23

AU:1

Communication with families

AU:2

MARY E. FALLAT, TIFFANY N. WRIGHT, and ANITA P. BARBEE

The ability to communicate effectively with patients and their families is one of the most valuable skills that a physician should possess. It is the vehicle through which physicians and other members of the multidisciplinary team engage in patient- and family-centered care and signals to family members that they are part of the care team [1]. Effective communication is the bridge to a relationship of trust between the physician and the child and family. This skill becomes even more important when a physician must communicate distressing information, when a child's condition deteriorates, or if death occurs. How such information is conveyed during catastrophic events has a profound impact on the coping and grieving process of families [2]. It is vital that a physician be educated in and adhere to principles of compassionate communication that are outlined by the Institute for Medicine and the American Academy of Pediatrics [3,4]. The informant's behavior and preparedness during these times of crisis will have a lasting effect on the family.

The three primary components of successful communication are compassion, clarity, and a proper environment [5,6]. Much useful information is available from retrospective reviews of family members' experiences during times of change or sudden death [1,7–9].

Compassionate delivery of information is one of the most important factors in acute event notification [10]. While a caring manner is often naturally displayed by physicians who have been directly involved in a patient's care, there are certain circumstances that complicate this interaction. One situation involves the initial care of an unstable trauma victim, in which a prior relationship has not been established with family members. Whether a trauma victim is hemodynamically normal or abnormal, the simple fact that their child has been injured will qualify as bad news to parents.

It is important for the family to know that helping their loved one is of paramount importance. This is conveyed by the use of phrases such as "We are doing (or we did in the case of death) everything we can (could) to help your child" and explaining the steps in the medical intervention [11]. Using the child's name during conversations about care is a simple action that immediately brings the interview to a more personal level. It is equally important to use correct pronunciation and appropriate gender references as defined by the young person. One can no longer assume a child's gender by their appearance. A simple way to understand gender identity of a patient is to ask what pronoun they use [1]. Most transgender people use pronouns we are most familiar with like "he" and "she," and usually dress and groom in alignment with our culture's gender expectations. However, there are exceptions. Some people are not able or do not want to align with binary gender stereotypes and prefer the subjective pronoun.

Basic public speaking skills such as eye contact and timing are important adjuncts to use when speaking with families. Looking at all persons gathered together while talking, in order to acknowledge the individuals present, including any siblings, makes a conversation more meaningful [1,12]. Speaking in a calm, quiet manner that conveys feelings of empathy about the child's condition and the impact that this news is having on family members is also part of compassionate communication. It is equally important to pause during the conversation, allowing adequate time for input and questions. Asking parents for information that might help treatment or lead to different courses of action is vital. Actually asking, "Are there any questions?" often prompts parents to seek answers they otherwise would have been afraid to ask. It also provides confirmation that their thoughts and questions are valid, and reinforces that the child and the family are equally important to the physician [13,14]. Ultimately, the message and the messenger are inseparable [15].

After compassionate delivery, clarity of the message is the most important factor in communication. During an acute crisis, it is not uncommon for family members to unconsciously repress intolerable facts. Even if they do hear what the physician has said, comprehension may be delayed. For this reason, the physician must be clear, honest, and give simple explanations. Repetition and patience are often required. The physician must set aside an ample amount of time to spend with a given family [13]. This is time well spent, as it paves the way for future interactions.

It is vital that the health-care provider should be aware of the facts related to the medical situation before the interview begins [13,16]. Possessing accurate knowledge allows a physician to be more confident and in control and conveys a sense that the family member has received care from an informed, prepared provider.

Often, it is not possible to relay all of the facts at one setting. This is when *pacing* becomes important. This means that the family is given time to process a fundamental but finite amount of information. After a period of time, the physician can return and add more information to this frame of reference. This facilitates understanding and more effective decision-making, if required [17,18]. In addition, it dampens the initial dismay when families are told of a concerning change in their loved one's condition. It is helpful to provide a summary of findings as each interview is completed, including a discussion about when the next meeting is likely to occur. Although the above concepts are pertinent to most encounters, it is important to adapt communication style to the given situation, as parental responses will be dependent on individual circumstances.

The conditions of the information session include the physical environment and the timing of the interaction. The best time to talk with families, particularly about acute change, is as soon as possible after the change occurs. This can be especially difficult in the emergency department, as the focus of the physicians' attention is on assessing and treating the child. A compounding factor is that the family may not arrive at the hospital until the child has been there for some time. The child may already have been taken to the critical care unit or operating room, resulting in a necessary delay before the physician can speak with family members. In this circumstance, one member of the trauma team may be asked to leave and communicate with the child's family.

The physical environment is extremely important for effective communication. Privacy is vital. Even in an acute setting such as the emergency department, a quiet area away from other people should be set aside, where the physician can sit down with the family and speak freely and openly. Ideally, the person who speaks with a family should be the health-care provider who has had the most interaction with them, and with whom the family has formed a relationship of trust. Since this is not feasible in the acute trauma setting, it is helpful to allow such interactions to take place in the presence of the family's support system and a member of the hospital's family support team. Family members want to be advised of distressing information expeditiously and in the company of their loved ones [15,19].

