ABSTRACT

DEALING WITH LOSS: PERCEPTIONS OF SPEECH-LANGUAGE PATHOLOGISTS

By: Jennifer D. Wojan

The purpose of the study was to obtain information of speech-language pathologists’ experiences with the death of a patient. Three hundred sixty-five subjects who work primarily with medically fragile patients completed a survey. The questionnaire contained items ranging from the number of patient deaths the speech-language pathologist experienced to the coping strategies utilized by speech-language pathologists following both the sudden and anticipated death of patients. From the results, we were able to create a profile of both the impact of the death of a patient and the degree of impact those deaths have upon a speech-language pathologist.
DEALING WITH LOSS:
PERCEPTIONS OF SPEECH-LANGUAGE PATHOLOGISTS

A Thesis

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DEDICATION

This project is dedicated to my supportive and loving parents, without whom, I would not have been given the opportunity to complete this project.
I would like to send my sincerest appreciation to each person that has been a part of this two year journey at Miami University. Without your help, support and love, I could not have accomplished so much.

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Finally, to my professors, family, and friends, your encouragement, empathy and interest has enabled me to grow and develop the skills necessary to become a caring, dedicated and professional speech-language pathologist.
CHAPTER I

Introduction

The field of speech-language pathology is a diverse profession, both in terms of setting(s) and in population(s) served. A potential common denominator across all settings and populations served involves speech-language pathologists coping with the death of a patient. As the medical complexity of patient caseload increases, it is logical to assume that the speech-language pathologist will have a greater chance of a patient dying. The literature in the field of speech-language pathology is lacking with regard to the impact the death of a patient has on professionals. Much of the available research on stress, grief and burnout has been conducted in related health care professions such as nursing, social work and medicine (Wessel & Rutledge, 2005; Ramirez et al., 1996). Studies conducted using other professions (Stenbecki, 2000, Redinbaugh et al., 2001) explore various experiences prior to, during and following the death of a patient. This study was designed to begin to explore the impact the death of a patient has upon a speech-language pathologist.

Review of the Literature

Grief

The loss of a patient can be a difficult experience for health care professionals. The grief associated with the loss of a patient may vary from sadness to pain. Grief can be defined as “the psychological distress associated with loss,” and may manifest as both an emotional response such as feelings of helplessness (Redinbaugh et al., 2001, p. 187) and physical symptoms such as headaches or high blood pressure (Redinbaugh et al., 2001). While health professionals may be prepared to deal with the grief of others, they may not be well equipped to cope with their own reaction to the death of a patient. Treating terminally ill or chronically ill patients may generate grief reactions in health care professionals (HCP’s) that may lead to burnout if the professional does not manage his or her grief appropriately. Care of these patients requires emotional involvement and can exhaust a HCP’s resources for coping with feelings of grief and sorrow (Redinbaugh et al., 2003).

Experiences that can generate grief in health care professionals may include the deaths of patients with whom they felt closeness, deaths of younger patients, and the deaths of patients
with an incurable disease (Redinbaugh et al, 2001). Further results indicate that increased exposure to the death of patients may increase the amount of occupational stress experienced by health care professionals leading to more frequent grief. More frequent experiences with death have been found to be connected with more frequent job burnout, reports of occupational stress as well as unresolved grief reactions (Redinbaugh et al, 2001). The reactions resulting from a patient’s death may surface in a variety of forms; health care professionals such as nurses and physicians may have varying levels of stress and grief. For some individuals the death of a patient can be so difficult that other employment may be pursued. However, with resources to help with the loss of the patient, a professional may find more constructive mechanisms to help cope with grief, stress, and death (Dixon et al, 2005).

Death

The death of a patient, sudden or anticipated, may have an impact on a health care professional and the care that they provide. Past, personal, and professional experiences may have an influence on the care that is provided by health care professionals, but also on the attitudes of the professionals regarding death and dying (Dunn, Otten, & Stephens, 2005). When working with medically fragile patients or patients in general, the possibility of death is often an issue. Commonly an anticipated death has a less traumatic effect upon an individual than that of a sudden death (Salinger, Cain, Porterfield, & Lohnes, 2004). Deaths of patients that are unexpected or more traumatic tend to be to have a greater impact upon the individual and the ability to come to terms with the loss (Malkinson, Rubin, & Witztum, 2000). Sudden deaths are termed a powerful situation and refer to the fact that such events are beyond one’s control and may have an overwhelming effect upon the individual (Malkinson et al, 2000). However, the impact of such experiences plays a varying role upon the professional is grief reactions and coping strategies (Dunn et al, 2005). Following both sudden and anticipated deaths, a professional may experience grief reactions including sadness, pain, anger and depression (Malkinson et al, 2000)

Empathy Fatigue

Individuals enter helping professions for many reasons, which may include, (1) to satisfy emotional needs in their lives, (2) to feel as though they are making a difference, (3) to gain insight into their personal concerns, (4) to care for others, (5) to unconsciously act as a rescuer and save others from pain, stress and grief (Stebnicki, 2000). Health care professionals
working with patients that have chronic illnesses or disabilities may place the needs of the client above their own and then have resulting feelings of grief and loss. Professionals may often have to be empathically available to not only the patients but also the families. As a result, professionals may experience a high rate of mental, physical and emotional exhaustion following the death of patients. The response is called empathy fatigue.

A related concept, “compassion fatigue” was first discussed by Joinson (1992) in the nursing literature. Compassion fatigue is a term generated from the psychology and trauma stress literature by Figley (1995) and may help health care professionals categorize the feelings and states of exhaustion experienced. The underlying theory of compassion fatigue is often acknowledged as a form of professional burnout.

Empathy and compassion are building blocks for creating a working partnership between clients and professionals. Such characteristics are essential for helping clients to adjust, adapt, and become accustomed to disability (Stebnicki, 2000). In order to effectively cope with the experiences of empathy fatigue, it is imperative for professionals working with individuals that require rehabilitation counseling, to deal effectively and efficiently with empathy fatigue. Further understanding is necessary concerning the precipitating factors that may elicit empathy fatigue and the relating issues.

**Stress**

Stress as defined in the field of communicative disorders consists of any events where environmental demands or personal demands overly affect an individual or a social system (Monet & Lazarus, 1977). Speech-language pathologists may deal with these stressors in a variety of ways including: (1) Burnout which is a condition characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal achievement or success (Lloyd et al, 2002); (2) Emotional exhaustion or a professional’s inability to provide necessary psychological support; (3) depersonalization or the individual may develop negative feelings toward their clients; (4) Reduced sense of personal achievement where the professional may have reduced feelings of accomplishments at work and an increased dissatisfaction with their work. A study completed with physicians found that their discomfort in dealing with the loss of a patient may be a result of a lack of education on dealing with death as well as inadequate coping skills; without coping skills and appropriate strategies, a physician experienced feelings of anger, stress, guilt and regret (Schulman-Green, 2003).
In addition, chronic stress may negatively impact an individual both physically and psychologically. Some potential physical effects may include fatigue, insomnia, headaches, hypertension, gastrointestinal problems and disorders, and heart disease. A professional may also experience psychological problems including anxiety and depression. These levels of physical and psychological effects may vary from mild to extreme depending on the individual, experience and level of training, (Lubinski et al, 1994).

*Preparation of New Professionals in the Field of Speech-Language Pathology*

Research has shown that professionals who are in the beginning stages of a career typically have limited preparation for having to be empathically available to patients (Stebnicki, 2000; Wessel et al, 2005). Younger professionals or new to the field of speech-language pathology may have insufficient life experience to make a career commitment. During the initial years of employment, it is common to experience high levels of stress and anxiety. Professionals with a ‘save the world attitude’ may present a greater risk of suffering from increased levels of exhaustion associated with empathy or compassion fatigue (Stebnicki, 2000).

Beginning level counselors or therapists reported feelings of being upset, disappointed and frustrated with the amount of unanticipated levels of stress and demands in the field (Stebnicki, 2000). Along with experience of a professional may come the ability to deal with levels of grief, stress and exhaustion. Individuals that are new to the profession have yet to develop the skills, comfort level, and the education needed for working with medically at risk patients. A study of 33 new home health and hospice nurses found that following increased education as well as exercises related to the death of patients, there was an increase in the subjects’ ability to deal with the loss (Wessel & Rutledge’s, 2005). It appears that professionals with increased levels of experience are able to cope with feelings of emotional exhaustion more easily than that of younger, less experienced clinicians due to the years in practice. In essence, older professionals have determined how to work more effectively in all work settings (Stebnicki, 2000).

*Countertransference*

Countertransference was first described by Freud in 1910 and is formally defined as a “reflection of the counselor’s unresolved internal conflicts which encompasses reactions of thoughts, feelings, and emotions as it relates to his or her clients’ experience” (Stebnicki, 2000,
Following an individuals’ experience with countertransference, diminished feelings of affection, respect, warmth, or respect for patients may be displayed. A study by Rando in 1984 addressed countertransference that occurs among professionals working with chronic life-threatening illnesses or disabilities. Results revealed that the death of patients may affect professionals in three ways, (1) increase awareness by professional of personal losses, (2) contribute to apprehension towards potential losses, and/or (3) increase awareness of individual mortality. With unresolved personal issues, a professional may have increased levels of countertransference when dealing with patients thus leading to experiences of empathy fatigue.

When dealing with patients, a professional may or may not have experiences of countertransference as a result of insight into their own feelings and understanding. A professional’s identification and awareness of emotions and attitudes toward a client are issues pertinent to professionals when creating a more enhanced relationship with the client (Stebnicki, 2000). The professional that is able to have an increased level of self awareness as well as the ability to have a greater level of insight will be able to deal with empathy fatigue more effectively. Thus, they will be able to effectively treat chronic patients.

**Professional Burnout**

Professional burnout is a condition that follows extreme levels of physical, emotional and mental exhaustion and is frequently found in professionals who work chronically ill patients. The consequences of working with medically fragile patients, compassion fatigue or empathy fatigue, may often emerge with little warning or as an unhealthily form of countertransference (Stebnicki, 2000).

It is important to understand the experience of burnout as it relates to empathy fatigue due to the distinct differences and similarities between these two conditions (Stebnicki, 2000). Burnout was first described by Freudenengerber (1974) as a state of physical, emotional, and mental exhaustion where the individuals who have experienced burnout may have negative feelings of not only themselves but possibly of the clients. Freudenburger studied the symptoms of clinical fatigue and frustration that was caused by excessive demands and stresses on personal resources among professionals working in United State’s clinics (1974). Following this first discussion of burnout, many definitions have emerged, one of which was defined by Randolph et al. (1986), as a result of stress from ones’ occupation that is sustained
for an extended period of time. Following the experiences of burnout, professionals may provide less compassion, genuineness and regard for their patients. This burnout can be a precursor to empathy fatigue.

A study conducted by Ramirez et al. surveying physicians, determined that oncologists who experience burnout also reported using alcohol, increased insomnia, and a desire to leave the field of medicine. Physicians also had feelings a decreased occupational satisfaction and a decrease in the communication with patients, families and co-workers (1996). Concentrating on the burnout of speech-language pathologists, a study conducted with SLP’s found that 43% of professionals surveyed considered themselves to have experienced burnout in a moderate to severe nature (Miller et al, 1982). Burnout was found to be related to job dissatisfaction, job effectiveness, lack of support for coping strategies and lack of management support. However, the burnout incidents were not related to the professional setting, years of employment, caseload size, paperwork demands, or the severity level of clients (Lubenski et al, 1994).

Stages of Burnout (3)

Stage one is described as an imbalance between the demands and the resources that are needed to deal with the stress of a helping occupation. Stage Two occurs following the lack of personal or institutional resources to balance the stresses and demands. This stage occurs when the individual reacts to the stresses with feelings of tension, fatigue, anxiety, and exhaustion. The final stage, Stage 3, is when coping strategies of a defensive nature arise and are characterized by emotional detachment, withdrawal, rigidity and cynicism. From these stages, a cycle emerges and causes the professional to experience even greater demands and stresses and a lack of resources to deal with the situation effectively (Cherniss, 1980).

