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**The Emotional Labor of Personal Grief in Palliative Care:
Balancing caring and professional identities**

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ABSTRACT

The paid provision of care for dying persons and their families blends commodified emotion work and attachments to two often-conflicting role identities: the caring person and the professional. We explore how health care employees interpret personal grief related to patient death, drawing on interviews with twelve health care aides and thirteen nurses. Data were analyzed collaboratively using an interpretively embedded thematic coding approach and constant comparison. Participant accounts of preventing, postponing, suppressing and coping with grief revealed implicit meanings about the nature of grief and the appropriateness of grief display. Employees often struggled to find the time and space to deal with grief, and faced normative constraints on grief expression at work. Findings illustrate the complex ways health care employees negotiate and maintain both caring and professional identities in the context of cultural and material constraints. Implications of emotional labor for discourse and practice in health care settings are discussed.

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A self-identity as a caring person is often fundamental for those who seek paid work in health care settings, particularly in palliative care, where the culture and practice prioritizes psychosocial support and emotional needs of both dying persons and their families, including empathetic and sensitive interactions (Skilbeck & Payne, 2003). However, within paid care work, this can be viewed as needing to be balanced against some degree of emotional distance and a professional identity, as both an organizational imperative and self-preservation strategy. For instance, Froggatt (1998) examined how hospice nurses characterized emotions as potentially dangerous energies needing to be contained rather than released into public space. They also protected themselves from emotional responses to others' grief through containment and distancing strategies. In another study (Hopkinson, Hallett, & Luker, 2005) hospital nurses caring for dying patients emphasized the “potential harm of becoming emotionally involved and it was seen necessary to exercise control over involvement, in order to sustain personal well-being and continuing ability to care over the longer term” (p.131).

Emotional control is also a professional norm, and is considered by some to reflect emotional intelligence, which has been idealized as a professional skill in palliative care providers (Codier, Muneno, & Freitas, 2011), even though “some current assumptions about emotional intelligence may be based on unsubstantiated rhetoric” (Smith, Profetto-McGrath, & Cummings, 2009: p.1632). Li and Arber (2006) documented how normative imperatives of emotional self-control shaped the identity construction of palliative care nurses.

The concept of emotional labor helps us better understand the work involved by paid care employees in balancing between the needs of self, other, and the demands of health care organizations (Hochschild, 1983; Hochschild, 2003). Emotional labor denotes commodified forms of emotion work, wherein employees, as a requirement of their job, manage and align their

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emotions with organizational expectations to satisfy clients or customers (Hochschild, 1983; Mann, 2005). Both emotions and emotional labor tend to be invisible in paid care work, and the latter has been identified as a ‘tacit and uncodified skill’ (Gray & Smith, 2009, p.253). Despite some attention to interpersonal work in health care, as well as to the ongoing and cumulative emotional effects of grief, sadness, and despair experienced by those working with dying persons (Wilson & Daley, 1998; Karlsson, Kasén, & Wärån-Furu, 2017; Stayt, 2009), there has been little connection to the concept of emotional labor in the palliative care literature. Yet within health care organizations, patient death can be an emotional labor-inducing event (Mann, 2005) particularly when it involves dissonance between the type or level of personal feelings and organizational or professional expectations of emotional display.

In other words, in part to meet the needs of the organization and satisfy patients and families, employees may suppress grief, try not to feel it, or otherwise moderate its display in social interactions at work. The concept of emotional labor extends beyond coping to examine whether, how and for what purpose grief may be expressed in the workplace. It also helps us connect grief to the dynamics of role identities. For instance, Theodosius (2012) outlined how individuals become aware of their emotions more fully as they interpret them in relation to their identities. She further proposes that the processes of emotional management learned and implemented within workplaces “can result in the inauthenticity of emotion and the alienation of self from self” (Theodosius, 2012, p.65).

As noted above, existing research has examined how care workers cope with grief – for instance, through interpretive and emotional strategies. Skilbeck and Payne (2003) reviewed how nurse specialists cope with grief-related distress through disclosing, or distancing, concealing or containing emotions. Studies of direct care workers and volunteers have also identified how

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coping with grief is shaped by broader social, cultural and religious frameworks or discourses, such as those that characterize death as a ‘merciful escape from suffering’ (Black, 2004; Black & Rubenstein, 2005; Dein & Quamar Abbas, 2005; Funk, Waskiewich, & Stajduhar, 2013-14; Moss, Moss, Rubenstein, & Black, 2003). Similar framing processes have been examined among bereaved family carers, who in one study strove to “narrow the distance between the ‘good death’ and the death [caregivers] witnessed” (Sinding & Aronson, 2003; p.103).

