Who Heals the Helper? Facilitating the Social Worker’s Grief

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ABSTRACT

Nurses, physicians, social workers, and other caregivers frequently encounter patient deaths in the course of their professional responsibilities. Although the literature in these fields addresses the cumulative effects of such losses in burnout and vicarious traumatization, scant attention is given to the manifestation of grief in professional caregivers and the strategies available to acknowledge and address the losses experiences in the course of professional practice. This article examines the scholarly literature from a variety of helping professions on anticipated and unanticipated loss, the impact on caregivers’ experience of grief, the variables that can compound or complicate the mourning process, and the available resources to assist social workers in processing and integrating patient deaths.

Patient deaths are not uncommon in the course of professional practice in the health and social services. Being with clients at this crucial and inevitable life stage can be a powerful and transcendent experience. But, as with other such losses, these deaths can also evoke feelings of regret, anger, sadness and hopelessness in those who provided care for the patient. Certain deaths may be especially difficult to address, such as those that are unanticipated, traumatic, or “untimely.” The literature on caregiver grief addresses some of these concerns. In particular, it provides attention to the effects of patient suicide and the cumulative effect of losses that may result in vicarious trauma or provider burnout. Insufficient attention, however, has been paid to the ways that caregiver grief is manifested and the organizational and individual strategies that can be employed to acknowledge and assist in the grieving process. Some settings, such as hospice or oncology units, have instituted sophisticated methods to respond to frequent loss. The question is how to illuminate these strategies and generalize them to settings where patient death may be a less frequent, but still troubling, feature of practice.

In this article we examine the scholarly literature on the caregivers’ experience of grief, the variables that can compound or complicate the mourning process, and the available resources to assist social workers in processing and integrating client deaths.

The Personal and Professional

The social work profession is diverse—in educational preparation, age, gender, socioeconomic status, sexual orientation, race, culture, and spiritual traditions. These various attributes will shape the individual caregiver’s experience of a patient’s death, as well as their personal loss experiences and the nature and length of the relation-
ship with the deceased. Professionals in certain settings, however, may have a greater vulnerability to the experience of patient death. Such professionals include those who work with a medically fragile population (Allen & Miller, 1988; Lauria, 2001; Servaty, Krejci, & Hayslip, 1996); have clients with a higher susceptibility to suicide and homicide (Landeen, 1987–1988; Keigher, 2001; Ruben, 1990), or in the case of hospice and other forms of end-of-life care, their professional role is oriented around the occurrence of death. When healers grieve, they are doing so from a dual role—their core human response, situated within their professional role (Litman, 1965). The latter may constrain the former, particularly when the clinician feels some responsibility for the patient’s death (Berman, 1995). For example, in the case of a child’s death in foster care, the professional’s apprehensions about liability may dampen genuine expressions of grief.

Although variants exist, the grief process is generally believed to progress through three phases—the first characterized by numbness and disbelief, the second by repeated challenges to confront the reality of the loss, and the third by accommodating the loss and re integrating it into a new way of being (American Cancer Society, n.d.; Attig, 1998; Rando, 1993). The process does not seem to vary whether the individual is mourning the loss of a client or a loved one: in neither case is it a linear or time-bound process. Rather, the mourner cycles in and out through these stages as events and interactions cause a resurgence in painful feelings and opportunities to examine the loss in different ways.

A social worker’s grief, like that of the general population, will be differentially impacted by the individual’s personal and organizational resources, as well as by the mode of death, its preventability, and the extent of trauma involved (Rando, 1993). Thus, those caregivers are most at risk who experience successive losses, “premature” deaths, such as those of child patients, and sudden or violent deaths, as occur through suicide or homicide. The particular features of anticipated and traumatic losses, and the vulnerabilities posed by each form of loss, will be addressed in turn.

