

# **ELNEC- For Veterans**

END-OF-LIFE NURSING EDUCATION CONSORTIUM

Palliative Care For Veterans

## **FACULTY**

## **GUIDE**

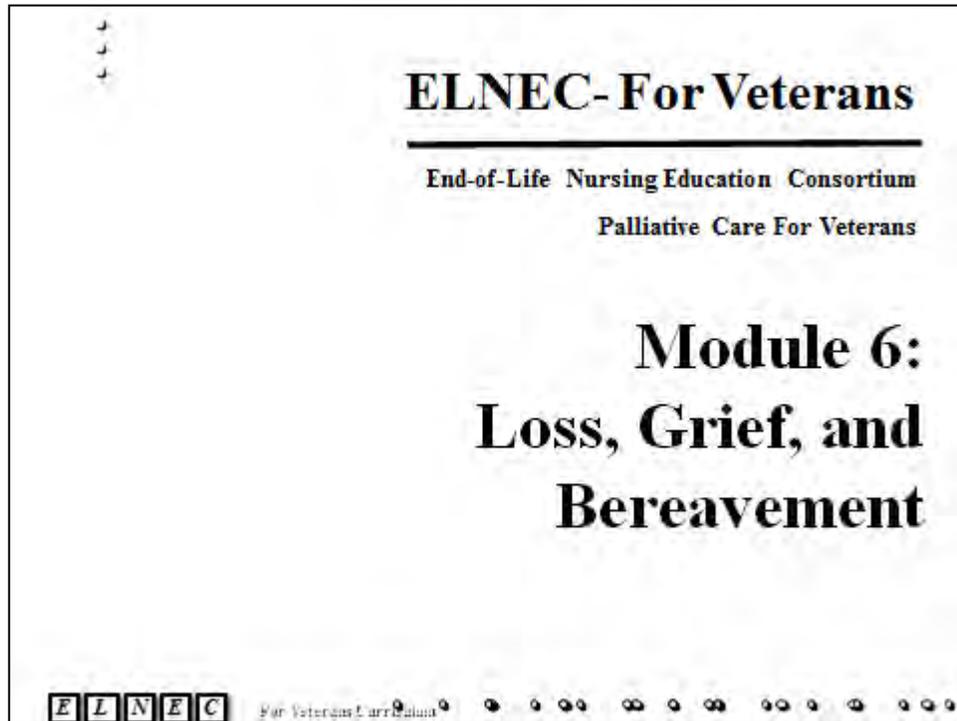
Module 6

Loss, Grief & Bereavement

The End-of-Life Nursing Education Consortium (ELNEC – For Veterans train-the-trainer program and curriculum was developed by the National ELNEC Project Team, a partnership between the City of Hope (Betty R. Ferrell, PhD, RN, MA, FPCN, FAAN, Principal Investigator) in collaboration with the American Association of Colleges of Nursing (Pam Malloy, MN, RN, FPCN, FAAN, Co-Investigator). Curriculum development and 6 national ELNEC-For Veterans train-the-trainer courses were generously funded by the US Department of Veterans Affairs (2009-2012).

## Module 6: Loss, Grief & Bereavement Faculty Outline

### Slide 1



*“In three words I can sum up everything I’ve learned about life:  
IT GOES ON.”*

*“Hope does not lie in a way around, but in a way through”*

*Robert Frost (1874-1963)*

This module addresses the challenging aspects of grief, loss and bereavement of Veterans and their families as well as the experiences of health care professionals. This module (developed to be interactive) will cover two areas:

1. Assessment and management of loss, grief and bereavement of Veterans, their families, and friends.
2. Assessment and management of loss, grief and bereavement of nurses, as they care for Veterans, their families and friends.

## Slide 2

**Key Learning Objectives**

**At the completion of this module, the participant will be able to:**

- 1. Define loss, mourning, grief and bereavement.**
- 2. Distinguish between anticipatory grief, normal grief, complicated grief, disenfranchised grief and traumatic grief.**
- 3. Describe three interventions that may be appropriate to facilitate normal grief.**
- 4. Identify three systems of support the nurse can access to assist in coping with grief and loss.**

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### Slide 3

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## Loss, Grief and Bereavement



- **Veterans, their families, and nurses all experience losses**
- **Veteran's grief can be unique**
- **Stoicism**
- **An interdisciplinary care approach is vital**

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- Loss, grief and bereavement are experienced by the Veteran, their families and nurses—each must grieve in their own way:
  - Using their own unique coping skills,
  - In accordance with their own cultural norms, belief and faith systems,
  - Past and present life experiences related to various types of grief,
  - The United States is a death-denying society. As such, Americans often deny the need to express grief and feel the pain that accompanies a loss. Both are beneficial to healing.
- Veterans who have had experiences on the battlefield may grieve differently than non-Veterans, due to multiple losses and the horror of war. For many, their military comrades are their family.
- Many Veterans have witnessed horrors on the battlefield and have learned to be stoic, so they are able to continue with their mission and “fight to the bitter end”. This stoicism can carry over into other areas of the Veteran’s life. Stoicism can also affect whole family systems. Grief may be hidden by a silent or angry facade (Grassman, 2009 & 2015).
- Nurses should utilize an interdisciplinary team (physicians, social workers, chaplains, volunteers, grief and bereavement counselors, psychiatrists, psychologist, etc) to facilitate the grief process of the survivor. Each discipline can contribute their expertise to the bereavement plan of care.

