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UNDERSTANDING ONCOLOGY NURSES' GRIEF: A QUALITATIVE META-ANALYSIS

BY

LISA CAVELL BARBOUR

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Lisa Barbour

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The thesis examination committee certifies that the thesis
and the oral examination is approved

Supervisor:

Dr. Beth Perry
Athabasca University

Committee members:

Dr. Katherine Janzen
Mount Royal University

Dr. Paul Jerry
Athabasca University

April 21, 2016

1 University Drive, Athabasca, AB, T9S 3A3 Canada
P: 780.509-7536 | Toll-free (CAN/U.S.) 1.800.788.9041 (7536)
fgs@athabascau.ca | fgs.athabascau.ca | athabascau.ca

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Abstract

Professionals, such as nurses, that provide care may experience a negative impact on both their personal and professional lives due to grief. Grief is the emotional response of a person who has invested emotionally in someone or something and then loses that person or thing. Variations in intensity and duration of grief may occur as oncology nurses care for patients for extended periods of time, sometimes from diagnosis to death. The experience of this extended relationship makes oncology nurses particularly susceptible. This study seeks to examine oncology nurses' grief through a qualitative meta-analysis. The many terms associated with the concept of nurses' grief were analyzed with the goal of obtaining a more comprehensive understanding of these terms as well as presentation of what was found to be the most suitable concept and a supporting definition.

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Chapter I: INTRODUCTION

I have been a nurse for 13 years, five of those years on an inpatient medical oncology unit. I also worked on a neurology/neurosurgery unit for four years, then two different medical units for three years and finally I spent the past year on a medical-surgical unit. I have experienced the death of patients, both expected and unexpected, and I have felt grief. However, I never felt the same intense grief I experienced as an oncology nurse during that five-year period.

I believe the more intense grief experience may partly be due to the nature of the cancer trajectory. The nurse-patient relationship in an oncology setting often occurs over a period of months or years with multiple interactions during a time of crisis (Feldstein & Gemma, 1995). In oncology settings there are ample opportunities for nurses and patients to become well known to one another and to develop connections. I have cared for many patients who were newly diagnosed with cancer and have seen these same individuals through to death. These deaths often leave me with a profound sense of grief. It is recognized that nurses may have conflicting experiences in remaining strong for their patients and for the patient's family, while also dealing with the pain they may feel for loss of the relationship that has developed (Gerow, Conejo, Alonzo, Davis, Rodgers, & Domian, 2010).

The purpose of my study was to examine oncology nurses' grief resulting from patient death or serious changes in the condition of patients they are caring for by examining the terms associated with nurses' grief and exploring the similarities and differences among them. For the purposes of this study, the more general term of nurses'

grief was used to encompass all of the negative emotional responses that a nurse experienced due to the death or serious changes in the condition of a patient.

Research has described the potential negative effects on nurses that grief can cause, particularly in the specialty of oncology nursing (Doka, 1989; Feldstein & Gemma, 1995; Saunders & Valente, 1994). However, these studies have often used a variety of different terms to describe the emotion of grief (e.g., bereavement, burnout, chronic compounded grief, compassion fatigue, compulsive sensitivity, disenfranchised grief, moral distress, moral fatigue, secondary traumatic stress disorder, stress of conscience, vicarious traumatization, etc.). In many instances the lack of clarity of terms has resulted in failure of researchers to build upon previous studies related to the negative consequences of nurses' grief. The meta-analysis of terms used to describe nurses' grief provides a foundation for further research in this area.

In this chapter, I provide background related to my own personal interest in this topic. Next, I outline the research purpose, research question, goals for the research, and introduce my methodology. Finally, I discuss the importance of the study that I undertook.

Researcher's Background

As an oncology nurse, I have interacted with patients over extended periods of time. Many oncology patients are admitted frequently for chemotherapy, complications related to neutropenia, or pain and symptom management. Oncology nurses have multiple responsibilities and roles, such as educators, counselors, patient advocates, caregivers, care coordinators, and listeners (Cohen, Ferrell, Vrabel, Visovsky, & Schaefer, 2010). Oncology nurses often administer the first chemotherapy; translate the

medical terminology and provide explanations related to treatments or disease processes. There is frequently a sense of intimacy and trust that develops between patients and their oncology nurses because of the intense emotional experiences that are shared (Cohen et al., 2010). Many factors affect a patient's hospital stay and many events affect patient outcomes and it is the nurse that is the constant in the lives of patients during these times.

There have been several occasions in my own experiences where after months of treatment, and overcoming obstacles, patients are faced with the news that there are no more treatment options and palliative care becomes the only course of action. There are also times when patients have been unable to recover from the side effects of chemotherapy, and they became palliative during the same hospital admission. The patients and their families came to rely on myself and the other nurses they had come to know and trust over the course of treatment to help them through their final stages. This familiarity can be challenging for some nurses. For example, Brown and Wood (2009), in their review of the literature, found that many oncology nurses were not grieving effectively and those nurses were at higher risk for repressing their feelings which could result in long-term negative effects.

When a patient dies those nurses who have come to know that patient, and the patient's family, experience loss but those same nurses often have no formal opportunity to grieve (Hildebrandt, 2012; Saunders & Valente, 1994). Grieving nurses still have other patients to care for and, often within a short period of time, and they will also be required to care for another patient who will occupy the recently deceased patient's room. These realities have inspired research focused on how to create a greater awareness of the

grief nurses feel, and in the long run create ways to reduce any negative effects that may occur professionally or personally from these grief experiences.

Ultimately it was hoped that this study would be the foundation for further studies aimed at helping oncology nurses grow both personally and professionally from these grief experiences. For the purposes of this study professional growth and well-being were the primary foci. It is important that oncology nurses understand how they experience and deal with the grief that is so much a part of caring for their patients who are seriously ill and perhaps dying.

Research Purpose, Questions and Goals

The long term goal of this research was to provide a foundation for studies aimed at finding ways that oncology nurses' could be better prepared and/or supported when dealing with grief from patient death or serious changes in the condition of a patient. My exploration of this topic began with a self-study that I conducted during the summer 2013 semester that addressed the research question, "What impact does the grief experienced when a patient dies have on oncology nurses?" Over a six-month period I reflected and journaled on incidents that caused me grief as an oncology nurse. Aycock and Boyle (2009) identified that the close interpersonal contact between patients and oncology nurses can "result in physical, emotional social and spiritual adversity" for the nurses (p. 183). In fact, it was the variety of ways grief has been described in the literature, as well as the potential career impact that grief can have upon nurses – particularly oncology nurses (Caton & Klemm, 2006; Perry, 2009; Potter, Deshields, Divanbeigi, Berger, Cipriano, Norris, & Olsen, 2010) that led me to want to explore the impact that grief had on my own practice.

The findings from the self-study reflected my own personal thoughts about death, and the feeling of sadness and helplessness I experienced when patients died. Yet, while the sadness or grief was the most common emotion, I also reported a wide range of other emotions throughout the self-study data such as fatigue, frustration, and anger. Rarely did I document in the self-study data the opportunity to communicate with others about the emotions I was feeling. On the few occasions when I did get that opportunity to talk with others about the grief I was feeling I indicated that it helped my grief.

While my own experiences with grief – both that I have experienced informally and that I recorded as a part of my self-study – were from a negative perspective, nurses who experience grief can also have positive outcomes from experiencing that emotion (Adwan, 2014; Becze, 2012; Emold, Schneider, Meller, & Yagil, 2011; Hunnibell, Reed, Quinn-Griffin, & Fitzpatrick, 2008; Janzen & Perry, 2015; Perry, 2008; Sinclair & Hamill, 2007). For example, Davies, Cook, O'Loane, Clarke, MacKenzie and Stutzer (1996) examined nurses who worked with chronically ill pediatric patients. They found that nurses who were able to prepare for their patient's death were able to prepare themselves for the grief, and even help other nurses work through their grief. Similarly, research has found that when nurses are allowed to experience and process their grief in a supportive manner, those nurses develop healthy coping strategies and also experience positive personal growth (Conte, 2011; Gerow, et al. 2010). However, as it was my own experiences that drove my choice of thesis topic, this study focused upon oncology nurses' grief from a negative perspective.

As my self-study increased my self-awareness of my experiences with grief and began preparing me as a researcher. This self-study also helped me become familiar with

literature that was included in my thesis proposal. However, my self-study also exposed me to the reality that there is not a common term used to describe nurses' grief. In fact, there are many terms used to describe nurses' grief, each seemingly with its own unique body of literature. As such, the purpose of my research was to examine how nurses' grief, specifically oncology nurses' grief resulting from patient death or serious changes in the condition of patients they were caring for, was described in the literature. To accomplish this I focused on comparing and contrasting the definitions of various terms linked to oncology nurses' grief. I hoped that by furthering the understanding of oncology nurses' grief forthcoming investigations would lead to recommendations for specific practice(s) to assist nurses in dealing with their grief. This general purpose of this study was focused by these research questions:

1. In comparing and contrasting the definitions for various terms related to oncology nurses' grief, what are the commonalities and differences among these terms?
2. Based on the outcome of this study, how could oncology nurses' grief be conceptualized in a manner that incorporates the current varying terms and definitions?

To answer the proposed questions a qualitative meta-analysis, also known as a metasynthesis, was selected as the methodology.

The primary goals of this research were to explore oncology nurses' grief and how it was described in the literature. These goals were interpretivist in nature (Crotty, 1998), as I was interested in describing the various terms used to describe the grief that oncology nurses experience, then compare and contrast these terms referring to grief to

determine commonalities and differences. A metasynthesis methodology was an appropriate approach to examine the proposed research questions because the purpose of a metasynthesis was to synthesis research findings into an explanatory, interpretative product (Schreiber, Crooks, & Stern, 1997). Further, a metasynthesis could "combine the evidence of multiple studies regarding a specific… problem to inform clinical practice and is the method of choice for evidence-based practice initiatives" (Whittemore & Knafl, 2005, p. 547). In this instance, the specific problem was to gain a better understanding of the various terms used to describe nurses' grief, and to compare these terms. The specific goal was an examination of how oncology nurses' grief resulting from patient death or serious changes in the condition of patients they were caring for was described in the literature.

Importance of the Study

In an examination of how the relationship nurses develop with patients may affect their psychosocial health and wellbeing, Sabo (2008) identified multiple terms that were applicable to the experience or effects of nurses' grief. Sabo noted that "some researchers argue that nurses are experiencing burnout; others claim that nurses may be experiencing compassion fatigue, while still others suggest vicarious traumatization" (p. 24). Similarly, as a part of her case study of the grief experienced by an oncology staff nurse, Bush (2009) wrote, "secondary traumatic stress incorporates the concepts of compassion fatigue and vicarious trauma caused by empathic engagement, but the subsequent emotions and behaviors may result in an acut

e stress disorder or symptoms similar to post-traumatic stress disorder" (p. 25). As both Sabo and Bush indicated, there was clearly a confounding of the terms used to

describe the grief experienced by nurses – particularly oncology nurses – in caring for seriously ill people.

One of the difficulties this confounding of terms creates is a lack of coherence in the field. For example, a researcher who is exploring nurses that experience compassion fatigue may not utilize research literature related to vicarious traumatization or moral distress in a comprehensive fashion. Further, a researcher exploring how to address moral fatigue may overlook some of the lessons learned from dealing with chronic compounded grief or disenfranchised grief. Essentially, the use of multiple and overlapping terms to describe the experience and effects of grief that nurses feel creates potential gaps in the research knowledge base. Finding a common understanding, as with the second research question, will allow for a more comprehensive spectrum from which to see the research in this area.

This study also has the potential to spark future research in other areas involving nurses' grief. As Granek, Mazzotta, Tozer, and Krzyzanowska (2012) stated, "patient loss in oncology is ubiquitous" (p. 2631). While in the literature, addressing the topic of grief related to patient loss is limited at best, "the tide may be turning" (p. 2531). For example, research does exist that analyzes nurses' grief, and the repercussions prolonged experience to this emotion has on individual nurses (even if that body of literature uses a variety of terms to describe grief). It was hoped that by synthesizing the known research base it would spark further, more comprehensive research on the effects of grief on oncology nurses. While understanding nurses' grief might have been at the forefront of this study, the results might also benefit other disciplines on the oncology team. Understanding the relationship surrounding loss, grief, and bereavement may help

support individuals in caring for people with any illness not just at the end of life (Nicol & Nyatanga, 2014). Other members of the oncology team play an important role in the care of the patient and may also be affected by grief. Thus, the results of this study might also have useful implications for other members of the health care team.

Definition of Terms

The definitions used for various terms may vary by author. However, to avoid confusion I employ the following definitions in this thesis study unless otherwise indicated.

Burnout – "is a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do 'people-work' of some kind" (Maslach & Jackson, 1981, p. 99).

Compassion fatigue – is the "state of tension and preoccupation with the cumulative impact of caring" (Figley, 1983, p. 10).

Grief – a pattern of physical and emotional responses to bereavement, separation or loss that is almost universal (Anderson & Anderson, 1998).

Oncology nursing – providing specialized nursing care to treat and care for people who have cancer (National Cancer Institute, n.d.).

Chapter Summary and Thesis Overview

I began Chapter One by describing my own personal interest in the topic of oncology nurses' grief, including discussing a self-study that I conducted prior to this thesis. This was followed by a statement of the goals and purpose of this thesis study, as well as the specific research questions that I planned to answer. I also stated that I would utilize a metasynthesis as the methodology for this thesis. Finally, I indicated that having

a common understanding of oncology nurses' grief, along with its potential applications in other disciplines or with other health care providers, were why this study was important at this time.

As an outline for the remainder of my thesis, in Chapter Two I critique the general literature related to nurses' grief. I begin this review with a general discussion of the concept of nurses' grief. The remainder of my literature review is organized along two themes, each organized on a term-by-term basis. First, I examine the most common terms for nurses' grief. Second, I discuss the common terms used to describe the reactions nurses have to grief. After re-stating the research purpose and questions, in Chapter Three I describe in greater detail the metasynthesis methodology that I utilized this thesis study. Next, I outline the manner that I collected and analyzed data for this metasynthesis. Further, I discuss how I maintained rigour in this study. Finally, I identify the limitations of this thesis.

In Chapter Four I detail the results of the metasynthesis, which was based on literature focused solely on oncology nurses. Based upon the data, I describe the various terms used to reference the physical and/or emotional effect that oncology nurses experience when grief occurs in their workplace. This description includes a more detailed analysis of four dominant terms used by various authors: compassion fatigue, burnout, grief, and stress. Next, I outline the term best used for understanding situations and investigations into oncology nurses grief.

Finally, in Chapter Five I summarize the results of the metasynthesis that was undertaken for this thesis study. I also outline two implications for practitioners: that nurses themselves need to be aware of the emotional risks associated with exposure to

grief and to ways to protect themselves, and that employers should look to encourage and support nurses as they attempt to deal with their grief. Finally, I discuss three avenues for future research: an examination of a variety of issues related to oncology nurses' grief, potential positive effects that come from oncology nurses' grief, and an examination of the specific similarities and differences of burnout and compassion fatigue.

Chapter 2: REVIEW OF THE LITERATURE

While there was literature available that focused on grief, nurses' grief, and oncology nurses' grief; there was a disconnect in the way the research is presented. There is little overlap or cross referencing of the different terms that are potentially so closely related, which causes a lack of clarity in understanding of the experience of nurses' grief. Essentially, because researchers are using slightly different terms to describe nurses' grief, in many instances they fail to build upon each other's work. Additionally, the various terms, often used interchangeably, result in possible confusion for other researchers and practitioners (Bush, 2009; Sabo, 2008). This project helps to clarify the differences in the meaning of terms used to describe nurses' grief, which may be of benefit to further research in the area. In order to address this issue, the first step that was necessary was to examine the meaning of various terms in the literature used to describe nurses' grief.

Fink (2014) advised researchers that when conducting a literature review, researchers should "systematically examine all sources and describe and justify what you have done. This enables someone else to reproduce your methods and determine objectively whether to accept the results of the review" (p. 14). As such, I began this literature review by searching for the terms nurses' grief in the Athabasca University electronic library databases (e.g., *ProQuest*, *Nursing & Allied Health Source*, *PubMed*, *CINAHL*, and *PsycInfo*) and open access resources available through *Google Scholar*. Based upon that initial search I was able to identify a variety of additional terms that were used for or that were associated with nurses' grief, specifically: bereavement, burnout, chronic compounded grief, compassion fatigue, compulsive sensitivity, cumulative grief,

disenfranchised grief, grief, moral distress, moral fatigue, patient death, secondary traumatic stress disorder, stress of conscience, and vicarious traumatization (Aycock & Boyle, 2009; Joinson, 1992; Medland, Howard-Ruben, & Whitaker, 2004; Sabo, 2008; Wenzel, Shaha, Klimmek, & Krumm, 2011; Wilson & Kirshbaum, 2011). My goal was to do a broad assessment of the common terms used in the literature specifically related to oncology nursing or cancer nursing. Since there was literature related to these search terms associated with other nursing specialties besides oncology, these sources were also included.

Twenty-eight articles were collected in the first review; 23 in the second search and 13 more were added from subsequent searches. Of the 64 articles included in this literature review, 51 articles were related to nursing, 35 articles to oncology, and 27 articles specifically to oncology nursing. Finally, 22 of the articles used the word grief, while the others used a different term to refer to grief or the reaction from exposure to grief. This initial literature search was supplemented during the data collection phase, which included a more systematic analysis of the literature related to nurses' grief (as was the general purpose of the metasynthesis) and literature was added – both were combined, reviewed and either included and excluded from the data set for this thesis.

