Responding to the emotional challenges of Covid-19

School of Surgery:
Grief & Trauma
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What we will cover

- Session 1: The grieving workplace
- Moderated chat: Q & A/Discussion

- Session 2: Understanding Trauma
- Moderated chat: Q &A/Discussion

John Bowlby

“The death of a loved person is one of the most intensely painful experiences any human being can suffer. Not only is it painful to experience, it is painful to witness, if only because we are so impotent to help”

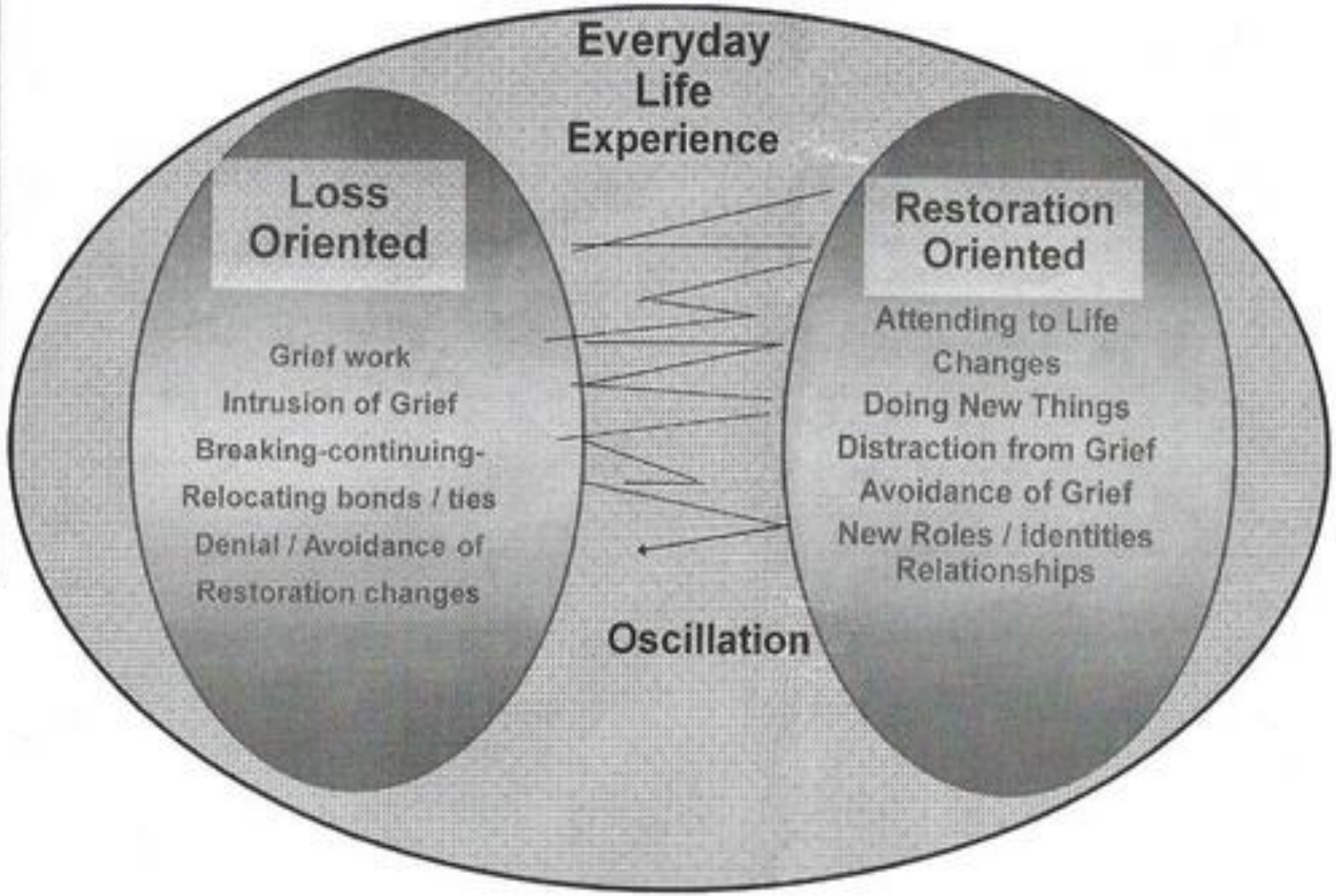
‘Normal’ grief reactions

Worden (2018)

