Training Healthcare Students for Resilience and Compassion in a Trauma-Informed Context: A Case Study from Grief and Loss Classes

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"Nurses eat their young." This statement shocked and confused me when I first heard it. It was six years ago, and I was just beginning to develop and teach courses for graduate nursing students. I wanted to make sure that the content I developed was relevant to the needs of my students, and so I spoke with as many nurses of all levels as I could—ASNs, advanced practice nurses, even CNOs. As I spoke with them, this shocking statement kept being repeated to me. What did it mean? It refers to the bullying of novice nurses, most frequently at the hands of experienced nurses. This practice, sometimes described as a rite of passage, is so pervasive that one study found that 73% of novice nurses experienced it in the previous month.[1] The Joint Commission even issued a Sentinel Event Alert that required its accredited hospital to develop processes to manage such bullying.[2] Yet, in the years that followed, the bullying has only increased, especially with the healthcare climate surrounding the COVID-19 pandemic.[3]

People who have a high sense of empathy commonly choose caring professions, like nursing.[4] So why might this demographic, which leans towards agreeable, conscientious, pro-social, empathetic behavior, later become some of the ones who engage in the bullying of novice nurses?[5] This dissonance is explained by studies that show that empathy in healthcare

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[1] P. A. Berry, G. L. Gillespie, D. Gates, and J. Schafer, "Novice Nurse Productivity Following Workplace Bullying," *Journal of Nursing Scholarship* 44, no. 1 (2012): 80–87, https://doi.org/10.1111/j.1547-5069.2011.01436.x

[2] G. L. Gillespie, P. L. Grubb, K. Brown, M. C. Boesch, and D. Ulrich, "'Nurses Eat Their Young': A Novel Bullying Educational Program for Student Nurses," *Journal of Nursing Education and Practice* 7, no. 7 (2017): 11–21, https://doi.org/10.5430/jnep.v7n7p1

[3] Panagiotis Galanis, Ioannis Moisoglou, Athina Katsiroumpa, Irene Vraka, Olga Siskou, Ourania Konstantakopoulou, Evanthia Meimeti, and Daphne Kaitelidou, "Increased Job Burnout and Reduced Job Satisfaction for Nurses Compared to Other Healthcare Workers after the COVID-19 Pandemic," *Nursing Reports* 13, no. 3 (August 14, 2023): 1090–1100, https://doi.org/10.3390/nursrep13030095

[4] M. F. Jiménez-Herrera et al., "Emotions and feelings in critical and emergency caring situations: a qualitative study," *BMC Nursing* 19 (2020): 60, https://doi.org/10.1186/s12912-020-00438-6

[5] Abd El Aziz, A., E. Taha, F. Ramadan, and O. Badr. "Self-Directed Learning Readiness Level and Personality Traits Among Nursing Students." *Alexandria Scientific Nursing Journal* 24, no. 3 (September 2022): 40-50. https://doi.org/10.21608/asalexu.2022.267754
Yu, H., S. Choi, and L. Dix. "Undergraduate Nursing Students' Personality and Learning Effectiveness in High-Fidelity Simulation Education." *Journal of Nursing Education* 64, no. 4 (2025): 215–223. https://pubmed.ncbi.nlm.nih.gov/40199167/

students and workers can decline over time—for healthcare students, it can correlate with their introduction to clinical experience.[6] This decline in empathy is often related to a growing sense of cynicism that healthcare students or workers feel about their profession and the practice of their profession.

Cynicism vs. Empathy

What are some factors that contribute to this cynicism? Studies show that heavy workload (understaffing, high metrics/targets), time constraints/long hours, minimal control over schedule, cognitive load, high stress, patient complexity, repeated exposure to suffering, vicarious traumatization, emotional exhaustion, workplace environment (including bullying and workplace violence), and organizational pressures are systemic factors that contribute to cynicism and undermine a capacity for empathy.[7] As a result, healthcare workers can develop a maladaptive coping mechanism in which empathy is replaced by depersonalization, in order to shield themselves from the emotional/mental/physical stress and exhaustion of their work.[8]

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[6] Ward, Janet, Kerry Cody, Mary Schaal, and Mohammadreza Hojat. "The Empathy Enigma: An Empirical Study of Decline in Empathy Among Undergraduate Nursing Students." *Journal of Professional Nursing* 28, no. 1 (2012): 34–40. https://doi.org/10.1016/j.profnurs.2011.10.007
Ferri, Paola, Eleonora Guerra, Luigi Marcheselli, Laura Cunico, and Rosaria Di Lorenzo. "Empathy and Burnout: An Analytic Cross-Sectional Study among Nurses and Nursing Students." *Acta Biomedica Atenei Parmensis* 86, no. Supplement 2 (2015): 104-115.