In this chapter I begin with a review of the general concept of nurses' grief to help establish a consistent understanding of the term. There is a focus on literature specific to oncology nurses, but there is also literature from other nursing specialties included to broaden the understanding of the terms. This dual focus (i.e., oncology and other nursing specialties) is maintained throughout the literature review. Next, the terms acute grief, complicated grief and pathological grief are defined and differentiated. Finally, the

concepts of nurses' grief and bereavement are compared and similarities and differences between these articulated. This is followed by an examination of each of the terms, on a term-by-term basis, that were included in my literature review (as noted in the list above). In the process of conducting this literature review, there appeared to be a distinction within the broader literature related to nurses' grief that some of these terms were used to describe nurses' grief, while other terms were used to describe the reactions nurses had to grief. As such, I have attempted to organize the final sections of my literature review along these two distinctions (although it is important to note that these distinctions were not always present in the literature – e.g., Davis, Lind, & Sorensen, 2013; Edmonds, Lockwood, Bezjak, & Nyhof-Young, 2012; Emold, et al., 2011; Fetter, 2012; Leung, Fillion, Duval, Brown, Rodin, & Howell, 2012; Wenzel, Shaha, Klimmek, & Krumm 2011).

The General Concept of Nurse's Grief

Parkes (1998) described grief as an emotional response or reaction to a loss, while Anderson and Anderson (1998) defined grief as a pattern of physical and emotional responses to bereavement, separation or loss that is almost universal. The intensity and duration of the response depends on what was lost (Parkes, 1998). This not only affects individuals emotionally, but also may affect work absenteeism, and cause a decrease in quality of work, errors, and decrease in productivity (Genevro & Miller, 2010). While the loss of a family member or friend may be a common cause of grief, there are other instances that also initiate this emotion (Buglass, 2010). Some individuals experience grief secondary to the loss of something or someone important to them personally

(Cowles & Rodgers, 1991). For example, the loss of a family heirloom or the death of an admired celebrity.

Grieving is a personal and highly individual experience (Maurer-Starks, Wise, Leone, & Kitsos, 2010; Saunders & Valente, 1994). How one grieves may be affected by many factors, including personality, coping style, culture, life experience, faith, and the nature of the loss (Buglass, 2010). However, grief can be unpredictable in its manifestations, intensity, and duration (Shear, 2012a). Although grief is well known and exists in many aspects of life, few people are equipped to deal with the loss associated with death without feeling a heavy psychological burden (Feldstein & Gemma, 1995). This may also be true for nurses who deal with death on a regular basis, even though the majority of those deaths are not of someone who was personally close to them prior to the beginning of their professional relationship (Aycock & Boyle, 2009). Within the nursing profession this sense of secondary grief is more common – as the loss is generally not someone that is the nurses' family member or friend.

Oncology nurses are faced with a unique world (van Rooyen, le Roux, & Kotze, 2008). Supple-Diaz and Mattison (1992) wrote that cancer care providers are affected by working with cancer patients. Medland et al. (2004) stated that recognizing the challenges of oncology nursing is essential to the success of an oncology program. As Perry (2008) noted, "oncology nursing involves caring for people who may require complex physical, emotional, and spiritual interventions" (p. 88). Caring for someone with cancer is a great source of stress; oncology nurses who choose this career put themselves at greater risk (Potter, Deshields, Divanbeigi, Berger, Cipriano, Norris, & Olsen, 2010).

This may be better understood by the following example, consider a 57-year-old male construction worker who has been estranged from his wife and two daughters for the past eight years. He has been a smoker for over 40 years, and recently began experiencing shortness of breath to the point that he has been unable to work. He has been admitted to the oncology unit after being told he has Stage Four small cell lung cancer. He has to have more tests to check for metastasis, the doctors are considering treatment options. The needs of this patient over the next few days and weeks may be very complex.

He may open up to his nurse over the course of his hospitalization and that nurse will need to be prepared to offer support. The complexity of this man's diagnosis means that he will require physical care by the nurse, but it is the poor prognosis and the estrangement from his family that propels the nurse to recognize his additional emotional and spiritual needs, and to assist in providing an outlet for him to express himself to address those needs. However, the repeated exposure to the suffering of others (such as in this example), add to feelings of helplessness and, if unrelieved, nurses may be more prone to adverse psychological effects described as compassion fatigue, burnout or vicarious traumatization (Sabo, 2008). In fact, some have argued that powerlessness and frustration are almost a prerequisite in order for oncology nurses to show compassion to parents of an ill or dying child (Furingsten, Sjögren, & Forsner, 2015).

Experienced oncology nurses may develop attitudes, knowledge and skills that enable them to better care for themselves and their own reactions to the kind of situation described above as the number of years of experience as an oncology nurse has an effect on the way in which nurses react to grief situations (Caton & Klemm, 2006). In fact,

Barbato-Gaydos (2004) found that nurses who were exposed to loss and grief on a regular basis often developed a sense of resilience. Jackson, Firtko, and Edenborough (2007) defined resilience as:

> the ability of an individual to positively adjust to adversity, and can be applied to building personal strengths in nurses through strategies such as: building positive and nurturing professional relationships; maintaining positivity; developing emotional insight; achieving life balance and spirituality; and, becoming more reflective. (p. 1)

Resilience can be a physiological or a psychological concept (Zander, Hutton, & King, 2013). Every nurse has the ability to develop resilience, but the ability to undergo personal growth in the presence of negativity is key for that development to occur.

The following sections begin with a discussion of the different types of grief in an effort to provide the reader with a brief understanding of the differences between acute, complicated, and pathological grief; as well as to underscore the focus of this thesis study in acute grief. This discussion is followed by two sections that provide an initial examination of many of the different terms that scholars have used to describe grief. These sections are divided into two general categories: terms related to the emotion of grief that nurses experience and terms used to describe specific reactions that may result from exposure to grief. Within each section, each individual term is discussed separately.

Differentiating Among Acute Grief, Complicated Grief and Pathological Grief

An important consideration is differentiating among the types of grief that fall on a grief continuum. Hughes (2011), in her article shades of grief, discussed at which point grief and mourning become pathological. Grief is a multi-faceted response to loss that

has emotional, physical, cognitive, behavioural, social and philosophical dimensions (Kain, 2013). The effects of grief are very individual, and Kain suggested that one's life experiences affect how grief will be expressed and perhaps where on the grief continuum individuals may fall. In the following sections three types of grief (i.e., acute, complicated, and pathological) are described.

Acute Grief

Acute grief is considered a normal reaction to loss (Holland, Neimeyer, Boelen, & Prigerson, 2009). Acute grief is thought to last less than six months and while it can have intense physical, emotional, and social manifestations it does resolve with time and without outside intervention. According to Moayedoddin and Markowitz (2015) most people experience normal acute grief as a reaction to a loss. Further, Tatsuno, Yamase, and Yamase, (2012) reported that people who experienced the sudden loss of a loved one tended to have stronger acute grief reactions than families who experienced death of a loved one after a long illness. However, these acute grief reactions can be intense and still be considered normal if the grief resolves in time and does not lead to further negative consequences for the individual.

Complicated Grief

Grief varies in intensity but also in complexity. Although most bereaved individuals experience a normal acute grieving process, Bonanno and Kaltman (2001) introduced the concept of *complicated grief* that was considered a psychological disorder. Prigerson and Jacobs (2001) labeled this prolonged grief disorder and define it as a state of chronic grieving that persists for six months or longer (i.e., sometime months or years) and include intense separation distress, emotionally troubling thoughts about the person

who died, lack of ability to accept the loss and diminished ability to function. Solomon and Shear (2015) defined complicated grief as, "intense grief after the death of a loved one that lasts longer than expected according to social norms and causes functional impairment" (p. 153). Some features of complicated grief – other than lasting for a prolonged time – include intense sorrow, yearning for the dead person, desiring to die to be with the deceased person (American Psychiatric Association, 2013). Shear (2012b) suggested that those with complicated grief have not integrated the loss into their lives and those with complicated grief are at risk for increased morbidity.

Pathological Grief

Occasionally, normal psychological, physiological, and social manifestations of grief that are normal in acute grief linger for many months or even years and are distressing and debilitating. According to Eckerd and Simonson (2013) *pathological grief* was a syndrome, which occurred for approximately 10-15 percent of bereaved individuals, had been labeled "prolonged grief" and it was considered pathological. In pathological grief there is severe functional impairment of the bereaved. Some have labeled pathological grief as complicated grief, traumatic grief, atypical grief, and delayed grief, among others. "More recently, 'prolonged grief disorder' has been proposed as the agreed term, representing a distinct clinical entity" (Dodd & Guerin, 2009, p. 442). Dodd and Guerin indicated that people with the pathological grief syndrome labeled prolonged grief disorder experience severe yearning, disbelief, bitterness over the loss, confusion about one's identity, a sense of numbness, distrust of others, a feeling that life is meaningless since the loss, difficulty accepting the loss, as well as feeling stunned by the loss, and must experience five of nine of these symptoms

for six months or longer after loss. Finally, Prigerson and Jacobs (2001) note that people with prolonged grief disorder have increased risk for other complication such as posttraumatic stress disorder, generalized anxiety disorder, major depressive disorder as well as suicidal ideation.

Summary of Acute Grief, Complicated Grief, and Pathological Grief

There are different types of grief that have been identified, and in this section I provided a brief examination of the differences between acute, complicated, and pathological grief. Acute grief was considered a normal reaction to loss, while complicated grief was the occurrence of chronic grieving that persisted for six months or longer. Finally, when pathological grief occurred severe functional impairment of the bereaved individual also occurred. Within this chapter, and for this overall thesis study, it was acute grief that was my primary focus.

Terms Describing the Concept of Nurse's Grief

The emotional response to a loss experienced by nurses (i.e., *grief*) has been described using a variety of inter-related, sometimes overlapping terms. In some instances, the specific term that was used within the literature reflected a more traditional understanding of grief (e.g., loss, bereavement, or mourning) (Dunne, 2004; Shear, 2012a). However, in other instances the terms used when discussing nurses' grief are more qualified forms of grief (e.g., chronic compounded grief, cumulative grief, disenfranchised grief, moral fatigue, etc.). This section examines some of these more common terms used to describe nurses' grief responses.

Bereavement

A term that has long been associated with the emotion of grief is *bereavement*. Bereavement has been viewed as a normal, natural human experience, it is associated with a period of intense suffering, with an increased risk of developing mental and physical health problems which most people overcome over the course of time (Stroebe, Schut, & Stroebe, 2007). Saunders and Valente (1994) referred to bereavement as "loss of a significant person by death and a process, which unfolds over time" (p. 320). Bereavement is a period of time that varies in length and severity depending on the level of attachment the grieving person had with the person who died (Maurer-Starks, et al., 2010; Saunders & Valente, 1994).

Bugen (1977) theorized that the closeness of the relationship, as well as whether the death could have been prevented, were both factors that predict the intensity of grief and how long bereavement will last. This was further supported by Schoulte, Sussman, Tallman, Deb, Cornick, and Altmaier (2012), who stated that many people will experience ongoing distress when they are bereaved. This ongoing stress included thoughts of lost loved ones and feelings of depression, but symptoms declined gradually over time (Schoulte et al, 2012). Bugen (1977) suggested that it is during this period some call bereavement that grief and mourning occur. More recently, Shear (2012b) stated that, "grief is the psychobiological response to bereavement" (p. 120). Nurses' knowledge of grief has been partially derived from personal experiences with the process of bereavement (Stroebe & Schut, 1998). The process or stages of bereavement include shock and disbelief, restlessness, disorganization and reorganization, and may occur in no particular order (Saunders & Valente, 1994).

Keene, Hutton, Hall, and Rushton (2010) suggested that offering health care workers bereavement debriefing sessions would give staff the opportunity to express their feelings, learn to manage their grief, and continue to support the patients and families that still need their care. Further, Boelen, van den Bout, and de Keijser (2003) posed that different treatment methods may be required for the various syndromes that develop in people who fail to recover from bereavement (e.g., medication for depression symptoms, anxiety management). More recently, Tranter, Josland, and Turner (in press) explored dialysis nurses' perceptions after the death of a patient, as well as their bereavement needs. The authors' findings considered the support of fellow colleagues in a tearoom debrief or the use of a counselor to be the most appropriate supports. Although it should also be noted that the hospital where the study was conducted already had a successful palliative care course, as well as a comprehensive supportive care service and forums on contemporary issues were held regularly within the renal department with good nurse attendance. As such, these regular mechanisms to prepare nurses for and support them during their grief may have also played a role.

Chronic Compounded Grief

Feldstein and Gemma (1995) studied grief experienced by oncology nurses who were repeatedly exposed to the deaths of their patients. They found increased evidence of despair and isolation, as well as somatization. They subsequently defined *chronic compounded grief* as a cumulative response to losses over time. Chronic grief is ongoing and affects one's entire life, sometimes somatized through chronic pains and other health symptoms that can be private and hidden (Papadatou, 2009). Macpherson (2008) related this response to 'loss overload.' This term first appeared in their study, which examined

the differences in the grief of oncology nurses who left their positions to those who stayed working in oncology, and found above normal levels of "despair, social isolation, and somatization" for both groups (Feldstein & Gemma, 1995, p. 234). Similarly, Adams, Hershatter, and Moritz (1991) described this experience using phrases such as accumulated loss and unrelieved sadness. Essentially, the nurses' left their oncology positions in the hope of deceasing their stress/grief, but for many their grief persisted (Feldstein & Gemma, 1995). While the Feldstein and Gemma study found that leaving the situation that caused the grief did not take away the grief or the feelings associated with it, they inferred that leaving or transferring from an oncology setting may be the only way to deal with these experiences (1995).

Additionally, Macpherson (2008) suggested that chronic compounded grief resulted when "multiple recurrent patient deaths with inadequate opportunity to address each can result in oncology nurses becoming overloaded with loss and grief" (p. 149). For example, after a patient dies, the room is cleaned and a new patient often arrives within an hour or two of the death. The same nurse must provide care to the newly arriving patient without time to grieve the patient who just died. The nurse is not provided time to grieve and must carry on in a hopeful manner with the new patient. As Irvin (2000) indicated, the emotional involvement that many nurses have with patients that they have developed long-term relationships with can place those nurses at risk of chronic compounded grief.

Cumulative Grief

Caring for dying people and their families is often considered to be one of the more stressful aspects of nursing work (Copp, 1998), as multiple experiences of caring

for dying patients and their relatives may lead to *cumulative grief*. Cumulative grief was defined by Marino (1998) as the potential emotional response of caregivers when they were not given adequate time or opportunity to grieve for each person who had died under their care. Houck (2014), as well as Shimoinaba, O'Connor, Lee, and Kissane (2014), also addressed cumulative grief as related to nurses. Both studies offered recognition of unmet needs resulting from the grief that nurses experience when they are not provided the opportunity to do so.

Nurses who experience cumulative grief may hesitate to become emotionally involved with dying patients in the future or do the opposite and become over involved in their care (Marino, 1998). Marino also suggested that when health care professionals are not able to grieve the results could be consequential – both personally and professionally. With no outlet for emotional expression, nurses often suppress their feelings of grief. The phenomenon affects the nursing staff as a whole, and not just individual nurses (Lindberg, 2012). Lindberg also suggested that it affected quality of care and the retention of nursing staff. Nurses may become impatient, weary, and bitter about the strains of their work places upon them, until they reach the point where they find themselves unable to meet the needs of their patients, causing withdraw from emotionally charged situations (Boyle 2015). Alternatively, Shorter and Stayt (2010) warned that, "the cumulative effects of grief may lead to occupational stress and burnout" (p. 165).

Disenfranchised Grief

Wilson and Kirshbaum (2011) described the more specific concept of *disenfranchised grief* as a "grief experienced by an individual but which is not openly acknowledged, socially validated or publically observed" (p. 560). According to Wilson

and Kirshbaum, "it was not until 1987 that Kenneth Doka developed the concept that some people who are bereaved feel unable or are not allowed to express their grief" (p. 564). This type of grief is not confronted therapeutically and remains hidden, unrecognized, or unhealed (Papadatou, 2009). Doka (2002) developed a typology that features four types of disenfranchised grief: (1) the relationship is not recognized, (2) the loss is not acknowledged, (3) the griever is excluded, and (4) the circumstances around family members' deaths are deemed socially unacceptable, for example, suicide, AIDS, or the death of children.

Although loss and death occur in nursing, often these events – or at least the impact that they can have on those involved – are overlooked or ignored (Wilson, 2014). Health care staff may experience disenfranchised grief due to a feeling that it is not acceptable to express their emotional responses to patient death in the workplace environment (Wilson & Kirshbaum, 2011). Disenfranchised grief experienced by health care staff including nurses could fall into Doka's (2002) typology as resulting from a relationship that is not acknowledged and the griever is excluded. Given the 'professional' nature of the patient-caregiver relationship society may not deem it a relationship that predisposes the caregiver to a grief response. However, since some caregiver-patient relationships result in a connection between these individuals a grief response in the event of a loss may occur. Additionally, to make disenfranchised grief in a health care giver even more complicated, Wilson and Kirschbaum (2011) noted that health care staff might also be called on to support others in their losses, with no acknowledgement that the death was a loss for them as well.

