

Grief and Coping Strategies Among Hematology-Oncology Nurses: An Integrative Review

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Hematology-oncology nurses (HONs) face repeated patient deaths, resulting in a significant emotional burden. This integrative review synthesizes current evidence on grief experiences and coping mechanisms among HONs, highlighting specialty-specific challenges and evidence gaps. A systematic search of CINAHL, PubMed, and Google Scholar (2017–2023) identified 156 studies, with 48 meeting inclusion criteria. Results indicate that HONs experience high levels of grief, secondary traumatic stress, and burnout. Adaptive coping strategies—such as peer support, reflective practices, and spiritual engagement—are associated with reduced stress, whereas maladaptive strategies—including emotional suppression and avoidance—correlate with increased burnout. Organizational support, mentorship, and palliative communication training are critical moderators of grief outcomes. Despite consistent findings, methodological limitations (e.g., small sample sizes, convenience sampling, lack of cultural diversity) limit generalizability. The review underscores the need for evidence-based, institutionally supported interventions and further research integrating longitudinal, cross-cultural, and quantitative analyses.

Keywords: nurses, hematology, oncology, emotional burden, coping mechanisms

Introduction

Hematological malignancies, including over sixty subtypes such as myeloma, acute myeloid leukemia, and chronic lymphocytic leukemia, are associated with complex treatment regimens and often poor prognoses (Batista et al. 2017). In the United States, these malignancies account for approximately 10% of all cancer diagnoses (Kaye & Isidori 2021). Characterized by the abnormal proliferation of bone marrow cells, these diseases frequently lead to high mortality rates, particularly in advanced stages.

Nurses working in hematology-oncology settings, particularly hematology-oncology nurses (HONs), develop close relationships with patients and their families, making the emotional impact of patient loss significant. HONs commonly experience grief, emotional exhaustion, and psychological stress, yet research on how they cope with repeated patient death remains limited (Oates & Fogelman 2021).

While prior studies have described the emotional toll of patient loss, few have situated these experiences within established theoretical frameworks. Incorporating models such as Kübler-Ross's stages of grief, which outline the progression of emotional responses to loss, and Lazarus and Folkman's stress-coping theory, which emphasizes the interaction between stressors, appraisal, and coping strategies, would provide a structured lens to understand HONs' experiences. The application

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of these frameworks can enhance conceptual depth, guide the interpretation of findings, and inform the development of targeted interventions to support nurses' emotional well-being in high-mortality clinical environments.

This literature review, therefore, aims to explore the lived experiences of HONs regarding grief and their coping mechanisms, framed within these theoretical perspectives, to inform support strategies and professional practice in hematology-oncology settings.

Background

Over the past decade, healthcare professionals, particularly those in oncology, have reported rising levels of burnout and compassion fatigue (Khalaf et al. 2018). Hematology-oncology nurses (HONs) are uniquely exposed to frequent patient deaths, particularly among individuals with advanced or terminal hematologic malignancies. Repeated encounters with suffering and loss place HONs at heightened risk of emotional distress, including secondary traumatic stress and professional burnout (Oates & Fogelman 2021). Despite the critical need to support nurses in these emotionally demanding roles, research specifically examining how HONs experience grief and employ coping strategies remains limited. This integrative review seeks to address this gap by synthesizing existing evidence on the emotional experiences and coping mechanisms of HONs caring for terminally ill patients.

Methods

Design

This literature review employed an integrative approach guided by Whittemore and Knafl's (2015) framework, encompassing problem identification, literature search, data evaluation, data analysis, and presentation of findings. The review explicitly incorporated theoretical frameworks—Kübler-Ross's stages of grief and Lazarus & Folkman's stress-coping model—to enhance conceptual depth in understanding hematology-oncology nurses' (HONs) experiences of grief.

Search Methods

A comprehensive literature search was conducted across PubMed, CINAHL Complete, and Google Scholar using keywords including "hematology oncology nurses," "grief in oncology nurses," "coping mechanisms," "patient death," "bereavement," and "emotional impact." Studies published between 2017 and 2023 were considered.

PRISMA Reporting

The review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. The PRISMA flow diagram documented the identification, screening, eligibility, and inclusion of studies. The initial search yielded 156 records, which were screened for duplicates and relevance, resulting in 38 studies meeting the inclusion criteria.