## Slide 4

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# Nurse's Role

- **Assess the grief**
  - Type
  - Reaction
  - Influencing factors
- **Assist with grief issues**
- **Support survivors**
- **Know goals of care**

Chovan et al., 2015; Corless, 2015; NCP, 2013



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- Nurses have a unique role in assessing, assisting, and supporting the Veteran and their family/friends who are experiencing grief, loss, and bereavement issues. The nurse's role includes (Chovan et al., 2015; NCP, 2013):
  - Facilitating the grief process by thoroughly assessing the grief
    - Type of grief - anticipatory, normal, complicated (including risk factors for complicated grief), disenfranchised
    - Grief reactions - normal or complicated?
    - Factors that may affect the grief process
  - Assisting with grief issues that the Veteran may be experiencing (i.e. loss of health, loss of a body part, loss of control, loss of a business, loss of a dream, impending loss of life, etc.) Refer to appropriate team members as needed.
  - Supporting the survivors to:
    - Feel the loss
    - Express the loss
    - Complete the tasks of the grief process
- Many caregiver survivors do not care for themselves while caring for their sick loved one. As such, an assessment should also include: (Corless, 2015):
  - General health check-up and assessment of somatic symptoms, dental/eye check-ups, nutritional evaluation, sleep assessment, examination of ability to maintain work and family roles
  - Assessment of social networks (i.e. VFW, American Legion, Fleet Reserve and other services-specific organizations may be vital networks for Veterans)

- Determination of whether there are major changes in presentation of self
  - Assessment of changes resulting from the death and the difficulties with these changes (Glass et al., 2015).
- Frequently identifying the Veteran's goals of care is vital in further assessment of risk and benefit, best evidence and Veteran/family preferences.

**Goal:** Address psychological needs, treat any psychiatric disorders, promote adjustment, and support opportunities for emotional growth, healing, reframing, completion of unfinished business, and support through the bereavement period (NCP, 2013).

## Slide 5

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# The Grief Process



- **Begins prior to death**
- **Not orderly/predictable**
- **Grief work: stages and tasks**
- **No one really “gets over it”**
- **Living with and accepting the loss**

Corless, 2015; Lindemann, 1940

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- Grief work is a process. Grief begins before the death for the Veteran and survivor as they anticipate and experience loss. Grief continues for the survivor with the loss of their loved one.
- 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", originally coined by Erich Lindemann (Lindemann, 1940). This work is non-linear and people can move forwards and then backwards through the trajectory.
- 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.
- Grief work begins as the survivor begins to live with and accept the loss (Corless, 2015).
- Nurses, who spend more time at the bedside than any other healthcare professional, have a unique opportunity to assist the Veteran and his/her family through the grief process. It permits us to be present, to listen, to care, and to be compassionate when people are the most vulnerable.

## Slide 6

**Loss, Grief, Mourning, and Bereavement**

- **Loss: A person, thing, relationship, or situation**
- **Grief: Emotional response to loss**
- **Mourning: Expression of loss**
  - Stoicism-affects the expression
- **Bereavement: Reaction to the death**
- *Be aware of and respect culture*

Corless, 2015; Grassman, 2015; Mazanec & Panke, 2015; Periyakoil, 2016

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- *Loss* is defined as the absence of a possession or future possession, and with this comes the response of grief and the expressions of mourning and bereavement. Loss can also include a change in body image, loss of a body part, functionality, etc. Loss of health can mean losses involving a job and /or financial security. Loss may occur before the death for the Veteran and significant others as they anticipate and experience loss of health, changes in relationships and roles and loss of life (anticipatory grief). After a death, the survivor experiences loss of the loved one. Most losses will trigger mourning and grief and accompanying feelings, behaviors and reactions to the loss. Veterans (loss of health, financial security, loss of body part, etc.), family members and survivors all experience loss. Veterans may suffer in silence (Periyakoil, 2016).
- *Grief* is the emotional response to a loss. Grief is the individualized and personalized feelings and responses that an individual makes to a real, perceived, or anticipated loss. 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 nurse. These feelings can include anger, frustration, loneliness, sadness, guilt, regret, peace, etc.
- *Mourning* is the outward, social expression of a loss. How one outwardly expresses a loss may be dictated by cultural norms, customs, and 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 mourns and how the survivor "should" act during the bereavement period. In addition, outward expression of

loss may be influenced by the individual's personality and life experiences (Corless, 2015). Be aware of stoicism, as it may affect the expression of grief (Periyakoil, 2016).

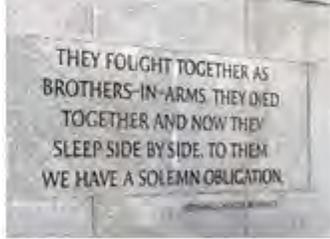
- *Bereavement* includes grief and mourning - the inner feelings and outward reactions of the survivor. It is often said that the survivor has a "bereavement period." This may be the time it takes for the survivor to feel the pain of loss, mourn, grieve and adjust to a world without the physical, psychological and social presence of the deceased. The bereaved person should be encouraged to:
  - Talk about the death
  - Understand that their feelings are normal
  - Allow sufficient time for the expression of grief
  - Solve immediate, practical problems, but postpone long-term decisions such as a place of residence or a change of job
- It is the nurse's responsibility to be aware of the cultural characteristics of grief and mourning for Veterans, family members, and survivors they care for. In thinking of culture, remember not only race, ethnicity, etc. but recall the culture of the military and the culture of stoicism that often accompanies it. In addition, the nurse should identify the type of grief based on characteristics, signs/symptoms of grief to be able to implement appropriate bereavement interventions and refer to other members of the interdisciplinary team members as needed (Grassman, 2015; Mazanec & Panke, 2015).

## Slide 7

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# Military Culture Influence on Bereavement Care

- **Stoicism**
- **Death can trigger PTSD or activate grief**
- **Brotherhood**
- **Estrangements, forgiveness, reconciliation issues.**



Grassman, 2009

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Military Culture can influence bereavement care:

- Stoicism may not allow the Veteran to be a gracious receiver of care.
- Death of a loved one can trigger PTSD or activate grief. Those with PTSD do not trust easily or reach out.
- Brotherhood that continues into caring for Veterans as they are dying.
- PTSD/alcohol abuse create multiple families, estrangements, forgiveness/reconciliation issues (Grassman, 2009).

