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The "specter" of cancer: Exploring secondary trauma for health professionals providing cancer support and counseling

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The "Specter" of Cancer: Exploring Secondary Trauma for Health Professionals Providing Cancer Support and Counseling

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Health professionals are vulnerable to occupational stress and tend to report high levels of secondary trauma and burnout; this is especially so for those working in "high-death" contexts such as cancer support and palliative care. In this study, 38 health professionals (psychologists, social workers, pastoral carers/chaplains, nurses, group facilitators, and a medical practitioner) who provide grief support and counseling in cancer and palliative care each participated in a semistructured interview. Qualitatively, a grounded theory analysis revealed four themes: (a) the role of health professionals in supporting people who are experiencing grief and loss issues in the context of cancer, (b) ways of working with patients with cancer and their families, (c) the unique qualities of cancer-related loss and grief experiences, and (d) the emotional demands of the work and associated self-care. The provision of psychological services in the context of cancer is colored by the specter of cancer, an unseen yet real phenomenon that contributes to secondary trauma and burnout. The participants' reported secondary trauma has serious repercussions for their well-being and may compromise the care they provide. The findings have implications for the retention and well-being of personnel who provide psychosocial care in cancer and the quality and delivery of services for people with cancer and their families.

Keywords: secondary trauma, health professionals, cancer, health services research, grief

Loss and grief support for people with life-limiting illnesses and their families is central to cancer care and palliative care. Indeed, palliative care guidelines in several countries, including the United Kingdom (National Institute for Health and Clinical Excellence [NICE], 2004), the United States (National Hospice and Palliative Care Organization [NHPCO], 2008), and Australia (Commonwealth of Australia, 2010) emphasize the need to provide support to families both before and after a loved one dies from cancer. These guidelines promote an evidence-based approach to identi-

fying patients and family members who need support (during treatment and after bereavement), and providing appropriate assessment and referral of those identified, based on their individual needs (Breen, Aoun, O'Connor, & Rumbold, 2013).

Despite the increasing emphasis on loss and grief support in cancer and palliative care, there are several factors limiting effective service provision. First, surveys of university courses show that at graduation, many health professionals (general practitioners, nurses, psychologists, social workers, and counselors) are not adequately prepared to provide loss and grief support (Breen, Fernandez, O'Connor, & Pember, 2013; Dickinson, 2007, 2012). Similarly, practicing health professionals tend to report limited access to training and professional development opportunities in relation to loss and grief interventions (Barclay et al., 2003; Breen, 2011; Lobb et al., 2010; Low, Cloherty, Wilkinson, Barclay, & Hibble, 2006; Payne, Jarrett, Wiles, & Field, 2002). Second, questions over the efficacy of interventions, coupled with limited funding, mean that loss and grief support tend to be underresourced (Breen, Aoun et al., 2013; Field, Payne, Relf, & Reid, 2007). Third, health professionals may experience substantial discomfort and anxiety in "high-death" contexts. For example, Kirchberg, Neimeyer, and James (1998) reported that counselors experienced significantly more discomfort when they viewed videotaped vignettes of clients who were dying or recently bereaved than when they viewed vignettes depicting marital discord, unemployment, disability, or sexual abuse. Importantly, although the counselors did not display less empathy toward the clients who were dying or bereaved, they appeared to experience a "blunting"

effect from being flooded with death and dying stimuli rendering them less responsive to the clients' needs.