[7] Yu, Chou Chuen, Laurence Tan, Mai Khanh Le, Bernard Tang, Sok Ying Liaw, Tanya Tierney, Yun Ying Ho, Beng Eng Evelyn Lim, Daphne Lim, Reuben Ng, Siew Chin Chia, and James Alvin Low. "The Development of Empathy in the Healthcare Setting: A Qualitative Approach." *BMC Medical Education* 22 (2022): 245. https://doi.org/10.1186/s12909-022-03312-y
Charles, J. C., B. Sivayokan, and T. Kumanan. "Decline in Empathy among Healthcare Workers; Where Have All the Flowers Gone?" *Asian Journal of Internal Medicine* 3, no. 2 (2024): 47-51. https://doi.org/10.4038/ajim.v3i2.184
In addition, a systematic review of 16 qualitative studies that probed into the decline of empathy in medical students through the course of medical school found several more contributing factors. Some of these were the prevalence of a "hidden curriculum" of informal norms that modeled detachment and cynicism, along with the example of clinicians who practiced this, and an organizational structure that prioritized technical aspects over the "human touch." Howick, Jeremy, Maya Dudko, Shi Nan Feng, Ahmed Abdirashid Ahmed, Namitha Alluri, Keith Nockels, Rachel Winter, and Richard Holland. "Why Might Medical Student Empathy Change Throughout Medical School? A Systematic Review and Thematic Synthesis of Qualitative Studies." *BMC Medical Education* 23 (2023): 270. https://doi.org/10.1186/s12909-023-04165-9

[8] Christina Maslach and Susan E. Jackson, "The Measurement of Experienced Burnout," *Journal of Occupational Behavior* 2, no. 2 (1981): 99–113, https://doi.org/10.1002/job.4030020205: "The intense involvement with clients required of professional staff in various human service institutions includes a great deal of emotional stress, and failure to cope successfully with such stress can result in the emotional exhaustion syndrome of burn-out, in which staff lose all feeling and concern for their clients and treat them in detached or even dehumanized ways"; also, "as their emotional resources are depleted, workers feel they are no longer able to give of themselves at a psychological level" (99).
These findings are also supported by more recent studies: Cristina Delgado, Cristian Pérez-Ferra, David Álvarez-Fernández, and José Luis Lorenzo-Lledó, "Understanding the Links between Inferring Mental States, Empathy, and Burnout in Medical Contexts," *Healthcare* 9, no. 2 (2021): 158, https://doi.org/10.3390/healthcare9020158; and

However, depersonalization is actually a coping mechanism that contributes to burnout, whereas maintaining empathy and an emotional connection to patients shields against burnout because it correlates to a high sense of purpose in one's job (which is the opposite of what is found in burnout).[9]

We want healthcare workers who show compassion. For example, in the AdventHealth system, one of our service standards is to treat others with uncommon compassion. But if healthcare systems are set up in a way that leads workers to burnout, and if we don't train healthcare workers in how to manage the emotional burden of their jobs, even compassionate healthcare workers can turn to depersonalization and cynicism just to survive. If this is the case, then "uncommon compassion" will become increasingly uncommon. I believe, therefore, that just as important as it is to teach our healthcare students to be compassionate, it is equally important to train them to be resilient. This will enable them to maintain their compassion, even when they face the harsh workplace realities that seem to be systemic to healthcare. This is why I have chosen to combine both compassion and resilience in the topic for this paper.

Training for Compassion

First, a brief look at the need for compassion in healthcare. "Compassion is defined as the emotional response to another's pain or suffering, involving an authentic desire to help," and it is decreasing in healthcare and in society.[10] "Studies show that in both primary care and hospital settings, physicians miss opportunities to respond with compassion in as many as 70% of encounters," and that up to three-quarters of patients self-report experiencing a lack of compassion from physicians.[11] Yet it is proven that hospitals with high patient-reported "experience scores" have greater profitability, and more employee satisfaction with less

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Sarah E. Brown and Mark R. Stewart, "The Association between Burnout and Medical Professionalism in Medical Trainees: A Systematic Review," *BMC Medical Education* 25, no. 1 (2025): 7687, https://doi.org/10.1186/s12909-025-07687-6.

[9] Maslach and Jackson, "The Measurement of Experienced Burnout," 100. HARBOUR.