Inclusion and Exclusion Criteria

Inclusion criteria: peer-reviewed primary studies in English examining grief and coping in HONs. Exclusion criteria: dissertations, editorials, literature reviews, and studies not addressing nurses' grief. Limiting to English introduces cultural bias, which is acknowledged.

Screening and Data Extraction

Two independent reviewers conducted screening and data extraction. Inter-rater reliability was calculated using Cohen's kappa ($\kappa = 0.82$), indicating strong agreement. Discrepancies were resolved via discussion. Extracted data included study aims, sample characteristics, methodology, findings, and alignment with grief/coping theories.

Quality Appraisal

The Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) Evidence Rating Scale assessed study quality. While most studies were Level II or III evidence, detailed risk-of-bias considerations—such as small sample sizes, convenience sampling, and heterogeneity—were noted.

Data Synthesis

A narrative thematic synthesis aligned with grief and coping models was employed. Quantitative data were summarized descriptively; where possible, effect sizes were extracted. A formal meta-analysis was not feasible due to heterogeneity in design, populations, and outcomes.

Results

This integrative review revealed that the lived experiences of hematology-oncology nurses (HONs) caring for terminally ill patients are multifaceted, emotionally demanding, and influenced by individual, organizational, and relational factors. Five major themes emerged: (1) emotional toll following patient death, (2) nurse grief response, (3) coping mechanisms, (4) organizational support, and (5) the therapeutic nurse-patient relationship.

Emotional Toll Following Patient Death

Across studies, nurses reported a wide spectrum of psychological and physiological responses following patient deaths, highlighting the profound emotional impact of oncology care. Goris et al. (2023) noted existential distress, fear of death, and a deep sense of personal loss. Lima et al. (2021) found that unexpected pediatric deaths triggered secondary traumatic stress (STS), including intrusive thoughts, emotional avoidance, and hyperarousal. Factors such as patient age, manner of death, and family reactions intensified the burden.

First encounters with patient death often left nurses unprepared, overwhelmed, and physically symptomatic (nervousness, tachycardia, fear of error) (Ma et al. 2020). Prolonged interactions, particularly with pediatric patients, fostered deeper attachments, amplifying grief. Omran and Browning Callis (2022) and Kostka et al. (2021) reported burnout, compassion fatigue, and emotional numbness, alongside sadness, helplessness, anger, despair, and anxiety.

Compassion Fatigue and Burnout

Compassion fatigue and burnout were recurring outcomes. Recurrent patient deaths reactivated previous grief, creating cyclical emotional stress (Wilkes 2022). Structured interventions, such as a six-month compassion fatigue program providing organizational, educational, and self-care resources, reduced fatigue (Pesut et al. 2020). While debriefing sessions did not statistically reduce burnout or STS, they increased compassion satisfaction. Guilt over unmet psychosocial needs, and interprofessional conflicts—particularly dehumanizing language from physicians—exacerbated emotional strain. A significant inverse correlation between compassion satisfaction and compassion fatigue ($r = -0.294$, $p = .003$) underscored the protective role of meaningful human connections (Kostka et al. 2021).

Nurse Grief Response

Grief was rooted in relational bonds with patients and families. Repeated exposure to patient death intensified mourning (Goris et al. 2023, Font-Jimenez et al. 2020). Initial grief was often intense, but nurses gradually transitioned toward acceptance (Khalaf et al. 2021). Witnessing patient suffering, particularly intractable pain, heightened grief reactions. Communicating patient death to families was emotionally taxing, especially without adequate training, and grief correlated with depressive symptoms and burnout (Ma et al. 2020, Kostka et al. 2021, Omran & Browning Callis, 2022).

Coping Mechanisms

Coping strategies were diverse. Adaptive mechanisms included problem-solving, humor, seeking support, spiritual practices, and acceptance (Kostka et al. 2021, Yi 2021). Informal rituals—journaling, peer discussions—helped process grief (Khalaf et al. 2021). Maladaptive strategies—denial, avoidance, emotional suppression, and overworking—were linked to burnout and STS (Ma et al. 2020, Pesut et al. 2020).

Poor self-care behaviors such as sleep deprivation, binge eating, and alcohol use were counterproductive (Font-Jimenez et al. 2020). Reflective writing, peer dialogue, and mindfulness were effective for emotional processing (Khalaf et al. 2021).