Cancer Support Services and Secondary Trauma

A systematic review of the literature demonstrated a high prevalence of burnout in professionals working in cancer services, with 26% experiencing emotional exhaustion and 34% experiencing depersonalization (Trufelli et al., 2008). A recent study of 20 oncologists' experiences of patient deaths highlighted their feelings of burnout, emotional exhaustion, and a sense of failure (Granek, Tozer, Mazzotta, Ramjaun, & Krzyzanowska, 2012). The oncologists attempted to mitigate their emotional reactions through creating boundaries around and "compartmentalizing" their emotions. However, despite these strategies, the majority ($n = 13$ or 65%) described "grief spillover" where their work emotions intruded on their personal lives. The oncologists' suggestions for institutional support included access to training and ongoing psychological support relevant to dealing with loss (e.g., grief fact sheets), open acknowledgment of their grief responses, individual mentorship and group debriefing, and encouragement to take vacations and study leave (Granek, Mazzotta, Tozer, & Krzyzanowska, 2012). The elevated risk of burnout may be explained by the emotional dissonance or conflict that may arise when attempting to display empathy without the intrusion of negative emotions such as anger, sadness, and frustration (Kovács, Kovács, & Hegedűs, 2010). In addition, high work-related stress might lead to impaired work performance, potentially compromising client care (Barnett, Baker, Elman, & Schoener, 2007).

Two recent reviews shed light on the factors associated with secondary trauma and burnout in the workplace. Trufelli et al. (2008) reviewed 10 studies of burnout in cancer professionals and Pereira, Fonseca, and Carvahlo (2011) reviewed 15 studies of burnout in palliative and hospice settings. The findings are summarized in Table 1. Both reviews revealed that the focus of research is limited to physicians and nurses rather than attending to all health professionals providing psychological care in the context of cancer.

In summary, secondary trauma and burnout have serious implications, not only for the well-being of health professionals involved in cancer care, but also for the provision and quality of patient care. However, to date, only a limited amount research has focused on exploring the consequences of work-related stress for health professionals who provide psychological care and support in the context of cancer care or palliative care. As such, we interviewed health professionals who provide grief support for people affected by cancer (patients diagnosed with cancer and/or their family members), with a particular emphasis on investigating the emotional consequences of providing this support. Data were collected from a larger study of the provision of grief support grief support for people affected by cancer.

Method

Participants

The sample comprised 38 professionals (32 women, six men) who provide grief support for people affected by cancer in Western Australia. Participants were recruited from various settings including hospital oncology and palliative care ($n = 17$), hospices ($n = 4$), private practices ($n = 9$), and community organizations ($n = 8$). There were 11 psychologists, 10 social workers, seven pastoral carers/chaplains, six nurses, three group facilitators (with no specific discipline training), and one medical practitioner. Experience within these professions ranged from 4 to 33 years and experience specific to cancer support ranged from 3 to 12 years. The psychologists specialized in grief support and had some experience in the cancer field, and the other interviewees provided some grief support but it was not the sole focus of their role.

Materials

A semistructured interview guide was used to interview each participant. The interview guide included topics such as their day-to-day practice, approach/style of interventions, criteria for referral and for termination of services, satisfaction with intervention, service delivery improvements, education and training in grief, understandings of grief and loss experiences and grief "risk" factors, accessing grief information, best-practice grief support and intervention, identifying and addressing grief risk factors, how current literature informs delivery of grief services, and the factors that facilitate or impede their work, such as the effects of the type of work on health and personal lives over time. In recognition that it might be difficult for health practitioners to discuss their own experiences of secondary trauma and burnout, we took an indirect approach to eliciting information about their emotional and behavioral experiences as opposed to posing specific and direct questions about secondary trauma and burnout that might have been confronting. The service providers were asked to provide examples from their practice experiences to ensure that the data were grounded in their realities and all interviews were digitally audio-recorded.

Table 1
Risk and Protective Factors for Secondary Trauma and Burnout

Risk factors	Protective factors
High patient loads, high stress, inadequate resources, insufficient training, and lack of confidence in communicating effectively with patients and families (Trufelli et al., 2008).	Choosing to work in oncology, role recognition, involvement in treatment decisions, interest in research, and engaging in recreation and leisure outside of the workplace (Trufelli et al., 2008).
Communication issues (lack of time and confidence to communicate effectively with patients and families), ongoing exposure to suffering and death, team conflicts, and a lack of organizational strategies for burnout prevention. (Pereira et al., 2011)	

