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PAPER

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Grief over patients, compassion fatigue, and the role of social acknowledgment among psycho-oncologists

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Abstract

Objective: Compassion fatigue—that is, secondary traumatic stress (STS) and burnout—is a traumatic emotional state experienced by health care providers and expressed in a reduced capacity to be interested in and empathic to the suffering of others. Compassion fatigue may be related to grief over patients' loss. We examined the relation between grief and compassion fatigue among psycho-oncologists while exploring the impact of social acknowledgment on this association. We hypothesized that social acknowledgment would moderate the relation between grief and compassion fatigue.

Methods: Participants were 60 Israeli psycho-oncologists in a cross-sectional study. Measures consisted of a demographic questionnaire, the Texas Revised Inventory of Grief-Present, the Social Acknowledgment questionnaire, and the Professional Quality of Life Questionnaire.

Results: The participants reported relatively high levels of grief and high levels of compassion fatigue. Grief and compassion fatigue were significantly positively associated (STS: $r = 0.41$, $p < 0.01$; Burnout: $r = 0.45$, $p < 0.01$). A k-means cluster analysis based on social acknowledgment and grief yielded three meaningful clusters: High Grief-Low Social Acknowledgment; Medium Grief-High Social Acknowledgment; and Low Grief-Medium Social Acknowledgment. Levels of STS in the first cluster were significantly higher in comparison to levels of STS in each of the other clusters ($F = 6.22$, $p < 0.01$).

Conclusions: Psycho-oncologists experience patient loss as part of their daily work. In response, they may develop grief reactions. This grief, when it is not perceived by them as being socially acknowledged, may result in high levels of STS: a phenomenon with undesirable personal and professional implications.

KEYWORDS

cancer, oncology, caregivers, compassion fatigue, grief, professional burnout, psycho-oncology, social acknowledgment

1 | INTRODUCTION

Grief is a common human experience in response to loss.[1] The emotional suffering following loss is one of the most painful experiences that individuals will face in their lifetimes. Grief is a complex phenomenon that comprises emotional, cognitive, and behavioral aspects, including different expressions of sadness, sorrow, and anger. Its expression may differ from one person to another and across different

situations.[2] Many grief theories have been developed over time, including among others: Freud's theory, the Kubler-Ross model, grieving as a meaning-making process, and the two-track model of bereavement. The main focus of these theories has been grief in response to the loss of a family member or a close friend.[2]

Traditionally, kin-based relationships are considered the most important relationships in a person's life,[3] and a family member's death is regarded as one of the most disruptive life events.[4] For this reason, grief is usually regarded as not developing in the context of a professional relationship, such as the relationship between health care professionals and patients. Nevertheless, there are professionals who act as formal caregivers in contexts that can be prone to producing grief.

In the oncology setting, health care professionals provide long-term and intensive care for patients[5] and face high mortality rates among their patients.[6] Therefore, formal caregivers in oncology settings may develop personal relationships with their patients and consequently experience grief in reaction to their deaths. Very few studies have examined grief over a patient's loss among this population. Those studies that have examined this topic have focused on physicians and nurses, and found that caring for terminally ill patients and witnessing their deaths indeed elicited grief symptoms.[7-9] In contrast to grief over family members, the grief of health care providers over patients was described as having a "smoke-like quality," as being intangible and invisible but also having a profound impact on their personal and professional lives.[9] In some cases, its complex and unique features resulted in health care providers reporting that they considered grieving over patients to be unprofessional, and even a personal and professional failure.[10]

Not much is known about grief among psycho-oncologists: that is, psychologists and social workers working in an oncology setting. The existing literature on psychologists' and social workers' grief reactions has primarily examined cases of patients' sudden deaths, for example due to suicide or accident, but has not evaluated their experiences following the loss of patients as a result of their terminal illnesses.[11] The knowledge we have about the effect of an expected death of patients after their great suffering and distress, and the cumulative exposure of psycho-oncologists to patients' deaths, is limited.