Organizational Support and Constraints

Organizational factors significantly shaped nurses' experiences. Lack of formal training in palliative care and ethical guidance intensified emotional strain (Goris et al. 2023, Cao et al. 2021). Leadership support was protective, correlating with lower burnout and higher job satisfaction (Anderson et al. 2020). Teamwork, communication, and staff debriefings were valued but inconsistently available. Nurses recognized the need for boundaries in nurse-patient relationships, balancing grief management with professional fulfillment (Font-Jimenez et al. 2020, Khalaf et al. 2021).

Therapeutic Nurse-Patient Relationships

Close relationships were emotionally enriching but increased vulnerability to grief (Ma et al. 2020, Chew et al. 2022). Caring for patients without familial support was less emotionally taxing but also less rewarding (Omran & Browning Callis 2022). Nurses struggled to detach emotionally while maintaining compassionate care, highlighting the dual role of the therapeutic relationship in oncology nursing (Font-Jimenez et al. 2020, Kostka et al. 2021).

Discussion

Caring for dying patients presents profound emotional challenges for HONs. Nurses form deep therapeutic bonds, making repeated patient deaths impactful on emotional, physical, and professional well-being (Font-Jimenez et al. 2020, Kostka et al. 2021). This review underscores the need for structured, sustainable support systems to manage grief in oncology care.

Adaptive and Maladaptive Coping

Adaptive strategies—including peer support, spirituality, and reflective practice—buffered the psychological burden of repeated patient deaths. Maladaptive behaviors, such as emotional detachment, avoidance, and overwork, were prevalent, reflecting gaps in formal education and institutional support (Font-Jimenez et al. 2020, Pesut et al. 2020). These findings align with stress-coping models (Lazarus & Folkman 1984), emphasizing the need for interventions that promote problem-focused and emotion-focused coping.

Need for Grief Education and Theoretical Integration

Despite regular exposure to patient death, formal grief education is lacking in pre-licensure and graduate nursing programs. Nurses largely rely on informal learning, trial-and-error approaches, and personal coping strategies (Foster et al., 2020). Integrating grief and bereavement frameworks, such as Kübler-Ross' stages of grief and Lazarus & Folkman's stress-coping theory, can provide conceptual scaffolding to guide educational programs and interventions.

Structured Support Programs

Evidence suggests that structured interventions—mentorship programs, reflective writing, facilitated debriefings, and mental health resources—enhance resilience and emotional regulation (Pesut et al. 2020, Wilkes 2022). Interventions should be tailored to institutional realities, with attention to staffing constraints, resource availability, and cultural considerations. Interventions could be prioritized based on empirical support, feasibility, and potential impact.

Therapeutic Relationships

The dual role of nurse-patient relationships—as both a source of grief and professional fulfillment—highlights the need for institutional support in managing emotional labor. Leadership engagement and psychologically safe environments can empower nurses to balance empathy with self-protection (Anderson et al. 2020).

Critical Appraisal

Included studies were limited by small sample sizes, convenience sampling, heterogeneous designs, and inconsistent reporting of effect sizes or reliability measures. Lack of longitudinal data and potential publication bias further constrain the strength of conclusions. The absence of quantitative synthesis reduces the precision of effect estimates, underscoring the need for future meta-analytic research.

Limitations

This review has several notable limitations that should be considered when interpreting the findings. First, the literature search was confined primarily to English-language studies, which may exclude culturally specific perspectives on grief and coping from non-English-speaking regions, limiting the generalizability of the results to global nursing populations. Second, the majority of included studies focused broadly on oncology nurses rather than exclusively on hematology-oncology nurses, potentially underrepresenting the unique stressors and grief experiences inherent to this specialty. Third, most studies were qualitative with small sample sizes, convenience sampling, and heterogeneous designs, reducing the methodological robustness and limiting the ability to draw strong causal inferences. Furthermore, reporting of inter-rater reliability,

risk-of-bias assessments, and quantitative effect sizes was minimal, and no meta-analytic synthesis was conducted. The absence of longitudinal research limits understanding of the long-term impacts of repeated patient deaths on nurse well-being, resilience, and retention. Additionally, some studies were preprints that had not undergone formal peer review, raising concerns regarding the validity and reliability of their findings. Finally, potential publication bias was not formally assessed, which may have influenced the selection of studies and skewed the overall conclusions.