Procedure

The project was approved by a university Human Research Ethics Committee. In total, 124 health professionals from publically listed grief support services in Western Australia were contacted via letter or e-mail to request an interview. Of these, 14 people no longer worked at the listed service, 48 did not respond, and 24 declined because cancer was not a specialty area ($n = 16$), they were short of time ($n = 6$), not interested ($n = 1$), or were not comfortable being recorded ($n = 1$). A mutually convenient time was arranged for each interview. There were 33 interviews; three involved two participants and one interview was of three participants. Of these, 23 interviews were conducted face-to-face in participants' workplaces and 10 were conducted via telephone. Interviews ranged from 19 to 84 minutes ($M = 54.64$, $SD = 14.38$).

Data Analysis

The data were analyzed using grounded theory analysis strategies which began with verbatim transcription, then reading and rereading of transcripts. Analysis began as soon as possible after each interview to inform sampling of subsequent participants (Strauss & Corbin, 1998). Analysis incorporated the three primary techniques used concurrently in grounded theory—coding, memoing, and diagramming (Strauss & Corbin, 1990). The first author supervised the collection of data and led the data analysis. The coauthors each participated in the analysis and interpretations of data, with preliminary analyses of transcripts circulated between and discussed among the research team until agreement was reached, thus contributing to the dependability of the findings (Lincoln & Guba, 1985). Data collection and analysis was conducted concurrently until saturation was reached; saturation was deemed to have occurred when the themes recurred and no new information emerged from subsequent interviews (Strauss & Corbin, 1998). In grounded theory, confidence in the theoretical scheme is high when saturation is achieved, ideas are well-developed, and there is both repetition and variation in the data patterns (Strauss & Corbin, 1998).

Results

The four major themes to emerge from the data were (a) the role of health professionals in supporting people who are experiencing cancer-related grief, (b) ways of working with people who are affected by cancer, (c) the unique qualities of cancer-related loss and grief experiences, and (d) the emotional demands of the work and associated self-care.

Role of Counseling for Grief and Loss

The role of grief counseling included helping clients to live until they die and supporting clients through their journeys, as described by a social worker:

> We can't alter the diagnosis, we can't alter the prognosis, but we can love, we can tender, we can nurture, so that whatever their journey is going to be they at least feel nurtured and protected and reconnected to their spirit a little bit.

Two participants described using humor as a way of connecting with clients and helping them to deal with negative experiences that arise from their losses. A social worker explained:

> I use humor a lot, which may be a bit strange in palliative care but I find it is really quite helpful. One of the techniques especially with family who get a bit overwhelmed with society and the negative things people say . . . like "Oh you could always have another child" or "It was God's will" and you know we laugh about that, about how insensitive people, in their desperate attempt to try and hide their own anxiety, come out with (trails off) . . .

Five participants detailed their role in providing practical supports and negotiating services and resources to meet clients' needs. For example, participants reported linking clients with community supports (such as church), home-based support services, carer respite, accommodation, transport supports (such as organizing a disability parking permit or taxi vouchers), referrals to related services (e.g., aged care), as well as assisting with finances and organizing funerals. A social worker stated:

> Part of what I do is try to help people with their finances. Trying to get superannuation when they're under 55 is like trying to get blood from a stone. The Cancer Council will give you only $500 [and] Sickness Allowance is about $455 a fortnight. Breast cancer is a "good" cancer to have because you have access to more money . . . Those kinds of implications are so huge in working with people; it's frustrating. It's horrible because people are just *so* sick and the system doesn't give leeway for that.

A key topic of discussion for many clients and their families focused on the family's future and potential role changes and conflicts. A social worker explained, "If [the patient] is dad who was out making the money, now money will be tight and mum might have to work more so she's not around as much. It's very disruptive to day-to-day living."