Slide 8

**Military Culture Influence on Bereavement Care (continued)**

- **Isolation**
- **Past experiences with violent/mutilating death**
- **No time to mourn the death of comrades**
- **Anger/bitterness towards how they have been treated**
- **May be eligible for burial benefits, including burial at a national cemetery**

Grassman, 2009

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- Isolation, “bunkering down.”
- Past experiences with death were violent and mutilating – and therefore, not peaceful (Grassman, 2009).
- No time to mourn the death of comrades – they were in danger and had to keep moving.
- Might have anger/bitterness towards how they have been treated: medals, pensions, name on Wall, staying alive for pension.
- Veterans may be eligible for burial benefits, including burial at a national cemetery.

## Slide 9

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# Influence of Military on Family Members and Bereavement

- **Stoicism**
- **Frequent relocation**
- **PTSD**
- **Possible anger, bitterness**



Grassman, 2009

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- Stoicism: Affects the Veteran and whole family system.
- Frequent relocation: no roots but also might know how to reach out.
- PTSD
  - Identifying PTSD for the first time often emerges during life review or the death vigil which can result in either relief or guilt for the family member.
  - Validate influence of PTSD on the family. Remember that caring for someone with PTSD may increase caregiver burden (Grassman, 2009).
- Might have anger/bitterness toward how their loved one has been treated: Lack of medals, pensions, name on Wall, etc.
- Secondary gain: keeping alive for pension (Grassman, 2009).

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## Complications of Bereavement

- **Traumatic grief**
- **At risk for mental and physical health problems (i.e. prolonged grief, depression, anxiety, alcohol, poor nutrition and more)**

NHPCO, 2011

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- When a death is sudden, violent and untimely, the bereaved will most likely also have other difficulties. The condition in which unmanageably intense and/or persistent grief symptoms occur is called *traumatic grief*. Traumatic grief may predispose to other psychiatric, medical, and behavioral problems that can complicate bereavement. These are generally treatable conditions and need to be recognized by professionals and by the bereaved individuals themselves.
- Bereavement is a risk factor for a range of mental and physical health problems. Among these are the following (NHPCO, 2011):
  - Prolonged grief of traumatic grief
  - Onset or recurrence of Major Depressive Disorder
  - Onset or recurrence of Panic Disorder or other anxiety disorders
  - Possible increased vulnerability to PTSD
  - Alcohol and other substance abuse
  - Smoking, poor nutrition, low levels of exercise
  - Suicidal ideation
  - Onset or worsening of health problems, especially cardiovascular and immunologic dysfunction

## Slide 11

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### Specific Losses Experienced by Veterans at End of Life

- **Life-time friends, comrades**
- **Body part(s)**
- **Overall health**
- **Financial insecurity**
- **Hopes and dreams**
- **Employment**
- **Sexuality**

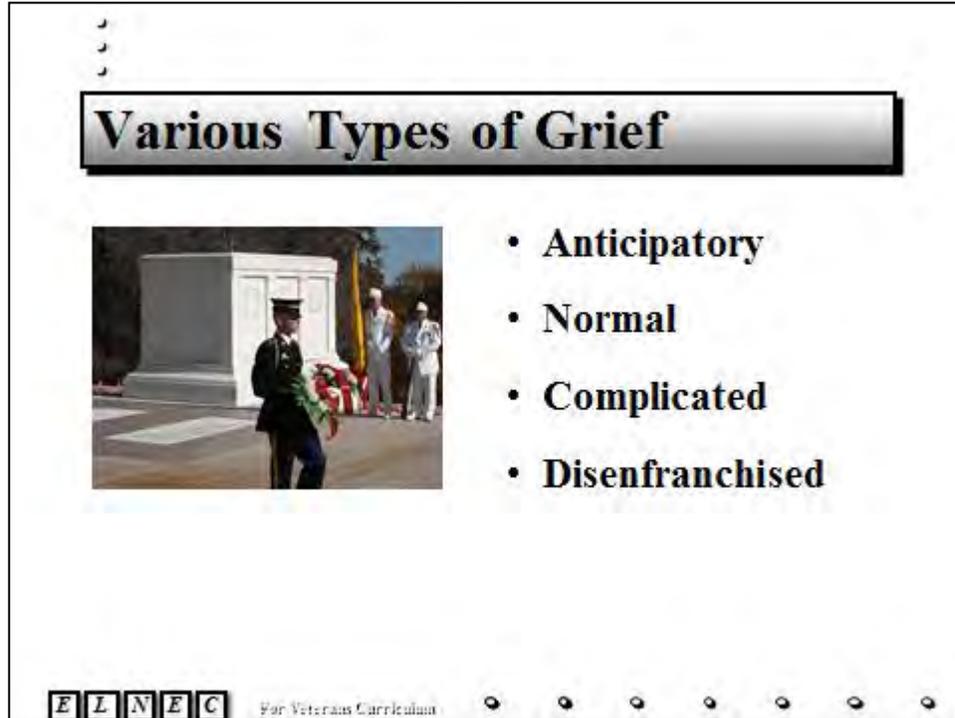


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- Veterans experience many losses as they witness the death of their own comrades, as well as experience their own end of life issues. Veterans feel a close bond to those they served in the military with, many who have become life-time friends. Many attend reunions and travel around the world to see their comrades.
- The loss of body parts, whether in the line of duty or due to secondary diseases can cause grief, as what-was-will-never-be again.
- The loss of overall health, due to being injured on the battlefield or just the natural progression of health as one ages, can cause mourning and grief. Additional anger may be felt by those who are experiencing a terminal illness due to wartime activities (i.e. exposure to Agent Orange, etc).
- Terminal illness can cause a decrease in financial security, due to extra expenses related to medical bills, travel to and from VA, non-VA Centers, possible lodging for those who live many miles away, help with homecare, and other costs related to care.
- People always have a dream—wishing they could live long enough to do something special or to go someplace they have always wanted to see. Terminal illness may mean that those dreams will not come to fruition.

- For Veterans who are still employed, their terminal illness may not allow them to continue with their profession. Many have their identity focused around their profession. So for some, they may not have only lost a job, but also their identity that is wrapped-up in their work.
- Sexual expression remains important well into the later decades of life and may be compromised due to injuries of War, PTSD, or depression (Matzo, 2015; Tran et al., 2015).