Grief and Anticipated Loss

Unlike the sudden death of a client, anticipated loss gives the helping professional time to prepare for the death, in conjunction with the client and his or her family members (Gustavsson & MacEachron, 2002). One predominant reaction to client death or suffering is anticipatory grief, wherein the professional attempts to deal with impending loss before the death occurs, balancing his or her desire to hold onto the client and the simultaneous need to let go of a suffering individual (Zilberfein, 1999). Anticipatory grief can be a positive experience because the caregiver can use the time to resolve unfinished business, increase communication, and maintain a sense of control over his or her own actions despite the inherent uncertainty of dying.

Anticipatory grief can lead to several forms of negative behaviors for the helping professional, such as detachment and avoidance of the client (Zilberfein, 1999). Caregivers may also begin to avoid contact with other dying patients, transfer to less stressful positions, and distance themselves from distress by being less empathic and less personally involved (Benoliel, 1974). Workers can also experience physical and emotional reactions to anticipatory grief, including memory impairments, confusion, difficulty in concentration, and inability to complete tasks (Gustavsson & MacEachron, 2002) which can be detrimental for the worker’s other clients.

Even when the client’s death is expected, the professionals involved may experience an immediate and sometimes prolonged sense of loss, insomnia and fatigue, diminished interpersonal skills, poor frustration tolerance, decreased work performance (Allen & Miller, 1988), health problems, and strained personal relationships (O’Hara, Harper, Charrtrand, & Johnston, 1996). Workers who routinely experience client death can react by perceiving life as having little value, or by romanticizing death (Martin & Berchulc, 1988). Because grief reactions are not just individual events, words or units within an organization are impacted by a client death, and may display heightened interpersonal conflicts, communication breakdowns, and other symptoms of distraction and tension (Ruben, 1990; Wallace & Townes, 1969).

More positive grief outcomes include an enhanced appreciation for life and for significant others as well as heightened empathy and facilitative abilities (Allen & Juet, 1982). Some clinicians may respond intellectually, focusing on the belief that they did the best they could to help the patient, that suffering ceased, and that death is a natural part of life (O’Hara et al., 1996). Other professionals focus on the transcendent aspects of end-of-life experiences, their response to the loss shaped by their sense of awe and privilege at participating in this profound life experience (Mulder, 2002).

Several factors influence the worker’s grief following an anticipated death. The individual’s personality, spiritual beliefs, the quality of the relationship with the client, and the attitudes of the worker’s colleagues, supervisor, and agency can all support a positive outcome or influence a negative one. Similarly, grief is influenced by professional norms about patient death, the work environment, and societal attitudes toward the particular type of loss (Benoliel, 1974).

Multiple Losses

Caregivers who experience multiple losses, either due to coincidence (a catastrophic accident) or the nature of their setting (a pediatric oncology unit), are at particular “risk of sustained psychologic stress” as a result of repeated deaths
(Wallace & Townes, 1969, p. 328). Those in the latter group may deny the severity of a patient's prognosis, focusing instead on even scant options for treatment or on the patient's remaining abilities. Some suggest that physicians' reluctance to address end-of-life issues and palliative care is as much a defense against these repeated losses as it is a byproduct of their medical training. Some clinicians may also experience a form of vicarious traumatization (O'Hara et al., 1996; Rando, 1993), including "burnout" and a diminished capacity for empathy as they repeatedly reconcile the conflicting "roles of comforter and bereaved" (Wallace & Townes, 1969, p. 331).

**Population or Work Setting**

Grief from anticipated deaths can also be exacerbated by circumstances particular to the population or work setting. For example, the client's own difficulty in dealing with the impending death can cause the treatment team intense feelings of stress, even before the death occurs (Martin & Berchuc, 1988). Helping professionals who work with persons with acquired immunodeficiency syndrome (AIDS) also face death on a routine basis, but have the added burden of working with an often young and stigmatized population. Although AIDS is typically a fatal disease, the course of the disease is often unpredictable and clients' conditions can worsen suddenly (Demmer, 1999). Social workers serving AIDS patients and other marginalized groups may experience frustration over the lack of quality financial, social, and medical services available, feeling feelings of injustice upon the patient's death (Leon, Altholz, & Dziegielewski, 1999).

