

https://dspace.org/

Exploring speech therapists' and audiologists' experiences regarding patient death and dying

Nagdee, Nabeelah

2019

https://hdl.handle.net/10539/32813

Downloaded from a DSpace repository. https://dspace.org/

Exploring Speech Therapists' and Audiologists' Experiences regarding Patient Death and Dying

A Dissertation Submitted in Fulfilment of the Requirements for the Degree Master of Audiology

In the Department of Speech Pathology and Audiology

School of Human Community Development

Faculty of Humanities

University of the Witwatersrand

By Nabeelah Nagdee

Supervisor: Dr Victor de Andrade

15/02/2019



The Ribbon of Grief

THE EXPERIENCES OF SPEECH THERAPISTS AND AUDIOLOGISTS REGARDING PATIENT DEATH AND DYING

Declaration

I, Nabeelah Nagdee, hereby declare that this research report is my own work except as indicated in the references and acknowledgements. I am responsible for the content of this study and the conclusions presented. No part of this dissertation has been previously submitted for a degree at any other University/Institution.



15/02/2019

Nabeelah Nagdee Date

ACKNOWLEDGEMENTS

This dissertation is dedicated to Nani

The journey with this project has been a roll coaster ride; filled with many twists and turns, ups and downs, some of which may be rather superficial now that I reflect on the experience. Nonetheless, this process has been a rather enlightening experience, particularly as a 'young' and 'inexperienced' speech therapist and audiologist. It has changed my approach towards my patients, and ensured that I uphold compassionate care when managing my patients. Shukr (Gratitude), to Allah (God) for showering His blessings on me during this journey.

I would like to thank the following individuals for making this project possible:

- To the participants, being your voice was no easy task for me. Thank you for sharing your experiences with me, which I know was not easy. I hope that I have done justice in making your voices heard.
- To my research supervisor, Dr Victor de Andrade, thanks for your support and guidance during this process. Thank you for sharing your research expertise with me. I need to specially mention and share my thanks for your thoroughness and timeous responses. It definitely led to my roller coaster ride having more 'ups' than 'downs'.
- To my parents, mom and dad, I know that this process was no easy task. We, as a family, suffered particular challenges this project. Thank you for your on-going support, words of encouragement, patience, and love. You two are my motivators in life and I hope that I have done you proud.
- To my friends, most of you who were in the same boat as me during this project, your empathy and support during this process have not gone unnoticed. I apologise for missing out on all of our coffee dates. I promise to make it up to you!

ABSTRACT

Background: Healthcare professionals (HCPs) such as speech therapists and audiologists (ST/As), who work within healthcare facilities and special needs schools, may be confronted with instances of patient death and dying. Thus, it is imperative for these professionals to be prepared for these encounters. There appears to be sparse research internationally regarding HCPs' perceptions of patient death and dying, and unexplored research regarding ST/As' insights concerning death and dying, especially in South Africa.

Purpose: This study aimed to explore ST/As' experiences regarding patient death and dying.

Method: ST/As employed in the healthcare sector and special needs schools were invited to participate in the study. A qualitative research design was employed to obtain insight into ST/As' experiences with patient death and dying. Data was collected by conducting 25 narrative interviews with participants. Thematic analysis was used to analyse the narratives obtained from the interviews.

Results and Conclusions: The results of this dissertation suggest that a hallmark of participants' professional identity was the implementation of the Ubuntu philosophy. Additionally, in participants' endeavours to uphold the principle of duty of care, they seemed to sacrifice their self-care. Therefore, their ethic of care was not upheld. This resulted in them experiencing grief when they were faced with patient death and dying. Based on participants' grief reactions, the researcher formulated a proposed grief model which describes the STAs' reactions to patient death and dying. Failure of participants being able to work through their grief may have resulted in participants being at risk for developing complicated grief. Therefore, the findings from the study indicate the need for ST/As to receive: pre-professional training regarding patient death and dying, to engage in collaborative practice when providing end of life (EOL) care and after patients' death, and the necessity for

organisational support. Professional bodies which ST/As may be members of need to provide professional guidelines on how these professionals need to approach patient death and dying.

Keywords: patient death and dying, speech therapists and audiologists, qualitative research, narrative interviews, narratives, Ubuntu philosophy, duty of care, self-care, ethic of care, grief.

TABLE OF CONTENTS

Declaration i

ACKNOWLEDGEMENTS ii

ABSTRACT iii

LIST OF TABLES x

LIST OF FIGURES xii

LIST OF APPENDICIES xiv

LIST OF ABBRIEVIATIONS xv

CHAPTER 1: INTRODUCTION 1

CHAPTER: 2 LITERATURE REVIEW 5

2.1. Concepts of Death and Dying 5

2.1.1. Death. 5

2.1.2 Dying. 5

2.2. Reactions to Death and Dying: Grief and Mourning 6

2.2.1. Five stages of grief. 6

2.2.2. Four phases of grief. 12

2.2.3. Seven stages of grief. 14

2.2.4. Four tasks of mourning. 17

2.2.5. Disenfranchised and complicated grief. 19

2.3. Death Anxiety 22

2.3.1. Definition of death anxiety. 22

2.3.2. Death anxiety among HCPs. 24

2.4. Variability in Grief Reactions and Bereavement Outcomes to Death and Dying within the South African Context 26

2.4.1. The influence of cultural diversity on grief processes. 26

2.4.2. The contribution of the high burden of injuries in SA on grief reactions. 28

2.4.3. Cultural diversity's impact on types of coping mechanisms employed by individuals. 30

2.5. HCPs' Perceptions regarding Patient Death and Dying 31

2.5.1. STAs' roles in providing EOL care. 31

2.5.2. The provision of EOL care. 32

2.5.3. Patient- and family-centred cared during the course of providing care to terminally ill patients. 39

2.5.4. Collaborative care during the provision of EOL care. 41

2.5.5. The influence of the nature of patients' deaths on HCPs' encounters with patient deaths. 45

2.5.7. The need for pre-professional training for HCPs regarding patient death and dying. 50
2.6. HCPs' who Practice in SA Confrontations with Loss 53
2.7. HCPs' Encounters with Significant Others of Patients who are faced with Death and Dying.. 55
2.7.1. Communicating with bereaved significant others 55
2.7.2. Providing social support. 55
2.8. Biographical Factors Influencing Responses to Loss and Grief 63
2.8.1. Age. 64
2.8.2. Gender. 65
2.8.3. Ethnicity and spiritual beliefs. 65
2.9. Coping mechanisms employed by HCPs to aid them in overcoming the death of their patients 66
2.9.1. Self-nurturance. 67
2.9.2. Letting go 68
2.9.3. Gallows humour. 69
2.9.4. Social support (informal debriefing). 69
2.9.5. Formal debriefing. 71
2.9.6. Defence mechanisms. 73
CHAPTER 3: METHODOLOGY 77
3.1. Research Aims 77
3.1.1. Main aim 77
3.1.2. Sub-aims. 77
3.2. Research Design 77
3.3. Context 78
3.4. Pilot Study 79
3.5. Participants 80
3.5.1. Sampling strategy. 81
3.5.2. Inclusion and exclusion criteria. 82
3.5.3. Participants' demographics 83
3.6. Data Collection Procedures 97
3.7. Data Analysis 99
3.8. Reliability, Validity and Trustworthiness 102
3.8.1. Reliability and Validity. 102
3.8.2 Trustworthiness. 104
3.8.3. Verisimilitude. 105
3.8.4. Utility 106
3.9 Ethical Considerations 106

3.9.1. Informed consent. 106
3.9.2. Confidentiality. 107
3.9.3. Autonomy. 107
3.9.4. Beneficence and non-maleficence. 107
3.9.5. Justice. 108
4.1. Causes of Patient Death and Work Settings where Patient Deaths have Occurred 110
4.1.1. Causes of patient death 110
4.1.2. Death in a Work Setting. 112
4.2. Pre-professional Training 113
4.2.1. Limited pre-professional training regarding patient death and dying. 113
4.2.2. Recommendations to improve pre-professional training. 116
4.3. Participants' Presence during Patient Death and Dying 119
4.3.1. Participants being present near patients' deaths or at the time of patients' deaths. 119
4.3.2. Trying to wake up a dead patient. 122
4.4. Types of Death 124
4.4.1. Child or young adult death versus the deaths of older adults. 124
4.4.2. Expectedness of patients' deaths. 128
4.4.3. The frequency and magnitude of patients' deaths. 136
4.5. Intra-professional relationships between participants and their ST/A colleagues 139
4.5.1. Causes of intra-professional conflict. 139
4.6. Inter-professional Relationships between Participants and the MDT 140
4.6.1. Types of interactions between participants and the medical team. 140
4.6.2. Effects of inter-professional conflict among participants in instances of patient death and dying. 149
4.6.3. Types of interactions between participants and the allied team. 151
4.7. Interactions between Participants and Patients as well as Patients' Significant Others 155
4.7.1. Types of interactions between participants and patients. 155
4.7.2. Types of interactions between participants and patients' significant others. 158
4.7.3. Limited support provided to patients' significant others. 163
4.7.4. The effects of interacting with patients' significant others or a lack thereof, on participants. 167
4.8. South Africa as a Context of Patient Death and Dying 169
4.8.1. The impact of SA as a context of patient death and dying on participants' experiences. 169
4.9. Personal loss versus Patient Death and Dying 172
4.9.1. The difference in grief reactions in instances of personal loss versus patient death and dying. 172

4.10. Professional Code of Conduct and Professional Performance 178
4.10.1. Effects of patient death on participants' job performance. 178
4.11. Organisational Practices 184
4.11.1. Organisational support or the lack there of, for participants. 184
4.11.2.Organisational support for patients' significant others. 190
4.12. Coping and Defence mechanisms 192
4.12.1. Methods for managing patient death and dying. 192
4.12.2. The role of spirituality in patient death and dying. 200
5.1. Shock and Denial 208
5.1.1. Unexpected death. 208
5.1.2. Being present near or at the time of patient death. 211
5.1.3. Magnitude and frequency of patient death. 211
5.2. Anger 212
5.2.1. Inter-professional conflict 212
5.2.2. Intra-professional conflict 216
5.2.3. Religious struggles. 217
5.2.4. Conflict with patients and their significant others. 218
5.3. Guilt 221
5.3.1. Altruistic guilt 222
5.3.2. Deontological guilt. 223
5.3.3. Anticipated guilt. 225
5.4. Pain 227
5.4.1. Sadness. 227
5.4.2. Helplessness and hopelessness. 228
5.5. Working Through Grief with the Aim of Reaching Acceptance 230
5.5.1. Religion and cultural practices. 233
5.5.2. Social support. 234
5.5.3.Organisational support 241
5.5.4. Work-life balance and leave. 243
5.5.5.Relaxation and physical activities as well as self-soothing behaviours 243
5.5.6. Personal loss. 243
5.5.7. Resilience and desensitisation. 244
5.5.8. Negative coping mechanisms. 244
5.5.9. Pre-professional training. 245
Chapter 6: Conclusions 249

6.1. Theoretical Implications 251
6.2. Practice and Policy Implications 251
6.2.1. Pre-professional training. 251
6.2.2. Organisational support 253
6.2.3. Social Support. 257
6.2.4. Data collection procedures. 258
6.3. Critical Evaluation of the Study 259
6.3.1. Strengths of the study. 259
6.3.2. Limitations of the study. 259
References 261
APPENDICIES 298

LIST OF TABLES

Table 2.1.1. Kroeber's (1963) comparison between defence and coping Mechanisms

Table 2.2.2. Description of the defence mechanisms proposed by Freud (1936).

Table 3.1.1. Summary of Participants' biographical information.

Table 3.1.2. Participants' biographical information.

Table 4.1.1. Profile of Causes of Patient Deaths based on Participants' Experiences.

Table 4.2.1. Lack of pre-professional training regarding patient death and dying

Table 4.2.2. Recommendations made by participants to improve their pre-professional training on patient death and dying.

Table 4.3.1. Participants' experiences when they were present near patients' deaths or at the time of patients' deaths.

Table 4.3.2. Instances where participants attempted to wake up deceased patients.

Table 4.4.1. The difference in participants' reactions in instances of child and young adult death compared to the death of older adults.

Table 4.4.2. Participants' reactions based on the expectedness of the death.

Table 4.4.3. Participants' reactions seem to be influenced by the frequency and magnitude of patients' deaths.

Table 4.5.1 Sources of intra-professional conflict among participants.

Table 4.6.1. Sources of inter-professional conflict among participants and the MDT.

Table 4.6.2. Effects of inter-professional conflict on participants.

Table 4.6.3. Types of interactions between participants and the allied team.

Table 4.7.1. Influence of interactions between participants and patients when these patients pass away.

Table 4.7.2. Interactions between participants and patients' significant others.

Table 4.7.3. Participants' explanations for providing limited social support to patients' significant others.

Table 4.8.1. The impact of residing in SA on encounters with patient death and dying.

Table 4.9.1. Differing grief reactions when participants' experienced personal loss versus patient death.

Table 4.10.1. Effects of patient death on participants' professional performance.

Table 4.11.1 The types of organisational support systems in place at participants' places of work.

Table 4.11.2. Facilities available for patients' bereaved significant others.

Table 4.12.1. Coping and defence mechanisms employed by participants in instances of patient death and dying.

Table 4.12.2. The influence of spirituality on participants' experiences with patient death and dying.

LIST OF FIGURES

Figure 2.1. The linear nature of the five stages of grief as implied by Haslam (2018)

Figure 2.2. Four phases of grief as suggested by Bowlby and Parkes (1970) and the oscillation between any two phases of this grief model.

Figure 2.3. The unstructured nature of the seven stages of grief.

Figure 2.4. The flexible nature of the of Worden (1991) tasks of mourning.

Figure 2.5. The elements of negativity bias as outlined by Peeters (1971).

Figure 2.6. The roles of ST/As' when providing EOL care, as proposed by Toner and Shadden (2012).

Figure 2.7 Humanistic nature of the Ubuntu Philosophy as proposed by Broodryk (2005).

Figure 2.8. Sources of inter-professional conflict among HCPs as per Zeinhom's and Higazee's (2015) as well as Merrill's and Miller's (2015) studies.

Figure 2.9. Ten Lessons of Successful Collaboration as proposed by Gardner (2005).

Figure 2.10. Triangle of countertransference as proposed by Katz (1990).

Figure.2.11. Types of social support.

Figure 2.12. Biographical factors suggested by Snyder et al. (2014) which may impact on individuals' grief processes.

Figure 3.1. An overview of the themes identified in this study.

Figure 3.2. The researchers' application of Braun and Clarke (2006) six-step approach of thematic analysis.

Figure 4.1. Work settings were Participants Experienced the most 'Remarkable Patient Deaths.

Figure 5.1.The proposed non-linear model of grief and its effects on participant's in this study work performance.

Figure 5.2. The vicious cycle of false hope.

Figure 5.3. The vicious cycle of learned helplessness and its contribution to participants' feelings of guilt.

Figure 5.4. The causes, features, and effects of guilt as well as guilt reduction factors.

Figure 5.5. The characteristics of pain as displayed by participants and the effect that these facets had on participants' professional identity.

Figure 6.1. The counter effect of upholding the Ubuntu philosophy and duty of care that is mediated by the ethic of care.

Figure 7.1. The Dual Process of Bereavement.

LIST OF APPENDICIES

Appendix A: Model of Grief: The Dual Process of Coping with Bereavement.

Appendix B: Ten Lessons to Reduce Conflict.

Appendix C: A Model for Communicating Bad News to Terminally ill Patients' Significant Others.

Appendix D: Definitions of Social Support.

Appendix E: Participant Information Sheet for Inviting Participants to Participate in the Study

Appendix F: Participant Information Sheet and Consent Form for Participating in the Narrative Interviews and Consent Form for Participating (Pilot Study)

Appendix G: Interview Guide and Feedback Form (Pilot Study)

Appendix H: Participant Information Sheet and Consent Form for Participating in the Narrative Interviews and Consent Form for Participating (Main Study)

Appendix I: Interview Guide (Main Study)

Appendix J: Participant Distress Protocol

Appendix K: Researcher Distress Protocol

Appendix L: Ethics Clearance Certificate (non-medical)

Appendix M: Audit Trail Outline

Appendix N: Plagiarism Report

LIST OF ABBRIEVIATIONS

ADDA: Anxiety and Depression Association of America

ACA: American Counselling Association

ADEC: Association of Death Education and Counselling

AIDS: Acquired Immunodeficiency Syndrome

ANA: American Nurses Association

APA: American Psychiatric Association

ASHA: American-Speech-Language-Hearing Association

CIA: Central Intelligence Agency

CISD: Critical Incident Stress Debriefing

CPD: Continuing Professional Development

CoP: Community of Practice

CORT: College of Respiratory Therapists

DSM-V: Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition

EWP: Employee Wellness Programmes

EOL: End-of-life

FCC: Family-centred Care

HCPs: Healthcare Professionals

HIV: Human Immunodeficiency Virus

HPCSA: Health Professions Council of South Africa

HST: Health Systems Trust

ICU: Intensive Care Unit

IOM: Institute of Medicine

IPFCC: Institute of Patient- Family-Centred Care

MDD: Major Depressive Disorder

MDT: Multidisciplinary Team

MHC: Mental Health Commission

NABSLHA: National Black Speech, Language and Hearing Association

NCI: National Cancer Institute

PCC: Patient-Centred Care

PFCC: Patient- Family-Centred Care

PTSD: Post-traumatic Stress Disorder

QoL: Quality of life

RURESA: Rural Rehabilitation of South Africa

RRT: Relational Regulation Theory

SAAA: South African Association of Audiologists

SADAG: South African Depression and Anxiety Group

SAHO: South African History Online

SANDTA: South African Neurodevelopmental Association Therapy

SANRA: South African Neurological Rehabilitation Association

SASLHA: South African Speech –Language-Hearing-Association

SA: South Africa

STs: Speech therapists

ST/As: Speech therapists and/or audiologists

STATS SA: Statistics South Africa

TAC: Treatment Action Campaign

UOC: University of California

UON: University of Nottingham

ZCC: Zion Christian Church

ZPD: Zone of Proximal Development

WHO: World Health Organisation

CHAPTER 1: INTRODUCTION

"The only certainty life contains is death" (Briggs, 1998).

Death and dying are inevitable parts of human life. 'Death' and 'dying' are synonymous terms, which have distinct definitions (Singh, Singh and Nizamie, 2003). From a biological perspective death is considered to be the absolute cessation of vital functions (Farlex Online Medical Dictionary, 2012; Singh et al., 2003), whereas 'dying' is the process of losing these functions (Singh et al., 2003). However, from a psychological and social view the concepts of death and dying are said to be multidimensional, subjective, and complex, that are accustomed to change (Singh et al., 2003). Since, the psychosocial model has a broader perspective regarding death and dying, it makes it somewhat difficult to define these terms. For the aforementioned reasons and considering that healthcare professions (HCPs) should be treating their patients within a bio-psychosocial framework, a broad definition that encapsulates the biological definition of death and dying while taking into account individuals' experiences regarding death and dying was used for the purpose of this study.

HCPs are actively involved in treating and caring for patients who are terminally ill and are faced with the process of dying (Niederriter, 2009). Sinclair (2011) proposed that HCPs may be able to provide explanations concerning mortality, which may benefit individuals who are facing the end of life (EOL). However, there is a lack of information regarding the impact that these experiences may have on these HCPs' personal and professional lives (Sinclair, 2011). Studies that have explored this have found that the death of a patient does negatively affect HCPs on a personal and professional level (Rivers, Perkins & Carson, 2009; Wojan, 2006; Woo, Maytral & Stern, 2006; Reynold, 2006; Niederriter, 2009).

Additionally, these aforementioned studies have explored: medical practitioners', nurses', and social workers' insights on death and dying. A common theme which stemmed from these studies was that these professionals felt that they were inadequately prepared for dealing with the death and dying process of their patients (Woo et al., 2006; Fulton, 2012; Niederriter, 2009). Furthermore, these studies indicated that nurses and medical practitioners experienced discomfort when consulting with patients who were near death as well as with these patients' significant others (Woo et al., 2006 ; Niederriter, 2009). This may suggest that these HCPs may be engaging in therapeutic nihilism. This is thinking that nothing more can be done for the patient who is facing the EOL (Woo et al., 2006).

Guwande (2014), a medical practitioner, stated that his inadequate training on coping with mortality resulted in him having dreams about the deaths of his patients. He reported the following: "I had recurring nightmares in which I'd find my patients' corpses in my house-in my own bed." (Guwande, 2014, p.5). Palmer (2008) who explored the coping mechanisms employed by nurses during the death and dying process of their patients; discovered that nurses may experience grief and anxiety and cumulative loss when they are unable to effectively cope with the loss of their patients. These studies indicated that HCPs, such as nurses and medical practitioners who encounter death and dying readily in their profession have difficulty in coping with the death and dying process of their patients. Furthermore, a study which examined American student speech therapists' or audiologists' (ST/As') perceptions regarding death and dying revealed that these students did not have the necessary coping mechanisms in place to overcome patient death (Rivers et al., 2009). This result may not only be attributed to the lack of formal pre-professional training, as stated by Rivers et al. (2009), but may also be due to ST/As not always realising the possibility of losing their patients, as they may be more concerned about providing rehabilitative services to their patients. This study aimed to further explore this notion.

ST/As who are employed in healthcare facilities may encounter patients who present not only with speech, language, swallowing, and hearing impairments, but may also present with fears of and grief about death and dying (American-Speech-Language-Hearing Association [ASHA], 2009). Therefore, ST/As need to ensure that they understand the dying process of their patients, so that they can understand the emotional and psychological challenges experienced by their patients and their patients' significant others (ASHA, 2009). This is particularly important for ST/As who are employed in South Africa (SA), as SA was ranked with a high mortality rate in the world- with 17.4 deaths per 1000 people (Central Intelligence Agency [CIA], 2014; Ferrante, 2014). Although ASHA (2009) has provided information to ST/As on how to manage patients who are nearing the EOL, they have not provided coping mechanisms to ST/As. on how to effectively deal and cope with the death and dying process of their patients. As a professional board ASHA (2009) should be providing this information, as the purpose of healthcare professional boards is to address matters related to the professions and to oversee the training and practices of HCPs (Health Professions Council of South Africa [HPCSA], 2017). Considering that ST/As may not always receive pre-professional training on patient death and dying (Rivers et al., 2009) and professional bodies, such as ASHA do not provide information as to how ST/As can overcome death and dying; how then do these professionals find ways to overcome the death and dying process of their patients? This study aimed to address the aforementioned question.

At the time of writing up this dissertation I had particular difficulties in dealing and coping with the death and dying process of my patients. I often wondered if I was providing effective services to ensure the enhancement of patients' lives. At times when these patients had passed away, I experienced feelings of guilt and asked myself: "Did I do enough for these patients and their families?" I have to agree with Guwande (2014, p.4) who stated that "You become a doctor for what you imagine to be the satisfaction of the work, and that turns

out to be the satisfaction of competence". As a helping professional, I feel that there is nothing more threatening to me than a patient with a problem that I cannot solve. Since I did not want to overstep my professional boundaries by discussing my feelings with my family members, I felt as if I 'bottled-up' my emotions in these instances. Moreover, my mentors and colleagues did not have the time available to assist me in overcoming my grief and anxiety associated with these instances.

Therefore, in summary, there is limited research internationally and no known research in SA regarding ST/As' experiences with patient death and dying. Furthermore, given the high mortality rate in SA, ST/As are bound to experience the loss of their patients in their line of work. Additionally, ASHA (2009) has clearly outlined the roles that ST/As need to play when managing patients who are nearing the EOL. I have also outlined the challenges which I had experienced when I treated patients who were nearing the EOL. For these aforementioned reasons, this study aimed to explore ST/As' experiences with patient death and dying.

CHAPTER: 2 LITERATURE REVIEW

2.1. Concepts of Death and Dying

2.1.1. Death. Death may be defined as the permanent and irreversible cessation of all vital functions which include: heartbeat, brain activity, and breathing (Farlex Online Medical Dictionary, 2012; Singh et al., 2003). Furthermore, it can occur at any point in time and is not dependent on age (Singh et al., 2003).

Weismann (2000) divides the meanings of death into the following four categories:

- Death is an extension of life which is a precursor to another form of life. Therefore, death is a transition rather than extinction.
- Death is inescapable and is the final stage of life.
- Death is an explanation and redemption of life.
- Death is a loss of life which may signify failure.

Although death is one of the few guarantees in life, it is clear that from the above mentioned definitions provided by Weismann (2000) that death is more than just the cessation of vital functions. Therefore, the concept of death is highly individualized and is dependent on individuals' attitudes towards and their experiences regarding death (Singh et al., 2003).

2.1.2 Dying. Dying is viewed as the process which begins when the individual has an untreatable disorder and disease that will inevitably end in death (Farlex Online Medical Dictionary, 2012). Kübler-Ross had developed a five stage framework to assist patients in accepting their impending death (Newman, 2004). She also urged that HCPs employ this framework when treating patients who are dying (Newman, 2004). This theory will be

outlined in the section which addresses Kübler-Ross' contributions to understanding the concepts of death and dying.

2.2. Reactions to Death and Dying: Grief and Mourning

Grief usually refers to the response to a loss (Dennis, 2009) In the case of this study loss is caused by death. Various theoretical frameworks have been used to conceptualise grief. These include: Kübler-Ross' (1969) five stage model of grief, Bowlby's and Parkes' (1970) four phases of grief, seven stages of grief suggested by Wright (2011), Worden's (1991) four tasks of mourning, and the dual process of coping with bereavement proposed by Stroebe and Schut (1987). The latter theory is outlined in Appendix A.

2.2.1. Five stages of grief. Kübler-Ross' (1969) five stages of grief (Figure 2.1.) is said to be used universally in order to describe grief reactions of bereaved individuals (Buglass, 2010). According to Kübler-Ross (1969), there are five responses which dying patients experience when dealing with grief: denial, anger, bargaining, depression, and acceptance.

The first stage of the grieving process tends to be denial. Denial appeared to be the most common reaction to the initial diagnosis but it may also occur at any point during the dying process (Jennings, Gemmil, Bohman and Lamb, n.d.). Denial may be used as a defence mechanism in order to come to terms with death (Freud, 1926). Additionally, Freud (1926) stated that the fear of death extracts the libido from the ego and the ego reacts by utilizing defence mechanisms to suppress this anxiety from consciousness. Furthermore, Kübler-Ross (1969) stated that denial may be substituted by partial acceptance and may not end until the EOL.

Once denial cannot be maintained any longer, feelings of anger may arise (Kübler-Ross, 1969). The dying individual may project their anger towards their significant others and

HCPs (Kübler-Ross, 1969). Kübler-Ross (1969) believed that anger is a cry for recognition, which may be used to indicate that the individual is alive and competent in some ways. On the other hand, significant others may direct their anger towards the individual out of feelings of abandonment (Kübler-Ross, 1969).

The third stage which may occur is bargaining. During this stage individuals may request their Higher Power to postpone their impending death. In order to explain the bargaining stage of grief, Kübler-Ross (1969) used the analogy of a naughty child (individual) who has realised that the parent (Higher Power) is more likely to respond favourably to good behaviour. Therefore, Kübler-Ross (1969) concluded that bargaining with the Higher Power may occur out of guilt (Kübler-Ross, 1969).

When individuals can no longer deny their imminent death and experience further deterioration in their health they may drown into the depression stage (Kübler-Ross, 1969). Depression is thought to be dependent on the reaction of individuals to the many losses they have experienced (Jemmings et al., n.d). These losses convince these individuals that their impending death is in fact a reality (Kübler-Ross, 1969). Furthermore, Kübler-Ross (1969) differentiated between reactive depression and preparatory depression. She viewed reactive depression as a reaction to the difficulties of losses, whereas preparatory depression was considered as grieving-for-self or a preparation to leave the world of the living (Kübler-Ross, 1969). Kübler-Ross (1969) added that when individuals experience reactive depression they tend to be quite verbal and require constant support and comfort around them. However, when individuals encounter preparatory depression they may become silent and isolated (Kübler-Ross, 1969).

Acceptance appears to be the final stage of the grief process as it is described as the peaceful acknowledgement of death (Kübler-Ross, 1969). It is the realization that death is inevitable (Jemmings et al., n.d).

Although Kübler-Ross' framework may help us recognise and describe responses to impending death, others have criticized her research process and theory (Jemmings et al., n.d.). The first criticism is based on the techniques which she used to obtain data (Stroebe, Schut & Boerner, 2017; Konigsberg, 2011; Jemmings et al., n.d.). Kübler-Ross (1969) conducted personal interviews with terminally ill patients but did not pose specific questions about these stages (Konigsberg, 2011). Therefore, the critiques of her model believe that she may have developed the stages based on her intuition rather than on the common responses of patients (Sanchez, 2007). Although her critiques reject her theory as they state that it lacks empirical evidence, an empirical study conducted by Maciejewski, Zhang, Block and Prigerson (2007) provided evidence of her stage theory. Maciejewski et al. (2007) conducted empirical testing of this stage theory with bereaved individuals. The study showed that the average bereaved individual may experience these five stages of grief when emotionally and cognitively processing the loss of a significant other (Maciejewski et al., 2007).

Additionally, critiques of Kübler-Ross' theory of grief stated that her stage theory has insufficient theoretical underpinnings and lacks depth (Stroebe et al., 2017). There may be truth in the claim that Sanchez (2007) put forth that Kübler-Ross did not make use of literature which was based on death and dying. Kübler-Ross (1969, p. xvii) stated in her book: "How do you research dying when the data is impossible to get?". This may suggest that Kübler-Ross (1969) did not make use of the research, particularly by Eisler (as cited in Stroebe et al., 2017) who examined how physicians approach a dying patient. Including research by Eisler (as cited in Stroebe et al., 2017), may have been particularly important for Kübler-Ross not only for depicting the emotions experienced by terminally ill patients; but also in the hope that HCPs will be mindful of these stages when treating terminally ill patients (Kübler-Ross, 1969).

Furthermore, those who oppose Kübler-Ross' theory argue that individuals do not grieve in stages. For example, a study conducted at Yale University discovered that terminally ill patients and bereaved individuals appear to have accepted death from the beginning (Nguyen, 2012). Participants tended to experience more yearning rather than anger or depression during the grieving process (Nguyen, 2012). This characteristic of grief was also noted by Bowlby and Parkes (1970), and will be discussed under the four phases of grief section. Although Nguyen (2012) study indicated that there was no evidence that all of the stages may be present when coping with death, it must be remembered that Kübler-Ross (1969) stated that each individual reacts to his or hers imminent death in his or her own way. However, Haslam (2018) seemed to refute this claim because when she applied Kübler-Ross's (1969) five stage model of grief to 233 bereaved significant others, it was concluded that this model is inflexible in nature and leads to individuals' grief being constrained (Figure 2.1.).

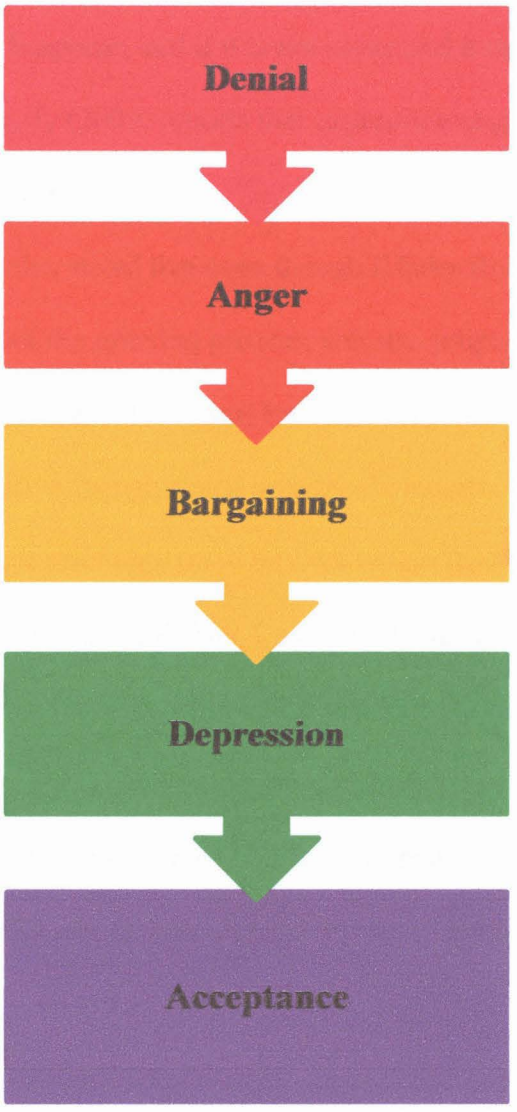


Figure 2.1. The linear nature of the five stages of grief as implied by Haslam (2018).

Kübler-Ross (1969) suggested that anger is a necessary stage in the healing process and that individuals should try and express this emotion. However, a study conducted by researchers at Columbia University found that those who appeared to supress their emotions after losing a loved one were less depressed and anxious than those who tended to express their negative emotions (Bananno & Burton, 2013). Therefore, researchers concluded that supressing feelings may be used as preventative measure against depression and anxiety (Bananno & Burton, 2013). However, Kübler-Ross and Kessler (2001) argued that

suppressed anger may not disappear, and if it is not expressed it may build up, which can be unhealthy. Furthermore, Brody (2009) reports that expressing anger may lead to a positive mood and improved social relationships.

Konigsberg (2011) also stated that even though Kübler Ross (1969) suggested that acceptance is the last stage of the grieving process, she also proposed that individuals may never reach the stage of acceptance. However, Bananno (2002) found that patients may not show signs of despair, intrusive thoughts, and anxiety six months after their loss. Therefore, they concluded that the worst grief appears to be over within the first six months after their loss (Bananno et al., 2002). However, Kübler-Ross (1969) stated that the acceptance stage may be reached if bereaved individuals address the conflicts and feelings that dying may elicit. This may suggest that having social support and having less sources of stress may assist in overcoming grief. Many of the participants in Bananno et al. (2002) study had reported the utilisation aforementioned strategies. This may explain why these participants reached the acceptance stage sooner.

Despite these shortcomings, Kübler-Ross' theory appears to provide the foundation for modern thanatology, the scientific study of death, and also explores the needs of the terminally ill and their significant others. She viewed death as being more than just the mere cessation of biological functions, which it appeared to be viewed as for the entire twentieth century (Hillier & Barrow, 2014; Hobson, 2004).

This conceptual framework has acknowledged that grieving is a typical human experience that individuals go through when they feel pain or display incremental recovery (DePoy & Gilson, 2012). Kübler-Ross' work also appears to have been embraced in healthcare settings because it appears to describe grief in an orderly and coherent way, while still accounting for the humanistic patient-practitioner relationship (Evans, 2010).

Kastenbaum (2015) has revealed similar flaws and limitations of Kübler-Ross' stage theory as the ones discussed above. However, irrespective of these deficiencies Kastenbaum (2015) has acknowledged that Kübler- Ross' theory may have also awakened societies' sensitivity towards the needs of a dying patient. Kübler-Ross indicated that it is possible and helpful to communicate with bereaved patients (Kastenbaum, 2015). Furthermore, through Kübler-Ross' workshops and lectures she inspired HCPs such as social workers and equipped them with strategies to overcome societal barriers which may prevent open and honest communication with dying patients (Kastenbaum, 2015).