Further, Vachon (1995) stated health care professionals may experience disenfranchised grief because they are exposed to multiple loses. Spidell, Wallace, Carmack, Nogueras-Gonzalez and Canto (2011) validated this by stating, "without recognition of grief reactions or the potential presence of disenfranchised grief, losses may be transformed into other emotions such as anger, anxiety, blame, helplessness, and guilt" (p. 77). However, Cohen and Erickson (2006) wrote, "how an individual nurse perceives and reacts to a patient care situation is a highly individualized process that depends on the individual's unique set of beliefs and values" (p. 777). Additionally, Doka (1987) found that the intensity of the grief that was felt might be significant, but the ability to acknowledge that grief, or the resources to help manage, might not be available. This sentiment may be compounded by the fact that the nurses' grief may not be recognized by colleagues or administrators who expect them to become immediately involved in another patient's care after a patient they are caring for has died (Wilson & Kirshbaum, 2011). Thus, disenfranchised grief is seen as a consequence of grief.

Moral Fatigue

In a statement by the Oncology Nursing Society, Edwards (2001) indicated that moral fatigue is a major issue for oncology nurses. Taylor (2002) stated that *moral fatigue* is the "logical consequence" of being in a prolonged state of moral distress, with moral distress being "a consequence of… believing that one is not living up to one's moral convictions" (Kelly, 1998, p. 1145) (see following section for a more detailed discussion of moral distress). Essentially, moral fatigue is the natural result for nurses who want to provide the best possible care for their patients but who must work within a system that focuses on other factors besides patient welfare (Taylor, 2002). Oncology

nurses work in an environment that has many moral conflicts. As Taylor noted, then nurses' duties were filled with uncertainty and a face-paced environment sometimes patients' real needs seemed to be neglected, resulting in moral fatigue that was an experience that had personal consequences for the nurse and negative effects on the institution. Additionally, Simmonds and Peter (2007) stated that the mental and moral fatigue that resulted from seeking to compromise, while knowing that it was not always possible to find an acceptable compromise, when competing and conflicting values occurred in situations and relationships.

The issue of moral fatigue has become so significant within the nursing setting that the North American Nursing Diagnosis Association has officially defined it as "the self-recognized state in which an individual experiences an overwhelming sustained sense of exhaustion and decreased capacity for physical and mental work that is not relieved by rest" (Carpenito, 1995, p. 379). Taylor (2002) stated that moral fatigue was found in environments where individuals must confront moral situations on a regular basis. When these situations become more frequent or intense, moral fatigue occurs. For example, sometimes a patient's chemotherapy orders are changed because the cost of the medication the patient was to have initially received was not covered by drug plans for in-patient care, but oddly enough was covered financially for outpatient care. As this particular patient was not well enough to be treated as an outpatient, his or her treatment plan was altered. The nurse may feel that the patient is not receiving optimal treatment. This kind of situation, over time, could lead to oncology nurses feeling a sense of moral fatigue.

Summary of Terms Describing the Concept of Nurse's Grief

As described in the previous sections, there are have been a variety of terms that researchers have used to describe the grief experienced by nurses. For example, bereavement is a grieving process that occurs over varying periods of time after a loss. Chronic compounded grief is a cumulative response to losses over time. Cumulative grief is the emotional response that may occur when individuals do not get adequate time to grieve before another loss occurs. Disenfranchised grief is experienced when the grief experienced is not socially acknowledged or validated and finally moral fatigue is defined as the consequence of prolonged moral distress. One of the factors that each of these terms has in common is time, mainly that there is not enough time provided for nurses to process events in a therapeutic fashion and that lack of processing can lead to negative consequences for the nurse.

Terms Used to Describe Effects/Syndromes that Result from the Nurses' Grief

In addition to the emotional response that nurses experienced due to loss, there is also literature focused on the syndromes or conditions that sometimes result from, or are caused by, the stress of grief experienced by nurses. This sub-set of literature related to how grief affects nurses, includes the various effects and syndromes that are often defined and described differently by various researchers/authors. There is confusion in how the various terms are used and understood in scholarly activities and in practice. This section examines some of these more common effects and syndromes in a preliminary way.

Burnout

"*Burnout* is a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do 'people-work' of some kind" (Maslach & Jackson, 1981, p. 99, emphasis added). Further, Mukherjee, Beresford, Glaser, and Sloper (2009) offered that burnout occurs when there is an imbalance between the demands and resources over a period of time. In addition, Grunfeld, Whelan, Zitzelsberger, Willan, Montesanto, and Evans (2000) indicated that health care professionals experienced burnout after prolonged elevated stress levels in their professional lives. For example, nurses who regularly experience the death or serious changes in the condition of a patient may experience burnout that results in "physical and emotional exhaustion, depersonalization and low productivity" (p. 167). Stress and burnout are closely related and are often used interchangeably. However, they are not the same (Wright & Sayre-Adams, 2012). Medland et al. (2004) agreed that burnout resulted from prolonged levels of high stress at work and, if left untended, could contribute to the exodus of health care workers from these emotionally intense situations.

Burnout has also been related to instances where staff exhaustion is experienced at work due to budget cuts and lack of staff and carries over into life in general (Cohen et al., 2010). Cohen and colleagues also suggested that individuals experiencing burnout might feel a disconnect, and feel depleted in their everyday life, not just at work. Participants in a more recent study by Berg, Harshbarger, Ahlers-Schmidt, and Lippoldt (2016) reported a variety of symptoms related to stress that included nightmares, 'flashbulb memories' regarding cases, and second-guessing of clinical decisions. Individual differences will affect how soon a person may experience burnout and how

extreme the experience will be (Papadatou, Anagnostopoulos, & Monos, 1994). Aspects such as personality traits have seemed to determine an individual's response to emotional demands and to the occurrence of burnout (Gama, Barbosa, & Vieira, 2014).

Compassion Fatigue

Compassion fatigue is defined as the "state of tension and preoccupation with the cumulative impact of caring" (Figley, 1983, p. 10), and has been used by scholars to describe the emotional grief response experienced by nurses. Joinson (1992) used compassion fatigue to describe the unique stressors that affect caregivers, particularly nurses, while she was investigating burnout in nurses. These stressors may begin with coworkers who are "tense, impatient, and hurried… tired, indifferent, or cynical" (p. 118). These dissatisfied individuals may play a role in a nurse's decrease in energy and enthusiasm towards their work. Perry, Toffner, Merrick, and Dalton (2011) specifically addressed oncology nurses in their examination of compassion fatigue. Perry and colleagues stated that, "the complexity of the care required, combined with the potential intensity of nurse-patient relationships in an oncology setting, may place cancer nurses at higher risk for compassion fatigue" (p. 91). Further, other stressors that may contribute to compassion fatigue may include dealing with home life after a stressful day and having lack of support at work from administrators (Mendes, 2015).

Compassion fatigue has also been defined as "a complex phenomenon that escalates gradually as a product of cumulative stress over time" (Bush, 2009, p. 25). Like burnout, one of the sources of stress that can cause compassion fatigue is the death or serious changes in the condition of a patient (Bush, 2009). Further, compassion fatigue has also been described as having potential to cause negative effects for nurses who

continually care for the seriously ill, wounded, traumatized and the dying (Melvin, 2012). Seriously ill and dying are descriptive phrases that could also be used to describe the patients that oncology nurses regularly care for (Beckstrand, Moore, Callister, & Bond, 2009; Becze, 2012). Figley (1995) stated that working with those who were suffering often included absorbing that suffering, a precursor to compassion fatigue.

Finally, while each of these definitions for compassion fatigue is similar, it appears that each of these researchers has made slight modifications to their understanding of the concept. After reviewing numerous definitions, one that appears to be the most inclusive is a definition by Coetzee and Klopper (2010), who described compassion fatigue as "a state where the compassionate energy that is expended by nurses has surpassed their restorative processes, with recovery power being lost" (p. 237). This definition appears to encompass the characteristics, temporal constraints, and symptoms that each of the other definitions of compassion fatigue included.

Interestingly, while nurses are particularly vulnerable to compassion fatigue, other health care providers who are in contact with a suffering patient are also affected emotionally (Boyle, 2011). Some articles specified doctors only, such as oncologists who grieve patient losses (e.g., Granek et al., 2012; Sanchez-Reilly, Morrison, Carey, Bernacki, O'Neill, Kapo, Periyakoil, & deLima, 2013). Similarly, another study by Hooper, Craig, Janvrin, Wetsel, and Reimels (2010) examined compassion fatigue among emergency nurses and compared their experience of compassion fatigue with nurses in other specialties. Thus while this particular study focuses on oncology nurses, it is evident that compassion fatigue also affects other health care professionals negatively as well.

Compulsive Sensitivity

The term *compulsive sensitivity* was devised by Forssen, Carlstedt, and Mortberg (2005), who described it as the emotional response felt when older women placed the needs and responsibilities of others before their own, but felt exploited by doing so. Another interpretation of compulsive sensitivity is that females, often trapped by circumstances, feel compelled to provide care to others – even if the time and emotional investment related to that care negatively impacts the female's own health and well-being (Fenchel, 2013). The fact that compulsive sensitivity is generally associated with females is of particular importance within the field of nursing, as according to the 2006 Canadian census, approximately 91.0% of working registered nurses in Canada were female – a figure that has remained relatively consistent since the 1991 census (Service Canada, 2013).

Within the health care setting, specifically oncology setting, some scholars have applied this concept to health care providers who indicate that they have "'no option' but to continue caring, regardless of the physical cost to themselves" (Ussher, Sandoval, Perz, Wong, & Butow, 2013, p. 907). For example, many times a patient will request care from nurses whom they have come to trust and rely upon. Nurses may honour these patient requests even though they have identified caring for a particular patient is emotionally or physically taxing to them. Differing from the original conception of compulsive sensitivity, health care providers in a study by Williams (2007) did not report feeling trapped into providing care for specific patients when requested to do so, but did feel that patients' health was worth sacrificing their own feelings for.

Moral Distress

Moral distress has been described as suffering that affects one's sense of self by impacting physical health, causing anxiety, or causing anguish and may adversely impact patient care (Water, 2008). In her thesis on the subject, Water wrote, "in a seminal definition, Jameton (1993) defines moral distress as a negative feeling associated with a person not being able to act (morally) as they wished" (p. 58). Further, Taylor (2002) described moral distress as occurring "when one knows the right thing to do but is constrained by the institution or one's coworkers from doing it" (p. 37). For example, a nurse may experience moral distress if she wants to stop intravenous fluids on a dying patient who sounds congested, but the physician orders the fluids to be continued. In this example there is dissonance between what the nurse believes is the best care and care the nurse has been direct to provide.

Cohen and Erickson (2006) likened moral distress with ethical dilemmas, which can cause frustration and powerlessness that lead to compromised care and job discontent. Corley (2002) indicated that nurses know what choices may be best for the patient, but those choices may conflict with the organization, the physician, the family, or other patients. For example, patients who have been in the hospital for an extended period of time may start to feel like they may never leave. Even though in many instances it is against hospital policy and frowned upon by physicians, if it is at all possible based on the patients' condition and treatment plan, the patients could be granted a day pass of a few hours to spend time in their own homes or simply to just go for a drive. Nurses may feel that just a few hours away from the hospital and the constant reminders of their illnesses could make a difference in the patients' outlook and allow

them to continue their struggle with greater hope. These nurses may experience moral distress because of the tension between hospital policy about day passes and doctors' advice that patients say in the hospital and what they feel may be best for their patients.

Secondary Traumatic Stress Disorder

As empathetic caregivers, oncology staff may also be at risk for secondary traumatic stress disorder. Similar to vicarious traumatization, *secondary traumatic stress disorder* is said to result from exposure to persons who have experienced trauma and from giving care to such persons (Quinal, Harford, & Rutledge, 2009). Dominquez-Gomez and Rutledge (2009) described secondary traumatic stress disorder as resulting from "exposure to a person or persons who are traumatized or suffering rather than exposure to a traumatic event itself" (p. 199). A few years earlier, Jenkins and Baird (2003) described it as "the sudden adverse reactions people can have to trauma survivors whom they are helping or wanting to help" (p. 424).

Oncology nurses often care for the same patients repeatedly, and continuously see their complications and struggles. For example, an oncology patient who had been transferred to the intensive care unit (ICU), after a period of time may return to the unit and be under the care of the same nurse who cared with that person prior to going to ICU. The patient and their family will often relay the ICU experience to the nurse, and thus initiate feelings of empathy in the nurse. This puts individual nurses at risk for secondary traumatic stress disorder, after hearing about the patient's ICU stay, and seeing the patient weaker and more compromised than before the ICU stay. Bride (2007) investigated the occurrence of secondary traumatic stress disorder in social workers. He identified symptoms that were most often reported as "intrusive thoughts, avoidance of

reminders of clients, and numbing responses" (p. 67). Less reported symptoms included distressing dreams and a feeling of reliving client's traumas.

Some scholars have suggested that secondary traumatic stress disorder is synonymous or comparable with compassion fatigue (Throckmorton, 2007). For example, Meadors, Lamson, Swanson, White, and Sira (2009) surveyed health care providers to compare and contrast what they felt were the overlapping concepts of secondary traumatic stress disorder, compassion fatigue, burnout, and posttraumatic stress disorder. The results of their study found that both the practical conceptions of, and the assessment used to measure, secondary traumatic stress disorder and compassion fatigue were unique enough to argue that both terms be maintained as separate concepts. Interestingly, a recent study by Sheppard (2015) speculated that compassion satisfaction, which she described as the sense of pleasure associated with doing a job well, had the potential to mitigate against a sense of secondary traumatic stress.

Stress of Conscience

Researchers in Sweden and Finland have found that care providers experienced their work as meaningful and satisfying, but that they also found it to be physically and mentally burdensome (Saarnio, Sarvima, Laukkala, & Isola, 2012). They called this mental state *stress of conscience*. Stress of conscience has been defined as stress related to a troubled conscience (Ahlin, Ericson-Lidman, Norberg, & Strandberg, 2012), and stress related to a troubled conscience or inner voice, guiding people how to be or how to act (Saarnio et al., 2012).

Conscience in healthcare concerns the feeling of responsibility to give good care in a situation, despite the lack of resources and opportunities to implement good care

(Glasberg, 2007). In their study of the stress of conscience, Ahlin et al. (2012) did not aim to define conscience, rather they provided a brief discussion of the religious and philosophical understandings of the term. Essentially, the impressions Ahlin and his colleagues left the reader with is that the conscience is an ill-defined sense of right and wrong that is developed and/or influenced by theological beliefs, societal norms, and one's own morals. As such, the stress of conscience is the stress that results from situations that challenge one's sense of right and wrong – almost putting one into moral distress (to borrow from the previous concept). Put another way, stress of conscience is "a troubled conscience when [nurses] feel that they cannot provide the good care that they wish – and believe it is their duty – to give" (Glasberg, Eriksson, & Norberg, 2007, p. 392). As such, it could be argued that stress of conscience occurs before moral distress or may lead to moral distress. Further, Glasberg, Eriksson, Dahlqvist, Lindahl, Strandberg, Söderberg, Sørlie, and Norberg (2006) stated "nurses experience pangs of conscience when they cannot supply the standard of care they would want for their own families" (p. 645). Consequently, caught between reality and the nurses' ideal interpretation of health care, this conflict results in a troubled conscience from feelings of not being able to do more than one would like.

Further, Juthberg, Eriksson, Norberg, and Sundin (2007) described the stress of conscience as when health care providers "refer to their conscience when being forced by organizational demands and expectations to take actions that go against their conviction" (p. 1898). For example, this may occur when physicians give orders to discharge patients home, yet these patients have told the nurses they do not know how they will manage at home alone. A supportive environment thus seems crucial in enabling the nursing staff to

follow their moral opinions (Tuvesson, Eklund, & Wann-Hansson, 2012). Additionally, Juthberg et al. (2007) indicated that stress of conscience "may [also] occur when not meeting the demands and expectations of organizations and colleagues" (p. 1898). For example, hospitals may have benchmarks that have to be met for patient discharge, and the nurse must either discharge the patient on time or face the consequences of being reprimanded if there is a delay in the discharge due to the nurse seeking additional help for the patient at home. This can cause negative consequences for nurses as their own morals or understanding of what is right is being challenged.

Vicarious Traumatization

Finally, *vicarious traumatization* was originally coined by McCann and Pearlman (1990), who identified that working with trauma victims may cause severe and lasting psychological effects. Vicarious traumatization refers to a transformation in the caregivers' inner experience, resulting from empathic engagement with people who are victims of trauma (Pearlman & Saakvitne, 1995). Essentially, vicarious traumatization refers to the cumulative effect upon the caregiver, of working with individuals who are experiencing or have experienced traumatic life events and is a natural outcome of working with traumatized patients, oncology nurses may experience some of the indicators associated with vicarious traumatization (Sinclair & Hamill, 2007).

In the process of helping others deal with various traumas, an individual may not realize the impact their work is having on themselves and how they process these interactions in the long-term (Pearlman & Saakvitne, 1995). Within the nursing context, vicarious traumatization focuses on the negative impact of working with individuals who have been traumatized and does not acknowledge the many positive aspects of trauma

work such as professional development and satisfaction from involvement in patient care (Sinclair & Hamill, 2007). For example, oncology nurses who care for patients experiencing the trauma of their diagnosis, treatment, and, potentially, end-of-life may begin to focus on the negative consequences of their relationship with that patient; as opposed to the individual success that the nurse has had with the patient and the overall level of patient care that they have provided.

