Review Article

Supporting Resilience and the Management of Grief and Loss among Nurses: Qualitative Themes from a Continuing Education Program

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Caring for patients with cancer is highly stimulating and rewarding, attracting health professionals to the field who enjoy the challenge of managing a complex illness. Health professionals often form close bonds with their patients as they confront ongoing disease or treatment impacts, which may be associated with multiple losses involving function and/or eventual loss of life. Ongoing exposure to patient loss, along with a challenging work setting, may pose significant stress and impact health professionals' well-being. The prevalence rates of burnout and compassion fatigue (CF) are significant, yet health professionals have little knowledge on these topics. A 6-week continuing education program consisting of weekly small-group video-conferencing sessions, case-based learning, and an online community of practice was delivered to health care providers providing oncology care. Program content included personal, organization and team-related risk and protective factors associated with CF, grief models, and strategies to mitigate against CF. Content analysis was completed as part of the program evaluation. In total, 189 participants (93% nurses) completed the program, which was associated with significant improvements in confidence and knowledge of CF and strategies to support self and team resilience. Qualitative themes and vignettes from experiences with the program are presented. Key themes included knowledge gaps, a lack of support related to CF and strategies to support resilience, organization- and team-based factors that can inhibit expression about the impacts of clinical work, the health professional as a "person" in caregiving, and the role of personal variables, self-skill practices, and recommendations for education and support for self and teams.

Key Words: Disenfranchised grief, Compassion fatigue, Psychological resilience, Psychological burnout, Education, Health personnel

INTRODUCTION

Caring for patients with cancer is highly stimulating and rewarding, attracting health professionals to the field who enjoy the challenge of managing a complex illness. Health professionals often form close bonds with their patients as they confront ongoing disease or treatment impacts, which are associated with multiple losses involving function and/or eventual loss of life. Ongoing exposure to patient loss, along with a challenging work setting, may impose significant stress, im-

pacting health care professionals' well-being and contributing to the development of burnout and/or compassion fatigue (CF). Burnout and CF are associated with significant emotional symptoms, including mental exhaustion, apathy, emotional detachment, and/or physical symptoms [1,2]. These impacts have been linked to reduced work-life satisfaction and increased absenteeism [1,3]. Thus, educating health professionals on how to recognize and mitigate risk for CF and burnout is important.

This article describes qualitative themes obtained from a continuing education program with the aim to improve knowledge of CF and strategies to support the management of grief and loss in practice. The program, entitled "Addressing Compassion Fatigue, Managing Grief and Loss Amongst Healthcare Professionals," was associated with significant improvements in confidence and knowledge, and participants left the program with proposed plans to address identified areas relevant to their personal work environment or their coping. The quantitative evaluation outcomes are described briefly in the supplement, with a full report elsewhere [4]. Here we describe nurse learner vignettes and qualitative themes from the program and its evaluation.

COMPASSION FATIGUE AND BURNOUT

The exposure to suffering, dying, and death in one's practice can contribute to an overwhelming sense of stress and grief. Medland et al. [5] emphasized the importance of addressing impacts of being exposed to loss and suffering and suggested that when health care providers ignore or fail to recognize feelings of grief, those feelings become chronic and cumulative. Longitudinal exposure to grief and loss, combined with high work-environmental demands, may lead to burnout and to the development of compassion fatigue (CF), a term used to describe the physical and emotional reactions occurring through the caregiving experience with suffering patients. Burnout has been described as having three dimensions of symptoms, including emotional exhaustion, depersonalization, and a lack of personal accomplishment [6]. Compassion fatigue (CF), in contrast, is defined as a specific tension related to caring, resulting from re-experiencing traumatic events and

persistent arousal associated with patient suffering and distress [7]. Common symptoms of CF include chronic exhaustion (emotional, physical symptoms, or both), reduced feelings of empathy, dreading working for or taking care of another, and feeling guilty as a result [7,8].