The loss of a child patient is among the most stressful and incomprehensible forms of patient death. It can lead to reverberating clinical implications, giving rise to troubling countertransference (Cipriani, Crea, Cvikel, Dagle, Monaghan, & Seldomridge, 2000) and diminishing the clinician's ability to get close to or invest in future clients. As with other high-risk deaths, the loss of a child client may result in feelings of anxiety, vulnerability, and helplessness (Ahrens & Hart, 1997) and a struggle to find meaning, including the "need to assign blame, mete out punishment, and regain a sense of control" (Rando, 1993, p. 659). If a pediatric death is misconstrued, the workers involved may adopt a more cynical and unfriendly worldview, where future hurt is mitigated by permanently diminished expectations.

**Grief and Unanticipated or Traumatic Losses**

Unanticipated deaths are typically sudden, random, and seemingly preventable, resulting, for example, from a heart attack, an accident, or disaster. Beyond being unexpected, traumatic losses typically involve violence, destruction, and other unnatural causes. Social workers in all fields of practice may be exposed to traumatic losses through client suicide or homicide.

Even professionals who are accustomed to patient death note that suicide's impact is considerable and distinct (Halligan & Corcoran, 2001; Maltsberger, 1992). Across an array of quantitative, qualitative, and case studies, researchers find significant professional and personal consequences following the death of a client by suicide. These reactions include shock, fear of another incident, guilt, distrust, intrusive thoughts, a sense of betrayal, depression, helplessness, loss of confidence, fear, hypomania, anger, and avoidance of triggering stimuli (Chentob, Hamada, Bauer, Kinney, & Torigoe, 1988; Cooper, 1995a; Menninger, 1991).

The grief process can be both interrupted and exacerbated by publicity surrounding the death and by formal inquiries into the circumstances of the suicide (Alexander, Klein, Gray, Dewar, & Eagles, 2000). Institutional reactions to the death can foster the healing process or exacerbate it through scapegoating or minimizing the loss (Cooper, 1995a). An already inhospitable work environment may not "make space" for mourning, for adjustments in workloads, or for processing the death, all of which are vital for appropriate acknowledgment of the loss (Hodgkinson, 1987). In contrast, a healthy environment can reassure staff and facilitate communication and grieving processes (Landeen, 1987–1988).

An aspect of post-suicide response unique to the helper among most other mourners is that of apprehension about his or her liability for negligent treatment. This dimension colors subsequent interactions, as clinicians are cautioned by lawyers not to discuss the death with colleagues as such material could be subject to discovery in a later court proceeding. Similarly, conversations with the patient’s family, which are already circumscribed by principles of confidentiality, become further distorted or avoided entirely due to fear of inciting a malpractice complaint (Pearlman, 1992; Schacht, 1992). Although such advice may be pragmatic from a risk-management perspective, it also runs counter to the very human desire to reach out to others, to seek understanding of the shared loss, and to offer comfort. The fear of a family’s reaction may keep the helper from attending the patient’s funeral or memorial service, yet typically such gestures are welcomed by the family, even if they have angry or ambivalent feelings toward the treatment provider (Kleebies, Penk, & Forsyth, 1993). Admonitions not to talk with colleagues may prohibit the clinician from seeking the very support that will be crucial to successfully negotiating the grief process. It may also keep clinicians from examining their practices and taking steps to improve assessments, seek supervision, monitor medications, or take other measures to decrease the likelihood of future suicides (Menninger, 1991).

Patient suicide has reverberating effects, which are particularly acute if the death occurred while the clinician was still in training. Following interviews with psychiatrists,
Brown reports that client suicide had a major effect on their development and “the details and names remained vivid even after 20 or 30 years” (1989, p. 107). In the aftermath of suicide, helpers may also develop one of two belief systems: either that suicides are inevitable and clinicians have limited control over such events, or that the clinician must intensify his or her efforts to prevent further self-destructive acts by clients (Menninger, 1991). Taken to their extreme, each of these resolutions may have a detrimental impact on the delivery of services in the future.