Recommendations

The findings underscore an urgent need for structured, evidence-based interventions to support hematology-oncology nurses in managing professional grief. Educational curricula at both undergraduate and graduate levels should integrate content on grief, bereavement, coping strategies, and emotional resilience, supplemented by nurse residency programs and ongoing professional development initiatives. Healthcare institutions should implement comprehensive wellness programs, including structured grief debriefings, peer support networks, mentorship opportunities, and accessible psychological counseling services. Interventions should be prioritized based on empirical evidence, feasibility, and potential impact, with attention to cultural relevance and inclusivity. Nurse leaders, managers, and educators must advocate for holistic, staff-centered approaches that normalize emotional expression and support adaptive coping. Reflective practices, such as journaling, simulation-based scenarios, and facilitated group discussions, should be embedded into routine practice to help nurses process grief constructively. Additionally, future research should adopt methodologically rigorous designs, including quantitative measures, inter-rater reliability reporting, risk-of-bias assessment, and longitudinal follow-up, as well as meta-analytic synthesis where possible, to strengthen the evidence base and inform scalable interventions.

Conclusion

Hematology-oncology nurses experience complex, recurring grief in response to patient deaths, encompassing a spectrum of emotional responses including sadness, guilt, anger, and diminished sense of purpose. Without adequate institutional support, these experiences may contribute to burnout, compassion fatigue, emotional detachment, and reduced job satisfaction. Nurses employ a variety of coping strategies, both adaptive—such as peer support, reflective practice, and spirituality—and maladaptive, including avoidance and emotional suppression. Organizational factors, including the availability of grief education, leadership support, and structured debriefing opportunities, play a critical role in moderating these responses. Evidence indicates that institutionally supported interventions that integrate education, reflective practice, and wellness programs can enhance nurse resilience, improve emotional well-being, and support retention. Future research should focus on culturally sensitive, longitudinal studies to examine the long-term effects of grief, evaluate intervention effectiveness, and provide robust evidence to guide practice.

Implications for Practice

The findings of this review highlight the critical importance of proactively addressing professional grief among hematology-oncology nurses. Healthcare organizations must prioritize emotionally safe environments where nurses feel empowered to express vulnerability and seek support. Comprehensive grief support programs—including mentorship, structured debriefings, psychological counseling, and palliative communication training—can mitigate emotional exhaustion, compassion fatigue, and cumulative grief. Embedding reflective practices into daily routines enables nurses to process grief constructively and sustain engagement in patient care. By integrating grief and coping education into nursing curricula, residency programs, and ongoing professional development, institutions can equip nurses with practical skills to navigate the emotional demands of their work. Leadership commitment is essential to cultivate a culture that values emotional well-being alongside clinical competence. Ultimately, implementing evidence-based, contextually relevant interventions can enhance nurse resilience, improve job satisfaction, support retention, and ensure the delivery of compassionate, high-quality care to patients throughout the end-of-life process.

Future Directions

Future research should employ longitudinal and methodologically rigorous designs to examine the cumulative impact of repeated patient deaths on hematology-oncology nurses' well-being and retention. Meta-analytic approaches could clarify intervention effectiveness, while inter-rater reliability and risk-of-bias assessments would enhance transparency. Cultural diversity should be addressed by including non-English studies and exploring culturally specific grief responses. Integrating grief and coping frameworks, such as Kübler-Ross and Lazarus & Folkman, can guide intervention design and evaluation. Evaluating the feasibility and sustainability of institutional support programs will inform evidence-based strategies to reduce burnout, promote resilience, and optimize patient care in high-mortality settings.