Effects of Burnout

According to Maslach (1982), there are four major categories of burnout. The four types are professional effects, psychological effects, physiological effects and effects on significant others. As a result of burnout, a professional often feels emotionally exhausted, frustrated, and physically worn out. The professional may react by withdrawing from the situation in hopes he or she will regain stability and strength. However, this withdrawal can leads to depersonalization and contributes to the professional’s resentment and anger towards other professionals, clients and individuals involved in the case or the problem (Lubinski et al, 1994). Table 1 summarizes the various effects of burnout. The majority of research on
Table 1
Summary of the Effects of Burnout

<table>
<thead>
<tr>
<th>Professional effects</th>
<th>Physiological effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detachment</td>
<td>Feeling of exhaustion and chronic fatigue</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>Increased susceptibility to illness and infection</td>
</tr>
<tr>
<td>Sense of inadequacy</td>
<td>Poor eating habits</td>
</tr>
<tr>
<td>Irritated with clients</td>
<td>frequent headaches</td>
</tr>
<tr>
<td>Do less work</td>
<td>Insomnia</td>
</tr>
<tr>
<td>Work performance deteriorates</td>
<td>Gastrointestinal disorders</td>
</tr>
<tr>
<td></td>
<td>Dermatological disorders (e.g. hives, edema)</td>
</tr>
<tr>
<td></td>
<td>Back and neck disorders</td>
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<tr>
<td></td>
<td>Hypertension</td>
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<td></td>
<td>Heat attack</td>
</tr>
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<td></td>
<td>Stroke</td>
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<table>
<thead>
<tr>
<th>Psychological effects</th>
<th>Effects on significant others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness</td>
<td>Marital conflicts</td>
</tr>
<tr>
<td>Anger</td>
<td>Family discord</td>
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<tr>
<td>Frustration</td>
<td></td>
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<tr>
<td>Tension</td>
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<tr>
<td>Anxiety</td>
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<td>Depression</td>
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<tr>
<td>Forgetful</td>
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<tr>
<td>Suspicious</td>
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<td>Paranoid</td>
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Adapted from Lubinski & Frattali, 1994.
burnout (e.g. Redinbaugh et al, 2001, Ramirez et. al., 1996, Whippen et al,1991) has been performed in the professional fields of nursing, medicine, and psychology. As discussed by Farmer et al, (1984), there are at least four factors found in helping professions that are extremely stressful. These include (1) the complexity of the clients, and patients and their needs, (2) the difficulty that is found with evaluating success, (3) poor perceptions of helping relationships by other individuals, and (4) the decision making process.

_Coping Strategies_

Speech-Language Pathologists work with patients for varying periods of time and may have to deal with loss. Coping methods are the behaviors that help to reduce or eliminate the source of stress or alleviate the emotions that result from the stressor (Lazurus & Folkman, 1984). Health Care Professionals often have similar coping strategies. A study of physicians’ emotional reactions to the death of a patient concluded that coping strategies most often used included receiving emotional support from others, finding something positive from the death and turning to other activities. Female doctors as well as Resident doctors often took advantage of more coping methods following the death of a patient (Redinbaugh et al, 2003).

In order to obtain a greater understanding of how nurses are affected by the loss of patients, Dixon et al (2005), surveyed 126 nurses. Forty-two percent of the subjects reported to have been negatively affected by the death of patients. The researchers found that the nurses experienced problems with morale, strained personal relationships, and reduced efficiency in their work environment. Professionals found methods of dealing with the loss of a patient by sharing feelings and talking with others.

Working with medically fragile patients often has an impact on doctors, nurses and other health care professionals. Literature suggests that HCP’s employ coping mechanisms to help alleviate such consequences as burnout and stress. This can be accomplished through mindsets of work being a challenge, feelings of accomplishment and organizational skills. The individual’s personality and personal qualities affect his or her ability to cope with the death of a patient and thus provide the means to deal with the loss. Thus, depending on personality traits, a person may or may not have a less difficult experience prior to or following the death of a patient (Redinbaugh et al, 2001).

The majority of research on coping for health care professionals has focused on identifying the sources and consequences of problems related to the work environment and aim
to help the individuals restore a sense of well being. Coping however refers to the ability of
the health care professional to use cognitive and behavioral strategies. Coping is an active or
passive effort to react to or respond to a situation that can be threatening and in relation to this
removing the discomfort or the threat itself (Hopkinson et al, 2005).

Potter and Rudensey (1984) studied how speech-language pathologists coped with
burnout and occupational stress. The results revealed that 16% of the professional involved in
the study were leaving the field of speech-language pathology because of “burnout”. Effective
coping strategies included the adaptation of more realistic personal career goals, understanding
their employment in a helping profession, having increased communication with management
as well as the development of a proactive attitude.

These approaches included systematic solicitation and implementation of employee
suggestions, group discussions, flexible break times, and a clear understanding of job
expectations. The authors concluded that one way to help in the decrease of burnout among
speech-language pathologists may be to have a team approach with administrators to help
improve the mental health of the clinical staff (Lubinski et al., 1994).

All health care disciplines should help to immediately identify or resolve burnout
(Dixon et al, 2005). One method of dealing with the loss of patients is through educational
programs including seminars and in-service educational courses. Such programs provide
professionals with opportunities to learn more about dealing with death, coping with the loss of
a patient, as well as managing grief. These interventions can help with successful coping. A
critical-incident stress-debriefing (CISD) program developed at Oregon’s Health Sciences
University by social workers was able to help professionals develop coping mechanisms
through educational programs. The social workers were able to focus on their own grief
directly after the unexpected loss of a client by identifying loss of control and their inability to
make necessary choices and decisions (Dixon et al, 2005). Additional issues that may need to
be recognized by healthcare professionals following the death of a patient may include guilt or
denial. Problems may occur if no intervention occurs following a critical incident.

The need for understanding and providing resources for healthcare professionals
dealing with the loss of patients was addressed by Dixon et al (2005). Respondents reported
talking with family members, clergy, friends or a spouse as well as consulting a therapist.
Resources within the hospital included clinical social workers, management, and co-workers.
In addition, subjects suggested more team building, workshops on resources, support for new staff and monthly support groups. The authors concluded that in order to successfully manage stress, the methods and techniques must be personalized to the individual rather than controlled (Dixon et al, 2005). Studies have shown varying methods of coping may be utilized by health care professionals and may include peer support groups, clinical supervision or mentoring with newer and less experienced professionals, team meetings, a decreased number of demanding clients or caseload size. Talking with colleagues, promotion of education and wellness for the professionals may also prove helpful. In addition, decompression activities and setting realistic goals by the individuals may help to cope with not only the loss of patient but accompanying stresses (Dixon et al, 2005).

Management of grief, loss, personal distress, and compassion fatigue on the part of healthcare professionals appears to be largely an informal process, with some formal support and provisions. It appears that many health care processionalhs have been successful in developing an informal model of stress management and have spent significant amounts of on the job time doing so. However, the authors believe that the next step in increasing the effectiveness of stress management in “loss” settings is to centralized these informal processing one’s job performance (Dixon et al, 2005, p. 86).

As a speech-language pathologist working with medically fragile patients, it is imperative that the professionals employ the coping mechanisms that are appropriate for their working environment, personality and stressors. Furthermore, it is essential that new professionals develop healthy coping mechanisms. Employers can assist all employees through educational program that help them to recognize risk factors and adopt individual coping strategies that will aid in creating a positive work environment.

Statement of problem

It is probable speech-language pathologists may have similar experiences related to professionals in health care and helping professions including nurses, physicians, psychologists and physical therapists with the death of a patient. Speech-language pathologists working in environments such as hospitals and long term care facilities as well as other settings, may work with medically fragile patients. While treating patients that are medically fragile, there may be a risk that the patient may die. Understanding the impact of death on a speech-language
pathologist is imperative to help develop appropriate training for new professionals and help assist already individuals in the field.

**Purpose of the study**

The purpose of the study was to obtain perceptions of speech-language pathologists of how the death of a patient(s) may affect the care provided by speech-language pathologist and their perceptions of providing care that care. The study compared the influence of a number of factors including: years in the field, employment setting and relative age of the patients. In addition, the study asked participants to identify any courses, seminars, or presentations that may have improved coping with the death of a patient. It was predicted that the ability to possess positive coping strategies may also play a role in a professionals’ long term view of the value of their work and job performance.

After the loss of patients, the professional may experience varying levels of grief, sadness, and stress. Through this study, a better understanding of how the loss of patients affects speech-language pathologists will be obtained. Each individual has varying methods of dealing with a patient’s death and thus impacting their role as therapists. Dealing with the loss of patients, often proves to be a difficult and challenging occurrence (Lubinski et al, 1994). Research will provide a better understanding of how a death changes a professional’s views and occupational values. The information from this survey will be used to help identify the short term and long term effects of working with patients at risk as well as help to develop educational tools for new professionals.

**Research Questions**

1. Does the age of a speech language pathologist have an effect on their emotional and physical reactions following the sudden death of a patient and the anticipated death of a patient?

2. Does the environment/work setting where a speech language pathologist is employed impact the emotional and physical reactions following the sudden death of a patient and the anticipated death of a patient?

3. Does the patient population influence a clinician’s emotional and physical reactions following the sudden death of a patient versus an “anticipated” death of a patient?

4. Does a class or in-service on death and dying have an effect on the coping strategies utilized by a speech language pathologist following the death of a patient?
5. Does a class or in-service on death and dying have an effect on the speech language pathologist’s emotional and physical reactions following the sudden death of a patient versus the “anticipated” death of a patient?

6. Does the number of deaths, years employed, and work setting have an influence a speech language pathologist’s emotional and physical reactions following the sudden death of a patient versus the “anticipated” death of a patient?

7. Does the number of deaths, years employed and/or work setting have an effect on the coping strategies utilized by a speech language pathologist following the death of a patient?

Null Hypotheses

1. The age of a speech language pathologist will not have an effect on the emotional and physical reactions following the sudden death of a patient versus the “anticipated” death of a patient?

2. The environment a speech language pathologist is employed by will not impact the emotional and physical reactions following the sudden death of a patient versus the “anticipated” death of a patient.

3. The population a clinician works with will not have an effect on their emotional and physical reactions following the sudden death of a patient versus the “anticipated” death of a patient?

4. A class or in-service on death and dying will not have an effect on the coping strategies utilized by a speech language pathologist following the death of a patient.

5. A class or in-service on death and dying will not have an effect on the speech language pathologist’s emotional and physical reactions following the sudden death of a patient versus the “anticipated” death of a patient.

6. The number of deaths, years employed, and/or work setting will not have an effect on the speech language pathologist’s emotional and physical reactions following the sudden death of a patient versus the “anticipated” death of a patient.

7. The number of deaths, years employed and work setting will not have an effect on the coping strategies utilized by a speech language pathologist following the death of a patient.
CHAPTER II

Methods

Subjects

The subjects used in this study included a sample of speech-language pathologists employed in the state of Ohio. The speech-language pathologists surveyed were working in various environments. No attempt was made to sample for a subject’s religion, ethnicity or otherwise recruit minority populations. The participants were recruited by the researcher through a compilation of speech-language pathologists. A list of potential participants was obtained from the Ohio Speech-Language and Hearing Association (OSLHA). The sample was based on the following criteria: (1) accredited speech-language pathologist, (2) geographically located in the state of Ohio, (3) employment setting in health care: settings included, hospitals, long term care facilities, private practices, rehabilitative centers, and MRDD. Initial focus of this population provided a profile of individuals who are more likely deal with death of a patient.

Inclusion Criteria

The subjects were professional speech-language pathologists employed in the state of Ohio. SLP’s were employed in positions related to health care, private practice and Mental Retardation and Developmental Disabilities (MRDD). The professionals were also members of the Ohio Speech-Language and Hearing Association.

Survey

The study utilized surveys to gain a better understanding of the perceptions of speech-language pathologists on grief and stress following the loss of patients. A list of potential participants and two complete sets of mailing labels were purchased from OSLHA. Each potential participant was sent an informational packet that contained a cover letter (Appendix F) introducing the study and a survey (Appendix G) created specifically for this project.

The survey was created to obtain a summary of demographic data of the sample, including the respondents, age, sex, ethnic background, religious rating, education, work setting (respondents could choose one or more setting), position, hours worked per week, years at present setting, type of clientele, and the number of years in the field of speech-language pathology. In addition, specific questions were asked regarding the respondent’s experience with courses, classes, or lectures dealing with death and dying. The subjects were asked
whether a death of patient had been experienced, and if so the number of adults and children. If the respondent had not experienced the death of a patient, they were asked to skip to the last question on the survey, question 12.

Those who had experienced the death of a patient were given the opportunity to convey a story associated with the death of a patient that had played a significant role in his or her career. Space was provided for the respondents to reply to this open-ended question. Categories were determined following the inclusion of eight or more responses.

The last survey item, question twelve, contained various coping strategies they used when dealing with death of any individual, subjects rated frequent use on a Likert scale from zero (meaning never), to 6 (everyday). Coping strategies were included following the review of the literature that revealed varying coping mechanisms, which might be utilized by health care professionals. Coping methods included peer support groups, clinical supervision or mentoring to newer and less experienced professionals, team meetings, decrease number of demanding clients or caseload size, talking with colleagues as well as promotion of education and wellness for the professionals (Dixen et al, 2005). The strategies or mechanisms included were; (1) I openly discuss events with peer professionals; (2) I openly discuss events with a support group(s); (3) I openly discuss events with a counselor; (4) I openly discuss events with family members; (5) I openly discuss events with a pastor, rabbi or other religious leader; (6) I help relieve my stress with exercise; (7) I help relieve my stress with humor; (8) I help relieve my stress with meditation; and (9) I find solace in prayer.