2.2.2. Four phases of grief. Attachment seems to provide a sense of security (Bowlby, 1980). Therefore, when this attachment is threatened or disrupted individuals react through grief (Bowlby, 1980). This claim may be refuted by Nesse (2015) who concluded that the intensity of individuals' grief is directly proportional to their genetic relationship with the individual who had passed away, as opposed to being triggered by a separation from others which individuals have formed bonds with. Bowlby and Parkes (1970) emphasised that the phases of grief which they propose is not set in stone and that individuals can move between any two stages at a time (Figure 2.2.). This according to Bowlby and Parkes (1970) is characterised by the following phases:

The first phase may be shock which is characterised by numbness. Thereafter, the bereaved may yearn for the individual to fill the emptiness which they feel as well as search for answers. As a result, the bereaved individuals may experience anger, anxiety, and despair. Despair and disorganisation marks the next stage proposed by Bowlby and Parkes (1970). During this stage bereaved individuals start accepting the loss of their dear ones. Therefore, these bereaved individuals may start isolating themselves (Bowlby & Parkes, 1970). Bowlby and Parkes (1970) added that it is important that bereaved individuals work through this stage

by re-organising their lives and adapting to life without their dear ones. This may ensure that they recover from their loss (Bowlby & Parkes, 1970). If bereaved individuals do not work through their despair they may continue to be consumed by anger and depression to the extent that they feel hopeless (Bowlby & Parkes, 1970).

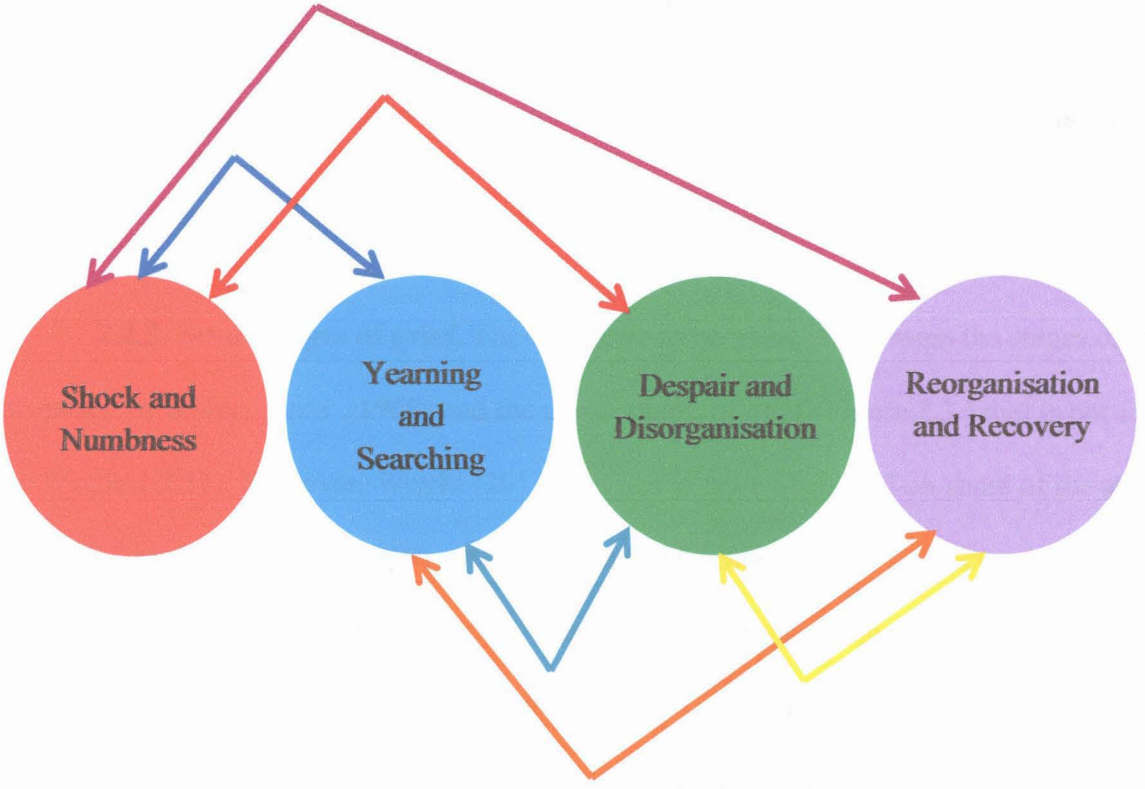


Figure 2.2. The four phases of grief as suggested by Bowlby and Parkes (1970) and the oscillation between any two phases of this grief model.

Stroebe and Stroebe (1987) described the Bowlby's and Parkes' (1970) model of grief as a 'depression model' of grief, as it views bereavement in terms of loss and explains grief in terms of individuals' emotional and behavioural reactions to it. . However, Fraley and Shaver (2002) argued against Stroebe and Stroebe (1987) as they felt that Bowlby's and Parkes' (1970) theory explains why loss is a stressor for individuals and why they react the way they do when loss occurs. I agree with Fraley and Shaver (2002), as based on Bowlby's and

Parkes' (1970) four phases of grief it seems that the stressor among individuals is caused by individuals' separation from other individuals.

Although Bowlby and Parkes (1970) refers to grief as being associated with personal loss, particularly the loss of a significant other, perhaps HCPs building therapeutic interpersonal relationships with their patients may also cultivate grief. Considering the definition of this concept, which is the "caring, and supportive non-judgemental behaviour that is embedded in a safe environment during a stressful period" (Kornhaber, Walsh, Duff & Walker, 2016, p.2).

2.2.3. Seven stages of grief. There appears to be overlaps between the stages of grief proposed by Kübler-Ross' (1969) and the seven stages of grief (Figure 2.3.) that is put forth by Wright (2011). However, Wright (2011) seemed to have expanded on some of the stages suggested by Kübler-Ross (1969) such as the stage of denial and offered new stages of grief.

Unlike the five stages of grief, Wright (2011) incorporates shock into the denial stage of grief, similar to Bowlby and Parkes (1980). This stage is marked by a "numbed disbelief" (Wright, 2011, para.4).Wright (2011) added that in order to ease the feelings of pain an individual may deny that a loss has happened. According to Wright (2011), shock may act as an emotional shield from being overwhelmed by the disbelief that an individual has died. Wright (2011) stated that bereaved individuals may experience feelings of shock and denial for a few weeks after the death of another individual.

An individual may also be suffocated by pain when a loss occurs (Wright, 2011). Wright (2011) advised individuals to embrace the pain. Furthermore, these feelings of pain may trigger feelings of guilt (Wright, 2011). However, through the concept of anticipated guilt feelings of guilt may be reduced. According to Miller (2013) and Wang (2011), anticipated guilt may occur when one thinks about one's approach to a situation and when

doing so feelings of guilt are triggered. Erlandsson, Jungstrand and Västfjäll (2016) showed that anticipated guilt may lead to individuals experiencing pro-social behaviour. This is behaviour which benefits others and society so that these individuals do not experience guilt if anything detrimental happens to others (Erlandsson et al., 2016).

Nonetheless, the literature divides guilt into deontological and altruistic guilt, which is based on the intra-psychic theory and interpersonal theory, respectively (Gangemi & Mancini, 2011; Izard, 1977; Lewis, 1971; Monteith, 1993; Mosher, 1965; Piers & Singer, 1971; Wertheim & Sachwatz, 1983; Hoffman, 1982).

According to the intrapsychic theory, deontological guilt usually arises from individuals experiencing moral distress (Gangemi & Mancini, 2011; Mancini & Mancini, 2015). Moral distress can be defined in relation to Festinger's (1957) theory of cognitive dissonance and emotional dissonance when individuals are constrained to go against their moral values (Berger, 2014). The former concept being a mental discomfort experienced by an individual that results from him or her simultaneously holding contradictory beliefs, or when an individual actions don't match their beliefs about how to approach a situation (Festinger, 1957). While emotional dissonance is the inconsistency in the emotions felt and emotions displayed when needing to conform to organisational rules and regulations (Hochscild, 1983). Through encountering moral distress individuals may violate the 'Do not play God' principle which states that no individual has the authority to cross the boundary of their social rank or function (Sunstein, 2005). In order to overcome this guilt, individuals may almost yearn to be punished (Gangemi & Mancini, 2011).

However, the interpersonal theory states that guilt results when individuals realise that they may have caused unjustified harm to another individual or simply because they were not altruistic towards an individual. Therefore, this theory is based on empathy (Gangemi & Mancini, 2011). In order to overcome this altruistic guilt, individuals may aim to rectify the

harm they caused to another by employing reparative behaviours (Cryder, Springer & Morewedge, 2012). This usually results in compassion (Gangemi & Mancini, 2011).

Additionally, individuals may display anger which is characterised by blaming others for a death. As a result, relationships may be affected and individuals may also question or bargain with a Higher Power as described in the bargaining stage of Kübler-Ross' (1969) five stages of grief model.

Just as individuals think that they may be beginning to accept the loss of their dear ones, they may encounter a period of "sad reflection" (Wright, 2011, para.9). Wright (2011) calls this stage: 'Depression', Reflection, and Loneliness. During this time individuals may realise the impact of their loss and may withdraw themselves from society and engage in self-reflection, whereby they reminisce about the past with their dear ones.

With time individuals may start to adjust to life without their dear ones, which Wright (2011) describes as the upward turn. During this stage individuals' physical and emotional reactions to a loss may start to wear off. They start to work through and reconstruct their lifestyle. They find strategies to overcome the difficulties that they are faced with. (Wright, 2011). Through this they seem to accept the reality of their loss (Wright, 2011).

The proposed seven stage model of grief by Wright (2011) is a fairly new theoretical framework about grief. There appears to be no known literature regarding it's appropriateness to describe grief. However, at times Wright (2011) tended to add a time frame for how long individuals may experience a particular stage of grief. Some grief theorists such as Worden (1991) may argue that individuals may move between stages or tasks of mourning (Figure 2.4.). However, Harvard Medical School (2011) argued that this entraps individuals in grief and hinders them from accepting the death of a loved one. Despite including an allocated a time frame as to how long some of the stages should last for, Wright (2011) just like Worden

(1991), stated that these stages may be re-encountered and can even be experienced simultaneously in no particular order.

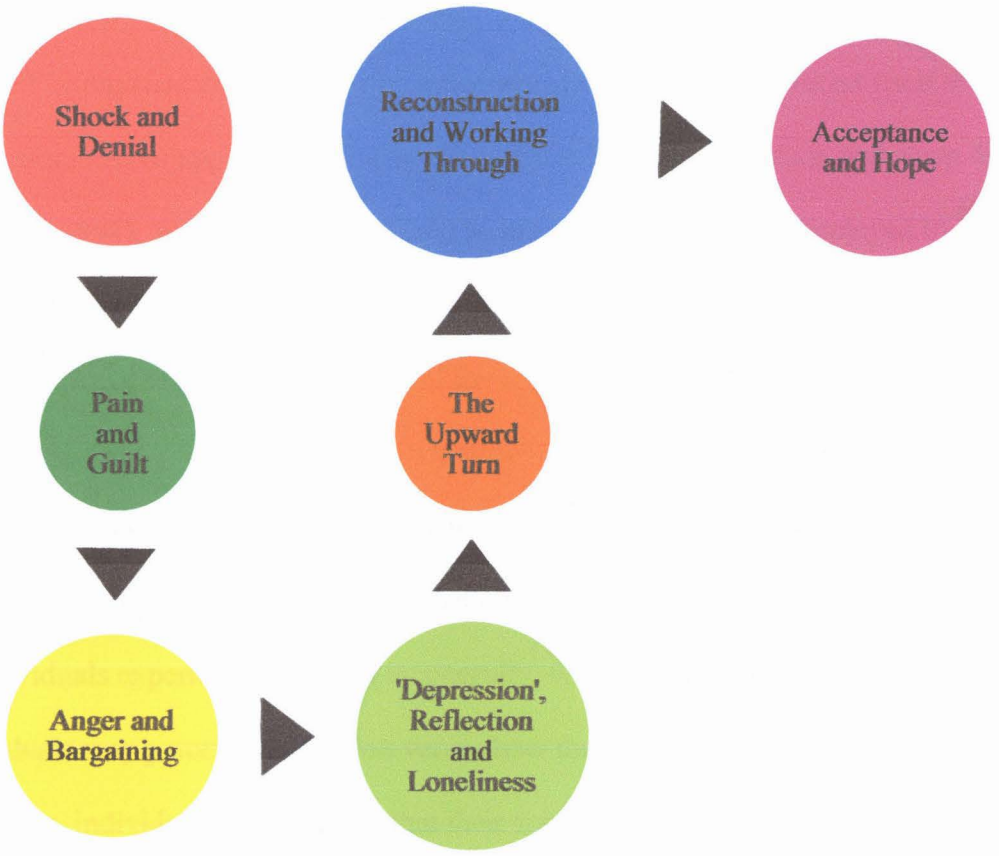


Figure 2.3. The unstructured nature of the seven stages of grief that was proposed by Wright (2011).

2.2.4. Four tasks of mourning. Worden (1991) proposed the four tasks of mourning (Figure 2.4.). The first suggested task is accepting and acknowledging the reality of the loss. Worden (1991) acknowledges that the bereaved may experience denial and shock, and may search for answers before they achieve the task. However, Worden (1991) maintains that traditional rituals may aid individuals in achieving this task, as these rituals may assist individuals in overcoming the disbelief of their dear ones deaths.

The second task of mourning is to experience the pain of grief (Worden, 1991). Worden (1991) divides the pain of grief into physical, emotional, behavioural, cognitive, spiritual, and social reactions to loss.

The physical and behavioural responses of the pain may manifest itself through: exhaustion, loss of appetite, muscle spasms, difficulties concentrating, and sleep disturbances (Worden, 1991). Whereas, the emotional facets of pain are usually displayed by experiencing dissonance where individuals may seem calm on the surface but internally they may be unsettled (Worden, 1991). As a result of these emotional symptoms, bereaved individuals may also experience cognitive responses which are marked by them feeling as if they are 'going crazy' (Worden, 1991). Individuals may also be faced with a spiritual crisis even if they have strong religious and cultural beliefs (Worden, 1991). Perhaps this may be a result of individuals experiencing mental incongruity, which is the discrepancy between how individuals may perceive a situation versus how they actually experience it (Tazelaar, 1980). Therefore, individuals may assume that their spiritual beliefs may provide them with comfort in distressing situations, but when a distressing situation occurs they may be faced with a spiritual crisis. Furthermore, bereaved individuals may display social isolation (Worden, 1991). Worden (1991) stressed that in order to successfully work through this task individuals need to employ healthy coping mechanism such as active coping mechanisms.

Thereafter, individuals need to find solutions in order to adjust to the loss of their dear ones (Worden, 1991). According to Worden (1991) through acquiring solutions to adapting to the absence of their dear ones, they may be able to achieve the fourth task of mourning (reinvesting their energy from the deceased into new life). They will realise that they are able to continue living without their dear ones by forming a new connection with them. Furthermore, performing rituals to work through this task may include wearing a locket with a picture of a deceased or hosting memorial services.

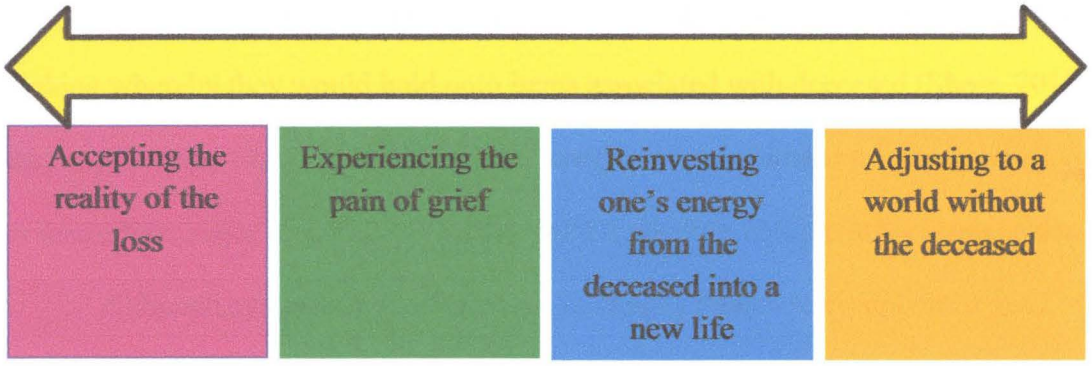


Figure 2.4. The flexible nature of the of Worden (1991) tasks of mourning.

Despite being a westernised model the four tasks of mourning have been considered to be successful in outlining grief reactions surrounding Acquired Immunodeficiency Syndrome (AIDS) —related death, particularly in Sub-Saharan Africa (Reder, 2003). Reder (2003) stated that other theoretical frameworks of grief tend to describe grief resulting from a single loss, whereas the tasks of mourning proposed by Worden (1991) can provide insight around grief of multiple losses. This is usually seen as a result of AIDs-related death (Reder, 2003). Since, Worden (1991) seems to place more emphasis on how grief needs to be worked through rather than grief reactions it may explain why Reder (2003) felt that Worden's (1991) model can tackle bereavement overload. Therefore, I am not fully convinced that Worden's (1991) four tasks of mourning may best describe grief reactions.

2.2.5. Disenfranchised and complicated grief. Grief which is not acknowledged, allowed to be mourned or socially supported is considered to be disenfranchised in nature, and so is termed as disenfranchised grief (Selby, 2007). If this type of grief is not addressed it can lead to complicated grief (Shear, 2012). This is prolonged chronic grief that is debilitating in nature and often goes unnoticed (Shear, 2012).

Complicated grief is said to manifest itself through the avoidance of emotional memories. For example, individuals would stay away from situations which would trigger

reminders of the deceased (Shear, 2012). Alternatively, individuals would display proximity seeking whereby they would hold onto items associated with deceased (Shear, 2012). This may explain why Shear (2012) stated that symptoms complicated grief are closely linked to or exacerbate major depressive disorder (MDD) which is colloquially known as depression.

Although symptoms of depression are closely related to complicated grief, conceptually post-traumatic stress disorder (PTSD) is said to be closely connected to complicated grief as both specific responses are triggered by a distressing life event. However, Shear (2012) warned against confusing complicated grief with PTSD. PTSD is a condition which is considered to be debilitating as it causes emotional and psychological stress (Anxiety and Depression Association of America [ADAA], 2018). It is triggered by encountering or witnessing a terrifying and traumatic event (ADDA, 2018). PTSD is diagnosed using the DSM-V (APA, 2013). According to the DSM-V (APA, 2013), it seems that individuals can only be diagnosed with PTSD if they meet the following criteria:

Criterion A: One stressor- traumatic event (e.g. death) is required to have been experienced, witnessed, or even indirectly exposed to a traumatic.

Criterion B: At least one intrusion symptoms which are features of the event that have been re-encountered through: unwanted upsetting memories (traumatic memories), nightmares, flashbacks, emotional distress, and physical reactivity to traumatic memories.

Criterion C: Individuals may display avoidance of trauma-induced stimuli through avoiding trauma-related thoughts, feelings or external reminders.

Criterion D: Individuals need to present with at least two negative thoughts and feelings which are made worse by trauma. These feelings and thoughts may be displayed in the following ways: inability to recount aspects of the traumatic event, negative outlook on life or poor affect, disinterest in activities, and/or feeling abandoned.

Criterion E: Trauma-related arousal and reactivity that was elicited and exasperated by the trauma in the following ways: irritability and aggression, hyper-vigilance, heightened startle reaction, difficulty focusing, and sleep disturbances.

Criterion F: The above mentioned symptoms need to be prevalent for approximately 1 month.

Criterion G: These symptoms can result in distress and affect participation in activities of daily living.

Criterion H: These symptoms cannot be triggered by medication, recreational substance abuse, and other illnesses.

PTSD should not be confused with vicarious trauma which is interchangeably referred to as secondary traumatic stress. Vicarious trauma described by Perlman and Saakvitne (1995) is thought to be a profound shift in the worldview of helping professionals due to their exposure to or working with individuals who have encountered traumatic events. Some literature describes vicarious trauma synonymously with compassion fatigue (American Counselling Association [ACA], n.d). However, I disagree with this, as compassion fatigue describes the emotional and physical erosion of caring for others (Joinson, 1992).

The features of PTSD and vicarious trauma may be similar. Therefore, individuals who present with vicarious trauma may also present with intrusive thoughts, emotional distress, physical behavioural reactivity, poor work performance, and conflicting relationships which may result in isolation.

Additionally, traumatic events may lead to negativity bias. Negativity bias is broadly defined as individuals' ability to draw on the negative experiences as opposed to the positive ones (Peeters, 1971). Rozin and Royzman (2001) propose four different types of negativity bias namely, negativity potency, negativity dominance, steeper negative gradients, and

greater differentiation in negative events. These components of negativity bias are described in Figure 2.5.

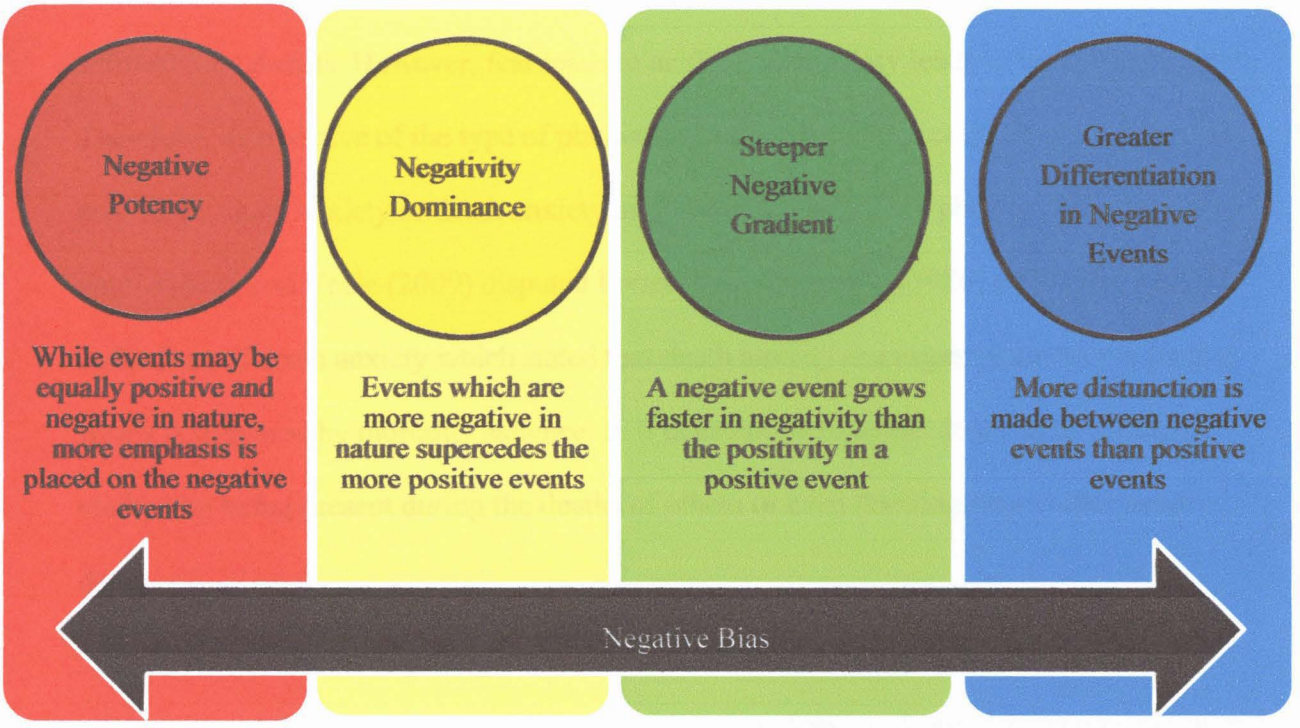


Figure 2.5. The elements of negativity bias as outlined by Peeters (1971)

2.3. Death Anxiety

This section will first conceptualise death anxiety, which can be used for this study. Thereafter, factors which may contribute to HCPs displaying death anxiety will be discussed.

2.3.1. Definition of death anxiety. There is much debate regarding the definition of death anxiety, therefore Nyatanga and de Vocht (2006) aimed to conceptualise death anxiety by examining various definitions which exist in the literature. Research usually refers to death anxiety interchangeably with the fear of death particularly thanatophobia, which is the fear of one's own imminent death (Balasubramanian, 2018). Furthermore, thanatophobia and death anxiety is distinguished from necrophobia which is the fear of objects associated with

death, or the fear of other individuals' deaths (Lehto & Stein, 2009; Willson & Veale, 2009). However, Nyatanga and de Vocht (2006) differentiated anxiety from fear by stating that anxiety is marked by uncertainty and insecurity, whereas a fear does not and in a sense is cultivated by threats. However, fear leads to anxiety and anxiety leads to fear (Suinn, 1969). Therefore, irrespective of the type of phobia-thanatophobia and necrophobia- each phobia may cause death anxiety or death anxiety may result in each of the phobias. This may explain why Wilsom and Veale (2009) disputed Lonetto and Templer's (1986) and Feifel's (1977) definitions of death anxiety which stated that death anxiety is a negative emotional feeling which is triggered by mortality salience, as it does not include that death anxiety may be elicited by being present during the deaths of others or even thinking about other peoples' death.

Researchers such as Thorson and Powell (1988) who aimed to characterise death anxiety, stated that the hallmarks of death anxiety are: denying death, fearing one's own and the deaths of others, avoidance of situations which may result in death, as well as a reluctance to interact with dying individuals. Wilson and Veale (2009) stated that although this may be useful in outlining how death anxiety may exhibit itself, it still does not clearly define what death anxiety is. Psychoanalytic theorists tended to perceive death anxiety as being triggered by separation anxiety (Freud, 1961). Therefore, it seems that Freud (1961) was insinuating that it is the anxiousness of being alone that cultivates death anxiety. However, Wilson and Veale (2009) disagreed with Freud (1961) as they maintained that death anxiety is a learned behaviour based on the experience of death.

Therefore, for the purpose of this study the researcher defined death anxiety as a possible learned response. This response is cultivated by the fear or the anxiety caused by thinking of one's own and others' death.

2.3.2. Death anxiety among HCPs. Abdel-Khalek and Tomas-Sebado (2005) examined death anxiety among Egyptian and Spanish student nurses. The researchers found that Egyptian student nurses exhibited higher levels of death anxiety as compared to Spanish student nurses who were also older than these Egyptian nurses. However, Spanish student nurses also displayed lower levels of work performance anxiety (Abdel-Khalek & Tomas-Sebado, 2005). Nia (2016) who reviewed this study attributed low levels of work performance anxiety as a contributing factor to Spanish student nurses displaying lower levels of death anxiety as compared to their Egyptian peers. However, Hammett (2011) maintained that death anxiety is influenced by cultural beliefs as there are different beliefs surrounding death across cultures.

Furthermore, another study which explored American nurses with limited exposure to dying patients, found that due to a lack of exposure to patient death and dying these nurses experienced death anxiety, and as a result they would avoid caring for terminally ill patients (Braun, Gordon & Uziely, 2010). This correlates with the characteristics of death anxiety proposed by Thorson and Powell (1988) which are keeping away from situations where death may occur and not engaging with individuals who are facing death and dying. This is in agreement Shokri and Akbari's (2016) findings that showed that death anxiety may be mitigated among the elderly who are self-efficient as self-efficacy is marked by individuals perception of how well they can complete a task (Bandura, 1994). Therefore, perhaps individuals who have accepted their imminent death may display limited death anxiety (Braun et al.,2010). This may be related to findings obtained by Peters et al. (2013) who noted and deduced that nurses who were frequently exposed to death and dying patients appeared to be more conscious of their own mortality which resulted in them experiencing anxiety and uneasiness when caring for patients. McKay (1991) concluded that when HCPs are confronted by patients who are dying, they may experience death anxiety. Death anxiety

among HCPs may cause them to think about, plan, and prepare for their own deaths (McKay, 1991). Furthermore, McKay (1991) added that patient death is imminent and is probably the most overwhelming situation that HCPs may have to encounter in their careers. Furthermore, Hammett (2011) stated that females are considered to be more emotional than males and thus exhibit high levels of death anxiety as compared to males. This claim by Hammett (2011) seems to display gender bias. However, it may be this gender bias which leads to social desirability among participants. Therefore, Hammett (2011) adds that social desirability may influence why females tend to display higher levels of death anxiety in comparison to their male counterparts.

The aforementioned factors contributing to death anxiety seem to be rather miscellaneous. Nonetheless, as Nia (2016) advised that death education should be included in healthcare professional pre-professional training. Nia (2016) made reference to a study conducted by Mooney (2005) to motivate his recommendation. Mooney (2005) found that death education for nursing students which was conducted in the form of lectures, discussions, and practical activities for a week seemed to have mitigated nursing students' death anxiety.

Furthermore, Wojan (2006) found that STs who were faced with more patient deaths appeared to be able to better deal with levels of grief and stress as compared to those STs who did not experience the death of a patient. Similarly, Sansone and Sansone (2012) discovered that supervising physicians who were frequently exposed to patient deaths appeared to need less emotional support than medical interns when they were faced with death. Likewise, nurses with longer working experience were inclined to be less anxious about being faced with patient death (Lange, Kline & Kline, 2008). Additionally, Sinclair (2011) noted that when HCPs and spiritual care providers who provided EOL care and reflected on their own death and dying, it aided them in effectively caring for dying patients.

2.4. Variability in Grief Reactions and Bereavement Outcomes to Death and Dying within the South African Context

SA is often referred to as the Rainbow Nation given its diverse population of multiple races, ethnicities, languages, and classes (South African History Online [SAHO], 2016; Druder, 2010). The grieving process differs among cultures (Snyder, Dwyer, Moxham, Parker & Stanely, 2014). This may be particularly important to make reference to when investigating grief reactions and bereavement outcomes among the diverse cultures in SA (Drenth, 2008). However, there appears to be sparse information regarding grief and bereavement within the South African context (Drenth, 2008).

2.4.1. The influence of cultural diversity on grief processes. Appel (2011) explored whether South Africans from varying cultures grieve differently from each other. She investigated this occurrence by providing women from three diverse cultures namely, Tswana, Islamic, and Afrikaans cultures with an opportunity to relate their stories of the deaths of their significant others. Appel (2011) discovered that individuals from Afrikaans and Tswana cultures appeared to have poorer bereavement outcomes and tended to grieve longer after loss as compared to the individual from Islamic cultures. However, she did not acknowledge how biographical factors such as age and gender may affect participants' grief processes and bereavement outcomes. These factors are thought to influence individuals' grief and mourning responses (Brunhofer, 2011; Snyder et al., 2014). Furthermore, Appel (2011) did not take into account the influence that sudden death versus anticipated death may have on individuals' bereavement outcomes. Kaltman and Bonanno (2001) point out that individuals who experience sudden and unexpected death may have poorer bereavement outcomes. Appel (2011) contested that preconceived ideas may have influenced her interpretations of participants' narratives. Thus, it may be insinuated that these interpretations may not accurately reflect how individuals from these cultures grieve. Therefore, perhaps the

attribution error of correspondence bias, which was proposed by Jones and Gilbert (1986) can explain the limitation of Appel's (2011) study. Baumeister (2007) stated that this type of bias can lead to systemic errors in research. Researchers may make presumptions regarding participants' personalities without considering the influence that situational factors (situational attributions) have on individuals' (Jones & Gilbert, 1986; Baumeister, 2007). This bias is caused either when those who make inferences do not believe: situational factors can impact on the observed behaviour, when the influence of situational factors is not thought about and thus overshadows the observers' beliefs about the situation, or when observers make deductions about individuals' behaviours irrespective of whether or not these behaviours were triggered by the situation (Jones & Gilbert, 1986). Nonetheless, despite the variability in severity of grief reactions among participants in Appel's (2011) study, she discovered that these participants experience the same grief reactions namely, shock, crying, yearning, and dreaming of the deceased.

Although Makgahlela (2016) noted that individuals from the Northern Sotho culture appear to experience spiritual crisis. They appeared to exhibit anger towards God or their ancestors. One participant even mentioned that the death of a child is more difficult to accept than the death of an adult, as one tends to ask the Higher Power what sin did the child commit to deserve to die. This differs from the reactions experienced by individuals from Tswana, Afrikaans, and Islamic cultures who found solace by confiding in a Higher Power when losing a significant other (Appel, 2011).

This is unlike some of the practices employed by people from traditional African cultures where death is viewed to be another phase of being (King, 2013) where grief processes are marked by rituals such as people shaving their hair or slaughtering domestic animals. It also seems that the rituals performed by the bereaved are dependent of the relationship that they shared with the deceased (Baloyi, 2014). For example, the Bapedi tribe

in Limpopo believe that a widow should not come home after sunset, visit neighbours, should not attend social gatherings, and should wear black clothes (Baloyi, 2014). The latter depicts the sadness and pain associated with the death (Baloyi, 2014). However, if a spouse passes away then the widower should not have intimate relationships until 6 months after the wife's death (Baloyi, 2014). These rituals are performed to ensure harmony between the living and the dead (Baloyi, 2014). This harmony speaks to the concept of *Umuntu Ngumuntu Ngabantu* that translates into "a person is a person because of or through others." (Tutu, 2004, p. 25). This notion is commonly referred to as the Ubuntu philosophy. This philosophy describes individuals and their relationship with others, and so is thought to form the basis of the concept of community and social interactions within African culture. However, this philosophy is not exclusive to the African culture as it refers to humanity, particularly within a racially and culturally diverse society (Khumalo, 2017).

The concept of Ubuntu also seems to extend the idea of community as far as insinuating that the survival of individuals is dependent on each other. Therefore, the Ubuntu philosophy is viewed as a way of-being-in-the world, and in the African culture this belief extends to the living and the deceased being interdependent on each other (Baloyi, 2014). Thus, Baloyi (2014) concludes that the Umuntu cannot achieve Ubuntu without the intercession of the living-dead.

2.4.2. The contribution of the high burden of injuries in SA on grief reactions.

According to Drenth (2008) the cause of death may influence individuals' bereavement outcomes. For instance, families who experienced a loss of significant others due to AIDS are at risk for experiencing poor bereavement outcomes, as they tend not to seek support due to the stigma associated with AIDS (Sikkema, Hansen, Kochman, Tate & Difranceisco, 2004). Furthermore, Lydall (2004) stated that due to the high incidence of AIDS -related deaths,

families may encounter a number of losses which may contribute to their poor bereavement outcomes. However, Sikkema et al. (2004) added that it's not only the high mortality rate associated with AIDS which may contribute to poor bereavement outcomes, but also the fact that individuals may have insufficient time to prepare for losses. Furthermore, Drenth (2008) speculated that given the high incidence of violent deaths and history of the military action during the apartheid era, losses during these instances may have resulted in grief reactions. However, there appears to be no known research which confirms this speculation and whether or not these reactions were attended to (Drenth, 2008). A study which explored how violent death may influence the grief and bereavement process found that grief is higher after violent death as compared to other types of deaths because it occurs suddenly and unexpectedly (Nakajima, Masaya, Akemi & Takako, 2012). Furthermore, it is caused by violence which is significantly different from natural death with regard to how it's perceived by bereaved significant others. Additionally, significant others who are bereaved due to violent death may experience societal distrust, which may result in them refusing to seek support (Nakajima et al., 2012). This societal isolation may negatively affect how these significant others attend to their grief. Furthermore, these individuals are at risk for presenting with poor bereavement outcomes but may also present with PTSD symptoms as they may need to face offenders, reencounter the crime by remembering details of the crime, and victims may be used as scapegoats by defence attorneys during legal proceedings (Nakajima et al., 2012).. These conclusions made by Nakajima et al. (2012) appear to be constant with Makgahlela (2016) findings as she discovered that traumatic violent losses led to participants experiencing grief for long periods of time, especially because they did receive support and were dependent on the victims. For example, one participant attributed her son's murder to witchcraft and believed that he turned into a ghost. Therefore, she felt that her son

was not resting in peace and thus she experienced greater grief reactions that were characterised by high levels of fear and anxiety (Makgahlela, 2016).