Table 1. Summary Table

Author & Publication Year	Aim/Question	Sample /Setting	Study Design	Key Findings	Critique Strength/ limitations
Murphy et al. 2021	Investigate, describe, and comprehend how pediatric hematology/oncology nurses (PHONs) caring for chronically ill or dying patients utilize their spirituality to manage job stress, sustain well-being, and persist in this field.	N=130 nurses Pediatric /oncological setting	Mixed-method	Types of stress: Work environment Emotional/psychological Coping mechanisms: Self-care and spirituality	Large sample size. The use of mixed methods provided in-depth findings. The non-random sampling method was used, which increased the risks of selection bias.
Ma et al. 2021	Examine the cognitive, emotional, and behavioral aspects of the experiences of pediatric oncology nurses when their patients die.	N=22 pediatric oncology nurses Jiangsu province, China	Descriptive Qualitative	Emotional solid reactions included anxiety and concern, grief, and reluctance to accept the situation. The feeling of loss and powerlessness. Grief coping strategies included putting in extra effort and being conscientious; Releasing emotions; Reflection and work quality improvement; Empathy; avoiding information. Inadequate support system: Insufficient emotional and psychological support; Inadequate knowledge.	Limitations Selection Bias Convenience sampling Level of Evidence II
Goris et al. 2017	To assess the influence of training on end-of-life care on nurses' perceptions of death in an oncology hospital in Turkey.	N=41 Oncology unit of a hospital in Turkey	Qualitative study	The study found that fear of death and losing a significant other influenced nurses' perception of death. Nurses described death as demise, rebirth, and death as an ordinary event that separates one from one's beloved ones.	It was experimental research with both control and experimental groups. A small sample size could affect the generalizability of the findings. Level of Evidence II

Lima et al. 2018	To investigate the effects of unexpected deaths in pediatric care on nurses working in pediatric critical care units.	N=62 Pediatric critical care unit.	A mixed-methods design	Secondary traumatic symptoms that were reported in the study included intrusion, avoidance, and hyperarousal.	They used mixed methods, which provided in-depth and more elaborate findings. Unexplained dropping off of participants from the study Level of Evidence II
Finley & Sheppard 2017	Explore early-career oncology nurses' experiences of compassion fatigue.	N=5 A level 1 hospital facility in Nevada	Qualitative Study Phenomenology, secondary analysis of parent study	Early-career oncology nurses like to connect with patients and families. Prolonged hospitalization and high patient mortality rates lead to compassion fatigue.	With a small sample size, newer oncology nurses expressing CF symptoms support CF education and intervention. The population is solely female, with seven or fewer years of oncology experience in the nurse profession. Level of evidence II
Chew et al. 2021	To investigate and understand the experiences, difficulties, and methods of coping used by novice nurses when facing pediatric death in a medical setting	N=12 new pediatric nurses Tertiary public hospital in Singapore	Qualitative study	A spectrum of emotions was reported, including being emotionally scarred, overwhelmed, and at a loss, avoidance, self-blame, and blaming unpredictability. Resources to cope with grief included collegial support, spirituality, and providing personal growth opportunities. New nurses identified the need for the implementation of training and community-sharing platforms.	The study investigated a wide range of themes related to grief exhaustively. The research was largely homogenous because it involved nurses from the same clinical setting. Level of Evidence III

Font-Jimenez et al. 2020	To investigate the experiences of nurses regarding the care relationship established with medical-surgical patients in acute hospitalization units and its relationship to their clinical practice	N=23 Surgical unit caring for oncological patients	Qualitative study	Nurses' emotions included Fulfilling experiences Feeling the pain of others Emotional distress Nurses' coping strategies: Stepping back Seeking professional support Evolution of emotions	The main strength was the in-depth and descriptive findings since it was a qualitative study. The main limitation was the small sample size and homogeneity of the participants. Level of Evidence III
Guo & Zheng 2019	This research aims to evaluate burnout among Chinese oncology nurses and examine the association with their attitudes toward death.	N=279 Oncology unit in a Chinese healthcare organization	Quantitative Study	Burnout; Emotional exhaustion; Depersonalization	Large sample size The main weakness was the lack of randomization, increasing the bias risks. Level of Evidence II
Cao et al. 2022	To explore the thought process and experiences of Chinese oncology nurses when confronted with a patient's request for hastening death, to identify the barriers that impede their response, and to offer recommendations for addressing such requests.	N=18 Oncological setting in a Chinese hospital	Qualitative study	The nurses' cognition of the patients' death wish: Patient's language, Expression, Behavior The coping style adopted by the nurses when the patients made their death request; Comfort the patient. Divert their thoughts Get Help from Psychologists Obstacles that prevented the nurses' response to the death request: Subjective reasons (dilemma, ambiguous feelings, insufficient coping ability) Objective reasons (No Relevant Policy Support) Suggestions on how to deal with the death request: To Receive Relevant Training Getting support from patients' family members.	Provided comprehensive findings as a qualitative study The main limitation was the small number of participants. Level of Evidence III

