**NHS Education for Scotland**

**Transcript of ‘Psychological Perspectives on Bereavement, Loss and Grief: Proactive approaches to support others and the importance of compassionate resilience for staff wellbeing’**

**NES Bereavement Conference 2021 session recording**

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Good morning, everybody. My name is Victoria Thomson. I'm a Clinical Psychologist by training and I work on the NES Psychology of Dementia team. So, I've worked sort of in different settings across my career from the acute hospital and providing psychological care to both patients and staff within kind of general and acute hospital settings, community hospitals and the care home sector with people of a range of ages, and more recently I've spent more of my time working in dementia services and services for people working to support people living with dementia and also families and caregivers. So I'm going to be talking to you today about proactive approaches to supporting others with bereavement and grief and the importance of compassionate resilience for staff wellbeing.

Okay, so I wanted to start by just having a bit of a discussion about why we are here and why are we talking about grief and, in particular, why are we talking about the psychology of grief and why it's so important for us to look after ourselves as staff. So, across health and social care settings, we know that there's going to be a range of staff who come into contact with people who have been bereaved or who have some form of involvement in bereavement care services. These people range from somebody who might work on a reception desk in a hospital and give directions to people, to those who deal with the immediate distress at the time of a death, to those involved in providing specialist bereavement support at a later date. And really, if we want to provide great quality bereavement support in Scotland, we need to create an informed workforce across the workforce, not just in specialist services, so that we are in a position where we can provide really individualised and person-centred support to help those who are grieving adapt to their loss. And obviously, throughout the last kind of couple of years, the number of people who have been bereaved in Scotland has increased significantly due to the Covid-19 pandemic and this further increases the need for us as a workforce to be able to respond competently and confidently to those people's needs.

There's also a saying that we use a lot when we're thinking about psychological trauma and trauma-informed practice, that you cannot pour from an empty cup. This is really a phrase that we use a lot to highlight the need for consideration of staff wellbeing and resilience so that our workforce can continue to do the important work in supporting others. And I hope that you agree with me that it's even more important for us to think about within the context of Covid, but specifically when we are thinking about supporting people with bereavement and grief, I think it's a really, really valuable way to think about things and to kind of base our ideas on staff wellbeing around.

So, today, we are going to briefly cover the psychology of grief and then we are going to think much more carefully about how you can support people who have been affected by a bereavement and then finally, we are going to spend quite a bit of time thinking about how you can look after yourselves and your colleagues and protect your own wellbeing in the process of supporting others.

So, moving on to thinking about the psychology of grief. It might be helpful, first of all, if we clarify some terms. So, anticipatory grief is really the emotions that people feel prior to a death that's expected. Bereavement is the state that we would describe which is associated with the loss of something really valuable, so it's about being robbed or deprived of something and then our society often refers to the death of a significant other. Grief, then, is the psychological response associated with experiencing loss or when something that we love or care about is taken away from us. And grief is really inevitable, it's intrinsic to life, it's functional, it's multidimensional and it's really diverse in its expression and it crosses all ages and cultures. Mourning is then the actions that we take and the manner in which we express our grief and this is heavily influenced by culture and ethnicity. So for example, when people hold mourning rituals, this is kind of dependent on the way that people think about their spiritual beliefs, their religious beliefs and the types of groups and organisations that they are involved in.

So, if we move on, then, to think about psychological models of grief. Since Freud, grieving and mourning has been understood as kind of processes whereby the bereaved person adjusts to the reality of their loss, which then sort of enables them to alter their engagement with the deceased and then invest in new pursuits or new relationships and continue on with their lives. I'm not going to go into loads of detail about each of the individual models because we could spend the whole session talking about that, but I've referenced them all in the resources section and you can go away and read more if you like. But I'm quite interested...to think about the models in terms of what they've got in common and, and what we actually know from evidence about what these models mean in, in practice and what actually happens in people's lives.