One well-known implication of grief over patients among health care professionals is the development of compassion fatigue.[12,13] This term, developed by Figley,[14] refers to a traumatizing emotional state experienced by health care providers who are preoccupied with the suffering and distress of those they care for, and is expressed in a reduced capacity and interest in being empathic to others.[15] Compassion fatigue elicits physical and emotional symptoms such as apathy, mental and physical fatigue, somatization, decreased functioning, and emotional detachment.[16] It may result in difficulties in delivering compassionate care to patients, as well as impairing the quality of their care.[17]

Various terms have been used to describe the negative effects of working in a traumatic and stressful environment.[18] Although there are nuances that ostensibly distinguish one term from another, the literature has thus far failed to identify the differences between the concepts. Stamm[18] suggested a theoretical model that dispels this confusion. In this model, compassion fatigue is composed of two distinct negative components: secondary traumatic stress (STS) and burnout. STS develops in response to exposure to patients' traumatic events, and its symptoms include intrusive thoughts, avoidant behavior, and hypertension.[18] Burnout is usually related to the work environment (eg, workload, nonsupportive work environment, etc.) and includes feelings of exhaustion, frustration, anger, and depression.

Although grief might naturally develop among formal caregivers in the oncology setting and lead to compassion fatigue, this kind of grief can be termed "disenfranchised grief." According to Doka,[3] disenfranchised grief is grief experienced by those who incur a loss that is not socially acknowledged and supported. The development of this concept is an acknowledgment of the fact that societies have unofficial norms that specify grieving characteristics and determine the legitimacy to grieve. When the loss is perceived by society as insignificant or not legitimate, the grief is disenfranchised. This theory provides an excellent theoretical model for understanding grief among formal caregivers in the oncology setting.

When coping with grief, a lack of social acknowledgment and support makes the bereavement more difficult and may lead to an exacerbation of symptoms.[19] Social acknowledgment connotes a person's experience of positive reactions from a society that displays an appreciation for his/her unique state and acknowledges his/her current difficult situation, after a traumatizing event.[20] Given that the experiences of death and loss can be traumatic,[21] a situation in which there is no social recognition of the individual's right to grieve or claim social support during the grief process may impair the grieving person's everyday functioning and emotional state.[22]

The relationship between psycho-oncologists and their patients might be perceived by the environment as a professional relationship. As such, the close, personal, and caring nature of the relationship that often develops in this context[23] may not always be taken into account. Psycho-oncologists may therefore experience their grief reactions as being inappropriate and not socially valid. This perception might consequently influence the psycho-oncologists' expressions of grief and affect their personal and professional quality of life. In a study that examined the support given to nurses who experienced cumulative grief, Shinbara and Olson[24] found that social acknowledgment of the nurses' grief over their patients facilitated the effective delivery of treatment and compassionate care for other patients. In addition, social acknowledgment can act as a resilience factor after the development of compassion fatigue.[25]

The goal of the current study was to examine how grief reactions influence the development of compassion fatigue among psycho-oncologists. First, we hypothesized that due to the unique characteristics of working in an oncology setting, psycho-oncologists would report grief stemming from the loss of their patients. Second, we hypothesized that this grief would be associated with compassion fatigue. Furthermore, the current study examined the possible moderating role of social acknowledgment in the association between grief and compassion fatigue. We hypothesized that psycho-oncologists who experienced high levels of grief and/or low levels of social acknowledgment (of their grief) would report higher levels of

compassion fatigue than those who experienced lower levels of grief and/or higher levels of social acknowledgment.

2 | METHODS

2.1 | Participants and procedure

Israeli psychologists and social workers working for at least one year in hematology/oncology departments, or in medical clinics with a diverse range of cancer patients, were recruited at the Annual Meeting of the 2018 Israel Psycho-oncology Society and during professional courses provided by the Israel Cancer Association. The participants signed informed consent forms and filled out the questionnaires via Qualtrics using their smartphones or computers. In appreciation, participants were given the opportunity to take part in a lottery. This study received approval from the ethics board of The Academic College of Tel Aviv-Yaffo (Approval number: 2018019).

2.2 | Instruments

2.2.1 | Demographic questionnaire

Questions regarding personal information (eg, age, gender), professional information (eg, years in the profession), and level of exposure to death of patients (eg, estimation of the percentage of patients' deaths from all the patients of the psycho-oncologist).

2.2.2 | The Texas Revised Inventory of Grief—TRIG—Present Scale[26]—Hebrew-language version[27]

A well-known and widely used 13-item questionnaire that assesses grief symptoms in reaction to loss by examining various aspects of grief, such as acceptance of loss, crying, and intrusive thoughts. The items were scored on a five-point Likert scale. The sum score ranged from 13 to 65. Cronbach's alpha coefficient of internal consistency was 0.83.