Finally, Sabo (2008) suggested that vicarious traumatization and continuous exposure to cruelty, trauma and suffering may leave an individual open to emotional and spiritual costs. By definition the effects of vicarious traumatization are similar to post-traumatic stress disorders feelings of "horror, fear and helplessness" (p. 25). Some workers exposure to trauma work results in emotional distress, which could be considered an occupational risk (Sabin-Farrell & Turpin, 2003). There are many professionals who may potentially encounter vicarious traumatization (Sinclair & Hamill, 2007). Prevention of vicarious traumatization involves heightened awareness of situations, as well as a supportive environment (Al-Mateen, Linker, Damle, Hupe, Helfer, & Jessick, 2015). An understanding of vicarious traumatization is not sufficient to protect individuals from negative outcomes.

Summary of Terms Used to Describe Effects/Syndromes that Result from the Nurses' Grief

In addition to the differing terms used to describe grief, there have been varying terms used in the literature to describe the negative effects that result from nurses' grief. Burnout has been noted to occur from prolonged levels of high stress, and it is known to affect the professional life of the nurse, as well as the personal life. Moral distress is the

negative feelings associated with not being able to follow a personal moral when adhering to others' guidelines or rules. Similarly, stress of conscience occurs in situations that challenge an individual's sense of right and wrong. Compassion fatigue is very complex and can gradually worsen into a more complex occurrence that can escalate gradually, as a result of cumulative stress over time. Compulsive sensitivity describes a feeling of being compelled to provide for others before one's self. Whereas, vicarious traumatization occurs when in the process of helping others deal with a trauma, the work impacts the caregivers themselves. Finally, secondary traumatic stress disorder may result in those who are caring for people who have experienced trauma.

Chapter Summary

This review of terms related to nurses' grief was not designed to suggest that these terms were necessarily equivalent to *nurse's grief*, only to introduce how there are many terms within the literature that describe both the actual emotion, and the potential responses to that emotion, that affected nurses who experience grief. Papadatou, Bellali, Papazoglou, and Petraki (2002) concisely defined grieving as "the process that comprises a person's grief responses and coping strategies in his or her attempt to adjust to an experience that is perceived as a loss and accommodated it into one's life" (p. 346). For the purposes of this study, the term grief or nurses' grief was used to encompass all of the negative emotional responses that a nurse might experience due to the death or serious changes in the condition of a patient. In this chapter acute grief was differentiated from complicated grief, and pathological grief. The type of grief that is the focus of this study is acute grief.

Nurses' grief can affect nurses both on the job and in their personal lives (Bush, 2009). The death of a patient can be one of the major causes of grief for nurses (Saunders & Valente, 1994). The experience of grief from the death or serious changes in the condition of a patient is a reality for many oncology nurses. As oncology nurses generally care for patients from diagnosis and sometimes to death, they are often more susceptible to experiencing nurses' grief (Caton & Klemm, 2006). The long trajectory of cancer care, combined with the intensity of the experience, provides a context in which strong connections may form between nurse and patient. The nature of these relationships means that when patient death or serious changes in the condition occurs the nurse may experience grief.

While there are many strategies that nurses, unit administrators, and hospital managers can employ to help nurses express and manage their grief, in many instances these strategies are ineffective (Huggard & Nichols, 2011). Further, repressing grief may be a protective mechanism; however, the appropriate balance between experiencing and repressing grief must be achieved or burnout and a desire to leave nursing may occur (Papadatou et al., 2002). Given these realities, there is a need to explore what is known about how oncology nurses experience grief that encompasses the variety of terms used to describe nurses' grief. Comparing and contrasting each of these terms provides a greater, more in-depth understanding of the concept of nurses' grief. It will also tie together many studies that have already been conducted on the broaden topic of nurses' grief, and the analysis has the potential to provide a foundation for future research into the issue.

Chapter 3: METHODOLOGY

The purpose of the study was to examine how nurses' grief, specifically oncology nurses' grief resulting from patient death or serious changes in the condition of patients they are caring for, was described in the literature. This general purpose was focused on answering these research questions:

1. In comparing and contrasting the definitions for various terms related to oncology nurses' grief, what are the commonalities and differences among these terms?
2. Based on the outcome of this study, how could oncology nurses' grief be conceptualized in a manner that incorporates the current varying terms and definitions?

To answer the proposed questions a qualitative meta-analysis, also known as a metasynthesis in the literature, was selected as the methodology (Sandelowski, Docherty, & Emden, 1997). The term metasynthesis was used synonymously with qualitative meta-analysis. For the purposes of this study, I used metasynthesis unless referencing required otherwise.

In this chapter, I describe the methodology and framework used as the foundation to conduct this thesis study. Next, I outline the method of data collection, which consists of using various online databases and multiple search terms to locate articles to contribute to this study. This is followed by a discussion of the analysis process used to look for emerging patterns and to generate themes that might not normally be easily identified. Finally, a discussion of how rigour was ensured and the limitations that were identified by the researcher is described.

Research Design

A metasynthesis methodology was an appropriate approach to examine the proposed research question because its purpose is to synthesis research findings into an explanatory, interpretative product (Schreiber, Crooks, & Stern, 1997). McCormick, Rodney, and Varcoe (2003) argued that qualitative works have not been "optimally combined, compared, contrasted, and integrated" with each other (p. 933). The authors suggested that there were too few methods available to qualitative researchers that would allow them to combine findings from various qualitative studies that use different approaches in methodology. These lack of methods made it difficult to identify the compatibilities in, and similarities of, underlying assumptions of the various qualitative approaches. The process of metasynthesis offered a systematic approach to bring new insights to a topic under investigation by further describing and explaining that topic in a broader, more encompassing perspective (Walsh & Downe, 2005).

Further, Whittemore and Knafl (2005) suggested a qualitative meta-analysis can "combine the evidence of multiple studies regarding a specific… problem to inform clinical practice and are the method of choice for evidence-based practice initiatives" (p. 547). Essentially, findings and recommendations from similar studies can be transformed into a more useable document using metasynthesis. Synthesizing multiple studies may be a complex process but it has the potential to broaden understanding of qualitative research (Whittemore & Knafl, 2005).

In this instance, the specific goal was to gain a better understanding of the terms used to describe grief oncology nurses may experience, and to compare and contrast these terms to determine commonalities and differences. Schreiber et al. (1997) identified

three ways in which meta-analytic techniques are used in a metasynthesis. First, theory building, which begins with describing and systematically abstracting the research to higher levels. It enables the researcher to use diverse data to create a formal theory. Second, theory explication, which begins with an abstract concept and branches out but identifies that all ideas that refer back to the original concept. Third, theoretical development, which is the synthesis of findings into a final descriptive and comprehensive product that offers a more complete analysis than any of the other individual studies. It is this third, and final technique that I had hoped to accomplish in this study.

Additionally, Whittmore and Knalf (2005) suggested the following five-stage framework to guide a metasynthesis:

1. Problem Identification: A problem is clearly identified and has a specified purpose. Nurses' grief, and terms associated with it, have been identified as the concept needing to be clarified to provide greater clarity and understanding of the concept. This clear problem identification facilitated identification of pertinent information during data collection.
2. Literature Search: All relevant literature must be reviewed. For the purposes of this thesis, relevant literature included the academic databases available through the Athabasca University electronic library (*ProQuest*, *Nursing & Allied Health Source*, *PubMed*, *CINAHL*, and *PsycInfo*) and open access resources available through *Google Scholar* that meet the inclusion and exclusion criteria listed below.

3. Data Evaluation: Evaluating and interpreting quality of sources, any literature will be included that adds to the understanding diversity of nurses' grief.
4. Data Analysis: Data were coded and placed in categories, then interpreted. The goal was to have a thorough and unbiased interpretation of the resources and synthesis of evidence. In this stage, data are reduced, displayed, compared, conclusions drawn, and verified.
5. Presentation: Includes a table or diagram depicting details from sources. Results capture the "depth and breadth" of the topics and contribute to a new understanding.

The above mentioned five-stage framework served as an outline for this metasynthesis of the concept of oncology nurses' grief. Each step was purposeful, and provided a concise picture of the problem and how to reach an end product that contributed to a better understanding of the concept of oncology nurses' grief.

Zimmer (2006) described metasynthesis as "a type of qualitative study that uses as data the findings from other qualitative studies linked by the same or a related topic" (p. 312). Further, Sandelowski et al. (1997) stated the findings from many qualitative studies have the potential to assist in knowledge development and practical utilization. However, to have an impact a larger interpretable context is needed that is "accessible and usable" in areas of practice and policy (p. 365).

Additionally, Sandelowski et al. (1997) identified three types of syntheses that have been attempted: 1) integration of findings from multiple analytic paths taken by same investigators, 2) synthesis of findings across studies by different investigators, and

3) using quantitative methods to aggregate cases across different studies. It was this second type of synthesis that I was interested in conducting: a synthesis of findings across studies by different investigators, which was the most common approach for metasynthesis research according to Walsh and Downe (2005). Researchers have begun to take on the synthesizing of qualitative research conducted by different investigators to combine and re-interpret findings (McCormick et al., 2003), as doing this amalgamation provides new data from which researchers can render new insights into what further research may be required on a specific topic – such as nurses' grief.

Literature Search and Data Evaluation

The initial literature search into nurses' grief utilized the Athabasca University electronic library holdings and open access resources available through *ProQuest*, *Nursing & Allied Health Source*, *PubMed, CINAHL, PsycInfo* and *Google Scholar*. Initial search terms included: grief, bereavement, secondary traumatic stress disorder, stress of conscience, moral distress, moral fatigue, compulsive sensitivity, disenfranchised grief, vicarious traumatization, cumulative grief, chronic compounded grief, burnout, patient death, and compassion fatigue. A second round of searching included oncology nurses, cancer nursing, and patient death.

After an initial review of the literature, I briefly defined various terms that were associated with nurses' grief (as discussed in Chapter Two). The literature search to generate the data for the study needed to be broader than the original literature search and have inclusion/exclusion criteria (described in the following sub-sections) in order to result in a pool of literature to which the metasynthesis technique could be applied.

Inclusion Criteria

The literature search to create the data for the metasynthesis included the following search terms: grief, bereavement, secondary traumatic stress disorder, stress of conscience, moral distress, moral fatigue, compulsive sensitivity, disenfranchised grief, vicarious traumatization, cumulative grief, chronic compounded grief, burnout, patient death, and compassion fatigue. Data were generated from the following databases: *ProQuest*, *Nursing & Allied Health Source*, *PubMed, CINAHL, PsycInfo*, and open access resources available through and *Google Scholar.* More specifically, inclusion criteria were limited to journal articles that were directly related to oncology nursing.

Walsh and Downe (2005) suggested that the search strategy be formed before the formal search begins to ensure a linear representation of available data. Thus, after accessing the data there was a systematic approach or strategy used, which was formulated before the search was conducted to guide the search. I considered the most recent literature first and then proceeded back in time until no new data points were found. Literature was included that added to understanding the diversity of terms related to oncology nurses' grief and the effects of this grief on oncology nurses.

Exclusion Criteria

The search excluded articles that dealt with the grief experienced by nurses in specialties outside of oncology, the nurses' family, physicians/doctors, other members of the health care team, patients, and patient's families. Government documents, industry reports, conference papers and presentations, dissertations and theses, and books were also excluded. The desire was to base findings on peer reviewed research, and the

process of peer review that journal articles undertake ensures a level of rigour in that empirical research that might not be present in these other forms of scholarship.

Data Analysis

In terms of the actual process or strategy for data analysis, Merriam (2009) stated that the goal of data analysis is to communicate understanding. The search for meaning in data was done through the identification of patterns. While some patterns were known – or at least suspected – at the beginning of the data collection, others emerged in the data analysis. Finally, Creswell (2013) indicated that the scope of the data analysis could be holistic (i.e., an analysis of the entire case) or embedded (i.e., a specific aspect is being analyzed).

Analysis of the articles collected was a time consuming and tedious task. I planned to use the constant comparative method (LeCompte & Preissle, 1993), which focused on identifying categories and on generating statements of relationship, to analyze the data. To undertake this process in a systematic fashion, I used the table format and the search and replace features *Microsoft Word*® as a tool for a four-stage process qualitative data analysis (Ruona, 2005). Ruona described each stage as follows. Stage one was when data were transcribed. In this instance, since the data were pieces of literature, it was already been transcribed. Stage two called for the researcher to become familiar with the data, reading and re-reading the articles, and jotting notes of initial observations.

It was during stage three that the actual coding of the data occurs. Cooper (2010) stated that, "if the number of studies involved in [the] synthesis is small, it may not be necessary before you begin to examine the literature to have a precise and complete idea

about what information to collect about the studies" (p. 85). Further, Cooper advised that in these situations an appropriate strategy would be to use the data itself to generate the codes. Based on this advice I used a process of open coding. Open coding was designed "to uncover, name, and develop concepts, we must open up the text and expose the thoughts, ideas, and meanings contained therein" (Strauss & Corbin, 1990, p. 102). Codes were generated directly from the data, and they allowed the researcher to identify and develop an understanding of the data based on close and multiple examinations of the data (Emerson, Fretz, & Shaw, 1995). Open coding helped the process of making comparisons in the data (Charmaz, 2000). Data were coded in three phases: initial, focused and theoretical (Penz & Duggleby, 2011). I used a hand or manual coding method to complete my coding (Saldana, 2012).

After reviewing the data multiple times in the coding process, data saturation was reached when redundancy in codes occurred or no new codes were identified (Bogdan & Biklen, 2006; Glaser & Strauss, 1967). Walker (2012) stated that there was no consistent manner in which to determine saturation in qualitative research, thus researchers may use many different strategies to do so. Data saturation was reached for this study when there were no new results generated following two rounds of review (i.e., the data were reviewed completely twice without new codes being generated).

Finally, stage four was where I began to generate themes to uncover overall meaning. Constant comparative method is a type of inductive analysis that involved scanning the data to develop and identify codes and relationships within individual pieces of data and between pieces of data (Ezzy, 2002; LeCompte & Preissle, 1993). While the constant comparative method of data analysis is commonly associated with grounded

theory (Charmaz, 2001; Glaser, 1978; Glaser & Strauss, 1967; Strauss, 1987), there is a growing movement within qualitative research to expand its use beyond studies that utilize grounded theory methodology (Boeije, 2002; Fram, 2013). After my initial coding of the data by creating my list of the most common words found in my data, I attempted to group together common words that were associated to each other to develop categories. Rich (2012) instructed, "through classifying differing and similar concepts, categories are formed and a researcher can further his/her own understanding of the concepts involved" (p. 4). I then put the words that I identified into categories (Strauss & Corbin, 1990). This was depicted in a table for better visual understanding. For example, Bates Averill (2002) described a matrix where terms could be arranged in rows and columns that would assist in describing the commonalities and differences.

While some words were easily placed in two or more concepts, I used my own judgment and go with what I thought was most fitting based on key words that appeared in the data (i.e., both based on author identification and my own coding) and on the consistency with other similar codes. This process provided me with a simpler analysis of my data because once a category was identified I could start to develop specific properties and dimensions for each one (Rich, 2012).

Once this was completed, I considered the potential of integrating or splitting of categories, until I was left with a set of core categories (Pidgeon & Henwood, 2004). After I had a table of categories created, I was able to see the beginnings of initial themes emerging from the groups of words that were not as easily identifiable from the larger list. Rich (2012) referred to these as patterns. By continuing to look at the data, ask questions and making comparisons, and using the inductive thinking process of relating

categories, I was able to validate similarities and relationships and then draw themes for further development (Kolb, 2012).

Ensuring Rigour

Reliability and validity have long been the measure of how rigourously a research study has been conducted (Merriam, 2009). Reliability and validity refer to the ability of the tools of the study to consistently and accurately measure the data (LoBiondo-Wood & Haber, 2005). However, some qualitative researchers have begun to question whether concepts such as internal validity, external validity, reliability and objectivity would be better conceptualized as credibility, transferability, dependability, and confirmability within the qualitative research methods (Lincoln & Guba, 1985). This alternative perspective of reliability and validity for qualitative research has been popular within health care and nursing research (El Hussein, Jakubec, & Osuji, 2015; Golafshani, 2003; Long & Johnson, 2000; Sandelowski, 1986; Thomas & Magilvy, 2011; Twinn, 1997). Interestingly, Creswell (2013) outlined how there was still division between many seminal qualitative scholars on the use of the traditional terms of reliability and validity or re-conceptualized terms. Regardless if an individual researcher chooses to use the rhetoric of one paradigm or another (Firestone, 1987), that researcher must still ensure the quality or rigour of the study (Patton, 2015). In this particular thesis study, I have sought to ensure rigour using four techniques: triangulation, audit trail, peer debriefing, and reflexivity.

Rigour in this qualitative research was primarily ensured by triangulation of the data. Stake (1995) defined triangulation as "working to substantiate an interpretation or to clarify its different meanings" (p. 173). Triangulation was accomplished by using both

multiple sources of data, and multiple data collection methods (Bogdan & Biklen, 2003). In this study, I compared various pieces of literature. Further, as there were multiple searches, this allowed for ongoing comparison of multiple data sources.

In addition to triangulation, another strategy that I used to ensure rigour in the study was to create an audit trail. Dickson, Buck, and Riegel (2011) advised that "methodological rigour of… qualitative analysis [can be] maintained through an audit trail [and] periodic debriefing with the co-investigators and discussions with colleagues knowledgeable about…" nurses' grief (p. 414). Further, Dickson and colleagues recommended that, "an audit trail of process and analytic memos and coding books [be] maintained to support the credibility of the study" (p. 414). In order to develop a detailed audit trail, I maintained a log of all research activities, developed memos, maintained a research journal, and documented all data collection and analysis procedures throughout the study (Creswell & Miller, 2000). As such, I maintained an audit trail including these items.