Risk factors for difficulties in managing grief and loss and for CF include a lack of support, lack of knowledge about CF, lack of time to provide high-quality care, being unable to ease suffering, and excessive attachment or involvement [9]. Men may be more likely to experience depersonalization than women [9]. Baranowsky and Schmidt [10] emphasized the role of personal variables and hypothesized that primary traumatic stress in one's early life can motivate individuals to become health care providers, who may then care for others while neglecting their own needs.

Attachment style has been investigated [11]. Pathological caregiving behavior is hypothesized to be one manifestation of insecure attachment [12,13]. Insecure attachment is associated with impaired stress management and subtle deficits in professional caregiving sensitivity, especially as one is exposed to increased demands [13]. One study assessing attachment styles among 84 UK hospice nurses, found 52% to be secure, 18% preoccupied, fearful (17%), and 13% dismissing. Approximately one-half had an insecure attachment style, a rate higher than that found in other studies of health care professionals and the general population. Interestingly, hospice nurses with an insecure attachment style experienced somewhat more stress and had more absent days. Those with a fearful or dismissing style were less likely to seek emotional social support as a means of coping with stress than hospice nurses with a secure or preoccupied attachment style [11,14]. Such personal variables, combined with current work environments and the socialization process in becoming a health care professional, can make it difficult to reach out for help or to recognize or admit to personal vulnerability, resulting in self-silencing.

Protective factors have also been identified, including colleague support, sense of competence, work-life balance, connection and compassion towards others (e.g., on the team), acknowledgment of grief and loss occurring in the clinical setting, maturity/experience, older age, and educational level [9,15,16].

SUPPORTING RESILIENCE AND THE MANAGEMENT OF GRIEF AND LOSS

Given the multi-factorial nature of the problem, interventions at the organizational, interpersonal, and individual levels are likely required [9,17]. Strategies that provide opportunities for de-briefing in group sessions have been recommended [18]. Rituals offer opportunities to come together as a team and to share in the expression around a loss and may contribute to sense of meaning in the work [18]. Greater attention has recently been paid to supporting team resilience or individual wellness through teaching mindfulness stress reduction [19] or enhancing skills in self- and other-compassion [8,10,20,21].

While knowledge of burnout and CF and skill in self-care have been identified as important competencies in oncology [22], health professionals have little knowledge on these topics [9,21].

THE EDUCATIONAL PROGRAM

The de Souza Institute, situated at the University Health Network in Toronto, Canada (www.desouzainstitute.com) provides educational programs to health professionals providing oncology or palliative care. The continuing education program was developed by a PhD psycho-oncologist with experience in working with grief and loss. The primary aims of the program were to increase knowledge and confidence related to the impacts of exposure to suffering and loss, including understanding CF and burnout and the associated risk factors, recognition of types of grief experiences, and specific individual- and team-oriented strategies to support resilience. The program was offered as a part of a menu of offerings, with educational credits, and was delivered on 14 occasions from 2011 to 2019.

1. Format

Participants attended small group weekly 1.5-hour video conference-based sessions over 6 weeks. Each group seminar included readings from the literature and was led by a PhD-level practitioner/educator with experience in grief/loss and psychotherapy. Weekly group discussions were further supported with an online community of practice (CoP), to add a further source of support and a place for sharing resources.

2. Content

The content was organized in relation to personal, system/organization, and team-related (interpersonal) factors contributing to CF and burnout, and strategies to support well-being and resilience (see Table 1). The first three sessions focused on grief models and reactions to loss. The grief material not only helped participants to reach a further understanding of how loss might impact personal well-being, but assisted learners in furthering knowledge related to their clinical work. Literature on burnout and CF was explored. Personal risk factors (e.g., attachment style, prior mental health challenges, or previous trauma) associated with burnout and CF were reviewed, as well as contributing factors related to work settings or the team (e.g., team conflict, lack of team cohesion, patient variables, and workload issues). Additional topics included concepts of compassion and empathic distress, and medical assistance in dying.