Feelings/Emotions	Physical	Cognitive	Behavioural
Sadness	Hollowness in stomach	Disbelief “It didn’t happen”	Sleep disturbance
Anger	Tightness in chest	Confusion/Jumbled thoughts	Eating disturbance
Blame	Tightness in throat	Pre-occupation	Distracted/absent minded
Self-reproach	Oversensitivity to noise	Sense of presence (of deceased)	Social withdrawal
Guilt	De-personalisation		Dreams of deceased
Anxiety	Breathlessness		Avoiding reminders
Loneliness	Muscle weakness	Hallucinations (visual/auditory	Searching/calling out
Helplessness	Lack of energy		Sighing
Shock	Fatigue		Restless/Hyperactive
Yearning	Dry mouth		Crying
Emancipation			Visiting places
Relief			Carrying objects of deceased
Numbness			Treasuring objects

The Dual Process Model of Coping with Bereavement

Stroebe & Schut (Death Studies, 1999)



Dual Process Model (DPM)

- The key defining feature of the DPM is that it focuses on the coping process of grief, rather than being an ‘outcome’ based model.
- DPM suggests that avoiding grief may be both helpful and detrimental.
- Also recognises the bereaved’s need for respite from grief.
- DPM recognises that both expressing and controlling feelings are important.
- DPM introduces a new concept of OSCILLATION between the painful processing of grief (loss) AND re-establishing an identity in a changed world where the loved one is so painfully missing (restoration).
- Grief is viewed as a dynamic rather than sequential process.

Supporting our grieving colleagues: What NOT to do

- Ignore/Avoid
- Use well intentioned platitudes that could be perceived as dismissive or minimising
- Assume you know how they are feeling: the so-called ‘stages’ of grief - remember oscillation and individuality within the grieving process

Supporting our grieving colleagues: What TO do

- ACKNOWLEDGE, check in
- Listen if they do want to talk
- Expect strong feelings/unusual behaviour - allow them, these are not personal
- Allow a ‘space’
- Respect difference
- Follow through - if you have offered some sort of support make sure you follow up on it
- Signposting

When a colleague dies (Employer)

- Tell others at work the person has died, in a timely, sensitive and personal way
- Contact the person's family or next of kin to offer condolences
- Let others know how they can give their condolences
- Share details of the funeral or ceremony, even during social distancing
- Informal de-brief

When a colleague dies. Support for one another

- Ongoing informal de-briefing and peer reflection. Open space, encourage reflection on feelings
- Organise commemoration rituals
- Follow up - not just a one off
- Remember oscillation - all grief is unique - death of peer/colleague brings death closer to each of us. Expect some fear, anger etc - ‘normal’ grief reaction
- Any bereavement will activate previous losses
- Signposting

Piercing the professional armour

- As healthcare professionals we are usually protected by our ‘professional armour’. We work with life-changing injury, illness, and death often on a daily basis. We wear our ‘professional armour’, this allows us to maintain (an illusory) sense of separation from work and our personal lives.
- During Covid-19 we must recognise that we have a breach of our professional armour - the illusion has been shattered and there is less of a clearer distinction between the trauma we encounter at work, and the potential for trauma within our own lives. Indeed being exposed to such traumas can heighten our own sense of ourselves and others not being safe.

If you are bereaved

- Don’t expect too much of yourself, yet expect the unexpected
- Try to arrange for ‘peer support’ at work
- Wobble room/space
- Self care
- Ask for help
- Time off/flexible working if necessary

Q & A

What is considered a **traumatic** event?