2.4.3. Cultural diversity's impact on types of coping mechanisms employed by individuals. With regard to the variability in participants' grief processes across cultures, participants' from various cultures seem to have employed different coping strategies to address their grief. It should be noted that even within the same cultures, individuals' spiritual and religious beliefs may influence the coping mechanisms they utilize. For instance, Sotho individuals who belong to the Zion Christian Church (ZCC) may adopt cleansing rituals that are guided by priests to overcome their bereavement outcomes (Makgahlela, 2016). Whereas individuals from the Sotho culture who consider themselves to be born again Christians, may condemn their cultural rituals and thus may engage in prayer and attend spiritual counselling sessions (Makgahlela, 2016). Setsiba (2012) discovered that Black South Africans, irrespective of their traditional socio-cultural background, who reside in urban areas appear to adopt the practice of after -tears parties. These individuals believe that this practice allows them to cope with the loss of a significant other and ensures that they are able to move on with their lives. However, for others being conscious about the impending nature of death may suffice in accepting death. For example, the Afrikaans participant in Appel's (2011) study stated that realising that the death is inevitable and that life needs to proceed helped her overcome the death of her relative.

Although, culture may impact on our grief experience and choice of coping mechanisms (Linton, 2015), we must remember that our individuality and uniqueness may lead to various responses to death and dying (Lewis, Hietkemper & Dirksen, 2004).

2.5. HCPs' Perceptions regarding Patient Death and Dying

Although this study inspects ST/As' experiences with patient death and dying, it is important for the researcher to refer to literature regarding HCPs' such as STAs' provision of EOL care to patients. This may influence their encounters with patient death and even more so, with dying. EOL provided by the medical team namely, medical practitioners and nurses, focuses on comfort care by managing symptoms such as pain (American Nurses Association [ANA], 2016).

2.5.1. STAs' roles in providing EOL care. In the introduction it was mentioned that ST/As do not seem to expect to encounter patient death. This may be due the ST/As' scope of practice stating that they are responsible for preventing, identifying, and managing swallowing and communication disorders (HPCSA, 2018). However, these professionals role may extend into providing EOL care to terminally ill patients. They are responsible for ensuring that these patients' quality of life (QoL) is being facilitated through managing the aforementioned disorders (ASHA, 2009). These disorders may arise from but are not limited to the following medical conditions: cerebral vascular accident (CVA), head injuries, respiratory illnesses, neurological conditions, cancer, tuberculosis, and HIV/AIDS (Toner & Shadden, 2012). Figure 2.6. provides a summary of ST/As' role in providing EOL as outlined by Toner and Shadden (2012)

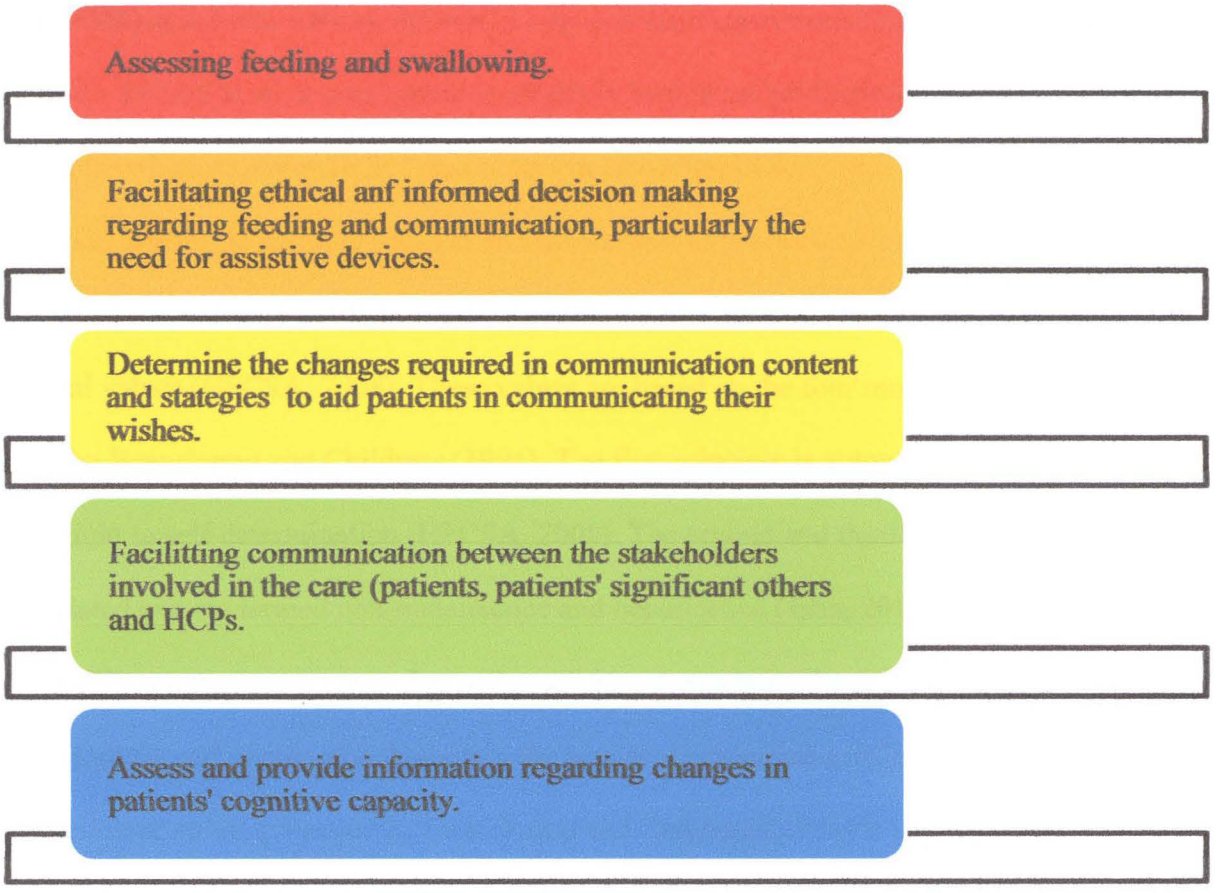


Figure 2.6. outlines the roles of ST/As' when providing EOL care, as proposed by Toner and Shadden (2012).

In order to provide effective EOL care, ST/As need to understand the dying process in terms of changes in terminally ill patients' communication, cognitive, and feeding abilities. Furthermore, they need to ensure that they know and uphold the ethical practices surrounding EOL care decision making.

2.5.2. The provision of EOL care. The HCPs' code of conduct and medical ethics which these professionals need to comply with remain the same during the provision of EOL care, as thanatology associations such as the Association for Death Education and Counselling (ADEC, 2010) state that the key requirements of providing EOL care services is ensuring these services are in line with ethical standards. Therefore, the researcher referred to

HPCSA (2008) and South African Speech –Language-Hearing-Association (SASLHA, 2016) guidelines to determine what good practice entails in healthcare professions and integrated it into literature which explores HCPs' encounters in providing EOL.

Good practice is not only focused on aspects such as professionalism and confidentiality, as outlined by HCP's code of conduct (SASLHA, 2016), but is also based on core ethical values (HPCSA, 2008). These values are based on the four moral principles proposed by Beauchamp and Childress (1994). The first principle is autonomy which is patients' right to self-determination (HPCSA, 2008). The second and third principles are closely related and are termed non-maleficence and beneficence (Jahn, 2011). The former refers to HCPs not performing acts that will result in patients being harmed, while the latter focuses on HCPs performing acts that are in the best interests of patients (HPCSA, 2008). The last moral principle proposed by Beauchamp and Childress (1994) is justice which emphasises that HCPs should treat all patients fairly and equally (HPCSA, 2008). Although not described simultaneously, the moral principle of justice may link to the concept of tolerance and respect for persons. Both of these ethical values highlight the importance HCPs respecting patients by ensuring that patients are valued, treated with dignity, and that their spiritual beliefs are accounted for by HCPs.

According to the HPCSA (2008) the ethical guidelines for HCPs are based on duties. The HPCSA (2008) defines duties as: individuals owing something to another individual. Therefore, the duty which HCPs owe to patients may revolve around ethical care and ensuring the well-being of their patients. Through this interpretation the duty of care concept may be employed given the standard definition of this concept which is ensuring that individuals avoid behaviours which may threaten the well-being of others (Farlex Online Legal Dictionary, 2005). This may talk to the ethical frameworks surrounding decision-making namely, deontological ethics and utilitarian ethics.

Deontological ethics was proposed by Misslebrook (2013) and seems to be more closely associated with the principle of duty of care, as it states that "morality of the action depends on the nature of the action" (Mandal, Ponnambath & Parija, 2016, p.4). In other words, deontological ethics suggests that harm is unacceptable (Misslebrook, 2013). Mandal et al. (2016) stated that deontological ethics is more concerned about an individual and so a medical decision based on deontological approach may not necessarily yield a favourable outcome for society, but rather for the patient. The rule of rescue may be encapsulated into the deontological approach as it describes the drive to save those who are facing death (Scheunemann & White, 2011) Therefore, this ethical framework is breeched by patient blaming, medical negligence, inhumanity, and dehumanisation (Mandal et al., 2016; Miller, 2011; Skeleton, 2016). All of which can threaten HCPs' professional integrity and patients' human rights, respectively (HPCSA, 2008). Dehumanisation may be considered to be a type of discriminatory practice, where individuals may deprive others of individuality and positive human qualities (Murrow & Murrow, 2015). One such example is ablelism, where able-bodied individuals are seen as a norm in society as they are considered to be 'whole', and thus individuals with disabilities are viewed to be lesser human beings as compared to able bodied individuals (Liddiard, 2017). Skeleton (2016) further added that a deontological approach may lead to patient autonomy being threatened. Furthermore, the HPCSA (2008) stressed that since HCPs are in a position of authority over their patients they must avoid being paternalistic during the decision- making process. Paternalism is a behaviour exhibited when individuals such as, HCPs who may be considered to be in authority over their patients, make decisions about what they believe is in the best interests of their subordinates (Dworkin, 1973). Paternalism threatens these subordinates right to self-determination (autonomy).

Additionally, it seems as if medical practitioners may perceive their patients materialistically. A patient questioned his medical practitioner as to whether his medical practitioner "was there to treat his diseases as an own entity, not as if it existed in a person with priorities, beliefs, and emotions" (Kurapati, 2018, para. 4). The medical practitioner did realise and agreed with the patient, as he said that medical practitioners do perceive their patients as being "intricate machines with faulty parts that needed to be fixed" (Kurapati, 2018, para. 6). Therefore, this materialistic perception seems to threaten patients' receiving holistic care.

Unlike deontological ethics, utilitarian ethics employs a consequential approach whereby "outcomes determine the morality" (Mandal et al., 2016 p.2). Furthermore, within the utilitarian approach decisions are made on how favourable a decision is for the greatest amount of individuals (Bentham, 2000). Therefore, it seems as if utilitarianism can lead to priotarianiasm which is prioritising those who are considered to be worst off in situations where resources are limited (Scheunemann & White, 2011). For example, a prioratarian may allocate medical resources to a young individual who is ill because he or she believes that young individuals still need to experience life and thus need to be saved (Scheunemann & White, 2011). Perhaps, South African HCPs may have to employ prioratarianism as the allocation of resources within the healthcare system are not equally distributed or controlled (van Rensburg & Fourie, 1994). This is despite the South African healthcare expenditure report stipulating that the provision of resources can occur at a low cost and prevent premature deaths (McIntyre, Doherty, Bloom & Brijlal, n.d.). This piroratarian approach may jeopardise the ethical principle of justice which is treating all individuals equally (Veatch, 1997).

This stance may also challenge the Ubuntu philosophy which is the expression of "compassion, reciprocity, dignity, humanity, unity, and mutuality" (Khomba, 2011, p.127).

Broodryk (2005) further indicated the humanistic nature of the Ubuntu philosophy by dissecting the word, as indicated in the Figure 2.7. The concept of Ubuntu features in healthcare literature and has shown to potentially create a caring atmosphere in healthcare. It seems that the caring atmosphere results in HCPs having a compassionate interest in their patients and these patients' significant others (Ncama, 2015).

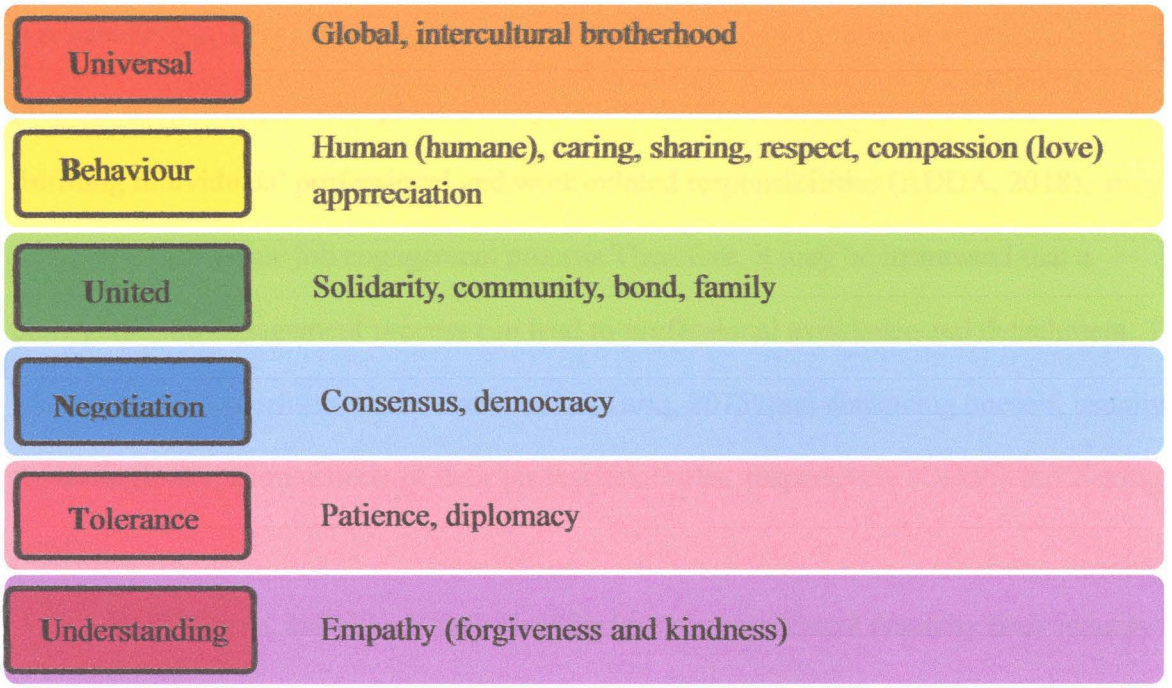


Figure 2.7. Attributes of the Ubuntu Philosophy, as proposed by Broodryk (2005). Figure adapted from Khomba (2011).

Although it is not clearly cited in the literature, it may be insinuated that the philosophy of Ubuntu may draw HCPs towards healthcare professions by them wanting to uphold their humanness and care for others. Therefore, they may perceive that choosing a healthcare profession to be a result of calling, and thus a calling-vocation match is made (Vinje & Mittlemark, 2007). This match can either result in salutogenic or pathogenic job engagement process (Vinje & Mittlemark, 2007). A salutogenic job engagement process results in favourable job experiences where individuals' calling-vocation match is maintained

through individuals' zest and motivation for work. However, Vinje and Mittlemark, (2007) imply that in a pathogenic job engagement process, individuals' zest for work is threatened by them needing to uphold the duty of care as it results in work-related stressors such as, work overload, moral distress, and burnout. Burnout is a psychological syndrome caused interpersonal work related stressors, and is characterised by emotional exhaustion, depersonalisation (detachment from work), poor self-efficacy, and low job satisfaction (Freudenberger, 1974). Although not mentioned by Vinje and Mittlemark (2007), professional anxiety or workplace anxiety, which are learnt responses to stress caused by fulfilling individuals' professional and work-related responsibilities (ADDA, 2018), may result in a pathogenic job engagement process Therefore, it may be insinuated that a pathogenic job engagement process can lead to professional avoidance and detachment. This is a reluctance to perform work-related tasks (Tariq, 2015) and distancing oneself, usually psychologically, from aspects of their professional roles, respectively (Oakley & Cocking, 2004).

Furthermore, individuals may also display role engulfment whereby their identity is defined by a role which supersedes their other roles (Shur, 1971). Therefore, role engulfment is generally described as being part of labelling theory (Shur, 1971). Furthermore, the concept of role integration which is the merging of roles (Ashforth, Kreiner & Fugate, 2000) may be applied to role engulfment, especially if there are high levels of integration between roles. This is because individuals may be performing tasks of one role instead of fulfilling their responsibilities of other roles that need to be carried-out at a certain time or in a certain environment (Peng, Dimotakis & Ilies, 2011). For example, individuals may complete work tasks at home (Peng et al., 2011) Therefore, role engulfment may result in individuals sacrificing their other roles (role abandonment). This may result in role conflict which is a component of role stress theory, and is defined as individuals having difficulty in fulfilling

both roles due ill-matched pressures being placed on individuals (Katz & Kahn, 1964). An aspect of role conflict is work-to-family conflict which is when personal and work demands are incompatible and the family role is almost renounced by the work role (Greenhaus & Beutell, 1985). The opposite to this notion is referred to family-to-work conflict (Greenhaus & Beutell, 1985), but for the purpose of this study work-to-family conflict will be discussed in terms of its relation to burnout. According to Greenhaus and Beutell (1985), these types of role conflict usually result from: one role taking up individuals' time which causes them not to have time to fulfil their other roles. Thus individuals may incur role strain as one role makes it difficult to fulfil their other roles and role expectations. The latter is when others discern how individuals should carry-out their roles (Biddle, 1986). The literature has shown a positive relationship between burnout and work-to-family conflict, because individuals may simply not differentiate between their work and personal responsibilities. This may lead to lead to poor job performance and may affect individuals' relationships with their family members (Bakker, Demerrouti & Schaufeli, 2005; Rubab, 2017).

As previously mentioned, healthcare professional bodies such as the HPCSA bind HCPs to the law of duty of care. This may result in HCPs encountering Kübler-Ross' (1969) stage of bargaining by having persistent thoughts about what they could have done differently when their patients have passed away to prevent their patients from dying (Goldberg, 2016).

Furthermore, the concept of Batho-Pele, which may influence HCPs' practice, is based on "people first" (KwaZulu- Natal Department of Health [KZN DOH], 2013, p. 2) and may link the law duty of care to the Ubuntu philosophy. The need for HCPs to uphold these principles may result in them becoming helpless helpers when they feel that they have failed to care for their patients (Rückert , 1988). This helplessness may be marked by what Larsson & Stern (2013, p.4) describes as 'emergency room panic', whereby helpers may feel that they

cannot do anything to resolve a traumatic situation, which is out of their control. This may contribute to burnout among helping professionals, such as HCPs.

Schroeter (2008) reminds HCPs that as much as they have a duty of care to their patients, they too have a duty of care to themselves (duty to self). Therefore, Close (2019) advises HCPs to uphold ethic of care when providing care to patients. This seems to be a new stance to this philosophy, as the pioneers of ethic of care viewed this concept as caring for those who cannot care for themselves (Gilligan, 1982, Noddings, 1984, Baier, 1987, Kittay, 1987, Ruddick, 1980, tronto, 1984 & Held, 2006).). This may explain why Close (2019) applied this ethical concept to the effects of the relationship between care-givers and care-receivers, and seemed to define ethic of care as: the balance between caring for others and caring for oneself when providing care. It may be important for HCPs to uphold ethic of care because as Silva et al. (2009) stated that in order for nurses to be effective care-givers they need to take care of themselves.

2.5.3. Patient- and family-centred cared during the course of providing care to terminally ill patients. Patient-centred care (PCC) and person-centred care seems to be used interchangeably based on their definitions. PCC allows for a dynamic relationship where HCPs account for patients' beliefs and values towards patients' well-being (Delaney, 2018; Ogden, Barr & Greenfield 2017). Therefore, PCC seems to foster patient autonomy as it moves away from the paternalistic nature in healthcare (Delaney, 2018). This concept of care appears to facilitate the bio-psychosocial model of care, which focuses on the interaction between patients' health and illness with individuals' biological, psychological, and social factors (Tonetta-Stanker, 2009). By treating patients within this model it allows for holistic patient management.

Involving patients' significant others when providing EOL care services to patients, may allow for family-centred care (FCC). This can also contribute to PCC as it allows for acknowledging and caring for individuals who provide care to their loved ones. FCC was designed around providing paediatric healthcare but can still be applied to the delivery of EOL care to terminally ill patients (Kuo et al., 2011), as in most instances these patients' significant others may be advocates in these patients' treatment regimens (Committee on Hospital Care, 2012 & Institute for Patient- and Family-Centred Care [IPFCC] , 2012). Therefore, an integration of PCC and FCC models can be employed by HCPs when providing care to patients who are nearing death. This integrated model is referred to as the patient- and family-centred care (PFCC) model, which allows for a mutually symbiotic relationship between patients, patients' significant others and HCPs (IPFCC, 2012).

EOL care which is characterised by the use of medical pre-set protocols is rather impersonal and may not allow for patient dignity, autonomy, and comfort. Therefore, the Institute of Medicine [IOM] (2015) recommended that EOL should be PFCC in nature. HCPs should recognise each patients' uniqueness in terms of their personal history, spiritual beliefs and financial standings (IOM, 2015). Providing information support and emotional support, which will be explored under the social support section, may also foster PFCC (IOM, 2015). Information support involves HCPs providing information to patients regarding their clinical prognosis and treatment processes. While the provision of emotional support can reduce the anxiety experienced by patients and their significant others when they are aware that patients are terminally ill (IPFCC, 2012). Nonetheless, the importance of providing physical comfort should not be disregarded when aiming to cultivate PFCC (IPFCC, 2012). The Picker Institute (2017) stated that providing physical comfort through pain management and support with activities of daily living may still cultivate PFCC. Participants in the Picker Institute's (2017) research study stated that the delivery of these types of physical comfort still had a

positive influence on patients' experiences when receiving treatment. However, during the provision of EOL care physical comfort may be facilitated through comfort care, as previously mentioned and stated by the ANA (2016). Therefore, by applying a PFCC approach when providing EOL care it may lead to patients' values being upheld which in turn ensures that quality care is being provided.

The implementation of PFCC may be challenging in certain healthcare settings such as, intensive care units (ICU), as these settings are considered to be aggressive and medicinal in nature (Tonetta-Stanker, 2009). Common barriers to employing PFCC when providing EOL services include fragmented care which is due to poor collaboration between patients, their significant others, and HCPs (Tonetta-Stanker, 2009). This poor collaborative care leads to unrealistic expectations regarding health outcomes among these individuals during the provision of EOL care services (Tonetta-Stanker, 2009).

2.5.4. Collaborative care during the provision of EOL care. The concept of community of practice (CoP) can be defined in various ways and applied to different social relationships that occur in various aspects of life (Lave & Wegner, 1991). Lave and Wegner (1991) who first introduced this concept defined CoP as a group of individuals who share common interests and goals in order to share information, deepen their expertise, and foster personal and professional development (Lave & Wegner, 1991).

Ranmuthugala et al. (2011) investigated the need and way in which the concept of CoP functions in the healthcare sector. It was found that CoP improved HCPs' work performance as it improved participants' work competencies, fostered information sharing, and reduced professional isolation (Ranmuthugala et al., 2011). Due to these conclusions, CoP may be cultivated through collaboration within multidisciplinary team (MDT). Since the MDT is comprised of members from different healthcare professions, who all have a

common goal that is to provide optimal quality care (Mitchell, 2012; College of Respiratory Therapists [CRTO], 2017; Ovretveit, 1993; & Yoder-Wise, 2013). The impression of CoP may be employed to the MDT. The MDT may be seen as a community since it could cultivate a sense of belonging and a social support system (Mental Health Commission [MHC], 2006); Corso, Giacobbe & Giacobbe, 2009).

According to Mitchell (2012) and CRTO (2017), a key principle of collaboration as well as to maintain the CoP between members of the MDT, each member needs to clearly understand each other's role (role clarity). The lack of role clarity can lead to role confusion and role-boundary crossing. This can threaten patients' understanding of their health and health outcomes particularly when conflicting recommendations are made by two different HCPs regarding the same aspect of a health condition (Stefors-Hayes & Kang, 2014).

Similarly, poor communication due to information not being shared timeously and accurately between members of the MDT may result in patient management being ineffective and even harmful. Therefore, both Mitchell et al. (2012) and CRTO (2017) stated that effective communication is a cornerstone for successful collaboration between HCPs.

Inter-professional conflict may threaten the concepts of social support and CoP. Inter-professional conflict can foster a stressful working environment, lead to professional isolation (Ramsay, 2001), and work place violence if not addressed appropriately (Zeinhom & Higazee, 2015). Majority of studies have explored inter- professional conflict between physicians and nurses. A study by Merrill and Miller (2015) who investigated the management of inter-professional conflict in a healthcare setting found that only social workers encountered conflict with physicians and nurses, but physicians and nurses encountered more intragroup conflict (conflict among members of the same profession). This was due to them competing for opportunities for professional growth and failing to address poor patient care within the intragroup, which may have resulted in this poor patient

management not being identified and rectified (Reader & Gillepsie, 2013). Unlike Merril and Miller (2015), Zeinhom and Higazee (2015) discovered that inter-professional conflict may exist between physicians and nurses due to: hierarchy and power, role boundary concerns, and unaccountability for their actions. The only common cause of inter-professional conflict between social workers with nurses and physicians as well as between physicians and nurses was that of hierarchy and power (Merrill & Miller, 2015; Zeinhom & Higazee, 2015). This may be due to physicians being considered to be in a dominant profession and the rest of the professions feeling intimidated to communicate their concerns with physicians' patient management (Zeinhom & Higazee, 2015; Merrill & Miller, 2015). Reasons as to why social workers experienced conflict with physicians and nurses include: systematic conflicts, conflicts on interests, and others are reflected in Figure 2.8.

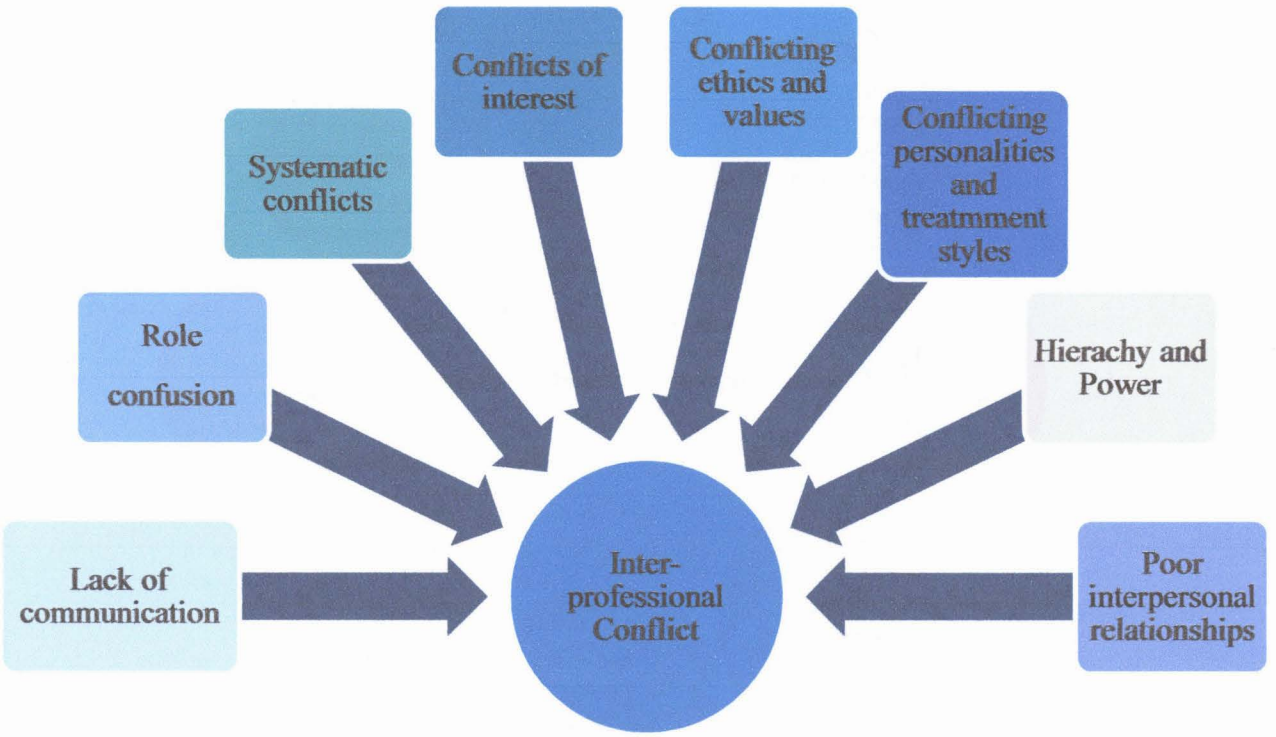


Figure 2.8. Sources of inter-professional conflict among HCPs as per Zeinhom's and Higazee's (2015) as well as Merrill's and Miller's (2015) studies.

Inter-professional conflict seemed to also exist between hospital chaplains and other HCPs Atherstone (2011) stated that early medical practices placed more emphasis on spiritual relief rather than physical relief. However, with advances in the medical field and its success in curing diseases, there has now been a divide between religion and medicine as medicine tends to focus more on the conquering the suffering than on the sufferer. Therefore, hospital chaplains seem to have difficulty finding their professional identity within the medical field.

Furthermore, Gardner (2005, p.3) proposed ten "lessons" (Figure 2.9.) to aid in mitigating the risk of conflict within collaborative partnerships so that successful collaborative practice is ensured relationships within teams . These "lessons" are outlined in Appendix B.



Figure 2.9. Ten Lessons of Successful Collaboration as proposed by Gardner (2005).

Another way to resolve inter-professional conflict may be due to collaborative education. Field (1997) suggested that collaborative education and training between HCPs may improve their ability to interact and collaborate with each other. Furthermore, collaborative education and training may also improve HCPs' efficacy in providing EOL care to patients. Nurses who completed modules in clinical psychology, found that this module allowed them to better understand human behaviour, mental conditions, and factors associated with medicine and cognition. This may be due to clinical psychology being an integration of emotion, intellectual, biological, cognitive, social, and behavioural facets of human function across cultures and socioeconomic levels (Wahass, 2005)

2.5.5. The influence of the nature of patients' deaths on HCPs' encounters with patient deaths. According to Balk (2014), it is commonly thought that anticipated death is easier for bereaved individuals to cope with than sudden death. Malkinson, Robin, and Witzum (2000) confirmed this belief, by concluding that sudden death patient death tends to have a greater impact upon the HCPs and their ability to come to terms with loss as opposed to when their patients' deaths were expected. This thought was further confirmed by Wojan (2006) who explored whether or not sudden versus anticipated death had an impact on how STs dealt with the death of patients. She found that sudden death appeared to yield greater physical and emotional responses among STs than anticipated death. For example, STs reported that they had experienced depression when their patients passed on unexpectedly and only felt sadness during instances of anticipated death.

This may be due to the concept of anticipatory grief, which was proposed by Lindermann (1944). Anticipatory grief may be defined as grief which individuals experience prior to experiencing a loss. It is said to be marked by feelings of guilt, confusion, disappointment, sadness, and desperation (Balk, 2011; Miller & Segal, 2010; Rolland, 1990).

Some authors refuted the existence of this phenomenon by stating that grief can only occur after a death (Glick, Weiss & Parkes, 1974; Parkes & Weiss, 1983; Silverman, 1974). However, those who believed in this notion stated that anticipatory grief reduces grief reactions prior to the loss, as it acts as a forewarning and allows for the individual to prepare for the social adjustments that are to come after the death (Margolis et al., 1988; Zielberfein, 1999). However, researchers such as Clayton, Halikas, Maurice and Robins (1973) found that anticipatory grief actually resulted in poor bereavement outcomes among widows and widowers. This may be due to these widows' and widowers' partners experiencing prolonged illnesses., Gerber, Rusalem Hannon, Battin and Arkin (1975) found that in instances where individuals experienced extended illnesses (over 6 months) it resulted in their partners having difficulty adjusting to their bereavement despite having experienced anticipatory grief.

Additionally, although Wojan (2006) aimed to explore the emotional and physical responses of STs to the deaths of paediatric and adult patients, she did not achieve this aim. However, Wojan (2006) provided evidence which suggested that STs are most likely to experience the death of an adult patient as compared to a paediatric patient, but did not provide reasons as to why this occurs. A possible reason for this occurrence may be due to the participants in her study being employed at long-term care facilities which serve much of the adult population (Toner & Shadden, 2012). Nonetheless, Wojan (2006) stated that STs who participated in her study presented with the following emotional reactions when loosing patients to death: detachment, depersonalization, sense of inadequacy, anger, decrease in work performance, sadness, frustration, depression, and anxiety.

Reynolds (2006) discovered that when medical practitioners experienced the loss of a paediatric patient they tended to question the quality of care provided to this patient. This may be due to these professionals believing that paediatrics are not supposed to be faced with

death as they have not had the opportunity to experience life (Wolfram, 2015). If this is true, then these HCPs may have employed jeunism, which is a form of ageism that favours young individuals and discriminates against the elderly (Bryan, 2014). Furthermore, Kübler Ross (1969) noticed that HCPs tended to shorten their treatment sessions and ward rounds when patients and their families were experiencing denial and anger. This practice is referred to as therapeutic nihilism, which may be conceptualised in terms of effort justification. Effort justification stems from the theory of cognitive dissonance, and is described as justifying the amount of effort being placed in achieving an outcome in terms of how great and favourable the outcome is (Festinger, 1957; Aronson & Mills, 1959). Therefore, these HCPs may have not necessarily placed effort in ensuring improved QoL of patients nearing the EOL, which some may argue is unjust. HCPs may have displayed therapeutic nihilism due to them developing learned helplessness. A concept proposed by Seligman (1967) who stated that uncontrollable events can weaken organisms, as they trigger submissiveness and passivity among organisms who are exposed to repeated trauma, as well as organisms failing to learn that responding to trauma can alleviate the emotional stress associated with the trauma. This interpretation is confirmed by Huffman and Stern (2003) who stated that individuals may feel helpless if they are unable to cure their patients. However, this was refuted by Bam and Naidoo (2014) who stated that despite nurses being aware of the reality of mortality among patients with Human Immunodeficiency Virus (HIV) and AIDS and them being overwhelmed by caring for these patients, they still went the extra mile to care for these patients thereby displaying discretionary effort.

Not being able to cope with death and dying, and avoiding patients who are terminally ill and their significant others may have had adverse emotional consequences on HCPs and affected the quality of care which they provided to these individuals (Wolfram, 2015). Due to medical practitioners not being emotionally prepared to deal with death, they may encounter

difficulties in displaying consoling presence. Therefore, hindering these patients psychological and emotional distress from being reduced (Tornøe, Danbolt & Kvigne & Sørlie, 2014 Reynolds, 2006; Wolfram, 2015).

2.5.6. The influence of personal loss on providing EOL care and being exposed to patient death. Personal and previous experience with death is presumed to provide fewer adverse reactions among bereaved individuals. Rivers et al. (2009) who explored student ST/As' perceptions regarding patient death found that although some students had experienced personal loss, they appeared to be inadequately prepared for patient death. In fact, they reported that they felt unprepared to deal with death and dying related issues in their practice (Rivers et al., 2009). However, in the same token, none of these students in reality had experienced a death of a patient (Rivers et al., 2009). Therefore, their perceptions of being inadequately experienced to cope with patient death and dying may not accurately reflect what would occur during the actual event. Unlike the deductions made by Rivers et al. (2009), Wojan (2006) concluded that through experiences of death outside of the workplace, such as the death of close relative or acquaintance, STs appeared to be better in overcoming the death of their patients. For example, one ST who participated in Wojan (2006, p.44) study wrote "After the death of my mother, I viewed death and the dying process with more understanding and acceptance. And I hope I have been able to assist my patients and their families understand it better also." The concept of the triangle of countertransference can possibly be applied to this participant's reports and it may have allowed her to psychological prepare herself for patient death.