The manner in which families are told of their child's status should be tailored to the individual situation. If you are interacting with a family who has come to the United States as an immigrant or refugee, they may not be able to speak or understand English (limited in English proficiency [LEP]), especially medical jargon. Thus, it is critical to alert the hospital so that a translator can be dispatched immediately to help with the communication effort or to use a trained translator by phone. Often younger members of the family speak and understand the English language better than parents or grandparents do, but it is preferable to have a professional adult translator rather than a minor, related child convey bad news to their elders. Family members, friends, and untrained bilingual hospital staff who provide *ad hoc* interpretation frequently commit errors of interpretation. In fact, false fluency errors by untrained hospital interpreters can be almost as common as by ad hoc interpreters because of a lack of skills training. The approach will also be dependent upon whether or not the child is likely to recover. Family responses will vary depending on the circumstances and their culture [20], and the physician should be prepared for this.

Fortunately, the most common scenario an individual physician will encounter when speaking with a family is one in which a child is likely to recover. In some circumstances, the child will recover and be normal, but in others the child will more likely recover with impairments. In either situation, the key to an effective interaction is clarity and honesty. The informant must be informed and forthright about every aspect of the patient's care and prognosis. Family members will understandably have questions. The medical care provider who is able to adequately address the questions will quickly and deservedly earn a family's trust, whether or not the answers to the questions are apparent when the conversation occurs [21].

When a child dies

Delivery of the news of a child's death has an impact that will last a lifetime [2]. In the case of sudden death, preparation is not possible. While the principles of communication already discussed apply, it is often difficult during times of acute crisis for families to remember what is told to them [22]. It is beneficial for a third party, often the chaplain or another member of the family support team, to remain with the family for a time or meet with them again to ensure that there are no unresolved issues or unanswered questions. This is helpful in preventing some aspects of pathologic grief that can stem from a lack of complete understanding on the part of the family [2,23].

Families of children who are chronically ill or have a more protracted course prior to death have a unique set of needs [24]. The physician and family have often had time to establish a relationship of trust and understanding. This scenario allows the health-care provider to more adequately prepare the family for the death or for the possibility of death [25]. However, there are situations where parents are not open to discussions about the eventuality of death. They naturally do not want to feel that they have given up on their child. Although more challenging, it is still the physician's responsibility to provide continual support and honest information during the child's illness and at the time of death. Follow-up after the death of a child is also critical for a sense of closure, to aid in family coping during the bereavement period, and to prevent feelings of abandonment by the medical team that cared for the child [26]. Specific recommendations for bereavement care include (1) reminding the family that "everything was done" for their child can help prevent complicated mourning; (2) attending visitations, funeral, or memorial services shows the family that members of the medical team cared for the child as an individual; (3) providing follow-up contact a few days after the death ensures family members they have the support they need; (4) scheduling a postdeath conference with the family a few weeks or months after the death will allow review of the sequence of events that led to the child's death and reassurance that bereavement support can reduce distress; (5) ensuring that family have access to ongoing support from social workers, therapists, or chaplains who are part of the multidisciplinary team will establish continuity of bereavement care; (6) referring family to other bereavement specialists in the community such as hospice, grief support agencies, *Compassionate Friends*, or other parent support groups will extend their support structure outside of the hospital family; (7) offering psychoeducation about the potentially prolonged nature of grief will allow them to better embrace and understand the normal grieving process; and (8) sending notes or calling on the anniversary will reinforce the memory of their loved one and let them know you have not forgotten them [1].

Family presence during resuscitation

A concept that is receiving more attention but remains somewhat contentious in the setting of acute trauma is family presence during cardiopulmonary resuscitation (CPR) [14,27]. Interestingly, most family members have a desire to be present during the resuscitation of their child. They want the reassurance through the observation that medical personnel is vigorously trying to save their child's life. It is also conceivable that this will be the last time that their child is "alive" and parents want to be there at the time of death. In interviews with family members who have been present during end-of-life procedures, there is a common theme of overwhelming gratitude for having been given the opportunity to be present. This seems to be constant, regardless of the outcome of the medical efforts. For the surviving family members, it removes doubt about what occurred and helps them understand that everything possible was done to save their loved one. This allows for a more healthy grieving process [27–30]. A recent systematic review of studies on family presence during pediatric resuscitations indicates that parents who were present during the resuscitation of their child would choose to be present again if faced with that option and would recommend the same to others. These parents had better coping and less distress related to their child's death than parents who were not allowed to be present for the resuscitation [31].

There also seems to be a strong desire on the part of family members, particularly parents, to be present during invasive procedures. The ability to stay with the child decreases the anxiety level of the parents and child. There is no consistent evidence that family presence distracts from the provision of optimal medical care. In fact, one study showed that only a few providers felt as though there was an impact on technical performance, therapeutic decision-making, or teaching [32].