So, in terms of the kind of first three models from Bowlby, Kubler-Ross and Worden, these kind of models all suggest that there are stages, tasks or processes of grief that people need to work through in order to be able to move on with their lives in a meaningful way. So, in particular, Bowlby suggests that the, the grief trajectory that people experience is determined by their early attachment styles and their relationships with the person that they've lost. So, those three models really think about there being kind of set sort of stages or tasks of, of bereavement that people work through. Silverman and Klass' model, on the other hand, suggests that bereavement or grief is never actually fully resolved, so we don't get to this place of kind of closure or recovery, but rather that the bereaved person negotiates the journey of bereavement and grief and renegotiates it over time and, and the meaning of the loss then changes over the course of time. So, their theory is about this idea of continuing bonds which emphasises the role of grief and mourning in terms of maintaining the presence of the deceased, retaining that kind of relationship with the deceased where they are remembered and remain active in the kind of family web or the social web even, although, they are not physically present. And then, finally, the model from Stroebe and colleagues is referred to as the dual process model and it suggests that the bereaved person oscillates between kind of orientating to their loss and focusing on the restoration of kind of plans and activities within their lives. So, they tend to focus more on the restoration aspect of things when the loss becomes too much to kind of bear, so the processing happens in response to the emotional components of the loss, when people need a break from that, they focus more on the practical aspects of things and on kind of the restoration of kind of social things and things within their lives. And within this model, it's quite clear that the coping task is maybe not about returning to previous levels of functioning, but negotiating meaningful life without the deceased.

Hopefully that all makes sense. Moving on, then, to thinking about what do these models agree on? So, the models that we've discussed so far sort of agree that bereavement responses exist on a spectrum from kind of normal grief or kind of more straightforward grief to prolonged or complicated grief. They all agree that the mourning process is necessary for kind of adaptive grieving and they agree that at any point on the spectrum from this kind of normal to more prolonged grief, there's the real potential for the grief that people experience to have a massive impact on their lives in a way that can diminish their health and wellbeing for a period that can last from months through to years.

So, the models also agree on the idea that the focus of grief is going to change over time and that it's a really individual, non-linear process, so people will experience different stages or phases of grief as they adapt to their loss on an individual basis. And though there were notions in the kind of first versions of some of these models that a natural response to loss should really be a kind of linear progression, through these stages or tasks of grief, resulting in a sort of endpoint where people have closure and kind of relinquish the attachment to the person that they’ve loved, what we actually know is that often people never get to a point of full resolution and that they oscillate back and forth between the stages of grief for a long period of time. The key is about how their functioning then is affected. And for the majority of people, they are able to adapt to the grief in a way that means that their grief will still recur at times, and they will move between these stages, but that on the whole they can kind of function with the kind of key tasks of life. More recent research has demonstrated the idea that healthy grieving is about the extent to which the person can accept the loss and integrate it into their life. So, going back to that idea of continuing bonds, the, the grief is really integrated in a way that supports them to move forward whilst not forgetting the significant other or not diminishing the importance that significant other continues to have in their life. And we know that, from research, this integration is a key determinant of how well people kind of progress through their grief and how well we can, we can kind of function. So, these kind of continued bonds and this integration is considered key to successful adjustment, if you like.

Okay, so if we think about that spectrum, then, from kind of uncomplicated grief through to the more kind of prolonged or complicated grief. What do we mean by uncomplicated grief? What does that look like? So, mourning the death of his wife in the 20th century, writer CS Lewis described grief as "sort of an invisible blanket between the world and me". And for anyone who has lost a loved one or experienced grief, you might be able to relate to this idea that it can feel a bit like a fog. If we're thinking about uncomplicated or more kind of 'normal' in inverted commas grief, at one end of the spectrum, this grief kind of initially does feel like it's really having a huge impact on people's lives, it is kind of creating a, a barrier between the world and the person, but, over time, what we see is that gradually resolving and that often the grief response then will kind of come in waves. These waves are often triggered by either internal events such as memories or external reminders of the loss, things like anniversaries, birthdays, holidays can be particularly difficult for people. We know that, even in kind of more straightforward grief responses, it is still very idiosyncratic and the, the differences that people exhibit in terms of their tendencies about wanting to kind of talk about the person who they've lost versus others who prefer kind of quiet time, mourning internally, those kind of differences are, are really wide and diverse and, again, are very heavily influenced by people's kind of culture and ethnicity and the mourning rituals attached to all of that.