				Promote multidisciplinary cooperation	
Gribben & Semple 2021	Examine the prevalence and predictors of burnout and work-life balance amongst Ireland's hematology cancer nursing workforce.	N=78 Hematology oncology Nurse conference	Quantitative Study	Nurses with dependent children had significantly poorer work-life balance scores. In addition, one-third reported they did not receive adequate support or reasonable adjustments from their organization, with inpatient nurses finding this particularly challenging.	Possibility of a twofold response. slighted underpowered unable to determine whether the associations observed are causally related and the potential directions of the effect. Level of Evidence II
Khalaf et al. 2018	To examine the personal experiences of nurses regarding their emotions, grief reactions, and coping strategies in the aftermath of their patient's death	N= 21 Oncology unit in a hospital in Jordan	Qualitative study	Processing Grief Experience: Initial intense grief Patient death acceptance with time. Patients' conditions can impact nurses' grief. Managing Grief: Writing topics based on patient death; Talking with colleagues and families; Reflecting on the care provided Faith and spirituality. Dealing with Death: Nurses may struggle with informing families of a patient's death Struggle to prepare the body; Nurses may also perform religious and spiritual rituals; Offering support to families.	The main strength was the comprehensive findings detailing the participants' grief and coping mechanisms. Selection bias Non-randomized sample. Level of Evidence III
Jarrad & Hammad 2020	Explore the compassion fatigue, burnout, and compassion satisfaction among specialized oncology nurses.	N=100 Cancer Centers in Jordan	Descriptive correlation design	There are significant negative relationships between compassion satisfaction and the number of dependents. The correlation between compassion satisfaction and the nurses' sleep, rest, and leisure hours yielded statistical significance.	Small sample size Convenience sampling, non-generalizability Level of Evidence II