When death and dying occurs within public, organizational settings, employees face additional barriers to coping with and expressing personal grief (Funk et al., 2013-14; Moss et al., 2003). Informal policies or unit cultures and localized manifestations of professional ideals may be influential in this regard (Ersek & Wilson, 2003; Goodridge et al., 2005; McClement, Wowchuk, & Klaasen, 2009; Moss et al., 2003). In this context some employees facilitate their grief expression and help validate losses by drawing on family metaphors to characterize their relationships with patients (Froggatt, 1998; McClement et al., 2009; Moss et al., 2003). Others manage barriers to grief expression through detaching emotionally from dying persons (Hopkinson et al., 2005).

Although coping and emotional labor are distinct concepts, the ways that workers talk about coping with grief can provide important insights into the dynamics of emotional labor and identity. As such, in this article we explore how paid care providers understand and interpret grief when working with dying patients and families, and the emotional labor they engage in as they manage grief in the context of their work.

Methods

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This interpretive inquiry necessitates an inductive, qualitative approach, given the complexity of interpersonal and emotional phenomenon. A qualitative approach seeks comprehensive understanding of social processes – in this case, how health care workers interpret the social and symbolic meanings of grief. Our inquiry is theoretically influenced by symbolic interactionism (Blumer, 1969; Charon, 2004), in its focus on how subjective meanings are communicated in social interactions, and more specifically in the influence of this theoretical tradition on the constructionist methodological orientation of interpretive inquiry (Gubrium & Holstein, 2000). Interpretive inquiry directs attention not only to the content or what people are saying, but also to the processes of talk or how they are saying it, for what these aspects reveal about meaning-making (Gubrium & Holstein, 2000). In interview research, this might extend to considering how both paid and unpaid caregivers cope with difficult experiences by trying to construct them in particular ways (Funk & Stajduhar, 2009). We also utilize emotional labor as a theoretical sensitizing concept; it guided the construction of interview questions and directed our analysis towards self-focused emotion work within paid care; using this concept helped us better understand social construction and identity in a professional caregiving setting.

In-depth qualitative interviews were conducted with employees of a multi-unit health care facility in Winnipeg, Canada. The facility includes both hospital and long-term residential care for patients with rehabilitation, palliative and long-term care needs. Health care aides (HCAs) and nurses (RNs) were recruited from palliative care and other residential units where patient deaths occur (e.g., long-term residential, complex chronic care, respiratory, dementia care).

Following university and care facility IRB approval, invitations were distributed to employees through contacts with unit managers. Interested participants contacted us directly and after written informed consent was obtained, interviews were conducted and recorded in-person.

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Interviews were guided by a set of broad questions about interactions with patients and families, professional boundaries, and personal emotions experienced at work. These interviews were focused on emotional labor in any aspect of participant work, not restricted to death and dying. Participants were encouraged to elaborate with specific examples of emotions and emotional labor, and in response to these questions, participants included situations involving death and dying; although in most instances these data were inductively generated, when talk about grief was not forthcoming in interviews, the interviewer (Peters) probed for this information.

Audio-recordings were transcribed verbatim. Funk and Peters analyzed the data, which included various steps: multiple re-readings of transcripts; sifting and sorting of data within interviews, identifying and grouping segments of text according to similar descriptive topics such as dying, bereavement and grief; collaborative development of thematic and conceptual codes based on the first five transcripts; continued refinement and development of code categories as applied to the entire set of interviews; and the comparison and contrast of pieces of data within each code, to generate further insights. This particular analysis focused on workers' interpretations of grief related to end of life and death, and thus the findings rely more heavily on the accounts of the eleven participants recruited from palliative care units, who spoke more about this issue, although relevant data from participants from other units were also included.

