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Who Helps the Helper? Lessons on Grieving for Athletic Trainers

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Context: Grief is something that will touch all of us. We *expect* loss to occur in our personal lives and seem to be somewhat prepared for how to cope with it when it happens. In the profession of athletic training, we may not expect loss to occur as readily--especially if we are working with a young, seemingly healthy population. As such, when an athlete, student, or colleague suffers a catastrophic injury, illness, or death, we may not be able to process the loss and be left with unresolved grief.

Objective: The purpose of this article is to review theories on grief, identify successful interventions by allied health care providers and offer suggestions on how to implement teaching strategies within athletic training curriculum regarding the issues of death, dying, and coping strategies.

Data Sources: We searched various databases, including MEDLINE, ERIC, SportDiscus, and CINAHL Information Systems using the terms grieving, death, bereavement, loss, and coping.

Data Synthesis: Pertinent articles were cross-referenced to gain additional information regarding the search terms.

Conclusions: Athletic trainers should consider using strategies that introduce issues concerning bereavement, death, dying, and healthy coping skills into the athletic training curriculum. Additionally, it is critical to create a support network for athletic training professionals and students to use in time of loss.

Key Words: grieving, death, bereavement, loss, coping.

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Who Helps the Helper? Lessons on Grieving for Athletic Trainers

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A little boy came home from his elderly neighbor's home a little late for dinner. His mother had noticed that the boy had been sitting with the old man whose wife had recently died. She was curious as to what they had talked about during his visit so she asked him. He responded, "Nothing, Mom . . . . I just helped him cry"[1(p56)]

What a simple act seen through a child's eyes--sitting beside someone who has experienced loss and helping them by merely being there. Loss can be defined in many ways within the context of athletic medicine.[2] The 'loss' of a season for an athlete who has been injured, the loss of time at work for a patient due to surgery, the loss of the use of bodily functions due to a catastrophic injury, and ultimately the loss of life. Our society has become acutely aware of what is occurring in the world, not only daily, but in some cases minute-by-minute updates due to technology and ready access to the media. With this increased use of technology, we can become first hand viewers into tragic events and may feel that we are part of the actual loss.

Specific to athletic medicine, technology and the media seem to have created heightened public awareness of athletic and catastrophic injuries and sudden death. We have witnessed the 'hot news stories' of the moment, including: Kevin Everett, the Buffalo Bills wide receiver who sustained a fracture dislocation of the third and fourth cervical vertebrae;[3] Hank Gathers, the All-American forward for Loyola Marymount who collapsed and died on the court;[4] Flo Hyman, the captain of the 1984 Olympic volleyball team, who died from a heart attack related to Marfan's Syndrome;[5] and George Boiardi, the captain of the Cornell University's lacrosse team, who was struck in the chest by a lacrosse ball and died.[6] Sadly, these are the top news stories one day, and forgotten the next. However, for people who know these individuals and provide their health care, it is not as simple turning the page to the next story.

As health care providers, we are educated to take care of *others'* physical and mental well being.[2] When it comes to *our own* care and needs, however, we may be lacking the ability to address our physical and mental health.[7] When a loss occurs to one of our patients, what do we do for ourselves to assist in our own grief when a patient suddenly dies? What do we do to help each other through the grief process? Who helps the helper? Therefore, the intent of this review is to define situations of grief in allied healthcare and present active strategies to cope/deal with these inevitable situations.

Grief

Grief has been defined as the psychological distress associated with and the emotional response to loss.[8] The intensity and duration of the grief response are relative to what is lost,[9] and is often viewed as an adaptational response.[10] Most athletic trainers (ATs) have been taught the Kubler-Ross stages of grief: denial, anger, bargaining, depression and acceptance.[11] However, some theorists feel that this model falls short when dealing with unpredictable loss, such as in the cases of cancer and sudden death,[12] when individuals are not allowed any 'preparatory grief' and may need more support and counseling[13] to avoid becoming overwhelmed to such an extent that they are unable to function.[14]

Athletic trainers are employed to give patient care in a variety of occupational settings ranging from secondary schools to colleges, hospitals, clinics, and other sites where the patient health outcome is usually not associated with death, as it might be at an oncology clinic, hospice, or intensive care unit. As such, ATs may not possess the grief and coping skills other health care professionals may have learned working in settings where patient death is a potential or certain outcome.[7] It should be noted that merely working in a setting at which death is anticipated does not automatically prepare a health care provider to cope with death. However, many facilities that experience patient death regularly may have programs in place to assist their health care providers through the grief process. For example, oncology nurses have described their grief process as having "a curtain drawn down and the pain forgotten, or placing the pain in a drawer and closing it away."[15p.9] When faced with loss, ATs also grieve; but unlike other health care providers, these feelings may be ignored by colleagues, administrators, or even themselves[16] or deemed as inappropriate or unprofessional, as death and catastrophic injuries 'come with the territory' and to openly express grief is unacceptable.[17] Before we can integrate coping strategies into the athletic training curriculum, it is important to understand the physical and psychological basis of grief.