A third way I ensured rigour was through peer debriefing (McBrien, 2008). I consult with my thesis advisor, and other senior colleagues that were knowledgeable about nurses' grief, throughout the thesis process. My advisor, along with her colleagues, explored the phenomena of compassion fatigue in oncology nurses (Perry, Toffner, Merrick, & Dalton, 2011). The results of their study built a strong argument for workplace support and acknowledging the unique experience of oncology nurses. Further, Perry (2009) studied exemplary oncology nurses who appear have avoided compassion fatigue. These nurses turned experiences seen as negative by some into more positive experiences for both the nurses and their patients. It was her background in the

broader topic of nurses' grief, specifically in the field of oncology, which made her a suitable knowledgeable critic. Similarly, I had access to several colleagues including a nurse practitioner who specializes in palliative care who wrote her thesis on vicarious traumatization, as well four of my oncology nursing colleagues who I also discussed the findings with. These colleagues provided feedback on the results as part of peer debriefing for study rigour.

A final approach used to ensure rigour was to incorporate reflexivity. Jootun, McGhee, and Marland (2009) stated that undertaking the reflexive process helps the researcher to develop insight. This process requires active acknowledgment that my actions and decisions as the researcher inevitably had impact upon meanings and the context of the analysis (McBrien, 2008). Reflecting on the process of my research, and trying to understand how my own values and views influenced the findings, added credibility to my research and was part of any method of qualitative investigation (Jootun et al., 2009). For example, I had been interested in nurses' grief and had read many articles before beginning data collection. Some of these articles I read again as they formed part of my data set. Earlier in the thesis I discussed some of my personal experiences with oncology nursing and shared my experiences with grief when patients I cared for died. This sensitivity to my biases, views and experiences with oncology nurse grief prepared me with self-awareness when conducting this study. Since I catalogued data – or placed data in categories – I took this opportunity to question my own understanding and tried to look at the data from different perspectives before making decisions over where information might best fit. I used reflective journaling to keep a record of those thoughts, feelings, and actions (Hubbs & Brand, 2005).

Subjectivity Statement

A subjectivity statement is designed as a space for the researcher to "review and acknowledge her or his subjectivity" (Cihelkova, 2013, p. 4). Peshkin (1988) argued subjectivity was inevitable, and "that researchers should systematically seek out their subjectivity" (p. 17). Further Peshkin stated that, "the purpose of doing so is to enable researchers to be aware of how their subjectivity may be shaping their inquiry and its outcomes" (p. 17). One of the reasons to undertake such an activity is that "insights about the observer's self can prove useful for understanding" one's research (Kreiger, 1985, p. 309), as well as be "useful in generating insights" about the data (p. 320). The following section describes my own subjectivities with respect to the topic of oncology nurses' grief.

Throughout my nursing career, I have had an awareness of my feelings towards my work – both positive and negative. I still remember one of the first patients I took care of that died peacefully, surrounded by her family after a stroke. I also remember my first patient to die of sudden cardiac arrest, who I had done chest compressions on during the code blue. Yet, it wasn't until I became an oncology nurse that I became increasingly aware of how patient deaths and other negative outcomes were affecting not just myself but also fellow nurses. As discussed in Chapter 1, the relationship that developed, coming to know one another on a different level, becoming a part of the oncology patients' extended family, I felt was the difference for me in how I reacted to these patient deaths. I remember several patients whom I gave their first chemotherapy to, I educated them, I provided one on one nursing for their transfusions, and I answered many of the patients and their families many questions. I saw these patients come and go from

our unit sometimes staying a couple days, sometimes a month or more. Then eventually I saw many of them die, some alone, some surrounded by family. But as was the norm in nursing, I had to care for three or four other patients and could not allow my grief to show or to affect my work.

I recognized that in some circumstances, death was a blessing for the patient. It was an end to the pain and to the suffering they had endured; yet there was still the period of mourning, even for an expected death. I started to wonder if my fellow nurses felt similar emotions and how they dealt with these emotions. Our families and non-nursing friends found these conversations depressing, and would often change the subject. Thus, we found we could only talk to each other in a frank, direct way about what had happened, and our feelings about it. Again, there were still nurses who did not wish to talk about their feelings and carried on as though nothing happened. But I, personally, found it easier to carry on if I could take a moment either alone or with a fellow nurse to debrief after a patient's death.

There have been opportunities to both laugh and cry, and despite attempts to hide any emotion – tears do come. Despite the support we gave each other, each occurrence was unique and needed its own moment to reflect. This is where my research interest stemmed from. Why do some nurses, like myself, need these moments and others do not? Does this frequent exposure have long-term effects on us as oncology nurses? If I could even begin to understand oncology nurses' grief and share my findings maybe these experiences can assist us to grow and be more equipped to help patients, families and fellow nurses with these feelings of grief. These were the subjectivities that I possessed as I approached my thesis study.

Limitations

Due to the nature of the study, and the fact that a single novice researcher was conducting the analysis, there was the potential for bias to impact the clarity and validity of the results (Drost, 2011). My own experiences had the potential to affect how I interpreted situations and other research findings. One way to guard against this is to bracket my existing beliefs and prior knowledge while looking at the data (Richards & Morse, 2013). While it is not possible to forget experiences or knowledge, it is possible to take prior experience and knowledge and placing it in a context where it does not affect the research. Bracketing involves not only removing the researcher's experiences and understandings regarding the topic being studied, but also society's understanding as well. Suspending perceptions assists the researcher to see the phenomenon in its purest form. Reflexive bracketing requires the researcher to develop a "thoughtful, conscious self-awareness" (Finlay, 2002, p. 532). Reflexive bracketing is a particularly useful technique for those who have personal experience with a phenomenon they are investigating. It was being aware of this that assisted in looking at the data from all angles, and not just a narrow lens. I might not recall all of the information related to the various articles, and needed to read and re-read articles. Further, the consultation with my thesis advisor and senior colleagues – as 'colleagues knowledgeable about nurses' grief' – also helped guard against this potential limitation (McBrien, 2008).

Additionally, due to the sensitive nature of the topic, I needed to identify signs that the data analysis could have caused me emotional distress. I took frequent breaks and took part in enjoyable tasks (Bowen, 2008) to help prevent or deal with this potential distress. I also spoke to family, friends, and fellow researchers regarding topics that

arose due to the distress of prolonged exposure to literature related to grief and forming negative emotions. Reading the literature regarding nurses' grief had the potential to trigger memories that were distressing and I needed to have self-awareness and sought support as needed to prevent any negative consequences of this experience.

Finally, considering how many terms I had already found in my literature review of various words related to nurses' grief, there was the possibility some had been excluded. Whittemore and Knalf (2005) identified that combining diverse data sources is complex and challenging. As part of the metasynthesis, a more in-depth literature search was undertaken and, if more terms were found that contributed to the understanding being sought, they were included in the final product. However, given the vastness and complexity of the concept of nurses' grief it is always possible that some relevant terms were left out of the analysis.

Chapter Summary

The purpose of the study was to examine how nurses' grief, specifically oncology nurses' grief resulting from patient death or serious changes in the condition of patients they are caring for, was described in the literature. This general purpose was focused by the following research questions:

1. In comparing and contrasting the definitions for various terms related to oncology nurses' grief, what are the commonalities and differences among these terms?
2. Based on the outcome of this study, how could oncology nurses' grief be conceptualized in a manner that incorporates the current varying terms and definitions?

A qualitative meta-analysis or metasynthesis was selected as an appropriate methodology to answer these research questions. There are instances where the terms were used as a synonym or a description of the emotion of grief, while many similar terms have also been used to describe responses of nurses to grief they experience. In some cases, the same term was used to describe both the emotion of grief and a nurses' response to grief, depending on which author(s) were consulted. It was hoped that the metaynthesis would provide a deeper understanding of the concepts and the terms used in the literature to describe this experience ultimately to create a fuller picture of the oncology nurses' responses to grief. This would provide a foundation for further research studies aimed at discovering ways that nurses could deal with grief and prevent or overcome the negative consequences associated with the grief experience.

A metasynthesis methodology best examined the research question by allowing the researcher to synthesize the findings into an end product that was explanatory and interpretative. Data were collected using various online databases and multiple search terms to generate articles that contributed to the study. Analyzing the data began with an attempt to find what patterns emerged as the data were reviewed. Open coding assisted in generating themes that might not normally be easily identified. Through triangulation of the data, rigour was enhanced. Rigour was further ensured by keeping an audit trail, as well as debriefing with my thesis advisor and senior colleagues. The topic for this thesis was chosen based on the researchers' own experiences as an oncology nurse, thus throughout the data collection and analysis I tried to be as transparent as possible, identifying my own subjectivities. Limitations included my own personal experiences and opinions that were set aside (or at least expressed for the reader's awareness) when

analyzing the data. Also it was important to monitor my own personal distress, and to do joyful things that kept my spirits high and maintained my psychological well-being while conducting this research study.

Chapter 4: RESULTS

In this chapter, I analyze the results in an effort to better understand the findings in a way that will specifically answer each of the research questions. I begin with a discussion of the results that were generated from the process that I followed to render the data for this metasynthesis. This discussion describes the number of articles found for each year included in the review, as well as the actions undertaken to decrease that number through further review using the exclusion criteria. Tables are used to summarize the large amount of data. After having described the process that was followed for this metasynthesis, I use the data to address each of my research questions individually. First, I examine the various terms that were used to describe oncology nurses' grief, including how the dominant or focus terms were described and some of the general themes from this data. Second, I compare and contrast the identified terms, as well as propose what I consider the most suitable term and definition to be used for oncology nurses' grief.

Based on my data collection efforts, I initially identified approximately 37,500 pieces of literature to review. These numbers were greatly reduced when inclusion and exclusion criteria were applied (see Table 4.1). The 'total found' column represents the total number of articles found for each year using the databases and search terms listed in chapter three. The 'first review' column looked at titles and allowed removal of articles whose titles were informative enough to exclude them. The 'second review' and 'third review' columns represent the number of articles remaining following the second and third rounds of review that required reading each article in-depth to be sure it met the inclusion criteria. The 'final review' column represent the number of articles remaining

following a fourth and final review that was conducted to ensure all articles met the requirements of inclusion.

Table 4.1

Data Search Numbers.

Year	**Total Found**	**First Review**	**Second Review**	**Third Review**	**Final Review**
2014	4430	23	7	5	4
2013	4490	23	4	4	3
2012	4530	22	8	6	6
2011	4420	12	7	6	5
2010	3900	15	2	1	1
2009	3590	12	4	4	4
2008	3660	10	3	4	3
2007	3110	2	0	1	1
2006	2750	5	1	1	1
2005	2620	1	0	0	0
Totals	*37,500*	*125*	*36*	*32*	*29*

For much of this literature the title alone was enough to exclude the piece as a possible data point, for example titles that referred to health professionals rather than nurses such as an article by Breen, O'Connor, Hewitt, and Lobb (2013) with the title "The 'Specter' of Cancer: Exploring Secondary Trauma for Health Professionals Providing Cancer Support and Counseling," or titles that referred to settings other than oncology such as critical care (Stayt, 2009) or a medical unit (Wilson, 2014). Other literature required a

closer examination to determine if it met the inclusion criteria (see Table 4.2 for a summary of excluded items).

Table 4.2

Why Literature Was Excluded During Second, Third, or Final Round

	2014	2013	2012	2011	2010	2009	2008	2007	2006	2005
Dissertation	5	1	0	0	0	0	0	0	0	0
Book	1	1	0	0	0	0	0	0	0	0
Not oncology	10	10	10	2	10	4	0	0	0	0
Not nursing	2	5	2	2	3	2	4	1	0	1
Not based on data	1	0	0	0	0	0	0	0	0	0
Not grief	0	4	1	0	1	1	1	0	1	0
Workshop	0	0	1	0	0	0	0	0	0	0
Poster	0	0	1	0	0	0	0	0	0	0
Not available	0	0	1	0	0	0	0	0	0	0
Totals	*19*	*20*	*16*	*4*	*14*	*7*	*5*	*1*	*1*	*1*

As indicated in the previous chapter the inclusion criteria were peer-reviewed journal articles that focused specifically on oncology, the research subjects had to be oncology nurses (as opposed to other health care providers or family members), and the article had to relate in some way to grief and/or death.

As the data search was conducted in reverse chronological order (beginning with the most current articles), there were some general trends from the search process (i.e., the data collection phase) that were more easily identifiable than others. For example,

during the three most recent years (2013-2015), the majority of articles that made the first cut were either not involving oncology or included specialties other than oncology. Further, the total number of articles available directly related to oncology nurses' grief increased for each year that was searched. To illustrate this point, for 2014 there were 4430 pieces of literature included in the initial search results related to nurses' grief in general, a figure that represented an increase of 1810 pieces of literature compared to 10 years earlier (i.e., from the 1994 calendar year). This general trend indicated that research related to oncology nurses' grief in a broad sense had increased.

Throughout the process of data collection and analysis it was evident that common themes were emerging. Words and concepts overlapped but many terms seemed to have one aspect that made them different from the others. To better answer the research questions, tables were utilized during the constant comparison of the data (i.e., the articles) to better organize and visualize that data. In particular, an analysis of the number of times particular words were used and what the most dominant words used by authors were allowed for a more in-depth comparison.

Research Question 1. In comparing and contrasting the definition for various terms related to oncology nurses' grief, what are the commonalities and differences among these terms?

After reviewing the data and examining the many factors that contributed to oncology nurses' grief, a total of 25 words or phrases were revealed that referred to similar physical and/or mental states (see Table 4.3 in Appendix A for a numerical representation and also see Table 4.5 in Appendix B for the complete summary). Patton (2015) indicated that quantitizing or translating qualitative data into a numerical representation was a common

practice, and the use of counting the number of codes associated with a particular theme was one of two main techniques of quantitizing. This representation was used to determine which terms to discuss as a part of this results section, as it would be difficult to discuss all 25 (although it should be noted that all terms were analyzed). In many instances, a single article referenced multiple and different terms related to oncology nurses' grief. Each word carried with it slightly different nuances that made it difficult to attempt to summarize and/or incorporate all of them into a single word, phrase, or concept.

As Table 4.3 illustrated, many terms occurred only once in the data. These single occurrence terms included: burnout syndrome, compassion overload, chronic burnout, chronic compounded grief, chronic stress, loss and grief, nurses' grief, professional grief, vicarious emotional suffering, health care giver grief, secondary traumatic stress, emotional exhaustion, secondary trauma, post-traumatic stress disorder, and traumatic stress. Further, there were a number of terms that were only mentioned in two to five articles each (i.e., moral distress, cumulative loss, and cumulative grief on two occasions; secondary traumatic stress disorder on three occasions; bereavement and vicarious traumatization on four occasions; and grief and stress on five occasions).

The two most popular terms used to describe oncology nurses' grief from the data were burnout (the focus of 22 articles) and compassion fatigue (the focus of 16 articles), followed by much broader terms grief (seven articles) and stress (six articles). Some articles had overlapping terms that were mentioned, but many articles used one particular term more than others (a dominant term or term of focus). In other instances, while the article referenced multiple terms (often in the literature review), there was a single term

that was the focus of the study/article (often used primarily in the methodology and results portions). It is this focus term that is drawn out as the focus of the current study.

Six of 22 articles that used the term 'burnout,' had the term in the title. These articles focused on a variety of questions related to burnout from comparing adult and pediatric settings (Davis, Lind, & Sorensen, 2013), to burnout of nurses in Iran (Farsi, Nayeri, & Sajadi, 2013), to psychosocial consequences of burnout (Sabo, 2008). Burnout was used in the introduction of many articles because it seemed, literature reviews on the subject of nurses' grief, referred to burnout before moving on to discussing other concepts. One might interpret from the literature that burnout had been portrayed as the initial concept researched when the impact of nurses' work on their physical and psychological well-being was first studied. Essentially, it seems that burnout was the foundational concept for the field of study related to nurses' grief, which may be why it was often discussed early in the articles.

Of the 16 articles that used the term 'compassion fatigue,' seven articles included the term in the title. These articles explored compassion fatigue in oncology nurses by focusing on nurses' experiences (Perry et al., 2011), prevalence of compassion fatigue (Potter, Deshields, Divanbeigi, Berger, Cipriano, Norris, & Olsen, 2010), how nurses coped after facing compassion fatigue (Houck, 2014), potential risk factors for acquiring compassion fatigue (Bush, 2009), how to recognize and combat compassion fatigue (Fetter, 2012), and/or suggested interventions for those with compassion fatigue (Aycock & Boyle, 2009). In each of these articles the researchers examined what compassion fatigue was, why compassion fatigue happens, and what can be done to prevent compassion fatigue.

The theme of the negative impact of compassion fatigue on the work of oncology nurses was also clearly evident. This negative impact affected nurses personally, as well as their level of productivity on the job (Aycock & Boyle, 2009; Najjar, Davis, Beck-Coon, & Doebbeling, 2009). One of the implications for practice from these articles that was quite apparent was the acknowledgment of oncology nurses' grief by other staff and managers allowed more opportunity to for nurses to share their feelings to help combat compassion fatigue (Fetter, 2012; Najjar et al., 2009). Most recently Boyle (2015) stated that a nurse's productivity and efficiency could both become impaired after being influenced by compassion fatigue (among other factors). Boyle even reported that some nurses decided to leave their current jobs, or leave nursing for different careers, as a result. While compassion fatigue can impact oncology nurses negatively, assisting nurses to process their thoughts before those thoughts become a burden could decrease the negative effects of compassion fatigue and help nurses find positive meaning in their experiences.