Specifically, since patients on units other than palliative care may also die, fourteen of the fifteen non-palliative participants spoke of their emotional experiences when they did encounter these situations at work. We did not wish to exclude their experiences, which were albeit fewer in number than for palliative care employees, but nonetheless important. Moreover, three participants had previous experience in palliative care units, and referred retrospectively to work

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on those units. We did, however, exclude one participant (an RN) from this analysis due to the lack of data in her interview about either death or grief.

Findings

Data from interviews with twenty-five participants are included here, including twelve HCAs and thirteen RNs representing palliative care (11 participants) and other non-palliative or units (14 participants, referred to as ‘Other’ below). Nineteen participants were female and six were male. Four participants were members of visible minority groups. The average age of the group was 44 years, and this ranged from 19 to 59. Years of experience ranged from 3 to 33 years and averaged 12 years. Participants worked a range of 24 and 40 hours weekly.

Death and dying work as a source of emotional distress

The first dominant theme identified in the data was that participants commonly described patient dying and death as a potentially significant source of emotional distress. As they strive to promote the emotional wellbeing of dying patients and families under heavy workload constraints, care workers discussed dealing with the emotional impact of grief on top of other difficult work-related emotions and emotional aspects of their personal lives. Although those working in non-palliative care units - that involve longer patient stays and where death was less expected - might arguably experience more bereavement challenges, participants generally identified palliative care as the most emotional place to work because of grief, and there was indication that on palliative care units, grief was more openly acknowledged and supported between coworkers. As one RN with experience in both units explained, palliative care can involve intense and unstable patient situations, resulting in fluctuating emotions. In contrast, she

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characterized residential care as less emotionally charged, but simultaneously less rewarding; she experienced a greater sense of purpose in palliative care that helped compensate for emotional exhaustion.

Participants also described grief as more difficult in certain circumstances, such as: when the deceased is of similar age or characteristics to the employee; when children are affected by the loss; when deaths are perceived as unfair or sudden; when several deaths occur within a short time duration; and when the employee feels emotionally close to the patient. Grief was further characterized as more difficult for younger or newer workers (a belief that will be problematized in a later section).

Situations in which workers are unable to help ease suffering or promote a good death, known as moral distress (Brazil, Kassalainen, Ploeg, & Marshall, 2010; McClement, Lobchuk, Chochinov, & Dean, 2010), were also identified as contributing to difficult grief. Some employees were unable to fully realize palliative care philosophy and practice, or witnessed suffering but were unable to help. For example, a palliative care RN described her feelings of anger and frustration towards herself when she cannot facilitate a good death. In this example, another underlying emotion appears to be guilt:

Then I get frustrated with that myself. I don't display that to the family or that. And then if they went into crisis sometimes I second-guess myself thinking why didn't I see that coming. So then I get myself frustrated because, did I miss something? And I second-guess myself and I get a little bit angry with myself.

Participants likewise described anger and frustration when understaffing and high workloads contributed to their inability to help. This could be problematic especially since it was also

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common for participants to try to manage grief by focusing their thoughts “on making the process the best that you can for [the dying patient] and for the family” (HCA, Palliative). Even when encountering considerable constraints on their ability to help patients at the end of life, participants still tried to remind themselves they did all that they could, which was sometimes difficult emotion work to accomplish in this context. As employees tried to focus on having done their best under the circumstances, they had to accept structural and other limitations on their abilities to help dying patients and bereaved families.

Coping with grief requires time and space

Given the emotional difficulties that can be generated by patient deaths, participants expressed that coping with grief requires physical time and space - for processing grief, for remembrance, and ritual. Moreover, participants indicated they generally lacked sufficient time and space to obtain emotional support from coworkers or take short breaks when a patient death occurred. Even in the palliative unit, where designated physical space – a private room - is available for employee use, conscientiousness and strained workloads often precluded this as a viable option. One RN (Other) who previously worked in palliative care explained:

If I needed to talk with a coworker that’s really the only support that we had, in the hallway...but I don’t feel like a lot of the time that we even had the time. You’re sitting there trying to figure out how you feel about someone’s loved one dying, and meanwhile there is someone dying in the next room and they need you. The family is at the end of the hall crying, and you need to...you turn that off because you have to continue on for the people that are still there...