Criterion A (one required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

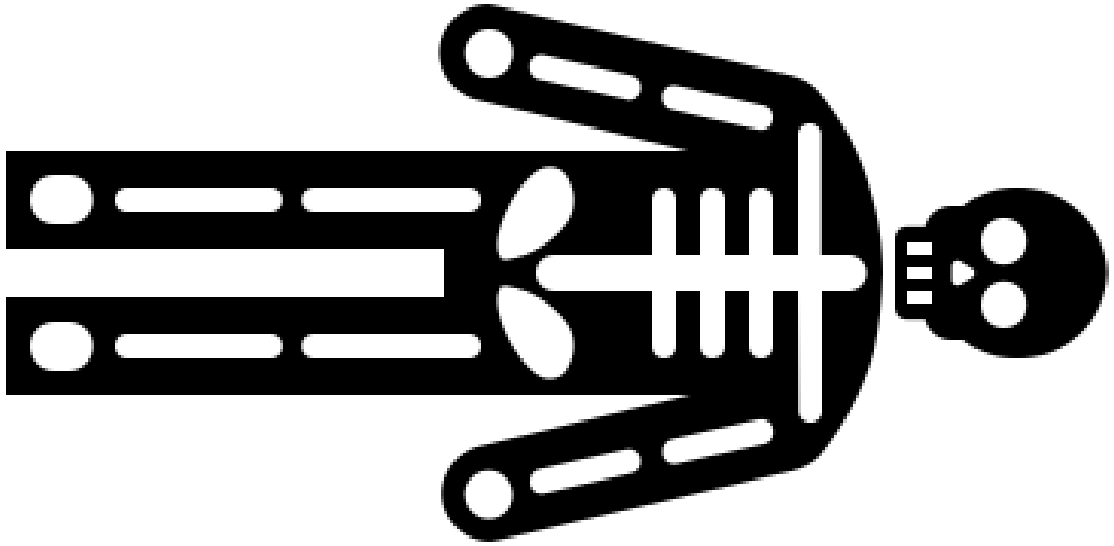
- Direct exposure
- Witnessing the trauma
- Learning that a relative or close friend was exposed to a trauma
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

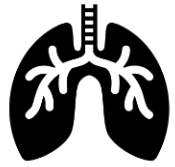
(DSM-V Criteria APA, 2013)

However…….

An event is considered to be traumatic if it is extremely distressing (Horowitz, 1999), temporarily overwhelms the resources of the individual (Lazarus & Folkman, 1984) and/or shatters their assumptive world (Janoff-Bulman, 1992).

Freeze Response





What is PTSD?

- Can occur one month following a traumatic ‘event’
- What to look for - ‘the big three’
    1. INTRUSIONS: Flashbacks/nightmares/ repetitive intrusive images, physical sensations, feelings
    2. AVOIDANCE & NUMBING: Places, reminders, physical sensations
    3. HYPER-AROUSAL: Constant sense of being ‘on-edge’, irritability, anger, significant sleep disturbance
    - It is NORMAL to experience some of this when under prolonged stress, if all three intensively persist past 4 weeks or more, may need to seek professional help

Compassion Fatigue (CF)/Secondary Traumatic Stress (STS)

Figley (1983) is noted for recognising the occurrence of PTSD in those who had cared for trauma victims, but who had not directly suffered the trauma themselves. This became known as *secondary victimisation, or secondary trauma.*

Compassion Fatigue/Secondary Traumatic Stress develops directly as a result of working with, treating, or caring for individuals who have been **traumatised**.

DISTINCTION: Primary PTSD - he/she who has experienced the trauma directly.

Secondary or 'Vicarious' Trauma - he/she who work closely with psychologically traumatised individuals, and exposure to salient details of death, horrific injury etc

Observable signs include:

Experiencing bystander guilt, shame, feelings of self-doubt

Being preoccupied with thoughts of patients outside of the work situation

Over identification with the patients (having horror and rescue fantasies)

Loss of hope, pessimism, cynicism

Distancing, numbing, detachment, cutting patients off, staying busy. Avoiding listening to patient or family's story of traumatic experiences

Difficulty in maintaining professional boundaries with the patient, such as overextending self

What happens when we are exposed to ***sustained*** traumatic events?