To further clarify the authors' individual foci, each article was reviewed again to determine which term or concept the authors themselves used as the focus of their study. During the initial data analysis, it was noted that authors often described many different terms in their introduction and/or literature review. However, it was evident in the methodology, results and/or conclusion of their work that most authors chose to consistently use a single term (i.e., that generally formed the focus of their study or article). The reason each author used specific terms is unknown, but in each piece of research there was a single, dominant or focus term that authors chose to investigate. For example, Aycock and Boyle (2009) referenced grief, burnout, compassion fatigue,

compulsive sensitivity, moral distress, moral fatigue, secondary traumatic stress disorder, and stress of conscience in their introduction, literature review, and discussion. Yet, the authors chose to solely use compassion fatigue in the title of their article, as well as in their description of the methodology and in the reporting of their results. Fundamentally, while the authors incorporated multiple terms when situating their study within the larger field of oncology nurses' grief, their actual study focused on the compassion fatigue experienced by oncology nurses. When each article was assigned a single term the results indicated that compassion fatigue was the most common term used in seven studies, burnout was the focus of six investigations, and stress and grief were the focus in four studies (see Table 4.4).

Table 4.4

Single Most Dominant or Focus Term in Articles Used as Data

Compassion fatigue	7
Burnout	6
Grief	5
Stress	4
Cumulative grief	2
Loss and grief	1
Emotional labour	1
Vicarious traumatization	1
Nurses grief	1

The top four terms (i.e., compassion fatigue, burnout, grief and stress) were further analyzed thematically (see Table 4.5 in Appendix B).

Based the data in Table 4.5, the terms compassion fatigue, burnout, grief, and stress were most commonly used when referring to oncology nurses' grief in the literature reviewed, and all four have common descriptive phrases.

Compassion Fatigue and Oncology Nurses' Grief

The descriptive phrases used by the authors of the seven articles related to compassion fatigue were similar. In all seven of these articles the authors referred to the terms 'emotional' or 'psychological,' often at the beginning or end of other words, to further qualify the mental aspect of the effect of compassion fatigue. For example, Fetter (2012) referred to emotional distress, while Wenzel, Shaha, Klimmek, and Krumm (2011) described it as psychological consequences, stress. Additionally, Perry et al. (2011) described psychological, as well as physical consequences; while Bush (2009) used emotional over involvement. All of these words and variations made clear the impact compassion fatigue could have on the mental well-being of oncology nurses.

Compassion fatigue in oncology nurses was the most commonly associated with the death or serious changes in the condition of the patient. As an example, Aycock and Boyle (2009) stated that compassion fatigue was the term that "most closely captures all the elements" of trying to conceptualize the experiences of oncology nurses as related to frequent exposure to death and grief (p. 184). Further, Bush (2009) called compassion fatigue a "complex phenomenon that escalates gradually" when nurses do not attend to their own emotional needs (p. 25). Similarly, Najjar et al. (2009) found that compassion fatigue led to being vulnerable to emotional distress. Compassion fatigue was also said to occur when patients died, and the feelings of grief and bereavement were high and

experienced by nurses. In these situations nurses required interventions to assist with managing situations and feelings (Wenzel et al., 2011).

When adults and children who have cancer receive a poor prognosis it affects not only the patients themselves, but everyone around them. Fetter (2012) stated that oncology nurses might identify they were experiencing emotional struggles and loss of meaning related to the care they provided, and that they were likely experiencing compassion fatigue but were unable to name it as such. Further, Wenzel et al. (2011) stated that "nurses may relive and re-experience traumatic events repeatedly in their minds" (p. E272). Yet, nurses are expected to carry on as normal in these situations (Aycock & Boyle, 2009). Essentially, the nurses' emotional response could be referred to as grief when it occurs in isolation for a single patient, but for multiple patients throughout an individual oncology nurse's career, compassion fatigue appears to be the most appropriate term to describe the repetitive emotional response.

There were several ways to address or prevent compassion fatigue presented in their literature. For example, Aycock and Boyle (2009) suggested that integrating self-care practices into daily life may help nurses avoid compassion fatigue. They also stated that oncology nurses should build upon non-clinical strengths and find balance in their lives to help minimize compassion fatigue. Further, Fetter (2012) suggested that oncology nurses support each other to prevent the burden from falling on one nurse. Having supports available to the nurses to assist them with work-life balance could prevent compassion fatigue from occurring (Houck, 2014). Finally, Wenzel et al. (2011) suggested that the involvement of hospital administrators in creating and promoting

supportive environments could decrease negative consequences of the oncology nurses' work in these caregivers.

Burnout and Oncology Nurses' Grief

Six articles in the data depicted burnout as the term of focus. The authors of these articles used descriptive phrases that included stress (Davis et al., 2013; Farsi et al., 2013; Hunnibell et al., 2008; Leung et al., 2012) and emotional exhaustion (Edmonds et al., 2012; Emold, et al., 2011; Farsi et al., 2013). Both Edmonds et al. (2012) and Davis et al. (2013) also referred to physical illness or physical depletion resulting from burnout. While the initial literature review of the broader field of nurses' grief indicated greater physical symptoms associated with burnout, the data did not support this initial assumption. Like compassion fatigue, the oncology nurses' grief literature indicated that burnout had both physical and emotional effects.

Interestingly, burnout was often used in the data in ways that had some positive inferences. For example, Emold et al. (2011) reported 33.3% of participants in their study on burnout reported feeling emotional exhaustion 'often,' yet 82% of the participants also reported 'positive self-actualization.' While this can be interpreted as the job being mentally draining, the job was also seen as being rewarding. Similarly, Leung et al. (2012) found that some oncology nurses who had a close connection to their patients' suffering were overwhelmed and distressed, but that these experiences also gave meaning to their work. While oncology nurses may identify the negative effect the work was having on them, this also indicated that they identified that their work also had positive effects on themselves and their patients.

High workloads and lack of support were found to be the most prominent factors contributing to burnout (Emold et al., 2011). Also, the witnessed suffering of their patients caused nurses internal conflict between encouraging their patients to fight the disease, while at the same time preparing for the possibility of the death or serious changes in the condition of their patients. Thus, oncology nurses need unique supports to help them find meaning in their work and be responsive to patients without becoming overwhelmed themselves (Leung et al., 2012). Oncology nurses' experiences varied depending not only on acuity of patient load, but also individual experiences with each patient, both of which authors concluded could affect the likelihood of burnout (Aycock & Boyle, 2009).

A contributor to burnout in oncology nurses was the deaths or serious changes in the condition of patients whom they had developed close relationships with. In order to reduce this particular cause of burnout, this strain must be recognized and nurses need to be made to feel more supported (Davis et al., 2013). Thus, problems with having enough staff and high work demands contribute to burnout, and the reduction of these barriers would help decrease the occurrence of burnout (Edmonds et al., 2012). For example, the organization (i.e., the hospital) would need to support the reduction of burnout by increasing the number of staff when acuity is high and by providing additional supports to those staff. Overall, it was identified that while caring for people who are seriously ill or dying can result in nurse burnout, caring for people in such circumstances can also had positive outcomes for some nurses. More specifically, providing nursing care in such demanding circumstances can give meaning to the caregiving role. Nurses who feel supported by administrators who provide adequate staffing at times of high patient acuity

can help minimize the negative effects of burnout and enhance the possibility of positive outcomes for nurses.

Grief and Oncology Nurses' Grief

While the term grief was used to describe some other label for oncology nurses' grief in many of the studies reviewed (e.g., chronic compounded grief, cumulative grief, or even compassion fatigue and burnout), there were a select few pieces of literature that used the term grief as the term of focus for the study. All four pieces of literature that used grief as the term of focus used descriptive phrases such as emotional reactions (Rice, Bennett, & Billingsley, 2014), physical manifestations (Rice et al., 2014), grieving (Hildebrandt, 2012; Rice et al., 2014), stress (Caton & Klemm, 2006; Macpherson, 2008), and anxiety (Caton & Klemm, 2006). Three of the four articles using the term grief specifically referred to death and end of life as the grief causing agents (Hildebrandt, 2012; Macpherson, 2008; Rice et al., 2014). Grief has been most recently described as the intense emotional reaction nurses have to patient deaths that they may ignore or hide because of ongoing work responsibilities (Rice et al., 2014). Nurses cannot stop their daily work to grieve one patient when there are four or five others they are responsible for. As a consequence, grief has been, and continues to be, a focus of attention for oncology nurses and is often described in association with burnout and with leaving the specialty (Caton & Klemm, 2006; Macpherson, 2008).

Feelings of grief affect the care oncology nurses provide to their patients. Dying patients and their families require the optimized level of care of specialty skilled nurses (Caton & Klemm, 2006; & Hildebrandt, 2012). The concept of oncology nurses' grief and the aforementioned bond between oncology nurses and their patients was the basis

for this thesis. Further, oncology nurses experience intense emotional reactions to their patient deaths but are unable to address them because of their ongoing responsibilities (Rice et al., 2014). Thus, identifying and providing ways to prevent or ease the occurrence of grief for oncology nurses would improve both the nurse and the patient experience.

Caton and Kleem (2006) suggested that grief should be addressed at the beginning of the oncology nurse's career, stating that adequate preparation for the possibility of experiencing grief would improve outcomes for both nurses and patients. In fact, all four articles discussed promotion of grief resolution as a way of decreasing negative effects of grief on oncology nurses. For example, Macpherson (2008) suggested exchanging of stories might help these nurses in dealing with their grief. Additionally, Rice et al. (2014) examined the impact of oncology nurses using a computer program to support each other, and found what they described as 'potential benefits' of the computer program intervention to facilitate grief resolution. Thus, grief resolution strategies are becoming necessary to help retain nurses and to create more positive work environments (Hildebrandt, 2012). It was evident researchers had been exploring ways to decrease grief in oncology nurses and the issue continues to occur and impact nursing care and nurse career satisfaction.

Stress and Oncology Nurses' Grief

Stress was also the term of focus used in four pieces of literature reviewed. Like grief, stress was used primarily as a descriptive phrase for either compassion fatigue and/or burnout. Physical and emotional stressors (Altounji, Morgan, Grover, Daldumyan, & Secola, 2013; Hecktman, 2012), overwhelmed (Altounji et al., 2013),

stress (Hecktman, 2012; Sabo, 2008), powerlessness (Sabo, 2008), and high demands (Wittenberg-Lyles, Goldsmith, & Reno, 2014) were the descriptive phrases used; which were again similar to the terms used to describe compassion fatigue, burnout, and grief. Stress was found to be a term of focus that occurred in literature, though it was used more as a descriptive phrase in reference to both physical and emotional effects experienced by oncology nurses.

While the term stress had been used in defining both compassion fatigue and burnout (e.g., Emold et al., 2011; Wenzel et al., 2011), four pieces of the research data used stress as the term of focus to examine aspects of grief in oncology nurses with a focus on interventions to prevent or minimize grief. For example, Altounji et al. (2013) examined the grief prevention strategy of self-care retreats for pediatric oncology nurses (i.e., retreats that included discussions about moral distress, massage, yoga, a walk to a beach, etc.). The authors stated that these nurses experienced high volumes of 'stressors' that might lead to burnout and the purpose of the self-care retreats was to heal past stress and allow the nurses to find ways to cope with the inevitable future stress of working with pediatric oncology patients. Similarly, Hecktman (2012) stated a variety of stress prevention and management interventions should be used to decrease stress in the oncology workplace. One of the defining features for these four pieces of literature was that in the discussion sections the authored tended to use the more generic term of 'stress' or 'stressors' rather than compassion fatigue or burnout.

Interestingly, in each of these four articles it was more difficult to narrow down the author's term of focus, as each article used many of the aforementioned terms (e.g., compassion fatigue, burnout, vicarious traumatization, and grief). Sabo (2008) stated that

there was a need to examine the type of stress oncology nurses endured to help better understand conditions such as compassion fatigue and vicarious traumatization. Similarly, Wittenberg-Lyles et al. (2014) identified that workplace stress resulted in greater occurrences of burnout. These researchers supported the idea of putting initiatives in place to decrease stress in the workplace before it develops into something more severe.

Negative consequences of stress were identified as psychological illnesses like depression and anxiety, but also physical effects such as headaches, hypertension and fatigue (Hecktman, 2012). Preemptive stress reduction and interventions for coping were labeled as important in the prevention of negative outcomes associated with prolonged stress. This was first reported by Sabo (2008), who stated that, "if the stress continues unabated, nurses may become vulnerable to adverse psychological effects such as those reflected in compassion fatigue, burnout and/or vicarious traumatization" (p. 24). While stress was identified as the fourth most used term of focus, in each article it was identified that it was the stress that led to compassion fatigue or burnout.

Providing oncology nurses with coping strategies to deal with the inevitable stressful situations that occur may decrease the incidence of stress among oncology nurses. For example, Altounji et al. (2013) proposed self-care retreats to assist in the prevention of stress, while Heckman (2012) suggested that hospital administrators understand the ramifications of stress and take part in efforts to provide an environment where its occurrence can be handled in a more efficient manner. This could help prevent the occurrence of negative effects from stress. With oncology nurses being able to use strategies to take care of themselves, along with the administrators contributing to

providing a positive work environment, stress can be decreased or even prevented (Wittenberg-Lyles et al., 2013).

Research Question 1 Summary

Compassion fatigue was frequently described in the data as having a negative emotional effect on nurses. While physical effects of compassion fatigue were mentioned, the emotional effects of compassion fatigue on the oncology nurse were emphasized. A similar observation was also found for burnout. While the burnout literature described emotional effects as well as the physical effects, it remained the emotional aspects of burnout that were more commonly referred to in the literature reviewed. Thus, it appeared based in the data that there was little distinction made between compassion fatigue and burnout. Essentially, the initial impression from the preliminary literature review presented in chapter 2 that one term was more associated with emotional consequences (i.e., compassion fatigue), and that burnout was more associated with physical effects on the body was not supported by the metasynthesis. These concepts (i.e., burnout and compassion fatigue) were identified as similar, in that they both had common negative physical impacts on oncology nurses and both were considered to primarily create negative emotional consequences.

Commonalities among the terms identified parallel the confusion felt by the investigator at the beginning of this metasynthesis. For example, Najjar et al. (2009) endorsed that compassion fatigue, burnout, vicarious traumatization, and secondary traumatic stress were all similar; but only slightly differentiate among the concepts. While the data did find that all of the terms were similar, at least one author was deliberate to identify how compassion fatigue was different from burnout (Bush, 2009).

Bush pointed out that burnout had been researched extensively, in various work settings and contexts, mostly involving physical and emotional exhaustion from lack of staff and excessive demands on energy and being worn out. This differed, according to Bush, from the excessive emotional and physiological demands that caused compassion fatigue. The data generated from this metasynthesis on oncology nurses favoured the position that most commonly used terms also had common descriptions and had common effects.

Discussion

It was interesting to note that in the initial literature review in Chapter Two identified numerous terms related to the general topic of nurses' grief (e.g., bereavement, burnout, chronic compounded grief, compassion fatigue, compulsive sensitivity, cumulative grief, disenfranchised grief, moral distress, moral fatigue secondary traumatic stress disorder, stress of conscience, and vicarious traumatization). Each of these terms had substantial support within the larger body of literature related to nurses' grief. However, based on the results of this metasynthesis the vast majority of these terms were rarely referenced in the literature specifically related to oncology nurses' grief. For example, the term vicarious traumatization was first referenced in the larger body of literature surrounding nurses' grief in the early 1990s (Pearlman & Saakvitne, 1995).

More recently, scholars have begun to notice the similarities between vicarious traumatization and post-traumatic stress disorder (PTSD) (Sabo, 2008); as PTSD becomes better understood by the larger medical community (O'Donnell, Creamer, & Pattison, 2014). However, within the literature focused on oncology nurses, PTSD was only mentioned in four articles (Altounji et al., 2013; Najjar et al., 2009; Sabo, 2008;

Sinclair & Hamil, 2007), and was only the term of focus chosen by the authors of one article (Sinclair & Hamil, 2007).

Similarly, moral distress was first defined by Jameton (1993), and had been closely associated in the wider literature surrounding nurses' grief with moral fatigue (Edwards, 2001; Kelly, 1998; & Taylor, 2002). Yet within the literature focused on oncology nurses' grief, moral distress was only mentioned in two articles, and was not chosen as the term of focus by either of the authors (Altounji et al., 2013; Aycock & Boyle, 2009). These examples were indicative of the wider trend that the terms related to nurses' grief in the general literature were not presented or rarely focused on in the literature related to oncology nurses' grief. It should also be noted that there were several deviations of more common terms that were referenced on one or two occasions within the literature related to oncology nurses. For example, deviations of the term burnout – such as burnout syndrome (Hunnibell et al., 2008) and chronic burnout (Davis et al., 2013) – were referenced in the literature related to oncology nurses although neither was used at the term of focus by any of the authors of the studies in the metasythesis.

Additionally, in the initial literature review the broader literature related to nurses' grief was divided into two general categories: terms related to the emotion of grief that nurses experienced and terms used to describe specific reactions that may result from exposure to grief. Based on the results presented here in Chapter Four, the two most common terms that were referenced in and were the focus of the literature related to oncology nurses' grief (i.e., compassion fatigue and burnout) both included descriptive phrases related to the actual emotion of grief, as well as the potential responses to grief.