Although the loss of a client to homicide or another form of sudden death can result in many of the same effects as suicide, a distinguishing feature is that typically the worker does not bear responsibility for the death. However, there are exceptions. Social workers in child welfare, partner violence, and criminal justice settings may experience feelings of guilt, helplessness, and professional inadequacy in light of a traumatic death. Like professionals whose clients died by suicide, these workers may hold themselves responsible for failing to detect and act on the risk of harm, and the public and their organizations may try to hold them similarly accountable (Gustavsson & MacEachron, 2002).

**Cumulative or Long-Term Effects of Grief**

In addition to understanding the effects of patient deaths, social workers must also be alert to the manifestations of unaddressed or cumulative grief and the resulting phenomena such as compassion fatigue.

*Compassion fatigue* refers to the emotional burden that helping professionals feel from overexposure to clients’ traumatic events (Schwam, 1998). It is believed to result from the constant empathy, caring, and emotional investment that helping professionals put into their work in order to be genuine and empathic to clients (Figley, 2002). In its extreme form, the professional’s intense emotional investment in alleviating client suffering can evolve into “secondary traumatic stress” (Figley, p. 1435). The features of compassion fatigue may parallel those of posttraumatic stress disorder: reliving the clients’ trauma, avoidance of trauma-related stimuli, and physical symptoms such as sleep disturbance, increased irritability, and angry outbursts. The effects of compassion fatigue can include diminished work performance, increased mistakes, and weakened coworker relationships (Schwam, 1998).

As a result of compassion fatigue, helping professionals can experience psychological and physical exhaustion, apathy, feelings of helplessness, frustration, and the desire to change professions (Leon, Altholz, & Dziegielewski, 1999). However, factors such as positive relationships with colleagues, a climate of open communication about traumatic experiences, a diverse caseload, and feedback from the client, family, and supervisor can mitigate compassion fatigue (Leon, Altholz, & Dziegielewski).

**Assisting the Helper With Grief**

Although the features and trajectory of grief will vary by the worker’s characteristics and faith traditions, the nature and number of the losses, the amount of personal and institutional support for mourning, and many other factors, there are numerous resources intended to facilitate the worker’s bereavement. Five measures, in particular, help the clinician effectively grieve the death of a patient. These include preparation, self-care, institutional support, review and debriefing, and mourning or memorial rituals.

**Preparation**

Across the professions, trainees are ill-prepared for the event of a client death. Mentors seem reluctant to discuss their own experiences and reactions, not only conveying a taboo on the subject of patient death but depriving learners of models for anticipating and managing such crises (Brown, 1989; Kaye & Soreff, 1991). Such discussions would help professionals reconcile the realities of grief with the conception that, as professionals, they should be able to “manage” such feelings (O’Hara et al., 1996).

Further, formal coursework on death and bereavement is typically absent or optional in curricula (Kleespies, Penk, & Forsyth, 1993; Spencer, 1994). The literature indicates that those who have course work or supervisory guidance in the physical, emotional, social, financial, and spiritual dimensions of grief are better prepared to deal with the sequelae of death than those who are not (Cipriani et al., 2000). Related to educational preparation is the importance of the practitioner’s self-awareness. Those who have contemplated their personal loss history and their understanding of death are better prepared intellectually and emotionally to address the loss of a client (Allen & Jaet, 1982; Krueger, 1979; Martin & Berchulc, 1988).

For social workers, the NASW Standards for Palliative & End-of-Life Care offer considerable guidance on the skills and strategies necessary for adequately helping clients with life-threatening or life-limiting illnesses. One standard in particular addresses the importance of self-knowledge and self-care to effectively help clients and to avoid the detrimental effects of compassion fatigue (National Association of Social Workers, 2004).