Freud (1959) defined countertransference as the unconscious process whereby psychoanalytic therapists redirect their feelings onto their patients. Therefore, countertransference is considered to be a barrier in the psychoanalytic treatment process.

However, Heimann (1950) and Little (1951) refuted this claim by stating that countertransference appeared to cultivate empathy among therapists. Katz (1990) agreed with these authors and stated that countertransference is a critical factor in therapeutic relationships. Katz (1990) used helping professions who worked with the aging, dying, and individuals with disabilities, as an example. Katz (1990) stated that there is a link between these professionals own aging process, these professionals' significant others' aging process, as well as patients' aging process. This creates a triangle countertransference (Figure 2.10.) among these individuals. Katz (1990) added that this phenomenon allows helping professionals to become more effective helpers. It also seemed to help provide helping professionals with insight into their own and their significant other processes. Therefore, Katz (1990) concluded that the concept of countertransference allows individuals to face their emotional reactions and thus can engage in fruitful interactions, which yields personal and professional growth.

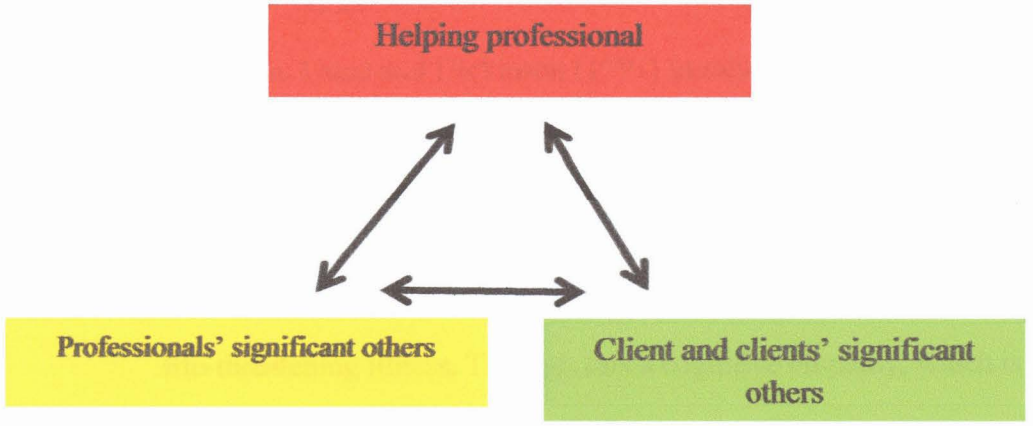


Figure 2.10. Triangle of countertransference as proposed by Katz (1990).

2.5.7. The need for pre-professional training for HCPs regarding patient death and dying. It seems that it's not only the ST/As Rivers et al. (2009) who felt poorly prepared for approaching patient death and dying (Rivers et al., 2009), but also other HCPs have reported gaps in their undergraduate, postgraduate, and continuous education programmes regarding the provision of EOL (Field, 1997). Field (1997) blames the medical education community for this, as he seems to feel that the community creates an ideology among student HCPs that death of patients is a failure.

The American Board of Internal Medicine (ABIM, 1996) has now identified this deficiency in HCPs' undergraduate training, and together with Field (1997) have provided suggestions in addition to instruction on EOL care on how the medical education community can better prepare HCPs for approaching terminally ill patients:

- Student HCPs require 'role-models' who specialise in palliative care such as MDT consulting teams, to guide them in providing EOL care to terminally ill patients. Interacting with patients who are nearing the EOL may also aid in preparing HCPs for providing palliative care services to these patients. A study conducted by Mermann, Gunn and Dickinson (1991) involved student medical practitioners being paired with terminally ill patients. These terminally ill patients were required to relay their encounters with interacting with student physicians and were required to inform these students about their experiences with living with a life-threatening illness. Through this a cognitive empathy, which is the ability to understand the emotional state of others (Omdahl, 2014), as well as a compassionate sense of wonder may have been created among HCPs. The latter is a notion of compassion that develops with time as a sense of wonder (Lally, 2018). This is a fairly new concept which is being applied to children socialising with others (Lally, 2018). Furthermore, providing EOL care to terminally ill

patients and interacting with these patients' significant others may make student HCPs aware of the dying process and it may familiarise them with how to manage terminally ill patients and their significant others. Therefore, hospice rotations and working within ICU settings are recommended. These settings are considered to provide student HCPs with increased opportunities to encounter terminally ill patients and these patients' significant others.

- A possible limitation of Mermann et al. (1991) is that HCPs did not have an opportunity to share their encounters with terminally ill patients with their peers. Sharing narratives of experiences with patient death and dying may provide a rich insight to grief and encounters with loss.
- Role-playing is said to form part of the educational curricula possibly because of its success in familiarising student HCPs on how to approach situations in reality. For instance, Tolle, Cooney and Hickam (1989) noted that when student HCPs' acted as residents informing patients' significant others of the patients' deaths, it seemed to prepare student HCPs with providing social support to patients' significant others.
- Working with simulated patients have also shown to increase HCPs' awareness to patients' concerns, and have fostered these students' skills in managing these patients, without exposing them to 'real' patients.
- Morbidity and mortality conferences, mourning reports, and ward rounds have also shown to aid students in developing and re-enforcing skills in providing EOL care to patients. These discussions may provide student HCPs with the chance to gain strategies for managing terminally ill patients' symptoms as well as provide them with the opportunity to communicate with these patients these patients' significant others.

Perhaps these suggestions made by Field (1997) should be provided in line with Vygotsky's (1978) zone of proximal development (ZPD). Vygotsky aimed to describe the current level of development of a learner and the use of joint collaboration with skilled individuals to help the learner in attaining to the next skill and knowledge level (Vygotsky, 1978). Through this collaboration, skilled individuals could scaffold learners (Wood, Ross & Breuner, 1976) so that they will be able to conceptualise knowledge on new concepts and acquire new skills (Vygotsky, 1978). Once the task is completed jointly, the learners should be able to complete the task independently (Vygotsky, 1978). Therefore, if these student HCPs are scaffolded by 'learned' individuals such as, terminally ill patients and their significant others, palliative care specialists, and supervisors who have provided EOL, they may be effective in providing this service to patients who are nearing the EOL as well as caring for these patients' significant others. Perhaps these skilled individuals may also serve as role-models to HCPs. Therefore, through vicarious learning regarding EOL, which is HCPs observing these skilled individuals providing EOL services to patients may improve HCPs' self-efficacy in providing this service (Bandura, 1994).

Practice guidelines, decision support systems, and symptom assessment tools may also aid student HCPs in providing evidence-based care and quality of EOL care.to patients (Field, 1997). Furthermore, continuing professional education and development has shown to improve professionals' self-efficacy as it facilitates skills and knowledge development (Continuing Professional Development [CPD], 2014). Field (1997) seemed to further suggest that continuing professional education programmes need to also be strengthened, by providing demonstrations, lectures, and self-learning programmes on how HCPs need to approach patients who are nearing the EOL (Field, 1997).

The recommendations made by Field (1997) may lead to mastery experience, in terms of HCPs providing EOL care to terminally ill patients and patients' significant others.

According to Bandura (1994), mastery experience occurs when individuals are successful in fulfilling a task. This may motivate them to complete a similar task and thus boost their self-efficacy (Bandura, 1994). However, possible limitations of the recommendations made by Field (1997) are that these suggestions focus more on providing EOL care rather than tackling patient death.

It is clear from the above discussion of the literature that HCPs may display grief when encountering terminally ill patients or when losing a patient (Sansone & Sansone, 2012). A number of psychological and contextual factors may affect HCPs' grief responses (Sansone & Sansone, 2012). Effectively overcoming this grief possibly through pre-professional training may reduce the emotional demands of clinical practice as well as the risk for professional burnout (Sansone & Sansone, 2012).

2.6. HCPs' who Practice in SA Confrontations with Loss

With a rate of 512 deaths per 100000 people, SA is said to possibly have one of the highest mortality rates in the world (Holtz & Elsway 2016). Tuberculosis is said to be the leading cause of death followed by pneumonia and influenza as well as HIV (Statistics South Africa [STATS SA], 2017). Other diseases which rank in the top ten leading causes of death in South Africa include: Cerebrovascular disease, diabetes mellitus, cardiac conditions, hypertensive diseases, intestinal infectious diseases, other viral diseases, and chronic lower respiratory disease (World Health Organization [WHO], 2016). Another contribution to South Africa's high mortality rate is road fatalities. According to the WHO (2016), South Africa accounts for more than half of Africa's motor vehicle accidents. Additionally, South Africa appears to lead the world in the terms of having the highest number of assault related deaths (Radebe, 2014).This may be due to South Africa ranking as the second highest county in the world for having gun-related deaths (Writer, 2015).

Given the high mortality rate in South Africa, HCPs may be frequently faced with death and dying. However, most of the research in South Africa explores HCPs' confrontations with AIDS-related loss. Findings from these research studies appear to be consistent with the international literature which explores various HCPs' reactions to death and dying. For instance, a research study conducted in Kwa-Zulu Natal which explored HCPs' experiences related to AIDS-related loss also discovered that these professionals had encountered challenges in assisting AIDS infected patients, as they were unable to cope effectively with their own bereaved feelings (Demmer, 2006). These professionals also felt that they were unprepared to deal with death and dying. Demmer (2006) discovered that HCPs who were exposed to on-going deaths appeared to have experienced burnout. As a result some of these professionals also reported that they could not foresee themselves working in their career field for much longer (Demmer, 2006).

Unlike the discoveries made by Demmer (2006), Bam and Naidoo (2014) found that nurses who provided long-term care to HIV-infected patients became more conscious of their own death while caring for these patients, and this assisted them in being more sensitive, compassionate, and it also increased their dedication to care for these patients.

These conclusions are particularly important for HCPs, such as ST/As who practice in South Africa. Due to the high mortality rates in South Africa, HCPs will most likely be faced with patient death and dying at some point in their careers. However, does this mean that ST/As are more likely to experience death anxiety due to being repeatedly exposed to death? This is the one of the many facets which this dissertation aims to explore, especially since some ST/As may choose the profession thinking that they may not be exposed to death, but their career paths may lead them to experience otherwise (Toner & Shadden, 2012).

2.7. HCPs' Encounters with Significant Others of Patients who are faced with Death and Dying

According to Kübler-Ross' (1969) observations she noted that terminally-ill patients' significant others appear to encounter similar stages of grief as patients. HCPs play an important role when caring for the bereaved significant other pre- and post-death of a patient (Osterweis, Solomon & Green, 1984). HCPs' sincerity and consideration towards patients and patients' significant others may aid the bereaved in coping with their grief (Kübler-Ross, 1969). A common barrier which hinders the facilitation of this form of FCC within palliative care is poor communication between HCPs and patients' significant others as well as family ruptures and separations. This may result in a lack of social support being provided.

2.7.1. Communicating with bereaved significant others. Warnock, Buchanan, Tod, Soreny and Foster (2017) aimed to investigate the experiences of nurses, medical practitioners, and allied HCPs when communicating bad news to significant others of patients who were terminally ill, and they developed a model based on the barriers experienced by HCPs. The model includes four categories: situational, organizational, patients and relatives, and individual factors (Warnock et al., 2017). This model is explained in Appendix C.

From the discussion of Warnock et al's. (2017) study, there is no doubt that breaking bad news to patients' significant others are daunting tasks for HCPs. However, distress from both HCPs and patients' significant others may result in bad news being communicated ineffectively (Campbell, 1995).

2.7.2. Providing social support However, how much truth is there in the claim that due to a lack of training, education, and expertise in knowing how to inform patients' significant others of patients' deaths, or knowing how to respond to the death of patients results in HCPs experiencing difficulties in supporting these patients' significant others? This

question was posed, as Cortezzo, Sanders, Brownell and Moss (2015) who discovered that despite HCPs expressing a high confidence level and adequate training in providing EOL care to newborns, parents felt abandoned at the time of death. These parents reported the need for follow-up appointments after the death of their newborns, and required bereavement support through debriefing and closure conferences (Cortezzo et al., 2015).

Social support is considered to be beneficial to an individual's emotional, physical, and mental health (Reblin & Uchino, 2008). Social support has shown to mitigate the effects of the bereaved significant others at the time of death. It offers a shield against loneliness (van Baarsen, 2002). Kaunonen (2000) examined the impact of social support on the grief reactions of the deceased patients' significant others. Nurses who participated in this study provided social support through a supportive telephone call to patients' significant others, after the patients' deaths. Therefore, these significant others' encountered emotional and information support from nurses. This provided the patients' significant others with an opportunity to discuss the patient, the death, and their grief. Those significant others who did not receive a call displayed disappointment (Kaunonen, 2000). Another study which explored the strategies that nurses employed to support terminal ill patients' significant others found that the majority of nurses who avoided discussing EOL care decisions led to these significant others perceiving these nurses as being uncaring, unprofessional, and distrustful. Whereas, those nurses who employed a utilitarian approach when providing EOL care, it assisted patients' significant others in accepting the patients' inevitable deaths (Adams et al., 2014).

2.7.2.1. definitions of social support. There appears to be no established definition of social support in the literature. These definitions will be explored in Appendix D. A more comprehensive and inclusive definition of social support is offered by Gottlieb (2000) will be

used to define social support in this dissertation. Gottlieb (2000) stated that social support is the process in which interaction in relationships cultivates: coping, esteem, belonging, and competence through the exchange of physical or psychosocial resources as well as provides emotional and spiritual self-nurturance (Nemcek, 1987). This definition suggests that communication creates an effective support system whereby two individuals can exchange physical and psychosocial resources between them (Matson & Hall, 2011). If the exchange of these resources is successful in addressing the social recipients' needs then a person-environment fit is created (Schumaker & Brownell, 1984). Communication can also allow individuals to cope with situations. It ensures that they feel cared for and improves their self-efficacy when they are required to perform tasks.

This definition seems to be more of an inclusive definition of support as it focuses on the support resources, type, and nature of social support (Williams, Barclay & Schmied, 2004). However, it should be remembered that this definition does not necessarily include the notions of time, intentionality of support, perception of social support, and characteristics of the social support recipient and providers, all of which need to be included when conceptualising social support (Williams et al., 2004) . Therefore, I have referred to social support theories to account for the gaps in the definition of social support.

Schafer, Coyne and Lazarus (1981) described five types of social support as outlined in Figure 2.11.:

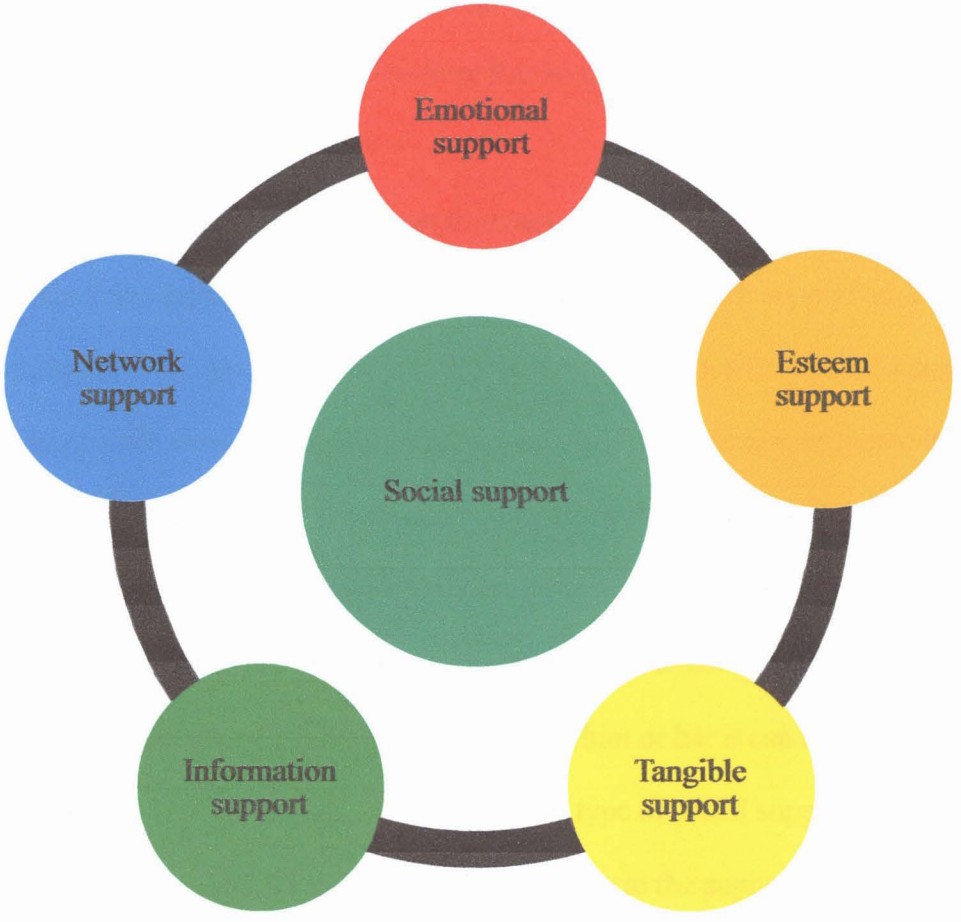


Figure 2.11. Types of social support.

The first type of social support is emotional support which relates to expressions of care, concern, sympathy, and empathy (Schafer et al., 1981). The aim of emotional support is to boost an individual's mood (Matson & Hall, 2011). Although not encapsulated in the definition of emotional support, but based on the description of emotional mimicry. This is the mirroring of emotions between two individuals, it may be assumed that emotional mimicry in social interactions can modulate people's affect (Hess & Fischer, 2014). The same may apply to the concept of emotional contagion, which is the contracting and allowing other's emotions to trigger your emotions (Planalp, 2001).

The next type of social support is esteem support which reaffirms the individual's self-esteem. This reaffirmation which is a form of verbal persuasion may also uplift

individuals' self-efficacy (Bandura, 1994). This type of support involves the support provider advising and encouraging the support receiver that he or she has the ability to tackle difficult situations (Schafer et al., 1981).

On the other hand, network support does not place emphasis on emotions and self-concept as the aforementioned types of support do, instead network support addresses the need of belonging to a supportive network (Schafer et al., 1981). Members of a supportive network may provide various types of social support, but the main aim of network support is to ensure that individuals are not abandoned in situations (Matson & Hall, 2011).

Another type of social support is information support which is communicating information (Schafer et al., 1981). If an individual does not know the details of a situation that he or she is faced with or the options available to him or her it can lead to the individual experiencing stress (Matson & Hall, 2011). The final type of social support is tangible support and is defined as physically providing assistance to the support provider (Ko & Wang, 2013).

The section below discusses theories which may explain why social support yields positive outcomes, such as adjusting to and coping with the loss of patients.

2.7.2.2. stress-buffering hypothesis. The stress-buffering hypothesis proposed by Cohen and Hoberman (1983) explained that social support can reduce stress. For the purpose of this study, stress may be broadly defined in accordance of the psychological definition of stress. Cohen and Wills (1985) stated that stress occurs when one perceives and experiences a situation as threatening, demanding, strenuous, and does not have the appropriate coping mechanisms in place to overcome this type of situation.

Cohen and Wills (1985) further developed the ideology of social support being a buffer against stress and found that stress may be mitigated when the support provider

provides support that addresses the emotional needs of the recipient. Therefore, Cohen and Wills (1985) provided evidence which suggested that the quality of social support is more important than the features of social support, such as the validity of the information provided. This is unlike social integration theory which maintains that the effectiveness of social support is based on the number and size of social relationships.

Turber-Cobb, Bloor, Wittemore, West and Spiegel (2006) investigated the relationship between the family history of breast cancer and psychological distress. Turber-Cobb et al. (2006) hypothesised that a social support network may help mediate the relationship between stress and losing a loved one to breast cancer. Their hypothesis was proved to be correct. Their findings indicated that positive and strong social support networks alleviated the prognosis of an individual's cancer diagnosis and future risk of developing cancer.

The stress-buffering hypothesis model explains how emotional support can reduce stressful events, but does not focus on how social support can mitigate stressful perceptions (Swartwood, 2014). This may be due to the lack of empirical evidence on how social support can serve as a buffer against stress (Cohen & Pressman, 1994).

2.7.2.3. relational regulation theory (RRT). RRT is a fairly new theory proposed by Lakey and Orehek (2011). The aim of this theory was to develop the link between social support and the emotional well-being of an individual. Lakey and Orhek (2011) stated the following eight key principles underpin RRT:

- Principle One: Support recipients are able to modulate their affect, action, and thought processes through social interaction.
- Principle Two: Through social relations the support recipients' affect, action, and thought processes can be regulated. This suggests that in order for social

support to have a positive influence on the support recipient, the recipient must choose the support provider.

- Principle Three: "Relational regulation occurs primarily in an ordinary yet affectively consequential social interaction" (Lakey & Orhek, 2011, p. 487). Social support can also be provided during any social interaction.
- Principle Four: RRT infers that relation regulation occurs through shared experiences and conversations. This principle suggests that support providers who understand the social recipient's interests, activities, and cognitive contexts are considered to be effective support providers. In correlation with this principle, Vaux (1990) showed that shared stressors may foster social support. Furthermore, the support recipient needs to determine how interactions with the support providers should take place in order for the desired affect, behaviour, and cognition to be obtained.
- Principle Five: Social support may be discerned based on relational regulation of the affect through ordinary interactions but also through enacted support. A support recipient may casually interact with a potential support provider to gage how supportive the provider may be. If the support recipient considers the provider to be effective then the support recipient may seek support from the provider during distressing events.
- Principle Six: Relational regulation is a dynamic and active process whereby the support recipient changes his or hers perception of the support provided in order to regulate his or her affect. Therefore, if a support recipient no longer considers the provider to be supportive, he or she will adapt by either changing the provider, activity or topic to regulate his or her mood. This may be due to factors proposed by Vaux (1990), such as conflict. Conflict may disrupt

relationships between the social support receiver and the potential social support provider. Therefore, the social support recipient may no longer consider the potential support provider as being effective in providing him or her with social support.

- Principle Seven: Social support interventions are regarded more effective if they produce relational regulation. Therefore, the ideal form of social support is intimate, and represents companionships and positive emotional well-being.
- Principle Eight: The greater the diversity of the potential support providers the greater the probability is for the support recipient to regulate his or her affect, behaviours, and cognition. This principle contests to the claim made by Vaux (1990) - the greater the array of support providers that the support recipient soughts after, the greater the likelihood of the aim of social support being fulfilled.

Since, RRT is a relatively new model of social support, there is a lack of empirical evidence. Although, RRT explains how relationships can regulate social support and well-being, it is difficult to determine the positive and negative effects of this theory. Therefore, Swartwood (2014) recommended that these characteristics should be individually investigated to determine their effects on social support.

Until now, the theoretical underpinnings and research studies discussed have focused on the implications of social support on the recipient and hardly on the social support provider (Brown, Nesse, Vinokur and Smith, 2003). Shumaker and Brownell (1984) stated that providing emotional support may be emotionally exhausting. Other costs which social providers may incur are the burden of providing tangible resources, such as finances. As a result of the physical and emotional exhaustion, support providers may experience depersonalization (Shumaker & Brownell, 1984). This may threaten the effectiveness of the

social support being provided. Depersonalization may result in the provider withdrawing from the relationship with the recipient, as well as the provider displaying a negative attitude towards the recipient. This can lead to negative social support, as pointed out by Ray and Miller (1984).

Although social support may be costly, there are benefits in providing social support, such as creating mutually nurturing relationships between the support recipient and provider. Boston, Fultz and Schoenader (1984) explain that because the provider is aware that he or she may have a positive influence on the recipient's life he or she may feel fulfilled and self-validated. Additionally, social support can lead to improved self-efficacy and resilience. Through vicarious experience they can develop coping mechanisms to overcome difficult situations (Shumaker & Brownell, 1984)

Furthermore, Hahn (2000) as well as Stephens and Long (2000) found that emotional support can have negative effects on the social recipient because it tends to pay heed to the negative effects of a situation. Furthermore Ray and Miller (1994) stated that social support may have negative effects if support recipients incur social undermining due them having a tensed relationship with the support provider. This is why, as suggested by principle 2 of RRT, for social support to effectively regulate affect, behaviours and thoughts, the provider must be chosen by the support recipient (Lakey & Orhek, 2014).

2.8. Biographical Factors Influencing Responses to Loss and Grief

A number of factors (Figure 2.12) may impact individuals' responses to death (Snyder et al., 2014). These factors include but are not limited to: age, gender, ethnicity, and spiritual beliefs (Snyder et al., 2014).

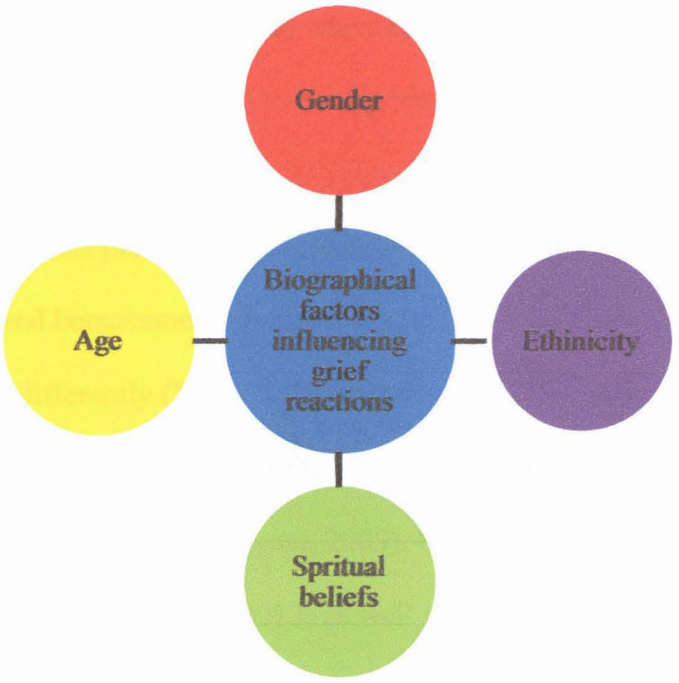


Figure 2.12. The biographical factors suggested by Snyder et al. (2014) which may impact on individuals' grief processes.

2.8.1. Age. It has been suggested that age appears to affect individuals' understanding and reaction to death (Snyder et al., 2014). Experiences of loss appeared to have increased individuals' understanding and acceptance of death (Snyder et al., 2014). As individuals age, death may be considered to be a normal occurrence. However, this does not necessarily suggest that early- and middle-aged adults find it easy to cope with death, but their responses to death may be influenced by their previous experience with loss.

Wojan (2006) discovered that the age of STs related more to the number of deaths they had experienced in their clinical practice. For example, STs with more clinical experience (approximately 7 years of experience) appeared to find death less difficult to come to terms with as compared to STs with less clinical experience (1 year of experience) (Wojan, 2006). Snyder et al.'s (2014) may state that these STs' frequent exposure to death may have increased their understanding of death. Similarly, a study which explored nurses' responses to patient death, found that nurses who were younger and less experienced

appeared to display high levels of anxiety when experiencing the death of a patient as compared to slightly older nurses with more experience (Braun et al., 2008).

2.8.2. Gender. As previously mentioned, it is believed that gender does have an influence on grief and bereavement, as men and women may experience and express grief and cope with loss, differently (Yoost & Crawford, 2015). This is thought to be due to societal stereotypes which may have resulted in them perceiving themselves and their roles in different ways (Corr & Corr, 2013; Bryant, 2003). In other words, this may have contributed to participants in Corr 's and Corr's (2013) as well as Bryant's (2003) studies displaying social desirability. Women tended to express their grief, whereas, men tended to suppress their grief in order to hide their vulnerability (Corr & Corr, 2013; Bryant, 2003) It must be remembered though, that individuals of both genders have different backgrounds, personalities, and lifestyles which may have influenced their grieving style (Corr & Corr, 2013).

Despite these theories, literature states that irrespective of a medical practitioner's gender he or she may react to death similarly and tend to offer the same amount of support to patients' significant others (Weiss & Lonnquist, 2015). Similarly, research studies which have explored other HCPs, such as, STs' reactions to death, found that gender had made no difference as to how these professionals reacted and coped with death (Wojan, 2006). However a study which explored physicians' grief, discovered that female physicians required more emotional support than male physicians in the aftermath of a patient's death (Sansone & Sansone, 2012).

2.8.3. Ethnicity and spiritual beliefs. Additionally, Wojan (2006) investigated whether or not STs' ethnicity influenced their reactions and coping mechanisms towards

death and dying. She found that their level of spiritual belief outweighed the influence of ethnicity on how STs' responded and coped with the death and dying (Wojan, 2006). This correlates with the conclusion made by Snyder et al. (2014) who concluded that spiritual beliefs greatly influenced individuals' reactions to death and their subsequent behaviour. This will be discussed in further detail under the section which explores the coping mechanisms employed by HCPs' to overcome patient death.

2.9. Coping mechanisms employed by HCPs to aid them in overcoming the death of their patients

From the literature reviewed it is clear that HCPs may have to deal with patient death and dying in their careers. Therefore, they need to use several strategies for dealing with their emotional responses to patients' deaths. Furthermore, experiences with patient death and dying may threaten HCPs' work performance, engagement, and self-efficacy given the negative somatic and emotional states which are associated to these events (Bandura, 1994). Therefore, Vinje and Mittlemark (2007) suggested a self-tuning process to ensure self-care among HCPs. This process is comprised of introspection, sensibility, reflection, and active coping. A limitation of this model is that it focuses mainly on how HCPs can maintain their job engagement under challenging conditions, rather than aiding them in regulating their affect, especially in instances of grief.

The mediating process of self-care is characterised by introspection, sensibility, and reflection (Vinje & Mittlemark, 2007; Bakibinga, 2013). These components identify challenges within individuals' work environments and through this process individuals discover active coping mechanisms in order to overcome these challenges. There are several active coping mechanisms which may not only allow HCPs to retain their job engagement, but may also help them to deal with their emotional responses to patient death. Kuo (2014) found that active coping mechanisms may not only have assisted individuals in adapting to a

situation, but also ensured their emotional well-being. This is unlike negative coping mechanisms, which is a passive form of coping. These types of mechanisms may provide some relief, but may still impact other areas of individuals' lives (Roter, 2017).

2.9.1. Self-nurturance. Langdon and Langdon-Starr (as cited in Papir-Bernstein, 2018; p. 294) and the Substance Abuse and Mental Health Services Administration (SAMHSA, 2016) in their guidelines recommended that professional burnout can be prevented by "nurturing your mind, body, spirit, and emotions". In order to maintain and nurture this biopsychosocial-spiritual notion within ST/As, Papir-Bernstein (2018) and SAMHSA (2016) advised that HCPs maintain a work-life balance. Key features of self-nurturance are feelings, attitudes, behaviours, and substances that facilitate growth within individuals (Nemcek, 1987). Self-soothing, shame reduction, and self-enhancement behaviours, which are key components of self-nurturance, seem to nurture self-esteem in individuals who are emotionally sensitive. Self-soothing and shame reduction go hand-in-hand and involve self-talk-an internal monologue which assists in individuals tackling situations (Gibson & Forster, 2007; White, 2008). Therefore, self-talk is closely linked to self-reflection, which is synonymously referred to as quiet reflection. Self-reflection is when individuals focus their attention on themselves and conduct an internal examination of their thoughts, feelings, beliefs, and behaviours (Rew, 2009). Therefore, self-reflection speaks to the cognitive aspect of self-nurturance (Nemcek, 1987, Langdon & Langdon-Starr, 2014). On the other hand, Ramsay (2010) states that self-enhancement is fostered through individuals participating in pleasurable activities and displaying their self-worth. Relaxation and physical activities such as leading a healthy lifestyle may be an example of self-enhancement which links to the physical aspect of self-nurturance (Nemcek, 1987, Langdon & Langdon-Starr, 2014).

Niederriter (2009) who aimed to investigate nurses' perceptions of death and dying, found that one of the coping mechanisms that nursing students employed was crying. Gračanin, Bylsma and Vingerhoets (2014) considered crying to be self-soothing as it improves individuals' moods. One student nurse, who shared her experience with patient death on Pamela's (2015) blog reported that during one of her clinical practicals she had lost a patient and was so distraught by the situation that she cried at the patient's bedside. Although this caused her to feel more overwhelmed, she was supported by her supervisor who allowed her to cry (Pamela, 2015). However, others may view crying as being unprofessional behaviour (Pamela, 2015). For instance, a physician had cried after losing a patient, her supervisor considered this to be unprofessional behaviour (Pamela, 2015). Does this suggest that HCPs are not allowed to grieve? Have we forgotten that individuals may bond through shared grieving? For instance, Wagner, Hexel, Bauer & Kropiunigg (2000) discovered that when HCPs cried on the job it served as them identifying the suffering experienced by the dying patient, and resulted in them bonding with the patient and the patient's significant others.

2.9.2. Letting go. Pargement and Rye (1998) advised individuals to 'let go' of encounters and negative feelings which contribute to life stress. Bakibinga (2013) recommended that individuals need to first accept the reality of a difficult situation, and work through the critical features that make the experience difficult. This may enable them achieve peace of mind (Bakibinga, 2013). In cases where nurses found themselves in situations which were beyond their control, they 'let go' of these situations (Bakibinga, 2013). This alleviated the risk of them experiencing helplessness (Bakibinga, 2013).

2.9.3. Gallows humour. Additionally, HCPs tended to use gallows humour as a coping mechanism to overcome a tragedy (Wojan, 2006; Reynolds, 2006). Gallows humour is considered to be humour that treats a sensitive subject like death and dying in a satirical way (Watson, 2011). Watson (2011) explored whether gallows humour in medicine is ethical or not. Watson (2011) discovered that gallows humour served as bonding and coping mechanism for HCPs as it assisted them in getting through a terrible event, such as death. Furthermore, HCPs who are frequently exposed to death and dying may experience high levels of stress and their stress levels may be buffered down with gallows humour or even using inappropriate phrases (Morris & Page, 2004; Boemer, 1998).However, Watson (2011) noted that it may be viewed as being unethical if gallows humour, which involves the patient's condition, is displayed in front of the patient as it has the potential to harm them (Watson, 2011).

2.9.4. Social support (informal debriefing). One of the commonly used coping strategies by HCPs in order to overcome grief is social support (Plante & Cyr, 2011). This may include HCPs debriefing to their colleagues, family members or friends (Plante & Cyr, 2011). With reference to the stress-buffering hypothesis, RRT, and from research studies such as those conducted by van Baarsen (2002), Finaly and Dallimore (2014), Kaumnen (2000), and Adams et al., (2014) it appears that social support can help individuals cope with loss. However, not all research studies have provided evidence which infer that social support has a positive effect on individuals affect, behaviour, and cognitions. Social undermining is a threat to the positive outcomes social support, as it yields psychological distress and induces stress (Vinokur & van Ryn, 1993). The following situations can lead to social recipients feeling socially undermined: misunderstood by the support provider, dysfunctional

relationship between the support recipient and provider, and lacking a diverse social support network.

Furthermore, Hahn (2000) as well as Stephens and Long (2000) found that emotional support can have negative effects on the social recipient because it attends to the negative effects of a situation. Furthermore Ray and Miller (1994) stated that social support may have negative effects because support recipients may incur social undermining due them having a tensed relationship with the support provider. This is why, as previously mentioned, for social support to effectively regulate affect, behaviours, and thoughts the provider must be chosen by the support recipient (Lakey & Orhek, 2014).