For those who had experienced the death of a patient, further information was requested. The respondents were asked to report the number of the deaths of adults and children. Questions relating to sudden and anticipated deaths effects upon a clinician’s value of work were explored following the previous question. Respondents utilized a Likert scale from one to five was used relating to one, (positive influence), to three (no influence) and five, (negative influence) to answer these questions. In addition, the same Likert scale was used to explore the speech-language pathologist’s perceptions of how sudden and anticipated deaths impacted the overall enjoyment of their work. The final question in this section, investigated, how experiences with death outside of the field impacted a clinician’s ability to deal with the death of patients.
The next question for individuals reporting the loss of a patient examined the impacts of sudden and anticipated death of patients upon the clinician. Further information was obtained about the length of time a speech-language pathologist experienced both emotional and physical reactions following the sudden and anticipated death of a patient. An Likert scale was used and included zero, (never), 1, (a few hours), 2, (a few days), 3, (one to three weeks), 4, (one to five months), 5, (six to eleven months), and 6, (a year or longer). The question was divided into (A) sudden death of a patient, and (B) anticipated death of patients. The respondents were asked to estimate the duration of both emotional and physical reactions following the death of patients, including, detachment, depersonalization, sadness, depression, anxiety, insomnia, and hypertension.

Procedure

The informational packets and surveys were sent to professional speech-language pathologists in the state of Ohio. At the initiation of the study, if an inadequate number of responses were returned, the questionnaire would have been resent with a second cover letter to the SLP’s requesting their participation again. The second sending was deemed unnecessary due to the significantly high return after the first mailing. Each survey (Appendix G) took approximately 15 minutes to complete and then was sent back to the researcher for review. Data was collected and entered into a database for further analysis. Information collected was anonymous and there was minimal risk of distress for this study. Human Subjects research protocol was followed as required by Miami University.

Statistical Analyses

The data was analyzed using descriptive statistics including means, standard deviations, and correlations to examine the results of the respondents. Pearson correlation t-tests were employed to examine the association between the age of the respondent and severity of the emotional and physical reactions following the sudden death of a patient or the anticipated death of a patient. Each individual was classified to have or have not worked in each work setting. For each work setting, the severity was compared emotional and physical reactions. Independent Sample t-test were performed to examine differences between the severity of the emotional and physical reactions following the sudden death of a patient versus the anticipated death of a patient between each work setting on the basis of working or not working in each setting.
Severity of emotional and physical reactions following the sudden death of a patient and the anticipated death of a patient were compared between speech-language pathologists working with three populations (adults, children, both) by a one-way analysis of variance (ANOVA). Significant differences were further investigated using a Tukey multiple comparison procedure. Differences in coping strategies and grief reactions due to having or not having a course on death and dying were analyzed using independent sample t-test comparison of means. A multiple regression analysis was performed to determine if there was a significant association between the total deaths, years employed and the work setting upon the emotional and physical reactions following the sudden death of a patient and the anticipated death of a patient. Examining the association between outcomes of grief reactions and coping (emotional and physical reactions following the sudden and anticipated death of a patient and coping strategies) and predictors of outcomes (total deaths, years employed and work setting) was performed using a multiple regression analysis.
CHAPTER III

Results

Subjects

Subjects were recruited from the membership roles of the Ohio Speech-Language and Hearing Association. A total of 700 questionnaires were sent out to individuals with a return rate of 365 (52%) surveys. Of the 365 (52%) surveys returned, the majority were completed by females, 355 (97%) and 10 (3%) by male speech-language pathologists. The average age for respondents was 40 years with a minimum of 21 years and maximum age of 75 years. Of the 365 clinicians surveyed, the professionals worked an average of 33.25 hours per week. The average number of years at the professionals’ current job was seven years with a minimum of 1 year and a maximum employment of 43 years. In addition, the mean number of years employed in the field of speech-language pathology was 14.5 years with a minimum of one year and a maximum of 43 years. Table 2 summarizes the subjects’ characteristics. The average subject was a 40-year-old female, whom worked an average 33.25 hours per week and has been at her current job for seven years. She has also been a speech-language pathologist for 14.5 years working with varying clientele.

Ethnicity and Religion

Of the sample collected, the majority of the 365 respondents, 350 (96%) were Caucasian. The ethnicity of the remaining respondents’ included 4 (1%) Asian, seven (2%) African American, two (.5%) Hispanic, and two (.5%) other ethnicities. Each respondent was asked to rate the significance of religion in his or her lives on a Likert scale from (1) very religious to (7) not religious at all. It was found that 246 (67%) of the surveyed individuals rated themselves as religious, (a score of one (1), two (2), or three (3). Sixty-one (17%) subjects rated themselves as moderately religious (a rating of four), and 16 (4%) rated themselves as not religious (a rating of six or seven). The information gathered indicates that overall individuals in the field of speech-language pathology described themselves as religious individuals. Tables 3 and 4 summarize the ethnic and religious profiles of respondents.

Degree Obtained

The majority of professionals in the field of speech-language pathology are required to
Table 2

Summary of Subject Demographic Data

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Average</th>
<th>Standard Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>362</td>
<td>40.49</td>
<td>11.07</td>
<td>21 to 75</td>
</tr>
<tr>
<td>Weekly Work Hours</td>
<td>365</td>
<td>33.25</td>
<td>11.96</td>
<td>1 to 80</td>
</tr>
<tr>
<td>Years at Job</td>
<td>365</td>
<td>7.45</td>
<td>7.42</td>
<td>.25 to 43</td>
</tr>
<tr>
<td>Years employed</td>
<td>364</td>
<td>14.58</td>
<td>10.30</td>
<td>1 to 43</td>
</tr>
</tbody>
</table>
### Table 3

Summary of Subjects Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>350</td>
<td>95.89</td>
</tr>
<tr>
<td>African American</td>
<td>7</td>
<td>1.92</td>
</tr>
<tr>
<td>Asian</td>
<td>4</td>
<td>1.10</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2</td>
<td>0.55</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0.55</td>
</tr>
</tbody>
</table>
Table 4
Summary of Subject Religious Significance in Their Lives

<table>
<thead>
<tr>
<th>Religion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious (1)</td>
<td>56</td>
<td>15.34</td>
</tr>
<tr>
<td>Religious (2)</td>
<td>122</td>
<td>33.42</td>
</tr>
<tr>
<td>Religious (3)</td>
<td>68</td>
<td>18.63</td>
</tr>
<tr>
<td>Moderately Religious (4)</td>
<td>61</td>
<td>16.71</td>
</tr>
<tr>
<td>Minimally Religious (5)</td>
<td>42</td>
<td>11.51</td>
</tr>
<tr>
<td>Not Religious (6)</td>
<td>9</td>
<td>2.47</td>
</tr>
<tr>
<td>Not Religious7</td>
<td>7</td>
<td>1.92</td>
</tr>
</tbody>
</table>
hold a Master’s of Arts or Master’s of Science degree. Following analysis of the respondents’
degrees obtained, it was found that 336 (93%) of the individuals held a Master of Arts or
Master of Science degree. In addition, only 9 (2.5%) held Bachelor of Arts or Bachelor of
Science degrees, 10 (3%) received their Doctor of Philosophy degree, Ph.D’s, 3 (1%) obtained
a Doctor of Education, Ed.D, and only 3 (1%) subjects had degrees in other fields. (See Table
5).

Work Setting and position

Descriptive statistics were obtained regarding the work setting of the 365 surveyed
individuals. Respondents were employed as follows; 133 (36%) respondents in a Hospital
setting, 41 (11%) respondents in Non-Profit settings, 45 (12%) respondents School, 57 (15%)
respondents in Private Practice office, 41 (11%) respondents in Private Practice in the home,
114 (31%) respondents at Long Term Care facility, 73 (20%) respondents in a Rehabilitation
Center, and 79 (21.5%) respondents were employed in other settings. Refer to Table 6. The
majority of individuals surveyed in this study were from a hospital, (36 %) or in long-term care
facility, (31%). Of the 365 respondents, 259 (71%) speech-language pathologists were
employed as staff members in their work setting. The remaining subjects held positions of
supervisor/manager, 38 persons (10%), 6 (2%) were administrators, 43 (12%) clinician owned
their own practices and only 18 (15%) persons surveyed are employed in other positions. (See
Table 7).

Populations Served

In the field of speech-language pathology clinician’s work with various populations
including adults, children or both. Individuals were asked to describe the population they
primarily work with including adults, children or equal. As seen in Table 8, the 365 surveyed
individuals described that 162 (44%) of the individuals work with primarily adults, 166 (45%)
work primarily with children, and 38 (10%) work with adults and children equally.

Course Work

Of the 365 surveyed clinicians 129 (35%) individuals had taken a counseling course
that included discussions of death and dying, 78 (21%) clinicians had taken a course
specifically on death and dying and 41 (11%) individuals had attended a conference
presentation on coping with the death of a patient. A t test was performed to determine if a
significant difference in responses was notable between those who had a course on death and
Table 5

Summary of Subjects Highest Degree Earned

<table>
<thead>
<tr>
<th>Degree</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelor or Arts/ Bachelor of Science</td>
<td>9</td>
<td>2.49</td>
</tr>
<tr>
<td>Master of Arts/ Master of Science</td>
<td>336</td>
<td>93.07</td>
</tr>
<tr>
<td>Doctor of Philosophy</td>
<td>10</td>
<td>2.77</td>
</tr>
<tr>
<td>Doctor of Education</td>
<td>3</td>
<td>0.83</td>
</tr>
<tr>
<td>Work Setting</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>Hospital</td>
<td>133</td>
<td>36.24%</td>
</tr>
<tr>
<td>Long Term Care Facility</td>
<td>114</td>
<td>31.06%</td>
</tr>
<tr>
<td>Rehabilitative Center</td>
<td>73</td>
<td>19.95%</td>
</tr>
<tr>
<td>School</td>
<td>45</td>
<td>12.26%</td>
</tr>
<tr>
<td>Private Practice Office</td>
<td>57</td>
<td>15.53%</td>
</tr>
<tr>
<td>School</td>
<td>45</td>
<td>12.26%</td>
</tr>
<tr>
<td>Private Practice Home</td>
<td>41</td>
<td>11.17%</td>
</tr>
<tr>
<td>Other</td>
<td>79</td>
<td>21.53%</td>
</tr>
</tbody>
</table>
Table 7
Summary of Subjects Work Position Held

<table>
<thead>
<tr>
<th>Position</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Member</td>
<td>259</td>
<td>71.15</td>
</tr>
<tr>
<td>Practice Owner</td>
<td>43</td>
<td>11.81</td>
</tr>
<tr>
<td>Supervisor/Manager</td>
<td>38</td>
<td>10.44</td>
</tr>
<tr>
<td>Administrator</td>
<td>6</td>
<td>1.65</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>4.95</td>
</tr>
</tbody>
</table>
Table 8  
Summary of Population Serviced by Subject

<table>
<thead>
<tr>
<th>Population</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>162</td>
<td>44.26</td>
</tr>
<tr>
<td>Children</td>
<td>166</td>
<td>45.36</td>
</tr>
<tr>
<td>Children and Adults</td>
<td>38</td>
<td>10.38</td>
</tr>
</tbody>
</table>
dying and those who had not as evidenced by the use of coping strategies. Refer to Table 9 for results. Coping strategies showed a significant relationship with participation in course work were; “I openly discuss events with peer professionals”, \( t(337) = -2.22, p\text{-value}= 0.027 \); “I openly discuss events with a counselor”, \( t(326) = -2.65, p\text{-value}= 0.0085 \); “I help relieve my stress with humor”, \( t(330) = -2.34, p\text{-value}= 0.0198 \). Results determined that there was marginal correlation between the completion of a course on death and dying and the use of some coping strategies following the death of patient.

**Death of patients**

The professionals surveyed were found to have various experiences with the death of patients. Of the speech language pathologist surveyed, 310 (85%) had experienced the death of a patient, 49 (13%) had not experienced the death of patient and 6 (2%) clinicians did not provide a response. Refer to Figure 1. Of the individuals that had experienced the death of a patient, they were asked to estimate the number of deaths of adults and the number of deaths of children. Following analysis, the results determined that of those who had experienced the death of a patient, there were 359 (98%) individuals experiencing the death of an adult patient. The mean number of deaths of adult patients was 16 and with a standard deviation of 30. The minimum number of deaths of adult patients was no patients and the maximum was 250 patients. Three hundred and fifty-nine (98%) clinicians responded they had experienced the death of a pediatric patient. The mean was one death with a maximum of 40 patients. There were a total of 310 clinicians who had experienced the death of a patient with an average number of deaths of both adults and children to be 17 patients.