So, in uncomplicated grief, we see this kind of gradual movement towards acceptance of the loss and after an initial period of, of that kind of fog and that blanket between the world and the person who's been bereaved, we see people's ability to sort of continue with basic daily activities, although it can be very difficult at times. And, people are able to kind of find meaning in life again without the deceased person and they are able to kind of reintegrate into society. And for these people that experience this kind of more straightforward grieving process, although it still continues to be difficult for them at times, there are no really significant kind of social or psychological or medical kind of consequences of the grief. However, for some people, unfortunately, they sit further along the spectrum than the kind of uncomplicated end and the grief doesn't resolve so easily, it can be ongoing and pervasive and quite debilitating for people. So, we refer to, to that as more of a kind of complicated or prolonged grief. And I think one of the reasons why I'm talking about this today is so that you can understand a little bit more about the types of things that differentiate a kind of normal or uncomplicated grief response with when things start to get maybe a little bit more tricky so that you're in a position where you're able to provide support to people, and appropriate support, if you can recognise the signs that things might not be resolving as we, as we might like.

So, complicated grief or persistent or prolonged grief are now contained both within the DSM and the ICD and both systems acknowledge it as a, a condition kind of separate from other emotional or psychological or mental health type conditions. Both classification systems agree that complicated or prolonged grief is characterised by really kind of recurrent, persistent and painful emotions. In the ICD 10 there is a minimum of six months and in the DSM there is a minimum of 12 months that those symptoms need to go on for, although it's six months for children. Symptoms that they are talking about include things like difficulty accepting the loss, a sense of bitterness about it, emotional numbness for some people, feeling hopeless or that life is not worth living, or a real kind of difficulty with activities of daily living and engaging in kind of other relationships and attending work and those kind of normal activities of life. We often see kind of comorbid difficulties with other mental health conditions, so things like depression disorders and anxiety disorders, we see that in about 53% of people who have a kind of complicated grief response. So they will also have these symptoms that are very specific to the grief, but there could also be other kind of symptoms that are more in keeping with a depression or anxiety disorder.

And, in terms of differential diagnosis, I suppose the thing that you want to be thinking about is that the complicated or prolonged grief is really characterised and marked by a pervasive yearning for the deceased person and a real difficulty accepting that that person is gone. So, that might help you to sort of differentiate between other conditions.

In terms of pre-pandemic prevalence, we know that between one and two people out of every ten who experience a bereavement will have a more persistent or prolonged grief response and that comes from a large meta-analysis study by Lundorff and colleagues. And we also know that the pandemic is likely to have increased the levels of prolonged and complicated grief and we're going to talk about that in a second. But without treatment, prolonged grief can persist indefinitely and can lead to other problems such as things like substance abuse as people try and kind of use substances perhaps to cope with their emotional state, an increase in suicidal thinking, problems with sleep, impaired immune function, and links with other kind of mental health problems. So, in terms of the kind of neurocognitive mechanisms at play in prolonged or complicated grief, studies are really lacking in helping us to understand what's actually going on in the brain when people experience a complicated grief and what kind of factors from a neurocognitive perspective contribute to that or might increase people's risk factors. But what we do know about increased risk is that we need to be able to... there is a lot of research about increased risk factors. We need to know about these to be able to pick up signs and symptoms and to be aware of those increased risk factors when we're working with people who might be at, in a place where they might need some additional support.

So, research has recognised all the different factors that can contribute to a more prolonged, or complicated grief. Those can be kind of categorised as sort of pre-loss factors, factors that are related to the actual death itself and then other risk factors. So, we know that, for people who are… pre-loss factors for people who are female, we're not sure what the, the mechanisms are behind that, but we think it might be to do with people's role in terms of their relationship with the deceased. So we know that people who've got a caregiving responsibility for the deceased are more likely to have a complicated grief response and in our society, the, the majority of caregiving is provided by females. We also know that if people are dependent on the deceased for practical or emotional needs, then the loss is more likely to be difficult to process. And we also know that if people have difficulty remembering the positive traits of the deceased, that can also have an effect.

Complicated grief is most common in people who have lost a child or a romantic partner, and it's also more common in people who experience the death of someone where the death is sudden or violent. So, for example, deaths by accident, suicide or homicide. So, these are now loss-related factors. And we know that death in ICU is also a significant risk factor. And research suggests, or a large meta-analysis of studies suggests that between 34% and 67% of families, if they survive a relative who passes away in ICU, will have a complicated or prolonged grief response. Other risk factors include things like the bereaved person dealing with multiple losses, having poor kind of social support, having a lot of stress in their lives or having a history of kind of mental health difficulties or psychological trauma in the past, and where people have a tendency to avoid thinking about the loss or begin to get stuck in sort of ruminative cycles about the loss... and ask questions about, you know repetitively, about why it's happened, about what could have been done differently and either judge themselves for their response in terms of "could I have done something to prevent this?" or judge themselves in terms of their response to their own emotional state as a response of the loss.