## Slide 12



### Various Types of Grief



- Anticipatory
- Normal
- Complicated
- Disenfranchised

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- It is important that nurses understand signs/symptoms of the various types of grief so they can consult with other members of the interdisciplinary team as needed. No matter what the Veterans' culture is, grief is a universal experience and should be assessed.
- *Anticipatory Grief:*
  - Anticipatory grief is defined as grief before loss and can be experienced by the Veteran, family and caregivers. Examples of anticipatory grief include:
    - Actual or fear of potential loss of health
    - Independence
    - Body part
    - Financial stability
    - Choice
    - Mental function
- *Normal Grief:*
  - Normal grief is described as normal feelings, behaviors and reactions to a loss.
  - Normal grief reactions to a loss can be physical, emotional, cognitive, and behavioral.
  - Active grieving can take years. We don't get over the loss, but the relationship with the deceased changes. There is a reconnection with the world of the living.
- **Complicated Grief:** Four types of complicated grief:
  - Chronic grief is characterized by normal grief reactions that do not subside and continue over very long periods of time.

- 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 (e.g. refuses to talk to anyone about the grief, not interested in bereavement groups, etc).
  - Exaggerated grief is illustrated by intense reactions that may include nightmares, delinquent behaviors, phobias (abnormal fears) and thoughts of suicide.
  - Masked grief is where the survivor is not aware that behaviors that interfere with normal functioning are a result of the loss (e.g. cancels playing golf with friends so they can go to the cemetery every day to see loved one's grave).
- *Disenfranchised Grief*: Disenfranchised grief is defined as any loss that is not validated or recognized and the person does not have the freedom to openly acknowledge their grief. Society may not want to acknowledge the grief and does not know how to deal with the loss. Those at risk include: Veterans who participated in “unpopular” war(s), partners of HIV/AIDS patients, ex-spouses/partners, fiancées, children experiencing the death of a step parent, etc.

**Note:** Veterans can have many risk factors for complicated grief: 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. Factors that can contribute to complicated grief are: Lack of support system, concurrent losses, and poor coping skills.

In addition, many resources cite that complicated grief is PTSD, as defined by the *Diagnostic & Statistical Manual* (DSM) (i.e. death is an experienced trauma; the griever keeps re-experiencing it with any number of trigger; they try to block it out by avoiding the triggers and/or locking up the grief; there are times when the memories intrude and interrupt anyway; this lasts beyond the usual time period) (Grassman, 2009).

## Slide 13

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### Traumatic Grief Specific to Veterans

- Sudden loss of Veteran
- Experience of multiple losses or deaths
- Exposure to accidental civilian deaths
- Death from friendly fire
- Self-blame for accidental death(s)



Pivar, 2004  
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- Traumatic grief is often seen in Veterans.
- Veterans often describe the attachment and bonding they feel with other Veterans. Some state that the relationships they have built with other Veterans (many went through training and deployment together) are the closest they have formed in their lives. So, when a Veteran colleague suddenly dies, it can be traumatic.
- Many Veterans have witnessed multiple deaths on the battlefield. They may have lost most of their comrades.
- Veterans may have witnessed the loss of a large number of civilian deaths due to bombing, firefights, accidents, natural disasters, accidents, etc. Many blame themselves for accidental deaths to innocent civilians (Pivar, 2004).
- Many Veterans have seen their fellow soldiers die from “friendly fire” and they re-play these events many times in their minds.

**Note:** Remember that not all Veterans saw combat duty. However, they are still affected by death. Many may feel guilty about not serving in a war. All of these points can relate to the Veteran’s current grief. This can play into their fear of grieving and deaths they have witnessed can trigger all of their past, unresolved grief.

Slide 14

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## Acute Traumatic Grief

- **Symptoms of grief are distinct from PTSD and depression**
- **Symptoms of distress: intense agitation, outbursts of anger, high-risk behaviors, self-accusations, suicidal ideations**
- **Self-imposed on normal bereavement**
- **Reactions of those who have lost comrades are many**

Pivar, 2004

Pivar, 2004

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- Symptoms of grief are distinct from PTSD and depression.
- Veterans who survive traumatic events, such as war, can exhibit acute symptoms of distress (i.e. intense agitation, outbursts of anger, self-accusations, high-risk behaviors, suicidal ideation, PTSD).
- These symptoms are superimposed on the symptoms of normal bereavement.
- It has been documented that soldiers who have lost their comrades in war have:
  - Attempted to make heroic efforts to save them or to even recover their bodies after they have died.
  - Reacted with great anger at the enemy.
  - Become withdrawn/loners to avoid making friends ever again.
  - Expressed anger at the events that caused the trauma and the personnel that brought them to the event that caused the trauma.
  - Remembered “no one left behind” and experienced guilt of they had to leave someone behind.
- Many may mask their emotions—showing vulnerability can indicate they are weak and unable to handle combat/war (Pivar, 2004).

**Exercise - Stop and Consider:**

- How frequently do you see Veterans experiencing traumatic grief in your own practice?
- Which of these symptoms do you see most often?
- How do you assess and manage this type of grief at your institution?

## Slide 15

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# Assessment and Treatment of Acute Grief



- **Intense grief is normal in early stage**
- **Masked feelings may emerge**
- **Ambiguous loss**
- **Open communication**

Ambiguous Loss, n.d.; Boss, 1999; Carroll et al., 2007

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- Intense feelings of grief are normal for the first few days, weeks, and months after surviving a traumatic loss.
- Data shows that soldiers who survive a traumatic loss in the actual war zone are more likely to mask their feelings of pain, sadness, vulnerability, anxiety, anger, and guilt. Balancing all of these emotions along with the intense grief and sense of loss can be overwhelming. This can impede their ability to cope, so it is important to be aware of the Veteran masking many of these feelings.
- Ambiguous loss may occur for some Veterans. There are two types of ambiguous loss situations: Type One occurs when there is physical absence and psychological presence. According to Boss (1999), this situations occur when someone is missing or bodily gone. Examples for Veteran's may the loss of include missing bodies in the context of war (Carroll et al., 2007). Type Two refers to people who are physical present but missing psychologically. This could include a returning Veteran who has suffered immeasurable mental health issues such as PTSD, traumatic brain injury, depression, addiction and more (Ambiguous Loss, n.d.).
- Veterans need to know that someone cares—someone wants to hear their story. Open communication with healthcare providers may be the first step in coming to terms with the actual loss.