Understanding brain death

While there are clear-cut medical criteria for brain death, this information is often very difficult to communicate to families [33]. Further, a misunderstanding of what brain death represents can be a source of parental guilt if volitional withdrawal of care occurs. Such grief can later stem from misconceptions that the family was an instrument in the child's death or gave up on the child too soon. The lay press and other media venues can be particularly misleading about recovery from "deep coma" [2,34]. One way to provide comfort to patient families is to clearly explain that waiting longer would not have helped. There are books available to help with communication efforts. Some families may wish to view test results or witness the apnea test.

Each state has criteria for brain death. An example of a legal definition for the determination of brain death is as follows. The occurrence of human death shall be determined in accordance with the usual and customary standard of medical practice, provided that death shall not be determined to have occurred unless the following minimal conditions have been met:

1. When respiration and circulation are not artificially maintained, there is an irreversible cessation of spontaneous respiration and circulation or
2. When respiration and circulation are artificially maintained, there is total and irreversible cessation of all brain function, including the brainstem.

Individual state criteria may require verification of brain death by more than one licensed physician, and verification more than once at some later time interval. If pharmacologic agents have been used that preclude doing an apnea test, a brain blood flow study may be needed.

An example of the clinical criteria for the diagnosis of brain death is as follows:

1. Determine and document the probable cause of death.
2. The patient must be normothermic (temperature >36°C).
3. The absence of narcotics, sedatives, and hypnotics.
4. Exclude high cervical spine fracture.
5. Glasgow Coma Scale of 3 (i.e., no motor or verbal response to pain and no eye opening).
6. Absent brain stem reflexes, including the pupillary light reflex, corneal reflex, gag reflex, cough reflex, oculocephalic (doll's eye) reflex, and the oculovestibular (cold water caloric) test.
7. Valid apnea test
   a. Monitor cardiac rhythm and arterial blood pressure. Stop test if moderate to severe hypotension or dysrhythmia occurs.
   b. Preoxygenate with an FiO_2 of 100%.
   c. Start test with a $PaCO_2$ of 40 mmHg.
   AU:3 d. Obtain an ABG prior to disconnecting the patient from the ventilator.
   e. Disconnect the patient from the ventilator. Supply 6–7 L/min of 100% oxygen though tubing inserted into the endotracheal (ET) tube.
   f. Watch the patient for any evidence of spontaneous respiratory effort.
   g. Approximately 10 minutes after disconnecting the patient from the ventilator, obtain an ABG.
   h. Connect the patient to the ventilator and adjust to pretest settings.
   i. $PaCO_2$ must be 60 mmHg or greater or 20 mmHg above the patient's baseline on the posttest ABG for the test to be valid.

Organ donation issues

In seeking consent for organ donation, effective communication is essential and should take place in a comfortable, private area and not at the patient's bedside [13]. This interaction should occur after the family has been notified of brain death and has had time to comprehend this information, and in the presence of a limited number of persons who have been chosen by the parents. The process of temporally separating brain death determination and potential organ donation is called *decoupling*. Decoupling gives the family time to grieve their loved one's death.

Once families have had time to process the death of their loved one, a discussion should be held regarding organ donation. The Centers for Medicare and Medicaid's Federal Conditions of Participation (COP) requires that all families be given the opportunity for organ and tissue donation. Numerous studies have shown that the organ donation rate is greatly dependent on this initial interaction. The COP requires that the discussion of potential organ donation be led by someone with specific training in this area, typically an organ procurement organization (OPO) representative. Physicians are also allowed to lead this discussion if they have had formal training approved by their local OPO. These discussions work best when they take place in a private area, and when the physicians and OPO representatives work together. Physicians are not prohibited from discussing organ donation if the family brings up the topic [35].

If organ donation is not chosen, it is an optimal time to begin explaining and discussing the process for discontinuing ventilator support. In either case, the goal of the physician is to lead surviving family members to a decision that is personal, thoughtful, and comfortable for them.

Bereavement

Losses are inevitable, but there is no greater acute stress for a family than the sudden loss of a child due to injury through an accident, natural disaster, suicide, or violent attack from domestic or neighborhood violence or war [36]. There are predictable windows for building resilience in the midst of an emotionally charged environment, for both providers and the patient's family.

The family—coping with unpredictability

Nothing in a parents' experience prepares them for the emotional chaos and lack of predictability that is characteristic of pediatric trauma. By the time their child arrives at the emergency room, the accompanying adults are understandably overwhelmed by feelings of shock, confusion, and fear for their child's safety. They literally place their child and their faith in the competent hands of the trauma team. The trauma team's first response is to the medical/surgical assessment and treatment of the pediatric patient. However, the focus of this section is to describe the accompanying psychosocial issues for the family that inform our handling of their needs.