Five participants reported assisting patients to adjust to diagnosis and treatment. They suggested that patients felt helpless and dependent, and had difficulty assuming the "patient" identity and yielding to the medical professions. A nurse commented, "When they become 'the patient' they leave the person they are at the door and being a patient is an incredibly dependent role." A psychologist asserted:

> They are going to be having all these hospital visits and doctors and invasions. Who knows what, it's horrible to have to go through that. Every treatment is *worse* and *worse* in many cases . . . they've *lost* control of their own rights. They're back and forth with numerous people saying go here, do that, take these pills, have this radiation. Come in for chemotherapy, don't eat this, don't do that, eat this, drink that . . .

Four participants noted that some clients are reluctant to engage in counseling services and attributed their reluctance to a lack of understanding about the counselor's role. A psychologist felt that some people "have a bit of prejudice against counseling" and another stated, "A lot of people feel very wary about coming to a counselor because they think you've got to be mad to have to go and see one . . . and they're not quite sure what to expect." Similarly, a social worker said of pastoral care, "People might think it's religious issues rather than emotional

and spiritual issues but it's much broader than religion." A chaplain considered older people and men to be more resistant than others to counseling.

Working With the Patients and Their Families

Six participants highlighted the importance of working holistically with the patient's family rather than with only the patient. As a social worker explained, "you're not just treating the patient; you're treating the whole family unit." Interestingly, "the family" was often spoken about and defined loosely as illustrated by a nurse:

> It may be that the family finds the loss difficult because they don't actually deal with that or don't talk to the person that is dying . . . or they don't know the right words to use and I say that they don't have to talk, they can just sit there and hold their hand.

Seven participants distinguished between the dying processes of patients and the loss experiences of families; accordingly, the grief responses to each differed from one another. A chaplain explained, "One of the big differences is that the person is losing their life, whereas everybody else is only losing a loved one. I think there is a bit of distinction, not that I want to grade people's grief." Consequently, patients and their families and friends have different experiences and needs, with family members described as experiencing feelings of helplessness and powerlessness in watching their loved one deteriorate. A pastoral care worker described a client:

> . . . whose husband had died and what she couldn't take or comes to terms with was this powerful man wasting away before her eyes. He wasn't even half of what he was and she couldn't do anything for him. That in itself is quite a traumatic experience, watching the person you love die.

Furthermore, four participants noted that working with patients and their families required an understanding of the needs and experiences of family members who provide care for the person with cancer. A nurse said, "The helplessness and sense of no control is huge in carers . . . I'm always conscious of the fact that the carer may in some respects need more support in caring for the patient" and a group facilitator explained:

> I think sometimes it's harder for the carer than the patient because they feel so helpless. They are watching and can't do anything and [the patient] is going through cycles and cycles of chemotherapy . . . The carers can often feel helpless; . . . you get over one hurdle and then you are knocked down again.

An additional point of difference between patients and family members centered on the latter's experiences of relief following the death of the patient because the patient is no longer experiencing pain and discomfort. For instance, a chaplain reported, "The person has suffered, has been in a lot of pain, [and had] a lot of medication, and finally the person is released from all the suffering, and sometimes people—I don't want to use the word happy—but they are relieved." Similarly, a nurse asserted, "When the patient dies, there's relief and sometimes the family can feel a bit guilty but I tell them that's normal."

Unique Qualities of Cancer-Related Loss and Grief

Some participants described a diagnosis of cancer as "shattering," "terrifying," and "a shock." In particular, the participants described cancer, or "the 'big C,'" as accompanied by "shame," "fear," "suffering," and "death." For example, a psychologist described:

> Everything—the language that is used around cancer. Whenever, whatever you read, it's very disturbing, very negative and it's always you know "so and so died after a great *battle* with cancer, the *struggle* of . . . (trails off)." It's not to say that those things are not there but some people don't *die* of cancer. Some people don't just survive, they live beyond it.