The final three sessions focused on strategies and resources that facilitate coping with grief and loss and mitigate against CF. Literature was provided on group-oriented retreats or debriefs, studies of mindfulness-based stress reduction groups, team or self-compassion interventions, rituals in settings that support grieving, and individual-oriented wellness and support interventions (e.g., counseling, psychotherapy, relaxation, and physical well-being strategies).

Participants were supported via the group discussions to identify specific challenges that they experienced personally and to assist them in preparing personal plans (e.g., based on their enhanced knowledge and identification of relevant personal/setting/team-related risk factors). Personal plans were shared during the group sessions. Participants were encouraged to consider what "they could do" to support their work, team, or setting. Participants were also invited to identify and share, if they were comfortable, any relevant personal factors (e.g., current stressors, coping style or background risk factors, such as prior trauma or loss). Potential barriers to implementation of plans were identified in the final session, with course participants brainstorming together on specific strategies to address them.

The Grief Experience Inventory – Revised (GEI-R) [23]

Table 1. Session Description.

Session	Topics	Course strategies
Session I	Burnout and compassion fatigue • Definitions • Prevalence • Symptoms	• Posting of a "difficult" case that felt unresolved; • Sharing/discussion • Assigned readings • Sharing in community of practice
Session II	Risk and contributing factors • Health professional personal variables • Patient variables • Team and work environment factors Review of grief models • Theory and grief symptoms • Assessment • Importance of having an "understanding" of a theoretical model of grief and loss	• Lecture • Assigned readings • Completion of GEI-R discussion • Sharing in community of practice
Session III	• Attachment theory/studies • Integration • Healing relationships • Compassion and empathy • Self-compassion and self-awareness • Interventions to support resilience and well-being	• Lecture • Assigned readings • Discussion • Sharing in community of practice
Session IV	• Strategies to support resilience/address compassion fatigue; prevention	• Lecture • Assigned readings • Discussion • Sharing in community of practice
Session V	• Strategies to support resilience/address compassion fatigue; prevention	• Lecture • Assigned readings • Discussion • Sharing in community of practice

Session VI	• Reconsideration of posted cases from week 1;
	• Personal plans going forward
	  (e.g. personal well-being, team-oriented plan;
	  organization-oriented plan)
		• Review of personal plans;
		• Discussion and identification of barriers/enablers and strategies
		  to address them
		• Discussion about the case posted in week 1

GEI-R: Grief Experience Inventory - Revised.
Source: Esplen MJ, Wong J, Vachon MLS, Leung Y. A Continuing Educational Program Supporting Health Professionals to Manage Grief and Loss. Curr Oncol 2022;29:1461-74.

was given as a self-assessment tool to facilitate insight into participants' own psychosocial functioning in relation to grief symptoms. The inventory has four domains—depression, existential concerns, guilt, and physical distress—and has been utilized in assessments of health professionals [24]. The GEI-R was also used as a teaching aid. For example, the course leader reviewed the tool's items to illuminate specific domain areas of assessment of grief in its application for assessing patients.

CASE-BASED LEARNING

Participants were asked to post a description of a "difficult case" that felt unresolved to them (e.g., "Consider and describe a case that has kept you up at night, or has stayed with you"). Case narratives were reviewed and utilized during class discussions to illustrate variables (e.g., patient variables, health professional-related variables, or work setting factors) that likely played a role in the sense of a lack of resolution. Participants revisited their shared cases during the final session, to re-consider the material with their gained knowledge, and consider what "they might do differently, if a similar situation presents once again."

PARTICIPANTS AND BRIEF SUMMARY OF PROGRAM EVALUATION

The participants were 189 healthcare professional learners; the majority were nurses and women (92.6%). Approximately 16% of the participants were younger than 29 years, 49% were between 30~49 years of age, and 32% were 50 or older. The participants reported a mean of 17.7 years of practice in health care, of which 7.3 years were in oncology. Approximately 38% worked in cancer centers, 23% in palliative care, 21% in community care, and 18% in general hospital units. In relation to loss, 65% of participants experienced 10 or more patient losses in a typical year; 12.2% experienced more than 50 patient losses per year.