The family's acute grief reaction

What do families need as they enter the emergency department? They look to the trauma team to assure them that their child will be all right. All parents want two characteristics in a physician during a crisis: expertise and experience. They want their surgeon (and hospital) to have the ultimate expertise and level of skill *and* they want their surgeon to be performing this skill on their child not for the fourth time but for the four thousandth time.

Expertise and experience: The perfect answer to the unpredictable event that has put their precious child at risk.

In the midst of trauma, therefore, the family must receive assurance about the team's expertise and experience.

- Who should communicate with the family?
- What can be expected as an understandable and predictable response to their acute grief reaction?
- What is "best practice" or protocol in this psychosocial arena, which anticipates family needs?

The term "protocol" suggests a prescribed procedure that responds in kind to the acute grief reaction from the family members as well as the child if he or she is conscious. Often a lack of time compromises the ability to foster a completely satisfactory communication. The family needs to know: (1) the status of their child, (2) what is being done, (3) what is the expertise and experience of those treating her, and (4) will she be okay? In some hospitals, written pamphlets or photos that introduce the various members of the trauma team are on display. In any event, a designated first person who acknowledges the adult accompanying the child soon after arrival can provide the needed reassurance by a simple direct statement "Your child, (use the child's name as you learn it) is in the very best place. Our team is ready and equipped to help her. What is unique to you is all too familiar to us." There is no need for more explanation as more is not necessarily better. This simple sentence provides much needed reassurance.

This designated first person may be a chaplain or a member of the family support services team and can also ask the family about past medical history and provide important information to the trauma team resuscitating the child. This individual acts as a liaison between trauma team and family.

The grieving parent's defense mechanisms

The three defense mechanisms employed by grieving parents are denial, projection, and detachment. Medical providers most often see these defense mechanisms as barriers between parents and providers.

Denial: "I'm sure Anthony will be fine. He is a real fighter."—parent
"Mrs. Terry is in such denial. I need to get her to accept that her child is not responding."—nurse
Projection: "Doctor, why didn't you tell me he was not going to live?"—angry parent
"I only want that nice nurse to be with my child; I like the way she looks at him."—parent
Detachment (not typical in acute grief reactions):
"I can't get to the PICU more than every few days to see my toddler; I have too much else going on in my life."—parent

When the death occurs, some important steps need to be taken to help family members overcome these defense mechanisms. First, family members need to see the deceased child [37] and have time to say good bye with some level of privacy. Second, just as the members of the medical team explained the steps in treatment and details of the interventions along the way, upon the news of the death, family members need to revisit the sequence of events leading to the death. This will both help them understand why the child died under these circumstances and how vigorously the medical team worked to try to save the child's life. This is also a time for members of the medical team to answer questions about the child's condition and treatment. Both pieces of information help the family make sense of the loss, which helps with long-term coping. Finally, members of the team can recommend that family members visit the site of an accident or natural disaster to better comprehend the severity of the incident, enhance feelings of closeness to the deceased and what they might have experienced, and come to terms with their loved one's death [36].When a child has died as a result of a suicide, or there is suspicion of child maltreatment or when the child has died via homicide by a nonfamily member, the criminal justice system becomes involved. Thus, the final family goodbye with the deceased child may need to be supervised.

Next steps: Surgery or "the impossible outcome"

One of the most difficult aspects of caring for a family during trauma is the lack of time to create a trusting relationship. Following stabilization, some children will be sent immediately to surgery. The multidisciplinary trauma team has done its job and has transferred the patient to the next set of capable hands. An expectant family still needs information and support as they identify a new set of providers in whom they entrust their child's care. If a child dies in the emergency department, the family has little or no time to understand what has happened, or how it is possible that their child could have been fine 1 minute and dead in a matter of minutes or hours.

If a child dies in the emergency department, the relationship that was initiated between the team and the family will serve the bereaved family for years to come. Anecdotal responses from bereaved parents suggest best outcomes when the pediatric trauma team demonstrated empathy and provided them with timely answers and understanding of their child's unique medical situation. A nurse that used their child's name or rubbed a mother's tense neck, a surgeon whose eyes filled up with tears as he described efforts made to save the youngster's life, a chaplain's sensitive tone of voice or presence throughout an impossible wait, all reassure parents and family members that their child was cared for in a personal way [7].

Long-term bereavement

When a child dies, particularly as a result of trauma, parents may suffer from major depressive disorder, posttraumatic stress disorder (PTSD) or prolonged grief disorder (PGD) [36,38]. In addition to making sense of how their precious child was healthy and alive one moment and dead the next, they need to revise two assumptions about their world:

- That their child will outlive them
- That they could protect their child

These basic assumptions about their world have been shattered, and normal mourning must work through these shattered assumptions. It is highly recommended that professional counseling be considered within the first 3 months following a child's death. No death is more isolating than parental loss of a child, as extended family and friends often feel inadequate to comfort and provide solace.

As is often the case with childhood trauma, understanding the precipitating events and processing and resolving the guilt that parents or caregivers experience is an additional stressor that deserves a professional's assistance. Professionally facilitated grief support groups, specifically for parents who have lost children, are often useful.