Grief Theories

Bowlby developed a theory of attachment[10] in which he described the bonds and attachments that are developed early in life. These bonds give the individual a sense of security and safety. Initial attachments are made between children and their parents, and remain active with other adults later in life. Anything that threatens these bonds, such as death, creates anxiety, and *having* an actual loss creates sorrow for the individual. The attachment theory relationship has three key features: proximity, the secure-base effect, and separation protest.[10] Proximity refers to the individual looking for the preferred figure; for example, children looking for their parents. The secure-base effect occurs when danger is near and the individual clings to the attachment figure. An example of the latter might be children clinging to their parents when they are introduced to someone they do not know. Separation protest is the response that is created when children are separated from their parent(s).[18] Bowlby speculates that behaviors associated with attachment are active only when the conditions of proximity, secure-base effect, and separation are not being met, as in the case of death or loss.[10] In short, this theory describes the human

need for contact and emotional attachments, that when broken, create distress and grief.

A second theory comes from a study done with widows, from which Parkes created a four-phase model that described that group's psychological grief process.[12] The first phase of the model is characterized by shock or numbness that occurs close to the time of the loss. There also is a general feeling of disbelief and an urgency to deny the truth. In the second phase, the individual moves through feelings of yearning, pining with grief, anxiety, and anger. This is followed by general disorganization, despair, depression, and the tendency to remove themselves from social circles. In the last phase, individuals recognize their behavior, and begins to reorganize and get their life back together.[12] A similar model proposed by Worden uses four phases through which an individual must pass in order for grief to be resolved:[19] to accept the reality of the loss; to experience the pain of grief, to adjust to this new environment without this individual and to withdraw emotional energy from the relationship and reinvest it into another relationship.

Although these models appear to be linear, individuals will not necessarily move through the process chronologically, nor will they progress quickly. Grief is a personalized phenomenon, and what one person values as important may not hold the same weight with another.[18] People grieve differently depending on the duration and intensity of the relationship and their own personal style.[17] It is also important to understand that grief is a *process* that may take a substantial amount of time to complete. Some theorists speculate that time is immeasurable with grief,[12,18,20] as there are constant reminders of the lost individual--their birthday, anniversary of their death, a song, or a favorite shared movie. Unfortunately, some individuals may not complete the grieving process and come to a healthy resolution, [8, 21-23] resulting instead in maladaptive behaviors (eg., depression, alcohol and drug use, or other psychosocial avoidance behaviors).[24]

What happens when someone does not progress?

Within the medical field, grief-related events are associated with occupational distress and burnout. Higher reports of stress and burnout in physicians and nurses have been linked to those who have greater exposure to patient deaths.[8,21-23] Similarly, hospice workers have demonstrated bereavement and unresolved grief, which leads to greater occupational distress and dysfunction.[25] Other consequences of unresolved grief can range from burnout to potentially harmful addictions,[24,26] insomnia, headaches, feelings of incompetence, or even thoughts of suicide.[27]

It is our assertion that ATs often experience grief coping mechanisms similar to other health care professionals by simply pulling "a curtain drawn down to have the pain forgotten, or by placing the pain in a drawer and close it away."[15, p.9] Not all health care providers will grieve immediately after the death of their patient; they postpone or repress the grief, which can surface later when least expected.[17,21] To better educate future practitioners and provide the skills necessary for them to positively cope with the grief associated with death and catastrophic injury and foster a sense of support who can assist another with the bereavement process, we will provide suggestions that academic programs may wish to consider adding to their curriculum.

Current Athletic Training Curricula and Grieving

While the profession of athletic training recognizes the need for grief education in formal curricula, there are limited competencies dedicated to this content.[28] For example, one competency specifically utilizes the word 'grieving': "describe the acceptance and grieving processes that follows a catastrophic event and the need for a psychological intervention and referral plan for all parties affected by the event."[28] Outside of this specific competency, there are two others that can be morphed into the grieving process, but only one competency that specifically identifies the grief process.[28] Are these three competencies enough to give future professionals the skills they need to not only assist others through the grieving process but themselves as well? Furthermore, do we need to consider expanding the competencies to include more specific grief-related content? There may be several valid reasons for the lack of bereavement education in athletic training education programs (ATEPs). While educators perhaps fail to recognize the importance of death education, they may also find the content too emotionally distressing to teach or they lack the opportunity to place additional content on grief in a program that is already so heavily mandated with other accreditation requirements. The Commission for Accreditation of Athletic Training Education (CAATE) requirements leaves little room to teach 'outside the box.' If the competencies were expanded, where does a program director 'fit' another required content area into an already 'full' curriculum?