Compassion fatigue was described using terms such as emotional, psychological, physical and, more specifically emotional distress, psychological consequences, and emotional over involvement (Fetter, 2012; Perry et al., 2011; Wenzel et al., 2011). Similarly, burnout was described with terms including physical illness, depletion, emotional exhaustion, overwhelmed, and distressed (Davis et al., 2013; Edmonds et al., 2012; Emold et al., 2011; Leung et al., 2012). In both instances, there were descriptive phrases that related to the emotion of grief (e.g., emotional, emotional distress, emotional exhaustion, overwhelmed psychological, and psychological consequences), as well as descriptive phrases that related to the reactions resulting from exposure to grief (e.g., depletion, distressed, emotional over involvement, and physical illness). The results of this metasynthesis found that within the oncology nurses' grief literature both compassion fatigue and burnout were described as including the emotion of grief and as being a response to the emotion of grief.

Further, in Chapter Two it was said that compassion fatigue was an emotional grief response that was described as being a reaction to feeling of grief in settings of intense nurse-patient relationships (Joinson 1992; Perry et al., 2011). Similarly, in Chapter Two it was said that burnout represented physical and emotional exhaustion and that it occurred after prolonged elevated stress levels at work, specifically for nurses who experienced patient deaths and reacted to their feelings grief (Grunfeld et al., 2000). Simply put, compassion fatigue was initially described as an emotionally laden response to grief, but the metasynthesis revealed additional negative physical effects of compassion fatigue such as headaches, hypertension, fatigue, weight gain, stiffness disrupted sleep, and anger (Brown, 2006); and cardiovascular consequences, diabetes,

gastrointestinal upset, and decreased immunity (Warshaw, 1989). On the other hand, burnout was depicted in both the initial literature review and in the results of this metasynthesis as including both emotional and physical reactions in nurses.

Additionally, while the larger body of literature related to nurses' grief suggested that compassion fatigue was caused by grief, the compassion fatigue literature related to oncology nurses' grief seemed to suggest otherwise. For example, Fetter (2012) equated compassion fatigue with emotional distress, and by doing so situated compassion fatigue as an emotional response that is felt – similar to grief. Houck (2014) also consistently equated grief, cumulative grief and compassion fatigue as being the same phenomenon, or at least consistent phenomena. Further, based on their review of 57 studies focused on compassion fatigue in oncology care providers, Najjar et al. (2009) described compassion fatigue as an emotional response – as opposed to something that occurred due to prolonged exposure to another emotion (e.g. grief).

Similarly Wenzel et al. (2011) described compassion fatigue as an emotional distress caused by caring for those who were suffering or dying. This was consistent with Anderson and Anderson's (1998) definition for grief, which focused on an "emotional response to bereavement, separation or loss" (p. 516). While the majority of the data where the authors used compassion fatigue as the primary term for their research did equate compassion fatigue with grief, there were contrasting views. For example, Perry et al. (2011) used LaRowe's (2005) definition of compassion fatigue, which described compassion fatigue as a "debilitating weariness brought about by repetitive, empathic responses to the pain and suffering of others" (p. 21). Similarly, Bush (2009) described compassion fatigue as a response to grief. However, based on the data from this

metasynthesis, the dominant view in the oncology nurses' grief data was the equating of compassion fatigue with grief and other emotions, and not as a response that nurses' had to experiencing grief.

This is not to suggest that the connection between compassion fatigue and grief was not evident in the literature. In their discussion, Aycock and Boyle (2009) suggested nurses could provide guidance to coworkers and promote dialogue with their peers regarding mutual grief. It may be particularly important to do these things after caring for a specific patient that has the potential to accentuate feelings of grief among the nurses that cared for that patient, and thus cause compassion fatigue. Interestingly, Fetter (2012) authored an article entitled "We Grieve Too: One Inpatient Oncology Units Interventions For Recognizing And Combating Compassion Fatigue." While the author used the word 'grieve' in the title of her study, the actual manuscript did not contain a single reference to the term. Fetter did use the terms compassion fatigue, bereavement, emotional exhaustion, and emotional distress – all in ways that were consistent with the definition of grief by Anderson and Anderson (1998) (i.e., "a pattern of physical and emotional responses to bereavement, separation or loss" [p. 516]). Essentially, while the larger body of nurses' grief literature suggested that compassion fatigue was something experienced by nurses as a result of feeling grief, the oncology nurses' grief data did not provide clear guidance on whether compassion fatigue was an emotional response similar to grief or a phenomenon that resulted from grief.

Finally, based on the results of this metasynthesis, grief and stress were two of the most common terms – both for being used in the oncology nurses' grief literature and for being the term that authors chose to focus on in the literature included in the

metasynthesis. However, neither of these terms were prominent in initial literature review of the literature conducted in Chapter Two. In Chapter Two the term grief was included as a component of other, more specific terms; such as chronic compounded grief, cumulative grief and disenfranchised grief (Feldstein & Gemma, 1995; Marino, 1998; & Wilson & Krishbaum, 2011). For example, disenfranchised grief was said to occur secondary to other feelings being held back because it was not seen as acceptable to express the emotional response to grief in the workplace (Wilson & Kirshbaum, 2011). Similarly, in Chapter Two stress was included as a part of other, more specific terms that included stress of conscious and secondary traumatic stress disorder (Ahlin et al., 2012; Quinal et al., 2009). As an example, secondary traumatic stress disorder was described as occurring from exposure to – and caring for – trauma victims or exposure to traumatized or suffering people, rather than the actual event that caused it (Dominquez-Gomez & Rutledge, 2009; Quinal et al., 2009).

It should also be noted that one of the descriptive phrases used in the oncology nurses' grief literature for grief was stress (Caton & Klemm, 2006; Macpherson, 2008) – which invariably links, and confounds, these two terms. Further, the literature that used stress as the term of focus often indicated that stress was a precursor to compassion fatigue or burnout (Altounji et al., 2013; Hecktman, 2012; Sabo, 2008; & Wittenberg-Lyles et al., 2014). Once again confounding the understanding and differentiating of these various terms (Bush, 2009; Dunne, 2004; Najjar et al., 2009).

Research Question 2. Based on the outcome of this study, how could oncology nurses' grief be conceptualized in a manner that incorporates the current varying terms and definitions?

In order to conceptualize oncology nurses' grief, in light of the varying terms and definitions, a review of factors that influence how nurses react was conducted.

Table 4.6

Similarities and Differences Among the Four Most Popular Terms Further Discussed

Similarities	**Term**	**Differences**
Emotional exhaustion and psychological disturbances Physical-exhaustion, physical demands.	Compassion fatigue	Spiritually draining Grief Emotional over involvement
	Burnout	Overwhelmed Stress Self- actualization
	Grief	End of life Stress Grieving
	Stress	Overwhelmed Anxiety End of life Powerless, helpless, and hopeless

While physiological and psychological effects dominated the results of similarities of the terms of focus, physical factors were also included in some way in seven of the 21 pieces

of data. For example, Aycock and Boyle (2009) revealed consequences of compassion fatigue when they stated, "unless interventions are available and used to counter the emotional component of oncology nursing, nurses may experience physical and emotional exhaustion" (p. 184). When the four top terms of focus in the data set were compared, compassion fatigue showed similarities with burnout, stress, and grief; and showed no obvious differences.

Further, Aycock and Boyle (2009) identified physical health consequences of compassion fatigue as, "nurse symptom distress such as headaches, increased blood pressure, fatigue, weight gain, stiff neck, disrupted sleep and anger" (Brown, 2006); and "increased incidence of cardiovascular disease, diabetes, gastrointestinal conditions, and immune dysfunction" (Warshaw, 1989, p. 508). This quote was also referenced by Fetter (2012), when she described physical symptoms related to compassion fatigue in oncology nurses. Similarly, Perry et al. (2011) explored oncology nurses' experiences with compassion fatigue where they found that fatigue – including physical and emotional tiredness – were reported by nurses in their sample, but no physiological causes for this fatigue were found upon medical evaluation.

Many researchers noted that if the negative emotional effects of nurses' grief were not addressed, more chronic conditions could develop – such as depression, anxiety and physical exhaustion from not caring for one's self properly secondary to the emotion being internalized (Altounji et al., 2013; Rice et al., 2014). For instance, Conte (2011) discussed grief and continually referred to it as loss and grief, saying, "pediatric oncology nurses experience multiple types of losses and grief because of the intense and emotional

relationships they form with pediatric oncology patients and their families" (p. 93). If the grief is internalized, negative effects ensue.

After much consideration compassion fatigue was chosen by this researcher as the best term to describe oncology nurses' grief. As such, a proposed appropriate definition of oncology nurses' grief was developed:

> *An all encompassing term that describes the emotional and physical effects experiencing various stressors on a regular basis has on oncology nurses. These stressors include caring for the oncology patients on a frequent basis, as well as care at the end of life*.

The emotional/psychological effects, as well as physical/physiological effects, of grief that were identified must be included in any description of oncology nurses' grief. The definition proposed, if used by future researchers, would provide consistency when referring to the experiences of oncology nurses and would provide clarity to readers.

Discussion

Regardless if you examine the broader field of literature related to nurses' grief or the more specific literature related to oncology nurses' grief, there was a wide variety of terms that had been used to describe both the emotion of grief and the reaction to experiencing grief. In examining the broader literature, terms such as bereavement, burnout, chronic compounded grief, compassion fatigue, compulsive sensitivity, cumulative grief, disenfranchised grief, moral distress, moral fatigue, secondary traumatic stress disorder, stress of conscience, vicarious traumatization were identified (Aycock & Boyle, 2009; Joinson, 1992; Medland et al., 2004; Sabo, 2008; Wenzel et al., 2011; & Wilson & Kirshbaum, 2011). Similarly, when the literature is limited to only

that which focuses on oncology nurses' grief there were a total of 25 terms that were referenced within the literature, and nine different terms that authors chose to make the focus of their study or article (Banning & Gumley, 2012; Brown & Wood, 2009; Conte, 2011; Sinclair & Hamill, 2007).

This metasynthesis found that within the oncology nurses' grief literature, compassion fatigue, burnout, stress and grief were used to describe both the emotion of grief and the reaction to experiencing grief (Aycock & Boyle, 2009; & Fetter, 2012). Compassion fatigue was conceptualized to include both emotional and physical factors (Bush, 2009; & Houck, 2014). When comparing the proposed definition of oncology nurses' grief that resulted from the metasynthesis to how compassion fatigue was defined and described in Chapter Two there are great similarities. The initial definition of compassion fatigue for the literature review was a "state of tension and preoccupation with the cumulative impact of caring" (Figley, 1983, p. 10). The definition of oncology nurses' grief produced from the metasynthesis was:

> *An emotional and physical consequence of experiencing various stressors on a regular basis has on an oncology nurses. These stressors include caring for the oncology patients on a frequent basis, as well as care at the end of life*.

The definition of compassion fatigue is consistent with the 'emotional and physical effects experiencing various stressors on a regular basis' portion of the proposed oncology nurses' grief definition. Similarly, Bush (2009) defined compassion fatigue as "a complex phenomenon that escalates gradually as a product of cumulative stress over time" (p. 25). This definition is similar to the proposed metasynthesis definition, as least with respect to the 'various stressors on a regular basis' in the metasynthesis definition

above. Also, describing compassion fatigue as 'emotional and physical effects' is consistent with how most would understand 'a complex phenomenon.' Further, Joinson (1992) used compassion fatigue as a way to describe the unique stressors (e.g., tense, impatient, hurried tired, indifferent, cynical, etc.) that affected nurses. Additionally, Perry et al. (2011) supported the idea that oncology was a unique area with unique stressors, which made oncology nurses more susceptible to experiencing compassion fatigue. While these specific descriptive phrases may provide more depth than is conveyed by the term 'stressors,' the listing of individual stressors that cause oncology nurses to experience compassion fatigue would make the proposed definition unnecessarily long.

Maslach and Jackson (1981) described burnout as syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who work with people. The similarities between this description of burnout and the proposed definition for oncology nurses' grief include the terms emotion (i.e., emotional exhaustion, emotional toll) and stress (i.e., enormous stress). As Grunfeld et al., (2000) indicated, health care professionals experienced burnout after prolonged elevated stress levels in their professional lives, coinciding with the uniqueness of prolonged contact with patients and families that oncology nurses experience, which again relate back to the list of stressors in the proposed definition.

The terms grief and stress, while not specifically defined in Chapter Two, came to light in the analysis as used repeatedly in the literature related to oncology nurses. While some authors used terms that had words qualifying grief and stress (e.g., chronic compounded grief, cumulative grief, secondary traumatic stress, and stress of

conscience), but in the end the similarities were evident. For example, the term grief described by Parkes (1998) as an emotional response or reaction to a loss, similar to the metasynthesis proposed definition in that oncology nurses' grief can be described using overwhelmed, overpowering stress and anxiety, and intense emotional reactions. Additionally, Rice et al. (2014) studied ways that oncology nurses could express and process grief regarding patients' deaths to better process their emotional reactions and feelings. This similar terminology (e.g., the way in which emotional stressors were described) to the proposed definition suggests they studied ways to help oncology nurses' grief. Further, Hildebrandt (2012) also addressed the 'stressors' of oncology nursing and the negative impact of unresolved grief in oncology nurses and symptoms that may develop because of it, which again is consistent with the proposed definition that also uses the term stressors.

Further, the metasynthesis revealed descriptors such as physiological and emotional stress, end of life stress, high workplace demand, stress on psychosocial health, powerlessness, and helplessness and hopelessness. Heckman's (2012) study was focused on pediatric oncology nurses but also clearly states that stress is a real and harmful effect of caring for nurses who care for oncology patients and their families. Wittenberg-Lyles et al (2014) revealed that opportunity for oncology nurses to process stress by attending support groups validates the emotions they endure. Thus both authors supported the proposed definition of oncology nurses' grief by using similar terminology (e.g., emotional, stress, etc.), and being inclusive of physical and emotional stressors. These stressors that oncology nurses face are constant and the need for therapeutic resolution

can only assist nurses in grief situations (Altounji et al., 2013). Thus making it an important piece of any definition of oncology nurses' grief.

Finally, one of the interesting things from the analysis of the data was that authors often used multiple terms in a single piece of literature. For example, Houck (2014) examined different interventions to help oncology nurses cope with both cumulative grief and compassion fatigue; stating that the cumulative grief contributed to the development of compassion fatigue – rather than the two concepts being the same. Further, it was common for these authors to discuss multiple terms in the literature review and discussion portions of their articles. For instance, Sabo (2008) referenced compassion fatigue, burnout, and vicarious traumatization in her study of whether oncology nurses were vulnerable to the negative consequences of their work. While Sabo described each concept individually, the similarities were quite noticeable (e.g., compassion fatigue was connected to the relationship between the nurse and patient, burnout was discussed with regards to relationship between care provider and recipient, and vicarious traumatization resulted from interactions that trauma workers had with their clients). This theme was consistent with the literature reviewed in Chapter Two (Aycock & Boyle, 2009; Joinson, 1992; Medland et al., 2004; Sabo, 2008; Wenzel et al., 2011; & Wilson & Kirshbaum, 2011). The use of a consistent term to describe nurses' grief, or specifically oncology nurses' grief, was something that was rarely observed in the metasythesis or in the initial literature review. Overall, these definitions and descriptions for compassion fatigue, burnout, grief, and stress from the literature synthesized, each have slightly different distinctions that can be summarized and included within the proposed definition.

Chapter Summary

This metasynthesis allowed a comprehensive comparison of the various terms used to reference the physical and/or emotional effects that oncology nurses experience when grief occurs in their workplace from caring for dying and seriously ill people. While there were slight differences in the terms and their usage, the similarities in how each of the most common themes were described was undeniable. There were four terms that were used within the literature as the term of focus by various authors. *Compassion fatigue* conceptualized the experiences of oncology nurses as related to frequent exposure to death and grief. *Burnout* often occurred with both heavy workload and lack of supports for oncology nurses. Oncology nurses required unique supports for both compassion fatigue and burnout. Further, both *grief* and *stress* have been – and continue to be – negative experiences affecting oncology nurses. As well, both grief and stress have been used in the defining and describing of both compassion fatigue and burnout. All four terms have been used to address or examine negative aspects of oncology nurses' work. However, it was an important finding that the stressful work oncology nurses engage in predisposes them to stress, grief, compassion fatigue and burnout but that caring for people is such vulnerable circumstances also can lead to professional fulfillment in nurses.

Based on the literature, I found using oncology nurses grief allows for a better understanding of situations and investigations and would have also increased support among findings of researchers. Thus, based on the outcome of this study, oncology nurses' grief could best be conceptualized using a combination of compassion fatigue burnout, stress and grief's varying definitions found throughout the literature from the

past 10 years. Both the concept itself, and the proposed operational definition of oncology nurses' grief, could be recommended to future researchers to provide a consistent concept definition.

Chapter 5: CONCLUSIONS AND IMPLICATIONS

The purpose of my thesis was to examine oncology nurses' grief. To undertake this study, I reviewed the past ten years of peer-reviewed research and conducted a metasynthesis of the data to analyze the existing literature related to the subject. In this chapter, I summarize the conclusions from my study. Next, I describe two implications for practitioners from my findings: one for oncology nurses' and one for employers of oncology nurses. Finally, I outline three potential aspects from this thesis that may be considered for future research.