Because of these attributes, the participants asserted that the social supports available to people with cancer and their families can wane or disappear. A nurse remarked, "Often friends don't know what to say so they avoid it" and a psychologist noted that family and friends can be "too frightened in facing their own mortality and so remove themselves." As a result, counseling and support services play an important role, providing a space for catharsis, as described by a group facilitator: "In the group I have said, 'When I call, how do you feel about that?' and they say 'No it's good, we want to talk about our loved ones.'" Similarly, a psychologist reported a client saying, "It's so good to be able to cry and not apologize because I can't cry in front of my husband and my children because they can't cope with it." Additionally, a social worker described training clients to be better-equipped in accessing social support:

> Sometimes it's learning the skills on how to talk to their friends because sometimes their friends don't know what to say . . . We assist them with some sort of practical strategy about how they can ask for help and they can surround themselves with people who make a difference for them.

Despite the varied and significant consequences of cancer, participants reported that a cancer diagnosis also provided many people with an opportunity for personal growth and meaning-making. A psychologist reported, "Many [clients] have said, 'thank God for my cancer, it's been a gift' or 'thank God for my lover or partner or wife for having cancer; I've learnt so much,'" while a nurse commented, "It's not all bad; sometimes these diagnoses have enhanced their lives. Some people have chosen to embrace experiences and not a lot of 'things' . . . "

The participants contrasted cancer trajectories with other illnesses as though to illustrate its "menace." Nine participants conceptualized cancer deaths as being similar to deaths from many diseases but distinct from sudden deaths because the illness trajectory is typically prolonged. For instance, a psychologist explained, "More often than not it's a prolonged process . . . They may go in remission after treatment and then they might be good for 5 years or 6 years . . . " Second, some participants described characteristics of the disease itself. Some participants commented that patients were "ravaged" by the disease, experienced the "relentless nature of deterioration of health," and were rocked by the unpredictable nature of cancer. A chaplain likened the trajectory of illness to being on a "rollercoaster." Similarly, a nurse stated, "Things can happen very quickly or people can, you know, sit on the plateau stage for quite a long extended period and that can be

very, very difficult as well." Third, some participants described the treatments for cancer as "so intense" and "often worse than the actual disease." In particular, a nurse described head and neck cancer as "very disfiguring and . . . the surgery is so dramatic and drastic that families actually didn't recognize patients after their surgery . . . and patients would prefer to be hidden away in rooms because they were so embarrassed about how they looked."

A fourth point of difference between cancer deaths and other deaths involved the secondary losses experienced by people with cancer and their families. These secondary losses include losses to control, privacy, and independence; intimacy, sexuality, and sexual function; friendships; body image issues such as hair and weight loss, fatigue, and treatments; personal and existential losses relating to the meaning of life and the shattering of assumptions about the world being fair; and financial security. A social worker commented, "The financial hardship people go through is really quite disturbing sometimes. Dealing with the cancer can be overshadowed by 'How am I going to pay these bills and put food on the table?'" The participants also noted that people affected by cancer often lose future aspirations and dreams such as traveling, raising children, retiring, and having "normal" family lives. For instance, a social worker described "some things that you took for granted, like watching your children grow old, are gone" while another social worker stated, "I've worked with a lot of young mums [with cancer] and for them, it's not being able to pick up their children or play with them, or take them to school, and that they might not be there to see them grow up."

These losses and the effects of treatment often had ongoing long-term consequences, even in remission. A social worker described, "Their lives will always be tinged with cancer and the unknown—is this just a cold or does it mean the cancer is back? Has he got a sore leg or does it mean the cancer is back?" In situations when the person with cancer doesn't die, the ongoing experience was termed "chronic grief," "chronic loss" or "chronic sorrow." These ongoing impacts were especially highlighted for children with cancer, as described by a social worker:

> Sometimes the cancer treatment impacts on the child through all sorts of ways either through hearing loss or other developmental delay issues, through growth hormones, you know there is all sorts of side effects that happen while the child may technically be in remission. The child will now need ongoing lifelong specialist care because of the cancer journey . . . [Parents] are grieving for the child that you no longer have, that is no longer the child they were when they started this journey.