**Selection of Work Setting**

As a speech-language pathologist working in hospitals, long term care facilities, and rehabilitative centers, experiences with medically fragile patients may have an impact on work settings. The respondents were asked to rate on a Likert scale the impact medically fragile patients had upon on their current work setting from a positive influence to no impact to a negative influence. Most individuals surveyed 347 (95%) stated that experiences during their graduate education did not have an impact on their current work setting. However, it was determined that experiences with medically fragile patients during the initial employment setting had a positive influence on the decision to select the present work setting.
Table 9

T Test Results for Course on Death and Dying and the Frequency of Coping Strategies Utilized by Speech-Language Pathologists

<table>
<thead>
<tr>
<th>Coping Strategy</th>
<th>DF</th>
<th>T value</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer professionals</td>
<td>337</td>
<td>-2.22</td>
<td>0.027*</td>
</tr>
<tr>
<td>Support Groups</td>
<td>327</td>
<td>-1.65</td>
<td>0.100</td>
</tr>
<tr>
<td>Counselor</td>
<td>326</td>
<td>-2.65</td>
<td>0.008*</td>
</tr>
<tr>
<td>Family Members</td>
<td>339</td>
<td>-1.04</td>
<td>0.300</td>
</tr>
<tr>
<td>Pastor, rabbi, or other religious leader</td>
<td>331</td>
<td>-0.84</td>
<td>0.403</td>
</tr>
<tr>
<td>Exercise</td>
<td>334</td>
<td>-1.25</td>
<td>0.211</td>
</tr>
<tr>
<td>Humor</td>
<td>330</td>
<td>-2.34</td>
<td>0.019*</td>
</tr>
<tr>
<td>Meditation</td>
<td>321</td>
<td>-1.23</td>
<td>0.218</td>
</tr>
<tr>
<td>Prayer</td>
<td>336</td>
<td>-.008</td>
<td>0.939</td>
</tr>
</tbody>
</table>

*p < .05
Figure 1: Summary of Percentage of Subjects Experiencing the Death of a Patient.
Figure 1.
**Effects of Sudden and Anticipated Death**

The impact of sudden and anticipated deaths of patients upon the value and enjoyment of the professional’s work were evaluated through ranking of Likert scaled questions. It was determined that neither the sudden or anticipated death of a patient had an impact upon the speech-language pathologists’ perspective of the value of work or enjoyment of work. Two hundred-ninety four (81%) individuals indicated that the sudden death of a patient had no impact on the perspective of the value of work. Two hundred and eighty-five (78%) SLP’s reported that the anticipated death had no impact upon the perspective of the value of work. In the case of sudden death, results indicated that 297 (81%) individuals revealed that the sudden death had no impact upon the overall enjoyment of work. Additionally, with the cases of anticipated death, 287 (79%) individuals indicated no impact upon the overall enjoyment of work. However, it was found that 306 (84%) respondents with an average response of 2.21, (a positive rating on the Likert scale), stated that experiences with the death outside of the workplace had a positive impact on the capacity to deal with the death of a patient.

**Emotional and Physical Reactions**

Each participant was asked to estimate the length of time that he or she experienced both emotional and physical reactions following the anticipated death and sudden death of a patient. Results are located in Figure 2 and 3. The majority of professionals experienced reactions for a few hours following both anticipated death and sudden death of a patient. Professionals indicated that the emotional response of sadness occurred for the greatest length of time with an average of 2.3 days following the anticipated death of a patient and an average of 2 days following the sudden death of a patient. The average emotional response of sadness lasted 1 day. The physical reactions following the anticipated and sudden death of a patient as reported by the subjects was found to be an average of approximately a third of a day following the anticipated death and approximately one fourth of a day following the sudden death of a patient. Clinicians experienced emotional reactions following the death of patient more than physical responses. The most common physical reactions reported were depression and anxiety. Two hundred-fifty six (70%) respondents reported the physical response of depression following the anticipated death of a patient and 251 (69%) with the sudden death. For the physical reaction of anxiety following the death of a patient, 254 (70%) reported
feeling anxious following a sudden death and 249 (68%) following the anticipated death of a patient.

Coping Strategies

The respondents were asked to rate the use of various coping strategies on a Likert scale from 0 (never) to 3 (a few times a month) to 6 (everyday), following a traumatic event such as death. This data is represented in Figure 4. As stated previously, the two most frequently utilized coping strategies were found to be openly discussing events with both peer professionals and family members. Results revealed that the 339 (93%) speech-language pathologists reported that they openly discuss events with peer professionals with an average rating of 3.19, or a few times a month. In addition, a total of 341 (94%) clinicians stated they openly discuss events with family members, with a mean rating of 3.2 (a few times a month); 336 (92%) respondents relieve stress through exercise with an average rating of 3.7; and 332 (91%) relieve stress with humor on an average of 4.1 or once a week. In addition, 338 (93%) respondents stated that they find solace in prayer following a traumatic event on an average once a week.

Significance Testing

All statistical tests were performed at the 5% significance level (p = .05). The result of the statistical analysis shows that there is a marginal significant correlation between the hospital work setting and the physical reactions following the anticipated death of a patient, (t= - 2.02, df = 255, p = .0449). Physical responses reported by subjects included exhaustion, insomnia, hypertension and frequent headaches. No other significant associations were found.

A significant difference in the use of peer discussions as a coping strategy and individual who work in a private practice and those who do not, (t = -2.16, df= 304, p= 0.032). No other significant differences were found.

Frequency of discussion with family members as a coping strategy was found to be negatively associated with years of employment (t=-2.46, df=304, p= 0.015). Frequency of discussing events with a pastor, rabbi or other religious leader as a coping strategy was found to be negatively related to employment in a long term care facility, (t = -2.27, df = 304, p = 0.024) and positively related to employment in a school, (t = 2.03, df = 304, p = 0.043) and marginally positively related to employment in a private practice, (t = 1.85, df = 304, p= 0.065).
Table 2. Emotional Responses Reported by Subjects Following the Sudden and Anticipated Deaths of Patients.

Figure 3. Physical Responses Reported by Subjects Following the Sudden and Anticipated Deaths of Patients.

Figure 4. Summary of Coping Strategies Used by Subjects.
Figure 2.
Figure 3.
Figure 4.
Table 10

Coping Strategies utilized by Respondents

<table>
<thead>
<tr>
<th>Coping Strategy</th>
<th>N</th>
<th>Average Response</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Professionals</td>
<td>339</td>
<td>3.19</td>
<td>1.96</td>
</tr>
<tr>
<td>Support groups</td>
<td>329</td>
<td>.29</td>
<td>.83</td>
</tr>
<tr>
<td>Counselor</td>
<td>328</td>
<td>.27</td>
<td>.79</td>
</tr>
<tr>
<td>Family members</td>
<td>341</td>
<td>3.24</td>
<td>1.98</td>
</tr>
<tr>
<td>Pastor, rabbi, or other religious leader</td>
<td>333</td>
<td>.57</td>
<td>.98</td>
</tr>
<tr>
<td>Exercise</td>
<td>336</td>
<td>3.74</td>
<td>1.89</td>
</tr>
<tr>
<td>Humor</td>
<td>332</td>
<td>4.13</td>
<td>2.05</td>
</tr>
<tr>
<td>Meditation</td>
<td>323</td>
<td>1.37</td>
<td>2.05</td>
</tr>
<tr>
<td>Prayer</td>
<td>338</td>
<td>3.96</td>
<td>2.25</td>
</tr>
</tbody>
</table>
Frequency of discussion with peer professionals as a coping strategy was found to be negatively related to employment in a private practice, \((t = -2.16, df = 304, p = 0.032)\). No other significant associations were found.

There was a marginal significant difference in the severity of emotional reactions following the anticipated death of a patient among the three speech-language pathology populations, \([F (2, 281) = 2.86, p = .0591]\). Follow-up Tukey multiple comparisons indicated that the largest observed difference in severity occurred between speech-language pathologists working with adults only and speech-language pathologists working with children only. No other significant differences were found.

**Respondent Experiences**

The survey created for this study included a comment section for individual stories about experiences with the death of a patient. After reviewing the comments provided by the subjects, it was found that there were seven specific themes or characteristics to the responses. The responses by professionals included; (1) 10 (11%) change of occupation or job setting; (2) 15 (16%) new perspective on death and dying; (3) 19 (21%) significant impact of a patient or family; (4) 18 (20%) specific impact on professional views and job responsibilities; (5) 9 (10%) first patient death; (6) 8 (9%) death of a child; and (7) 13 (9%) other.

The responses were often poignant and written with much thought and reflection. Following the assessment of the replies, the most frequently occurring themes were new perspectives on death and dying, the impact on one’s family, the impact on professional’s views. The following is a sample of responses, the remainder of responses can be found in Appendix I.

The first category (1) new perspective on death and dying, consisted of comments such as respondent number 219 experienced:

“All after working for 2 or 3 years, I saw a patient with locked in syndrome from a brainstem CVA. He had not received speech therapy previously and communicated only yes and no with eye blinks. Once he was able to communicate with an augmentative device, he said that he wanted to die. He communicated this with his family, his physician, his attorney, and the ethics committee. Each time he needed to communicate this, I was asked to go into his room to ensure he was understood. This
Table 11

Emotional and Physical Responses Following the Anticipated and Sudden Death of Patients

<table>
<thead>
<tr>
<th>Response</th>
<th>N</th>
<th>Percentage</th>
<th>Average Rating</th>
<th>Standard Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Responses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Sudden</td>
<td>284</td>
<td>78%</td>
<td>1.00</td>
<td>.84</td>
<td>0</td>
</tr>
<tr>
<td>B. Anticipated</td>
<td>274</td>
<td>75%</td>
<td>.87</td>
<td>.80</td>
<td>0</td>
</tr>
<tr>
<td>Physical Responses</td>
<td></td>
<td></td>
<td></td>
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<td>250</td>
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<td>.28</td>
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</tbody>
</table>
Table 12

Analysis of Variance (ANOVA) Results for the Relationship between Emotional and Physical Reactions Following the Anticipated Death of a Child Patient

<table>
<thead>
<tr>
<th>Variable</th>
<th>DF</th>
<th>F Value</th>
<th>P Value</th>
</tr>
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<tbody>
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<td>2, 281</td>
<td>2.86</td>
<td>0.0591*</td>
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<td>of a Patient</td>
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<td>Following the Anticipated Death of a Patient</td>
<td>2, 221</td>
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<td>Physical Responses Following the Sudden Death of a Patient</td>
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<td>0.74</td>
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<td>0.836</td>
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</tbody>
</table>

*p < .05
was difficult for me. Eventually, he requested that all support and medication administration be stopped. Though this process I learned that there are things worse that death. Death can be a blessing. The experience really changed my perspective on death.”

The second most frequent theme found included comments regarding significant impact of a patient or family or theme three. Respondent 236 reported:

“Every time a patient of mine passes, I am very sad. It’s not the same kind of sadness that I feel with a family member passing however it is still unsettling. It is almost like I feel more for their family members and their loss. Working a hospital setting I see traumatic events effecting patients and their families lives everyday, it’s my job to help them through this time in anyway possible. I feel that obligation. To answer the question, I guess, No, they have all made an impact. Everyday is so different when you work in a hospital setting; I feel that is why I enjoy it so much. It’s real.”

Another speech-language pathologist, 237 shared:

“Each death is important and affects you in a different way’. I find that the patient is grateful for any comfort you can give them whether it is to wipe their face with a cloth, clean out their dry mouth with a moist towelette, and hold their hand. I usually always try to say a prayer in my head for them as I stand at their bedside. When you work with the elderly, death is very common but is never insignificant. At times I do feel sad when an old friend passes on but I also feel happy for them to see and end to their suffering. I have old friends I will never forget, Ralph, Eva, Ruth… They taught me life lessons that I still carry with me. I love my job and I love my “old” people who when you get to know them are really young at heart. They just look different.”

The third most frequently used theme found with the respondents consisted of responses in the fifth category relating to the death of the clinician’s first patient. Respondent 161 replied:

“The first time I experienced the loss of a resident in a SNF/ECF/LTCF. The resident was young, in her 60’s, and quite educated. She had a progressive disease, a form of MS (Multiple Sclerosis). I was a. frustrated that funding via Medicaid took months for an augmentative communication device (Dynavox), b. presenting with mixed feeling of the progression of her disease, i.e. maybe I’ll be relieved when she passes, or I’ll be very sad. I can’t tell you how much of an advocate I’ve become for AAC in the geriatric population secondary to seeing the
benefit of communication she experienced following the months she had the device. She used the device for 11 months before “expiring”. The first time I saw the word “expired” I became upset, I felt it was too sterile, too insensitive. I’m used to it now. But now her son, who has the same disease, now uses the device- I trained him along with his mother. To this day, and it’s been five years, I miss her. I grew close because AAC training is very involved. And, even though the process is so very lengthy to apply for a device (and my employer won’t pay for all the time to write the application because it’s not billable/productive time), I will take the paperwork home- it’s that important to me because of her.”