Pre- and post-course evaluations assessed participants' confidence and knowledge in core domain areas related to burnout and CF. The program evaluation demonstrated significant improvements in knowledge and confidence in relation to identifying symptoms of CF and burnout, risk factors for CF, and strategies that support resilience and help manage exposure to loss and suffering (7) (see Supplement 1 for further information). Satisfaction with the program was high (85%), with no dropouts.

QUALITATIVE COMPONENT

The quantitative survey included open-ended questions on participants' experiences with managing grief and loss in practice to enhance our understanding of the quantitative findings and capture satisfaction in participants' own words. Participants answered the study questions: "What new information did you learn and value most in the course? Are there recommendations for addressing this area among health professionals?"

DATA ANALYSIS

For the qualitative aspects of the project, the concept of Burnard's method for content analysis was chosen [25]. Qualitative analysis was supported by NVivo and conducted by the instructor and research team on data provided by the open-ended questions and reports of participant plans. An explora-

tion of textual data was conducted, grouping together similar types of statements to construct a systematic list of themes and categories. The author (MJE) started the analysis by reviewing text several times to become familiar with the data. Key issues, so-called meaning units, were coded and grouped. To increase validity, additional team members analyzed the text with comparisons and discussions of categories and subheadings. The aim was to reach consensus and review for saturation to ensure that the thematic categories in the final group covered all aspects of the participants' answers.

RESULTS

1. Qualitative themes

The content analysis revealed the following themes:

1) Educational needs on topics of CF and strategies to support wellness and resilience

All participants expressed that they had wished that they had received information on burnout, CF, risk factors, and strategies to support impacts of clinical work much earlier in their careers. Participants suggested that a formal integration of these topics would help professionals from the onset of their careers understand that the stress associated with exposure to loss and suffering can have significant impacts. Participants recommended a core competency related to knowing what to look for in self-monitoring, knowledge of self, and team-based strategies to support resilience. Examples of expressions included, "This program should be encouraged during our education."; "I would have known earlier what to look for and not be so ashamed."; "My supervisors do not themselves know this information.". "It is in the closet, and no one teaches about these issues…we are expected to just suck it up and cope." Participants also strongly recommended that continuing education programs be offered in practice settings. "If you do have lectures in our education, I think reminders on how to practice self-care or on team supports need to occur in the work setting."; "I might need to know what to be doing as a nurse later, when I lose a patient and issues start to really occur—before you know it you are having issues."

2) Barriers to address CF and burnout

Participants described time pressures inhibiting opportunities for team reflection or expressions of difficulty in coping. Other barriers identified included a culture that perpetuated fears concerning how one might be perceived by colleagues or managers, and how these perceptions can impact opportunities or performance reviews. Expressions of shame or a need to "be strong" were frequently expressed. These findings were identified as barriers for reaching out for assistance. Expressions documented included: "There is no time, and this stuff is not considered on the team, so when can I bring it up?"; "I'm not going to bring it up being the junior on the team…they will think I'm not strong enough to cope with the work."; "I wonder how others are coping or deal with it."; "I'm afraid to raise it…the older nurses told me I will never last if I don't toughen up."; "If you cry it is frowned upon."; "Once an older nurse suggested I go for coffee, I did and I appreciated that suggestion, but I didn't have anyone to talk to, so I just cried alone in the washroom."

3) The health professional as a 'person' and the relevance of personal variables

All participants expressed that they had gained insight concerning the role of personal factors in relation to their role in developing CF or burnout, and how personal variables support resilience. Examples of expressions included: "I had no idea that my own history played a role."; "I knew I didn't eat right, but I had no idea how my coping style is playing a role."; "I didn't realize how the loss of my mother might have played a role in choosing this profession, or my 'need' to be such a good caregiver."; "I realize and was astounded that I have no idea how to take care of myself."; "I was shocked to see how I scored on the grief tool… it is so obvious that I may even have some depression."; "I never ask my staff about their backgrounds, and didn't think it played a role…now I want to see if I can be more caring and show interest in my staff to help support them."