Emotional Demands and Associated Self-Care

Five participants emphasized the importance of an emotional connection with their clients and patients. A nurse noted that the provision of grief supports "obviously can be very especially challenging . . . You can't help it at times, you tend to develop a quality friendship with them too and their families." In fact, two participants became teary when discussing their experiences during the interview. A psychologist described:

> To be quite frank, it's taxing for therapists . . . It's hard work, and unlike the medical profession, we're trained to be empathic and to build a connection so it's taxing for us. Whereas medically, they're trained to be more detached, and they have to be, but that's part of the

problem too, because patients are aggrieved by that "matter-of-factness."

The participants reported the necessity of learning to be comfortable with their own mortality and with their attachment to dying patients, in order to work effectively and respectfully with their clients and patients. However, the emotional load of the work was clearly a substantial component of their labor. A social worker described the work as "emotionally and psychologically demanding and draining." The professionals described at times being "exhausted" and "drained" by their work and another stated, "For me it is a cumulative thing that has started to catch up with me to be honest." Ten participants described the emotional load of the work, four noting the extra difficulties in working with dying children and adolescents. A psychologist described the challenge of working with a dying client while managing the emotional load:

> I have had a patient right now who is [speaks softly], who is dying and very close to death and the last time he came what I heard was him shuffling down the side of the house. I heard his steps so labored and shuffling and I knew [from the sound that he was deteriorating] . . . I *care* for this person [says passionately]. He's my patient, but I *care* for him very much and you know it grips you [voice raises slightly], to see something like that *but* I don't let him see that [pauses] and I can't let him see that. I have to maintain that boundary.

As a result of secondary trauma, 10 participants highlighted the importance of looking after themselves and identified self-care strategies on which they relied to enable them to provide grief supports. For instance, a nurse stated, "It's not easy watching people die—it's never easy—and it tugs at the heart strings and you have to look after yourself . . . otherwise you burn out." Five participants stated that they debriefed with colleagues, as described by a nurse:

> We had a particularly difficult case from a staff point of view so we accessed debriefing for staff. We haven't had to access that often, professionally, but we often sit down as a group to talk about what's been good and what's not been so good about particular cases, but in some cases we have actually accessed professional support.

Five participants reported engaging in formal psychological supervision, which one psychologist described as "pretty essential . . . from a professional skills point of view as well as be able to offload a little bit ourselves." Two reported maintaining a professional front. For instance a psychologist stated, "If somebody is crying, you're not crying as well, which you might if it was just a friend . . . but you don't [with a client] because you've got the professional role." Participants also mentioned several barriers to accessing supervision including time, lack of potential supervisors within the workplace, and money required to pay for supervision outside the workplace. A nurse described, "I do supervision once a month that I organize and pay for myself. I think that's a safety mechanism in this role that I think is important. I do it out of work but I don't see why I couldn't do it in work." The same nurse also described the difficulty in encouraging self-care for large teams. She noted:

> If you've got 70 people in the roster, how do you capture them all? We have meetings but there are people who don't come who probably need it and then others who do come but already have great self-care

[strategies]. It's really difficult to instill self-care strategies. Making it a priority and recognizing that you need it are starting points.

Participants also described personal strategies for self-care including yoga, massage, horse-riding, and focusing on "happier" things. As an example of the latter, a social worker stated:

I think you have to be able to detach yourself but it does come at a cost of your own life. So for me I don't watch sad movies, I don't read books with bad endings; I have to be quite prescriptive about things that I expose myself to so I watch comedies with happy endings and I read books that are happy.

A psychologist reported engaging in her own therapy and analysis as it is "essential to the work to be working on myself" and a social worker stated that she would consider leaving the profession if the emotional load became too much.

Discussion

Health professionals providing cancer support and counseling, including bereavement care, experienced both satisfaction and stress. A key emotional challenge that participants faced was being surrounded by the negative connotations associated with cancer diagnosis. The provision of psychological services in the context of cancer is colored by the "specter" of cancer, an invisible yet real phenomenon that contributes to secondary trauma and burnout. Although this specter of cancer can't be "seen," it evokes a mental and image that is unpleasant or menacing and that penetrates their work and, therefore, their emotional experiences of the work. Given the variety and emotional intensity of some aspects of the professionals' roles, it is not surprising that many noted the importance of self-care.