So, when we think about what's happened throughout the pandemic crisis, we can see that the conditions for risk factors for complicated or prolonged grief have been sort of inflated. So, if we think about the types of things that have been happening to people with, who have passed away as a result of Covid-19, often those people have died in intensive care units, where they’ve been ventilated. Often the, the death has been quite sudden or has been unexpected because they potentially weren't significantly unwell before they, they contracted Covid. We also know that for lots of people, the ability to be with their loved one at the time of their death was impacted when we were in lockdown and people weren't allowed into hospitals, and we also know that the ability for people to mourn and conduct mourning rituals has also been affected through limitations on things like funerals and those sorts of things. Even things like delays in administering people's death certificates can cause a significant delay in people accepting the loss which can then cause a delay in people's grief response and can contribute to the grief response becoming more complicated.

So, it's really important that we kind of think about some of these things and particularly around after the death, the type of support that is being provided to people. Often that real physical support and that kind of tactile response and, and, and reassurance has been missing as lots of support has moved to kind of online or, or telephone-based and even in people's own kind of social lives, there has maybe been more of a reliance on things like phone calls and messaging and FaceTime rather than someone actually coming round to the house and sitting with someone and, and spending time with them. So, things to kind of bear in mind to help you to maybe clock when somebody might be at increased risk.

So, from that, then, we need to think about the support that we provide and how that differs depending on how somebody's response to the, the loss develops. And there's going to be different types of support for people who have a more kind of normal grief response versus those where that's a bit prolonged. So, in terms of proactive approaches, there are some really, really useful practical things that we can all do. A lot of this stuff is not for bereavement specialists, a lot of this stuff is about the whole workforce doing some of these things consistently in order to make a huge difference to whether or not the, the families of people that, that have died are able to kind of accept the loss and then move naturally into the grieving process and, and that then determines how well they are able to kind of move forward with things.

From research from Stephen in 2006 summarises a bank of evidence that supports the notion that,

actually, the way that those who are bereaved are supported in events before and around the time of death has a huge influence on the trajectory of their grief. And when services get it right and provide really good support to the dying and good support to those who are likely to be bereaved, the, the outcomes are better. However, when services maybe aren't able to provide that same amount of support, that can lead to additional distress for people which might interfere with that transition into the grieving process and increase the risk of a more prolonged or complicated grief response. And obviously, the way in which we respond, then, given the impact on the individual and the wider implications of that in terms of our services, service use and the wider kind of social economy of the nation, there's a huge impact and a massive importance on getting this right from the very beginning. So, if we think about the kind of model that we use to kind of guide the support that we offer, in Scotland we've got a national framework to enhance the understanding and care of those who are dying and, or who have been bereaved. It's called Shaping Bereavement Care - a framework for action, which was published in 2011, and I have linked that in the resources section that will accompany the slides for today.

And, the national framework kind of follows a very similar process to the NICE three-component model of bereavement support which is kind of supported by a kind of public health approach at that kind of care before death and universal support level. So, these models kind of work on the basis that bereavement in itself is not an illness, it does not need to be pathologized, it's a normal human response to loss. And the majority of people will be able to experience a kind of normal grief response and there is not evidence in support of using kind of specialist therapeutic interventions for everybody who has been bereaved. The evidence suggests that clinical interventions in grief should be high quality and delivered by those with specialist training to those who, after a period of months, manifest a more complicated or prolonged grief reaction and need additional help.

So, it's a kind of stepped care framework. And when we are thinking about children, that advice is slightly different, that actually children who are more vulnerable to complicated grief, the evidence does support more early intervention with kind of evidence-based approaches. And, again, I'll link to some of those in the, in the notes. But for adults, the advice very much is this kind of care before death and universal support. And then for those that do have maybe a more prolonged or complicated response, we then kind of step up through the framework.