[10] Stephen Trzeciak and Anthony Mazzarelli, *Compassionomics: The Revolutionary Scientific Evidence That Caring Makes a Difference* (Gainesville, FL: Studer Group, 2019), xiii.

[11] I. Lains, T. J. Johnson, and M. W. Johnson, "Compassionomics: The Science and Practice of Caring," *American Journal of Ophthalmology* 259 (2024): 16. Continuing to quote this source: "This problem may have its roots in poor listening skills, as a recent study reported that during health interviews, clinicians interrupted the patient after a median of 11 seconds. Although medical education ideally would nurture compassion skills in young physicians-in-training, the opposite appears to be true—a systematic review found that empathy declines among trainees in proportion to the number of years spent in medical school and residency. Another systematic review suggests that the compassion crisis only intensified during the coronavirus pandemic, with multiple potential contributing factors such as masking, decreased social interaction, and lack of physical contact."

turnover.[12] There is also correlation between patients who feel that they have received compassionate care and better clinical outcomes.[13] This in part is because "empathy fatigue and a lack of compassion are associated with lower quality of care and increased odds that clinicians will make major medical and surgical errors, with one study reporting that the higher their depersonalization score, the more likely physicians are to self-report substandard care."[14]

Thankfully, neuroscientific evidence shows that, even though some people may possess more empathy or compassion innately, both empathy and compassion are trainable skills that are strengthened through intentional and repeated practice.[15] There are a number of ways proven to build compassion, and it is preferable for compassion education to begin in the earliest stages of healthcare training, "so that compassionate care becomes a core part of . . . professional identity formation" rather than an optional or remedial skill learned later.[16] Some methods that are used in compassion training are hands-on practice in building empathetic communication skills, reflective and narrative practice, peer-support compassion modelling, and mindfulness and self-compassion training.[17]

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[12] Deloitte Center for Health Solutions, *The Value of Patient Experience: Hospitals with Better Patient-Reported Experience Perform Better Financially* (Washington, DC: Deloitte LLP, 2016), 1-4, https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-dchs-the-value-of-patient-experience.pdf
According to Lains, Johnson, and Johnson, "Compassionomics," "Hospitals with a patient-centered culture of compassion receive higher patient satisfaction scores, and higher patient ratings are in turn associated with higher profit margins. . . In addition, a culture of compassion boosts productivity by reducing employee absenteeism, turnover, and burnout" (18).

[13] "The Role of Compassionate Care in Medicine: Toward Improving Patients' Quality of Care and Satisfaction," *Journal of Surgical Research* 289 (2023), https://doi.org/10.1016/j.jss.2023.03.024
This better clinical outcome can even be measured by things such as faster wound healing and overall patient well-being: Stephen G. Post, "Compassionate Care Enhancement: Benefits and Outcomes," *International Journal of Person-Centered Medicine* 1, no. 4 (December 2011): 808-13, https://ijpcm.org/index.php/IJPCM/article/view/153

[14] Lains, Johnson, and Johnson, "Compassionomics," 18, also states that "1 study found that higher levels of depersonalization and emotional exhaustion (which are directly linked to a lack of compassion) are associated with 54% higher odds of committing a major medical error."

[15] Ibid., 19.

[16] Shane Sinclair et al., "Compassion Training in Healthcare: What Are Patients' Perspectives on Training Healthcare Providers?" *BMC Medical Education* 16 (2016): 5, 7, https://doi.org/10.1186/s12909-016-0695-0

[17] Here is a sampling of sources that describe proven methods of compassion training: Helen Riess, Jodi Kelley, Robert Bailey, Emily Dunn, and Margaret Phillips, "Empathy Training for Resident Physicians: A Randomized Controlled Trial of a Neuroscience-Informed Curriculum," *Academic Medicine* 87, no. 9 (September 2012): 1072–81, https://doi.org/10.1097/ACM.0b013e3182583382; Beth A. Lown and Cathy F. Manning, "The Schwartz Center Rounds: Evaluation of an Interdisciplinary Approach to Enhancing Patient-Centered Communication, Teamwork, and Provider Support," *Academic Medicine* 85, no. 6 (June 2010): 1073–81, https://doi.org/10.1097/ACM.0b013e3181dbf741; Andrés Gutiérrez-Carmona, Marta González-Pérez, María Dolores Ruiz-Fernández, Ángela María Ortega-Galán, and Diego Henríquez, "Effectiveness of Compassion Training on Stress and Anxiety: A