Within the first year of bereavement, grieving parents often find themselves ready to understand the medical details surrounding their child's death. A compassionate surgeon who treated their child, and is willing to interpret the autopsy report with the parents, can help parents accomplish the powerful and significant task of understanding their child's death. This is a necessary requirement of their grief resolution. In fact, studies have shown that the majority of parents would like to meet with the physician who was caring for their child at the time of their death to discuss the events leading up to and following the death, as well as provide feedback on their experience [39]. This and AU:4 other follow-up behaviors noted on pp. 6 and 15 have been found to lessen the blow of the death and prevent prolonged grieving.

Au:4 In the Introduction and under the heading Grieving Parents' Defense Mechanisms

ersonal, professional

ponse by parents to the death of their child varies greatly and is influenced by their sense of culpability, whether they have surviving children, their own coping skills, and perceived support from extended family and friends [2]. Parents who report a strong religious belief often draw upon that strength during difficult times in the bereavement process. Grieving parents must be made aware of the fact that coping with a death is a very personal process that can be influenced by many factors such as personality, gender, culture, resilience, and one's own trauma history [40]. Thus, each parent is likely to grieve differently. This understanding may help mitigate problems down the road when, for example, a mother becomes upset that her husband copes by working harder and holding in his emotions so that she can feel that he is strong and reliable. If parents are encouraged to communicate frequently about how they are dealing with the child's death even in the presence of a marriage and family therapist, this may keep them from breaking apart, which often occurs after a child dies [41].

Surviving siblings

Surviving siblings often experience the loss of their brother or sister as a dual loss, as they also have lost their parents as they know them. Family life will never be the same. The task of creating a "new normal" is painful at best and is realized by each family member at their own pace.

Following the death of a sibling, children often suffer from anxiety, irritibility, and loneliness. Without additional support or counseling, long-term anxiety may be up to four times higher in siblings. This may be compounded by feelings of marginalization during the acute illness of the deceased sibling. Surviving siblings may benefit from open and honest communication that is appropriate for their developmental age, as well as family counseling following the death [42]. All of the follow-up activities noted above should include siblings to acknowledge their loss as well as help them cope with an overwhelming and emotional event in their young lives.

Children's understanding of death

For adults, death creates a sense of disequilibrium or a disruption in their usual "steady state." For children, however, death represents a "developmental interference that results in a suspension of their ongoing growth." The goal of a clinical intervention with children is to get them "unstuck" and to help them get through, over, under, or around a temporary barrier to their normal and healthy forward movement [3,23,40,43]. The clinician should view the child's ability to cope with a significant loss or death in relation to three factors:

- The child's ability to make sense of the death developmentally
- The child's history of loss and death
- The child's normal ability to cope with change

Although Piaget did not specifically address a child's ability to understand death, much of the current thinking about how children perceive death comes from his theories about cognitive development. This framework is very helpful in assessing a child's reaction to the death of a loved one and the clinician's role in providing anticipatory guidance to the adults in the child's life (Table 23.1). As useful as this

Table 23.1 Developmental stages in children's understanding of death

Developmental stage	Perception of death	Reaction to death	Anticipatory guidance
Infant (0–2 years)	No cognitive understanding of death, perceived as separation or abandonment	Distress, frustration, regression	Identify a surrogate caregiver, learn caregiver's routine, provide nurturing and dependable environment
Preschooler (3–5 years)	View death as temporary or reversible, or possibly as punishment	Associated with magical thinking that wishes can come true	Respond to questions with concrete, simple explanations. Avoid euphemisms such as "lost, sleeping, gone to heaven, with the angels"
Latency age (6–8 years)	Understand death to be final, irreversible but not universal	Children this age do not think that they themselves will die; find death difficult to understand	Reassure that life will still be safe. Have a need to discuss details of the death. Need direct, simple answers regarding what will be the same and what will be different due to this death (i.e., predictability)
Preadolescent (9–12 years)	Views death as final, irreversible and universal (adult understanding)	Intellectualize death, often unemotional, may be sarcastic or seemingly insensitive	Be authentic. Verbalize that in spite of your grief, you are still able to care for your children
Adolescent (13–18 years)	Have an adult understanding of death, but behave as if they are immortal	Interested in exploring society's attitudes about life and death. Often reject traditional adult rituals surrounding death and create their own using abstract and philosophical reasoning	Need adults to help sort out often colliding feelings of sadness, anger, disbelief, and isolation

framework is, children regress under stress and the boundaries are meant as developmental markers only. A child's history with loss or death, personal temperament, and prior ability to cope with change all inform us of an individual child's reaction to death.