In addition, clinician 270 answered, “At the onset of my career, I worked in a medical facility. Two of my adult / stroke patients died within the first year. I was devastated. Consequently I left my position and entered public education. This placement was such a positive move for me.”

Clinician 248 responded:
“I took my first job out of graduate school in a long term care facility. I certainly was not prepared for the impact death and dying would have on me as a professional. I will share with you my first experience with death and dying on the job. I had been treating a patient who had survived a stroke. He seemed to be doing very well with all of his therapies. Suddenly his behavior changed. He began refusing his therapies etc. I became very concerned about this patient. One morning on my thirty minute drive to work. I was thinking about him the entire time. I was the first therapist to attempt to treat him that morning. Upon entering his room I was unable to wake him, even with a good stern rub, etc. Then I noticed that his skin look yellow and his finger nails were blue. I ran to get the nurse. I thought he was possibly on stronger medication which sometimes makes it difficult to wake patient (In addition, I had no previous experience with death and dying and body was still warm). The nurse entered the room. When she came back and she told me that the patient had “expired”. This patient’s death was hard for all of the therapists. He had been doing so well. And his death was unexpected.”

Chapter Summary

Data analysis revealed that there was a marginal significant correlation between the hospital work setting and the physical reactions following the anticipated death of a patient. A significant relationship was found between working in a private practice and the use of peer
discussion. In addition, discussing events with family members was related to years of employment in a long term care facility. This section also provided seven categories of responses of subjects regarding their experiences with the death of patients.
CHAPTER IV

Discussion

The primary motivation for this study was the need to identify the perceptions of speech language pathologists following the death of a patient. The study examined how the speech-language pathologist deals with the death of a patient. The average respondent was a 40 year old female, who works an average of 33.25 hours per week and has been at her current job for seven years. She has also been a speech-language pathologist for 14.5 years while working with varying clientele. The most common work environment was found to be the hospital setting with 36% of the respondent employed in this setting. This is similar to statistics provided by the American Speech and Hearing Association. According to ASHA membership data, 35% of speech-language pathologists are employed in health care settings with the majority, 14% working in hospitals, 6% in Skilled Nursing Facilities, and 4% in both home health and SLP office settings (American Speech and Hearing Association, 2005). In addition, 60% of speech-language pathologists’ work approximately 40 hours per week and approximately 28% worked part-time for 20 hours per week (ASHA, 2005). The average number of years experience in the field of speech-language pathology was found to be approximately 17 years (ASHA, 2005). Furthermore, only 5% on average of employed speech-language pathologists are males and racial minorities employed in the field averaged to be only 3.5%. Thus, the sample collected by this survey is a consistent representation of the professionals in this field and therefore, the professionals dealing with the death of a patient.

The results suggest the majority of speech-language pathologists working in health care and with medically fragile patients (86%) will have to deal with the death of a client at some point their career. The overall response to a death did not appear to be different for deaths that were sudden versus those that were anticipated. The most common emotional response was sadness with detachment and the decrease in work performance as the second most common. Exhaustion was the most common physical reaction following the death of a patient. As the results reveal, the length of the response lasted from a few hours to a few days. The death of a patient does have an effect upon a speech-language pathologist but as results suggests, the estimated time is approximately a day due to the varied work environment and caseloads of the individual therapists.
Results regarding the emotional and physical responses following the sudden death of patient appear to be greater than those succeeding the anticipated death of a patient. It appears that speech-language pathologists working with medically fragile patients respond with greater reactions of sadness and depression to death of patients that occur unexpectedly. This also seems to be true for physical reactions following the death of a patient. The results suggest that the sudden death of a patient produces greater physical reactions including exhaustion and insomnia. Associations may be made toward a trend that the sudden death of patients has a greater impact upon speech-language pathologists and thus the impression it leaves upon clinicians.

As suggested by the results, professionals who work with medically fragile patients may present with a greater number of emotional and physical responses as well as increased use of coping methods. The findings help to support that the individuals in the field of speech-language pathology deal with death by utilizing varying strategies. The majority of speech-language pathologists utilized the coping mechanism of discussing events most often with family members and with peer professionals. However, each coping strategy was found to be used by different clinicians, in many work environments and at varying times. The uses of coping strategies are a large part of dealing with the death of a patient and the grieving process.

Results imply that the experience with death outside of the work place, such as the death of family members, spouses, or children has an impact on a speech-language pathologist’s ability to deal with the loss of clients in the workplace. Through the experiences with these deaths, clinician’s indicated that they are able to better deal with the death of their patients. For example, one subject wrote, “After the death of my mother, I viewed death and the dying process with more understanding and acceptance. And I hope I have been able to assist my patients and their families understand it better also.”

Relationships between work environment, educational courses on death and dying, and the number of deaths experienced with coping strategies and grief reactions also appear to have an impact on speech-language pathologists. The subjects included in the research worked in environments such as hospitals and long term care facilities. In such environments, professionals may often experience greater number of deaths as well as more stressful work environments (Redinbaugh et al, 2001). In addition, environments such as skilled nursing
facilities and long-term care facilities are settings where speech-language pathologists may deal with grief more frequently.

As indicated by the results, speech-language pathologists who have taken a course on death appear to be more comfortable talking with others, be it a counselor or a peer professional, regarding the death of patients. These individuals may understand the importance of discussing issues surrounding the death of their patients with others and utilizing correlating coping mechanisms.

The majority of speech-language pathologists stated that they were religious to some degree (96%). This finding may be related to the use of prayer when coping with the death of a patient. With varying degrees of religious affiliation, results reveal that the professional regards themselves as religious and utilize their religious beliefs to help cope with the death of a patient. The use of not only prayer but other beliefs and spiritual outlets appears to provide speech-language pathologists a means to cope with the death of a patient.

Results also indicate that the age of a speech-language pathologist relates more to the number of instances a therapist has faced the death of a patient and how they have learned to cope with these losses. If early in one’s career, the speech-language pathologist finds dealing with death and dying to be inherently difficult, they may choose to work with in a less critical environment or with less medically fragile patients.

The findings of this research suggest that there is a consistent response by speech-language pathologist following the death of a patient in grief reactions and coping methods. This alludes to the fact that there is a universality to the experience of the death of patient. There are various ways that a clinician may deal with the loss of a patient; it is an experience that has a significant impact upon the therapist. Speech-language pathologists fill the general mode of a helping professional. They utilize internal coping mechanisms, religious support and cross-professional assistance in dealing with a patient’s death.

From the subjects’ comments, as well as through the results, a patient’s death has a significant impact and can remain with the speech-language pathologist throughout his or her career and personal life. This was demonstrated by subject number 270, “At the onset of my career, I worked in a medical facility. Two of my adult / stroke patients died within the first year. I was devastated. Consequently, I left my position and entered public education. This placement was such a positive move for me.” There is not a correct answer nor a correct
method of coping with or dealing with the death of a patient. It is an experience unique to each and every speech-language pathologist and will continue to remain to be one exclusive to that professional and to his or her patients. This study demonstrates the variety of response and coping mechanisms used by a speech-language pathologist. Whether the experience with death be one person or may it be 100 people, each loss plays a significant role in the practice of speech-language pathology and upon the therapist.

The death of a patient is an experience that is dealt with by professionals and the impact of the professional’s age, number of deaths, and work setting does not necessarily play a significant role in determining how a person reacts to or copes with the death of patient. Rather, the loss of a patient as found through this study effects speech-language pathologists in many ways. Simply stated, death affects all professionals.

As professionals in a helping profession, grief is a universal emotion; dealt with by all individuals, in varying work environments and with various clienteles. Through the investment of the professional into the lives of his or her patients, a common and significant relationship is formed. Following the death of patients, the experience is dealt with through coping strategies which may be different for each individual professional. Furthermore, there is not one common coping mechanism that is the most valuable tool for professionals to use; rather, many strategies such as talking with family members, the use of humor as well as prayer are used at different times, with different patients and with varying experiences. The research relates to the fact that the death of patient can not be dealt with one way or with one coping strategy; there is not one concrete method of dealing with and coping with the death of a patient. An involvement of a wide range of strategies, methods and mechanisms must be used in order to deal with the grief and sadness following the death of a patient.

Limitations of the Study

The study presents limitations in its design and population sample used. The subjects were restricted by geographic location and work settings by the compilation of speech-language pathologists employed in positions related to health care, private practice and Mental Retardation and Developmental Disabilities (MRDD). The sample used was not a full collection of the speech-language pathology population and may not be consistent with other work environments such as general school systems.
**Future Research**

Further information must be researched with regard to burnout in the field of speech-language pathology. Inquiry into the effects of burnout upon professionals must be understood to help speech-language pathologists deal with the death of patients as well as the stresses of working in a helping profession. In addition, through further research, better understanding must be made available to provide professionals with the best strategies, educational tactics, and methods for dealing with and coping with the death of patients and medically fragile patients. Through further understanding of how the death of a patient and burnout affects speech-language pathologist, professionals will be able to provide the best quality of care to the patients.

**Clinical Implications**

While it appears that each individual speech-language pathologist has developed personal coping strategies; universality exists in various aspects of the individual’s personality, including humor, religion and personal support systems. After much analysis and review of the literature, it appears as if speech-language pathologists fall into the same category with other helping professionals. They find personal and internal coping mechanisms as well as the support of their family and other professionals to help deal with the death of patients.

It also appears that course work, seminars, etc. have the potential to positively impact a speech-language pathologist. However, it seems as though the significance of such course/seminars is dependent on the experience of the professional offering the course. In essence one who has actually faced the death of clients has the potential to provide a more useful roadmap for clinicians to use.

The demographic of speech-language pathologists is similar to other helping professions such as nursing, medicine, psychology, etc. The information gathered impacts not only the field of speech-language pathology but may also transfer to other clinical fields. The importance of education and curriculum on grief and coping strategies should be available to all professionals involved in caring for medically fragile patients. Support, education and strategies should be provided to students of medicine, nursing, speech-language pathology, etc. as well as those entering the health care field. All professionals should be provided with the necessary knowledge of grief reactions and coping methods to help create better responses following the death of a patient. Such curriculum can transfer from the field of speech-
language pathology to other clinical areas and strengthen not only the health care field but also professionals’ attitudes, reactions and perceptions following the death of a patient.
REFERENCES


Appendix A

Table 13

Emotional and Physical Responses Reported by Subjects following the Sudden (A) and Anticipated (B) Deaths of Patients

<table>
<thead>
<tr>
<th>Question</th>
<th>Number</th>
<th>Average Response</th>
<th>Standard Deviation</th>
<th>Minimum</th>
<th>Maximum</th>
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<td>1.12</td>
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<td>.36</td>
<td>.90</td>
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<td>.35</td>
<td>.89</td>
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<td>Sense of Inadequacy</td>
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<td>.97</td>
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<tr>
<td>B. Anticipated</td>
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<td>3</td>
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<tr>
<td>Frequent</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Sudden</td>
<td>248</td>
<td>.21</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>.81</td>
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<td>B. Anticipated</td>
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<td></td>
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</table>
### Appendix B

Table 14

Summary of Subjects Gender

<table>
<thead>
<tr>
<th>Sex</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10</td>
<td>2.74</td>
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<tr>
<td>Female</td>
<td>355</td>
<td>97.26</td>
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Appendix C

Table 15

Summary of Impact of Experiences with Medically Fragile Patients on Work Setting

<table>
<thead>
<tr>
<th>Question</th>
<th>Number</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact of Experiences with Medically Fragile Patients in Graduate School and Decision to Work in Present Setting</td>
<td>347</td>
<td>2.62</td>
<td>.86</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Impact of Experiences with Medically Fragile Patients in Initial Employment and Present Work Setting</td>
<td>350</td>
<td>2.42</td>
<td>.91</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Experiences with the Death of Adults</td>
<td>365</td>
<td>15.65</td>
<td>30.04</td>
<td>0</td>
<td>250</td>
</tr>
<tr>
<td>Experiences with the Death of Children</td>
<td>365</td>
<td>1.37</td>
<td>3.50</td>
<td>0</td>
<td>40</td>
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<tr>
<td>Total Deaths</td>
<td>357</td>
<td>17.01</td>
<td>30.19</td>
<td>0</td>
<td>250</td>
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Appendix D

Table 16

Summary of the Impact of Sudden and Anticipated Deaths on Work Value and Enjoyment

<table>
<thead>
<tr>
<th>Question</th>
<th>Number</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden death and the impact on value</td>
<td>294</td>
<td>2.83</td>
<td>.93</td>
<td>1</td>
<td>5</td>
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<tr>
<td>on value of work</td>
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</tr>
<tr>
<td>Anticipated death and the impact</td>
<td>285</td>
<td>2.54</td>
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<td>5</td>
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<tr>
<td>on value of work</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Sudden death and the impact on</td>
<td>297</td>
<td>3.44</td>
<td>.93</td>
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<td>5</td>
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<tr>
<td>enjoyment of work</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anticipated death and the impact</td>
<td>287</td>
<td>3.21</td>
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<td>on enjoyment of work</td>
<td></td>
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</tr>
</tbody>
</table>
Appendix E

Figure 5. Summary of Subjects Work Setting
Appendix F

February 28, 2006

Dear Colleague,

There is an increasing number of Speech-Language Pathologists (SLP) who work in environments with patients who have a higher risk for death. Other health care professions have compiled information about some of the issues that surround the death of a patient. It is now time for our field to explore this significant issue.