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Likewise, despite formal opportunities such as memorials and life reviews for remembering patients and discussing emotions, other participants worried about how coworkers might manage while they were absent. For example, one palliative care HCA explained why she did not attend the life review sessions: “I always felt guilty; I never went because if I went they would be short staffed and that’s not good.” Participants’ caring concern for coworkers and other patients intertwined with resource constraints to hinder the management of workplace grief, and as the quote from the RN above indicates, this promotes grief suppression – an issue that will be returned to later in this article.

A lack of time and space to grieve patient loss was a structural constraint with additional symbolic elements. Some participants explained how the quick pace of room turnover on some units hinders coping, and as one palliative care RN added: “bang, bang, bang, we’re moving onto the next person. I really haven’t said my finalities, my goodbyes in the way I wish I could and you have just sort of swept this person away and brought somebody else in.” In contrast, on a non-palliative unit where rooms were not as quickly refilled after a death, this had a positive symbolic effect, as an HCA (Other) explained:

That means they’re not trying to make money and just rush people out and in. They know they’ve got to take their time; because say this one guy he was there for over ten years and he passed away. They never replaced his room right away, which is nice. Yeah, they do that with almost everybody.

Ultimately, the only time and space available to deal with work-related grief may be at home, although some sought to maintain a boundary in this regard, as discussed later in this article.

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Humor helps mitigate grief but must be used cautiously

Participants at times also positioned humor as an important antidote to grief, and several participants described coping with ongoing or daily experiences of grief as well as other distressing emotions through the careful use of humor. Death-related humor was described as “black” or “gallows” humor and as “warped,” and participants acknowledged this humor is normally kept “behind closed doors” between coworkers so as not to upset families or patients – an organizational and therapeutic imperative. The risk involved in the use of humor is in appearing to others, or to oneself, as cold-hearted, disrespectful and even cruel. In one instance an HCA was greatly distressed when a coworker played a practical joke involving a dead body; she interpreted this as violating respect for the body, indicating that there are implicit boundaries to the appropriateness of death-related humor among coworkers. Indeed, in talking about the use of humor, participants were generally cautious to construct this as appropriate – a form of emotional labor in which participants sought to maintain appropriate levels of reverence and solemnity in the face of dying. For example, one RN (Palliative) explained how everyday gallows humor helps staff release sadness, but added: “just joking, but nothing harsh.” When working directly with dying patients and families, death-related humor was generally avoided, and even other forms of humor were used with caution; although humor can help lighten the mood with families and patients, there is also the risk of offense, and participants emphasized needing to get to know patients and families first to ascertain whether they would be receptive to humor.

Grief suppression as a professional imperative

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Despite suggestions that managing sadness and grief requires both time and space, another theme dominating participant accounts indicated that professional norms of self-control and related stigmas inhibited public and sometimes even private grief expression. Here, we explore what this data reveals about the assumed appropriateness of felt grief as well as grief displays in private, public, to family, and to coworkers. These data provide insights into the social interpretations of workplace grief as well as the emotional labor implications of normative grief containment.

Several participants either suggested that crying is a sign of weakness, or were aware this was how grief tended to be viewed by their coworkers. Employees frequently mentioned that they should not cry in front of patients and families, and in some cases were also reluctant or ambivalent about sharing grief with coworkers. Most often, the expression of grief was interpreted as appropriate only in limited ways - in specific rare instances, in private, and for short moments of time. Even in palliative care, where grief tended to be more openly acknowledged, professional norms of self-control still operated. For instance, one RN (Other) had previously worked in palliative care and although she believed most staff there were “very in touch” with their emotions, she believed that expressing grief was nonetheless viewed as a weakness. A wide variety of participant comments also reflected interpretations of grief expression as symbolizing inexperience, fear of death, a lack of professionalism and skill, and not having a natural aptitude for working with dying people. In this regard, professional norms overlap with moral ideas about identity and worth, and as such, employees experiencing grief may believe that something is wrong with them. The result is a difficult form of emotional labor that is reflected in the interview data, in which participants tried to align themselves with professional ideals of self-control when recounting their stories about grief at work.