4) Self-skill practices to support well-being

It was common for learners to describe the lack of time for, or attention on themselves, in relation to physical or emotional health. Most learners were women and reported competing time demands at work and home, in relation to childcare or caregiving for older adults in a family. Several participants realized that their own physical health (exercise, nutrition, sleep) was likely being compromised. Some participants found that they dismissed their needs to maintain physical well-being and reported planning to pay more attention to work-life balance. Examples of expressions included: "I put myself last on the list."; "I don't take time to even have regular meals."; "My patients pretty much come first, I'm lucky if I get a break."

5) Team-related factors

All participants reported gaining insight into team-related variables that contribute to an individual and team's coping level. More than 50% of participants' personal plans involved taking the topic or strategies to their teams to facilitate discussions, to address a unit culture or time-related barriers. Strategies identified in personal plans included giving team-based grand rounds (75%); sharing a paper with team members in a lunch-and-learn for discussion (40%); working with the supervisor to bring in a guest for a compassion team care-oriented workshop, mindfulness workshop, or retreat (42%); meeting with the supervisor to plan for meeting with leadership in one's work setting (27%); volunteering to organize a staff event around wellness/resilience (48%) and working with the supervisor or planning for a conflict resolution skill workshop (28%). Examples of statements included "I feel now that others are not dealing with this or really opening up."; "I don't know my team, we rarely do things together or even lunch."; "I like the idea of calling someone to check in on them or to follow up after a patient death."; "I have permission from my supervisor who paid for this course to work on a workshop or a half-day retreat for our team."

6) Organizational/institutional factors

One of the most concerning factors related to health care settings was the lack of acknowledgement that patients die in the care setting. This pattern was more evident in large institutions or in acute care settings. Several participants described settings with little opportunity or encouragement towards expressing on experiences with death or suffering. Learners described putting feelings and thoughts aside, "just carrying on." Some participants described trying to find relief with partners

at home. In contrast, among participants working in palliative care settings where the acknowledgment of grief and loss existed, expressions of relief were observed and a high value was placed on recognizing that deaths occur. Examples of learners' expressions included: "If a patient dies, no one and I mean no one talks about it—not where I work anyhow."; "I had to clean up the room right away, a patient was waiting."; "The doctors or we as nurses never speak about this.". "We have very sick patients and some die but we just have to keep going, it's a busy setting."; "I appreciate that we have rituals each time a patient dies—we place a dove on the wall and come together"; "That is why I work in palliative care, at least we all know why we are there and my supervisor checks on me in my evaluation."

A few participants expressed that leadership (e.g., managers or hospital executives) did not value the need to support staff well-being. Some participants expressed feeling that there was "lip service, but no attention paid to the matter." These participants described settings with few opportunities to reflect upon or express themselves about work-related challenges. Frequent descriptions included a sense of working in an "assembly-line type of unit," related to workload. Examples to illuminate these themes included "There are always patients waiting for the bed."; "No one really cares if you give exceptional emotional care, what is important is efficiency, we just make do in regards to our own needs or coping."

7) Need to incorporate self-care, resilience, and coping as topics in annual reviews

Several participants recommended that it would be helpful if supervisors included reflection items or opportunities to have someone check in with them on how they are coping in relation to providing care to their clinical populations. Recommendations included applying a self-report tool and open discussions in annual reviews. Ideally, this recommendation was suggested for leadership roles, but other options included pairing staff (e.g., a buddy-like system) or incorporating a resilience program as part of onboarding training, to highlight the importance of self-care and ongoing monitoring as part of clinical work. Expressions included "I think everyone should be reflecting on this and having someone check in on them, yearly or every couple of years."; "A self-report tool might

help for us to see how we are doing and then we can follow up if we see an issue we may not be aware of."; "I am going to now build this into reviews of my staff."