Many individuals find the concept of death morbid and seek to avoid it all together. However, when a catastrophic injury or sudden death occurs, we as individuals and as a profession need to possess the skills to help ourselves and others through the grieving process. Little formal instruction on coping skills and strategies is given to health care professionals in their academic preparation programs, yet they are likely the ones providing the primary care to catastrophically injured or dying patients. It is reasonable, therefore, to suggest that ATs need more exposure to bereavement education and coping with loss. Several studies suggest that healthcare professionals recognize their own limitations in death, bereavement, and grief,[13, 29-32] but there has been no athletic training-specific research. While the findings may be somewhat similar to these other groups, the ultimate question becomes, how can we effect positive change in our profession?

Teaching techniques and ways to bring bereavement education into the curriculum

One of the most effective ways to deliver information on bereavement could be to include a formal course on death, dying, and bereavement in the mandatory curriculum. Topics for the class could include the importance and the process of grief, how attitudes toward death develop throughout the life cycle, how variables, such as gender, occupation, religion, social class, and culture, affect these attitudes, the history, purpose, and current

practices in funeral rituals, traditional philosophical and theological attitudes toward death, and ethical issues as related to the area of death and dying in contemporary society. With the current time and content constraints imposed by CAATE accreditation, adding a course on death and dying might not be realistic for most programs. A second suggestion would be to offer a workshop or seminar on the topic to cover the grieving process and how to progress through it, professional responsibilities (disclosure to media, parents, administration, students, athletes, team, and coaches), how to establish a support network for yourself, and identifying when you might need further assistance to progress forward through use of school and community resource networks.

If neither adding a course on death and dying nor holding a seminar is a realistic, perhaps adding content to existing courses is the best option. Classes that may offer the best fit for this content could include: first aid/first responder/emergency response course; an assessment course(s); clinical experience course(s) (didactic portion); or a senior seminar course. The content for discussion could include: current events regarding traumatic injuries/illness/events that have occurred (eg., use case studies from recent events), personal experiences with death and loss, inviting members of a hospice organization to speak about their experiences, and having students complete volunteer hours at a hospice.

While some ideas can be supported at the programmatic level, others are better suited to be tackled on a national scale. Since the most common grief theme in the allied health literature is support,[16, 31, 32] and those left without support or guidance can become dissatisfied with their jobs or stressed to the point of burnout,[33] perhaps the NATA could create a support network of individuals willing to offer their assistance to those in need when a crisis hits. The NATA has recognized the need for crisis intervention for athletes, and has focused presentations on encouraging ATs to develop crisis management plans that assist athletes dealing with uncontrollable circumstances. Our focus, however, is to help the ATs themselves develop interventions and/or teaching strategies to successfully deal with grief, bereavement, loss, and death. This might include being a sounding board to a fellow professional who is dealing with the sudden loss of a patient, holding workshops at district and/or national levels to guide professionals through the grief process so that we might be able to assist others, or offering a web space for resources which could provide a listing of support services. Each of these suggestions could be enacted at the state, district, and national level.

As a comparison, the nursing profession seems to be more proactive in bereavement education than other allied health professions, and has worked to establish bereavement programs within their professional work places to help staff members process grief when one of their patients has died.[17] Most often these programs include peer support groups, whose members assist the nurse(s) with stress management and process other feelings related to a sudden or traumatic death.[17] Group counseling that uses an intervention 'team' to solicit the health care providers' interpretations of the patient's death is also employed to give the providers 'permission' to grieve and bring a sense of closure.[17]

As ATs, we are taught to be prepared to treat injuries and conditions ranging from minor blisters to sudden cardiac arrest. Although we each have emergency treatment protocols and contingency plans in our professional bag-of-tricks, we always have hope that we will never be called to use all of them in our professional world. For example, if we initiate CPR on a patient, complete it correctly, use the automated external defibrillator (AED) correctly, and our patient still dies, we question our abilities as health care providers. We acted correctly and to the highest professional standards, and yet the patient died. How do we process this?

In summary, the very notion of grieving involves a process; going through steps to arrive at a resolution or acceptance of the loss. As health care professionals, ATs must recognize that it is okay to grieve and cry, and that we must work to help both ourselves and others overcome the adversity presented by an unexpected loss. "It's only human to hurt, to cry, to grieve, when a person who's influenced you in someway has died. Please cry with your patients and their families; it's okay for you to grieve too."[1, p. 56]

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For Becca Payne, someone who left imprints on our hearts.

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