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For example, one RN (Palliative) explained that she struggles with grief but is careful to characterize herself as unafraid of death and as accepting dying as natural: “I’m not afraid of death or dying now...it’s a normal, natural process. What I have difficulty with [are] the emotions behind it.” Likewise, another HCA (Other) described the emotional challenge in witnessing family grieving processes, yet also positioned herself as accepting of death: “I know it’s part of life but it’s still painful.” Worker interpretations of palliative care philosophies and professional health care identities can lead them to equate an ability to remain unemotional in the face of death with acceptance of one’s own and others’ mortalities and an idealization of death as a natural process. Displayed emotions such as crying were thus interpreted by many participants as pathology - an unbalanced response to death and dying.

Some participants further expressed that palliative care is unsuitable for employees who cannot accept the reality of death, although facing death’s reality was characterized as suppressing grief. When one RN (Palliative) described younger coworkers who required more emotional support from coworkers after a death, she suggested that this places a burden of time and energy on older staff, and takes time away from patients and families. She added:

I’ve worked with a few that you really had to... they cry a lot and after awhile I’m tired of whiners. I have to say that personally. It’s like you know what? This is not where you should be. You’re not ready for this.”

Likewise, an HCA (Other) emphasized that care aides should not react sensitively, and elaborated:

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We're trying to orientate some of the HCAs who tend to show their emotional feelings when a resident dies or something. Some HCAs would really be devastated about it. It's okay, it's a human feeling, but always remember that working in healthcare, dealing with people, the power to control your own emotions is part of your skill.

This participant viewed himself as a strong champion of emotional self-control within his unit: “in our behavioral rounds that's always one issue that we deal with...I'm trying to make sure that staff members know the boundary.” This example reflects the institutionalized manifestation of emotional control norms at the unit-level and within management practice.

Preventing grief through emotional detachment

Some participants not only sought to suppress and contain grief, but to prevent feelings of grief from occurring through adopting an emotionally detached approach to their work and their interpersonal interactions with patients and families. In the most direct form, this included participants who avoided working with particular dying patients, such as those for whom they might feel grief most strongly. Others also actively avoided developing emotional attachments to patients and families, and this approach was supported by professional ideals about maintaining relational boundaries when working with dying patients and families. In the following example, one palliative care HCA was asked about relationships with patients. Although her response espouses a goal of emotional detachment, it also belied some of her ambivalence and her struggle to maintain a caring identity:

You have to go into it knowing to guard yourself too because you can't become too emotionally attached either. There are obviously the few times you do but again we can't sit there and cry every time someone

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passes away. Like because this week that means every single shift I would sit and cry and I can't do that.

You have to keep yourself together; not that you're emotionally cold or anything like that but it's like you come into work knowing this person is terminally ill. They're not going to get better...

This quote illustrates how emotional detachment, especially when it conflicts with workers' identities as caring individuals, can entail significant emotional labor. Ultimately as our data indicated, for some individuals, it was very difficult not to become emotionally attached to patients and families – to “care less” even though they may wish to do so. Findings further indicated, however, that workers who found it easier to remain emotionally detached often still endeavored to convey a sense of caring, closeness and empathy outwardly, as workers recognized that this was important for the wellbeing and satisfaction of patients and families. Whereas the former examples delineate the emotional labor involved in trying to reduce feelings of caring and closeness, the latter indicates the labor involved in trying to display such feelings in their absence.

Grief spillover and unfinished business

Another theme identified in the interview data indicated that the effects of grief suppression were at times characterized as a form of unfinished business that must later be dealt with. Participants who felt unable to feel or express grief at work tended to talk about ‘shelving’ or ‘bottling’ grief, and becoming task-focused. However, some participants indicated that suppressing or containing grief could be risky; it could lead to an unexpected and overwhelming release at work or spill over into the private sphere of the home. For example, one palliative care RN explained how she copes with grief by putting it “on the back burner.” However, sometimes

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one patient death triggers a large reaction: “all the tears come and you’re like, where is this coming from? It’s just been shelved and then all of a sudden it has to come out.” Another RN (Other) explained that in palliative care, due to the lack of time to grieve, she was ‘stuffing’ her emotions: “you try your best to maintain in that role and to maintain your emotions and they may just be inside ready to break.”

In a similar example, an RN (Palliative) conveys the idea that unresolved and unspoken grief can be displaced as conflict between coworkers: “we let out our frustration on each other when it’s not really what the issue of what we’re arguing about; but because there’s things that haven’t been dealt with.” From her perspective, actively addressing rather than suppressing grief is framed as a form of caring obligation to one’s co-workers.