I am writing to ask for your assistance in completing a survey regarding the perceptions of Speech-Language Pathologist’s on the loss of a patient. The purpose of this study is to obtain a greater understanding of how the death of a patient affects a Speech-Language Pathologist’s. The information from this survey will be to help identify the short term and long term effects of working with fragile patients in order to help develop educational tools for new professionals and will be disseminated via journal publications and presentations.

Your answers to the questions will be anonymous and will only be released as summary information. If for any reason, you feel uncomfortable with a question, you do not need to provide a response and you may stop at any time. Completion of the questionnaire constitutes your agreement to participate in the study. Please return the survey even if it is incomplete.

The questionnaires will take approximately 15 to 20 minutes to complete. I have provided you with the surveys as well as a postage paid envelope for returning the survey.

Your assistance will help to provide a more complete and accurate representation of SLP’s in the state of Ohio. I greatly appreciate your assistance with this project; I know your time is very valuable.

If you have any questions regarding your rights as a participant in this study please contact the Office for the Advancement of Research Scholarship by electronic mail at humansubjects@muohio.edu or phone at (513-529-3734).

If you have any questions or comments about this study, please contact Jennifer Wojan by electronic mail at wojanj@muohio.edu or by phone at (231-342-4552) or Dr. Laura Kelly at kellylj@muohio.edu or (513-529-2505).

Sincerely,

_____________________________
Jennifer Wojan, B.A.
Miami University Graduate Student
Appendix G

Survey

Your sex: _____ (1) Male _____ (2) Female

Your age: _____ years

What is your ethnic background? (Check only one group.)

____ (1) Asian     ______(2) Black/ African American
____ (3) Latino/Hispanic/Mexican American ______(4) Native American/American Indian
____ (5) White/ Caucasian ______(6) Other (please specify) _____________

How religious do you consider yourself to be? (Circle the appropriate number)

1 2 3 4 5 6 7
very religious             not at all religious

What is the highest degree you have received?

____ (1) B.A./ B.S. ______ (2) M.A./M.S. ______ (3) Ph.D. ______ (4) Ed. D.
____ (5) other

How would you describe your work setting(s) (check all that apply)

______ (1) hospital __________ (2) non profit agency __________(3) school system
______ (4) private practice –office based __________(5) private practice –home based
______ (6) long term care facility __________(7) rehabilitation center
______ (8) other (please specify) ________________

What is the level of your primary position? (check only one answer.)

______ (1) staff member ______ (2) supervisor/manager ______ (3) administrator
______ (4) practice owner
______ (5) other (please specify) ________________________________

How many hours per week do you work at this job indicated above?

_____ hours per week

How long have you been at your present job?

_____ years

Do you work with primarily

__________Adults ________ Children ________ about equal
How long have you been employed in this general type of work?
______ years

1. Have you ever: (check all that apply)
   ______ taken a counseling course that included discussions of death and dying?
   ______ taken a course specifically on death and dying?
   ______ attended conference presentations on coping with the death of a patient?

<table>
<thead>
<tr>
<th></th>
<th>Positive Influence</th>
<th>No Impact</th>
<th>Negative Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

2. To what extent did experience(s) with medically fragile patients during your graduate education impact your decision to work in your present setting?
   1     2     3     4      5

3. To what extent did experience(s) with medically fragile patients in your initial employment setting impact your decision to work in your present setting?
   1     2      3      4       5

4. Have you experienced the death of a patient at any point in your career?  __Yes__ or __No__

   **IF YOU ANSWERED NO TO ITEM # 4 PLEASE SKIP TO ITEM # 12 AND THEN CONTINUE TO THE LAST PAGE**

5. If you have experienced the death of a patient(s) as part of your work estimate the number of adults ___________ and children ___________.

<table>
<thead>
<tr>
<th></th>
<th>Positive Influence</th>
<th>No Impact</th>
<th>Negative Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

6. In the case of sudden death how did the death impact your perspective of the value of your work.
   1     2     3     4      5

7. In the case of an anticipated death how did the death impact your perspective of the value of your work
   1     2     3     4      5

8. In the case of sudden death how did the death impact your overall enjoyment of your work.
   1     2     3     4      5

9. In the case of an anticipated death how did the impact
your overall enjoyment of your work.  1  2  3  4  5

10. Have your experiences with death outside of the workplace impacted your capacity to deal with the death of your patient(s).  1  2  3  4  5

11. In the space provided, use the key to estimate length of time you experienced the following after:

   A. Sudden death of a patient and/or  B. Anticipated death of a patient.

   0 - Never  1 - A few hours  2 - A few days  3 - 1 to 3 weeks  4 - 1 to 5 months
   5 - 6 to 11 months  6 - a year or longer

   A. _____  B. _____ Detachment
   A. _____  B. _____ Sense of inadequacy
   A. _____  B. _____ Decrease in work performance
   A. _____  B. _____ Sadness
   A. _____  B. _____ Depression
   A. _____  B. _____ Anxiety
   A. _____  B. _____ Hypertension
   A. _____  B. _____ Other

   A. _____  B. _____ Depersonalization
   A. _____  B. _____ Anger
   A. _____  B. _____ Frustration
   A. _____  B. _____ Exhaustion
   A. _____  B. _____ Insomnia
   A. _____  B. _____ Frequent Headaches

   ____________________________________________________

12. Using the key below please mark how often the statements apply to you.

   0- Never  1- A few times a year or less  2- Once a month or less  3- A few times a month
   4- Once a week  5- A few times a week  6 – Everyday

   ____________________________________________________

When I experience a traumatic event such as a death:

   _______ I openly discuss events with peer professionals.
   _______ I openly discuss events with a support group(s).
   _______ I openly discuss events with a counselor.
   _______ I openly discuss events with family members.
   _______ I openly discuss events with a pastor, rabbi or other religious leader.
   _______ I help relieve my stress with exercise.
   _______ I help relieve my stress with humor.
   _______ I help relieve my stress with meditation.
   _______ I find solace in prayer.
   _______ Other

Do you have a story associated with the death of a patient that has played a significant role in your career? If yes, please describe:

   ____________________________________________________

CON'TINUE TO THE NEXT PAGE TO FINISH THE SURVEY
Appendix H

MBI

<table>
<thead>
<tr>
<th>HOW OFTEN:</th>
<th>0</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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</thead>
<tbody>
<tr>
<td>Never</td>
<td>A few Times a Year</td>
<td>Once a month or less</td>
<td>A few times a month</td>
<td>Once a week</td>
<td>A few times a week</td>
<td>Every Day</td>
<td></td>
</tr>
</tbody>
</table>

HOW OFTEN:

0-6 Statements:
1. _____ I feel emotionally drained from my work.
2. _____ I feel used up at the end of the workday.
3. _____ I feel fatigued when I get up in the morning and have to face another day on the job.
4. _____ I can easily understand how my recipients feel about things.
5. _____ I feel I treat some recipients as if they were impersonal objects.
6. _____ Working with people all day is really a strain for me.
7. _____ I deal very effectively with the problems of my recipients.
8. _____ I feel burned out from my work.
9. _____ I feel I’m positively influencing other people’s lives through my work.
10. _____ I’ve become more callous toward people since I took this job.
11. _____ I worry that this job is hardening me emotionally.
12. _____ I feel very energetic.
13. _____ I feel frustrated by my job.
14. _____ I feel I’m working too hard on my job.
15. _____ I don’t really care what happens to some recipients.
16. _____ Working with people directly puts too much stress on me. I can easily create a relaxed atmosphere with my recipients.
17. _____ I can easily create a relaxed atmosphere with my recipients.
18. _____ I feel exhilarated after working closely with my recipients.
19. _____ I have accomplished many worthwhile things in this job.
20. _____ I feel like I’m at the end of my rope.
21. _____ In my work, I deal with emotional problems very calmly.
22. _____ I feel recipients blame me for some of their problems.

Thank you. We appreciate your time and willingness to share your thoughts with us.
Appendix I

1. Changes of occupation/job setting due to death

15. I used to work in nursing homes and had several patients who would a) die after significant progress, b) have recurrent strokes and lose skills after having made significant gains, c) be very depressed over loss of skill and unwilling/unmotivated to improve their situation, d) be legitimately ready to die as they felt they had lived a full life. These factors influenced my decision to go into pediatrics instead. Losing a pediatric patient is always difficult because it puts me in touch with my own emotions regarding how I would feel if I lost one my own children.

21. When I was a fairly new therapist I worked in the TBI unit on the pediatric wing of a hospital. I ended up leaving after a few years due to young patients at low level comas and a death of one. On TBI units- sometime they “death” of the person aren’t when they stop breathing. The grieving process you go thru with family is long and begins right after the injury. As the Shaivo case brought out last year- it’s very difficult and therapist working with these patients feels all the above symptoms often. There was a time when all of my patients were at a coma level similar to Ms. Shaivos. I quit rehab following the death of a 5 yr. old near drowning patient. That was about 14 years ago. I can do per diem in those units, but not full time again. * One of the best things about our profession is its diversity. If we become burned out with a certain population we can change. I don’t think I enjoyed the geriatric population-long term heath facility – when I first started as I do now.

175. I had seen several patients die of lung CA. When my dad got lung CA I didn’t deal with it well. I backed away from coworkers, friends, work, my work efficiency went down severely. I couldn’t deal with any critically ill pts. Which was my whole practice because I saw my dad in all of them? I ended up getting let go from my position when they were looking for someone to let go because productivity was so low and I have now taken a position that does not place me with as critically ill pt and I will never do them again. I wished I had dealt with it better because I was good at it while I was emotionally able but I didn’t deal wit it correctly and now I can’t be a good therapist to a group of people who need them.

119. Working with medically fragile patients in a nursing home during my clinical experiences made me realize how I did not want to work with the elderly population due to the fact that often you are making them more comfortable until they die, especially with swallowing therapy. I see much more progress in the school setting, even with my students with low instance disabilities, it is very much less depressing place to work, when compared with a nursing home.

139. Approximately 15 years ago I was working in an acute care position in a hospital. I evaluated a recent CVA patient and met his entire family. I left to write my evaluation and when I returned to his room to chart the protocol, he was being teamed. He died and I spent the night at his bedside with his family. Within a few months I transferred from acute care to outpatient rehab. I am still there today.
295. It was difficult to answer above questions as the only sudden death of a patient I experienced was in graduate school. I don’t think it was solely the death of this patient, but being exposed for the first time to illness, old age, suffering on a daily basis that made me spiral into a pretty dark depressive hole for a while. However, some of this may have been due to PTSD as my sister had died suddenly several years previously, and I definitely did not deal well with that. That’s where the “detachment” came in - then when I was again confronted with hospitals, all the feelings surfaced. In general, I still do much better in a pediatric setting! (i.e. typical language delayed kids.)

226. The death of the adult (in nursing home) told me I could not and did not want to work with the elderly- I became too attached to them… Kids shouldn’t die at the rate of the elderly. (but they did and still do).

157. As a student clinician in a hospital setting, a patient we were seeing for swallowing therapy suddenly died. It upset me and made me feel very sad, therefore, I made the decision to work with children, not adults, and to avoid the acute care setting.

192. As a graduate student, I became fond of an elderly stoke pt. and his wife. After working with them for a week, or so, I arrived for our next visit to find that Mr. Gorshine had died. 35 years later, I still remember his name, so you can see it had an impact on me. I decided work with children would be better for me.

191. I recently worked with a patient who refused all diet recommendations. Reluctantly the patient participated in therapeutic exercise. She was improving, and then she stopped participating all therapy. Less than one week later, she was diagnosed with pneumonia and expired in ICU. I felt guilty, helpless and thought about changing careers. This patient still continues to impact the value of my work as SLP’s.