Conclusions

In this study of oncology nurses' grief, there were four dominant terms or terms of focus that were found in the existing literature. Compassion fatigue and burnout were found to be the two most used concepts used in the literature related to oncology nurses' grief over the past 10 years. Compassion fatigue and burnout were both described in the literature as having a negative effect, both emotionally and physically, on oncology nurses. Based on the data reviewed, there was actually little distinction between the terms compassion fatigue and burnout. Interestingly, it was this commonality between these two terms that created my initial confusion, and also instigated this thesis and my desire to delve deeper into the issue.

In addition to compassion fatigue and burnout, grief and stress were also commonly used terms within the literature related to oncology nurses' grief over the past 10 years. Primarily used as descriptive phrases for a variety of other terms associated with nurses' grief in general, and specifically oncology nurses' grief, grief and stress were each the chosen terms of focus by the authors in four pieces of literature selected for

the metasynthesis. Experiencing grief can affect the care that oncology nurses provide to patients, as these feelings are difficult to suppress. Similarly, stress is an inevitable occurrence on a busy oncology unit that ultimately affects a nurse's reaction to different situations. Additionally, it is important to note that although the authors choose to focus on what they called stress, in the end all of the studies ended up discussing compassion fatigue or burnout. Stress, it seems, may have been a precursor or precipitator to these other conditions.

In the end, a definition for oncology nurses' grief was proposed and was followed by a discussion of how the proposed definition related to the four most used terms in the metasynthesis. This definition of oncology nurses' grief was developed by the researcher as a result of the metasynthesis. Grief was defined as:

> *An all-encompassing term that describes the emotional and physical effects experiencing various stressors on a regular basis has on oncology nurses. These stressors include caring for the oncology patients on a frequent basis, as well as care at the end of life*.

The definition proposed, if used by future researchers, would provide consistency when referring to the experiences of oncology nurses and would provide clarity for those interested in the issue.

Finally, it is also important to note the significant differences between the way that the many of the terms used to describe oncology nurses' grief were in the data, compared to the larger body of literature related to nurses' grief that was critiqued in the literature review. For example, compassion fatigue was described in the nurses' grief literature as an emotional response to nurses experiencing grief. However, the data for

this metasynthesis presented compassion fatigue as something that included both emotional and physical responses; which was the same way that burnout was described in the data. Similarly, the oncology nurses' grief data that focused on compassion fatigue described compassion fatigue was an emotion similar to grief, although there were some data that described it was a response to experiencing grief. While oncology nurses grief has been presented as the best term for future researchers to use based on this metasynthesis, there continues to be some confounding of the terms associated with this concept.

Implications for Practice

The amount of research that has been conducted into the experience of, and reaction to, grief using a number of different terms, offers little doubt that the occurrence and impact of grief needs to be considered by oncology nurses and their employers. Based on the results of this thesis, there are two main implications that I recommend for practitioners are various levels.

First, oncology nurses need to be aware of the emotional risks associated with exposure to grief and of ways to protect themselves from negative outcomes of acute grief experiences. Second, employers should look to encourage and support nurses as they attempt to deal with their acute grief. Instead of the usual negative connotations, grief should also be promoted as a form of potential growth and expressions of grief a normal response to the unique work that is done by oncology nurses.

Being aware of the issue of oncology nurses' grief and ways to counter it will assist nurses to combat its potentially negative effects. For example, Houck (2014) found that when nurses knew they were not alone in the way they felt, there was more

interaction, sharing stories and sharing coping strategies among nurses who worked together. Talking and sharing these experiences may result in nurses converting them into positive experiences and actualization of the importance of their work and the position career fulfillment outcomes that can result. Hunnibell, Reed, Quinn-Griffin, and Fitzpatrick (2008) referred to this in their study as self-transcendence.

As self-transcendence increases, burnout decreases (Hunnibell et al., 2008). Higher levels of transcendence would enable nurses to better withstand, lessen or rise above burnout and compassion fatigue. Further, Reed (1991) also described ways in which nurses could help each other, as well as their patients, deal with mortality issues by encouraging and assisting with "meditation, self-reflection, visualization, religious expression, peer counseling, journal keeping, and life review" (p. 75). Once oncology nurses become aware of the potential negative consequences of caring for seriously ill and dying people, and learn ways to prevent those consequences from occurring, nurses can become equipped with the means necessary to avoid the negative reactions and focus on the potentially positive outcomes of working in the challenging role of oncology nursing.

Second, employers must also play a key role in providing nurses with various supports to combat stress, express grief, and prevent burnout and compassion fatigue. Fetter (2012) examined support systems and, based on this examination, developed a bereavement support group to provide the team with ways to combat compassion fatigue. Similarly, Aycock and Boyle (2009) investigated interventions to counter compassion fatigue and found numerous practices to be effective; including recommending guidance, ensuring availability of resources, facilitating intervention individualization,

acknowledgement of achievement, training, sensitivity to risk factors, time for expression, providing pastoral care, providing retreats, program planning, including prevention strategies, and encouraging peer support. By supporting nurses, employers would be rewarded with positive experiences for both their staff and for the patients that those nurses care for.

While employers have the potential to provide and encourage many of these grief management strategies, demands on nurses – both personally and professionally – may prevent them from taking part in any of these available supports. Childcare, transportation, and other responsibilities outside of work prevent nurses from taking part on their days off in stress reduction activities (Caton & Klemm, 2006). High patient acuity means nurses may feel like they are unable to take full breaks or any breaks at all, let alone attend in-servicing or meetings during their shifts. Nurses could be encouraged to form support groups, or staff committees to brainstorm ways to combat burnout and promote self-awareness to reduce stress (Hunnibell et al., 2008). With organizational support and promotion, the effort could even translate into greater employee satisfaction and retention. Further, less experienced nurses would benefit most from employers providing education and training related to all aspects of grief and stress, as it would give them a good foundation on coping strategies to deal with grief situations (Lange, Thom, & Kline, 2008). Thus identification of the needs and the implementing of interventions can offer positive impact on provision of care by oncology nurses and decrease the occurrence of compassion fatigue and burnout, particularly for those with less experience.

Suggestions for Future Research

While there has been wide array of research done on nurses' grief, as well as oncology nurses' grief, I believe there are still a number of avenues for further research. First, this metasynthesis resulted in a great deal of data that could be further analyzed to answer additional research questions surrounding nurses' grief. Second, I believe there would also be value in furthering the study of the potential positive outcomes of the grief experienced by oncology nurses. Third, a more in-depth examination of burnout and compassion fatigue, to better identify the specific similarities and differences that exist between these two, and potentially other terms related to nurses' grief, would be a useful study.

While the purpose of this thesis was to examine how oncology nurses' grief was defined and if there was a best way to describe it based on the literature, this ignored all of the other rich information that could have been mined from the data set that was generated. For example, what are the main causes of grief for oncology nurses based on the literature? Are these causes consistent with the causes of grief for nurses in other specialties or with other health care providers within the oncology discipline? Similarly, the data could also be mined to examine the effectiveness of various strategies to assist oncology nurses to manage that grief, or what prevents oncology nurses from accessing these supports. The analysis for research question one provided in Chapter Four offered a cursory discussion of some of these queries, however, a more thorough investigation of these topics using this data.

Second, the idea that negative experiences (i.e., oncology nurses' grief) could potentially have positive effects on oncology nurses needs further investigation. While

this sounds multifarious, research has begun to show positive effects that can emanate from oncology nurses' grief or at least from working in situations that predispose nurses to grief experience. For example, Gama, et al. (2014) compared nurses who worked in internal medicine, oncology, hematology, and palliative care; and found that palliative care nurses showed lesser levels of emotional exhaustion and depersonalization with higher levels of personal accomplishment. What was it about palliative care nurses in this study that made their experience different than the nurses from internal medicine, oncology, and hematology? Oncology units, hospices and intensive care units are all associated with a high incidence of deaths or serious changes in the condition in their patients. Collective studies have found that nurses in these three specialties are impacted, both professionally and personally, when a patient death occurs (Wilson & Kirshbaum, 2011).

Further, in recent years multiple studies have reported nurses who were successful, and had positive experiences in the presence of death and dying had higher career satisfaction. For example, while not specifically focused solely on oncology nurses' grief, there was literature promoting grief resolution (Adwan, 2014; Becze, 2012), as well as exemplary nurses (Janzen & Perry, 2015; Perry, 2008) that all said working in oncology nursing can lead to career fulfillment. The question remains why this occurs? A study by Lange, Thom, and Kline (2008) revealed that years working as a nurse, age and years in the oncology field were strong indicators of positive attitudes toward caring for the dying. As well, resilience and the ability to cope with stressors are worth investigating further (Zander et al., 2010).

As such, it would be worthwhile to investigate further what the palliative care nurses in Gama et al.'s (2014) study did differently to experience a sense of accomplishment from the emotional experience of grief to determine if those experiences could be integrated into other nursing specialties, like oncology, in an attempt to decrease the negative effects of nurses' grief. For example, research conducted on exemplary nurses by Perry (2008) identified that while oncology nurses cared for complex patients "who may require complex physical, emotional and spiritual interventions" (p. 88) exemplary oncology nurses viewed these experiences as a source of pride. Future research should focus on finding what works to help prevent, reduce the occurrence, or reverse negative effects of oncology nurses' grief.

Third, the results of the metasynthesis indicated that burnout and compassion fatigue were quite similar. However, my own personal experiences as an oncology nurse were what prompted me to investigate the topic of nurses' grief. It was the interpretation of my own feelings that led me to believe I was experiencing compassion fatigue, as defined by Bush (2009) as "a complex phenomenon that escalates gradually as a product of cumulative stress over time" (p. 25). I had recurring patients and I became familiar with their suffering. Their subsequent deaths affected me and the way that I carried out the rest of my shift that day or even the next few days. I wanted to understand more about this experience to help myself and other nurses.

For the past year I have worked on a medical/surgical telemetry unit that is more physically exhausting than was my work on an oncology unit. In my current position patients are admitted and discharged within a day or two and have a variety of diagnosis that cover a broad range (e.g., irregular heart rhythm, congestive heart failure, acute

kidney injury, hypertension, cellulitis, as well as drug and alcohol overdose, etc.). I do not believe that I experience grief or sadness caring for these patients, but I do experience physical and emotional fatigue from being on my feet and from going from patient to patient with limited time for breaks. This current experience I more closely compare to burnout, as a "syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do 'people-work' of some kind" (Maslach & Jackson, 1981, p. 99). Grunfeld et al., (2000) indicated that health care professionals experienced burnout after prolonged elevated stress levels in their professional lives. My own personal experience aligns more with the literature reviewed in Chapter Two, and less with the results I presented in Chapter Four.

Further, as noted earlier, both within the broader literature related to nurses' grief review in Chapter Two, as well as the oncology nurses' grief included in the data in Chapter Four, there continued to be significant confounding of the terms associated with grief. While the purpose of this study was to find the best way to describe and/or define the grief experienced by oncology nurses, I would recommend that future research work to distinguish between compassion fatigue and burnout, as well as some of the other terms identified in this study, in a way that make each of them uniquely meaningful. Undoubtedly some of the terms described in Chapter Two, and reported in Chapter Four, are redundant or simply muddy the waters on this line of inquiry. However, it would be helpful to undertake future research into the utility of these many terms to determine which ones are useful and should be explored.

Chapter Summary

In summary, this metasynthesis of literature from the past 10 years revealed that compassion fatigue, burnout, grief, and stress were the most common terms used, at least based on the term each author chose to focus their study/article on. As with the larger body of research into nurses' grief, there continued to be a confounding of terms within the oncology nurses' grief literature – at least in terms of how each of these dominant terms were described. Oncology nurses grief was chosen by the author as the most suitable term that describes what these nurses experience, using the proposed definition in hopes of providing clarity to those interested in the issue.

There were two implications for practice that were identified from this metasynthesis of oncology nurses' grief. First, the need for oncology nurses to be aware of the emotional risks associated with the grief potentially caused by their work, and find ways to protect themselves and each other from experiencing compassion fatigue, as well as the possible negative consequences. Second, employers can help oncology nurses they employ by offering guidance and support through awareness of the potential problem of grief, assisting with the organization of retreats, and by incorporating education about recognizing and addressing grief into the orientation for new nurses.

Finally, based on the results of this metasynthesis of oncology nurses' grief literature there were several avenues identified for future research. These included conducting studies that further analyze oncology nurses' grief, how grief is unique within the oncology discipline, what causes grief, and what can be done to prevent grief from occurring. Second, further study of the potentially positive outcomes after grief is experienced by oncology nurses, and how those outcomes can have a constructive

influence on their work. Finally, a more in-depth examination of both burnout and compassion fatigue, as well as other terms related to oncology nurses' grief, to determine if these are separate phenomenon and, if they are distinct, what is their relationship to each other.

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APPENDIX A

Table 4.3

Number of Occurrences of Each Term Related to Grief

Term or Concept	**Number of Occurrences**
Burnout	21
Compassion fatigue	15
Grief	7
Stress	5
Bereavement	4
Vicarious traumatization	4
Secondary traumatic stress disorder	3
Moral distress	3
Cumulative loss	2
Cumulative grief	2
Loss and grief	2
Emotional exhaustion	1
Burnout syndrome	1
Compassion overload	1
Chronic burnout	1
Chronic compounded grief	1
Chronic stress	1
Nurses grief	1

Professional grief	1
Vicarious emotional suffering	1
Health care giver grief	1
Secondary traumatic stress	1
Secondary trauma	1
Post-traumatic stress disorder	1
Traumatic stress	1

APPENDIX B

Table 4.5

Four Most Used Focus Terms and Their Descriptive Phrases

Reference	**Terms**	**Focus Term**	**Top Descriptive Phrases**
Aycock, & Boyle (2009)	• Moral distress • Secondary traumatic stress disorder • Moral distress • Vicarious trauma • Compassion fatigue • Cumulative loss	Compassion fatigue	• Intense emotional distress • Physical, emotional and spiritually draining
Bush (2009)	• Compassion fatigue	Compassion fatigue	• Grief and loss • Emotional over-involvement
Fetter (2012)	• Compassion fatigue	Compassion fatigue	• Emotional distress • Loss of physical strength and increased weariness.
Houck (2014)	• Compassion fatigue • Cumulative loss • Cumulative grief • Grief	Compassion fatigue	• Physical and emotional exhaustion • Grief

Reference	Terms	Focus Term	Top Descriptive Phrases
Najjar, Davis, Beck-Coon, & Doebbeling (2009)	• Compassion fatigue • Burnout • Secondary traumatic stress • Vicarious traumatization • Post-traumatic stress disorder	Compassion fatigue	• Profound emotional disturbances • Prevention and early recognition
Perry, Toffner, Merrick, & Dalton (2011)	• Compassion fatigue	Compassion fatigue	• Negative psychological and physical consequences • Negative impact on well-being
Wenzel, Shaha, Klimmek, & Krumm, (2011)	• Compassion fatigue • Burnout • Professional bereavement	Compassion fatigue	• Psychological disturbances • Managing stress
Davis, Lind, & Sorensen (2013)	• Burnout • Chronic burnout • Stress	Burnout	• High stress levels • Emotional stress • Physical illness.

Reference	Terms	Focus Term	Top Descriptive Phrases
Emold, Schneider, Meller, & Yagil, (2011)	• Burnout	Burnout	• Frequent experiences of emotional exhaustion • High levels of self-actualization
Edmonds, Lockwood, Bezjak, & Nyhof-Young, (2012)	• Burnout. • Emotional exhaustion	Burnout	• Emotional exhaustion • Social desirability
Farsi, Nayeri, & Sajadi (2013)	• Burnout	Burnout	• Stressful nature of job • Emotional exhaustion
Hunnibell, Reed, Quinn-Griffin, & Fitzpatrick (2008)	• Burnout • Burnout syndrome	Burnout	• Self-transcendence • Emotional toll of repeated exposure

Reference	Terms	Focus Term	Top Descriptive Phrases
Leung, Fillion, Duval, Brown, Rodin, & Howell (2012)	• Traumatic stress • Burnout • Vicarious emotional suffering • Compassion fatigue	Burnout	• Enormous stress • Overwhelmed • Witness suffering
Rice, Bennett, & Billingsley (2014)	• Bereavement • Grief	Grief	• Intense emotional reactions. • Physical manifestations. • Grieving
Hildebrandt (2012)	• Chronic compounded grief • Compassion fatigue • Burnout • Grief	Grief	• Unresolved grief • Grief coping strategies
Macpherson (2008)	• Grief • Burnout	Grief	• Peer-support • Stress, burnout and attrition

Reference	Terms	Focus Term	Top Descriptive Phrases
Caton & Klemm (2006)	• Stress • Burnout • Grief	Grief	• Overwhelming stress and anxiety • Little end of life education
Altounji, Morgan, Grover, Daldumyan, & Secola (2013)	• Burnout • Compassion fatigue • Vicarious traumatization • Secondary trauma • Moral distress • Grief and loss • Stress	Stress	• Physical and emotional stressors • Overwhelmed with grief
Hecktman (2012)	• Stress • Compassion Fatigue • Burnout	Stress	• Physiological and emotional stress • Stress prevention and management interventions
Sabo (2008)	• Compassion fatigue • Burnout • Vicarious traumatization • Stress	Stress	• Increased stress • Stress on psychosocial health • Powerlessness, helplessness, hopelessness

Reference	Terms	Focus Term	Top Descriptive Phrases
Wittenberg-Lyles, Goldsmith, & Reno (2014)	• Compassion fatigue • Burnout • Stress	Stress	• End of life stress • High workplace demands