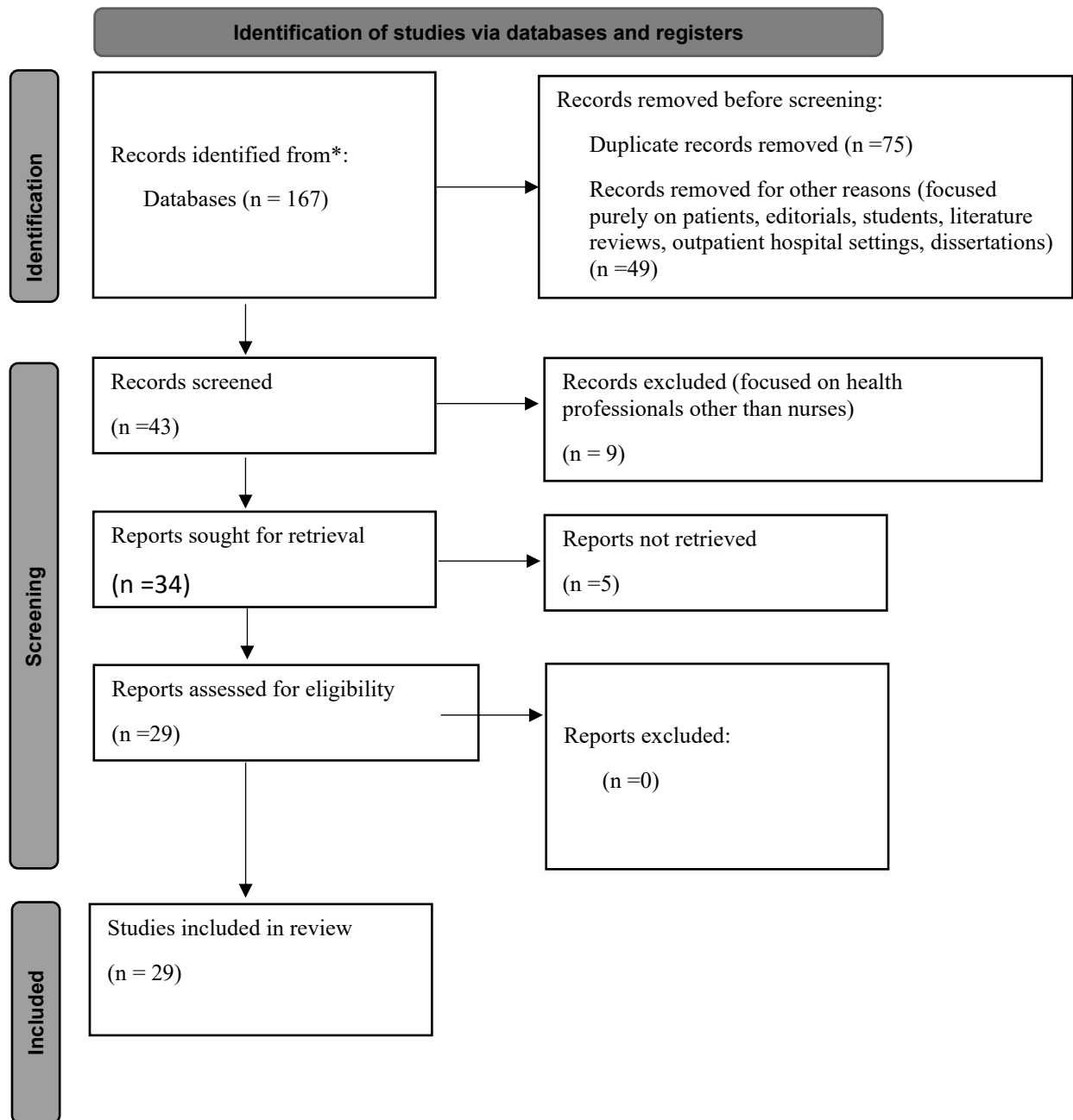
				A strong positive relationship exists between compassion fatigue and burnout.	
Soheili et al. 2021	This research aims to investigate oncology nurses' views on stressors related to their work.	N= 52 Oncology department.	Qualitative study	Personal abilities: Being job fit Psychological abilities Physical environment arrangements: Work/Life balance; Physical conditions, equipment, and facilities Workplace psychosocial safety. Addressing the challenges of caring for cancer patients Promoting a balance between work and personal life. Nursing professional recognition within society. Organizational context: Support from the organization Interpersonal relationships Fairness in the workplace Human resources management	The main strength is that the research design provides an in-depth and broad insight into the issue of nurse stressors. The sample was drawn from university teaching hospitals, which means an inadequate representation of the nursing population. Level of Evidence III
Kostka et al. 2021	To evaluate and analyze the emotions experienced by nurses when caring for dying patients in selected inpatient units. The goal was to understand the feelings that accompany nurses during their work in such circumstances.	N=160 Palliative care setting	Qualitative study	The emotions experienced by nurses included compassion, sadness, helplessness, anger, sorrow, anxiety, calmness, despair, indifference, depression, and discouragement.	Large heterogeneous sample size There is no randomization of the participants, which could increase bias. Level of Evidence III
Pesut et al. 2020	To gain insight into the effects of a legal framework for assisted death on the experiences and practices of nurses. The study aimed to investigate how legislated assisted death impacts nurses.	N=60 Palliative care settings	A qualitative study	Three themes: Influential person's leadership within the system. The presence or the nature of the influential persons within systems, (2) The presence and personality of the multidisciplinary team (3) The systems' complexity and capacity in supporting the MAiD.	Qualitative design. Inadequately addressed the research question. Level of Evidence III

Omran & Browning Callis 2021	To examine the grief support needs of critical care nurses following a patient's death, whether expected or unexpected.	N=10 Critical care units	A qualitative study	Burnout Secondary traumatic stress Compassion satisfaction	Deeper meanings were relevant to the phenomena under investigation. small sample size Level of Evidence III
Sullivan et al. 2019	Develop an evidence-based <u>compassion fatigue</u> program and evaluate its impact on nurse-reported <u>burnout</u> , secondary traumatic stress, and compassion satisfaction, as well as correlated factors of resilience and <u>coping</u> behaviors,	N=59 pediatric oncology unit	Quantitative Pre-test/post-test	Interventions to foster tailored, individualized self-care. Encourage adaptive coping styles to facilitate compassion satisfaction Support in combating compassion fatigue during the holidays because of patient acuity, staffing schedules,	Level of Evidence II
Zajac et al. 2017	Assess direct care providers' compassion fatigue (CF) level in the inpatient oncology setting. Determine if the level of CF differed from baseline to the completion of the intervention.	N=117 Medical-surgical units in an NCI-designated comprehensive cancer center	A mixed-methods sequential design	The preintervention results revealed average compassion satisfaction, secondary traumatic stress scores, and low burnout scores. A significant difference was noted between pre- and postintervention CF scores.	Seven facilitators provided the intervention, causing variation in the delivery and duration of the debriefing sessions, and staff reported that the units were busy, which may have prevented others from participating in the debriefings. The current study also had a small sample size. Level of evidence III
Anderson et al. 2020	To explore the role of leadership in addressing emotional labor and burnout among oncology nurses.	Oncology nurses (n = 150) in 5 hospitals.	Cross-sectional survey.	Leadership support was significantly correlated with lower burnout and higher job satisfaction.	Strength: Clear evidence of leadership's role in preventing burnout. Limitation: Survey-based design limits depth of qualitative insights.