2.2.3 | Social Acknowledgment Questionnaire—SAQ[20]—Hebrew-language version[28]

A 15-item questionnaire that assesses the degree to which people feel validated and supported by their social environment following trauma. It includes not only acknowledgment from close social networks (eg, family, friends) but also from peer groups (eg, individuals at the workplace). The items are clustered into three subscales: Recognition, Family Disapproval, and General Disapproval. For the purposes of the current study, we used the general score of the questionnaire in our statistical analysis. We also examined each subscale and used each subscale score separately in the moderation model; this examination, however, did not result in any meaningful differences. The items are scored on a five-point Likert Scale. The total sum score ranged from 15 to 75. The Cronbach's alpha for the general score was 0.70.

2.2.4 | Compassion fatigue—Professional Quality of Life Questionnaire—ProQOL, version 5, Hebrew-language version[18]

This scale is a 30-item self-report measure that enables an evaluation of levels of compassion satisfaction and compassion fatigue (the negative aspect of working with and helping others who experience suffering and trauma). This measure is composed of two subscales: STS, which is a response to exposure to patients' traumatic events (10 items; eg, "I feel depressed because of the traumatic experiences of the people I help") and burnout, which is related to the work environment (10 items; eg, "I feel trapped by my job as a helper"). The items are scored on a six-point Likert scale. Subscale sum scores range from 0 to 50. The Cronbach's alpha of the subscales was 0.64 for burnout and 0.81 for STS.

2.3 | Statistical analysis

In order to test the moderation model, the participants were divided into three groups by means of cluster analysis. We used k-means cluster analysis based on the scores of grief and social acknowledgment in order to group the participants with maximal between-cluster differences and minimal within-cluster differences. In order to identify the meaning of the clusters, the grief and social acknowledgment indexes were divided into three categories, as presented in Table 3: Low (a score below one standard deviation from the mean sample score), Medium (a score between one standard deviation below the mean sample score and one standard deviation above the mean sample score), and High (a score above one standard deviation from the mean sample score). The three groups obtained by the cluster analysis can be characterized according to this division: High Grief—Low Social Acknowledgment (n = 23); Medium Grief—High Social Acknowledgment (n = 16); Low Grief—Medium Social Acknowledgment (n = 21). There were no significant differences between the groups in age, $F(2) = 1.382$, $P = .259$; seniority, $F(2) = 1.297$, $P = .282$; occupation, $\chi^2(2) = 0.33$, $P = .848$; or level of expertise, $\chi^2(2) = 3.06$, $P = .217$. We used ANOVA and Scheffe post-hoc analysis in order to compare the level of STS and burnout between groups.

3 | RESULTS

3.1 | Descriptive statistics

Out of approximately 90 eligible Israeli psycho-oncologists, 60 participated in the study. The average age of the participants was 40.62 years (SD = 7.38, range 26-86), and their average number of years working in the profession was 13.42 (SD = 8.33, range 1-33). Most of the participants were married females who were born in Israel. Table 1 presents the sample's demographic characteristics.

In accordance with our first hypothesis, all participants reported high exposure to patients' deaths (M = 44.30, SD = 27.16 percentages of patients' deaths from all the patients of the psycho-oncologist) and

TABLE 1 Demographic characteristics

		N	%
Gender	Male	8	13.3
	Female	52	86.7
Marital status	Single	5	8.3
	Married	53	88.3
	Divorced	1	1.7
	Widowed	1	1.7
Place of birth	Israel	55	91.7
	Other	5	8.3
Occupation	Psychologist	26	43.3
	Social worker	33	55
Level of expertise	Expert	35	58.3
	Intern	15	25

moderate to high levels of grief relative to the mean sample score (M = 27.83, SD = 7.50). Participants also reported moderate levels of social acknowledgment relative to the mean sample score (M = 48.73, SD = 7.41) and high levels of STS (M = 15.81, SD = 6.88) and burnout (M = 23.56, SD = 4.92), compared with the published norms by Stamm.[18]

3.2 | Intercorrelations between the study variables

Correlations between grief, social acknowledgment, STS, and burnout are presented in Table 2. Grief was positively associated with STS and burnout, confirming our hypothesis. In addition, social acknowledgment was negatively associated with STS and burnout, and there was a negative correlation between social acknowledgment and grief. That is, psycho-oncologists who reported higher levels of grief also reported higher levels of STS and burnout, and lower levels of social acknowledgment.