Slide 16

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## Assessment and Treatment of Acute Grief (continued)

- Respect Veteran's ability to cope
- Acknowledge the loss
- Self-care
- Interdisciplinary team

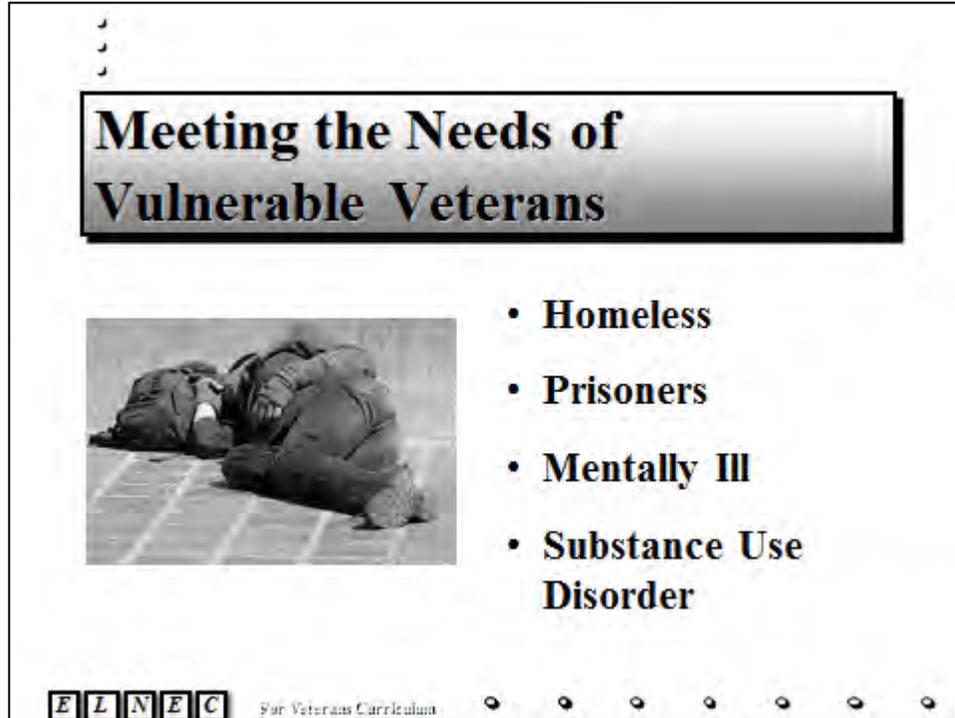
Grassman, 2009; Pivar, 2004

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- Respect their feelings and their ability to cope—create a safe emotional environment so they can share if they want to.
- Acknowledge the loss.
- Encourage them to take care of themselves not only physically, but also emotionally, mentally, socially, and spiritually. This allows them to relax and feel comfortable around those who care for them. Healthy coping mechanisms (i.e. exercise, proper nutrition and rest) can holistically nurture the body, mind, and soul. The interdisciplinary team needs must be involved (Pivar, 2004).
- Give them permission to grieve. Crying does not mean they are a weak soldier.

**Goal:** Not to take Veterans away from their grief, which may make them feel abandoned. Rather, show them how to go into their grief, which does not come naturally for Veterans (Grassman, 2009).

## Slide 17



The slide features a title box at the top with the text "Meeting the Needs of Vulnerable Veterans". Below the title is a photograph of a person curled up in a sleeping bag on a paved surface. To the right of the photo is a bulleted list of four categories: Homeless, Prisoners, Mentally Ill, and Substance Use Disorder. At the bottom left of the slide is the logo "ELNEC" and the text "For Veterans Curriculum".

### Meeting the Needs of Vulnerable Veterans

- Homeless
- Prisoners
- Mentally Ill
- Substance Use Disorder

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- Meeting the needs of vulnerable Veterans experiencing grief issues is an enormous challenge for the VA. Every effort should be made to assess these Veterans when they enter a VA healthcare facility for loss, grief, and bereavement issues.
- As learned in Module 1 and 4, many Veterans are homeless or are incarcerated. Homelessness and prison is all about loss and the grief that surrounds it.
- Veterans with mental health issues require special attention to grief and loss, including those with PTSD and depression or substance use disorders (SUD).

### **Exercise - Stop and Consider:**

- If a vulnerable Veteran was brought to your institution (as mentioned in the above slide), what systems are in place to assess for loss, grief, and bereavement?
- What systems of care work well?
- What are areas that need improvement?

### **Note:**

- The VA offers a wide array of special programs and initiatives specifically designed to help homeless Veterans live as self-sufficiently and independently as possible. The VA is the only Federal agency that provides substantial hands-on assistance directly to homeless persons. Although limited to Veterans and their dependents, VA's major homeless-specific programs constitute the largest integrated network of homeless treatment and assistance services in the country. For more resources regarding homeless Veterans, go to

*Ending Veteran Homelessness*; retrieved March 9, 2016 from <http://www.va.gov/HOMELESS/index.asp> and the *National Coalition for Homeless Veterans* at: <http://www.nchv.org/>

- The VA has a homelessness prevention strategy and programs to assist Veterans who are in prison to not return to the streets after being incarcerated (More information on this in the Culture Module).