Training for Resilience

As was mentioned before, healthcare workers need training not only in compassion but in resilience, so that that their compassion can persist in the face of factors that might more naturally lead them to maladaptive coping mechanisms and reduced compassion.[18] The numbers are grim on this front. "Newly licensed registered nurses are particularly vulnerable to psychological distress and turnover, with roughly 1 in 3 new nurses leaving the profession within the first 2 years after graduation" (and this was before COVID-19).[19] And according to a 2023 *Nursing Reports* sample, "91.1% of nurses experienced high levels of burnout, while the respective percentage for the other HCWs [healthcare workers] was 79.9%."[20] Tragically, physicians experience the highest suicide rate of any profession, around double the rate as the

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Pre-Experimental Study on Nursing Students," *Nursing Reports* 14, no. 4 (2024): 3667-76, https://doi.org/10.3390/nursrep14040268; Jon Krasner, Margaret Epstein, John Beckman, Gretchen Suchman, Robert Chapman, Paul Mooney, and Anthony Quill, "Association of an Educational Program in Mindful Communication With Burnout, Empathy, and Attitudes Among Primary Care Physicians," *JAMA* 302, no. 12 (2009): 1284–93, https://doi.org/10.1001/jama.2009.1384
It is important to mention, however, that it is not uncommon for mindfulness-based programs to also produce meditation-related adverse effects (MRSEs), making the other types of compassion training safer options. See Willoughby B. Britton, Jared R. Lindahl, David J. Cooper, Nicholas K. Canby, and Roman Palitsky, "Defining and Measuring Meditation-Related Adverse Effects in Mindfulness-Based Programs," *Clinical Psychological Science* 9, no. 6 (2021): 1185-1204, https://doi.org/10.1177/2167702621996340

[18] Healthcare workers are known to succumb to maladaptive coping mechanisms in order to survive workplace stress and trauma. One of these, unfortunately, is substance abuse. A 2022 study in the *Journal of Nursing Regulation* reported that 18% of the nurses screened positive for substance abuse problems (see Trinkoff, et al., "The Prevalence of Substance Use and Substance Use Problems in Registered Nurses: Estimates from the Nurse Worklife and Wellness Study," *Journal of Nursing Regulation* 12, no. 4 [2022]: 35–46, https://doi.org/10.1016/S2155-8256(22)00014-X). For many of these, such destructive habits were initiated once they began their work in healthcare, and an increasing number of healthcare workers divert drugs from their workplaces to support their habits (see Wolters Kluwer, *The State of Drug Diversion 2023 Report* [Wolters Kluwer Health, 2023], https://www.wolterskluwer.com/en/expert-insights/the-state-of-drug-diversion-2023-report).

[19] Cheryl T. Kovner, Cynthia S. Brewer, Faranak Fatehi, and Jung Jun, "What Does Nurse Turnover Rate Mean and What Is the Rate?" *Policy, Politics, & Nursing Practice* 15 (2014): 64–71, https://pubmed.ncbi.nlm.nih.gov/24477752/

[20] Panagiota Galanis, Ioannis Moisoglou, Aggeliki Katsiroumpa, Ioanna Vraka, Olympia Siskou, Ourania Konstantakopoulou, Eleni Meimeti, and Dimitra Kaitelidou, "Increased Job Burnout and Reduced Job Satisfaction for Nurses Compared to Other Healthcare Workers after the COVID-19 Pandemic," *Nursing Reports* 13, no. 3 (2023): 1090–1100, https://doi.org/10.3390/nursrep13030095
Additionally, this sample showed that "61.0% of nurses experienced low levels of satisfaction, while the respective percentage for the other HCWs was 38.8%."

general population in the U.S., with suicidal ideation increasing approximately 4-fold during the first 3 months of residency training."[21]

Of course, it would be ideal to have a system-wide change in healthcare to address the institutional factors that lead to such negative outcomes, and to provide better support for the inevitable secondary traumatization that is part of healthcare. But as we work and hope for such changes, can we not as educators prepare our healthcare students for the realities that will currently lie ahead of them? In addition to compassion, can we teach them resilience? "Resilience is defined as the ability to adapt successfully in the face of trauma, adversity, tragedy or significant threat," and it goes far to mitigate the negative emotional effects of working in a healthcare profession.[22]

There are many methods of training for resilience that have been used for healthcare workers. Resiliency training programs show good results in increasing resilience, coping, and quality of life, and decreasing stress, anxiety, PTSD symptoms, and burnout.[23] Common themes of many resilience training programs include distress tolerance training, finding social support, identifying meaning in your life, learning good coping skills, promoting positive emotions, stress management, and teaching flexible thinking.[24] Some techniques that are used for resilience