In the current digital age, individuals have adapted the ways in which they seek social support (Tsai, Crawford & Strong, 2018). One of these ways is using online support groups which are fostered through listserv and mailing lists (White & Dorman, 2001). These members communicate about a shared and specific topic which is usually health-related (White & Dorman, 2001). Through these group online support services, communities are formed through shared experiences and interests (White & Dorman, 2001). This may confirm the fourth principle of RRT (Lakey & Orhek, 2014).

Online support groups may allow for asynchronous communication as group members may access these support services at any time. Therefore, it does not take time away from their other responsibilities (White & Dorman, 2001). Furthermore, access to online social support services are not hindered by geographical and transportation barriers (White & Dorman, 2001). These groups allow for anonymity, which can mitigate the risk of discrimination and stigmatization (Ferguson, 1997). Therefore, group members, the social support recipients, may be more open to share sensitive and intimate issues (Ferguson, 1997). Although some researchers hypothesised that online social support services may be impersonal, their studies showed that these services cultivated social connectedness and

belonging (Ferguson, 1997). This in turn enhanced social health among individuals who sought out online social support services (Ferguson, 1997).

Online social support services may be fostered through social media. To date the research seems to have explored how blogging and Facebook have facilitated social support. Blogging is thought to be successful in providing and receiving social support, as individuals share common experiences (Tsai et al., 2018). Sharing experiences with others who may be in similar situations may reduce the risk of individuals feeling socially undermined, because there is a nuanced understanding among individuals about a particular encounter (Tse & Wan, 2011). Research has also shown that Facebook may be an effective platform to seek social support (Knowles, 2013). However, social support recipients tended to seek social support from social contacts who they shared meaningful relationships with (Knowles, 2013). This may be due to claims made by Vaux (1990) who stated that close relationships between social support recipients and providers may motivate social support providers to provide support to the recipients. The support bestowed on the recipient may be more effective as the social support providers may be more in-tuned with the social support recipients' needs (Jones, 2018).

2.9.5. Formal debriefing. Furthermore, half of the nurses who participated in Bickham's (2009) study reported that they did not feel the need for formal debriefing. They felt that debriefing occurs naturally by talking to colleagues which resulted in them unintentionally debriefing each other (Bickham, 2009). However, according to Reynolds (2006), registrars reported the need for formal support as they felt that their bereaved feelings were not taken into account after losing a patient. This structured debriefing is commonly referred to as psychological debriefing. It aims to alleviate the negative impact associated with exposure to critical incident stress such as patient death (Reynolds, 2006).

Much controversy exists in the literature as to whether or not debriefing is a successful technique in mitigating symptoms of PTSD. Rose, Bisson, Churchill and Wessely (2009) discovered that psychological debriefing among HCPs appeared to increase their risk developing PTSD. However, the methodology utilized by Rose et al. (2009) included intervention sessions for individuals who had experienced a recent traumatic event. It must be remembered that psychological debriefing models, such as the critical incident stress debriefing (CISD) model is not a treatment nor a therapy model; it is rather a formal and structured method of supporting individuals undergoing stressful events (Robinson, 2004). Furthermore, psychological debriefing sessions should occur within 72 hours after the incident has occurred (Mitchell & Everly, 2001). This results in less short- and long-term psychological consequences associated with a critical incident (Mitchell & Everly, 2001). However, participants in Rose et al. (2009) study only underwent intervention sessions a month after the traumatic incident had occurred.

Wojan (2006) also discovered that the least coping strategy employed by STs, is consulting with a psychologist or a counsellor, while most participants in her study used their religious and spiritual beliefs to overcome the death of their patients. Suzanne (2010) stated that HCPs are reluctant to acknowledge how taxing it is to practise in the medical field. Furthermore, HCPs may display public self-consciousness. This is attending to aspects of oneself that are observer-able to others (Gould & Barak, 1988). They may perceive themselves as being care-givers and not care-receivers, and may thus be apprehensive to consult with counsellors or psychologists (Suzanne, 2010). It must be remembered that the psychological state of HCPs may have adverse repercussions on them professionals and on the quality of care which their patients receive (Suzanne, 2010).

Although psychological debriefing after a traumatic event is thought to increase the risk of individuals developing PTSD (Rose et al., 2009), group debriefing such as CSID

allows for group members to share not only their perception of the critical event but also their own coping mechanisms can be shared with the rest of the group members (Hanna & Romana, 2007; van Wyk, 2011). Group debriefing within the work place may even reduce the risk of disenfranchised grief as it allows for employees to individually share their personal experiences with traumatic events. Furthermore, group debriefing is considered to boost employees work morale (Hanna & Romana, 2007). It has been suggested that it results in employees being freed from job stress which these traumatic experiences may have otherwise fostered (Hanna & Romana, 2007).

Therefore, despite the value of formal structured debriefing being questioned, the fact still remains that some form of debriefing is better than none. For instance, employee wellness programmes (EWP) foster health and well-being among employees, as it creates an awareness of these facets and allows for opportunities to seek counselling services (Universal Healthcare, 2018). Unlike, Rose et al. (2009), Navare (2008) concluded that counselling within an organisation, can equip individuals with managing their personal and work-related stressors. Researchers who hold the same opinion as Rose et al. (2009) may state that perhaps counselling services are more successful in reducing work-related stressors as opposed to personal issues.

2.9.6. Defence mechanisms. Coping mechanisms are considered to be conscious processes which individuals use to overcome difficult situations (Goldstein, 1995). Whereas defence mechanisms are unconscious tools which individuals use to fight against threatening situations (Goldstein, 1995). Furthermore, Table 2.1. highlights Kroeber's (1963) differentiation between defence mechanisms and coping mechanisms:

Table 2.1. Kroeber's (1963) comparison between defence and coping mechanisms.

Defence mechanisms	Coping mechanisms
Rigid and conditioned.	Flexible and involves options.
Conditioned by past experiences.	Motivated by future experiences.
Distort the reality of the situation.	Focused on solving the reality of the situation.
Uses primary process thinking and unconscious thinking processes.	Involve conscious and preconscious thinking processes.
Aims to remove the challenging effects of situation even if it's not completed in realistic ways.	Works through disturbing affects even if not all of the disturbances are mitigated.
Allows for delayed gratification.	Leads to instant gratification.

Sigmund Freud proposed the concept of defence mechanisms which his daughter Anna Freud later elaborated on (Freud, 2013). The ego-defence mechanisms were devised on the basis of how the ego tackled itself against internal situations such as, impulses which the ego viewed as being impermissible (Baumeister, Dale & Sommer, 1998). Freud (2013) proposed repression as defence mechanism, which is blocking disturbing situations out of the conscious mind. It differs from suppression, which involves consciously blotting threatening events out of the conscious process but still having an awareness of the events. Despite the conscious nature of suppression it still seems to be considered as a defence mechanism (Heather & Christol, 2009) as it inhibits anxiety-provoking thoughts, feelings and impulses (Haber & Runyon, 1978).

Freud (1936) offered the following defence mechanisms: regression, reaction formation, isolation, undoing, projection, introjection, turning against the self and reversal. These mechanisms are tabulated below in Table 2.2.:

Table 2.2. Description of the defence mechanisms proposed by Freud (1936).

Defence mechanisms	Description
Regression	Reverting to past behaviours which provided individuals with comfort.
Reaction formation	Transforming social inappropriate impulses into socially appropriate advances.
Isolation	Shunning away from the affect through repressing feelings triggered by a distressing event.
Undoing	Annulling a guilt provoking thought and behaviour.
Projection	Stereotyping others aids in avoiding self-recognition.
Introjection	Taking on characteristics of others to overcome emotional and psychological distressing events.
Displacement	Changing the target of the aggressive impulse.
Turning against the self	Substituting oneself to be the target of the negative impulse.
Denial	Refusing to perceive distressing occurrences in reality.
Sublimation	Matured mechanism which involves converting.

Given the high mortality rate in SA, HCPs who practice in SA may be required to provide EOL care and will most likely be confronted with patient death at some point in their careers. It is evident that patient death and dying may have adverse effects on HCPs' personal lives and professional careers. However, the result of these bereavement outcomes may be influenced by HCPs' demographics. Nonetheless, these professionals may employ coping

mechanisms, which vary from individual to individual following the death of a patient. Furthermore, from the literature review there appears to be sparse research exploring ST/As' encounters with death and dying. Therefore, this study aimed to contribute to this subject by investigating STAs' reflections on patient death and dying, their encounters with bereaved significant others of patients who are terminally ill or have passed on, as well as the coping mechanisms that these professionals utilise to conquer the negative effects of patient death.

CHAPTER 3: METHODOLOGY

3.1. Research Aims

3.1.1. Main aim. The main aim of the study is: To explore ST/As' experiences regarding patient death and dying.

3.1.2. Sub-aims. The three sub-aims of the study are:

- To describe ST/As' encounters with patient death and dying in light of theoretical models of grief.
- To investigate ST/As' experiences with patients' significant others who are faced with death and dying.
- To determine the coping mechanisms employed by ST/As to overcome the death of their patients.

3.2. Research Design

Methodologists have recommended that when aiming to obtain an in-depth understanding of participants' insights surrounding their experiences, a qualitative research design should be employed (Sutton & Austin, 2015). Additionally, qualitative research can allow researchers to describe individuals' beliefs, behaviours, as well as how individuals make sense of life events (Knudsen et al., 2012).

Furthermore when exploring experiences of research participants, narratives should be used (Rejnö, Berg & Danielson, 2013). Narratives may also explore participants' perceptions of their experiences (Rejnö et al., 2013). Additionally, narratives may depict a holistic view and a deep understanding of complex and multidimensional phenomena, such as death and dying (Hall & Powell, 2011).

Maple, Edwards, Plummer & Minichiello (2010) utilized narratives when exploring parental experiences of death by suicide of young adult children. They concluded that by employing a narrative methodology to their research study it allowed them to contextualize and personalize participants' narratives (Maple et al., 2010). Therefore, it seems that research which involves narratives cannot be generalised to the population being explored (Ziebland, 2013). Furthermore, they stated that using narratives did not only aid them in addressing the objectives of their study but also ensured that they were able to hear voices which may have otherwise remained silent (Maple et al., 2010).

Furthermore, Mattingly and Lawlor (2000) showed that narratives can be used to investigate practical reasoning, such as clinical reasoning in HCPs such as occupational therapists. Therefore, these authors concluded that narratives can allow for professionals to reflect on their practice.

Therefore, for the purpose of this study a qualitative research design was used to acquire narratives from the ST/As. This enabled me to obtain an in-depth understanding of ST/As' experiences concerning patient death and dying. Acquiring narratives also aided me in portraying participants' realities to a larger audience (Riessman, 2006). Furthermore, obtaining narratives assisted me in adding to the theoretical foundations of ST/As' experiences regarding patient death and dying (Clandinin et al., 2015). These narratives were analysed using thematic analysis. These procedures will be discussed in further detail in the data collection and data analysis sections, respectively.

3.3. Context

This study was conducted across all 9 provinces of South Africa. Wemmer (2007) stated that by including participants who practice across all 9 provinces of South Africa, she was able to obtain a representative profile of audiologists' views regarding the efficacy of the

undergraduate and postgraduate audiology curriculum. South Africa has approximately 410 public hospitals, 215 private hospitals, and 448 special needs schools (Biermann, 2017; Mediclinic, 2016; Albino & Deliwe, 2017). Most of these institutions appear to provide specialized services such as speech and hearing therapy (Treatment Action Campaign [TAC], 2012; Health Systems Trust [HST], 2007; Walton, 2015).

3.4. Pilot Study

A pilot study aims to evaluate the feasibility of an approach that is intended to be used for the main research study (Leon, Davis & Kraemer, 2011). Additionally, it can be used to indicate flaws within the research design, which can be addressed prior to the conduction of the large scale study (Clark-Carter, 2012). Furthermore, Creswell (2009) advised researchers to pilot an interview session prior to conducting interviews, as this may refine the interview content, determine the feasibility, and appropriateness of data collection procedures.

Wright and Sim (2000) recommended that a pilot study should involve a few members which the study sample is to be drawn from. Therefore, once ethical clearance was obtained, I conducted a pilot interview over Skype with one audiology master's student. By piloting the interview beforehand it may have aided me in reviewing whether the interview questions maintained a narrative character, as well as helped me in determining whether the narratives obtained resonated with the depth of information required to address the aims of the study (Shkedi, 2005). Additionally, by piloting an interview it provided me with feedback regarding the clarity of the questions posed to participants as well as whether questions asked were reasonable and effective in eliciting useful information (Grady, 1998). Furthermore, prior to conducting the pilot interview, the participant distress protocol (Appendix J) was given to the participant to guide her in case she encountered distress during the interview.

This also aided me in determining whether the protocol would have been successful in assisting participants in overcoming potential distress that may be encountered.

The participant who participated in the pilot study was required to complete a feedback form (Appendix G) in which she commented on the content, flow, and clarity of the questions asked during the interview, as well as the usefulness of the distress protocol. The audiology master's student provided positive feedback, but warned against me making assumptions about participants, even if it is regarding their biographical information. She also advised me to consider providing a brief introduction about the study prior to conducting the interview, even though it is outlined in the information leaflet (Appendix E). The participant also made note of the poor internet connection while conducting the interview over Skype, and thus recommended that I should ask for clarification if need be or even acknowledge if I understood participants' responses correctly. The participant also recommended that I request participants to share more than one experience with patient death, and suggested that I display more empathy when conducting the interview. The participant commended me on including helpline numbers in the participant distress protocol (Appendix J). I applied the recommendations by her when I conducted the interviews for the main study.

It should be noted that the findings acquired from the pilot study were excluded from the main study, as the main purpose of a pilot study was for me to review the research approach (Woken, n.d.).

3.5. Participants

Prior to 1999 speech therapy and audiology was considered to be one profession (Wemmer, 2007), but post-1999 some university departments introduced a split-curriculum and trained students as either speech therapists or audiologists. However, majority of the universities still train students together up to their second year of studies, besides the

University of Stellenbosch which only offers a speech-language therapy programme (Wemmer, 2007). This is to ensure that despite students qualifying as either speech therapists or audiologists they are still able to treat patients who present with communication disorders in a holistic manner (Wemmer, 2007). Given the history of the speech therapy and audiology profession in South African and the need for therapists to have an integrative view when treating patients who present with communication disorders, I was able to explore speech therapists', audiologists', and dually qualified therapists' experiences regarding death and dying.

3.5.1. Sampling strategy. Maximum variation sampling which is a form of purposive non-probability sampling strategy requires the researcher to purposefully select participants who may have varying perspectives and experiences regarding a particular phenomenon that is being studied (Profetto-McGrath, Polit & Beck, 2008; Pitney & Parker, 2009). Therefore, I employed maximum variation sampling by inviting ST/As who practice at different types of institutions and who may have diverse backgrounds, which may influence their perspectives and experiences of death and dying (Snyder et. al, 2014), to participate in my study. This allowed me to obtain a greater insight into ST/As' experiences regarding patient death and dying.

An information leaflet was emailed to ST/As via the portals of the following organizations: South African Speech –Language-Hearing-Association (SASLHA), South African Association of Audiologists (SAAA), South African Neurodevelopmental Association Therapy (SANDTA), South African Neurological Rehabilitation Association (SANRA) National Black Speech, Language and Hearing Association (NABSLHA), and Rural Rehabilitation of South Africa (RURESA), as ST/As may form part of these organizations (SASLHA, 2017; SAAA,2017; SANDTA, 2012; SANRA, 2009; NABSLHA, 2017 RURESA, 2017). On my behalf, only SASLHA , SANRA, SANDTA, and RURESA

uploaded the information leaflet onto their portals; while the SAAA no longer provided this service to researchers and NABSLHA did not respond to my request. Additionally, this information leaflet provided to potential participants with background information regarding the study, the purpose of the research study, and the nature of involvement of participants. (University of Nottingham [UON], n.d.).

Additionally, I employed snowball sampling by requesting my participants to notify other ST/As about my study. This may have aided me in recruiting participants who otherwise may not have been easy to recruit (Macnee & McCabe, 2008). Snowball sampling may have also aided me in including various experiences of patient death and dying (Macnee & McCabe, 2008). If potential participants were willing to participate in the research study they were invited to contact me telephonically or via email. Therefore, I did not directly approach these potential participants.

For any sample to be meaningful it must be representative (Coon & Mitterer, 2008). This means that a representative sample can even be a small group of participants whose characteristics can accurately reflect those of the population that it is being drawn from (Gillian, 2010). Since the participants who were invited to participate in the study make up a small population; a small sample size was chosen. This may have accurately reflected the population's experiences regarding death and dying. Therefore, the 25 (n=25) ST/As who participated in the study were still reflective of the ST/A population of 1510 (N=1510) qualified ST/As in South Africa (HPCSA, 2006).

3.5.2. Inclusion and exclusion criteria. In order to participate in the narrative interviews, participants were required to have experienced patient death and dying. This was to guarantee that I do not encounter the same limitation as Rivers et al. (2009) encountered which was that the results obtained were not reflective of how these students would feel in

the during instances of patient death and dying as majority of the students had not experienced the death of a patient.

Before engaging in the narrative interviews participants were presented with an information sheet and consent form (Appendix F & H). The consent form needed to be signed by participants in order to indicate that he or she was willing to participate in the study. Furthermore, by signing the consent form, the participant was denoting that he or she was willing to be audio-recorded during the interview as well as be quoted in the dissertation and future studies.

3.5.3. Participants' demographics. Table 3.1.1. indicates the biographical information of the ST/As who participated in the study. As mentioned previously, a total of 25 (n=25) participants were recruited, all of whom were female but were of various ages and had differing years of experiences which ranged from 2 months to 40 years. These participants were also from differing religious and cultural backgrounds and worked in a variety of settings. Table 3.1.1. serves as a summary of participants' biographical information. It should be noted that the biographical information reflected in Table 3.1.2. has been presented verbatim as per participants' reports. In this table it may seem as though there is overlap between participants' religious affiliations and ethnicities, however when participants were are asked about these demographical factors; the recorded descriptions were the ones that were proffered to the researcher. Furthermore, some participants included their nationality when describing their ethnicity. Due to this variation in responses, ethnicity is not included in Table 3.1.1.

Table 3.1.1 Summary of participants' biographical information.

Biographical Information		Number of Participants
Gender	Male	0
	Female	25
Age (years)	<25	6
	25-40	15
	>40	4
Race	White/Caucasian	24
	African/Black	0
	Coloured	0
	Indian	1
	Others	0
Religious Affiliation	Christianity	16
	Hinduism	0
	Islam	0
	Judaism	4
	None	2

	Other	3
Designation	STA	12
	ST	12
	A	1
Number of years in practice	<5	13
	5-10	6
	>10	6
Work environments	Public Sector	24
	Private Sector	14
	Schools	9
	Academia	8
	Other	2
Provinces participants' practiced in	Gauteng	18
	Eastern Cape	1
	Northern Cape	0
	Western Cape	3
	Free State	0

	Kwa-Zulu Natal	3
	Limpopo	0
	Mpumalanga	5
	North West	0
	Unspecified	2

Table 3.1.2. Participants' biographical information.

Participant Number	Gender	Age in Years	Race	Religious Affiliation	Ethnicity	Designation	Number of Years in Practice	Work environments	Provinces participants practiced in
1	Female	29	White	None	British and South African	Speech therapist and audiologist	6	State (rural) institution, frail care facilities and researcher	Mpumalanga and Gauteng
2	Female	26	White	Christianity	Afrikaans	Speech therapist	2	State (urban) institution, mainstream schools and researcher	Gauteng
3	Female	67	White	Christianity	Caucasian	Speech therapist	40	Department of education, school, private practice practiced overseas at an ear, nose and throat (ENT) clinic, lecturer	Gauteng
4	Female	26	White	Catholicism	British, South African and Indian	Speech therapist and audiologist	4	State (rural) institution, private practice and practiced overseas as an audiologist	Mpumalanga and Gauteng
5	Female	25	White	Christianity	Afrikaans	Speech therapist	3	State (urban) institution, private practice and school	Gauteng
6	Female	24	White	Greek Orthodox	Greek	Speech therapist and audiologist	1.5	State (not specified) institution, practiced overseas at a cochlear implant centre and researcher	Mpumalanga
7	Female	23	White	Judaism	Jewish	Speech therapist and audiologist	1	State (urban) institution and researcher	Gauteng

8	Female	23	White	Judaism	Jewish	Speech therapist and audiologist	1	State (urban) hospital, private practice and research	Gauteng
9	Female	47	White	Agnosticism	Not specified	Speech therapist and audiologist	20	Practiced overseas as an audiometrist, school, private practice and state (urban) institution.	Mpumalanga
10	Female	23	White	Catholicism	Italian	Speech therapist and audiologist	1.1	State (urban) hospital and private practice	Gauteng
11	Female	35	White	Christianity	Afrikaans	Speech therapist and audiologist	13	State (urban) clinic and hospital	Gauteng
12	Female	27	White	Christianity	Afrikaans	Speech therapist	2	State (rural) hospital and school	Not specified
13	Female	33	White	Christianity	English	Speech therapist	11	State (urban) hospital	Mpumalanga
14	Female	27	White	Agnosticism	English	Speech therapist	2	State (rural) psychiatric hospital and private practice	KwaZulu-Natal
15	Female	26	Indian	Christianity	Indian	Audiologist	4	State (urban) hospital and private practice	KwaZulu-Natal, Western cape and Gauteng
16	Female	31	White	Christianity	Not specified	Speech therapist	5	State (urban) hospital	Guateng

17	Female	40	White	Catholicism	British	Speech therapist	11	Practiced overseas at a school, special needs school and private practice	Western Cape and Gauteng
18	Female	24	White	Judaism	Jewish	Speech therapist and audiologist	0.2	State (urban) hospital	Gauteng
19	Female	30	White	Atheism	Western	Speech therapist	6	State (not specified) hospital and private practice	Eastern Cape and Western Cape
20	Female	52	White	Christianity (Anglican)	English	Speech therapist	27	State (not specified), university, private practice and rehabilitation facilities	Not specified
21	Female	32	White	None	Greek	Speech therapist and audiologist	9	State (rural and urban) hospitals, and special needs schools, private practice and university	Kwa-Zulu Natal and Gauteng
22	Female	31	White	Judaism	Jewish	Speech therapist and audiologist	10	State (not specified) and private practice	Gauteng
23	Female	26	White	Christianity	Not specified	Speech therapist	4	State (urban) clinic and hospital	Gauteng
24	Female	29	White	Christianity (Anglican)	Not specified	Speech therapist and audiologist	7	State (urban) hospital, private practice and special needs school	Gauteng
25	Female	24	White	Christianity	English	Speech therapist	1.2	State (urban) hospital and private special needs school	Gauteng

3.6. Data Collection Procedures

The purpose of narrative interviews was to allow participants to relay their stories about their own experiences of events. In order to obtain an in-depth understanding of ST/As' experiences regarding patient death and dying I conducted one –to- one narrative interviews which were open-ended in nature. Lieblich (2014) and Medeiros (2013) stated that when conducting narrative interviews, open-ended questions should be posed as it creates a platform through which narrators can inflict their own meaning on both questions and responses.

Muylaert, Sarubbi, Gallo, Neto and Reis (2014) recommend that narrative interviews should follow an unstructured format. This seemed to be in line with the suggestion made by Knudsenet al. (2012) who explored qualitative research methods within the audiology field. These authors suggested that when conducting narrative interviews it should be conducted within a conversational format, but it can be guided by a broad question, as this may allow for participants to produce their own stories. Therefore, prior to conducting the interviews I had formulated some questions that I had asked participants during the interviews (Appendix G & I). Furthermore, it should be noted that I began the interview by posing questions regarding participants' biographical information as well as an immanent question which Muylaert et al. (2014) stated is the research question. In the case of this study, the immanent question was: What are ST/As' experiences concerning patient death and dying? Thereafter, I tapered into participants' responses by asking more intrinsic questions based on their narratives. These questions were also formulated through reflexive guiding. In doing so it allowed me to determine from which angle I would choose to conduct each of the interviews (Malterud, 2001). Therefore, based on participants' responses it aided me in approaching one interview to the next.

Participants produced small story narratives when they relayed their experiences regarding patient death and dying to me, as this topic does not necessarily relate to a larger

story (Bamberg, 2007; Medeiros, 2014). This seemed to have allowed me to obtain a wide range of narratives which may accurately reflect participants' experiences regarding patient death and dying (Bamberg, 2007). For instance, and as recommended by the participant who participated in the pilot study, participants were required to recount as many experiences of patient death and dying as they wanted to.

I made use of an audio-recorder, as Oxfam (2012) stated that a digital recorder allows for the interviewer to concentrate on what the interviewee is saying without being distracted. All of the ST/As consented to be audio recorded. The interviews took approximately 30 minutes to complete. This ensured that not much valuable working time was lost (Green, 2000). Additionally, eight face-to-face interviews were conducted, while 17 interviews were conducted over Skype. By conducting interviews over Skype it also ensured that no time was taken away from the ST/As completing their daily responsibilities. A computer was used to conduct the interviews over Skype to ensure good internet connection (Farooq & de Villiers, 2017). Conducting interviews over Skype allowed me to interview participants who reside in different provinces to me, as well as gave me the opportunity to interview three South African qualified ST/As who have practiced in South Africa but now reside overseas.

Member checking requires the participants to review the data and the researcher's interpretation of the data to ensure that the information obtained is credible and accurate (Creswell & Miller, 2010). Once, I had transcribed the narrative interviews, I employed the member checking technique by emailing participants their individual interview transcriptions. By corresponding with participants via email it also ensured that participants had time to read the interview transcriptions and reflect on the questions. Only four participants did not have an opportunity to review their interview transcriptions.

3.7. Data Analysis

I employed thematic analysis to analyse the narratives obtained. Thematic analysis is defined as a method whereby the researcher extracts recurrent patterns (themes), which may arise from the data acquired (Braun & Clarke, 2006) According to Patterson (2013), when analysing an experience-centred narrative, researchers should describe the narratives obtained thematically.

I used the six-step approach to thematic analysis recommended by Braun and Clarke (2006) when I analysed participants' narratives (Figure 3.2.). I familiarised myself with the data obtained by transcribing the narratives through writing and thereafter through typing (Braun & Clark, 2006). Once, I familiarised myself with the data set, I generated codes (inductive and deductive), as advised by Braun and Clarke (2006), by manually highlighting extracts of the narratives and collating all of the extracts from participants' narratives which shared the same code. In the case of this study, the codes were formulated based on theories. Thereafter, I sorted through the codes to identify themes (Braun & Clarke, 2006). Once these themes where identified they were tabulated and coupled with a brief description. It should be noted that at times different codes actually branched into themes. The themes identified either acted as the main theme, sub-theme, and sub-subthemes. These different levels of themes are

outlined in Figure 3.1.

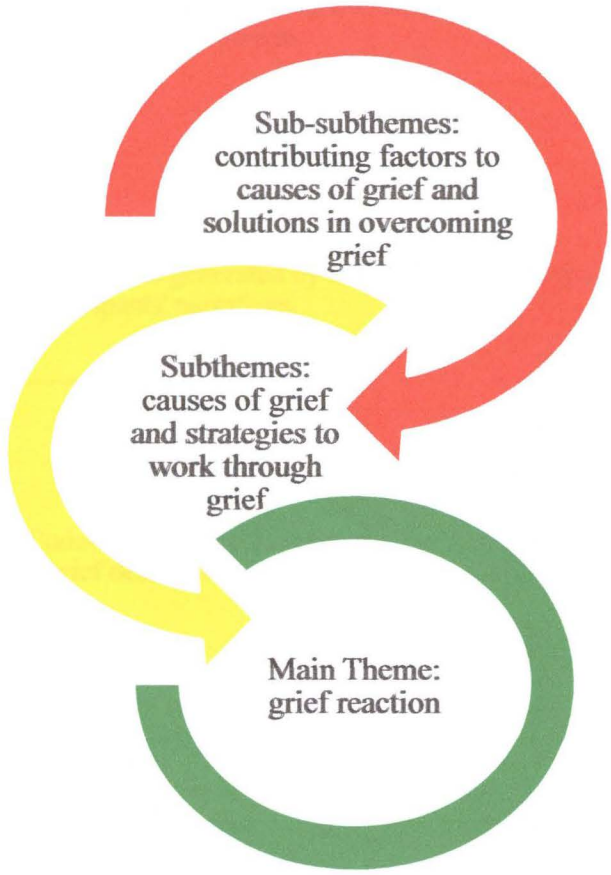


Figure 3.1. An overview of the themes identified in this study.

I then reviewed the identified themes in accordance with the two levels recommended by Braun and Clark (2006). During the first level of the review I re-read the coded extracts as per each theme devised from the extract. The themes did form a logical link with each other. Therefore, I moved onto level two where I ensured that the reviewed themes represented the data obtained. The themes formulated seemed to be reflective of the data obtained and the data set did not have to be recoded. Thereafter, I defined the themes in terms of the key features of the data (Braun & Clark, 2006). The themes presented in this dissertation aim to outline participants' experiences with patient death and dying in a succinct and coherent manner. Interestingly, I could relate to participants' experiences with patient death and dying. Since, I have had similar, if not the same, experiences when encountering patient death and dying.



Figure 3.2. The application of Braun and Clarke's (2006) six-step approach of thematic analysis.

3.8. Reliability, Validity and Trustworthiness

3.8.1. Reliability and Validity. Reliability and validity are ways of denoting and ensuring rigour of the research process as well as trustworthiness of the research process (Roberts, Priest & Traynor 2006). Simon (2011) maintained that in qualitative research there should be no assumption that the results obtained may be replicable due to the uniqueness of the results obtained. Therefore, instead of discussing the validity of the results obtained in qualitative research, I commented on the trustworthiness of the results, and rather than discussing the reliability of the results I addressed the dependability of the results obtained (Webster & Mertova, 2007).

3.8.1.1. research methods. Trahar (2013) as well as Barkhuizen, Benson and Chik (2013) stated that conventional notions of reliability and validity may not apply to narratives because of the variability and individuality of participants' experiences.. Furthermore, the reliability of narratives may be measured by accessibility and accuracy of the data (Webster & Mertova, 2007). Therefore, in order to ensure accessibility of the participants' narratives, I included excerpts from participants' interview transcriptions in the results section of the dissertation.

Furthermore, Webster and Mertova (2007) reported that the persuasiveness and coherency of the narratives yielded may improve the reliability of the study. Therefore, since the researcher endeavoured to describe participants' grief reactions in light of theoretical stage theories of grief by extracting common grief processes based on their narratives, it may have improved the reliability of the study. Reismann (1993) claimed that the persuasiveness of the data obtained and the conclusions deducted is ensured when theoretical claims are supported by evidence from participants' accounts. Additionally, Webster and Mertova (2007) stated that the coherence of the data obtained may also improve the reliability of the

study. Hobbs and Agar (1982) reported that researchers need to ensure narrative coherence by modifying their hypothesis about participants' beliefs with regard to the structure of the narratives and by extracting recurrent themes from the narratives. Thus, I ensured narrative coherence by utilising member checking. During this process, participants in addition to reviewing their transcriptions they needed to provide written clarification on the information which the researcher was unsure about. These techniques which were adapted from Chase (2017) may have allowed for enhanced member checks as extra heed was paid to the sensitivity of participants' experiences with patient death and dying.

3.1.8.2. researcher and subject bias. Researcher and subject bias has shown to affect the validity and reliability of the findings obtained (Pannuci & Wilkins, 2011). Pannuci and Wilkins (2011) added that both researcher and subject bias occurs during data collection and can either be regarded as conscious or unconscious.

The researcher attended to interview bias by conducting the pilot interview with the audiology master's student (Tolmie, Muijs & McAteer, 2011). As previously mentioned, subject bias may be reduced by conducting interviews in a location that is familiar with the subject (Prasad, 2015). Therefore, the interviews were held with participants at a location of their choice.

3.1.8.3. etic and emic positions. Research studies need some degree of balance between emic and etic perspectives, as some level of knowledge of the occurrence or event being investigated may assist the researcher in developing a rapport with the research participants (Salmons, 2015).The etic approach refers to a researcher's insight and analysis of the raw data. Whereas, the emic perspective relates to the research participants' perspectives and the researcher interpreting the perspectives of these participants on the facets being explored (O'Reilly & Kiyimba, 2014; Heigham & Sakui, 2009).

When these two approaches are combined, researchers can conduct confirmatory research (Currall & Towler, 2003). I used both the etic and emic perspectives when analysing the results obtained. I acquired an understanding of ST/As' experiences regarding patient death and dying and also acknowledged my encounters as a ST/Awho has been faced with patient death. I employed the emic approach when I analysed participants' narratives. This aided me in obtaining a comprehensive understanding of ST/As' behaviours when attending to patient death and dying. Furthermore, I employed the etic approach by recording my thoughts and insights of the data obtained. By applying these approaches it aided me in verifying my findings ,and allowed me to obtain a better understanding of the behaviours which ST/As exhibited when being exposed to patient death and dying.

3.8.2 Trustworthiness. Mills, Durepos and Wiebe (2010) stated that trustworthiness is an imperative component when exploring the quality of a research study. According to Olivia (2016) trustworthiness comprises of four components: creditability, transferability, conformability, and dependability.

3.8.2.1. credibility and conformability. Credibility relates to whether the findings obtained are accurate enough to be believable (Pitney & Parker, 2009).Whereas, conformability focuses on the extent to which results reflect participants' responses and are free from subject and researcher bias (Olivia, 2016). By conducting the member checking technique it ensured that these components were upheld.

3.8.2.2. dependability. Dependability is the degree to which findings are consistent and the study could be replicated (Pitney & Parker, 2009). This was ensured by me developing an audit trail. The purpose of an audit trail is to ensure that readers are able to trace the research steps and the researcher's logic to determine the reliability of the findings

(Carcary, 2009). Appendix M is an outline of the audit trail which was formulated based on suggestions made by Lincoln and Guba (1985). The audit trail created, consisted of: raw data (consent forms and audio recordings), data reduction, analyses, reconstruction and syntheses facets (interview transcriptions, feedback received from the member checking review, tabulations of codes (extracts) and themes extracted from these codes and instrument development information (feedback received from participant who participated in the pilot study).

3.8.2.3. transferability. Lastly, transferability refers to whether or not the researcher can generalize the findings obtained to other contexts such as, to similar populations (Olivia, 2016). However, in the case of qualitative research studies, transferability has a focus on particularity instead of generalizability (Garvis, 2015). Garvis (2015) added that with regard to qualitative research studies, transferability refers to readers determining whether the study is meaningful or not. Therefore, although the researcher aimed to depict ST/As' insights and experiences regarding patient death and dying, the audience will need to determine the appropriateness of the research study.

3.8.3. Verisimilitude. Since, studies which use narratives rely on interpretations of participants' experiences, it is important to uphold the principle of verisimilitude. Verisimilitude refers to the interpretation of data, which in the case of this study is the narrative being a true reflection of participants' experiences regarding patient death and dying (Webser & Mertova 2007). Therefore, by employing the member checking technique the researcher upheld the criterion of verisimilitude (Loh, 2013).

3.8.4. Utility. The principle of utility refers to the relevance of the study (Loh, 2013). For a study to be useful it must be able to be used as a basis for other researchers who aim to explore a notion further (Reissman, 2008). Furthermore, if the study explores a group of individuals' experiences regarding a particular event it still needs to be relevant to the other individuals from the same population which the sample was drawn from (Reismann, 1993). In order to ensure that data and interpretation thereof applies to the population at large, I ensured the following, which is in accordance with Loh (2013): the data aids in understanding a particular event and the interpretations extend beyond what is already known about a particular event. Therefore, by utilizing the member checking technique the researcher ensured that the data obtained is relevant and useful in contributing to research exploring ST/As' experiences regarding patient death and dying.