2. New perspective on death and dying

309. Each death of a patient reminds me of the fragileness of life and our responsibility to help when possible in treatment and communication with that patient, their family, co-workers, and medical staff about status, expectations and anytime changes are noted.

98. Years ago I worked with a client who was about sixty years old but appeared much older. I made the initial diagnosis of dysphagia and provided all treatment and training. She maintained for quite a long time until other body systems started to shut down. I was intimately involved in discussions of end of life issues with the guardian and in the ultimate decision to remove life support. In my mind this experience developed depth and growth in both my professional and personal lives that could never have been achieved without walking this path.

41. I last had a gentleman with whom I had worked- 6 months (dysphagia treatment). He died of complications related to pneumonia. I was difficult to come to the realization that if you do everything in your power, sometimes it still might not be enough.
106. I know this is not directly related to your question, but I have gained insight into how the human spirit triumphs not strictly from personal encounters but from books like “Tuesday’s with Morrie”, Christopher Reeve’s book. Certain passages have been shared with patients on occasion.

108. I have been surprised to find that many patients I work with, who are mostly elderly with multiple medical problems, want to die and are ready to do so. I have been mostly surprised that death can be viewed as a positive thing, in that situation because it’s a relief and freedom from a body that is no longer vital. I have been happy for some patients because they were release from their suffering. Of course sometimes, that’s not the case and then it is sad.

110. Death is a grace. To live it with a family and to see the pain of Jesus face to face. It is only in this pain that I see hope for eternal life. It is this hype that allows me to keep working with the children and family bringing them hope.

111. Death has increased my awareness of just how fragile ALL of US are and that it is important to value each day. This comes from personal experiences as well as experience with the individuals I serve.

7. Positive Impact: very intense rehab patient (vent, PEG, etc.) who rehabbed to full communication (with mild aphasia symptoms) and PO with modified diet. Wonderful family support. Good quality of life achieved post CVA. Died several years later. Left all with sense of inspiration due to his character/motivation/achievement. Negative Impact: Younger (70ish) patient. Easy to relate to, slipped into sever depression following treatable medical complications. Required dysphagia treatment (me) developed attachment and felt inadequate and mildly depressed during and after dying process.

16. In the case of sudden death of a client, I’m usually stunned, saddened for a little while; perhaps leave condolences to the family and find solace in thinking about the end of the patients suffering and burden of care giving that usually has been on other family members. In the case of anticipated death, it is often a privilege and blessing to be in the company of a client that has accepted his own coming death. They often display peace grace, dignity and even humor.

337. After the death of my mother, I viewed death and the dying process with more understanding and acceptance. And I hope I have been able to assist my patients and their families understand it better also.

339. Yes, the death of both grandmothers to cancer- I was with my paternal grandmother at the time of her death and I cared for my maternal grandmother when she was ill. I do not fear death as a result.

366. My career and my whole life; when I was 16 and a nurse’s aid, I was talking to a woman patient. She took my hand and said, “you have to love so that when you get to this point you can look back and say it was all worth it.” Then she said, “Please get the nurse now, I’m going
to die.” I pushed the call button and the woman was dead. It was peaceful and has given me a lot to think about over the years.

158. The death of a client that had the most negative impact upon me involved the apparent suicide of a young woman with TVI with whom I worked up to daily. We’d worked together for several years and her death— which assumed the shape of a coma— ending in the family relinquishing life support systems was a tragedy. There was a failure in her support system and as part of that system, I was frustrated and angry. Suicide leaves the living with many unresolved issues. I think.

79. I recently lost a patient with ALS— she was around 45 years old. She was on hospice and voluntarily stopped all PO intake. I was able to provide her with a communication board to increase communication during her final weeks. For this she was truly grateful. I’ll never forget how I was able to be a positive influence on her final days. When she passed ALL I could think of was— that could be my mom— It still hurts.

218. My experience was not with a specific patient rather than a specific philosophy of death and dying. I worked shortly after graduate school with the sisters of charity— they taught a very young clinician what it was like to die with dignity. The hospice philosophy of comfort care was truly lived at their facility. When aggressive measures were not needed they went along with testing, surgery, etc. When outcomes could be positive. When outcomes were questionable choices were made to allow their residents for quality of life during their remaining time on earth. What a strong lessoned to be learned early in a geriatric career— quality vs. quantity.

219. After working for 2 or 3 years, I saw a patient with locked in syndrome from a brainstem CVA. He had not received speech therapy previously and communicated only yes and no with eye blinks. Once he was able to communicate with an augmentative device, he said that he wanted to die. He communicated this with his family, his physician, his attorney, and the ethics committee. Each time he needed to communicate this, I was asked to go into his room to ensure he was understood. This was difficult for me. Eventually, he request that all support and medication administration be stopped. Though this process I learned that there are things worse that death. Death can be a blessing. The experience really changed my perspective on death.

3. Positive impact of one patient and patient’s family

19. When my patient was dying (his sister was a nun) – his whole family was gathered together— and as I was passing his room, at the moment of his death (I found this out later— there was an overwhelming sense of the presence of God which almost took me to my knees.

39. Not a specific patient but I feel everything I do to improve quality of life for a patient (and their family) at the end of that patient life, is rewarding. I work in long term care knowing, some of my patients are going to pass away. It’s a given. You do get closer to some patients/ families and there is sadness when they pass, expected or unexpected.
71. Each child and family is a story worth telling. As a professional and a person, I am changed from having known them and being a part of the bittersweet process of life.

81. A woman died of CHP after surviving a CVA and making significant progress. She was always grateful—her husband continues to appreciate our services and stops to visit us regularly. These kind people are such a joy. The people make this work worthwhile. I can go on and on about more- others.

95. A few days before receiving the questionnaire I attended a funeral of a client. I hadn’t worked directly with Chris but had kept up because the therapist I work with had been in the home. Something unique about my situation is that I had known Chris for 16 of his 18 years. I’ve had the same caseload for 20 years. I know his parents, siblings, grandparents, aunts and uncles. A month ago at Brian’s funeral his MRDD school connections were there in a display of pictures, mentioned in the eulogy and his mother stood and thanked the school staff. For school age kids the biggest problem for me has been those kids in decline with feeding issues and respiration. Are they going to choke- is the mucous plug in their next breath? I also serve infants. I had a mother tell me years after she had lost her baby (Trisomy 18) that the therapists were the only people who could interact with her and her baby in a relaxed and normal way. She said that meant a lot to her to have someone who knows her baby as a person and not a tragedy. We also have several children who go through multiple crashes, more than 1 intervention by hospice- whom those children finally go and find that I’m very disturbed by this- it can feel more shocking than a sudden death.

96. Working in long term care, I feel I am helping people enjoy their last days to the fullest. I feel the patients have lived a long life; I am making their last days comfortable before they pass on from this world. When patients die, I do not feel sad, I am happy for them to be out of pain and to join other loved ones. They are at a happier place.

193. No specific story, but working with children who are under age 3 and diagnosed as “medically fragile”, I have a different philosophy and insight into their “family life” and what is really the most important aspect. Keeping the child as safe and healthy as possible, first priority: providing a fun learning environment that enhances their life… not taking my therapy so seriously, second priority and offering support to the family not just in my role as an SLP.

198. Dealing with family members of a deceased patient can be very rewarding.

201. One resident daughter wrote me a thank you card after her father’s death. She was grateful that I helped ease his suffering and was always kind to him.

186. I found solace in helping the adult patient (with anticipated death) to talk with family, resolve concerns and to be able to “say goodbye” in a loving manner. With a child it was comforting to remember their play, their smile, and the communication interaction (or ability to eat) that so gave the family unit hope. (sudden death).
167. Adult with cancer of the heart. She had tremendous strength and a positive outlook. She was very special. I had another adult who suffered a stroke. She had been an English teacher and once she found out that she would be able to totally repair speech, she gave up.

141. Yes. A stroke patient with Aphasia-age 60, was about to be discharged from his home visits. I arrived at his home and received no answer to my knock, or cell phone call. I knew he was inside because the storm doors were locked from the inside. I went to a neighbor to help me break in. The patient had had another stroke and was lying on the bathroom floor. He was barely alive. I called 911 and he was life flighted to the hospital. Had I not found him he would have died within a couple of hours. He never recovered but his family was very grateful to be able to be with him at his death. They didn’t want him to die alone. And yes, he was able to speak a little after the 2nd stork, so he said his good-byes.

148. 1. A student died suddenly in the summer. The parents were never satisfied with special services. When I went to the funeral, a family member asked me to leave, that was very difficult to deal with.

2. I went to the calling hours of an elderly woman with whom I worked on cognitive dysphagia. I talked to the family often. I went to support hem and show my respect/ sympathy to them.

235. At a memorial service my patient’s daughter hugged me and thanked me for helping here mom recapture her cognitive –language skills; she said her mom loved me and appreciated my friendly visits after she’d been discharged from treatment. It really reaffirmed my skills as a professional and human being.

236. Every time a patient of mine passes, I am very sad. It’s not the same kind of sadness that I feel with a family member passing however it is still unsettling. It is almost like I feel more for their family members and their loss. Working a hospital setting I see traumatic events effecting patients and their families lives everyday, it’s my job to help them through this time in anyway possible. I feel that obligation. To answer the question, I guess, No, they have all made an impact. Everyday is so different when you work in a hospital setting; I feel that is why I enjoy it so much. It’s real.

302. One very special child was Randy. He was born with multiple congenital anomalies. He was deaf, blind, breathed only with the help of a ventilator, etc. His mother’s wish was that he could use a switch to turn on a fan to blow out candles on a birthday cake because she wanted to have a “real” birthday party for him. Her wish was granted in March and she had a wonderful party. He died in June of that year. His mother said she was happy. Someone believed in her wish enough to make it happy. Never discount the dreams of parents. I experienced the loss of an infant of my own and of a grandchild. I think I have an empathy for families that comes from personal experience. Death in our culture is feared and frightening. Families need help finding comfort and peace. But hey also need to know that it is okay to grieve, to cry, to be angry. I will be there to hug and to listen whenever they need me.
311. We don’t realize how much like family we become to our patients or how much we really care. She just tuned 5 and I had been thinking about getting her ballet slippers since my mind’s eye could see her dance. CP kids don’t usually dance but I knew one day she would. I remember our last therapy session telling her that I could see her dance. A missed session. Another. Flu symptoms. A phone call at home- she was gone. Her mom and I cried. I still cry and I still call her mom to see how the family is doing. It’s hard to believe she’s gone.

345. I remember two people one had tongue cancer, the other had ALS. They were both very strong women who enjoyed life and a good laugh. I valued our time together and felt like I could offer an ear and some humor. I don’t work in a hospital setting anymore but I still hold some of my patients in my heart.

237. Each death is important and affects you in a different way. I find that the patient is grateful for any comfort you can give them whether it is to wipe their face with a cloth, clean out their dry mouth with a moist towelette, and hold their hand. I usually always try to say a prayer in my head for the m as I stand at their bedside. When you work with the elderly, death is very common but is never insignificant. At times I do feel sad when an old friend passes on but I also feel happy for them to see and end to their suffering. I have old friends I will never forget, Ralph, Eva, Ruth… They taught me life lessons that I still carry with me. I love my job and I love my “old” people who when you get to know them are really young at heart. They just look different.

4. Specific impact on professional views and job responsibilities

55. I was working with an elderly gentleman with dementia and dysphagia. He had recently had a sudden decline, and his intake wasn’t good. I was treating him at lunch one day when he patted my hand and said “I’m tired. Just let me go”. He knew he was dying and was at peace with it. I changed my view of the whole end of the process, how we as health care providers try so hard to “hold on” to people, even when their quality of life is poor. I feel we need to involve the patient’s values and wishes (along with the family). And educated them better regarding degenerative disease processes. Because, as you’ll find out, the physician’s don’t do it.

68. I wish more people would explore palliative care or hospice versus prolonging suffering. I also wish doctors would make a terminal diagnosis sooner so patient’s don’t suffer.

13. A patient in a nursing facility passed away. I came to see her not being informed prior to going to her room. Her roommate with Alzheimer’s disease was present. I sat and spoke with her for 30 minutes. She was lucid and desperately wanted to talk about her experience losing her roommate. Everyone else had ignored her assuming she didn’t realize what was happening. She was not my patient but she according to staff began to eat again and participle more in activities following our talk. She didn’t have family members who visited.

72. Not a particular patient but several- mostly the ALS patients. When you can improve the quality of life for any individual facing a devastating disease it is very rewarding.
Anger and frustration primarily at overall care- constraints made by providers- particularly Medicaid.