The findings from our study support those of previous studies in the international literature. For instance, we documented the emotional work required in attempting to support people with cancer and their families (Granek, Tozer et al., 2012; Kovács et al., 2010) and the protective role of self-care strategies for professionals engaging in this work (Kearney, Weininger, Vachon, Harrison, & Mount, 2009; Trufelli et al., 2008). Additionally, we emphasize the need for workplace, as well as individual, strategies that acknowledge the health professionals' feelings and needs and bolster their communication skills (Granek, Mazzotta et al., 2012; Pereira et al., 2011; Trufelli et al., 2008), as well as highlighting the job satisfaction that often accompanies such roles (Ablett & Jones, 2007; Sinclair, 2011).

The delivery of loss and grief support should not be achieved at the expense of professional well-being; rather, we need strategies to optimize the health and wellbeing of patients, families, and professionals. Existing research demonstrates that secondary trauma has serious repercussions for well-being and may lead to compromises in the care professionals provide. Our findings highlight the importance of identifying strategies that (a) enhance health professionals' psychological well-being and resilience to secondary trauma and burnout, and (b) may be inculcated into their clinical practice.

Clinical Applications

Despite increasing recognition of the role of self-care for health professionals, especially those working in high-death contexts, there is limited evidence to guide the development of self-care strategies. Importantly, there is a tendency to focus these strategies at the individual level rather than also examining teams and organizations (Kearney et al., 2009). Across the spectrum of levels, there is a need for recognition of, and strategies for limiting, the factors that may contribute to secondary trauma and burnout for health professionals providing cancer support and counseling (see Table 2). These strategies need to be accessible by all members of the cancer support workforce, including volunteers, and across disciplines, as a strategy that works for one might not work for another.

The implementation of standardized protocols of assessment and intervention may be useful in meeting the needs of patients and their families as well as reducing unnecessary interventions, which may negatively affect patients, families, and professionals. An example of this approach is the application of a public health model to bereavement services (Aoun, Breen, O'Connor, Nordstrom, & Rumbold, 2012) as it provides care according to need and is aligned with best-practice policies (e.g., NHPCO, 2008; NICE, 2004). The model's three tiers of support (information and compassion, nonspecialist support, and specialist interventions) were established by research demonstrating that grief interventions for those with "normal" grief tend to be minimally, if at all, effective and may even result in harm, and instead should be directed only to people with higher levels of distress (Currier, Neimeyer, & Berman, 2008). It would be prudent for this model of offering support and interventions according to need to be applied across the cancer spectrum.

The alignment of grief research and interventions is a central concern in loss and grief (Bridging Work Group, 2005; Center for the Advancement of Health, 2004). However, there is limited evidence to drive the development of interventions programs that enhance the health and well-being of professionals involved in loss and grief support in the context of cancer. There is a clear need then for these interventions to be trialed and evaluated. Involvement in research appears to protect against burnout (Trufelli et al., 2008) and these avenues for applied research could be investigated within and across organizations with health professionals as co-investigators. Whitworth, Haining, and Stringer (2012) provide a useful model of roles and strategies to build research capacity among practitioners.

Neimeyer (2008) differentiated between grief support (informal compassion and information from people who do not have professional bereavement training), grief counseling (provided by a trained professionals), and grief therapy (provided by trained professionals to people with mental health concerns); our sample included all three groups. There is scope for further research exploring secondary trauma and burnout within each of these support categories. A review of available research revealed that burnout was more common in oncology professionals, who are concerned with active treatment and cure, than in those working in palliative care, which facilitates dying (Pereira et al., 2011). However, little is known about rates and experiences of burnout for professionals who may experience patient deaths intermittently. It may be that those who choose to work in high-death contexts are less likely to experience deleterious consequences, perhaps because they are more comfortable with mortality than those who work with people affected by cancer only occasionally or on a nonvoluntary basis (e.g., compulsory oncology and palliative care