Medical providers

Nurses and physicians

The pediatric trauma team confronts the stressful possibility of a death every time a patient arrives for medical treatment. When the outcome is death, everyone involved in the child's care understandably grieves. Even the most seasoned physician may frame the death in terms of his own perceived failure. Every nurse understands the profound grief that the family now faces. Routine debriefing of the treating team is seldom the norm in hospital emergency departments or even in neonatal and pediatric intensive care units. Medical providers are often understandably reluctant to become vulnerable and participate in the unfolding of the psychosocial aspects of treating the pediatric patient, particularly in the real-time context of treating other trauma patients. They are purposely "defended" and that defense needs to be respected.

Several major medical centers across the country have begun to develop comprehensive programs to assist their health-care workers process their grief. At Johns Hopkins Children's Center, a part of this comprehensive program includes routine bereavement debriefing sessions. These sessions are offered after all patient deaths with invitations extended to all health-care providers caring for the deceased patient. The sessions are facilitated by a bereavement coordinator and focus on the details of the incident, disruptions the traumatic event can cause both physically and emotionally, as well as the emotional response of the health-care professionals. Time is spent focusing on the relationship to the deceased patient and his or her family members as well, not just on the death event. These sessions are typically scheduled approximately 1 week later, to allow the individuals some time to process their thoughts and feelings first. These sessions are almost universally found to be helpful, informative, and meaningful by the participants [44]. AU:5

Secondary trauma and PTSD

It is not uncommon for health-care workers such as physicians, nurses, aides, social workers, and EMT professionals to suffer from secondary traumatic stress (STS) after being exposed to a single patient who is injured or who AU:6

dies from any number of traumatic events such as suicide, homicide, child maltreatment, accident, war, or natural disaster [45]. This may also be repetitive, which is particularly true when a health-care provider works in an emergency department or pediatric intensive care unit and faces numerous instances of death and traumatic injury due to violence or other causes. An individual with STS has been exposed to an extreme traumatic event or stressor or multiple traumatic events to which he or she responds with fear, helplessness, or horror [43,46–48]. Given time, most people will recover from the psychological effects of a traumatic event or secondary traumatic exposure. However, research has shown that repeated exposure to traumatic events takes an emotional toll on health providers and can lead to burnout and PTSD [45,49,50]. PTSD represents a failure to recover from trauma exposure and is characterized by intrusive thoughts including distressing memories or nightmares related to the event, numbing or attempts to avoid reminders of the event, and symptoms of hyperarousal. STS can be prevented or addressed through individual and group engagement in self-care activities (e.g., engaging in exercise, taking mental health days, receiving massages, celebrating birthdays and work successes within departments), attentive supervision, provision of social support by supervisors and colleagues, and active engagement of staff in hospital policy development. Treatment for PTSD involves educating the person about the nature of the disorder, providing a safe and supportive environment for discussion, and relieving the distress associated with memories and reminders of the event through such evidence-based interventions as trauma-focused cognitive behavioral therapy (TF-CBT) or eye movement and desensitization and reprocessing (EMDR). The judicious use of medications can also benefit traumatized patients and professionals with high levels of STS by alleviating the symptoms of stress and PTSD and improving ability to function. Both secondary trauma and PTSD can be diagnosed and treated by primary care physicians, psychiatrists, and clinical psychologists. Debriefing programs for health-care workers have sometimes been found to be useful in helping individuals cope with traumatic events sufficiently enough to alleviate the symptoms or signs of secondary trauma and prevent PTSD.

SUMMARY

It is important to remember that families do not “get over” their loss. Rather, they change their lives to accommodate the loss.

It is estimated that 19% of the adult population has experienced the death of a child, including adult children. In studies of how the relationship of the family member to the deceased affects the level of grief, it is well known that parents surviving their child’s death have significantly higher intensities of grief than other studied groups.

Very few parents seek help from therapists or formal support groups. This underscores the importance of medical care providers and the health-care system as a whole taking the initiative to offer support services to surviving parents and family members [51,52].

Three terms aid in understanding: denial, wish, and hope. Denial is the unconscious repression of intolerable facts. To wish is imagining a future despite the available facts. Hope is imagining a future in light of the available facts. The principle goal of the health-care team is to provide the framework for families to begin again to hope. This involves helping them reach a point where they can understand what has happened to their loved one, recognize the long-term consequences, and work toward a realistic future under these conditions.

Many institutions, particularly children’s hospitals and trauma centers, have family support teams. The purpose of these individuals is to support families in crisis or newly bereaved and to provide comfort measures. The goal of the intervention is to positively impact the grieving process by supporting parents and other family members as they make the drastic transition into life without their deceased loved one.

Another adjunct that can be provided is a resource center that lists resources to address grief caused by the loss of a loved one, as well as other associated forms of loss such as bankruptcy, chronic illness, divorce, and loss of employment.

Allowing parents and other surviving family members to discuss their feelings about the deceased and relay memories of their loved one seems to have countless benefits. By allowing parents to secure the memory of their child in the people around them, it permits validation of the child’s life. Otherwise, parents may feel that they have lost the child’s presence *and* the memory of the child. Sadly, friends and family members that are potentially one of the greatest sources of support may avoid even mentioning the child for fear that it’s too painful to the parents. The family’s support network needs to know that recalling the past is one of the forms of therapy that parents need most.