3.9 Ethical Considerations

The research proposal (H17/11/42) was submitted to the University of Witwatersrand Human Research Ethics Committee (non-medical).Thereafter, ethical clearance was obtained from the above mentioned committee (Appendix L).

3.9.1. Informed consent. Informed consent is an interactive process in which individuals' voluntarily agree to participate in a research study after being informed and understanding the risks and benefits that the study involves (Marshall, 2007).

In order for the participants to have participated in the narrative interviews they needed to voluntary agree to participate in the study, and thus needed to consent by signing the participation consent form (Appendix F & H). Furthermore, participants were required to sign a separate consent form if they agreed to be audio recorded during the interview (Appendix F & H).

3.9.2. Confidentiality. Confidentiality pertains to how the information obtained from participants is treated. Monitoring confidentiality helps to protect participants from potential harms including the psychological harms, such as distress and social harms such as loss of employment (University of California, [UOC] 2014).

Participants were informed through an information leaflet that confidentiality was ensured throughout the study by their identities only being disclosed to me. Additionally, numbers were used to refer to participants. The participant name-number links will remain separate from the other data obtained.

The data obtained was also stored in a password protected computer of the University of Witwatersrand Department of Speech Pathology and Audiology.

3.9.3. Autonomy. Autonomy refers to the individual's right to withdraw from the study when he or she wishes to do so (Sneddon, 2013). In order to ensure autonomy, participants were informed that participating in this study was not obligatory and that they could withdraw at any point of the study. Furthermore, they were notified that if they opted to withdraw from the study it would not result in any repercussions.

3.9.4. Beneficence and non-maleficence. The principle of beneficence considers that participants as well as the population that participants are being drawn from will receive some benefit from the outcome of the research study (Carter & Lubinsky, 2015). Whereas, the principle of non-maleficence aims to protect participants from potential harm (Evans & Rooney, 2013). In order to ensure that these ethical principles were upheld, I developed a distress protocol (Appendix J) in case the topics discussed during the interviews lead to distress among participants. This distress protocol was adopted from Draucker, Martsolf and

Poole (2009). All participants were given the distress protocol prior to the commencement of the interviews. The information leaflet (Appendix F & H) provided to participants also included the contact details of the counsellors and/or psychologists who form part of the South African Depression and Anxiety Group (SADAG).

Additionally, by conducting the interviews over Skype using a computer, I was able to identify signs of emotional distress Farooq & de Villiers, 2017). Furthermore, I was attentive to participants' verbal cues, such as pauses, hesitations, and tone of voice (Farooq & de Villiers, 2017). If I noticed that participants were experiencing discomfort during the interview I provided them with the option of discontinuing and rescheduling the interviews (Draucker et al., 2009; Farooq & de Villiers, 2017).

Although some participants did encounter uneasiness during the process, none of them requested for the interview to be aborted or rescheduled. Additionally, participants in this study considered the participant distress protocol adopted from Draucker et al. (2009) to be useful. However, none of the participants in this study referred to it during the interview process.

3.9.5. Justice. Justice relates to the burdens and benefits being balanced during the research process (Hulley, Cummings, Browner, Grady & Newman, 2007). Since participants may encounter emotional distress especially during the interview, they may be considered to be vulnerable participants. The distress protocol discussed under the beneficence and non-maleficence section was to be employed to reduce the risk of participant vulnerability.

When researchers aim to explore sensitive topics they may encounter research distress during the data collection analyses processes (Shabbar, 2016). Therefore, they may need to follow the researcher distress protocol (Appendix K) in order to overcome the uneasiness associated with researcher distress. The researcher distress protocol which was utilized was

also adopted from the researcher distress protocol proposed by Draucker et al. (2009). I did encounter discomfort during the research process and thus as stated in the researcher distress protocol, I consulted with a psychologist.

Chapter 4: Results

Results obtained from *n*=25 participants' narratives will be reflected in this section. In section 4.1., I will first outline the medical causes of patient death, and depict in Figure 4.1. the work settings where the most remarkable patient deaths had occurred. These aforementioned factors did not heavily weigh on participants' experiences with patient death and dying and thus did not really affect my interpretation of participants' narratives. However, the excerpts from participants' responses (codes), which are reflected in section 4.2.- 4.12 were critical in me formulating sub-themes around participants experiences with patient death and dying. These sub-themes are presented in the following sections: pre-professional training on patient death and dying participants, being present at the time of patient death and during patient death and dying, the types of patient death and dying, participants' relationships with the relevant multidisciplinary team members who also treated patients, participants' interactions with patients and patients' significant others, SA as a context of death and dying, the possible link between personal loss and patient death, the impact participants' code of conduct on their encounters with patient death and dying and the effect of this phenomenon on their professional performance, support provided to participants by their work settings in instances of patient death and dying as well as the coping and defence mechanisms employed by participants when attempting to overcome patient death and dying.

4.1. Causes of Patient Death and Work Settings where Patient Deaths have Occurred

4.1.1. Causes of patient death. Table 4.1.1. indicates the causes of patient deaths, which were relayed by participants to me. Please note that the number of causes of death reflected in Table 4.1.1. exceeds 25, as participants shared more than one encounter of patient

death and dying with me. Three participants did not feel comfortable to discuss patients' causes of death due to the gruesomeness of the deaths; these causes of death are termed as unspecified. Furthermore, when three experiences of patient death were relayed to me, I did not inquire about the causes of death, hence why these causes of death are unknown.

Table 4.1.1.Profile of causes of patient deaths based on participants' experiences

Causes of Patient Death		Number of Deaths
Infection	Aspiration Pneumonia	8
	Upper Respiratory Tract Infection	1
	Septicaemia	1
	Burn Wound Infection	1
	Pneumonia	1
	Diarrhoea	1
Surgical Complications	Percutaneous Endoscopic Gastrostomy Site Infection	4
	Haemorrhage Post-Tonsillectomy	1
Preterm Birth Complications		2
Syndromes		2

Tuberculosis	Pulmonary Tuberculosis	2
	Tuberculosis Meningitis	1
Cerebral Vascular Accident		4
Cardiac Arrest		1
Cardiopulmonary Arrest		2
Respiratory Distress		2
Brain Death		3
Cancer		5
Malnourishment		4
Smoking-related Deaths		2
Drowning		3
Suicide		2
Unrelated to Medical Condition		8
Unspecified		5
Unknown		3

4.1.2. Death in a Work Setting. Patient deaths which stood out for participants were experienced within a variety of work settings. Figure 4.1. shows that 55 of these deaths occurred within the public sector and four in the private sector, while three deaths took place

at a frail care centre. Furthermore, while participants practiced at a school, they were faced with three patient deaths

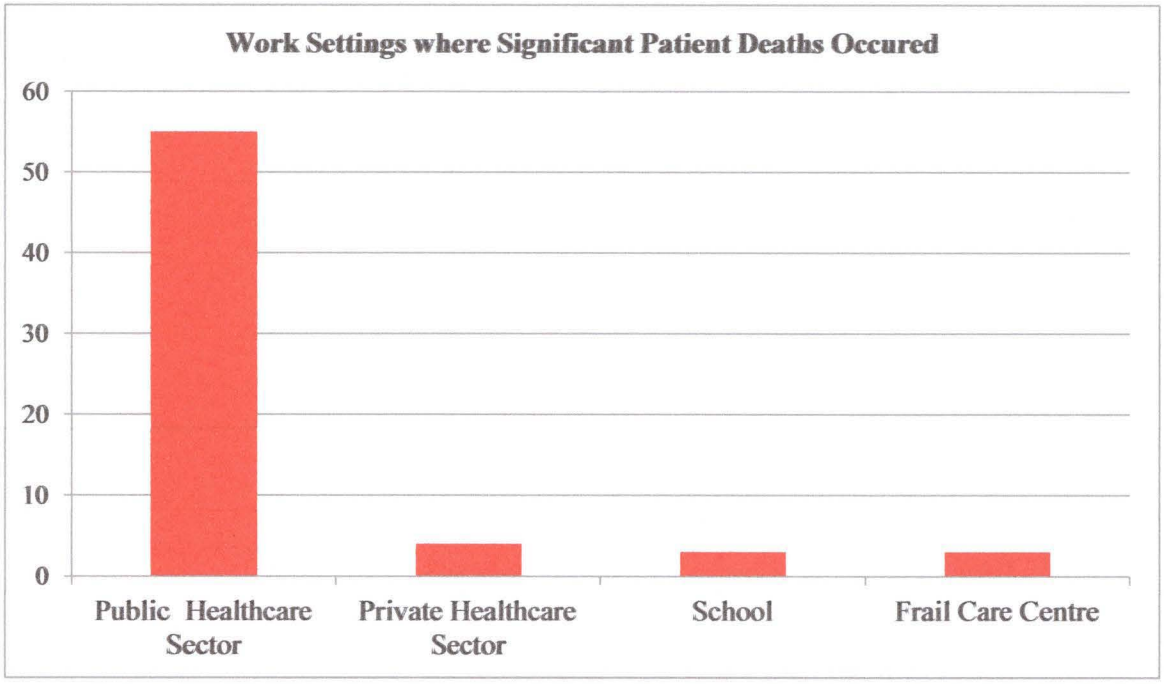


Figure 4.1. Work settings were participants experienced the most 'remarkable' Patient Deaths.

4.2. Pre-professional Training

In this section participants' comments on pre-professional training regarding patient death and dying are presented.

4.2.1. Limited pre-professional training regarding patient death and dying.

Although only eight participants' excerpts are presented in Table 4.2.1., all 25 participants who were interviewed for this study reported that they did not receive pre-professional training regarding patient death and dying.

Table 4.2.1. Lack of pre-professional training regarding patient death and dying.

Participant number	Participants' Responses
1	*"I don't think anyone is prepared to deal with patient death until they experienced it. When we were training for undergraduate studies we did have counselling courses. We spoke about it in class but I don't think until you experience the loss of a patient that you are prepared for death."* Lines 372-375.
2	*"I think it could start at university because every community service therapist goes into that situation even if you are in a small rural clinic, you are going to be faced with the reality of death. I don't really remember them speaking to us about the reality of losing patients."* Lines 316-318.
6	*"I don't feel prepared at all. I never experienced a patient death at all when I was in my undergraduate studies."* Lines 320-323
7	*"University does not prepare you for this. They kind of just tell you these are the pathologies which you are going to see and this is how you are going to treat them. No one tells you that you are going to build a relationship with your patients. No one tells you they may die and what you need to do from there. For me there was a gap in skills of being able to deal with that."* Lines 73-77. *"One thing that stood out for me during my community service, was that you are literally surrounded by death all the time. Coming from a student mind-set where you are protected and someone has always got your back, into an independent*

	mode it's very different. It's a completely different environment that you have to deal with by yourself." Line 364-366.
10	"*At university they didn't prepare us for stuff like this. They talk about debriefing but not specifically, death. I think it is something that is important to talk about; so, we can understand how to deal with it.*" Lines 60-62. "*It would have been nice to know the frequency of it and maybe having a few people talk about their experiences, what they did and how to deal with it. Anyone who experienced loss in different situations could be a good indication as well as having an audiologist as well as speech therapists who have lost patients in either a hospital (in- and outpatient) or home setting, can present. That may allow us to see that it happens in all different situations and the impact which it has on you.*" Lines 416-421
13	"*When I studied at university the thought of patients dying didn't even exist. You get the ideal patient, as I call it, who come with a certain disorder which you treat. You don't really think that death could happen; and when you start working you suddenly realise that wait a minute, my patients actually die and it's a bit of a shock to the system because you know that at university it wasn't like that. You now have to deal with all the emotions, grief and the patients' family. I feel that you not always prepared because you don't expect that it's going to happen.*" Lines 167-173. "

17	*"I think because of my history I have taken it upon myself to process death and dying, not only as an individual but also as a professional. While I was studying, I actually did extra courses and workshops that were offered on death and dying, I think that we did touch a bit on it during our undergraduate training."* Line 165-168. *"The workshops which I did were based on Kübler-Ross' teachings which I find that now it has grown and has been added to. The workshops were presented academically with a personal overlay."* Line 180-186.
20	*"I had a most unfortunate experience to deal with- I had youngster job shadowing me a while ago. We had popped into the ward to see one of the patients and I could see that he was dying. I had to hustle her out because I thought I cannot expose this kid to that."* Lines 283-285

4.2.2. Recommendations to improve pre-professional training. Table 4.2.2. reflects five participants' recommendations on how their pre-professional training on patient death and dying could have been improved. This included: talking about patient death, attending lectures and workshops, role-playing of patient death and dying, and sharing experiences of patient death.

Table 4.2.2. Recommendations made by participants to improve their pre-professional training on patient death and dying.

Participant Number	Recommendations made by participants to improve their pre-professional training
1	*"I think it would have been nice to have spoken about death or been told more about coping strategies, but I don't think I really know how you can prepare someone for it."* Line 375-377
6	*"I studied psychology .... Maybe, if I did clinical psychology I may have been more prepared for this."* Lines 366-367.... *"We could also do smaller sessions where everyone can relay their experiences. I feel like if we can get more personal it's definitely a way that can prepare us more. For example, something happens to one of your colleagues. I will give you an example of one of my colleagues, when I was in my undergraduate studies she had experienced the death of a child and she was recounting it to us. All you feel in that moment is horrified you don't go through the same stages. Maybe if it was in a setting where you could discuss it, for example, she would say this is what happened to me and then we could discuss it in a more safe environment."* Lines 374-380. *"I think role-playing what do you do in the instances of patient death. I don't mean to take out the seriousness of it but I do think that role- playing is a good way of what you do if you walk in and the patient is gone: What do you think? What do you do to process that information? If you encounter the family and a build a relationship with them, what is the right thing to do? What is the right thing to say? I don't*

	know because I'm not a grief counsellor, but something like that." Lines 383-388.
7	"*...they need to have lectures or have a psychologist come in and speak about what is going to happen when your patient passes away; or how to develop relationships with patients so that you are safe. I think research regarding patient death and dying can help speech therapists and audiologists deal with patient death. There should be lectures like psychology or any other professionals who feel like they could address this topic. For example, let's say that you have done all the research on patient death. You have seen tons of perspectives of how people experience death and deal with patient death- you could even do these lectures as a speech therapist and audiologist. You may be very relatable to other speech therapists and audiologists. You could even do a lecture together with psychology, they could give you the situation and you can give the relatable speech therapist and audiologist experience that we can identify with.*" Lines 378-389.
13	"*I think that at university you should be told that patient death is a possibility and what the necessary steps are to be taken if you encounter patient death. It's important that you deal with your emotions because you can't sweep it under the carpet and you have a right to feel those emotions. You need to work through the emotions because if you don't they will catch up with you and eventually it will bottle over and you're not going to cope.*" Lines 175-179.
17	"*I think as part of training all therapists should be expected to attend a workshop like that because it would be really good preparation; especially,*

	because therapists start out so young and it's assumed that they haven't experienced a deep loss. Thus, if there was a workshop or course targeting death and dying it would open a door for therapists to look for information so that when death happens they have some starting point." Line 184-186

4.3. Participants' Presence during Patient Death and Dying

Participants' presence during patient death and dying refers to participants either witnessing patients' deaths or dying processes, as well as them attempting to wake up deceased patients. These scenarios are discussed in the section below.

4.3.1. Participants being present near patients' deaths or at the time of patients' deaths. Of the 25 participants who participated in the study, two participants were present near patients' deaths, while one participant was present at the time of the patient's death. These encounters are reflected in Table 4.3.1.

Table 4.3.1. Participants' experiences when they were present near patients' deaths or at the time of patients' deaths.

Participants' presence	Participants' responses
Near the time of death	Participant 1: "*She was in her mid-30s. Majority of the clients were much older but this client had a degenerative disorder. One day, I went into her room and she had stuffed a lot of tissues into her mouth and it must have taken her ages as it was very difficult for her to move. She had packed her mouth full of tissues and was struggling to breathe. I had rushed in and taken all the tissues out of her mouth. I was like maybe she has bit of cognitive decline and didn't know what she was doing. It was only after everything had kind of calmed down and we had some time to settle it, I realised that she was trying to kill herself because she just didn't want to live anymore. I felt so guilty for taking that away from her. It's something that I think quite a lot about because in that situation the right answer is to go and help her, and remove the tissues from her mouth, but ethically speaking I don't really know where I stand because I don't know if I took something away from her.*" Lines 136-141. Participant 23: "*She got better and they were looking at discharging her and all of a sudden she had a relapse.*" Line 199. "*I remember that day as I went to see her in the wards because she started to have extreme difficulty with dysphagia and other related aspects. I sat with her, the head nurse as well as the nurses who were changing her bedding at the time. The nurses*

	had put her in the chair and they were going to give her the Fresubin shake to drink and all of a sudden everything just turned. I was still writing in the file and I could see that she wasn't doing well. All of sudden she was just unresponsive. The nurses patted her on her back and put her back on the bed. She was also moved to a room where she was alone because of her deteriorated state. The doctors were monitoring her closely. She was connected to the vitals monitor and at the time of the incident her oxygen saturation levels went crashing. I was in utter shock. I literally froze while everyone was moving and I said to myself, 'What is happening?". I remember that I just went out and gave the doctors and everyone else space to work. They resuscitated her and moved her to ICU. She didn't make the night...." Lines 201-212. *"I don't even know how to explain it. In that moment, I just felt so nauseous. I don't know if I felt nauseous because of the shock. I also just blanked out while everyone else was moving. I didn't know what to do. I wanted to help but obviously it's not in my scope to help the doctors and the nurses with the resuscitation. I think that the situation was out of my control but I also felt out of control in that situation."* Lines 224-228.
At the time of death	Participant 10: *"It was my very first patient who in the first month of work had passed away. I had no idea what to do. I was just upset. I did everything that I knew that I had to in a situation like that. I was so upset."* Lines 54-56. *"I think what made it difficult was finding him aspirating on his own vomit- I found him like that. I tried to wake him up but he wouldn't wake up. I went to do therapy and I found him lying in bed. I couldn't wake him up.*

	He had a very weak pulse so I called for resuscitation. There was doctor who was on call and took over. It took me a while to realise where I was and the situation that I was in. I kept trying to wake him. He was just in a deep sleep. I kept shaking him trying everything that I could to wake him up. I realised that there was nothing that I could have done so I had to call for resuscitation. The hardest part is that I found him like that." Line 93-100. "*I was in a lot of shock, for a long time and definitely for the rest of the day.*" Line 106. "*I know that it affected me more than I thought it had when I had dreams about him and another patient that passed on who was in the bed near his. Then I realised how much more it affected me than I initially thought it did.*" Lines 110-112.

4.3.2. Trying to wake up a dead patient. Two of the participants who participated in this study attempted to wake up deceased patients. In both these cases, it was participants' first experience with patient death. These situations are reflected in Table 4.3.2.

Table 4.3.2. Instances where participants attempted to wake up deceased patients.

Participant number	Participants' responses
12	*"One specific day, I went into his room and said, 'Hello' and started speaking to him; and when I touched him and said, 'Hey, how are you doing?' he didn't respond. I discovered that he was dead."* Line 40-41. *"My first emotion was shock, obviously, because I wasn't expecting it. I don't know how to really explain it, I was very sad because it was my first experience with death. It was someone that I had grown to have a relationship with so, for me I felt that loss."* Line 97-99.
21	*"I was called because this stroke patient needed feeding management. I thought that this was really exciting, so, off I went to the ward. I read the patient's file and it said that the oxygen should be on and that the nasogastric tube feeds should be running. I was like, all of this is cool so I do the patient's side of the bed and said, 'Hello' and there was no response. I said it louder and I touched her and eventually, I was shaking this woman saying, 'Wake up', 'Hello', 'Sawubona', 'Can you hear me?' and she was just completely unresponsive. I mean the oxygen was on there was no nasogastric tube (NGT). I went to the patient's file to write my notes: patient not responsive and the nurse passed and I said, 'Oh sorry, do you know what's happening with this patient?' and he looked at me as if I was mad and said, 'She's dead' and I was like, 'Sure, sure'. I crossed out my noted and wrote RIP. I went back to the department sat down and said, 'I*

	can't believe this happened to me!". This was my first patient and she's actually dead and I didn't even realise that she as dead. For me that kind of set the bar to expect anything and prepare for anything." Line 254-266.

4.4. Types of Death

The types of death refer to child, young adult, and older adult deaths, as well as to the expectedness of patients' deaths. These types of deaths are discussed below.

4.4.1. Child or young adult death versus the deaths of older adults. Table 4.4.1. reflects only six participants' reactions to child and young adult death in comparison to the death of an older adult. Some of these participants used the following words to describe the deaths of children and young adults: shocking, surprising, and sad. However, Participant 14 said that the death of older adults are sad but not surprising- "*There was an adult patient who passed away just after this teenager had passed on. With his death it was just sad it wasn't as surprising as the death of the teenager. I think this wasn't as surprising because he was 79 years old.*" Line 181-183.

Furthermore, only one of the two participants' who wondered if they challenged patients too much excerpts is reflected in Table 4.4.1.

Table 4.4.1. Differences in participants' reactions in instances of child and young adult death as compared to the deaths of older adults.

Age of the patient	Participants' responses
Child death or young adult death	Participant 1: "*If I think of child deaths, we did have a number of them at the rural hospital. There was one mother who when we were doing ward rounds one morning she was just sitting by the bed crying. We had just gone around, we probably had been doing ward round with the doctors for about 45 minutes before we got to her. She was absolutely sobbing by the time we got there. She was saying that her baby stopped breathing about 40 minutes ago and she just sat there because she felt so lost. She didn't call anyone, didn't ask the nurses for help, she just sat there because she felt that the situation was so helpless. That was a terrible passing of the child because a lot of people in the room felt they could have helped her a lot more.*" Line 322-329. Participant 2: "*In those cases, where I had young people dying it was quite a shock.*" Line 53-54. "*I think it's the entire situation of you thinking that they going to be ok and then the next moment, a young relatively healthy person dies. So, I think the fact that she was young and the fact that she seemed to be making a recovery and then suddenly died-that made it difficult.*" Line 91-94. "*If I had to describe my reaction when I first found out I would say that I was speechless. I couldn't believe that she had passed away. I couldn't believe it. I would question if it really happened?*"

	Line 210-213. Participant 3: "*He went away for the weekend and he drowned.*" Line 53-53. "*With the student being a little bit older than me, I felt that it was unfair that he passed on. We know what the course of life is but why did this have to happen? The fact was that he could swim. It was an unfortunate incident and there were all these 'why' questions especially, because I wasn't that much older than him so, it did give me a shake. The first question I had was why?*" Line 103-107. Participant 15: "*I would say that deaths of younger patients are hard because they haven't experienced life so you feel that they were robbed of the opportunity as opposed to an adult who experienced having children and grandchildren-they have experienced that fullness of life. So, I think that it is easier to accept the death of an older patient as opposed to a younger patient.*" Line 184-187. Participant 17: "*I think that child death generally feels a little bit more shocking in the sense that it feels more out of the natural order. To us as a society and to us as individuals when our children, whether they are clients or friends' children, do pass away there is always that aspect of shock and element of sadness; because there is this loss of potential of what might have happened. Whereas, with adults they have achieved what they needed to and they have got to experience their life.*" Line 145-150. Participant 22: "*It's always sad to see child death because it's a loss of a future whereas, with adult death they have had some life. With a child's*

	death they are robbed of a future. It's sad for the family because when you bring a child into this world you have all these hopes and aspiration for where their lives will take them and when it gets cut short it's unfair." Line 393-396. Participant 23: "*The patient was young, she was younger than I was at the time so it was very sad for me. I think that's why her death touched me. She was 24/25 years old. If I look at myself there is so much that I haven't done and still want to do. If I think about how young she was I'm sure there were things that she had to do and wanted to do.*" Line 41-45. Participant 24: "*I had a patient who had a syndrome and passed away when she was 13 years old, all my other patients had passed away under the age of 4 years. Death of the young children is sad because they haven't lived life. If I think of this 13 year old girl, her death was also sad because she was doing so well. Before she passed away we had a feedback meeting with her parents as we wanted to change her grading. We as well as her parents found out later that she had lived passed her living age.*" Line 143-148.
Older adult death	Participant 21: "*I suppose now, when I look back at those adults, I think and wonder the last time that I left their bedside was it a positive experience for them. I wonder if I was too hard and challenging on them as well as if they were upset because they couldn't do all those things that I asked them to do? I kind of think about all those things.*" Line 228-231.

4.4.2. Expectedness of patients' deaths. Table 4.4.2. indicates 17 participants' reports on how the expectedness of patients' deaths influenced their reactions to patient death and dying. In cases of sudden death these participants reported that they had experienced: shock and denial. Four of these participants stated that when patient death was expected (anticipated death) they were able to prepare themselves for the death. While Participant 5 said: "*I must say even if you anticipate it, well you know some day it's going to happen, you still aren't prepared for it. You are never prepared for someone passing away.*" Line 165-168.

Furthermore, Participant 19 stated: "*If the death is anticipated the team may have a few more family meetings and group discussions where we discuss how we want to proceed and what we want to focus on.*" Lines 270-271.

Table 4.4.2. Participants' reactions based on the expectedness of the death.

Expectedness of death	Participants' responses
Sudden death	Participant 1: "*If a person passed away quite suddenly and we were surprised by it, I would often call a physiotherapist, occupational therapist or nurse to discuss what had happened.*" Lines 252-253. Participant 2: "*I had another patient who had motor neuron disease (MND)*". Line 116. "*With her death it was another type of shock because I worked with her for a few months, from the beginning of the year.*" Line 122-123. "*...but it was one of those cases where I thought she was doing better and I didn't think that she would pass away so soon.*" Line 130-131.

	Participant 4: "*With sudden death, it's something that you don't expect.*" Line 214-215. "*You go through the grieving process from the start. I think it's usually the denial which is the emotion to it.*" Line 243-244. "*I suppose if it's a sudden case you start all over and you think 'What if it's something that I did. Did I communicate more effectively with the doctor? Was I not assertive enough?*" Line 259-261. Participant 7: "*I went to the sister and asked her where the patient was-for example, was she moved to a different ward and she said actually she passed away. She was deceased. I actually, looked at the sister and said, 'How is it possible? She was fine, she wasn't sick and she was going to be soon discharged. How could she have passed away?*" Line 49-52. "*I did question the nurse as to how this was possible. The nurse went to the deceased book and was looking for the reason for death and said that the patient had passed away from an upper respiratory tract infection (URTI). I was just like, 'This wasn't in her file, I don't understand'. ... I just kind of took a step back, tried to process what I just heard.*" Line 58-61. Participant 7: "*I think of another patient there was a young boy, ...*" Line 255-256 . "*He was in a motorbike accident and was not communicating.*" Line 258-259. "*I didn't get to a build a relationship with him because he wasn't responsive. When he passed away, well, I wasn't expecting him to pass away because he was actually quite stable. I went on leave and when I came back from leave someone said that he passed away.*" Line 261-267. "*It was so weird that I didn't have to go see him again. It was kind of like*

	that empty space inside of me that was not there. It was weird because I hadn't developed a relationship with him but because I had taken care of him for such a long period of time, I guess I had developed a relationship with him that I even wasn't aware of." Line 273-275. "*I think with my response, the 'wow ok' response. It was just kind of shock. I really wasn't expecting it and there were lots of mixed feelings. I really didn't know what to feel.*" Line 277-279. "*With the second response which was, 'I am happy for him'; I was happy for him because he was a young boy the same age as me and he was trapped inside his body. He wasn't even all there..... No one was really caring for him.*" Line 281-282. "*It was very sad but I was happy for him because he does not need to suffer anymore-he can now be his old self in the afterlife or whatever he believes in.*" Line 284-285. "*I didn't realise how much energy I placed into someone who can't even communicate. He became a big part of my week. I would plan my whole week around him, as to when I'm going to see him because he wasn't a priority as he couldn't communicate and was feeding through a percutaneous endoscopy gastrostomy (PEG) tube. There was not much more I could do as a speech therapist besides cognitive stimulation. So, my weeks were planned around him. I couldn't go a week without seeing him even if I had a million other patients that I had to see.*" Line 288-294. Participant 8: "*I had another patient pass away who I had been seeing for months. She did take a turn for the worse and I wasn't expecting her to pass on. I had been seeing her for so long that even when she passed away, I would still instinctively walk to her room. I did this even a few*

	days after she passed. It took longer to sink in. I did expect it but it took longer to sink in." Line 165-168. "*I feel if it's sudden it's more difficult for me to go to my next patient. I will often have to go back to the office and gather my thoughts... as I was scared that my mind-set would be influenced by my emotions about that patient.*" Line 181-184. Participant 8: "*If the patient passed away suddenly, the allied team wouldn't have really interacted with the patients' significant others.*" Lines 455-456. Participant 10: "*With anticipated death the process is slower so it's sadness and because it's slower it's easier to accept. The sadness is reduced and is limited to small quantities. It's spread over a longer period of time.*" Line 360-362. Participant 11: "*If it is a sudden death-it's a shock. First of all you feel shock and ask, "What happened he was healthy yesterday, I came and the patient was quite healthy". Then second, you question "Did I do something wrong?" I would go through my stuff and make sure that I didn't do something wrong and you always wonder if someone else did something wrong. I trust my colleagues in the hospital-the doctors and the nurses, but I also know that they make mistakes.*" Line 157-162. Participant 13: "*With sudden death you are not expecting death and so you think that you have time and sometimes you are lexidasical.*" Lines 341-342. "*Whereas, with anticipated death we can tell the family that the*

	patient is terminally ill and give them information in that moment." Lines 344-345. Participant 13: "*It was difficult and an unpleasant experience especially, because I got my hopes up thinking what could I do for the child; then suddenly I got the call that therapy is not going to continue anymore because there is no child to give therapy to.*" Line 47-49. Participant 16: "*The nurse had phoned me to say that the patient was no longer there and I said to her what does she mean that he is no longer here? ... They said we mean that he has gone to a better place. I asked if he was gone to a bigger ward and eventually the nurse told me that the patient had passed away.*" Line 129-133. Participant 16: "*I think that I almost questioned her by saying, 'What do you mean he has died? I saw him last month'. I was in an utter state of shock. I didn't think of her emotions and how she was feeling, I mean she just buried her child and here I was a little snotty white girl phoning her to ask her why she didn't bring her child for his therapy appointment. I was just shocked absolutely shocked...,*" Line 269-273. "*With sudden death I think that I have questioned everything that I've done such as, 'Was it enough for the patient?' and 'What did I miss?' That's why I feel that the cases of sudden death stick with me more. I think that particularly in the SAM case because SAM is my field and the child went from being fine, healthy and developing to death all in a period of a month, I think that*

	knocked me." Line 313-317. Participant 16: "***When a patient suddenly passes, the physiotherapist, for example, will phone and say, 'The patient died. I'm so sorry, but you know it's for the best.' It's more information sharing rather than consoling each other in the moment. It's almost seen as if you don't need to support each other***" Lines 476-479. Participant 21: "***If you were treating a patient and they suddenly pass way you're most likely going to have the same response, ..., but you're projecting and bouncing ideas off the other person. So, if the other person feels like crying you also feel the same. If you both feel the same then you kind of say, 'Well this isn't so bad, someone else is feeling how I'm feeling'; which I think helps.***" Lines 505-509. Participant 21: "***She had a rare condition but she didn't die from the condition. She died from diarrhoea which is just mind-blowing.***" Line 41-42. "***When I got the news I kind of said to the occupational therapist 'What? Can you say that again? I heard that you said diarrhoea but did you say that she passed away?'***" Line 67-68. "***I think it stood out for all of us, because at the funeral we couldn't believe that we were at this child's funeral. When the occupational therapist phoned me to say that this child passed away, I was like are you sure that it's no another little boy who had cerebral palsy who had aspiration pneumonia. You think, 'I'm sorry, but I expected this child to pass away from genuine complications of his condition; and you're telling me that this other girl passed away from***

	diarrhoea" Line 141-146. *"I mean the previous year she went through a bilateral hip operation."* Line 149. *"You think that she pulled through that which took months and then she had diarrhoea for a day and then died. You're like, 'I'm sorry but there is this complete mismatch at the end of the day."* Line 153-155. Participant 22: *"I saw a couple, husband and wife. I perceived the wife to be the frail one of the two of them. She had chronic pulmonary disease- lung disease. The husband was always the support system, the stronger (physical stronger) one in the relationship he only had a hearing loss.... One day his phone number came up on my phone, it was actually his wife who called me. She said to me, "I'm Mr X's wife. I'm calling on behalf of him because he has been diagnosed with Alzheimer's disease and his not doing so well. Please can you come and adjust his hearing aids". I went and it was such a shock to see the shift in roles and the role reversal from him being the provider and the strong one. At the end he did pass away before her. It was a life lesson for me because you can't predict the situation."* Line 241-251.
Anticipated death	Participant 4: *"If you anticipate death you can sort of counsel yourself more on the fact that it's going to happen."* Line 229-230. Participant 6: *"You are just hoping- I mean she was discharged before and would come back a few times. I thought that she might have gone home."* Lines 58-59 *"... even though it had been coming-it was still a shock. I think it is because I hadn't given up on her."* Line 239-240. Participant 7: *"If they had renal failure or if they had a cerebral vascular*

	accident (CVA)-stroke which they could not recover from; when you first met these patients you were kind of prepared for what was to come. My boss even told me when I got to the hospital that I was going to soon learn a certain breathing pattern and if I hear this pattern, it means that the patient is going to pass away soon." Line 151-153. *"I think when you can prepare for it, it isn't so shocking as it is when it is unexpected. With anticipated death because you don't have the opportunity to develop a relationship with the patient, when you find out that they have passed away there aren't really feelings of shock."* Line 242-244. Participant 8: *"On the Thursday he was pretty much on his death bed because of developing aspiration pneumonia."* Line 55-56. *"I went into his room and he was covered. I almost didn't believe it. I almost wanted to pull his blanket back and start therapy with him-start it for myself. I left the room and even though, he passed away I still asked the nurse what happened to him. They said that he had passed away. I remember just standing there not knowing what to do in that situation and with the fact that he died. I actually didn't process it for a long time."* Line 61-65. *"You do expect some patients to pass away, but when you form a bond with them and see them every day you might expect them to pass away but you hope that they won't."* Line 73-74. Participant 15: *"Based on the physiotherapist's notes I could also tell that the patient was not well...which helped me determine if the patient was well enough to have his hearing tested. There was also someone who could also back up my subjective view of the patient. When the patient died*

	I was able to accept his death because I remember her saying that she was unable to mobilise the patient so I knew that if he lived his quality of life (QoL) *would been compromised. We didn't have interaction with each other after the patient passed away and even when the patient was alive we only communicated via our notes.*" Lines 305-308. Participant 21: "*I think if the death is anticipated...you as a team have more time more time to talk about what's going to happen and decide whether the both of you are talking the same thing such as is this person going to pass away. You have that opportunity to bounce your feelings off the other person and them to you.*" Lines 517-521. Participant 25: "*I did, however, feel relieved when he passed away because I saw the death process and the extent of his suffering which was over a long period of time. It's almost like he didn't have to fight anymore he just needed to let go.*" Line 219-221. "*There were also feelings of relief which I didn't expect. It plunged into feelings of guilt. I ended up Having these whirlpools of mixed emotions.. For example, I questioned myself if I was happy that the patient was gone-it as very weird.*" Line 227-228.

4.4.3. The frequency and magnitude of patients' deaths. Table 4.4.3. highlights three participants' reports on the influence of being exposed to a number of deaths, and the impact of death occurring on a large scale. These participants stated that being exposed to death in their clinical practice either scared or prepared them for death. Whereas, one of these

participants reported that the magnitude of patients' deaths also made her apprehensive to see other patients.