**Self-Care**

Although some social workers are employed in settings where there is adequate support after a client’s death, many will need to create their own. Welsh suggests that emotional stress can be mitigated when workers practice “responsible selflessness” (1999, p. 183) through self-care, becoming involved in other activities, taking lunch and other breaks, and leaving work behind at the end of the shift. Another technique is for the worker to redefine his or her notion of success. Although most professionals have some negative feelings after a client’s death, the
worker must not consider the totality of his or her work with that client to be a failure, but acknowledge the positive outcomes that did occur.

Peer support can serve both a preventive and supportive function for the professional's grief reaction (Alexander et al., 2000; Allen & Jaet, 1982; Chemtob et al., 1988; Menninger, 1991). For reasons of propriety and professional development, the primary source of support for the mourner should be supervisors and colleagues. These resources can offer empathy, permission to grieve, and encouragement to talk about and integrate the feelings that emerge (Brown, 1989; Chemtob et al., 1988; Krueger, 1979). Group or individual supports are particularly important in settings where professionalism appears to be synonymous with concealing personal feelings, as discussed by Lenart, Bauer, Brightin, Johnson, & Stringer, 1998. These authors, a group of intensive care nurses, describe the group model they implemented in their unit, in which those attending review specific deaths (when all staff involved in the case are invited to attend) and discuss general grief responses and stress management techniques.

**Institutional Support**

An organization's procedures and climate can work to effectively address grief and prevent burnout. The development of a “psychiatric disaster plan” (Tan & McDonough, 1990, p. 140), for example, helps all employees determine who is responsible for each action that will occur after a traumatic event. Established protocols to deal with client death can eliminate confusion and ease the apprehension for the professionals involved. Such resources would include provisions to make contact with the family simple and meaningful, for example, easy access to the family's contact information, the availability of commercial condolence cards at the agency, and an updated list of community bereavement services for referrals (Ellison & Ptcack, 2002). The effectiveness of such procedures and resources, however, depends upon the extent to which employees understand and utilize them (Ferris, Hallward, Ronan, & Billings, 1998), so organizations must continuously educate employees about the protocols and reinforce their use.

Institutions can also train workers to notice signs of compassion fatigue and grief before these symptoms become problematic, and they can develop response systems for troubled workers. Supervisors should also assign workers to a variety of cases to decrease the number of high-risk clients one clinician has, and strongly encourage workers to engage in self-care efforts (Leon, Altholz, & Dziegielewski, 1999). Agencies that offer support services must also strive to make them accessible, offering them at a time and location that facilitates workers' ability to take advantage of the supports (Demmer, 1999).

Beyond improving policies or services, organizations can also develop norms that assist professionals grieving the loss of a client. A survey of palliative care nurses indicated that the level of perceived support in the professional environment, more than the actual client death, has the greater effect on the worker's experience of burnout (Plante & Bouchard, 1995–1996). Unfortunately, a “conspiracy of silence” (Figley, 1990, p. 1440) pervades all types of patient death. Workers often feel compelled to keep their emotions away from other coworkers and especially to keep feelings hidden from supervisors.

Conversely, agencies can prevent compassion fatigue and other detrimental outcomes by normalizing grief reactions and creating a culture where it is natural to be affected by a client's death (Schwam, 1998). Workers who experience high levels of institutional support experience lower levels of burnout, even in highly stressful conditions (Plante & Bouchard, 1995–1996).

**Review and Debriefing**

Formal processes for reviewing patient deaths (referred to as postvention by Shneidman, 1971) can take the form of critical incident stress debriefing (Farrington, 1995), a psychological autopsy (Kleece, Penk, & Forsyth, 1993; Chemtob et al., 1988), or individual or group processing of the case (Pilsecker, 1987). Each of these has a slightly different intent and focus, but each offers the opportunity for acknowledgement of the loss, contemplation, supportive review, and deepening understanding.

Critical Stress Incident Debriefing (CISD) is short-term intervention to alleviate the immediate stress employees experience after a traumatic event (Burns & Harm, 1993). The initial CISD session should be within 2 days of the incident, be presented as a necessary and beneficial intervention, and promote sharing by all participants in order to increase understanding of the event and to decrease feelings of isolation. Because CISD should be offered within the first few days of the client death, the agency must be prepared to immediately offer CISD by a trained facilitator and make arrangements for all affected employees to be able to participate (Farrington, 1995).