So, first of all, care before death is incredibly important. The national framework and the NICE model really emphasise the importance of commencing bereavement work before an expected death or at the earliest possible point if a death is unexpected or sudden. And the evidence tell us that when bereaved people have been prepared for the death and have been supported in the events that follow, their bereavement outcomes are usually much better. So, how can we provide good quality care before death? This is about kind of minimising the risk of that prolonged grief through sensitive communications from a really early stage in the kind of death process with the dying patient and, and close relatives to support the acceptance of the loss. Provision of really, really clear information regarding what to expect and that's particularly important for friends or relatives who want to be present when the person passes away. Promotion of choice is really important and choice should be offered wherever possible. And that also relates to people's kind of spiritual, religious and cultural beliefs. These need to be identified and those needs should be kind of met wherever possible before and after death according to people's choices. And other emotive issues need to be discussed clearly and as early as possible. So things around protocols, post-mortem examinations, tissue donation, and, and clear information about what actually happens to a person's body after they've passed away. Clear and accurate information, also, about, for those who have been bereaved about... the immediate tasks that they might need to undertake as a result of the death. The bereaved should be given a clear point of contact should they wish to speak to anybody after a death either about the kind of practical bits or the kind of emotional side of things. And this approach really kind of advocates for a really direct approach to difficult conversations in anticipatory care planning. And it's really about supporting people to have all of the information they need, to know what to expect and to be able to make their own decisions, informed decisions, and to know where, then, that follow-up support can be provided.

Universal support is very much about providing practical, after the death, practical information and support for, for everyone who has been bereaved, and involves information about the process of bereavement and giving people the time and space to reflect on this and signposting people towards other resources. It's about helping people to kind of lay that foundation that enables good outcomes. And potentially there is a role here for kind of psychological first aid if the death has occurred in a kind of crisis-type situation.

Going up the levels of the framework, then, selective and indicated support are for those who are... Selective support is really for those who are identified as at risk of a complicated bereavement, and indicated is for those who are showing symptoms of a kind of complicated or prolonged bereavement. And at that selective level it is really about linking people up with self-help resources and support groups and groups within their own community that can help them to kind of work through the grief process and reflect upon their experience. At the indicated level, it's about additional support being provided by accredited professionals, so specialist interventions that may involve mental health services, psychological services or counselling support. And what we know from evidence is that psychological therapy is kind of considered a gold standard and that psychological treatments can be really, really effective.

In terms of medication management, we know that pharmacotherapy is, is indicated where people have comorbidities, but not for the actual grief itself. So, for example, if people had a complicated grief with a comorbid depression or anxiety disorder, you would perhaps want to treat the depression or anxiety with medicine, but there is no evidence for the use of medicine in prolonged grief where there isn't another mental health component.

So, there are some really good resources to help you to think about how you support others and I really encourage all of you to access the Support Around Death website where there is a wealth of information. On NHS inform there is a bereavement self-help guide and a guide that is more kind of practical information about when someone has died. On Turas Learn, there's the psychosocial mental health and wellbeing support site that also has a huge section on how to support others. And also, if you are interested, the Bereavement Charter for Scotland sets out how we approach bereavement care in Scotland and some links to, to other resources. And, within my resources section, I will also link you to, to other areas of kind of support.

So, everybody has got a role in some way or another of supporting people who, who are potentially been bereaved. And working with people around the time of death and with those who have been bereaved can be demanding for health and social care practitioners and it's really important to ensure that we think about looking after ourselves and approaching our own wellbeing from a really proactive perspective to enable us to continue to do the important work that we are involved in.

So, we're going to talk a little bit now about wellbeing and resilience within the workforce. And first of all, I want to think a little bit about the risks to wellbeing. So, we know that our workforce is exposed to lots of stressors and chronic stress has a huge impact on people's physical and emotional health. Burnout is related to this and it is a sort of negative psychological syndrome characterised by the World Health Organisation as resulting from chronic workplace stress, characterised by three dimensions - so, feelings of depletion or exhaustion, indifference towards the person's job and reduced professional efficacy. And there are a range of kind of consequences for individuals and organisations in terms of burnout, but we know that when people are burnt out, their perceptions of care are poorer and burnout is also associated with poorer physical and mental health outcomes for staff and patients and also an increase of absenteeism and turnover.