Table 4.4.3. Participants' reactions seem to be influenced by the frequency and magnitude of patients' deaths.

Frequency/Magnitude of death	Participants' Responses
Frequency	Participant 1: "*I think it shaped how I viewed the world in a lot of ways. A lot of patients I've learnt a huge amount from. It makes me think about certain things in a different way. I feel like I'm more prepared for death than most people. I have a will ready just because I have worked with so patients who didn't have a will, and having to see their families struggle, I didn't want my family to go through that. I think I've discussed a lot of my wishes with my family and what I would want especially, after seeing patients in the intensive care unit who are kept alive and then their families needing to make a decision. My family knows that if I'm in a situation like that, I should be switched off. I've had discussions with my family about what my choices would be and also asking them what their choices will be. That is also something that I discussed with my grandparents and mom, which I don't know if I would have done as much if I didn't face the clinical experience of patient death.*" Lines 496-506. Participant 18: "*I think that what scared me the most was how I was*

	only working at the hospital for only 2 months and 5 or 6 of my patients had already passed away." Line 40-41. "*That fact made it hard, I went to the ward all excited thinking that I'm going to change the world only to find out that one of my patient's had passed away. Then I thought, 'Ok, well at least there is always another one' so I went upstairs and I was like 'What?' It's hard to plan and then wonder whether or not you did something wrong, 'Is it because the doctors didn't insert a nasogastric tube (NGT) or did they still aspirate even though it was inserted?'*" Lines 55-59.
Magnitude	Participant 1: "*I was seeing the six patients who were in that ward and were at the end stages of HIV. They were really not doing well. I was asked to see them all and to determine if we could do any feeds that day. I went back the next day and every single one of the patients had passed away. I know that it wasn't anything to do with me and I didn't cause it; but as a way of coping with death and dying, the office started joking that I had death hands. I was quite nervous for a few days afterwards to actually see patients because I had just gone into a room and they said that every single patient had died. I know that I didn't do anything to cause it and rationally I know that, but I think it was quite a shock just to see death on such a large scale. It made me quite apprehensive to see other clients.*" Line 115-125.

4.5. Intra-professional relationships between participants and their ST/A colleagues

The section below outlines the relationships that participants shared with their fellow ST/A colleagues.

4.5.1. Causes of intra-professional conflict. Table 4.5.1. indicates the sources of conflict. According to the two participants' reports, it seems that conflict existed between these individuals due to them not being supported by their supervisors or not being told about their patients' deaths.

Table 4.5.1. Sources of intra-professional conflict among participants.

Cause	Participants' responses
Lack of supervisory support	Participant 12: "*I did have a supervisor. She was a dual therapist but her focus was audiology.*" Line 73. "*.... I didn't feel like she supported me.*" Line 85
Cultural conflict	Participant 12: "*I didn't feel like she supported me*" Line 73. "*...because she would say 'Oh well. Shame, I'm sorry to hear that'...she wasn't of the same culture as me. I kind of was an outsider.*" Line 85-87. "*I would have liked someone to have shared it with.*" Line 291.
Lack of information sharing	Participant 23: "*The colleague who I handed the case over to didn't want to tell me that she had passed away because I was affected by the deaths of patients.*" Lines 54-55. "*I actually asked my colleague how the patient was doing because when I did therapy with her I could see that she was improving.*" Lines 133-134.

4.6. Inter-professional Relationships between Participants and the MDT

This section outlines the characteristics of participants' relationship with the MDT. The MDT comprises of the: medical team (nurses and medical practitioners) and allied healthcare team.

4.6.1. Types of interactions between participants and the medical team. Table 4.6.1. notes 11 participants' reports on their interactions with the medical team.

Table 4.6.1. Sources of inter-professional conflict among participants and the medical team.

Sources of inter-professional conflict	Participant Responses
Inhumanity	Participant 2: "*They would cover them in plastic and put three bodies on a stroller.*" Lines 162-163. "*I feel that the medical system has lost the humanness-they don't treat people like people.*" Lines 169-170. Participant 7: "*I felt a lot of frustration because they just laugh in your face. You are speaking about a human being and that was just really hurtful that people can sometimes not care. There was just no care for human life.*" Lines 194-196. Participant 6: "*For me death is very serious and solemn especially, when someone breaks the news to me- 'Oh it's just RIP or discharged to heaven'-which is my least favourite phrase. I feel that it's completely inappropriate. I can't handle it that because I feel*

	you need to acknowledge that someone's life is lost." Lines 396-399.
Neglect	Participant 2: "*Those were the patients who if they got the adequate medical care they could have survived. Those are the patients who suffered because they didn't get the respect from the nurses and they didn't get the attention from the doctors.*" Lines 166-168. Participant 11: "*An 8 year old child with CP who got a Foley's catheter instead of a proper gastrostomy tube. The tube migrated ..., it just started to create a stoma-it was absolutely huge.... Everything came out of the stoma. So, when you give feeds through a nasogastric tube (NGT) it comes out of the stoma. If you try oral feeds it also comes out of the stoma. So this child died because of not getting enough food because that particular doctor didn't care.*" Lines 94-100. Participant 21: "*They inserted her NGT tube in her lungs so, basically she drowned from her food. ...We put a lot of work in this woman and she really was making progress and some negligent person basically, killed her for us.*" Lines 209-304.
Unfamiliarity	Participant 10: "*Another thing which frustrated me about the doctors and the nurses was that they didn't even know the individual. They were all asking what her diagnosis name was. Here I was the little speech therapist being like, "She had TB meningitis, she wasn't eating nicely and she couldn't communicate and this is her name.*" Lines 213-215.

Moral view points and threats to ethics	Participant 1: "*The doctor outright refused, he thought that it would be kinder to let the patient die These were his words to us.*" Lines 53-53. Participant 4: "*I think that the doctors and nurses had the mentality that if the patient was end stage HIV and had all these comorbidities; they would leave the patient to die. I sought of fought just to say well it's inhumane to let him or her just die like that.*" Lines 65-67. Participant 7: "*I feel like when the patient is older they kind of label them as poor prognosis so, they going to become the second or the last priority.*" Lines 90-91. Participant 10: "*The doctor who was doing compressions stopped to fix her bracelet....They were very wishy washy about determining whether she was for resuscitation or not. For me, that shouldn't make a difference, they should start compressions regardless.*" Lines 235-241. Participant 11: "*When I confronted the doctor, he said the child is better off dead. The doctor even asked me if I would have taken the child home and taken care of it because the child had CP. I think sometimes in these cases we see that some doctors feel, 'Why even make an effort? Because they won't have the ability of a normal child.'*" Lines 102-105.

	Participant 16: "*He had people treat him differently because people thought that he was retarded and they would even write that he was, in his file despite, him being able to understand and speak. He was even transferred to the psych unit even though he wasn't a psychiatric patient, but he was treated as if he had poor mental health.*" Lines 46-49. Participant 20: "*I feel quite strongly that the outcome was affected by the young doctor on duty because he rushed around and gave the patient adrenaline and she was put on antibiotics...., I actually felt quite angry that she was treated aggressively with antibiotics when perhaps, she could just gone peacefully.*" Lines 77-81. Participant 20: "*I had some conflict with the team over that because I felt that we should ask her to indicate whether she wished to be resuscitated or not. Other people in the team felt that she shouldn't because they wouldn't necessarily be able to carry out her wishes.*" Lines 154-157. Participant 20 "*I can remember being irritated at her funeral because there were a lot of children in the congregation and the minister said, "You must be sitting wondering why she had to die when she was so young". I was irritated thinking most of us were wondering why she had to live so long; but generally, death of a younger patient is worse.*" Lines 220-223. Participant 21: "*The pastor spoke about how this child's life was so fulfilling, but this child couldn't run, she couldn't go to the toilet by herself and she couldn't talk; yet the pastor was saying how her life*

	was fulfilling and now she was fixed....We thought really that's who she was and that's why we loved her." Lines 107-113.
Personality and Style	**Participant 8:** "***The doctors were very harsh and cold. They came in*** *for 2 minutes when they were available, spoke to the families and ran* ***out.*** " Lines 432-433. "***The doctors didn't really interact well with*** *the* ***significant others and most of the time the patient's family would*** ***wait around for the doctors who would never come.***" Lines 446-447. Participant 14: "*Because of him being so spastic people didn't take* ***the time to communicate with him. He was very isolated and because*** *he was difficult to transport he sat out of a lot the events. He had a* ***specialised wheelchair but it was just a hassle to get him to go*** ***anywhere.***" Lines 70-73. Participant 25: "***The doctors were very pessimistic and very*** ***emotionally detached.***" Lines 405-406.
Threats to professional integrity	**Participant 11:** "***I was very mad about it because even afterwards the*** *doctors said to me that the baby died because of natural causes. I* ***said that you could clearly see that the tube had migrated into the*** ***abdomen and the doctor stuck with the death being a result of*** ***natural causes.***" Lines 65-67. Participant 16: "***The nurse came and took me and said to me that I*** ***can't say that, but I told her that it was-it was all of our faults. I told*** ***her that she can't tell me that this was a natural event. I had to go*** ***speak to my boss and she said to me that you can't say that it was***

	your fault and I said to her that it was my fault, it was all of our faults. Nobody took responsibility and the feeling was, "Oh he died of old age, shame." Lines 141-146. *"It just bothered me that no one took responsibility, and then I was almost scolded at for taking responsibility for the patient's death."* Lines 159-160. *"I don't think that I will ever get closure from the patient's case because nobody was held accountable and nobody said, 'I'm sorry. I neglected him.'"* Lines 191-192. Participant 21: *"You will ask, 'Who were the nurses on duty?' and they would say, 'We don't know, it was shift change'; or you would ask, "Who was the doctor attending to the patient?' and they're like, 'The professor wasn't here so this person took over.' So, it becomes this blur of information because no one really wants to take responsibility-it's horrible."* Lines 319-323.
Avowing	Participant 8: *"I remember when one of the doctors said to me... 'I know that you don't want to hear this but the patient had aspiration pneumonia. You were right'. I remember him saying that and me wanting to shout and say, 'If you just listened to me'."* Lines 115-117.
Lack of collaboration	Participant 4: *"I contacted the doctor to put in an IV line or insert and NGT but then she passed away from pneumonia, aspiration pneumonia. That is what we had been saying the whole time."* Lines 137-139. *"...aspiration pneumonia because no one had followed through with what we were saying."* Line 205.

	Participant 14: "*There was a little bit of anger towards the nursing staff because they were quite apathetic when I tried to create dysphagia awareness.*" Lines 136-137. Participant 25: "*I fought for him as much as I possibly could and there was just nothing that was happening.*" Lines 152-153. "*It was almost as if the doctors and the allieds were fighting each other.*" Line 408.
Conflicting Findings	Participant 4: "*They said that she was actually fine to feed. They said that she puts on an act when I'm there and when the family is there. You can't really act out penetration-she was literally choking when you even gave her a sip of water.*" Lines 119-121
Professional Hierarchy	Participant 4: "*As a speech therapist and audiologist you sort of looked down upon. You're seen as the people who play with the children or the people who feed patients yoghurt. You're considered as not doing anything important. Then when a patient passes, you feel that maybe you weren't assertive enough in trying to advocate for the patient and their treatment.*" Line 263-266.
Role confusion	Participant 4: "*The nurses were arguing with me that they were the ones who assess feeding, not us so who are we? They played a race card.*" Lines 121-123.
Lack of communication	Participant 2: "*She had kids...they weren't informed about the situation. No one communicates with anyone. Things like that influenced me a lot.*" Lines 77-79.

	Participant 7: "*I felt angry because they wouldn't tell me why she had gone.*" Lines 108-109. Participant 8: "*Often, the doctors did not interact with the families of the patient as well as with me. For example, no explanations regarding the patient's death were given. Sometimes I didn't expect the patients to die, yet the doctors did-but that was never communicated.*" Lines 447-450. Participant 25: "*I was running after the doctor trying to get them to communicate with me.*" Lines 122.
Unasigned Tasks	Participant 10: "*She called for help but no one came to help her. She was struggling to do anything on her own and she looked at me and said, "Please can you help me". My instinct was to help. I had done a basic lifesaving course but I didn't remember a lot, but she needed my help lifting the body onto the plate to start compressions.... The doctors came into help but they kept swopping over with compressions and no one was assisting me with bagging. I didn't even know if I was doing it right. I had no idea. I was trying my best for this patient, was hoping she would make it and praying for her.*" Lines 165-175. Participant 11: "*The nurse told me that the baby was dead and that I shouldn't tell the mom.... The whole time I was sitting with the mom the mom was talking about what she's planning for the baby, but I already knew that the baby was dead.*" Lines 53-55. "*I was very*

	upset and mad at the nurse. I felt that it was not handled professionally on their side. I felt that it wasn't my job to keep the mom company with the dead baby. What can I tell her- I also felt helpless." Line 61-63. *The mom as very upset with me when she found out that the baby was dead.*" Lines 69. Participant 12: "*I specifically recall a patient who I was treating for dysphagia I went into his room about twice a day to check on him and see if he was getting the medication that he needed; because at the hospital I was working at they would just forget about patients.*" Lines 40-42.
Systemic challenges	Participant 6: "*Myself and the three other therapists who seen her tried to lodge an incident report. We wanted to make it clear that we felt like her death could be avoided. We lodged two different complaints at two different times but never heard back. That was something else.*" Lines 116-118. Participant 11: "*One of the babies that I had, I knew for 3 months. The baby was in hospital for 3 months. There was a big strike in 2006 .... Eventually, they had to get army nurses and doctors to help out in the hospital. The army doctors and nurses don't work with neonates and my baby died. I knew the baby for 3 months and it literally was one of those really sad things, but at least I know that I have done my best.*" Lines 114-118.

	Participant 14: "*I feel like if he was in an acute hospital the nurses would have been on-top of intubating him so that he would of at least been able to breathe despite there being an airway blockage.*" Lines 134-136. Participant 25: "*A lot of them almost did not want to put in a feeding tube because they did not want to waste resources which created more feelings of anger towards them.*" Lines 406-408.

4.6.2. Effects of inter-professional conflict among participants in instances of patient death and dying. Table 4.6.2. highlights only six of the ten participants' reports on the effects of their relationship with the medical team

Table 4.6.2. Effects of inter-professional conflict on participants.

Theme	Participants' Responses
Betrayed	Participant 4: "*We did try and bring it up with management at the hospital but nothing ever happened.*" Lines 146-148.
Deceived	Participant 1: "*He said that he had put in the NGT but when we went to see the patient there wasn't an NGT inserted. We had spoken to the nurses and they said he never put in a NGT.*" Line 55-57.
Undervalued	Participant 1: "*Myself and the physiotherapist said to him, "We think that you inserted it incorrectly, we think that it is in the lungs." He said, "I'm the doctor, you're not qualified. You insisted on having this, you will feed the patient now". We said, "We think it's in incorrectly" and*

	He said, "No, this is my medical call it's in correctly, you will feed the patient". Myself and the physiotherapist did not feel comfortable to do it and the nurses fed the patient. The patient passed away because the patient aspirated on his food." Lines 64-68. Participant 6: "*The doctors and the nurses look down upon us.... I feel like sometimes they feel like we are getting in the way of them doing their jobs.*" Lines 464-466. "*I think doctors and nurses don't take us seriously so it adds to a lot of the anger that I feel when things don't get done. We come from a place where we are told to be collaborating but I feel that people are just ignoring us.*" Lines 492-494.
Inhumanity	Participant 4: "*I think you sort of end up seeing patients as numbers and not as people or as a diagnosis and not as a person.*" Line 236-438.
Threats to collaborative practice	Participant 11: "*I fought with the doctors regarding the insertion of catheters instead of gastrostomy tubes. I was even thrown out of the doctors' ward.*" Lines 598-600. Participant 16: "*I was very annoyed with the doctor. I was actually quite rude to him in the sense, that I would just greet him, but didn't have a relationship with him anymore.*" Lines 157-158.

4.6.3. Types of interactions between participants and the allied team. Table 4.6.3. indicates that ten participants considered the allied healthcare team to be supportive. They were able to debrief with these individuals, while three participants did not seem to perceive the allied healthcare team in the same regard.

Table 4.6.3. Types of interactions between participants and the allied team.

Types of interactions between participants and the allied team	Participants' responses
Supportive	Participant 1: "*I think working in the multidisciplinary team is a huge part of dealing with stressful situations. We didn't have a formal debriefing space. I think most therapists make it themselves. I think it is nice to have someone with you in those situations so you don't feel so isolated so you can also justify what you did was actually what you were supposed to do.*" Lines 89-94. Participant 4: "*I think it's a lot nicer working within an MDT, it's more supportive.*" Lines 333-334 "*We could share how we were feeling and counsel each other. I think it also helps because you can relate to the situation and you don't feel alone. Feeling the same thing is more meaningful than if you go for counselling and seek professional help afterwards, as it is more detached counselling. Whereas, with allieds it is more attached counselling.*" Lines 342-344. Participant 11: "*If you have a good team with you, not for emotional support, but just for having information about the patient. I think that really helps if you have good communication with the MDT so that you*

	know what's happening with the patient. It also helps prepare you and prepare the mom better. It changes your expectations for the baby; as a speech therapist we are so focused on our little part of what's *happening with the patient we don't see the big the picture For me, I* ***would be realistic in terms of my goals for example, I would ask myself,*** *"Do I really want this baby to feed perfectly before he or she goes* ***home or just functionally?" If they able to get the milk in without*** *aspirating he or she should get home.* " Line 391-408. Participant 7: "***I think it makes it easier to work through the experience of patient death. It's one thing to speak to a colleague who didn't know the patient; but when you speak to someone who worked with on the*** *case and knew the patient like you did,...*" Lines 501-503. "*...it's quite* ***nice to work within a team.***" Lines 509-510. Participant 10: "***When I spoke to the physiotherapist about the 80 year*** *old patient who had a CVA.*" Lines 602-603. "*...* ***we were able to understand each other more. I think because allied HCPs talk to a patient a lot, there are more interactions, communication and relationship building as compared to the doctors. I think working within the MDT creates more of a shared experience with people who*** *understand what you are feeling because you are there with them.*" Lines 611-612. Participant 11: "***Like us, they build quite a strong relationship with the***

	patient." Line 471. "*I think it's more about the personalities of the allied team members; we are more alike as compared to the doctors.*" Lines 473-474. Participant 13: "*I think sometimes it makes it better and a little bit easier to deal with when it's a patient who has been seen by multiple people because I have someone to talk to who is in the same shoes as me. You can grieve together and talk about it. You are able to support the family together and not just on your own.*" Lines 282-285. Participant 14: "*The physiotherapist and I had common goals... We tried to give him experiences that otherwise he wouldn't have had so, when he passed away it was good to know that there was someone else who felt the same way that I did and I could speak to her about my feelings.*" Lines 350-353. Participant 18: "*I would doubt myself, but having that reassurance for the other allieds helped because then I knew it wasn't just me who thought that a patient had regressed.*" Lines 244-246. " *In a way, I also prefer the interaction with the MDT because they knew the patient so they can understand the situation.*" Lines 286-287. Participant 20: "*I think working in a team helps because when something goes wrong and they don't do as well as you thought they were going to do, ... where we question and doubt ourselves- 'Did I do*

	something wrong?' or 'What could I have done differently?',the team is extremely supportive." Lines 443-447. Participant 25: "*The allied team were completely different.*" Line 392. "*I felt a lot less lonely in a team because all worked together with a patient. So, I think that felt more calm and I had the right emotions because looking at people and seeing that it is ok to feel the same way and you can take more openly about it because they are reacting the same way.*" Lines 394-398.
Unsupportive	Participant 6: "*I never felt like I went through the patient's death with the team. Irrespective, if the patient's death was sudden or anticipated. I feel like this wasn't something that we spoke about even those patients that I was treating with OT most of them would say, 'Yeah it's terrible' and you'd say, 'Yes, it's terrible.* '" Lines 524-527. Participant 8: "*I feel like the MDT...had encountered more death than I have. So they'd brush it off...and say, 'Don't bother going seeing Mr so, and so his dead'. You will see the flipping through the file documenting RIP. They almost make you feel that you don't have a right to be upset.*" Lines 403-406 *If they're coping with it...you must do the same.*" Line 410. Participant 16: "*I remember... speaking to other professionals who saw him and they said, 'Oh ok'. They were very aloof about patient death. I think that my feelings towards their reaction were twofold because they*

	didn't get attached as I did so, I couldn't get upset by their responses but at the same it did bother me." Lines 436-437.

4.7. Interactions between Participants and Patients as well as Patients' Significant Others

This section outlines the relationship between participants and patients, and patients' significant others

4.7.1. Types of interactions between participants and patients. Three participants reported that patients did not: follow through with treatment recommendations, were not always co-operative in treatment, and did not take care of their health. Furthermore, four participants stated that they had formed: attachments, relationships, and connections with patients. These reports are mentioned in Table 4.7.1.

Table 4.7.1. The influence of interactions between participants and patients when these patients pass away.

Types of relationships	Participants' reports
Conflict	Participant 5: "*He refused any other treatment from a hospital, he refused a tracheostomy tube and a PEG. He literally was at the point where he couldn't swallow and breathe at the same time and needed a PEG.*" Line 256-258. Participant 16: "*When I heard the news, I felt this incredible guilt because the patient had died from malnutrition and in the end the patient started to resent me because I told him what he could and couldn't eat and he would fight with me. I had this mind-set that I was the speech therapist and I knew best. All the patient wanted was a McDonald's burger and I wouldn't allow him to have*

	the burger." Line 134-138. "*I went to the ward in the afternoon and his sister was there. The minute I saw her I hugged her and cried. I said, "I'm sorry. This is my fault" and that is all I kept saying.*" Line 140-141. Participant 18: "*She passed away from a respiratory infection which was related to her smoking. Her lungs weren't strong enough to support her.... People die because they don't have an option but in this case she had a choice and I feel that she brought death upon herself. It was just so sad.*" Line 81-82 & 89-90. Participant 25: "*I was frustrated that it was the same thing over and over again. He was always crying and always in a bad space. I couldn't get my treatment done so it was also anger towards him.*" Line 70-72.
Therapeutic interpersonal relationship	Participant 5: "*I got emotionally attached to him. I really had so much hope for him- that he will improve and maybe return back to his family one day.*" Line 85-86. Participant 12: "*It's much more difficult when you've know them for longer and you know their experiences. I had one specific incident where a gentleman, who was at a retirement village, had passed away 4 years ago and even when I still go pass his room, despite the fact that two families have subsequently moved into, I still think about him. He was one of the patients which I've seen earlier on my career and I had a special connection with him- he was such a lovely man.*" Line 330-334. Participant 14: "*We built a relationship with him.*" Line 79. "*Through the*

	relationship we had built, I was trying to expose him to what he had been missing out on." Lines 80-81. "*I promised him that I would visit him and I had a complete sense of regret that I hadn't gotten a chance to visit him before he passed on.*" Lines 130-131. Participant 18: "*You do form an attachment to your patients. For instance, I saw this one patient every day for 3 weeks and the one day I went there she had passed on. It was just sad.*" Line 61-63. Participant 23: "*I think that with this patient her death was quite emotional for me because of the way she spoke to me-she was such a lovely person.... Her personality and who she was is what made her death difficult for me. In her case, she was well and then suddenly she was a completely different person. She had set-backs. It was really hard for me because she wasn't able to eat by herself and she was proud person. I think for a person who is proud and used to doing things by themselves and then not being able to do anything for themselves is quite a big thing.*" Line 116-124.

4.7.2. Types of interactions between participants and patients' significant others.

Table 4.7.2. reflects the interactions that participants had with patients' significant others. Three participants reported that patients' significant others abandoned patients, and did not seem to follow through with treatment recommendations. Furthermore, Participant 22 stated that when her father was nearing his death she viewed him as clinical case. Thus she seemed to be concerned about him not wearing his hearing aids, as she reported: "*The speech therapist in me would be analysing his speech and cognition and I would just have say to*

myself, "Be the daughter". Lines 67-69. *"I was getting clinical with a family member I was such an audiologist. He passed away in the middle of the night and literally, on the day that he passed away I had walked into his room and he wasn't wearing his hearing aids. I asked my mother, 'Why isn't dad wearing his hearing aids', it just shows the audiologist in me that, that was the first thing that I noticed; my mother said to me that he was completely unresponsive so there was no point in him wearing his hearing aids. I said to her that I'm just going to put on his hearing aids so that I can see it for myself."* Lines 76-81.

Participant 22 reported that patients' significant others did not support each other, while Participant 20 said patients' significant others seemed to have attributed the causes of patients' illnesses to them doing something bad in their lives, as she said: *"I've worked with quite a few people who have a view that illness or disease results from something wrong that a person had done in their life. I'm always grateful that in a sense I don't believe that because I think that must colour judgement of the person and making dealing with death harder or easier- I don't know. I personally, don't have those beliefs, I believe that if you get a stroke or brain injury it is a just a question of really bad luck, but some people feel differently and I think that probably does affect their experience."* Lines 371-377.

However, six participants made reference to supporting patients' significant others by: contacting them telephonically, sending them text messages, emailing them, speaking to them, attending patients' funerals, or giving them space to come to terms with their loss. However, Participant 24 stated that when she would see the deceased's' significant others she would be reminded of the deceased, as she said: *"The mom obviously came when the other twin needed to come for his routine check-up. So, I saw... We also did communicate through messages."* Lines 57-58. *"I think that it just kept bringing it back. I think that it was just a reminder, every time the family walked in I would think about it."* Lines 73-74. Additionally,

two participants said that deaths of patients were difficult when they built a rapport with patients' significant others or when these individuals cared for patients.

Table 4.7.2. Interactions between participants and patients' significant others.

Types of interaction with patients' significant others	Participants' reports
Conflict	Participant 5: "*The family never came to fetch him at the hospital. They didn't visit him while he was in the ward. He just gave up because he didn't seem of any interest to anyone.*" Lines 132-133. Participant 8: "*He died from aspiration pneumonia. It was a very difficult case because the family believed that he could eat even though, I kept educating and counselling the family. When their loved one asked for food they would give him or her food to make him or her happy.*" Lines 86-89. Participant 11: "*I had once instance where the mom just gave the baby rooibos tea....We counselled her and the baby just continued to lose weight. She just kept on saying that she didn't want this child, she has 6 other children, and she didn't care of the baby lives or dies. It was baby with a cleft lip and palate. She continued to give the baby rooibos tea and the baby died.*" Line 679-684. "*The friend was present and had the audacity to say that the baby cries night and day. I said, 'Well, if you only had water to drink you would also*

	cry night and day. He is hungry!" Lines 689-691. Participant 12: "*I noticed that if babies had a lot of complications the parents would kind of abandon them. For me that made it harder than a baby passing away because I felt that the baby was going to get medical attention, then go back to their parents and then in 3 months' time they were going to get readmitted.*" Lines 205-208. Participant 22: "*I am Jewish and since the importance of family has been ingrained into me, it does surprise me when you encounter family members who will tell you about instances where one child is left to handle everything.*" Lines 488-490. "*...you wonder, 'Why didn't they all pull together?', as a Jewish person you assume that everyone is going to be there for each other and sometimes it is more solitary for one sibling or sometimes the family won't always be the support structure.*" Lines 491-494. Participant 25: "*There was just a deep frustration that there was no need for him to be in hospital for that long. The only reason that he was there was because no one wanted to or could not afford to take him out.*" Lines 88-90.
Supportive	Participant 1: "*I would go speak to the patient's family after the patient had passed on or emailed the patient's family members.*" Line 108."*I know a lot of the family said to me that they were pleased that she was in a better place; because she was really struggling. So, in some ways it wasn't a difficult situation, at least*

	we knew that she wasn't struggling as much as she had been." Lines 185-190. Participant 5: "*I think it was the mom trying to do her best and just caring for the child-that really stood out. I think that is why it made it so difficult for me because I knew that she tried her best. I think also the fact that the mom knew that one day her child would pass away.*" Lines 73-76. Participant 8: "*I built a rapport with them.*" Line 129."*When he passed away I remember wanting to give them their space. It was a brief encounter after the patient's passing...I went to say, 'I'm sorry for your loss'. They were sobbing between tears and they just said, 'Thank you for what you have done'. It was heart-breaking because they thanked me between tears*" 138- 142. Participant 12: "*I think it definitely influenced my reaction because when a mom was very supportive and came to feed her baby, stay at the hospital with her baby, cup feed her baby or even tube feed her baby; if that baby passed away, I would be devastated because that mom tried her best. I would feel for the mom because with some of them you could see they were trying their best; they were holding that tiny premature baby who looked like he or she was going to break but the mom was doing the best that she can do.*" Lines 255-260. Participant 13: "*Being a mom...even though, I may have not lost a*

	child I can imagine what it means to lose a child. Thus, I'm able to give the parents support and the comfort which they may need." Lines 85-88. Participant 16: "*I had phoned the patient's son to give him my condolences.*" Line 91. "*He seemed okay with his dad's passing so I was also fine with it.*" Lines 105-106. Participant 20: "*I think it's a way of acknowledging to families that you recognise their loved one as a person who had a life before a stroke, for instance. It's an acknowledgement of the person's life, their humanness and their personhood which I find is important.*" Lines 132-136. Participant 21: "*I went to the funeral to support the parents.*" Lines 123-124.

4.7.3. Limited support provided to patients' significant others. Table 4.7.3. highlights that nine participants provided limited support to patients' significant others. This was due to participants not wanting to overwhelm them and wanting to give patients' significant others' time to organise patients' funerals. Furthermore, language barriers, geographical barriers, financial constraints, significant others' defaulting counselling sessions, and participants needing to fulfil their work-related responsibilities, all contributed to participants' not being able to support patients' significant others.

Additionally, five participants wanted to maintain self-preservation. Therefore, they did not contact patients' significant others. Two participants also reported that they were at a

loss for words, and were thus unable to support patients' significant others. Participant 4 stated that she was in an uncomfortable situation, as she said: *"It was a difficult situation because you don't want to tell them that the doctors and nurses aren't doing their jobs. So, you trying to explain to them what is going on and they asking why the doctors and nurses aren't doing they supposed to do. You can't put the doctors and nurses in a bad light either as they are staff."* Lines 141-146., and was thus unable to provide support to patients' significant others. On this note, Participant 5 stated that *"Some professionals may feel like that is closed now; they don't end up contacting the patient's family."* Lines 410-413.

Table 4.7.3. Participants' explanations for providing social support to patients' significant others.

Reasons for limited interactions between participants' and patients' significant others	Participants' responses
Systematic challenges	Participant1: *"I think often you don't work within a team and you wouldn't approach a family as a huge team as I think it's very overwhelming for the family."* Lines 102-103. *"After, a death there is so much to deal with and so much information is given to families, it's not always helpful to kind of impose yourself in certain situations."* Lines 234-235. *"It was very much the doctors' or the nurses' roles. At the organisation the social work team were fantastic in negotiating that". It really depends on the work*

	setting. In the hospital, we had fewer opportunities to speak with the patients' family and that was due to language barriers. I will leave it up to the family to contact me." Lines 246-250. Participant 2: "*They weren't allowed in the ICU. I never heard anything from the family. They were never there at visiting hours.*" Lines 107-109. "*Depending on how long the patient was in hospital for, we would make appointments with the families so that we could counsel them together... but they didn't always come back. You don't always know where they are after that.*" Lines 283-286. Participant 7: "*I never met the patient's family after the patients passing. I've always come after a few hours after it has happened or day after it's happened. The body has already been taken by the patient's family.*" Lines 322-325. "*They weren't living in South Africa.*" Lines 341-342. Participant 10: "*In government we didn't have the opportunity to meet the patient's significant others. I think it's got a lot to do with cost. I feel that if the patient is close to his or her family, his or her family members are probably working to try and save up money. It' not easy to get off work. I know a lot of my patients' family members lived far away.*" Lines 261-266. Participant 12: "*I didn't meet the family. I was told that he had children but they lived far away; so he was all alone.* Line 167-

	168. Participant 13: "*My encounters with them were very brief and it was just over the phone.*" Line 111. "*If the patient is admitted into hospital and passes away...,there are other professionals dealing with them and our encounters tend to be brief. I think from the family's point of view, they want to move on organising the funeral and grieving.*" Lines 131-133. Participant 18: "*By the time I came to the wards all their records had been taken. I didn't have access to their families' contact details.*" Lines 126-127.
Personal attributes	Participant 3: "*I was quite close to the parents of the student. We had a good professional bond that I felt what should say to the family-it was so difficult. You don't know what to say either than 'I'm very sorry, my deepest sympathy.'* " Lines 55-56. Participant 6: "*I didn't really talk to the patient's family after the patient had passed.*" Lines 227-230. "*I think it's a lot of self-preservation. If I had to sit and talk to someone about how they lost their sister, mother or children-I would just completely fall apart...I shunned away from it unconsciously.*" Lines 403-404. Participant 15: "*I basically offered my condolences and thanked him for bringing in his father-in-law's hearing aids.*" Line 108. "*If the son-in-law stayed longer he would have explained the whole process and that would have affected me more because*

	then it would have shed more light into the picture. Since, the interaction with him was limited I didn't really grasp the whole story." Lines 115-118. Participant 18: "*The truth is that I wouldn't have known what to say to the patients' families, like would I have said, 'I'm the speech therapists who helped your family to talk and now she's dead.*' " Lines 128-130. Participant 18: "*I didn't encounter their family members. I think that it was good for me because in a way I didn't feel so much loss.*" Line 126. "*I think that if I spoke to the patient's child it would have been more real for me.*" Line 136-137. Participant 19: "*I didn't feel comfortable to chat to them.*" Line 74. "*Therefore, I think not having interaction with the patient's family actually made it easier. I didn't have to phone them and awkwardly say how sorry I was.*" Lines 95-96. Participant 23: "*I think that it would have been really hard for me if I had to speak to patient's family.*" Lines 98-99. "*I wanted emotionally protect myself.*" Line 104. Participant 25: "*I didn't have contact with them afterwards. I don't know if was because I didn't want to think about it-I mentally pushed it away-or because I forgot about it subconsciously.*" Lines 115-116.

4.7.4. The effects of interacting with patients' significant others or a lack thereof, on participants. Participant 3 stated that the following characterised her interaction with patients' significant others: "*I think grieving with them and trying to understand meant so much because basically, what they said was that they had to share the bad news but at the same time they wanted to just thank me for what I've done.*" Lines 160-162.

Table 4.7.4. indicates how having and not having interaction with patients' significant others influenced participants' experiences with patient death. Two participants were able to receive closure from patients' deaths when they interacted with patients' significant others. However, due limited contact between participants and patients' significant others, it resulted in three participants not being able to receive this closure.

Table 4.7.4. The influence of interacting or having limited interaction with patients' significant others.

Interaction with patients' significant others and a lack thereof	Participants' responses
Interaction with patients' significant others	Participant 3: "*I think grieving with them and trying to understand meant so much because basically, what they said was that they had to share the bad news but at the same time they wanted to just thank me for what I've done.*" Lines 160-162. Participant 17: "*Certainly, the memorial and interaction helped a lot. I think that it was critical in moving through the process because some of my colleagues who worked closely with this little boy and hadn't*

	experienced loss in their lives were struggling more than me. It offered some closure and it allowed. I think having a bit more information helped as well as getting a sense of how the family were coping it *helped. I felt that they were going to be ok and that the ok.*" Lines 112-119.
Limited interaction with patients' significant others	Participant 4: "***I don't think that I was able to give the family closure and in turn that also did not completely give me closure. I don't know*** *what the family was told or how they were told. I might have been able* ***to give the different insight to the situations and empathy.***" Member checking. Participant 7: "***I had a lot of questions about how the family was*** *doing....I think it would have helped 'heal' by knowing that they were able to give her a burial...and that the family she cared for and loved were coping.*" Member checking. Participant 22: "***I think that in government not having that interaction*** *with family members resulted in not having closure when the patients passed away. You so often wonder, "What happened to the child's family?...Did the family manage to cope with the patient's death.*" Lines 418-420.