References

1. Jones BL, Contro N, Koch KD. The duty of the physician to care for the family in pediatric palliative care: Context, communication and caring. *Pediatrics* 2014; 133: Supplement 1:S8–S15. AU:7
2. Oliver RC, Sturtevant JP, Scheetz JP, Fallat ME. Beneficial effects of a hospital bereavement intervention program after traumatic childhood death. *J Trauma* 2001; 50(4):1–9.
3. Field MJ, Behrman RE; Institute of Medicine, Committee on Palliative and End-of-Life Care for Children and Their Families. *When Children Die: Improving Palliative and End-of-Life Care for Children and Their Families*. Washington, DC: National Academy Press; 2004.
4. Committee on Hospital Care and Institute for Patient- and Family-Centered Care. Patient- and family-centered care and the pediatrician's role. *Pediatrics* 2012; 129(2):394–404.
5. Dear S. Breaking bad news: Caring for the family. *Clin Counsel* 1995; 10:31–33.
6. Danis M, Federman D, Fins JJ et al. Incorporating palliative care into critical care education: Principles, challenges, and opportunities. *Crit Care Med* 1999; 27(9):2005–2013.
7. Stevenson M, Achille M, Lugasi T. Pediatric palliative care in Canada and the United States: A qualitative metasummary of the needs of patient and families. *J Palliat Med* 2013; 16(5):566–577.
8. Orioles A, Miller VA, Kersun LS, Ingram M, Morrison WE. "To be a phenomenal doctor you have to be the whole package": Physicians' interpersonal behaviors during difficult conversations in pediatrics. *J Palliat Med* 2013; 16(8):929–933.
9. Meert K, Eggly S, Pollack M, et al. Parents' perspectives regarding a physician-parent conference after their child's death in the pediatric intensive care unit. *J Pediatr* 2007; 151(1): 50–55.
10. Jurkovich GJ, Pierce B, Pananen L, Rivara FP. Giving bad news: The family perspective. *J Trauma* 2000; 48(5):865–873.
11. Fallat ME, Barbee AP, Forest R, et al. Family centered practice during pediatric death in an out-of-hospital setting. *Prehosp Emerg Care*. 2016; 20(6):798–807.
12. Gursky B. The effect of educationl interventions with siblings of hospitalized children. *J Dev Behav Pediatr* 2007; 28(5):392–398.
13. Miles MS, Perry K. Parental responses to sudden accidental death of a child. *Crit Care Q* 1985; 8(1):73–84.
14. Meyers TA, Eichhorn DJ, Guzzetta C, Clark AP, Klein JD, Taliaferro E, Calvin A. Family presence during invasive procedures and resuscitation: The experience of family members, nurses and physicians. *AJN* 2000; 100(2):32–42.
15. Krahn GL, Hallum A, Kime C. Are there good ways to give bad news? *Pediatrics* 1993; 91(3):578–582. AU:8
16. Antonacci, M. Sudden death: Helping bereaved parents in the PICU. *Crit Care Nurse* 1990; 10(4):65–70.
17. Huddleston D, Alexander R. Communicating in end-of-life care. *Caring Mag* February 1999; 16–20.
18. Miles MS. Emotional symptoms and physical health in bereaved parents. *Nurs Res* 1985; 34(2): 76–81.
19. Cottrell DJ, Summers K. Communicating an evolutionary diagnosis of disability to parents. *Child Care Health Dev* 1990; 16:211–218.
20. Kreuter MW, McClure SM. The role of culture in health communication. *Annu Rev Public Health* 2004; 25: 439–455.
21. Woolley H, Stein A, Forest GC, Baum JD. Imparting the diagnosis of life threatening illness in children. *Br Med J* 1989; 298:1623–1626.
22. Murphy S. Cognitive problems among parents bereaved by the sudden violent deaths of theirs adolescent and young adult children. *Maddvocate* 2000; 10–15. AU:9
23. Mian P. Sudden bereavement: Nursing interventions in the ED. *Crit Care Nurse* 1990; 10: 30–41.
24. Shields CE. Giving patients bad news. *Oncology* 1998; 25(2): 381–390.
25. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health. The pediatrician and childhood bereavement. *Pediatrics* February 2000; 105(2):445–447.
26. Back AL, Young YP, McCown E, et al. Abandonment at the end of life from patient, caregiver, nurse, and physician perspectives: Loss of continuity and lack of closure. *Arch Intern Med* 2009; 169(5):474–479.
27. Petterson M. Family presence protocol can be a powerful healing force. *Crit Care Nurse* 1999; 19(6):104.
28. Meyers TA, Eichhorn DJ, Guzzetta C. Research: Do families want to be present during CPR? A retrospective survey. *J Emerg Nurs* 1998; 24(5):400–405.
29. Powers KS, Rubenstein JS. Family presence during invasive procedures in the pediatric intensive care unit: A prospective study. *Arch Pediatr Adolesc Med* 1999; 153:955–958.
30. Tsai E. Should family members be present during cardiopulmonary resuscitation? *NEJM* 2002; 346(13):1019–1021.
31. McAlvin SS, Carew-Lyons A. Family presence during resuscitation and invasive procedures in pediatric critical care: A systematic review. *Am J Crit Care* 2014; 23:477–485.
32. Curley MA, Meyer E, Scoppettuolo L, et al. Parent presence during invasive procedures and resuscitation. *Am J Resp Crit Care Med* 2012; 186(11):1133–1139.
33. Wijdicks EFM. The diagnosis of brain death. *NEJM* 2001; 344(16):1215–1246.