## Slide 18

Remember the Children:  
They Grieve, Too

- **Based on developmental stages**
- **Can be normal or complicated**
- **Symptoms unique to children**



Limbo & Davies, 2015; NCP, 2013; Williams, 2006

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- Children or grandchildren of Veterans, whether young or old, grieve based on their developmental stage and their grief can be normal and/or complicated.
- Symptoms of grief in younger children are numerous: Nervousness; uncontrollable rages; frequent sickness; accident proneness; rebellious behavior; hyperactivity; nightmares; depression; compulsive behavior; memories fading in and out; excessive anger; excessive dependency on remaining parent; recurring dreams of wish-filling; denial and/or disguised anger.
- Symptoms of grief in older children include: Difficulty concentrating; forgetfulness; poor school work; insomnia or sleeping too much; reclusiveness or social withdrawal; antisocial behavior; resentment of authority; overdependence; regression; resistance to discipline; talk of or attempted suicide; nightmares; symbolic dreams; magical thinking; frequent sickness; accident proneness; overeating or under eating; truancy; experimentation with alcohol/drugs; depression; secretiveness; sexual promiscuity; staying away or running away from home; compulsive behavior.
- Children's cognitive development may interfere with their ability to understand the irreversibility, universality, and inevitability of death. This can lead to emotional confusion as they filter through their own personal thoughts, as well as seeing their parents/siblings mourn (Limbo & Davies, 2015).

- Developmentally appropriate assessment and support must be provided to children and grandchildren of adult Veterans (patients) (NCP, 2013).
- For children who lost a parent in active duty, the death is compounded by secondary losses (i.e. relocation, loss of military community/culture, changes in support network and friends) (Williams, 2006).

**Note:** Does your facility offer these services to children? Do you have a Child Life Specialist and/or a Child Psychologist on your team?

Slide 19

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## Stages and Tasks of Grief

- **Stage 1: Notification and Shock**
- **Stage 2: Experience the Loss**
- **Stage 3: Reintegration**

Corless, 2015

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- 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.
- Stages and tasks of grief include (Corless, 2015):
  - *Stage 1: Notification and shock*  
Task - share acknowledgment of the reality of the loss, recognize the loss.  
Characteristics - assist survivor in coping with initial impact of death, survivor may have feelings of numbness, shock, poor daily functioning, isolation, avoidance.
  - *Stage 2: Experience the loss emotionally and cognitively*  
Task - share in the process of working through the pain of the loss.  
Characteristics - Survivor may feel anger at person who died, abandoned by them. Anger may be directed at physician, nurse, family, and friends. Survivor may feel guilt based on perceptions of "not doing enough." Survivor may experience sadness, loneliness, emptiness, lack of interest in daily life, insomnia, changes in appetite, apathy, and disorganization.
  - *Stage 3: Reintegration*  
Task - Reorganize and restructure family systems and relationships and reinvest in other relationships.  
Characteristics - Survivor finds hope in the future, feels more energetic, participates in social events, and accepts death.

**Note:** *The Wounded Warriors: Their Last Battle Facilitator's Guide for Grief Work with Veterans' Families* was developed by a workgroup of the National Hospice and Palliative Care Organization's (NHPCO) Veterans Advisory Council (VAC) and is part of a series of materials and resources produced for hospice and other healthcare providers in the community (NHPCO, 2012).

The slide features a title box at the top with the text "Factors Influencing the Grief Process". Below the title, there is a list of seven factors arranged in two columns. At the bottom left of the slide, there is a logo for "ELNEC For Veterans Curriculum" and a series of navigation icons.

**Factors Influencing the Grief Process**

- Survivor personality
- Coping skills/patterns
- History of substance abuse
- Relationship to deceased
- Spiritual beliefs
- Type of death
- Survivor ethnicity and culture

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- There are many factors that affect the grief process:
  - Survivor personality
  - Coping skills
  - History of substance abuse
  - Relationship to the deceased - do not assume that all relationships were warm and loving.
  - Survivor religious/spiritual belief system
  - Existing support systems that are in place through the survivor's church, mission, synagogue (etc.)
  - Type of death -- Sudden? Long/chronic illness? Suicide?
  - Survivor ethnicity, cultural traditions, rites and rituals. There are variations among rituals and mourning practices in different cultures which provides a context for the grief experience. It gives members a sense of security and of coherence and the emotional, social and physical resources in which to frame it (Mazanec & Panke, 2015). Refer to *Module 5: Culture* for further information.
- Other factors to consider regarding the survivor: Suicidal tendencies, history of mental illness (i.e. depression), survivor gender, support systems, concurrent stressors, experience and history of losses, death preparation.

**Exercise - Stop and Consider:** Be aware that those who served in the Vietnam conflict have had the most difficulty with activities of daily living than those who served in Korea or the Persian Gulf Wars. So there may be fewer support systems assisting those who served in Vietnam (Daratsos, 2011).

Slide 21

Slide 21 content:

- **Plan of care**
- **Attitude**
- **Cultural practices**
- **What to say**
- **Anticipatory grief**
- **Grief work is never completely finished**
- **This can be NURSING AT ITS FINEST!**

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- Bereavement interventions are multi-faceted.
- Plan of care - After assessment, the nurse, along with other members of the interdisciplinary team (i.e. psychologists, social workers, etc) creates a bereavement plan of care with the goal of facilitating the grief process. The team implements bereavement interventions.
- Attitude - The nurse should maintain an accepting, non-judgmental attitude when providing bereavement support and care.
- Cultural practices - Each survivor's cultural practices in mourning and grief reactions should be respected and honored.
- What to say - Nurses may fear "saying the wrong thing" to a survivor, or they may fear not knowing what to say to a survivor. Points to remember:
  - Be present, listen actively
  - Assist in identifying support systems
  - Collaborate and refer to bereavement specialists/bereavement resources
  - Normalize the grief process
  - Individualize the grief process
  - Actualize the loss and facilitate living without the deceased
- Anticipatory grief - Often a Veteran and/or family member experiencing anticipatory grief requires the same grief interventions as a survivor of a deceased Veteran. Provide emotional

support, encourage verbalization, assist with role changes, education and/or resources, encourage life review, educate about dying process, encourage completion of unfinished business. Provide presence, active listening, touch, and reassurance.