Vignette: Anne

Anne (not her real name) was a nurse working in acute care. She brought forward a clinical situation where she described feeling "haunted." One of her patients, a young woman, was diagnosed with metastatic ovarian cancer and upon admission was realizing the seriousness of her situation. Surgery was planned and Anne was assigned to the woman to help prepare her for surgery. Anne identified in many ways with the woman, who was a mother with young children. The woman had her surgery, but experienced a downward course during her hospitalization and died. Anne had several interactions with the woman's husband and had met the children during her caregiving. With the downward spiral of the young mother's health, Anne had little time to prepare herself or to help support the woman's family. Anne described her clinical experience as "devastating" and recalled wondering if she could continue to work in the setting. Anne found herself thinking about the young woman years later. She described feeling overwhelmed and recalled that she cried for days following the woman's death. Anne reported that although she was given a couple of days off after the woman's death (suggested by her manager), no one talked to her about her feelings and loss. Anne found herself having fears around her own well-being. She also described trying not to become "too close" to her patients, fearing she would be "too attached" and feel devastated by their loss. Anne believed her reactions inhibited her ability to provide optimal care to her patients. During the program, Anne shared openly and began to notice that she "over-identified" with the young mother, who had a similar background and children of the same age of her own. She also disclosed that she had experienced some trauma in her youth and received counseling at the time. Anne increasingly began to wonder if her past experience with the loss of the young woman was playing a role in her quality of life, and on perceptions of her nursing role.

The course facilitated Anne to reflect on and share about the readings and her "case." Anne came to discover new informa-

tion about herself, her coping challenges, and how her patient loss was impacting her and her work. The gained knowledge and support prompted Anne to seek personal counseling to work through what she felt were personal issues. In her post-program evaluation, Anne reported that she had entered therapy, describing it as an important step for her. She also expressed hope that it would lead to greater satisfaction with her work and that she would once again enjoy nursing in the acute care unit.

Vignette: Ellen

Ellen (not her real name) worked long-term in a palliative care inpatient setting, exhibiting a high level of knowledge on end-of-life care. She was often asked to "train" newly hired nurses. Ellen was initially hesitant to express challenges related to her coping and well-being, in fact, she expressed pride in her ability to juggle her clinical load and "help (her) patients through this important journey." Her nursing role clearly provided a great deal of meaning for her. Ellen enthusiastically participated in the sessions and routinely "mentored" the more junior learners. However, over the program Ellen became increasingly aware that her care team members and manager did not talk openly about the topics discussed in class. She was "astounded" at some of the potential impacts that the clinical work could have on team functioning and well-being. She also came to question her own approach to teaching. Ellen wondered if her own way of managing clinical experiences resulted in junior nurses within her presence feeling pressure to be "strong." Ellen admitted that she rarely opened up on her feelings and recalled that in her early days, "no one asked me about my experiences." Over time, Ellen asked the program leaders if she could use lecture slides for rounds at her hospital site. She approached her institutional leadership to inquire about funding to organize a staff retreat. Ellen reported on a lunch-and-learn session, where she shared a paper from the class and led a discussion with physicians and nurses. She reported that her team talked about their own perceptions and experiences, relating to the article. The team members responded with the goal to create more opportunities to support their members. Ellen sought out and succeeded in getting funding for an outside expert to present at her work setting.

The example with Ellen highlights how a very experienced palliative care nurse came to revisit some of her earlier assumptions and reflected on her own experiences and training. By the end of the course, Ellen reported that she had changed her approach to mentoring junior staff and had become a kind of "team resource."

DISCUSSION

A continuing educational program focusing on enhancing knowledge and confidence around managing grief and loss and addressing CF demonstrated benefit. The qualitative themes from the open-ended content on the post-evaluation survey indicated that nurses (majority of participants in the program) recommend that information on CF and burnout and individual- and team-oriented strategies to support resilience be offered during their educational preparation for their careers. In addition, course participants unanimously recommended that continuing educational programs are needed to support ongoing practice. This recommendation was in relation to both the clinical care staff level and leaders/managers of organizations, who participants believed are important enablers in successfully addressing the issue. Consistent with the prior literature [26,27], several participants in the program expressed feeling silenced, prohibited, or fearful to disclose difficulties with coping or around symptoms related to burnout or CF. As a result, there was a tendency for nurses to "carry on," keep silent, and "hope that issues will resolve." Others attempted to manage challenges by talking about the issue at home with partners. Participants expressed concerns about being "discovered," fearing that nurse or other health professional colleagues would see them as "weak" and "not equipped to deal with the care unit."