34. Reed MD. Sudden death and bereavement outcomes: The impact of resources on grief symptomatology and detachment. *Suicide Life Threat Behav* 1993; 23:204–220.
35. Williams M, Lipsett P, Rushton C, et al. The physician's role in discussing organ donation with families. *Crit Care Med* 2003; 31(5):1568–1573.
36. Kristensen P, Weisaeth L, Heir T. Bereavement and mental health after sudden and violent losses: A review. *Psychiatry* 2012; 75(1):76–97.
37. Chapple A, Ziebland S. Viewing the body after bereavement due to a traumatic death: Qualitative study in the UK. *Br Med J* 2010; 340:c2032.
38. Shear KM, Simon N, Wall M, et al. Complicated grief and related bereavement issues for DSM-5. *Depress Anxiety* 2011; 28:103–117.
39. Meert K, Eggly S, Pollack M, et al. Parent perspective regarding a parent-physician conference after their child dies in the pediatric intensive care unit. *J Pediatr* 2007; 151(1):51–55.
40. Wijngaards-de ML, Stroebe M, Schut H, Stroebe W, van den Bout J, van der Heijden P, Dijkstra I. Couples at risk following the death of their child: Predictors of grief versus depression. *J Consult Clin Psych* 2005; 73(4):617–623.
41. Rogers CH, Floyd FJ, Seltzer MM, Greenberg J, Hong J. Long-term effects of the death of a child on parents' adjustment in midlife. *J Fam Psychol* 2008; 22(2):203–211.
42. Warnick A. Supporting youth grieving the dying or death of a sibling or parent: Considerations for parents, professionals and communities. *Curr Opin Support Palliat Care* 2015; 9:58–63.
43. Vasa RA, Gerring JP, Grados M, Slomine B, Christensen JR, Rising W, Denckla MB, Riddle MA. Anxiety after severe pediatric closed head injury. *J Am Acad Child Adolesc Psychiatry* 2002; 41(2):148–156.
44. Keene E, Hutton N, Hall B, et al. Bereavement debriefing sessions: An intervention to support health care professionals in managing their grief after the death of a patient. *Pediatr Nurs* 2010; 36(4):185–189.
45. Bride BE. Prevalence of secondary traumatic stress among social workers. *Soc Work* 2007; 52(1):63–70.
46. Gerring JP, Slomine B, Vasa RA, Grados M, Chen A, Rising W, Christensen JR, Denckla MB, Ernst M. Clinical predictors of posttraumatic stress disorder after closed head injury in children. *J Am Acad Child Adolesc Psychiatry* 2002; 41(2):157–165.
47. Rusch MD, Gould LJ, Dzwierzunski WW, Larson DL. Psychological impact of traumatic injuries: What the surgeon can do. *Plast Reconstr Surg* 2002; 109(1):18–24.
48. Yehuda R. Post-traumatic stress disorder. *NEJM* 2002; 346(2):108–132.
49. Dominguez-Gomez E, Rutledge DN. Prevalence of secondary traumatic stress among emergency nurses. *J Emerg Nurs* 2009; 35(3):199–204.
50. Healy S, Tyrrell M. Stress in emergency departments: Experiences of nurses and doctors. *Emerg Nurse* 2011; 19(4):31–37.
51. Hu X, Wesson DE, Kenney BD, Chipman ML, Spence LJ. Risk factors for extended disruption of family function after severe injuries to a child. *Can Med Assoc J* 1993; 149(4):421–427.
52. Montgomery V, Oliver R, Reisner A, Fallat ME. The effect of severe traumatic brain injury on the family. *J Trauma* 2002; 52(6):1121–1124.

Author Queries

AU:1	Page No 353	Please check whether the hierarchy of heading levels is identified appropriately.
AU:2	Page No 353	Please check whether inserted author details are appropriate.
AU:3	Page No 356	Please spell out ABG at first instance.
AU:4	Page No 358	Please provide exact section head instead of page numbers.
AU:5	Page No 359	Please confirm whether “the country” can be changed as “the United States” in the sentence “Several major medical centers…”
AU:6	Page No 359	Please spell out EMT at first instance.
AU:7	Page No 361	Please check whether inserted page range is appropriate.
AU:8	Page No 361	Please check whether inserted details are appropriate.
AU:9	Page No 361	Please provide volume number for Ref (22).