- 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.
- Provide presence, active listening, touch, silence, identify support systems, use bereavement specialists/resources, normalize and individualize the grief process, actualize the loss and facilitate living without the deceased, acknowledge disenfranchised grief, encourage public funerals/memorial services/rites/rituals/traditions, assess for need of spiritual care, recognize grief of children, make referrals as needed.
- Being able to do this work during the time of future or immediate loss can bring out the best in all nurses. It allows us to do what we do best - care and advocate for Veterans and their families. Many nurses feel the importance of doing some concrete application to bereavement interventions. For example, some units send bereavement cards to grieving families two weeks after the funeral/memorial service of their loved one. At the one-year anniversary of the death of the Veteran, another card is sent to the family. Some plan “memorial services” on a quarterly basis for those who died within the last 3 months. VA staff, as well as the bereaved family members are invited to attend this service, which is held at the VA facility. The names of each Veteran who died in the past 3 months is read. It is an opportunity to honor Veterans and to say, “We remember.”

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## Nurses Experiences and Compassion Fatigue



- **Witness to medically futile care**
- **Can lead to prolonged suffering, denial of palliative care services, moral distress and compassion fatigue**

Ferrell, 2006; Ferrell & Coyle, 2008

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- With the advancement of technology and the ability to prolong life, nurses frequently witness medically futile care. Examples of medical futile care that nurses frequently witness include:
  - Aggressive care that denies palliative care and prolongs suffering
  - Code status or resuscitation not being addressed
  - Ventilator/life support, nutrition, hydration, feeding tube, blood transfusions, chemotherapy, dialysis being recommended and knowing it will provide futile care
  - Poor pain management or other symptom management, like agitation or PTSD
  - Violation of Veteran (patient) decisions
  - Disagreement with the choices that the families make (i.e. feeling that the family is being inappropriately aggressive)
- This can lead to prolonged suffering and denial of palliative care services for their patients and intense moral distress for themselves. Nurses experience a great deal of moral distress regarding medically futile care and this can lead to a variety of responses and emotions. These may include:
  - Advocacy for patients and their families
  - Torture, assault, violence, or cruelty to patients receiving futile care
  - Personal frustration, distress, anger, or feeling demoralized, powerless, helpless, or hopeless
- Many times these experiences will lead a nurse to become frustrated and powerless to change “the system.” Their distress and discouragement can be devastating as many will experience compassion fatigue and some will choose to leave the nursing profession.

- All of these factors can lead to compassion fatigue. It is vital that nurses identify these various conflicts and emotions and collectively give a voice to these topics through greater support of the nursing profession, scholarship, and advocacy for their Veteran patients and families (Ferrell, 2006; Ferrell & Coyle, 2008).

## Slide 23

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# Cumulative Loss

- **Succession of losses**
- **Unable to resolve before another loss occurs**
- **Anticipatory and normal grief simultaneously**



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- Cumulative loss is a succession of losses experienced by nurses who work with Veterans with life-threatening illnesses and their families, often on a daily basis.
- Many times, nurses do not have time to resolve losses before another loss occurs. It is not uncommon that a Veteran from the operating room or emergency department is placed in the same bed and room where a Veteran died two hours prior. This does not provide nurses and other members of the interdisciplinary team an opportunity to remember the Veteran who just died and their family. No time for rituals (placing a rose on the bed for 24 hours where a patient has died, etc.).
- Nurses can experience anticipatory and normal grief before and after the death of a Veteran.

### **Exercise - Stop and Consider:**

- Do you personally experience cumulative loss frequently?
- How do you resolve grief issues while experiencing cumulative loss?
- When you witness medical futility (treatments/procedures provided to prolong suffering unethical use of Veteran/family financial resources, etc.), how do you deal with it?

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## Factors Affecting Nurse Stress and Compassion Fatigue

- Professional education
- Personal death history
- Life changes
- Support systems



Vachon et al., 2015

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- There are numerous factors that influence the stress, compassion fatigue, burnout with coping and resilience of palliative care nurses:
  - Professional education: In the past, health care professionals were often told to control emotions and to emotionally distance themselves from patients and families. Veterans at the end of life require intense interpersonal involvement and compassionate care and continuing to be educated will provide the knowledge and comfort to do this work well.
  - Personal death history: Past experiences with death on a personal and/or professional level and possible unresolved grief issues can influence the professionals' ability to cope with caring for dying Veterans and their families.
  - Life changes: Life changes may include a death in the family, caring for elderly parents, and separation from loved ones, children leaving home, divorce and illness. These changes may signify losses, trigger grief responses and make it difficult for the nurse to cope with caring for dying Veterans (patients) and their families.
  - Support systems: the presence or absence of support systems can influence the ability to move through the stages of adaptation. Emotional support provided by peers, family, coworkers and nursing faculty greatly increases the capacity to adapt to and cope with the care of the dying (Vachon et al., 2015).

Slide 25

The slide features a title box at the top with the text "Systems of Support". Below the title is a photograph of a wooden plank bridge crossing a calm river in a forested area. To the right of the photo is a bulleted list: "• Balance", "• Assessing support systems", and "• Spiritual support". Below the list is the text "Vachon, 2015". At the bottom left of the slide is the logo "ELNEC For Veterans Curriculum" and a series of navigation icons.

- There are various systems of support for the nurse:
  - Balance: Balance is the ability to provide compassionate, quality care to dying patients and their families and find personal satisfaction in work as professional nurses.
  - Assessing support systems: The purpose of a system of support is to balance the effects of death anxiety and cumulative loss by assisting the nurse in exploring and expressing feelings associated with anxiety, loss and grief and adapting to caring for the dying Veteran (patient) and family.
    - Does the clinical setting support or inhibit the nurse's professional adaption, growth and development in caring for dying Veterans (patients) and families?
    - Does the nurse have a mentor? Does the nurse have a mentee?
    - Does the clinical setting provide a supportive environment where the nurse feels safe to express death anxiety, emotions, loss and grief and to debrief? For example:
      - ◆ Formal support systems (staff meetings where nurses can express feelings in a safe environment, debriefings after a death, memorial ceremonies to acknowledge and express grief for all patients who have died).
      - ◆ Informal support (one-to-one sharing of experiences with co-workers, peers, instructor, pastoral care, bereavement counselor, etc.).
      - ◆ Instructor support (presence of a supervisor, mentor, nursing faculty during the care of the dying, when a family member visits, and/or at the time of the patient's death can greatly decrease anxiety and provide immense support to the nurse. The nurse will often find comfort in knowing she/he is not alone (Vachon et al., 2015).
  - Spiritual support: Many nurses seek spiritual support to do this sacred work. By attending a formalized meeting/worship service or being alone, many seek and find solace and peace through spiritual support.