Moral injury in distress, then, is more about when people's ethical or kind of moral code is violated. So, when they are unable to act in the way that they consider to be kind of demonstrating good quality care or when they see others either intentionally or unintentionally providing care that is not up to standard. And, also, people who may feel that they have been betrayed by others in an important situation. And lots of these factors are influenced by kind of capacity and pressures and we've seen a massive increase in moral injury in our workforce throughout Covid.

Compassion fatigue is the risk that people become kind of burnt out and unable to be compassionate in their role in working with patients or service users. When we are talking about service improvements in health and social care, we talk about this triple aim, which is about improving outcomes for people who use our services, enhancing the care we provide and working efficiently or saving money. But we know that the health and social care workforce report widespread burnout and stress and dissatisfaction and that was before Covid. So, we know that the risks to wellbeing for staff are great and we know that has a huge knock-on effect on our costs, our care and our outcomes. So, it’s therefore essential that we add this fourth pillar in, of workplace wellbeing or kind of provider wellness, and it comes back to this idea of resilience. So, the word resilience is rooted in the Latin meaning of resilire, which is the ability to bounce back. The way we talk about resilience is often, so it's an automatic process, like it's elastic. And although, you know, relatively, I'm a newcomer to the NHS, I've been working full-time in the NHS for 12 years, I quickly learned that we don't just spring back. So, it's not about how much we can endure but how much we can kind of, care for ourselves in the process of our roles and how we can support our own learning and growth. And there are these five kind of domains of resilience. And at the Roffey Park Institute, which I will link to, there is the ability to kind of self-assess yourself in terms of these domains of resilience and how, how you can then develop a bit of an action plan for thinking about some of the things that you might want to do if you are identifying that your resilience is maybe being affected. So, it’s about, the perspective is about how you think about things and having a more kind of positive mindset. Emotional intelligence is about how we kind of identify and manage our emotional states. Our purpose, values and strengths is really about having clarity about these things and being able to kind of act in a way that is in accordance with our values and how our work role fits with all of that.

Connections is really about having a strong and reliable network of people to rely on inside and outside of work for support in difficult times. And the managing physical energy bit is the stuff that we all tell other people to do, but maybe aren't perhaps so great at doing ourselves – so, prioritising sleep, exercise, good quality diet and making time for things that are joyful or things that help us to relax.

So, compassionate resilience is about this idea of bringing compassion and resilience together where we are able to think about how we engage with people in a conscious way, so we respond to their distress in a conscious way and maintain our physical, emotional and mental wellbeing as we do so. So, it's about kind of using energy productively in order to care for those who are suffering and identifying and preventing the things that cause compassion fatigue. And really, it's a really simple process where we need to recognise the distress through being mindful, we need to think about

regulating our emotional state and then we need to think about engaging in kind of soothing activities or activities that bolster compassion. And I want you to think about this idea of the window of tolerance. I'm going to signpost the videos that talk about this in detail. But essentially, during extreme times of stress, we might not be able to kind of process things properly in the brain and this leads to our brain kind of almost shutting down in a way, if you like, it affects our ability to think about things rationally and we can become dysregulated in our emotions, which can take the form of hyper- or hypoarousal.

In hyperarousal, this is what we know is kind of fight or flight where people feel very overwhelmed,

where there can be feelings of anxiety and panic and emotional outbursts. In hypoarousal, it's very much when people become a bit lacking in kind of arousal, they become, it's sort of freeze response where people feel a bit emotionally numb. And in these periods, people are said to be out-with their window of tolerance. Everybody has a different window of tolerance, some are narrower than others and the important thing is to think about how we can identify the things that push us out of our window of tolerance, but also to do things proactively to try to maintain a wide window of tolerance, so taking a really proactive approach to self-care. Now, when people move out of that window, there are things that we can do. So, we can get into the green zone in various ways, all of which is sort of reliant on the level at which we kind of up or down regulate. And so it's important to think about not only what pushes you out of your window of tolerance, but what kind of things you need to think about to get yourself back into that zone of regulation and what works for you. And the videos that I've linked to will help you in that process.

So, we need to think about kind of the window of tolerance and our emotion regulation as key to our resilience and our wellbeing as individuals, as teams and as organisations. And some of the other resources that I will link you to also kind of provide support for that proactive approach to wellbeing and will support you to kind of begin a bit of a wellbeing journey if you're not already on one. Does anybody have anything they wanted to raise about any of the three kind of topics that we’ve discussed?

