as suicide.	
	9.4 Masked grief - The survivor is not aware that behaviors that interfere with normal functioning are a result of the loss.	

Use only with professional audience – others, skip this section.	10.0 Risk factors for complicated grief include sudden or traumatic death, suicide, homicide, dependent relationship with deceased, chronic illness, death of a child, multiple losses, unresolved grief from prior losses, concurrent stressors, difficult dying process such as pain and suffering, lack of support systems, lack of faith system.	Slide 10
Little time & emphasis here.	10.1 Complicated grief reactions may include severe isolation, violent behavior, suicidal ideation, workaholic behavior, severe or prolonged depression, replacing loss and relationship quickly, searching and calling out for the deceased, avoidance of reminders of the deceased, imitating the deceased.	
If audience is advance practice use “risk factors, if not, use “examples”	11.0 Dis-enfranchised grief	Slide 11
	11.1 The grief encountered when a loss is experienced and cannot be openly acknowledged, socially sanctioned or publicly shared.	
	11.2 Those at risk include partners of HIV/AIDS residents, ex-spouses, ex-partners, fiancées, friends, lovers, mistresses, co-workers, children experiencing the death of a step-parent, the mother of a stillborn delivery, terminated pregnancy.	
	11.3 Dis-enfranchised grief - acknowledge and validate the survivor's relationship with the deceased, feelings, grief reactions and support his/her need for ritual, memorial service/funeral, traditions	
	11.4 Public funerals, memorial services, rites, rituals and traditions; private rituals	
	11.5 Spiritual Care	
See reference section for theorists	12.0 Stages and tasks of grief	Handout III
	12.1 There are many theorists who have developed stages of grief and a series of tasks for the survivor to successfully complete their grief work and adapt to life without the deceased.	

Task work facing bereaved	13.0 Stages and tasks of grief	Slide 12
	13.1 Stage 1: Notification and shock	
	13.2 Task - share acknowledgment of the reality of the loss, recognize the loss.	
	13.3 Characteristics - assist survivor in coping with initial impact of death, survivor may have feelings of numbness, shock, poor daily functioning, isolation, avoidance.	
	14.0 Stage 2: Experience the loss emotionally and cognitively	Slide 13
	14.1 Task - share in the process of working through the pain of the loss.	
	14.2 Characteristics – Survivor may feel anger at person who died, abandoned by them. Anger may be directed at physician, staff, family, friends. Survivor may experience sadness, loneliness, emptiness, lack of interest in daily life, insomnia, changes in appetite, apathy, disorganization.	
	15.0 State 3: Reintegration	Slide 14
	15.1 Task – Reorganized and restructure family systems and relationships and reinvest in other relationships.	
	15.2 Characteristics – Survivor finds hope in future, feels more energetic, participates in social events, acceptance of death.	
Focus is exposure to concepts. If professional audience, there are assessment variables.	16.0. Factors affecting the grief process: 1. Survivor personality 2. Coping skills 3. History of substance abuse 4. Suicidal tendencies 5. History of mental illness a) depression b) self-esteem 6. Relationship to the deceased a) survivor age b) deceased age 7. Survivor gender 8. Survivor religious/spiritual belief system 9. Survivor ethnicity, cultural traditions, rites and rituals 10. Quality of relationship 11. Type of death 12. Experience and history of losses 13. Concurrent stressors 14. Support systems 15. Death preparation	Slide 15 Use with families

Teaching Cues	Content	Resources
Full text for advance practice clinical audience – if non professional, use items with *	17.0 Anticipatory grief: Often a resident and/or family member experiencing anticipatory grief require the same grief interventions as a survivor of a deceased resident. Anticipatory grief interventions may include: 17.1* Emotional Support 17.2 Encourage verbalization of the anticipated loss. 17.3 Assist with role change, education and/or resources to master needed life skills for the survivor. 17.4 Encourage life review. 17.5 Education the resident and family on signs and symptoms of disease progression and the dying process. 17.6 Encourage the resident and family members to complete unfinished business. 17.7 * Provide presence. 17.8 Active listening, touch, * reassurance (based on cultural norms). 17.9 Decrease sense of loss as appropriate - for example, adaptive equipment such as wheelchairs to minimize loss of mobility, advance directives to minimize feelings and fear of loss of control in decision-making.	Slide 16
If non professional use * If professional use all examples	18.0 Grief interventions: 18.1 * Presence 18.2 Active listening, touch, silence 18.3 * Identify support systems 18.4 * Use of bereavement specialists, bereavement resources 18.5 Normalizing the grief process and individual differences 18.6 Actualizing the loss and facilitating living without the deceased 18.7 Identifying and expressing feelings	Slide 17