- The “pre-traumatic condition” (van der Kolk, 2020)
- *Lack of predictability, immobility, loss of connection with others, loss of safety*
- If there is a history of trauma, expect previous traumatic experiences to be re-activated

Moral Injury

- Moral injury is defined as the profound psychological distress which results from actions, or the lack of them, which violate one's moral or ethical code

- Potential morally injurious events (PMIE) can include acts of perpetration, acts of omission or experiences of betrayal from leaders or trusted others

- PMIE's do not directly cause or lead to PTSD, but can leave one with very distressing thoughts about themselves, which can lead to difficult feelings such as guilt, shame & disgust

- Moral Injury is not a psychiatric diagnosis, like PTSD but can lead to other difficulties such as depression anxiety and possibly PTSD

Williamson, Murphy & Greenburg, 2020

Potential risk factors for moral injury

1. Increased risk of moral injury if there is loss of life to a vulnerable person (e.g. child, woman, elderly);

2. Increased risk of moral injury if leaders are perceived to not take responsibility for the event(s) and are unsupportive of staff;

3. Increased risk of moral injury if staff feel unaware or unprepared for emotional/psychological consequences of decisions;

4. Increased risk of moral injury if the PMIE occurs concurrently with exposure to other traumatic events (e.g. death of loved one);

5. Increased risk of moral injury if there is a lack of social support following the PMIE.

Self Help: Pre-Traumatic Condition & Moral Injury

- Pre-Traumatic condition- flashcards in programme manual for strategies in 4 key areas:
- *Lack of predictability, immobility, loss of connection with others, loss of safety*
- *Moral Injury - 'Managing difficult emotions' module has strategies*

- *All self help designed for use at an individual level or with a trusted peer, or more widely within teams*

Recommended guidelines

- Staff to be made aware of possibility of developing PTSD & Moral Injury
- Allows for active self and other monitoring
- Facilitate team cohesion: social support is good for mental health
- Informal de-briefing. NOT formal, with frank discussions about the risks
- Leaders should regularly ‘check in’ with teams
- Reflective, evaluative, shared learning spaces
- If persists, professional help sought earlier rather than later. Help should be widely advertised and rapidly available

Hopefulness

- Not everyone will go on to develop PTSD or have a mental health condition
- Not everyone will experience difficult decision making/exposure as a PMIE
- The important thing is to notice the signs and act quickly. It is OK to reach out & ask for help. It is NOT ok to suffer unnecessarily
- Research following mass traumatic events shows that some people can go on to describe a sense of growth, and/or enhanced personal resilience as a result of surviving something horrific

Q & A

List of references

Stroebe, M., & Schut, H. (1999). The dual process model of coping with bereavement: rationale and description. Death Studies, 23 (3), 197-224.

van der Kolk.B. (2020). Covid-19 : caring for yourself. https://www.besselvanderkolk.com/ retrieved 1.4.2020.

Williamson, V, Murphy, D & Greenberg, N. (2020) COVID-19 and experiences of moral injury in front-line key workers, *Occupational Medicine, ,* kqaa052, https://doi.org/10.1093/occmed/kqaa052

Worden, J. W. (1991, 2018). Grief Counselling and Grief Therapy: A handbook for the mental health practitioner (5th Ed). New York: Springer Publishing Company.

FREE ongoing support

Nicola Forshaw is an experienced psychotherapist, coach and educator. Nicola leads on training and ongoing support for the development of NHS internal coaching teams. She also provides clinical supervision (psychological support) for NHS palliative care and cancer specialist nursing teams. Nicola has an academic interest in resilience, and has expertise in supporting clinicians through the principles of self care in avoiding the development of occupational (vicarious) trauma and burnout .

Download your FREE programme of psychological and emotional support - an introductory webinar, programme manual and podcasts to guide your relaxation skills training, and for managing sleep disturbance. The programme covers essential Covid-19 life skills in the areas of:

Facing Fear & Addressing Anxiety
Raising Resilience
Understanding trauma, grief and loss

Please pass these resources onto ANYONE who you feel will benefit from them . Let's remain united in supporting one another through the Covid-19 crisis.

https://www.nineteaching.com/copy-of-guided-self-help-1

You can find out more about grief, trauma and loss at

https://www.nineteaching.com/copy-of-individual-psychotherapy-1

You can contact Nicola at: nicola@nicolaforshaw.com

National sources of support

Cruse Bereavement Care
www.crusebereavementcare.org.uk

The WAY Foundation (Widowed and Young)
Suite 35,
St. Loyes House,
20, Loyes Street,
Bedford.
MK40 1ZL (Tel. 0 300 012 4929)
www.wayfoundation.org.uk

Winston's Wish (childhood bereavement)
Clara Burgess Centre,
Bayshill Road,
Cheltenham,
Glos.
GL50 3AW (Tel. 01242 515157)
www.winstonswish.org.uk