For some individuals, however, an expectation of grief spillover might be part of an active grief postponement strategy that involves waiting until they are at home to grieve, cry, and attend to self-care and coping. As such, it represents an additional form of emotional work. As just one example, an RN (Palliative) stated: “usually I just sort of put those emotions away and then I deal with it when I get home.”

In contrast, other participants drew on the ideal of “work-life boundaries” to emphasize the importance of leaving grief at work, and protecting themselves and their families against spillover: “when you leave the hospital that’s it. Your day is over” (HCA, Palliative). However, this was difficult and not always successful, especially as it was common for participants to draw connections or parallels between deaths experienced at work and their own personal life experiences, and to their own sense of mortality. Relational attachments also sometimes very directly spilled over into home lives, as when some employees spoke of giving family members their home phone numbers so that they might call them at home. Moreover, participants’ caring

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identities, specifically their concern to avoid talking about their grief to family members, added an additional complexity. In the following quote one palliative care HCA strove to present herself as strong and self-controlled in the face of grief, implicitly aligning this with her identity as a good mother, although her comment belied her difficulty:

I try not to let it bother me too much and I seem to be able kind of to leave most of it at the workplace. But often I'll tell my kids stories and such, but I think I do try to sort of on purpose come home and have a separate life more. I hope I maybe do that on purpose because I have to also have a life with my kids. I think it's kind of important to leave work and keep most of it there. It doesn't happen that way, but yeah, you can definitely be for a couple of days feeling the loss of someone.

Tension between professional ideals and caring identities

As evident in some of the excerpts above, professional norms favoring emotional self-control, relational detachment and grief suppression may conflict with employees' sense of themselves as caring individuals. In their narratives employees sometimes appeared to struggle to maintain identities as both professional and caring – as being affected by others and caring about them, but also having self-control. This was most evident in the subtle contradictions and qualifications that pervaded accounts of grief. Experiencing and demonstrating grief was often spoken about with caution or ambivalence, perhaps in consideration for how it might be interpreted by others as unprofessional. As a further example, a palliative care HCA described how witnessing death and family grief is emotionally exhausting, and initially stated: “you can't be afraid to cry if you need to...and then pull yourself together.” She then told a story of witnessing a touching encounter between a dying wife and her husband, attributing her strong

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sadness to her youthful inability to handle the emotional nature of the work. She added: “but that’s the only time I’ve cried at work; like that’s it. You don’t cry. You can’t. You have to be tough for them.” This participant then framed emotional control as symbolizing caring rather than coldness, in the following excerpt:

You can’t be upset about every little thing. Lots of people would be like, ‘oh that’s heartless,’ but it’s not. Like it actually to me it shows way more heart because it’s like you’re pulling through for someone else right? So it might sound heartless, like, that I don’t cry, but I don’t think so. I think it takes more balls to not cry, to be there for someone.

Another nurse participant, who reflected on her previous work in palliative care, likewise described “the only time” she felt sadness when working on the unit, upon the death of a patient with whom she was close and whom she still remembers fondly. She added, however, that: “you do have emotions with residents, but you learn to sort of steer it away.” In a similar example, an RN (Palliative) articulated the personal effect of a death of a patient to whom she was emotionally attached: “you can understand that then you get slightly emotional but I try to contain it while I’m in the room. If you shed a tear or two that’s okay...” Another participant noted that she is sometimes upset or sad after a death, but also cautiously positioned her emotions as professional:

You can’t really dwell on it so much...I mean you will dwell on it but only in a healthy way or to a certain point and then...you still think of them years later, but not overly acute. You can’t be...and this is with I think any professional...like you’re not going to be obsessed with it or something...(HCA, Palliative)

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Another participants similarly made comments in which they sought to explain difficult emotional reactions related to death and dying in their work, yet then qualified or minimized the emotional effects, re-positioning themselves as emotionally stoic and capable workers. One HCA (Other), for instance, explained how counselors were recently brought in to the unit to help the staff cope when one patient chose to take himself off his ventilator, because there were many employees on the floor, including himself, for which this type of death was a new experience:

...so that was the first time any of us had really seen that. Well I've seen...none of it fazed me because when I was working [elsewhere] I had to wash dead bodies. I've done it. I've had a lot of family members die so I'm kind of used to it. It's not a surprise anymore.