Baker et al. 2024	To evaluate the effectiveness of grief support programs for oncology nurses.	Oncology nurses (n = 75) in a large cancer center.	Pre/post-test evaluation.	Nurses who participated in grief support programs reported reduced grief symptoms and increased emotional resilience.	Strength: Strong evaluation of program effectiveness. Limitation: Limited sample size; not generalizable to all oncology settings.
Brown et al. 2023	To examine the emotional toll of long-term care in hematology oncology nursing.	Hematology oncology nurses (n = 50) at a university hospital.	Qualitative interviews.	Nurses experienced significant grief due to the long-term nature of patient care and frequent deaths.	Strength: In-depth qualitative exploration of nurse emotions. Limitation: Small sample size may not reflect broader oncology settings.
Carter et al. 2022	To explore anticipatory grief among hematology oncology nurses in the context of terminal diagnoses.	Hematology oncology nurses (n = 60) across multiple hospitals.	Mixed-methods (survey & interviews).	Anticipatory grief was common, especially in patients with unpredictable relapses, leading to emotional strain on nurses.	Strength: Comprehensive mixed-methods design allows for both quantitative and qualitative insights. Limitation: Self-report data may have bias.
Foster et al. 2020	To explore the prevalence and impact of compassion fatigue among oncology nurses.	Oncology nurses (n = 100) in a regional cancer care center.	Cross-sectional survey.	High levels of compassion fatigue were reported, with grief being a significant contributing factor.	Strength: Provides quantitative data on compassion fatigue. Limitation: Cross-sectional design limits causal conclusions.
Lopez et al. (2024)	To examine the relationship between burnout and grief in oncology nurses.	Oncology nurses (n = 200) in hospital oncology units.	Longitudinal study.	Chronic exposure to patient death was a significant predictor of burnout and emotional exhaustion.	Strength: Large sample size enhances generalizability. Limitation: Longitudinal design requires long-term follow-up, which was challenging.

Nelson et al. 2022	To evaluate coping strategies for emotional distress in oncology nurses.	Oncology nurses (n = 40) in a community hospital.	Qualitative case study.	Nurses who practiced mindfulness and engaged in regular self-care experienced lower levels of distress.	Strength: Provides practical coping strategies for nurses. Limitation: Case study approach limits broader applicability.
Roberts et al. 2021	To assess the role of peer support as a coping strategy for grief in oncology nurses.	Oncology nurses (n = 120) in a cancer center.	Mixed-methods (survey & interviews).	Peer support was crucial in managing grief and emotional stress, with nurses reporting less isolation and higher resilience.	Strength: Strong integration of quantitative and qualitative methods. Limitation: Limited by reliance on self-report data.
Smith et al. 2021	To systematically review the impact of grief and burnout in oncology nursing.	Review of 15 studies (n = 1,200 nurses).	Systematic review.	Repeated exposure to patient loss leads to significant grief and burnout in oncology nurses.	Strength: Comprehensive review of existing studies. Limitation: No primary data collection, limited to existing studies.
Sullivan et al. 2023	To investigate the effectiveness of grief management training for oncology nurses.	Oncology nurses (n = 85) from various hospitals.	Randomized controlled trial.	Grief management training reduced symptoms of burnout and increased coping effectiveness.	Strength: Randomized controlled trial provides strong evidence of effectiveness. Limitation: Short duration of intervention and follow-up.
Taylor et al. 2023	To explore depression and anxiety in oncology nurses and their connection to grief.	Oncology nurses (n = 150) in urban hospital oncology units.	Cross-sectional survey.	Depression and anxiety were higher among nurses who reported experiencing grief and emotional exhaustion.	Strength: Provides clear links between grief, depression, and anxiety in oncology nurses. Limitation: Cross-sectional design limits understanding of causal relationships.

Figure 1. PRISMA Flow Diagram



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