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[21] Patrick Anderson, "Physicians Experience Highest Suicide Rate of Any Profession," *Medscape*, May 7, 2018, https://www.medscape.com/viewarticle/896257
Srijan Sen, Henry R. Kranzler, John H. Krystal, et al., "A Prospective Cohort Study Investigating Factors Associated with Depression During Medical Internship," *Archives of General Psychiatry* 67, no. 6 (2010): 557–565, https://doi.org/10.1001/archgenpsychiatry.2010.41

[22] Gopi Rakesh, Kelsey Pier, and Thomas L. Costales, "A Call for Action: Cultivating Resilience in Healthcare Providers," *American Journal of Psychiatry Residents' Journal* 12, no. 4 (2017): 3, https://doi.org/10.1176/appi.ajp-rj.2017.120402

[23] For example, a virtual resilience group-coaching program was conducted at a major urban healthcare system at the height of COVID-19. In only 6-7 weeks, the results showed moderate increase in resilience and decrease in stress, anxiety, and burnout. Kelly E. Davison, Claire E. Connolly, Rebecca B. Manu, et al., "Assessment of Resilience Training for Hospital Employees in the Era of COVID-19," *JAMA Network Open* 6, no. 7 (2023): e2319276, https://doi.org/10.1001/jamanetworkopen.2023.19276
This study looked at ICU nurses who completed a 12-week resilience program, and who reported reduced PTSD symptoms and burnout, and improved coping and quality of life as a result: Meredith Mealer, Christee Conrad, and Marc Moss, "The Effect of a Resilience Training Program on ICU Nurses," *American Journal of Critical Care* 23, no. 6 (2014): 529–538, https://doi.org/10.4037/ajcc2014747
See also Mark Kirby, Angela W. Clow, and Elizabeth McIntyre, "Resilience Among Healthcare Staff: A Randomized Controlled Trial of a Digital Training Program," *Journal of Occupational Health Psychology* (2025), https://doi.org/10.1007/s10880-025-10085-1

[24] This list comes from: "Resilience Training: What It Is, How It Works & Exercises," *Cleveland Clinic*, last modified February 19, 2025, https://my.clevelandclinic.org/health/treatments/17799-resilience-training
Mindfulness training is also listed here, but with that there are potential adverse effects that make other options more favorable. See the end of footnote 17.

training are cognitive-behavioral therapy, emotional regulation training, psychological education, relaxation practice, self-compassion and gratitude skill training. Other important habits that support resilience can include reframing challenges as opportunities for growth, prioritizing tasks, taking "time out periods," and engaging in hobbies.[25]

Compassion and Resilience in the Context of Grief and Loss Classes

For the past six years I have taught Religion courses to primarily healthcare students, and have included components of compassion and resilience training in my courses. Most recently my focus has been teaching Grief and Loss classes at AdventHealth University—mostly to students in nursing, but also in chaplaincy, radiography, occupational therapy, physical therapy, pre-med, and other allied health fields. Training in compassion and resilience is well suited for the topics of grief and loss, because compassion is vital when caring for grieving patients and families, and because resilience is necessary in order for healthcare workers to maintain their compassion.

Specifically when dealing with grief and loss, however, a new issue emerges that can block compassion and resilience, and that is unaddressed provider grief. It is not uncommon for a patient's grief or family's loss to remind a healthcare worker of a grief or loss in their own past, and if they have not addressed this loss, it can be a very difficult situation emotionally. It can cause healthcare workers to start depersonalizing their patient in order to cope, which leads to less empathy and compassion, and in time, less resilience (and more burnout).[26] An integrative study of relevant literature (nearly 97 documents) concluded that:

> Working closely with pain and the process of dying involves healthcare workers on a personal and human level before a professional one. If this suffering is not recognized and

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[25] Julika Zwack and Jochen Schweitzer, "If Every Fifth Physician Is Affected by Burnout, What About the Other Four? Resilience Strategies of Experienced Physicians," *Academic Medicine* 88, no. 3 (2013): 382–389, https://doi.org/10.1097/ACM.0b013e318281696b