The psychological autopsy has predominantly been associated with client suicide. It is an informal, in-depth study of the life and death of the client. Its primary purpose is to make sense of the facts of the case, not to deal with the associated emotions. Cooper (1995b) advocates for a combination of the psychological autopsy and CISD in order to concentrate on both the facts of the event and the associated emotions.

Mortality and morbidity conferences have been routinely employed by hospitals to examine cases with negative outcomes, assign responsibility for the events, and to understand how to change the system to avoid a similar outcome in the future (Kinzie, Maricle, Bloom, Leung, Goetz, Singer, & Hamilton, 1992). These conferences tend to involve all clinical staff involved with the case. Although these conferences are predominantly involved in
discovering facts of the case, the process can open up a forum for candid discussion and help those attending to make sense of the situation.

**Mourning and Memorial Rituals**

Rituals to mark a death are as important to the grieving professional as they are to the general population. The experience of shared grief can be achieved through attendance at the patient’s funeral (Kaye & Soreff, 1991; Ryan, 1992), through a memorial service with the treatment team and the deceased’s fellow clients (Hodgkinson, 1987), or through allocating time for a remembrance ritual within a regularly held meeting (Alexander et al., 2000; Landeen, 1987–1988). However, many professionals may not feel empowered by their agency or professional body to engage in memorial rituals. Without the implicit approval of supervisors and agency management, some helping professionals may avoid public mourning rituals, despite the potential benefit to themselves.

It may be incumbent upon social workers and their fellow caregivers to initiate and institute organizational changes, such as the development of rituals, policies that encourage self-care, and improved organizational structures. Paradoxically, the need for these changes is most acutely felt when deaths have occurred and personal reserves of energy and strategic thinking are limited. We therefore urge proactive organizational change measures. Authors such as Brager and Holloway (1983) and Frey (1990) offer guidance on strategies for change. Other resources include the NASW (2005), the Project on Death in America (www.soros.org), and Social Workers in End-of-Life and Palliative Care (www.swlc.org), which can provide networking, information on best practices, and insights into emerging issues.

**Next Steps**

Despite the amount that has been written on the phenomena of the helping professional and client suicide, there is far less research devoted to the effects of other types of client death, particularly within the field of social work. Client death can also occur as a result of unanticipated nontraumatic death, such as an accident or sudden illness. Besides suicide, clients can experience other forms of unanticipated traumatic death, such as by drug overdose, gang violence, homicide, domestic violence, terrorism, and natural disaster. Better research would offer a clearer understanding about the differential effects of different types of client losses on grief processes.

Research also needs to examine the effect of client death for all types of helping professionals. The majority of the research cited in this article focuses on client death for nurses and physicians, who typically provide medical services. There is far less information about the experience for a person providing therapy or case management services to a client, such as a social worker, occupational therapist, psychologist, or substance abuse counselor.

Finally, research needs to focus on new interventions and the efficacy of the previously described intervention efforts to relieve the stress of client death. For instance, CISD seems to be an approach commonly used in medical settings with nurses, but is this strategy an effective intervention for professionals in other types of settings, like social workers on an inpatient psychiatric ward? Future research could also examine the long-term efficacy of these interventions: Are workers able to avoid the harmful effects of complicated grief and do helping professionals continue to work in the field when offered positive coping strategies?

**Conclusion**

Professional responsibilities and norms may interfere with the social worker’s experience and expression of grief, even while this population is at greater risk for exposure to loss and high-risk deaths. Resources exist, however, to prepare for the loss experience and to adaptively respond to losses in the course of professional practice. Overcoming the barriers imposed by personal, professional, and organizational culture requires, first, naming grief and loss. Further, individuals and organizations must identify grief responses, invite and support expressions of grief, and utilize protocols and programs to ease the aftermath of a patient death.

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