TABLE 2 Correlations between study variables

	Grief	Social Acknowledgment	STS	Burnout
Grief	1	−0.40**	0.41**	0.45**
Social Acknowledgment		1	−0.26*	−0.34**
STS			1	0.61**
Burnout				1

*$P < .05$, **$P < .01$

3.3 | Testing the moderation model

The results according the k-means cluster analysis, presented in Table 3, showed a significant difference between the groups in STS, but not in burnout. A Scheffe post-hoc analysis showed that the first group, High Grief—Low Social Acknowledgment, had significantly higher levels of STS in comparison to the other two groups. Thus, the combination of high grief and low social acknowledgment resulted in high levels of STS. These findings are consistent with our third hypothesis, which was that social acknowledgment would moderate the relationship between grief and STS.

4 | DISCUSSION

The current study examined the influence of social acknowledgment on the association between grief over patients' deaths and the two components of compassion fatigue—STS and burnout—among psycho-oncologists. The participants reported moderate to high levels of grief due to their high exposure to patients' deaths, resulting in high levels of STS. The combination of grief over patients' deaths and the lack of social acknowledgment was found to be significantly associated with STS. The highest levels of STS were found among psycho-oncologists who reported high levels of grief and low levels of social acknowledgment.

To the best of our knowledge, the current study is the only study that has quantitatively examined grief among psycho-oncologists. The presence of grief reactions among psycho-oncologists is consistent with previous findings regarding grief among physicians and nurses in the oncology setting.[29] Caring for patients who are coping with life-threatening illnesses, and for terminally ill patients, over a long time period, and then facing their deaths, could evoke grief symptoms. Indeed, experiencing grief is very common and highly relevant in this specific setting.[30]

These findings support the concept of grief as a normal response to loss, even within a professional relationship, such as between psycho-oncologists and oncology patients. In general, the work that psycho-oncologists do is uniquely characterized by close and

TABLE 3 One-way ANOVA results

	Mean and SD	Cluster 1: High Grief-Low Social Acknowledgment n = 23	Cluster 2: Medium Grief-High Social Acknowledgment n = 16	Cluster 3: Low Grief-Medium Social Acknowledgment n = 21	ANOVA	Scheffe Post-hoc analysis
Grief	27.83 (7.50)	34.68 (4.05)	27.31 (5.91)	20.71 (3.81)	F(2) = 52.04***	1 > 2,3
Social Acknowledgment	48.73 (7.41)	42.82 (5.01)	56.56 (4.95)	49.21 (5.17)	F(2) = 35.02***	1 > 2,3
STS	15.81 (6.88)	19.43 (5.66)	12.93 (5.38)	14.03 (7.60)	F(2) = 6.22**	1 > 2,3
Burnout	23.56 (4.91)	25.43 (4.39)	22.72 (4.91)	22.14 (5.03)	F(2) = 2.96	N.S

*$P < .05$, **$P < .01$, ***$P < .001$

personal relationships. In addition, psycho-oncologists are exposed to painful emotions such as their patients' sadness and fear; they must also witness, care for, and accompany these patients throughout their entire illness trajectories, including the end-of-life phase.[31] The experience of grief can therefore be seen as inevitable for psycho-oncologists, as their daily work is typified by cumulative and significant loss.[8]

The most significant finding of the current study regards the interaction between grief and lack of social acknowledgment: Specifically, the psycho-oncologists who had high grief reactions and low social acknowledgment showed the highest levels of STS. This moderation model is consistent with the existing literature and suggests that disenfranchised grief intensifies symptoms and emotional reactions associated with grief, such as anger, guilt, and feelings of powerlessness.[32] Disenfranchised grief deprives bereaved individuals of the opportunity to receive social support; it also deprives them of the legitimacy to grieve in public and to take part in rituals that are usually helpful when coping with grief, such as funerals.[3] Due to the professional nature of the relationship, psycho-oncologists might experience a lack of social acknowledgment of their grief over patients to whom they were attached, and of the impact of their having to face death almost daily.[25]

Disenfranchised grief, which reduces potential sources of support, magnifies the individual's bereavement so that "normal" grief may metamorphose into something "beyond" grief and manifest in feelings such as intensified anger, guilt, and powerlessness.[33] In the context of health care professionals, this disenfranchised grief may result in the development of compassion fatigue.[34] In turn, the compassion fatigue may impact not only the professionals' distress but also the quality of care they provide to their patients.[35] Conversely, it has been found that when health care professionals are given the appropriate support and legitimacy to grieve, compassion fatigue will not necessarily develop.[36] Hence, social acknowledgment might be considered a resilience factor against the possible negative implications of facing death and grieving over patients.