## Slide 26

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# Developing Self-Awareness and Practicing Self-Care

- **Self-Awareness:** Innate psychological function that allows you to expand your choices and provide more creative responses
- **Self-Care:** Protection from occupational stressors and allow for renewal



Kearney et al. 2009; Strada, 2016

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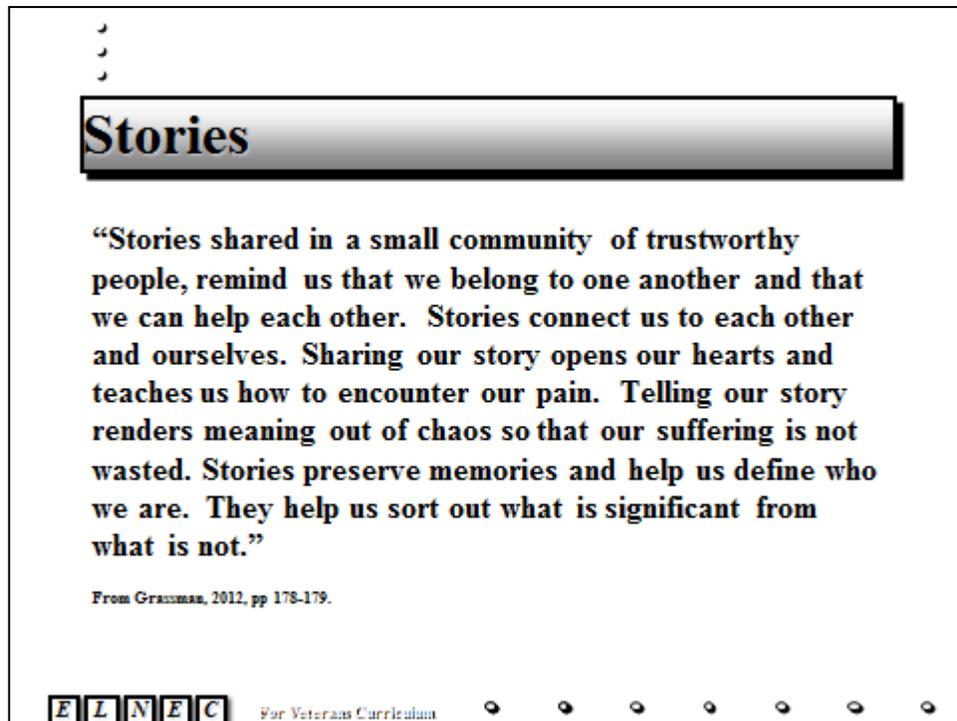
- In order to continue working AND thriving in palliative care, it is important that healthcare providers develop self-awareness and practice self-care. Self-awareness involves the nurse's ability to engage in personal self-reflective dialogue and the recognition of core values, belief systems and behaviors related to loss and grief (Strada, 2016). This innate psychological function allows for the expansion of choices and creative responses.
- Examples of self-care and self-awareness practices in the workplace include (Kearney et al., 2009):
  - Set your watch alarm for midday. Use this as a reminder to perform an act of centering (take slow deep breaths, think of a beloved family member and/or friend, recite a prayer).
  - Stop at a window and notice nature—give it your full attention for 2-3 minutes.
  - Take half a minute of silence or take turns reading a poem at the beginning of interdisciplinary team meetings.
  - Use the suggested 20-second hand-washing rule creatively—feel the sensation of the water on your skin. See this as an act of conscious acknowledgement to yourself—“I am worthy of my own time.” Or, repeat a prayer, poem.
  - Use humor.
  - Look for something unique in the Veteran's (patient's) room.
  - When approaching the hospital or a situation that you are uncertain about, recite, “Make me an instrument of thy peace.”
  - Practice meditation daily.

- Other suggestions for self-care include: Acknowledge limitations, don't hesitate to ask for help (i.e. employee assistance), journal, exercise, relax, socialize, continue/find a hobby, and take a vacation.

**Exercise - Stop and Consider:**

- What brought you to this work?
- Are you currently developing self-awareness and practicing self-care? If so, how? If not, what prevents you from doing this? Where are you most vulnerable?
- What does your institution have in place to develop a system of support for nurses and other members of the interdisciplinary team?
- How can you be involved in beginning and/or nurturing this system of support for yourself and your colleagues?

## Slide 27

The slide features a title bar with the word "Stories" in a bold, serif font. Below the title bar is a quote in a smaller, bold, serif font. At the bottom left of the slide is the acronym "ELNEC" in a stylized font, followed by the text "For Veterans Curriculum". At the bottom right, there are seven small circular icons arranged horizontally.

**Stories**

**“Stories shared in a small community of trustworthy people, remind us that we belong to one another and that we can help each other. Stories connect us to each other and ourselves. Sharing our story opens our hearts and teaches us how to encounter our pain. Telling our story renders meaning out of chaos so that our suffering is not wasted. Stories preserve memories and help us define who we are. They help us sort out what is significant from what is not.”**

From Grassman, 2012, pp 178-179.

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## Stories

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### Slide note:

This slide emphasizes the power of stories and story-telling as a way to promote self-awareness, self-care and connections to people around us.

Slide 28

Summary



- **Care does not end with the death**
- **Assessment is on-going**
- **Nurses must recognize and respond to their own grief**
- **Interdisciplinary care**

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- Nursing care and responsibilities to the dying Veteran and their family do not end with the death.
- Loss, grief and bereavement should be assessed upon admission and bereavement care should continue after the death of the Veteran.
- Nurses, as all professionals, must recognize and respond to their own grief in order to provide quality palliative care.
- Bereavement care is interdisciplinary care and our psychosocial colleagues have much to offer.

*“When we attend to ourselves with compassion and mercy, more healing is made available for others.”*  
*Wayne Muller*