Yeah, some people working in the chaplaincy service and hearing about grief amongst clinical staff. The issues about getting time released to enable more group support. Absolutely. The time pressures that we face at the moment are a massive, massive issue for us.

And… worked clinically throughout the last 18 months, interested in support for nursing AHP workforce who have faced multiple and daily deaths throughout Covid. What I can do is I can email you some resources specifically about those kinds of issues, which will hopefully help you with some of that as well.

Saying that she is a social worker and has recently experienced an, where an individual experienced sexual abuse as a child, was triggered following the death of an abuser. I wasn't sure if this was a grief or combination of trauma. Yes. So, these, these kinds of responses are often incredibly individual. I can send you some details as well from a trauma perspective that might help you with your kind of understanding and your work with this person. Often, the two can be very closely tied together under circumstances like that. And it can, it can be very complicated. And those would be the kind of things that we would be thinking about potentially putting people at risk of a more prolonged or complicated grief response or kind of reigniting a, a trauma response.

So, I've got some comments here from people that work as mental health... midwives. And support women with mental health difficulties in pregnancy and sometimes there are real kind of difficulties. So, the question is, "Could complicated grief be identified so shortly after the loss?". We can identify the risk factors for complicated grief in the people we are working with and we can kind of be aware that a person is probably at risk of a complicated grief response and we can kind of really try and bolster the support that they’re provided under those circumstances, but in terms of those kind of specialist-level interventions, we wouldn't provide those earlier in, in the grieving process because, actually, too much interference in somebody's natural grieving response and, and the way in which they navigate that as an individual can actually cause more damage or can... can come at a point that is kind of too early for the person to work with or process, which is why we've got these kind of guidelines about, about allowing people time to try to work through it, perhaps with some additional support for that, but those kind of specialist interventions not coming until a bit later on.

Yeah, if anyone does want to email me with any other questions or if anybody is looking for specific resources, I can definitely provide those, but there will be a really comprehensive list that goes out with the slides.

Yeah, and they’re saying that she works in a hospice and would say that moral injury is something that a lot of nurses have struggled with, and I can signpost to some specific resources around moral injury as well if that would be helpful for people. The resources that I will link to are really comprehensive and I would really encourage you to go away and look specifically at the videos that I’ll provide around the window of tolerance and how we can support that as individuals, but also as an organisation. And also the Turas Learn resources that are composed of an animation and an e-learning module and then an accompanying staff wellbeing plan that support staff to take a really kind of proactive and measured approach to thinking about preserving their wellbeing.

Yes, this session could have done with being twice as long, absolutely. I definitely could have talked for a lot longer about these sorts of things. A question there about where we will get access to the slides and the list of resources. So, those will be provided by the kind of conference team, they will be available to access after the conference. But if there are any specific resources that you are looking for or need pointed in the right direction, please, just send me an email.

"I'll be interested to know at what point you consider a special psychological intervention should be offered?”. So, that would really be at that kind of 6-12 month point where somebody was really displaying some of those symptoms of more kind of complicated or prolonged grief and where they had accessed maybe some of the other support in terms of kind of peer support and those kind of things and those hadn't worked for them. We'd also be considering things like the other risk factors that people have and other comorbidities. So, for people who have got other comorbid mental health problems, then a psychological intervention would probably be of, of great benefit to the, the person, but obviously there are other factors to consider in terms of how people understand their grief and how kind of emotionally literate people are and how willing they would be able, they would be to kind of engage in a psychological approach. But certainly, we would be thinking about kind of psychological therapy interventions that are evidenced based at that top tier of indicated support at anywhere from that kind of 6-12 month period and for people, in particular, who have got those comorbid, comorbid conditions.

So, in my list of resources that you’ll get, there are a number of self-help guides. The one on NHS Inform is really good if you need it more urgently, but there are a few really good ones that I've listed on the, the resource guide. Okay, I think we are about to get kicked out, but thank you very much, everyone, for joining me.

The film was produced in November 2021 and can be found at [www.sad.scot.nhs.uk](http://www.sad.scot.nhs.uk/) or <https://vimeo.com/680542368>

For more information visit [www.sad.scot.nhs.uk](http://www.sad.scot.nhs.uk/) or contact [SupportAroundDeath@nes.scot.nhs.uk](mailto:SupportAroundDeath@nes.scot.nhs.uk)

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