This study also supports Stamm's theoretical distinction[18] between the two components of compassion fatigue: STS and burnout. Burnout is the result of nontraumatic but stressful work conditions, and is associated with a sense of hopelessness and difficulties in dealing with work or in doing one's job effectively. STS, however, develops from exposure to others' traumatic events, such as providing care for people who are dealing with prolonged diseases. As a result of this continuous exposure, caregivers may report feeling trapped, exhausted, overwhelmed, and "infected" by others' traumas, and these feelings can be manifested in the caregivers' limited ability to provide compassionate care to other patients.[18]

Although we found grief to be associated with both STS and burnout, the moderation model was relevant only for STS. Thus, the association between grief and burnout seems not to be dependent on levels of social acknowledgment. This finding implies that the effects of grief on burnout are evident regardless of social acknowledgment. Burnout seems to be a more acceptable reaction than STS in different work settings, and society's approval therefore less needed.

It should be mentioned that psycho-oncologists directly witness their patients' suffering, are exposed to their patients' deaths, and experience their own personal loss when their patients die.[29] Hence, the cumulative experiences of grief may actually be perceived as a primary trauma for the psycho-oncologists,[9] and not only as secondary exposure to the traumatic experiences of others. It may therefore be that psycho-oncologists develop symptoms of compassion fatigue due to their primary exposure to the cumulative loss of their patients, in addition to their secondary exposure to their patients' trauma and suffering.

4.1 | Study limitations

The current study had several limitations. First, most of the participants were female. It is not unreasonable to assume that the relationship between grief, social acknowledgment, and STS might differ by gender, as emotional reactions may be more socially accepted for females than they are for males. Second, the fact that almost all of the participants were born in Israel—a country in which rituals, and especially mourning rituals, have great significance and are socially constructed—might have influenced the importance of social acknowledgment as a moderating factor for the association between grief and STS. Third, although the sample represents approximately two thirds of the psycho-oncologists in Israel, it may be considered a relatively small sample. Moreover, due to the cross-sectional nature of the study, conclusions cannot be drawn regarding causality. Thus, it is important to conduct longitudinal follow-up studies. In addition, the TRIG questionnaire was originally used to assess grief following the death of a loved one. Although this commonly used questionnaire allows us to better understand our results in comparison to results regarding other bereaved populations, and although it has high reliability, it is possible that a more specific questionnaire would better assess this kind of grief.

4.2 | Clinical implications

Given that death and grief over patients is an integral part of the oncology setting, there is a need to provide interventions for psycho-oncologists, such as education about death and grieving. Such interventions would hopefully allow these professionals to learn how to cope with loss.[29] Another potentially effective intervention would be participation in peer support groups, where formal caregivers could share their feelings of grief over their patients' deaths. Such peer support groups would likely strengthen social acknowledgment and normalize the experience of professionals' grief, and would validate and recognize it as an integral part of working with terminally ill patients.[37] Moreover, it is important to educate psycho-oncologists, as well as others in their work environment, about the signs and symptoms of STS, as doing so might help minimize individuals' vulnerability to this phenomenon.[38]

5 | CONCLUSIONS

In conclusion, grieving over patients is a complex experience which may exert negative professional and personal effects on psycho-oncologists, and might result in the development of STS. Understanding the effect of social acknowledgment on the relation between grief and STS could lead to a reduction of this phenomenon and to the development of relevant interventions for managing grief. Consequently, there would also be a decrease in STS among psycho-oncologists.

As far as we know, no study has yet examined grief and its implications for psycho-oncologists, nor has there been a study looking at the effect of social acknowledgment on the relation between grief and compassion fatigue. Grief is a normal human experience which cannot necessarily be prevented (nor perhaps should it be). However, the consideration of social acknowledgment as a relevant factor influencing the relation between grief and the development of compassion fatigue among psycho-oncologists might enable us to shed light on the relation between these two constructs. Optimally, this exploration would lead to the development of interventions aimed at decreasing the frequency and level of compassion fatigue as an outcome of grief.

CONFLICT OF INTEREST STATEMENT

No conflict of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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