Conclusion of grief section for residents and families	19.0 Completion of the grieving process: 19.1 No one can predict when the grief work will be complete. 19.2 Grief work is never completely finished as there will always be times when a memory, object, anniversary of the death or feelings of loss occur. 19.3 Grief can diminish and healing occur as characterized by: the pain of the loss is less, the survivor has adapted to life without the deceased, the survivor has physically, psychologically and socially "let go." The survivor, however, will continue to experience memories of the deceased.	Slide 18
Introductory: focus is staff	20.0 THE LONG TERM CARE STAFF: DEATH ANXIETY, CUMULATIVE LOSS, GRIEF	
Definition and examples	20.1 Death anxiety: 20.2 Working with dying residents can trigger a healthcare provider's awareness of his/her personal losses and fears about his/her own death and mortality. 20.3 The healthcare provider may also fear expressing emotion in a medical setting that promotes "control". 20.4 Death anxiety occurs when the healthcare provider is confronted with fears about death and has few resources or support systems to explore and express thoughts and emotions about dying and death.	Slide 19
Description of negative behaviors	21.0 Defenses: When overwhelmed by death anxieties, staff may use defenses to allay fears including focusing only on physical care needs, evading emotionally sensitive conversations with residents and families, speaking only when spoken to by residents and talking only about topics that are comfortable for the healthcare provider.	Slide 20
	21.1 These behaviors result in emotional distancing, avoidance and withdrawal from dying residents and their families at a time when residents the end of life need intensive interpersonal care and active involvement by the healthcare provider.	

	21.2 Healthcare provider should be aware of their feelings, responses and reactions to death so they can provide touch, convey caring, acceptance and respect for residents and families and communicate effectively.	
Can use handouts for discussion. If using handouts, debrief participants.	22.0 Personal death awareness	Slide 21 Handout V
	22.1 One's comfort with death is affected by personality, cultural, social and spiritual belief systems, life experiences and experiences with death.	
	22.2 Adapting to caring for the dying may require the healthcare provider to explore, experience and express his/her personal feelings regarding death.	
	22.3 Personal death awareness activities/exercise, discussion of belief systems about death/afterlife with friends, peers, pastoral care workers, self-exploration and reflection may promote an understanding and acceptance of death.	
Awareness	23.0 Cumulative loss	Slide 22
	23.1 Cumulative loss is a succession of losses experienced by health care providers who work with residents with life-threatening illnesses and their families, often on a daily basis. Healthcare providers can experience anticipatory and normal grief before and after the death of a resident.	
	23.2 Not only is loss painful, but when the healthcare provider is exposed to death frequently, he/she may not have time to resolve the grief issues of one resident before another resident dies.	

Focus on new staff	24.0 Stages of adaption for the healthcare provider. Staff new to working with dying people may need to emotionally and spiritually adapt to care for the terminally ill.	Slide 23
	24.1 There are five stages of adaption of the healthcare provider for dying residents and their families including: • Intellectualization; • Emotional survival; • Depression; • Emotional arrival; • Deep compassion.	
	24.2 Working through these stages is crucial to assist the healthcare provider in relieving anxiety about dying and death, attaining personal and professional growth anf adapting to comfortably caring for redidents at the end of their life and their families.	
Intro	25.0 Factors influencing the clinician's adaption process	
	25.1 Professional training	
	25.2 In the past, healthcare providers were often told to control emotions and to emotionally distance themselves from residents and families. Residents at the end-of-life require intense interpersonal involvement and compassionate care.	
	25.3 Verbalizing feelings and expressing emotions helps the healthcare provider process grief and loss and provide quality care at the end of life.	
Refer to Handout IV	25.4 Personal death history: Past experiences with death on a personal and/or professional level and possible unresolved grief issues can influence the healthcare provider's ability to cope with caring for dying residents and their families.	