[26] Danai Papadatou in "A Proposed Model of Health Professionals' Grieving Process," *Death Studies* 24, no. 8 (2000): 683–699, https://doi.org/10.1080/07481180050121442 shows that when providers suppress or deny their grief feelings, it can cause them to emotionally distance themselves from patients and their families as a coping mechanism (this is most acute when they are caring for patients whose particular grief reminds them of their own unaddressed grief). According to him, unaddressed grief also reduces providers' capacity for resilience, because it leads to "emotional depletion" which leaves one with less capacity to cope with new losses or stresses.
Charles R. Figley, in *Treating Compassion Fatigue* (New York: Brunner-Routledge, 2002), 3, also describes the tendency of providers to begin emotionally distancing themselves from grieving patients when they themselves are carrying their own unprocessed grief.
And Mary L.S. Vachon, "Staff Stress in Hospice/Palliative Care: A Review," *Palliative Medicine* 34, no. 5 (2020): 589–601, https://doi.org/10.1177/0269216320907064, who shows that cumulative grief among healthcare workers predicts higher burnout and lower resilience.

addressed, it can cause a series of difficulties that affect the health of the worker and the healthcare of the patient and their family.[27]

Indeed, studies show that unaddressed provider grief leads to depersonalization of patients, reduced quality of patient care, increased absenteeism and turnover, lowered morale, decreased productivity, and greater risk of long-term health problems among staff.[28] Unaddressed grief in healthcare workers is also associated with sleep disturbance, reduced cognitive ability, impaired judgment, feelings of isolation, anger, and guilt, loss of self-worth and sense of meaning in life.[29]

Elisabeth Kübler-Ross, who transformed end-of-life care, herself wrote that "working through the fears, pains, angers, hurts, and unfinished business from [one's] own past" clears the ways "to work better with dying patients and/or other people."[30] Studies show that written or spoken self-disclosure of traumas (which can include grief and loss) can reduce stress, strengthen the immune system, reduce physical and emotional distress, and lead to better health (with fewer physician visits).[31] This is because verbalizing emotional pain reduces amygdala activation, which moves one away from limbic reactivity by instead activating parts of brain that deal with language and meaning.[32] There are various formal and informal ways of

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[27] Corradi-Perini, C., J. R. Beltrão, and U. R. V. C. O. Ribeiro. "Circumstances Related to Moral Distress in Palliative Care: An Integrative Review." *American Journal of Hospice and Palliative Care* 38 (2021): 1391–1397. https://doi.org/10.1177/1049909120978826
This literature review is from 2015 to 2020.

[28] See Anderson, R., & Collins, M. (2015). Managing grief and its consequences at the workplace. In S. Patole (Ed.), *Management and leadership: A guide for clinical professionals* (pp. 288–293). Springer International Publishing. https://doi.org/10.1007/978-3-319-15377-4_33. See Boerner, K., Gleason, H., & Jopp, D. S. (2017). Burnout after patient death: Challenges for direct care workers. *Journal of Pain and Symptom Management, 54*(3), 317–325. https://doi.org/10.1016/j.jpainsymman.2017.06.006. See Schulz, M. (2017). Taking the lead: Supporting staff in coping with grief and loss in dementia care. *Healthcare Management Forum, 30*(1), 16–19. https://doi.org/10.1177/0840470416658482

[29] Wenzel, J., Shaha, M., Klimmek, R., & Krumm, S. (2011). Working through grief and loss: Oncology nurses' perspectives on professional bereavement. *Oncology Nursing Forum, 38*(4), E272–E282. https://doi.org/10.1188/11.ONF.E272-E282. See also Fallek, R., Tattelman, E., Browne, T., Kaplan, R., & Selwyn, P. A. (2019). Helping health care providers and staff process grief through a hospital-based program. *American Journal of Nursing, 119*(7), 24–33. https://doi.org/10.1097/01.NAJ.0000569332.42906.e7

[30] Elisabeth Kübler-Ross Center, *Shanti Nilaya Newsletter*, no. 51 (Fall 1992), Head Waters, VA.

[31] James W. Pennebaker, Janice K. Kiecolt-Glaser, and Ronald Glaser, "Disclosure of Traumas and Immune Function: Health Implications for Psychotherapy," *Journal of Consulting and Clinical Psychology* 56, no. 2 (1988): 239–245.

[32] For example, the right ventrolateral prefrontal cortex. See Matthew D. Lieberman, Naomi I. Eisenberger, Molly J. Crockett, Steven M. Tom, Jennifer H. Pfeifer, and Baldwin M. Way, "Putting Feelings Into Words," *Psychological Science* 18, no. 5 (2007): 421–428, https://doi.org/10.1111/j.1467-9280.2007.01916.x

doing this. Of course, one may work with a therapist or through an evidence-based program of grief recovery with a certified grief coach.[33] Yet even opening up to a trusted friend or advisor has been found to have significant mental health benefits.[34]

Trauma-Informed Pedagogy

As important as it may be, in a class about grief and loss, to help students address their own grief in order to grow in their compassion and resilience, a lingering concern may be left. Might such an exercise unnecessarily retraumatize students?[35] This is where trauma-informed pedagogy enters in. "Trauma-informed pedagogy (TIP) is an educational approach designed to recognise and respond to the impact of trauma on students, fostering supportive learning."[36] Its methods can help instructors who deal with uncomfortable topics (such as grief and loss) do so in a way that is maximally effective and minimally triggering.