135. When I worked at a SNF, I had a patient who really did not want to be there. I used to take him outside on nice days and do therapy out there. He enjoyed being out of the facility temporarily. I hadn’t realized how sick he was, and when he passed away, I was glad I had provided him with some form of happiness in his last days. It served as a reminder to put the patients’ best interests first and not to get so caught up in our own agendas.

80. I experienced a resident who suddenly died because of a respiratory therapy student’s error in setting a ventilator. I did not sleep for days, felt very anxious, sad/tearful and guilty. I felt horrible for the resident, their family and for the respiratory therapist who accidentally made such a horrible mistake. I worried about that therapist grieving and depression and felt inadequate to provide professional support. I also felt very inexperienced and frightened when dealing with legal questioning from law enforcement and lawyers.

92. A family death has. I used my knowledge as a professional and knowledge of her to help maintain her involvement in things she thought were important to her, also to help provide oral comment. The hospice nurse involved in care never offered these types of tips but gave the response “that’s part of the natural course.” I try now to help add to my patient/ family comfort and studied about EOL issues. There I presented about SLP service at a cancer conference to help dispel myths.

184. I have experienced pt. deaths of children. The most impact it had on me was the day I would attend the funeral (usually with other staff) or calling hours. Attending with fellow employees helps you cope.

171. While I worked in skilled nursing facilities, I worked with several very sick people. Unfortunately several of my patients past away. However, I did not focus on the frustrations per say with the individual dying. I like to look at the situation as I was able to help that individual till the end have the best quality of life possible.

213. One of my experiences includes care for a family/patient whose young son was hospitalized after suicide attempt by hanging strangulation. His very limited recovery ultimately ended in death- a prolonged period of care leading to futility. Another patient in my memory was a gentleman post stroke, who actually passed an MBS- his only functional change in rehab- and began to eat meals. His smile was so rewarding. Heart failure lead to his demise the next day. I am not the chair person of our hospital Ethics committee and I have been involved in this ethics program/education for the past 7-8 years.

163. Did a MBS on a fairly intact 80 year old male, found significant aspiration could not elicit any effective protective strategies in rec. NPO until further intervention. This occurred on Friday and on coming in Monday, I learning via grapevine, he had died Sat. I communicated with MD and got little info re cause of death. Really made me push for better formalized communication between Hospital personal.
156. My most memorable was counseling CFY’s after the patient died shortly following their sessions or they walked in and found the pt. dead. These were in LTC settings and the deaths were not unexpected but not anticipated. I can also remember a couple year period of doing swallowing evaluations and treatment on patients who were at the end of life. Now I eval and the team (nurses, social work, dietary, ST, and MD) discuss hospice after my eval and I don’t put them on for the treatment now.

150. Many of the deaths have inspired me to try to be the best I could be as I witnessed much character, strength in little ones whose lives were often a tremendous hardship and struggle.

321. I am much more willing to speak with physician before making an elderly patient NPO recommendation; after 3-4 weeks of treatment of a 90 year old patient who was silently aspirating on MBS that was performed by me, the family still couldn’t not decide on a PEG tube and physician would not make a recommendation one way or another. Patient slowly dehydrated and became non-responsive; after 2 weeks, the patient’s family wanted a PEG but the patient was then too weak and unable with only IV nutrition. Patient eventually died, however, in mean time before non-responsiveness, I spend hours with patient and family EVERYDAY with patients begging for food or water. I still to this day think of this case and it bothers me as I can still see her eyes and the sadness that she experienced as a result of my recommendations- that was 4 ½ years ago!

290. A lady with 2 brothers had a CVA and was admitted to the hospital where I worked. I was close friends with one of the brothers, but the other was her POA. There were conflicts about providing a g-tube in the family and my friend was asking me for personal opinion as well as professional perspective on his sister. When she eventually died, I really had learned about how to deliver information in a way that isn’t swayed by personal opinion. Both brothers thanked me for being supportive.

326. I once called a physician to voice my concerns about a patient's swallowing. I told him that she was not safe for PO intake. He told me he would come and check on her the following morning. He did not; instead he transferred her case to another physician who never saw her. She choked the following night at dinner. I felt responsible, although I had followed my protocol and fully informed the physician.

367. Male patient, age 75 years came back from hospital to LTC setting with mechanical soft and thin liquid diet. SLP conducted bedside swallow evaluation. Patient passed test with flying colors. Two days later, respiratory treatment reported patient’s difficulty swallowing juice. SLP screened and evaluated patient with report of patient demonstrating no wallow reflex. Patient went to hospital for MBS, recommending NPO with G-tube placement with aspiration of all consistencies. Patient died on same day back to LTC facility from hospitalization for G-tube placement. This particular patient demonstrates to me as a therapist how crucial two days can be when someone is tailing that manner.

274. I had a patient die in the middle of a swallowing evaluation during which her daughter insisted on feeding her. The image of the patient has remained with me 5 year later. I am mostly frustrated by the whole thing because the doctor insisted on completion of the
evaluation despite my contention that the patient was too medically fragile. The patient’s
daughter blamed herself. I was able to look upon it objectively and realize that it was simply
coincidental that she happened to pass during the evaluation. Other staff members helped to
reinforce this notion.

5. First patient’s death

84. I did a graduate practicum at a VA with very damaged Vietnam Vets. Close to my age.
They were so devastated and depressed. It depressed me.

164. When I was a CFY, I was asked to do a bedside swallow evaluation on a man with severe
CP. He was nonverbal. He had intact eye gaze with me and I presented 1/8 tsp. of applesauce
and then stopped because he seemed to be refusing. And I wasn’t comfortable give anymore. I
went across the hall to see another pt. (this was in a SNF) and when I came out, the nurse said
“Mr. X.” just died. I went into shock and felt that I had killed him. The nurses tried to
reassure me that he had been going down hill, but it didn’t ease my guilt. I still remember his
gaze and am tormented that he may have been trying to tell me something and I didn’t
understand.

161. The first time I experienced the loss of a resident in a SNF/ECF/LTCF. The resident was
young, in her 60’s, and quite educated. She had a progressive disease, a form of MS. I was a.
frustrated that funding via Medicaid took months for an augmentative communication device
dynavox), b. presenting with mixed feeling of the progression of her disease, i.e. maybe I’ll be
relieved when she passes, or I’ll be very sad. I can’t tell you how much of an advocate I’ve
become for AAC in the geriatric population secondary to seeing the benefit of communication
she experienced following the months she had the device. She used the device for 11 months
before “expiring”. The first time I saw the word “expired” I became upset, I felt it was too
sterile, too insensitive. I’m used to it now. But now her son, who has the same disease, now
uses the device- I trained him along with his mother. To this day, and it’s been five years, I
miss her. I grew close because AAC training is very involved. And, even thought the process
is so very lengthy to apply for a device (and my employer won’t pay for all the time to write
the application because it’s not billable/productive time), I will take the paperwork home- it’s
that important to me because of her.

264. not really, but I remember the name of the first patient that died (over 20 years ago) and I
don’t remember the others- except for the children- I remember all of them!

270. At the onset of my career, I worked in a medical facility. Two of my adult / stroke
patients died within the first year. I was devastated. Consequently I left my position and
entered public education. This placement was such a positive move for me.

245. I had a client during my externship that had a 2nd stroke and was obviously dying
although he did not die during my externship. That’s when I knew I couldn’t work with the
elderly because, for me, I couldn’t stand that they had once been like me and were now dying.
However, the children I knew who died had been sick their entire lives. They never knew what
with was like to live without constant suffering, so, when they died, it was sad but knowing
they wouldn’t suffer anymore kept me from being so sad. There was actually an element of relief.

346. The very first head/neck cancer patient I treated was right after I got my masters (10 years ago). She was funny and sweet, and had severe dysphagia. I became attached to her and used to lie awake at night, trying to think of ways I could help her. When she died from the cancer, I was very sad for a while. I think I will always remember her. I treated her like she was my own family member, and try to do that daily.

248. I took my first job out of graduate school in a long term care facility. I certainly was not prepared for the impact death and dying would have on me as a professional. I will share with you my first experience with death and dying on the job. I had been treating a patient who had survived a stroke. He seemed to be doing very well with all of his therapies. Suddenly his behavior changed. He began refusing his therapies etc. I became very concerned about this patient. One morning on my thirty minute drive to work. I was thinking about him the entire time. I was the first therapist to attempt to treat him that morning. Upon entering his room I was unable to wake him, even with a good stern rub, etc. Then I noticed that his skin look yellow and his finger nails were blue. I ran to get the nurse. I thought he was possibly on stronger medication which sometimes makes it difficult to wake patient (In addition, I had no previous experience with death and dying and body was still warm). The nurse entered the room. When she came back and she told me that the patient had “expired”. This patient’s death was hard for all of the therapists. He had been doing so well. And his death was unexpected.

151. In my graduate studies, I worked with an older man who had had a laryngectomy. He complained during every session about his condition and how unfair it was. One day prior to our session, I saw him outside smoking. I felt angry that he cried during our sessions, still had cancer and was still smoking. Another case several years later involved a cardiac surgeon during his rehab for a stroke. He anticipated his death and felt defeated in all attempts at rehab.

6. Death of a child

14. I had a sudden death of 9 months old that I was treating for feeding issues. He had a heart condition but was doing very well, eating all his formula from a bottle and they had just removed the NG tube the day before his death. He sudden spikes a high fever and had seizures and died that night. The doctors think that the virus that attacked his heart at 1 month of age lay dormant and then something triggered it. Even though I know his death had nothing to do with is swallowing ability, it was still difficult to deal with. I tried to go to the service, but I couldn’t shuffle my patient around and we didn’t have other coverage.

18. Every death has been hard. The hardest was a 2 year old who had left my office 2 hours prior to aspirating- brain death occurrence- was in ethic meeting to determining of life timing- that death affected me the most.

153. I experienced the sudden death of a 4 year old patient, which made me appreciate the aging of other children and their overall health.
229. I lost a little girl who was only 2 years. She was the youngest death I faced. It was very sad and something you never forget. I saw here the day before she died and touching her, she was so warm and alive (although on machine). At the funeral home, I went to touch her and was shocked at the coldness. It really hit me then, that she was gone.

288. I unexpectedly lost an elementary student with severe scoliosis and was devastated. I knew he had scoliosis but never expected the complications to be life threatening. It was made more tragic knowing this family and 2 of their children, they lost 2 toddlers previously. I have a child now who is terminal. I’ve worked with her since age 3 and she is now 9. Knowing what lies ahead for her is unbearable. She has spinal muscular atrophy.

266. In 23 years, I have had many experiences with the death of a patient. I think the most difficult ones are the young patients, who have brain tumors with poor prognosis. I find it difficult to be detached and find that compassion and normalcy is what they are really looking for.

269. I often recall fond memories of the little girl who had a trach and I worked with on an inpatient unit for years. I think of her when I work with other kids with trachs.

333. The death of a baby is the hardest especially if it is due to a traumatic event. They do not have any control, but need others to keep them safe.

7. Other

227. I find it interesting in general that the more experience I have gained/ the longer I’ve been an SLP, that it affects me less and less, even if I was particularly close to the patient and/or family.

233. Early in my career death affected me much more but in last 5 to 8 years I have gotten older and have seen more I am able to separate work form my home life.

17. I do not have a story but I find my ALS patients the most emotionally draining.

59. I had a dream about 1 patient who had died. I saw him in heaven, walking and talking (things he had not done, other than saying a handful of individual words). He said “I know you don’t recognize me, but you used to take good care of me. “ I had a feeling of reassurance and a sense of accomplishment after that dream.

116. None that I can remember at this time.

325. I was raised around death my entire life. My father /family own a funeral home. My father is a funeral director/embalmer, my mother is also a funeral director on the side and my sister is now a funeral director too. My answer to this survey maybe a little skewed compared to the rest since I have a different outlook on death/dying.
354. Many-when a patient experiences multiple strokes it is hard to watch them struggle. One man appeared to a “medium” pastor- who told me he appreciated all the help I gave him.

359. Being able to help my patients maintain their communication through adaptive and technological means through the course of their terminal illness is a comfort to me. It helps to know that I’ve been able to help them communicate their thoughts, wishes, feelings, and desires regarding their cure and life support with family and medical staff.

244. I worked with therapist who has directly worked with individual on their caseload that has died.

275. No. But you don’t forget them even after they have passed.

286. I have not really been involved with patient death.

271. I love my job.

9. I have an 11 year old client who was dying. Hospice came to speak to a small group of people about death and dying, which was very informative, since then, this little boy has improved and his health appears to lie stable. I do not know if this will last of if he will once again be as sick as he was before. It was very hard on everyone involved.

20. No- “death” as normal-typical to be expected not as a surprising event. Death is a simple event. Separation of body from one’s spirit and soul life is short. Brief but a “vapor”. According to the God of the universe as recorded in Psalms. Who am I to question? Should they be in Heaven with Jesus they have never been better!