List & Explain	25.5 Life changes: • Life changes may include a death in the family, caring for elderly parents, separation from loved ones, children leaving home, divorce or illness. • These changes may signify losses, trigger grief responses and make it difficult for the healthcare provider to cope with caring for dying residents and their families.	
	25.6 Support Systems: • The presence or absence of support systems can influence the ability to move through the stages of adaption. • Emotional support provided by peers, family coworkers and instructors greatly increases the capacity to adapt to and cope with the care of the dying.	
Introduce positive responses	26.0 Systems of support	Slide 25
	26.1 The purpose of a system of support is to balance the effects of death anxiety and cumulative loss by assisting the healthcare provider in exploring and expressing feelings associated with anxiety, loss and grief and adapting to caring for the dying resident and family.	
	26.2 Balance is the ability to provide compassionate, quality care to dying residents and their families and find personal satisfaction in work as healthcare providers.	
Evaluation by administration of agency	27.0 Assessing support systems	Slide 26
	27.1 Does the setting support or inhibit the healthcare provider's professional adaptation, growth and development in caring for dying residents or families?	
	27.2 Does the setting provide a supportive environment where the healthcare provider feels safe to express death, anxiety, emotions, loss and grief?	

Intervention by administration for an agency.	28.0 Formal support systems can include: 28.1 Pre-planned gatherings where the healthcare provider can express feelings in a safe environment. 28.2 Post-clinical debriefing after the clinical experience can help relieve anxieties by allowing the student to relate the emotion to the experience and explore and express feelings related to dying and death. 28.3 Ceremonies, programs to acknowledge and express grief such as planned memorial services for all residents who have died.	Slide 27 Handout VI
	29.0 Informal support • Informal support is one to one sharing of experiences with co-workers, peers, instructor, pastoral care worker, physician.	Slide 28
	30.0 Mentor/Preceptor Support • The presence of a supervisor, mentor, instructor during the care of the dying, when a family member visits, and/or at the time of the resident's death, can greatly decrease anxiety and provide immense support to the healthcare provider. 30.1 The healthcare provider will often find comfort in knowing she/he is not alone.	Slide 29
	31.0 Spiritual support • Pastoral care workers and/or spiritual advisors can assist the healthcare provider in spiritual reflection, exploration, and spiritual replenishment.	Slide 30
	32.0 Education in end-of-life care • Knowledge and skills in end-of-life care promote competence and self-confidence, which decreases anxiety in caring for residents at the end-of-life and their families.	Slide 31 Handout IV

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	33.0 Individual facilitated support The healthcare provider also has a personal and professional responsibility to seek individual facilitated support systems to cope with death anxiety, loss and grief including:	Slide 32
	33.1 Acknowledge limitations;	
	33.2 Ask for help from co-workers, other professionals including social workers, pastoral care persons, supervisors, instructors. Tell them what you need and how they can help;	
	33.3 Journal writing – writing about feelings is often an effective expression of emotions and can assist the healthcare provider with release, introspection and reflection in a safe environment;	
	33.4 Exercise;	
	33.5 Relaxation;	
	33.6 Socialization with friends;	
	33.7 Hobbies;	
	33.8 Play.	
	CONCLUSIONS 34.0 Staff care and responsibilities to the dying resident and their family might not end with the death of the resident. Loss, grief and bereavement should be assessed upon admission and bereavement care should continue after the death of the resident.	Slide 33
	34.1 Bereavement care is interdisciplinary care and our psychosocial colleagues have much to offer.	
	34.2 Healthcare providers, as all professionals, must recognize and respond to their own grief in order to provide quality palliative care.	

Teaching Cues	**Comment**	**Resources**
Discussion	John & Rose Case Study	Handout VII
	Additional Resources: 1. Last Acts Pamphlets Helping Through Difficult Times 2. Caregivers 3. A friend 4. Children 5. Healthcare providers 6. The elderly	

Resources

Doka, K. (1989). Grief. In R. Kastenbaum & B. Kastenbaum. (Eds.). Encyclopedia of Death (p. 127). Phoenix, AZ: The Oryx Press.

Parkes, C.M. (1999). Bereavement: Studies of Grief in Adult Life. Lkondon: Tavistock.

Worden, J.W. (1991). Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner (2nd Ed.). New York, NY: Springer Press.

Rando. T. A. (1984). Grief, Dying and Death: Clinical Interventions for Caregivers. Champaign, IL: Research Press.