In this excerpt the participant repositioned himself from someone relatively new to someone who is experienced and strong in the face of death.

As notable exceptions, a few participants stated that expressing and feeling emotions at work is helpful and appropriate. For instance, one HCA (Other) explained how on her unit, when a death occurs “we pull [together] as a team and support each other and say it's okay to be sad.” Three other participants drew on caring ideals to suggest that it was appropriate to cry with the family after the death; they suggested that crying demonstrates to families “[that] you are human” and cared about the patient, and that families appreciate this demonstration of empathy. However, allusions to caring identities conflicted with professional imperatives, and as such there was some ambivalence in talk about expressing grief. For instance, one RN (Other) described a time when she cried with a family:

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The priest was doing the last rites and the families were around and the family they were sobbing. So I just grabbed my Kleenex and then kind of... like I was - not to show, but I was just really touched with the whole, what's going on. And then I think one of the family members came and hugged me after the rites was over. So I was touched, really. And they would say it's okay to cry...

However, this participant also added the qualification that “for the most part I’m always calm, even.” Another participant (RN, Palliative) likewise expressed her views tentatively: “it’s okay to cry with [families]. They actually appreciate when you show some emotion. I mean to an extent. We’re not going to be bawling. But to cry with them sometimes is okay, yeah.”

Discussion and Conclusion

Our interpretive approach to this research facilitated the examination of symbolic meanings associated with grief and the expression of grief among those caring for dying patients and their families, and highlighted the connection of these meanings to participants’ identities. Although we examined the content of participant talk, we also considered how participants spoke during the interview interaction about their emotions and coping with grief, which provided important information about how particular frameworks of meaning can generate ambivalence and contradiction. Study participants’ narratives revealed complex, ambivalent, and even conflicting interpretations regarding the appropriateness and meaning of feeling and displaying grief and sadness at work. Although working with dying patients and their families was characterized as emotionally difficult, and it was believed that employees needed time and space either at work or at home to manage emotions such as grief, organizational needs, alongside participants’ caring concern for others (coworkers, other patients, family members), served as

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barriers in this regard. Participants were further hampered by organizational imperatives in their ability to use humor to manage grief, and by resource constraints and moral distress in their ability to focus on having done “the best they could” for patients. Moreover, professional norms of self-control, and their internalization, stigmatized those who displayed grief in the workplace. Lastly, although participants sometimes sought to prevent grief through limiting emotional attachments, this could conflict with self-identities as caring individuals, and in some cases also with organizational and therapeutic imperatives emphasizing patient and family well being and satisfaction.

The work involved in balancing tensions between empathetic caring connection and emotional distance has been identified in other research as particularly salient when working with dying persons and their families (Candrian, 2014; Kessler, Heron, & Dopson, 2012; Sorensen & Iedema, 2009; Stayt, 2009; Wilson & Daley, 1998). This includes, for instance, when nurses help patients and their families navigate the transition to palliative care and discuss treatment futility; nurses in one study viewed themselves as performing significant emotional labor during this time (Broom et al., 2015).

Participants in our study tended to express that emotional distance was required to protect themselves from the risks of emotions resulting from connections to others – most notably grief, largely conceptualized by participants as a negative/pathological emotion. However, other research has emphasized how difficult it is to avoid attachments to patients, and to suppress emotions in health care work (Froggatt, 1998; Kessler et al., 2012; Theodosius, 2012). Further, not all workers adopted a distancing strategy. In this respect our findings resonate with Stayt (2009) who found that despite concerns about professionalism and emotional vulnerability, some nurses established more intimacy and emotional involvement with patients/families; these nurses

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found it both satisfying and emotionally exhausting. Given the strength of the professional imperative of grief suppression, however, it is also possible to consider some participants as actively drawing on caring and relational ideals to legitimize feelings of grief to themselves and others, and facilitate its expression at work.

Professionalism is a powerful organizational norm in health care, and may provide some care workers with means to rationalize emotional distance in caring work to themselves and others, to protect themselves; however, there is little evidence to suggest that this is actually the best strategy. It is unclear whether grief suppression enhances job satisfaction and retention and reduces turnover, or whether it cumulate to affect employees in harmful ways, as indicated by some participants in this study.