Table 2
Factors Contributing to Secondary Trauma and Burnout for Health Professionals Providing Cancer Support and Counseling and Strategies to Address Each Factor

Contributing factors	Strategies
Emotional dissonance (Kovács et al., 2010).	Facilitating the development and maintenance of protective factors such grief education (Lobb et al., 2010) and psychological factors such as hope (Duggleby, Cooper, & Penz, 2009) and meaning (Sinclair, 2011).
	Offering training/workshops to improve professionals' communication skills for working with clients and their families.
Empathy fatigue (Kirchberg et al., 1998; Stebnicki, 2007).	Recognition of psychological supervision as an essential component of the role of personnel who provide grief. counseling for people affected by cancer, as well as their managers (Granek, Mazzotta et al., 2012; Lobb et al., 2010).
	Open acknowledgement of grief responses and encouragement to take leave (Granek, Mazzotta et al., 2012).
Professional isolation (Breen & O'Connor, 2013).	Opportunities to access debriefing, supervision, and professional development (Breen & O'Connor, 2013).
Limited grief knowledge and skills (Barclay et al., 2003; Breen, 2011; Lobb et al., 2010).	Grief professional development education and training (Granek, Mazzotta et al., 2012; Lobb et al., 2010).
Lack of self-care strategies (Pereira et al., 2011).	Development of self-care strategies through programs such as "Take Care!" to reduce secondary trauma and burnout (Le Blanc, Hox, Schaufeli, & Taris, 2007). Collation and dissemination of the self-care strategies practiced by staff before embarking on more complex analyses of organizational barriers and enablers of self-care.
Inadequate resourcing for grief interventions (Breen, Aoun et al., 2013; Field et al., 2007).	Use of standardized protocols for assessment of needs and interventions to avoid unnecessary and costly intervention (Aoun et al., 2012; Breen, Aoun et al., 2013).
Limited evidence to guide secondary trauma and burnout interventions.	Assist in the trial and evaluation of interventions to enhance professional wellbeing, e.g., co-investigators in research (Trufelli et al., 2008).

rotations). This paradox warrants further study. Additionally, the effects of health professionals' emotional fatigue and burnout on patient and family well-being remain underexplored.

Strengths and Limitations

The use of interviews and their systematic analysis provide a contextual and data-driven account of cancer grief and loss counseling practice in Western Australia. Attempts were made to ensure the process was as rigorous as possible, including multiple sources of data and conducting the research in a team. A key strength of the study is the sample size, which is large for an in-depth qualitative study, and the diversity of professionals who participated; this diversity and depth enhance the study's ability to contribute to practice (Daly et al., 2007). However, although the data provide a detailed snapshot of secondary trauma in the context of cancer care in Western Australia, the findings might not be transferable to other contexts. Additionally, we did not collect information as to each participant's ethnic background, sexual orientation, religious affiliation, and income, yet these demographics would potentially impact the data and their interpretations. Finally, we took an indirect approach to asking health professionals about their about their emotional and behavioral experiences. An exploratory, indirect approach was also taken by Granek and colleagues (Granek, Mazzotta et al., 2012; Granek, Tozer et al., 2012) in their research on oncologists dealing with patient loss. Future researchers could pose direct questions about secondary trauma and burnout in the context of cancer care. A direct approach would suit a larger study incorporating validated scales of secondary trauma and burnout. Such an approach would

more likely enable the determination of factors that predispose health professionals to secondary trauma and the testing of interventions to assist them.

Conclusion

This study provides a detailed picture of the practice of cancer grief and loss counseling and highlights the challenges of providing support and counseling to patients and their families. These data show that the specter of cancer permeates throughout the work. As such, a key challenge for health professionals, at the individual, team, and organizational levels, is to find a balance between caring for patients and families and caring for themselves. A focus on "caring for carers" has the potential to enhance the supports and services available to people affected by cancer while mitigating the risk of secondary trauma and burnout.

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