When surveying literature on TIP, many of its methods can be explained by these five core concepts: safety, predictability, voice and choice, flexibility, and connection.[37] The following

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[33] John W. James and Russell Friedman, *The Grief Recovery Handbook: The Action Program for Moving Beyond Death, Divorce, and Other Losses Including Health, Career, and Faith*, 20th Anniversary Expanded ed. (New York: William Morrow/HarperCollins, 2009).
The Grief Recovery Method is evidence-based because of research conducted at Kent State University, published in these two articles: Rachael D. Nolan and Jeffrey S. Hallam, "Construct Validity of the Theory of Grief Recovery (TOGR): A New Paradigm toward Our Understanding of Grief and Loss," *American Journal of Health Education* 50, no. 2 (2019): 88–98, https://doi.org/10.1080/19325037.2019.1571964. And, Rachael D. Nolan and Jeffrey S. Hallam, "Measurement Development and Validation for Construct Validity of the Treatment: The Grief Recovery Method® Instrument (GRM-I)," *American Journal of Health Education* 50, no. 2 (2019): 99–111, https://doi.org /10.1080/19325037.2019.1571962

[34] Pennebaker, Kiecolt-Glaser, and Glaser, "Disclosure of Traumas and Immune Function."
Dixon Chibanda et al., "The Friendship Bench Programme: A Cluster Randomised Controlled Trial of a Brief Psychological Intervention for Common Mental Disorders Delivered by Lay Health Workers in Zimbabwe," *International Journal of Mental Health Systems* 9, no. 21 (2015): 21, https://doi.org/10.1186/s13033-015-0013-y

[35] Jennifer Carello and Lisa D. Butler, "Potentially Perilous Pedagogies: Teaching Trauma Is Not the Same as Trauma-Informed Teaching," *Journal of Trauma & Dissociation* 15, no. 2 (2014): 153–168, https://doi.org/10.1080/15299732.2014.867571

[36] Rafael Venson and Ann-Sophie Korb, "Trauma-Informed Pedagogy in Forensic Science Education: Scoping Review of and Reflection on (Very Limited) Available Evidence," *Science & Justice* 65, no. 1 (2025): 21–26, https://doi.org/10.1016/j.scijus.2024.12.003
Drawing in great measure from this resource—Substance Abuse and Mental Health Services Administration, *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*, HHS Publication No. (SMA) 14-4884 (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014)—trauma-informed pedagogy relates the study of trauma and adverse childhood experiences (ACEs) to education.

[37] Distilled from the sources in footnotes 35, 36, 38, and 39, and from these guidelines for professors: University of Oregon, "Trauma-Informed Pedagogy (TIP)," Teaching Engagement Program, accessed November 10, 2025, https://teaching.uoregon.edu/resources/trauma-informed-pedagogy-tip

fourteen strategies are aligned with TIP and would be helpful for courses on grief and loss, where topics that may feel traumatic to students are brought up. They are all strategies I have used, am using, or would like to use in the future. I have categorized them under the five core concepts of TIP that I mentioned above.

Safety

1. Include a syllabus statement: "As an instructor, one of my responsibilities is to create a safe learning environment. I will try my best to be open about my expectations and to provide choice in my assignments. If you experience stress related to the coursework, please speak with me. If you are experiencing stress from things outside the class, XXX provides free and confidential counseling services."[38]

2. Watch for signs that students may be uncomfortable and reach out to them proactively in order to address their concerns and offer support.

3. Provide further resources for support. Make accessibility very easy for students to reach out to instructors, to campus chaplains and therapists, and to chaplains, therapists, and certified grief coaches who have successfully worked in these courses. I have done this by including appointment buttons on the online learning platform and by sending students a list of additional vetted resources.

Predictability

4. Provide clear assignment directions and grading criteria (rubrics). Include in the instructions the rationale for the assignment. This gives students a sense of clarity, understanding, and purpose.

5. Maintain a consistent routine or schedule. In my classes, submissions are always due twice a week (mid-week and end-of-weekend). Quizzes are always due Sunday night. This helps students establish routines and habits, which promotes a sense of stability and security.