Professional norms of grief suppression and detachment may also create greater challenges for meeting the emotional needs of dying patients and families through being friendly, empathetic, and so on. Indeed, although trying not to feel close to patients and families involves deep acting (Hochschild, 1983) designed to prevent grief, it may not accurately reflect emotional labor per se, because detachment can actually detract from patient and family satisfaction. Although some families may desire some professional distance in interactions, most commonly, patients and families seek to feel cared about as individuals. Yet those who try to convey caring while remaining emotionally detached may experience increased dissonance and potentially negative effects.

When groups of workers try to defensively respond to difficult situations such as death by relying on professional narratives, normative aspects of these narratives can become unquestioningly accepted over time, reinforcing and facilitating negative workplace cultures (Kessler et al., 2012; Sorensen & Iedema, 2009). Thus, although professional discourses help

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mitigate the affective stresses of work with dying patients, they may exclude alternative ways of talking about death (Candrian, 2014), of experiencing grief and of embodying professionalism when working with dying patients. The normative power of professional detachment also further stigmatizes those who express grief, and generates ambivalence among workers who are simultaneously trying to maintain a sense of themselves as caring individuals.

When the onus is placed on individual workers to defend themselves from feeling and/or expressing grief, this can divert attention from features of health care systems and organizations, such as resource constraints, that are implicated in exacerbating work-related grief. As Candrian (2014) suggests: “the burden should not fall on providers alone to manage exhaustion, “to ‘save’ themselves in a culture that does not embrace help from the outside” (p.64). Time and space to process emotion at work, or take advantage of existing opportunities to do this, was limited for participants in this study. Emotional detachment is a common strategy to cope with grief, particularly when there is a lack of time and space to work through grief in other ways. As such, the professional imperative obscures existing time and resource constraints and the positive outcomes of expressing grief on an ongoing, everyday basis. Even in the absence of explicit, written or formal rules against the expression of grief, organizations can indirectly promote grief suppression in the context of heavy workloads, where the only option for workers to suppress grief and carry on.

There was some indication that on non-palliative units, the emotional impact of patient death was not as recognized or openly discussed as on palliative units. Palliative care tended to be viewed as a more emotionally intense workplace, requiring more support. However, workers on non-palliative units also experience grief and have needs for support; indeed, this was why their data were included in this analysis, even though their accounts were on average focused less

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extensively on death and dying. Some have suggested that non-palliative care employees are more likely to have negative attitudes about death and a lower sense of purpose in their work, which may complicate grief (Ablett & Jones, 2007; McNamara, Waddell, & Colvin, 1995; Sorensen & Iedema, 2009). Even on palliative care units, however, grief still tended to be viewed as needing to be contained and suppressed. Although Sorensen and Iedema (2009) found it difficult to explain why emotional restraint was characterized as the most appropriate response to despair in health care settings, one might consider looking to the close alignment between these dominant interpretations and organizational demands.

There have been calls for greater formal and informal bereavement support, debriefing and counseling for paid care workers, to prevent burnout and distress (Funk et al., 2013-14; Katz, Sidell, & Komaromy, 2001; Rickerson et al., 2005; Sawbridge & Hewison, 2013). This is a good starting point, and should incorporate consideration of factors and situations which have been proven to contribute to more complicated grief among professional carers, such as when patients are of a similar age or gender to the worker (Wilson & Kirshbaum, 2011).

However, in the context of strained workloads and a professional culture that emphasizes emotional suppression, employees will often sacrifice their own needs in order to carry on helping others. Greater attention needs to be directed to the organizational and professional context that influences grief experiences as well as the expression of grief. For instance, although death cannot be avoided, health care organizations and unions can minimize moral distress among those working with dying patients and families by ensuring they are adequately supported – both in providing quality end of life care as well as having the time and space to manage and express grief. Organizations, professional bodies and employee assistance programs can together also promote critical reflection among both managers and employees about the meaning and

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interpretation of grief in paid care work, and facilitate alternative interpretations and practices that reduce the moral and professional stigmas associated with feeling and expressing grief in the workplace. In doing so, they can promote employee awareness that emotions related to grief in care work can actually be associated with wellness, not weakness.

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Conflict of Interest Statement

The Authors declare that there is no conflict of interest.

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