Given the volume of patient loss endured by participants, it was striking that most participants reported having little or no access to resources, or opportunities to come together as a team to reflect on the work to address feelings associated with losses within their care settings. Some participants reported that professionals from spiritual care offered forums; however, few attended. Participants expressed time pressures or fears related to "being noticed who was attending" as potential barriers to attendance. Opportunities for debriefs or rituals

around patient deaths were reported more frequently among participants working in palliative care settings. Time pressures and lack of formal structures are barriers previously described in the literature [28], including in some palliative care settings.

While challenges such as patient volumes or time constraints were the most common factors identified at the onset of the program, by course completion all learners shifted in their perception to encompass a broader view of factors contributing to CF or burnout. The role of the "self" was highlighted throughout the program. Personal variables and experiences are relevant. Nurses and other professionals in caregiving aim to provide person-centered care, which necessitates the use of the "self" within a relationship with vulnerable patients to provide psychosocial care [29]. Palliative care has been described by Barnard et al. [30] as whole-person care, where the whole person of the caregiver is involved, requiring care that is given through the human relationship. Oncology, similarly, is at its best when delivering whole-person care.

Financial costs were identified as a key barrier to supporting recommended strategies. Team-based retreats, compassion-oriented group sessions, and mindfulness-based stress-reduction programs have associated costs, often requiring outside expertise. Given the implications for attrition, absenteeism, and employee morale, competencies related to self-monitoring, self-care, and team-based functioning are vital and an important investment in maintaining a healthy workforce [9,22].

Most (88%) participants reported that issues related to well-being were not raised during performance appraisals. This finding underlines a work culture focused on patient and system outcomes. It may also reflect personal and cultural barriers in expressing personal coping challenges among peers [9,27]. The exercise of having participants reflect upon their own feelings of grief or loss and consider how the tool might help guide assessments or discussions with their patients was well-received. Self-assessment tools, including those that assess CF, are a helpful resource in supporting health professionals to acknowledge, recognize, and express more directly their support needs.

The program's content being organized along the categories of personal factors, interpersonal/team, and organizational factors was well-received. All participants reported the program as being the first opportunity to learn about their own personal risk or potential vulnerability factors (e.g., prior mental health history, prior loss, coping style, or attachment style).

The CoP was one of the most valuable features of the program. Learners also reported value in course leaders sharing openly about their own personal experiences around vulnerability and challenges related to their practices. (e.g., "I appreciate the leader disclosing and sharing and the openness of the forum"). Comments such as, "Seeing that others were having similar issues was surprising and I learned so much from them" support a group-oriented approach to facilitate normalization and vicarious learning that may reduce stigma in the expression of personal experiences around clinical work.

CONCLUSIONS

In summary, a program designed to assist health professionals to gain confidence and knowledge around managing grief and loss demonstrated benefits. Participants identified information and support needs at the start of the program. High value was placed on the small-group learning format and the opportunity to openly share experiences, as well as on the content around contributing factors to CF and strategies to support resilience. Several themes related to personal, team, and organization/institution-related barriers to addressing challenges in managing grief and loss were illuminated.

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CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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AUTHOR'S CONTRIBUTIONS

Conception or design of the work: all authors. Data collection: JW. Data analysis and interpretation: all authors. Drafting the article: all authors. Critical revision of the article: MJE, JW. Final approval of the version to be published: all authors.

SUPPLEMENTARY MATERIALS

Supplementary materials can be found via https://doi.org/10.14475/jhpc.2022.25.2.55.

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