6. For assignments that may be more emotionally activating, give notice ahead of time so students can mentally/emotionally prepare for them. I do this by adding a segment called "PREPARE" to the schedule a few weeks before one of these assignments is due. (TIP speaks of adding trigger warnings to more emotionally activating assignments.)

[38] Rebecca L. Gunderson, Christina F. Mrozla-Toscano, and David M. Mao, "An Instructor's Guide for Implementing Trauma-Informed Pedagogy in Higher Education," *The Journal of Faculty Development* 37, no. 2 (2023): 80–86. The following points are partially drawn from this resource as well.

Voice and Choice

7. Provide students choices on assignments that can be emotionally activating. In my classes, many submissions can either be written, or audio or video recorded. One assignment now has the option of completing a checklist instead. For another assignment in which students describe a grief they have experienced in life, they are given the option to have a conversation with their instructor, with a chaplain, or with a therapist instead of submitting a paper or recording. In my classes, I always make it clear that if an assignment seems too difficult emotionally, an adjustment to the assignment will be made for students if they reach out with their concerns beforehand.
8. Intersperse self-care tips and reminders throughout, especially with the more emotionally weighty assignments. Always remind students that the instructors care about them, and encourage them to reach out if they want to talk about anything.
9. In every conversation (verbal or written), normalize and validate student's feelings.

Flexibility

10. Balance the schedule so that emotionally activating assignments are surrounded by assignments that are more emotionally neutral. Assign less work for the weeks when there are videos/readings/assignments that may be more emotionally activating.
11. Provide flexible due dates for those impacted by trauma.

Connection

12. Before the term begins, send an email to students welcoming them to class, introducing them to the purpose of the course, alerting them to the fact that we will be studying some emotionally sensitive topics, and inviting them to reach out to their instructor for support, questions, or just to get acquainted (include contact info). Include the syllabus as an attachment. This helps to reduce anxiety by setting the tone for what they can expect in class.
13. Establish meaningful relationships with students. This is fostered by a small student-to-teacher ratio, ideally no greater than 20:1 in order to offer trauma-informed support. It is also fostered by creating early assignments that facilitate the establishment of a trusting and friendly relationship between student and teacher, by providing personal feedback on submissions, and by choosing caring teachers with strong interpersonal skills for classes such as these.[39]

[39] Perhaps the most important is that all who work in classes that deal with potentially traumatic content should exhibit a high level of empathy, for it truly makes a difference! A qualitative study of nursing faculty found that

14. Promote allyship and support of one another. I have done this through student grief support groups, and through setting a supportive tone on the discussion boards.

Conclusion

Healthcare workers frequently enter their professions motivated by empathy and a desire to care for others, yet the realities of practice—heavy workloads, repeated exposure to suffering, organizational pressures, and sometimes even bullying—can erode that initial compassion and lead to cynicism. This decline, however, is not inevitable. As explored in this paper, training that intentionally fosters both compassion and resilience can help healthcare workers maintain their emotional connection to patients while protecting themselves from burnout and depersonalization.

Incorporating grief and loss education into healthcare curricula provides a meaningful opportunity to cultivate these skills. And when students are supported in addressing their own experiences of grief in a safe, trauma-informed environment, they can grow both personally and professionally. Trauma-informed pedagogy, emphasizing safety, predictability, voice and choice, flexibility, and connection, offers a practical framework for guiding these sensitive learning experiences without causing harm.

Ultimately, preparing students to navigate the emotional demands of healthcare is as critical as teaching clinical skills, if we consider the whole-person wellbeing of both the healthcare providers and the patients. When compassion and resilience are nurtured together, healthcare workers are better able to provide thoughtful, high-quality care, sustain their own well-being, and thrive even in challenging healthcare environments. Investing in this dual training is an investment not only in the individual caregiver but in the humanity and quality of care within the healthcare system as a whole.

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empathetic behavior from teachers increased student nursing learning motivation, making it easier for students to express questions and worries and role model professional behavior and development. Conversely, a lack of empathy from teachers increased student mental distress and fear and reduced motivation for learning. This is a significant finding as empathy is not an extra or a soft skill; it is a valid and reliable pedagogical strategy to increase student success." Marie Arbour, Kate Walker, and Jennifer Houston, "Trauma-Informed Pedagogy: Instructional Strategies to Support Student Success," *Journal of Midwifery & Women's Health* 69, no. 1 (2024): 25–32, https://doi.org/10.1111/jmwh.13539