4.8. South Africa as a Context of Patient Death and Dying

This section outlines on how SA serving as a context of patient death and dying impacted on participants' experiences.

4.8.1. The impact of SA as a context of patient death and dying on participants' experiences. Table 4.8.1. highlights how participants' residing in SA impacts on their experiences with patient death and dying. Participant 20 stated the following: *I am currently working in a place where there is a strong feeling that everything possible should always be done; so even in cases where people have living wills.*" Lines 394-396. "*I have had one case just a couple of weeks ago where the patient had explicitly stated that she wished to not be fed non-orally but the decision was made to put in a nasogastric tube (NGT) anyway. I found that quite shocking because that actually wasn't her wish but there is a very strong institutional culture here that you do everything humanly possible.*" Lines 398-401. "*Even in South Africa we have pockets where there is great difference so I have worked in environments, for example, where there are 10 or 20 profoundly demented people who are unresponsive and being fed through a gastrostomy tube. Equally, I have worked in environments simply where that wouldn't happen and putting a gastrostomy tube would not even be considered, even if a patient has advanced dementia.*" Lines 417-421. Therefore, the MDT approach to EOL care is dependent on the type of environment that participants' practiced in.

Furthermore, only five of the 14 participants' reports are reflected in Table 4.8.1. These participants stated that being exposed to death in South Africa left them feeling angry, helpless, hopeless, and yet desensitised them to death.

Table 4.8.1. The impact of SA serving as a context of patient death dying on participants' encounters.

Impact of residing in SA	Participants' Responses
Anger	Participant 2: "*I feel if you look at South Africa there are so many things which could be prevented if taxes were rightly used.*" Line 373-374. "*...how is it possible that there aren't enough nurses to treat people? Since, resources aren't spread equally or fairly it does make you a bit negative about the government...*" Line 378-380. Participant 12: "*...at the hospital that I was working at no one cared. People working in the hospital are desensitised to death.*" Line 375-376. "*I wouldn't be able to be desensitised because for me death is something that is not taking lightly especially, if someone had to suffer before they died. I think living in South Africa has made me very frustrated. I feel like people could do more, if they just cared more, then a lot of problems would be solved.*" Lines 380-383. Participant 25: "*I think that adds to my feelings of mild indifference which then makes me angry because I'm like, 'Why are we all letting this happen?' It then reinforces those feelings of helplessness which leads me to feel angry.*" Lines 369-371
Learned helplessness	Participant 7: "*You actually have to accept that there is nothing more you can do, as much as you speak to the doctors and the*

	nurses to try and give the best care to your patients, you just have to accept that nothing is going to be done about it and move on." Lines 174-176."*...I kind of have this, which is so sad, I have this expectation that people are going to get neglected because there is a lack of finances going into hospital and lack of resources.*" Lines 475-477. "*...you kind of expecting things like death to happen all the time because that is the country that we live in. You will be more shocked about a peace rally than patients dying.*" Lines 484-486. Participant 16: "*I think that it made me feel helpless at times because you're faced with the worse of the worse. At times, I would feel down-casted and hopeless as to why they were so violent and why did they wait so long to consult with a doctor if they had a tumour.*" Lines 418-420.
Desensitised	Participant 25: "*I think that death is more apparent here, it's everywhere and people have been in near death experiences. So, I think that, in a way, it kind of numbs you a bit towards everything.*" Lines 363-364. "*The shock factor is absorbed by the exposure of death and violence which we have on a daily basis.*" Lines 368-369.

4.9. Personal loss versus Patient Death and Dying

This section focuses on how personal loss contributed to participants' experiences with patient death and dying, and visa versa.

4.9.1. The difference in grief reactions in instances of personal loss versus patient death and dying. Participants' statements reflected in Table 4.9.1. reflect how these encounters, if at all, influenced each other. Two participants stated that patient death and personal loss influenced each other. However, two participants stated that they had different grief reactions in experiences with patient death versus in instances of personal loss. Of these two participants, one participant stated that she grieved longer when her significant others had passed away, as opposed to when her patients had passed away. Personal loss seemed to have prepared participants for patient death, and ensured that they provided supported to patients' significant others. Furthermore, two participants either used strategies that they had gained from experiencing personal losses to counsel patients' significant others, or participants adopted practices employed by patients' significant others to work through their (participants) personal losses.

Table 4.9.1. The influence of participants' experience with personal loss on patient death and dying, and visa versa.

Influence of personal loss on patient death and dying and visa versa	Participants' Responses
Duration of grief	Participant 12: "*If it's someone more close to you, it would take you longer to go through the stages but if you grieving for a patient it would only take you a few days to go through the*

	stages." Line 336-338.
Grief intensity	Participant 12: "*I have lost a grandmother and grandfather luckily, not close friends; even with my grandmother and grandfather I wasn't close to them. That is also a different kind of grief because it's family- it's someone that you know and share memories with.*" Line 310-312. *I don't think that you go through all the stages.*" Line 340. "*You kind of go through, 'What could I have done differently? What could I have done to prevent this? What could someone else have done to prevent this?'*" Line 348-349. Participant 25: "*I can say that the feelings which I had towards the patient's death were not the same feelings that I had towards my aunt's or grandmother's deaths. It did cause a weird feeling of should I have felt guilty for not feeling more. I mean I miss my grandmother more than I miss the patient, my body was automatically like that isn't fair, it's almost an irrational way of thinking like I should have felt sad for the patient by I didn't.*" Line 189-193.
Triggering emotional and traumatic memories	Participant 10: "*I feel like they both influenced each other in a way. I've noticed that it did affect me especially, with the last patient because I know he went through resuscitation. I wondered if the hospital he was admitted into, whether or not the staff did everything they could or were they slacking like the*

	nurses in my hospital were, and did they do everything they could have?" Lines 462-466. Participant 17: "*I lost my sister to drowning when I was a child. Therefore, it was particularly significant because I had experienced a similar loss when I was a child.*" Lines 57-58. "*I suppose that if you experience something similar or hear it in the news it does stand-out, and definitely this experience took me to the same place.*" Lines 76-77.
Psychological preparation	Participant 5: "*In my community service year I had so many patients passing away and you become more emotionally mature, in the way that you deal with these situations and how you accept it and adapt.*" Lines 214-216. "*I think it's just that you learn to cope better with it. It still touches you emotionally; and by emotionally mature I mean that the patient passes away and you learn better coping mechanisms.*" Lines 223-225. Participant 6: "*I think one thing that is good of have gone through the death of someone you loved and patient death is that you are less scared of death. You are less scared of being close to people who are dying.*" Lines 269-271. Participant 13: "*I think that my personal experience with death has taught me to view death in a way that it is not something we should fear and that it something which is inevitable whether it*

	happens expectedly or unexpectedly. It's also made me aware that it's ok to talk about death, it's ok to grieve and have feelings towards patient death and it's fine to express your feelings and concerns towards death." Line 227-231.
Provision of social support	Participant 1: "*When I'm counselling families, I may sometimes use it as an example of how we managed to do something especially, a lot about the practical things after death were the things I didn't know until I experienced it with my family. It has been quite useful to use it as an example. I don't always think it's appropriate, I think there is a time or a place to share those types if stories with families. I think it has given me a different perspective with how I work as a therapist because I feel that I have quite a good understanding of both sides.*" Lines 391-396. Participant 6: "*My grandfather died a few years ago. When he was really sick, the first time he was in hospital, my aunt couldn't handle it. For some reason seeing people in pain and being there for them- it is something that you learn. So, when he needed someone and when he was in a lot of pain and very sick my mom and aunt couldn't handle it; .... It wasn't so scary because, yeah it is scary, but you know that you can overcome it. You know that it is better. You know that you can do this because you have done it before. Even if you know that he is going to go-he still deserves someone close to him. Death can be really scary for people who haven't gone through it before. It*

	doesn't take away the sadness that you feel but being able to be with someone and say to someone, "I know that you are going through terminal cancer but you have someone who is here and is willing to walk that path with you", I think that has made me a better clinician. I think I'm more likely to sit with a patient now and it breaks down the barrier of well I am just here to treat you." Participant 16: "*I think that when it comes to a family member of a patient who passed away I think that, I try to support them as much as I can, because I know that when the family goes home what they will be going through.*" Line 383-385. Participant 17: "*I think it gave me a much deeper empathy for the family while watching it from the side-lines-seeing how they experienced the loss and coped with it. I think it brought richness in the way I responded as a professional. For example, it influenced my reaction in terms of how I could use what I knew and experienced to help the family. I was also able to share my perspective and experience with other professionals, teachers and children to help them be supportive of the child's family.*" Lines 77-82. Participant 22: "*With other patients the experience was more removed but with my dad it was quite personal. After my dad's death and actually even prior to his passing, what I try to do is*

	get my patients and their families to donate their hearing aids to me. I find that it often provides comfort to the family. They are at ease because they feel as if they are doing something more proactive. When I sifted through his hearing aids and tried to figure out which patient I'm going to fit them on, I experienced similar feelings to my patients' families when they donate their family members' hearing aids to me; I feel like I'm doing something positive." Lines 228-234.

4.10. Professional Code of Conduct and Professional Performance

The section attends to how patient death was influenced by participants' code of conduct, and how patient death and dying impacted on their professional performance.

4.10.1. Effects of patient death on participants' job performance. Two participants explained that frequent exposure to patient death ensured that they go the extra mile for their patients. However, two participants stated that frequent exposure to death demotivated them, and led them to justify the amount of effort that they were going to put into caring for their patients. However, four participants reported feelings of: disappointment, despondence, and guilt. Furthermore, two participants stated that patient death made them apprehensive to attend work or resulted in them avoiding treating certain patient populations. It should be noted that the latter behaviour was mentioned by three participants. Although only two excerpts are included in the study, ten participants reported experiencing compassion fatigue and burnout. The effects of patient death on participants' professional performance are displayed in Table 4.10.1.

Table 4.10.1. Effects of patient death on participants' professional performance.

Effects on participants' professional performance	Participants' Responses
Discretionary effort	Participant 1: "*When I was working in frail care; we had one whole floor of patients who were very ill and were in palliative care. What was quite important to me was making sure that the patients' last few days and weeks were as happy as they could be, managing them so that they could communicate with their families or that they could eat.*" Lines 131-134. Participant 20: "*I think my attitude and approach to every patient is to try to do my best possible job so that I can feel that I did all that I could. I think the worst kind of patient deaths, for me, are those when I feel I haven't done that.; so I try not to be in that situation.*" Line 506-508. "*To some extent one even works harder with patients who are severely ill or have the worse prognosis. I definitely would not like to be feeling, after a patient has died, that I should have done something differently...*" Lines 510-512.
Effort justification	Participant 2: "*At times, I did get a bit demotivated because you feel that why are you doing all of this, if it's just not going to work anyway? It would upset me.*" Lines 405-406.

	Participant 21: "*You kind of think that if you have this patient who might die tomorrow, you don't know how hard you are going to work. I definitely had that like I said, I mainly worked in the adult medical wards where it literally was one stroke after the next stroke and 60% of the patients didn't make it. How can you not get despondent? So, death definitely does affect how you perform.*" Lines 537-541.
Hopeless	Participant 15: "*It stood out for me because he was struggling to communicate and so he was withdrawn. I finally fitted him with a hearing aid and I think that when you fit patients with a hearing aid you think that you have rectified that portion (hearing) of their life so that they can integrate back into their families especially, during their last few years. I think that this patient's death stood out for me because I wanted him to integrate back into his family and spend time with them but then he passed away; so he didn't get enough time to integrate himself back into his family.*" Lines 68-74. Participant 17: "*I had been involved in assessing a 4 year old boy who had cerebral palsy.*" Lines 44-45. "*I also worked closely with the physiotherapists who were on this little boy's case and one of their goals was for him to become mobile because he was trying to wiggle around. He actually ended up drowning in the family pool.*" Lines 48-51. "*That was the most tragic part for me and the physiotherapists felt it even deeper because it was more their direct*

	goal. Nonetheless, for all of us it was the thing which we enjoyed watching especially, because he was enjoying walking so much. This is the tragedy that comes back to me on a regular basis, the fact that something that was supposed to be wonderful became such a critical piece of the puzzle that led to the accident." Lines 65-69. **Participant** 22: "*It was disheartening because my father was a guinea pig, I could always fit him with nice technology-the best of the best. When we could get a fitting right, it would be so exciting and then boom 2 months later he would report that he was experiencing poor communication in background noise and struggling in group settings- I would feel so disheartened. You just get it right and then you lose track.*" Lines 171-175. Participant 25: "*If I had to put a name to the emotion it would just be disappointment like, "Oh shucks, that is really horrible", to disappointment like it was a knock in my stomach-you feel sad for the therapy which you did that didn't progress. I say disappointment because you can move on a bit quicker if you just hear that a patient has died whereas, with this patient I saw the whole thing. It was honestly just a feeling of sadness for me, sadness is a much heavier feeling than disappointment because it was devastating. I knew him for such a long span of time and like I said, it looped me right back to my gran because I obviously saw her often. My grandmother, for example, was a very well put*

	together woman and towards the end she had spaghetti all over her jersey and didn't care. That was like this patient I saw quite a season of characteristics that just went. I think that just made me fearful for my own suffering and future suffering of others-my patients and family members. I think that as a result of being present during the dying process I experienced much more fear compared to the deaths of other patients." Lines 203-215.
Worthless	Participant 25: "*There was a lot of guilt involved around his death because I kind of saw this person during his last breath and wondered that this man could hardly express himself so what could I have done more for him.*" Lines 80-83.
Powerless	Participant 2: "*I think the fact that she was still pregnant- it wasn't just the person dying but also the child dying. There wasn't anything that I could do for them. She was declared brain-dead and the machines were turned off.*" Lines 87-89. Participant 6: "*It was just horrible, it was awful because I think he was relatively young-may be in his 40's. When he came in he was just such a funny guy then he rapidly deteriorated.*" Lines 172-173. *You had to go from knowing this person to someone who just became completely not able to communicate and not able to move. His motor functioning went down so he couldn't take care of himself. It was horrible.*" Lines 177-179. "*I think in this case there was utter helplessness. There was nothing anyone could do and it*

	is really cheesy to say, everyone says this, 'I come into the profession because I want to help people'- but we do. When we can't fix it, we can't help someone and so we feel terrible." Lines 199-201.
Professional avoidance	Participant 10: "*I found myself avoiding paediatrics because of this (patient death), in a hospital setting. I did have an opportunity to work at the paediatric hospital for my practice. I do go there when I need to cover for my colleague but I think I have a lot more difficulty in dealing with paediatrics because they are so small. The concept of a paediatric patient passing away, always frazzled me-it confused me. I don't understand it. Someone is to be born into the world and suffer through medical probing and prodding, medical doctors and medical machines beeping, only to just pass away upsets me.* " Lines 391-397.
Workplace anxiety	Participant 25: "*I think that it made me want to try harder but it also made me afraid to come to work sometimes just because of the fear of coming in and someone is dead and I feel that relief which in turn makes me feel guilty.*" Lines 440-442.
Compassion fatigue	Participant 25: "*Having these whirlpools of mixed emotions.*" Line 227. "*Patient death really changes your emotional make up to a point where you become less emotionally involved with patients and you feel really tired. It does exhaust you to a point where you can't feel emotion.*" Lines 447-449
Burnout	Participant 1: "*I think when I left the frail care centre, I left for a*

	studying opportunity-to study further, but one of the reasons I wanted to study further was because I felt clinically burnt-out." Line 490-491.

4.11. Organisational Practices

The section below attends to organisational practices that were in place for participants and patients' significant others. Participants also made recommendations as to how their work settings could have better supported them in instances of patient death and dying. As per participants' reports, it seems that organisational practices which may serve as a support in one institution may not be a supportive system in another institution.

4.11.1. Organisational support or the lack there of, for participants. Table 4.11.1. reflects the types of organisational support provided in intuitions where participants are or were employed at, and the provisions that participants recommended that their work settings have in place. Participant 20 made the following comment about having opportunities for organisational support, "*I think it's a fact of whoever is in charge of that particular unit and environment as well as how they treat death and dying.*" Line 336-337. *When I first started to work, I worked for someone at their private practice and we had a lot of progressive neurodegenerative disorder type of patients. We were encouraged to go as a group or individually for grief counselling. I sort of did a course with a social worker which was very good and useful. It was modelled by the owner of the practice and that was a good thing to start with. At the one rehabilitation facility that I worked at we also had debriefing facilities and opportunities for all of the staff. It was less to cope with dying but more to cope with difficult patients but I think that it is also useful to create a forum where people can actually get help. It's one of the things that troubles me now working within a private practice setting. Although, I work with a team there is no formalised opportunity to get help. When I worked in*

a rehabilitation facility and I was a manager, for example, if I could see that someone is battling I could refer them to get some help. Whereas, now when you or someone is in trouble, it's actually difficult because there really isn't a mechanism for you or them to get help. I think that that is something that one was be-careful of when you work alone. I work on my own and I have created a supportive network but not everyone does that." Line 531-538.

Three participants mentioned the availability of formal debriefing opportunities. However, two of these participants reported that debriefing was ineffective and inefficient. Nonetheless, three participants would have liked to have had platforms for debriefing. Furthermore, Participant 19 stated that team meetings functioned as a debriefing opportunity, but Participant 11 stated that in her experience: "*It's* (mortality and morbidity meetings)...". *It's very factual, there is no emotion attached to it. They go through the facts-this is what happened etc.*" Line 173-174.

Furthermore, Participant 1 stated that "*At the frail care facility, we had a room in the office where when you kind of needed a bit of space, you could go lie down and have a sleep; or you could just go and give yourself a few minutes of quiet and pull yourself together. If you experienced something which was quite difficult, you had that quiet space where you could reflect and think about before you had to then go back out and face it again.*" Lines 215-219. Furthermore, two participants requested that workshops and guidelines be made available to them to aid them in approaching patient death and dying. Participant 9 also made the following request: "*...if the work could have daily get together and say that these are the patients who have lost their lives in the last 24 hours, let's discuss and share anything about the patients with each other.*" Lines 710-712.

Table 4.11.1 The types of organisational support systems in place at participants' places of work

Type of organisational support provided to/recommended for speech therapists and audiologists	Participants' Reports
Debriefing opportunities	Participant 1: "*At the frail care centre, there were far more formal facilities set up to talk about death, so as a member of staff we could talk to each other; but because I was externally funded, I think it was a requirement that once a month I had to speak to a counsellor over the phone to debrief formally. This was really nice and something which I wish was offered in more places.*" Lines 360-363.... "*There should be a space in the work setting regardless of the work setting, to be able to debrief. Whether that is through monthly meetings or through informal meetings, there should be a safe space where people can talk about things in a non-judgemental environment.*" Lines 517-519. Participant 2: "*They could also offer a debriefing system or a counselling thing because you end up getting used to death which I don't think is normal. You start to say, 'Oh it's just another patient who died'. You get emotionless with regard to death.*" Lines 327-329.

	Participant 6: "*You have to go onto your next patient and show no reaction to that either. Are we all set up to become these apathetic robots that are treating people? Is that what the system does to us?*" Line 356-358. *It would have been nice to have a platform where we could talk about patients even if it's just saying a silent prayer for minute. We could have a moment of silence for a person who passed on or remember a patient for a few minutes. We could have had a space to talk about the fact that our patients mean something to us.*" Lines 571-574. Participant 11: "*If you wanted to see a psychologist for debriefing you had to make an appointment just like any other patient. You were on a waiting list for 3 months and in 3 months times you already experienced 10 patients die so, by then you coped.*" Lines 622-625. "*At my current workplace, they do have one person who is the employee wellness counsellor.* Line 627. "*I don't think that it is suitable for everyone because there are some things that you don't want to discuss with someone who works in the same environment as you-that can make it difficult. The lady in charge of the EWP is an older white lady and I don't think that all cultures and the younger generation are very comfortable with talking to her about their issues, which I completely understand.*" Line 632-636.

	Participant 13: "*I think that it's just the attitude of the hospital that you work at. People don't really like talking about their emotions. I think for some people it makes them feel that they are weak therapists. I think it depends on whether you have supportive colleagues who encourage you to talk about these kinds of experiences.*" Lines 188-191. "*I think that the hospital attitude differs across hospitals but I think that generally we are seen as medical professionals, we're the superheroes and we don't get sad- I don't think we should be viewed like this.*" Lines 193-196... "*I think having people available to speak to so that it can help you in accepting a patient's death and your feelings. I think it should be compulsory to have debriefing sessions every 6 months especially, because patient death is something that all employees go through.*" Lines 404-406. Participant 16: "*I think that they have started this thing in government with the helpline number, which I don't think is helpful because I don't know who the people are to contact if you are in a difficult situation.*" Lines 351-353. "*There isn't a debriefing process. Our employee wellness is a joke. The lady is so overwhelmed that she just asks, 'How do you feel?' There is no support system within the hospital setting.*" Line 535-537. Participant 17: "*Other therapists were able to access the psychologist informally and they had an open door policy where*

	you could go and chat with the school psychologist. They weren't able to see us in a professional capacity. I don't remember there being an offer for a specific kind of counselling but I think if the staff needed it, they probably went privately." Lines 103-106. "*I would encourage young therapists to actually see a counsellor. I would see a counsellor not because I was in a dire state but because it assisted me with my preparation of patient death. I think that in the workplace having counselling support at the time of patient death is critical.*" Lines 186-190 Participant 19: "*During the week we also had team meetings where we discussed patients and had time to show and chat how we felt about the patient's passing.*" Lines 115-116. Participant 24: "*I think that death in a school setting was a little bit worse because you don't expect it...The school didn't know how to deal with it so that made it worse. Whereas, in a hospital setting you expect to see death around you so it was easy to talk to my colleagues at the hospital as they would bring me back to reality and help me make sense of the death, whereas at the school that was more difficult.*" Line 177-184.
Private space	Participant 1: "*At the frail care facility, we had a room in the office where when you kind of needed a bit of space, you could go lie down and have a sleep; or you could just go and give yourself a few minutes of quiet and pull yourself together. If you experienced something which was quite difficult, you had that quiet space where you could reflect and think about before you had to then go back out and face it again.*" Lines 215-219.

Guidelines	Participant 11: "*With cancer patients something else which should be raised is the ethical practice-when you know that the audiology patient is terminally ill-should you fit the patient or shouldn't you fit with a hearing aid. There are a lot of ethical questions around that.*" Line 237-239. "*From a management perspective, I would like to have more debriefing sessions with staff. For example, get someone on board who can give more professional guidelines on how to cope with it.*" Line 268-270.
Availability of continuing professional education opportunities	Participant 13: "*I think having a workshop on debriefing as well as workshop on death and dying.*" Line 403.

4.11.2.Organisational support for patients' significant others. Table 4.11.2 highlights the facilities which offered patients' significant others support. Two participants stated that patients' significant others could either hold their own informal service or the institution actually held informal services for these individuals.

Table 4.11.2. Facilities available for patients' bereaved significant others.

Type of organisational support provided to for patients' significant others	Participants' Reports
Commemorations and	Participant 17: "*I don't know if he had siblings but the parents were amazing and came to the school's pre-primary section and*

memorials	*held an informal service.*" Lines 90-91. "*The psychologists, other professionals and the teachers had spoken to the children, supported them and prepared them for the service. Afterwards, they had created a memory table, we placed photographs and the children could bring things or flowers. The parents of the little boy came to speak to the children.*" Lines 93-96. "*The informal memorial was definitely the way the team presented a united front of solidarity and support to the patient's family. I know that the psychologist at the school offered support to the little boy's family and as a team we were satisfied that the family was accessing the level of support from the school.*" Lines 98-101. "*I think that the school did a good job working through this boy's death with the children at the children's level and they addressed the death with these children's parents. There seemed to have been a lot of informal support for everyone in the team. The school allowed the team to spend the time we needed together and they created a space for people to connect as they needed to.*" Lines 297-301. "*I'm not a hundred percent sure, but I think that in the school newsletter after the little boy's passing there was a photograph and story about him. The school didn't sweep it under the carpet- his life and passing was marked quite nicely by the school.*" Lines 303-305.
Private space	Participant 1: "*We had a room at the organization, where the family could hold a religious ceremony after the patient's passing. Often, staff*

	would go to those ceremonies to show support for the family." Line 109-111.

4.12. Coping and Defence mechanisms

This section presents the coping and defence mechanisms employed by participants in instances of patient death and dying.

4.12.1. Methods for managing patient death and dying. Table 4.12.1 indicates that one participant made use of sublimation. Furthermore, 14 participants made use of debriefing, reflection, crying, humour, physical activities, religion, and culture to aid them in coping. Additionally, two participants made reference to taking leave and balancing one's personal and professional life.

Table 4.12.1 Coping and defence mechanisms employed by participants in instances of patient death and dying.

Coping and defence mechanisms	Participants' Responses
Sublimation	Participant 2: "*I tried to make a shift because there were other patients who needed my help and I could still make a difference in their lives, and getting stuck on a patient who passed away wouldn't help because I needed to care for the patients who were still alive. At times, you do get demotivated but you needed to get over it and do your best for the other patients.*" Lines 406-410.
Informal debriefing	Participant 7: "*I think the first thing I tried was speaking to people at home such as, my boyfriend and my mom. I quickly learnt that*

	that was a bad idea because they can't relate to it on level that speech therapists or allieds can. They don't have the same experiences that we all have. They tend to say, 'Shame that's so sad.' And you like, 'But you don't understand what I'm trying to say. I saw this happened today or I had to experience this today'; and they like 'Oh, well ok'. They try to understand and help but it's just that they don't know what you talking about. So, it doesn't help-it doesn't give you relief. Therefore, it's better to speak to someone who knows and understands what you are going through. " Lines 554-561. "***I also spoke to my friends from university who studied speech therapy and audiology with me. If I had a tough day I would tell them about it. Although, they may not be in the same environment as me, they may be going through the same experiences so they would be able to relate to me. I'm a talker so my coping mechanism is talking.***" Lines 563-566. **Participant 10:** "***When I was having those dreams, I spoke to a colleague about it. I tried to establish a debriefing system with a few of my colleagues just to discuss it. I tried to get it out of my mind and system.***" Lines 126-128. "***...debriefing with someone who understood my situation; so, if I had to speak to my family about it for example, my mom would obviously comfort me but it was not an appropriate coping mechanism because she didn't understand it; so, it's easier to debrief with those who have gone through it or understand it. I do find debriefing with colleagues helpful and the***

	best." Line 652-656. "*I think informal debriefing is better than formal debriefing. Formal debriefing doesn't tackle the situation at an emotional level; whereas, if you debrief with a colleague who understands you at a more personal level it may help you in a better way and rationalise as opposed to a general address.*" Lines 684-687. Participant 16: "*I remember that when I went home that day, I just cried to my husband for half an hour. His response was, 'Maybe government is not for you' and I was like, 'I know that you are trying to fix it but people die everywhere'. I felt like he was my grandfather....*" Lines 148-150. "*I stopped speaking to my husband because he didn't understand the context, setting or environment. He is also extremely logical so he tries to fix an emotion. For example, I will tell him if I am having a bad day but I avoid the detail. I leave the detail for people who are in the setting, people at work and people who are in separate fields. I have a friend who works in human rights and she works in the same demographics so she kind of sees the same things as I do.*" Lines 488-493. "*...it's easier to chat to people who are in a similar arena as you. I think that you just need to be wise in who you confide in.*" Lines 502-503.
Formal debriefing	Participant 6: "*I was seeing a therapist at the time so that really helped me because when I went into community service death really scared me. We did cognitive behavioural therapy and she*

	equipped me with techniques to help make sense of the process of death. We spoke about death and dying." Lines 533-536. Participant 8: "*I have a brother who is currently completing his master's in psychology. He was always at home so I could run into his room every day, after work, and debrief to him. I would talk to him if I had a case that I wanted to talk about but I obviously kept in line with confidentiality. He also worked as a paramedic on ambulances so he dealt with death himself. Therefore, speaking to my brother was a coping mechanism in itself because he could relate to me and also give me a few skills and tips to move on.*" Lines 466-472.
Leave	Participant 1: "*...that you will get burnt out at point and will need a break. They tell you to be aware and listen to yourself when you need a break, and actually to take a break is a big deal.*" Lines 467-469.
Work-life balance	Participant 1: "*One of the things which I've learnt from my experience is making sure that if you working 9 to5, you only work 9 to5. Sometimes you get so drawn in working weekends, you don't get time to breathe and give yourself a break.*" Lines 471-473. Participant 8: "*My biggest coping strategy was that I believed what happens at work I left at work. It would take me half an hour to get home every day, I would do this even while I was still at university, whatever happened at university on that day I would spend a half*

	an hour in the car thinking and crying about it, if I needed to; once, I got home I would let it go. I would you take the time in the car to think about my patients and feel emotional about them, but as I left the car to enter my home I tried to leave those emotions behind and not take them home with me." Lines 474-479.
Self-talk	Participant 10: "*...speaking out loud, going through the situation and frequently discussing it; even if it was just out loud to myself. Just by hearing and processing it helped me. It's important to verbalise it than to just keep it in.*" Lines 657-660.
Reflective practice	Participant 5: "*I realised that whatever happened I couldn't have changed the circumstances or whatever happened to them. I did my best with what I had at the time when I saw them, I did my best that I could have.*" Lines 182-184. Participant 25: "*...it's not only important to debrief with other people but I also need to reflect on myself. For instance, I kind of need to have the imagery of myself letting go of the feelings of guilt.*" Lines 428-430.
Reminiscing	Participant 25: "*In the case of the patient who passed away from gangrene, I looked back at the happier times and saw the pros for example, his wife died so at least now they can be reunited.*" Lines 434-435.
Gallows humour	Participant 10: "*Giggling to overcome the anxiety was also a*

	coping mechanism which I employed." Lines 656-657.
Emotional reactions	Participant 5: "*I cried about patients passing on.*" Line 149
Relaxation and physical activities	Participant 21: "*I think for me I am a very active person-very physical so, for me it's just being physical and active outside of work.*" Lines 528-529. Participant 25: "*I think also doing nice things helped such as, running a bath for myself, having a long walk where I try not to think about anything else, exercising, dancing and yoga. You kind of nurture yourself to the best that you can be.*" Lines 430-433.
Religious and cultural beliefs and practices	Participant 5: "*I think my religion basically helps you cope better because I think in a way prayer and reading the bible really supports and motivates you, it supports you in remembering that you can't take all the responsibilities and emotional reactions of people....and trusting God with that emotional experience and relaying these experiences to him makes it better for me to cope with it. I then know that I am not alone and don't need to carry these burdens on my own so, I think that's what made it easier for me to cope especially, with the death of the patient who had a TBI as well as all the other patients' death.*" Line 454-461. Participant 13: "*I think that my religion helps me to deal with patient dying. I am able to pray about it and try to ask God to show me or give me comfort in the case of patient death. From that view, religion does help me and it's a coping mechanism for me if one of*

	my patients do pass away." Line 247-249. "*In terms of culture, I think it influences the moment in which I deal with it. The way I deal with it stems from my culture whereas, my religion helps me accept that it has happened, helps me in working through it and not to get confused by it.*" Line 251-252. "*... where I come from it means for me to say that, that's their culture and religion, that is the way in which they deal with it, and that's the way they were brought up; I deal with it in a different way which is a more quieter way. For instance, if a patient has died, I deal with it privately-I cry about it, process it, and don't show my grief in front of the families, but at the same time I'm sensitive to the patient and their family who I'm dealing with.*" Line 255-259. Participant 16: "*I think that my religion helps me get closure in places where I can't get closure because ultimately I don't have control over anything, in the greater scheme of things. I can think that I can control things and that I know the outcomes, but I don't, and no matter what I did, I just need to know that I have given 100%, and at times when I haven't I have to ask God to teach me what I did wrong and I need to learn and grow from it; because I can't live in that space of condemnation as that's not what my religion is about.*" Line 401-406. Participant 17: "*I think that it has definitely softened more of my cultural beliefs-the British cultural process. For instance, I have*

	experienced much more open African kind of style of mourning. Therefore, by seeing it and feeling it I have learnt to be drawn towards it, I have marked death and dying." Line 236-239. Participant 21: "*My family is Greek Orthodox(* participant does not have a religious affiliation*) and they have a lot of traditions around death. I think for me it makes it easier because I just feel that I do not have to conform to these traditions. It was nice to just go off the chart and pay your respects. I can deal with it in my way, so for me it was easier to deal with."* Line 433-436.

4.12.2. The role of spirituality in patient death and dying. Seven participants stated that spirituality aided them in dealing with patient death and dying. Furthermore, two participants stated that their work settings did not allow them to grieve as per their spiritual beliefs. Nonetheless, four participants stated that their spiritual beliefs ensured that they provided support to patients significant others. One participant stated that not having a belief system did not influence her experience with patient death. Table 4.12.2. reflects the influence of spirituality on participants' experiences with patient death and dying.

Table 4.12.2. The influence of spirituality on participants' experiences with patient death and dying.

Role of spirituality	Participants' responses
Coping mechanism	Participant 2: "*My religious beliefs are that death will be the end of pain so, for me dealing with death is not necessarily a bad thing. Therefore, my religious beliefs helped me feel more at ease.*" Line 360-361. "*...in essence, death for me isn't a bad thing it's something that you have to accept. For me, death is part of life it's something which we can't control.*" Line 363-365. Participant 5: "*I think my religion basically helps you cope better because I think in a way prayer and reading the bible really supports and motivates you, it supports you in remembering that you can't take all the responsibilities and emotional reactions of people....and trusting God with that emotional experience and relaying these experiences to him makes it better for me to cope with it. I then know that I am not alone and don't need to carry these burdens on my own so, I think that's what made it easier for me to cope especially, with the death of the patient who had a TBI as well as all the other patients' death.*" Line 454-461. Participant 13: "*I think that my religion helps me to deal with patient dying. I am able to pray about it and try to ask God to show me or give me comfort in the case of patient death. From that view, religion does help me and it's a coping mechanism for me if one of my patients*

	do pass away." Line 247-249. *"In terms of culture, I think it influences the moment in which I deal with it. The way I deal with it stems from my culture whereas, my religion helps me accept that it has happened, helps me in working through it and not to get confused by it."* Line 251-252. *"... where I come from it means for me to say that, that's their culture and religion, that is the way in which they deal with it and that's the way they were brought up; I deal with it in a different way which is a more quieter way. For instance, if a patient has died, I deal with it privately-I cry about it, process it and don't show my grief in front of the families but at the same time I'm sensitive to the patient and their family who I'm dealing with."* Line 255-259. Participant 16: *"I think that my religion helps me get closure in places where I can't get closure because ultimately I don't have control over anything, in the greater scheme of things. I can think that I can control things and that I know the outcomes, but I don't and no matter what I did, I just need to know that I have given 100%, and at times when I haven't I have to ask God to teach me what I did wrong and I need to learn and grow from it; because I can't live in that space of condemnation as that's not what my religion is about."* Line 401-406. Participant 17: *"I think that it has definitely softened more of my cultural beliefs-the British cultural process. For instance, I have experienced much more open African kind of style of mourning.*

	Therefore, by seeing it and feeling it I have learnt to be drawn towards it, I have marked death and dying." Line 236-239.
Disenfranchised grief	Participant 8: "*Working within a hospital setting, you don't have 7 days to mourn for or grieve for someone because of your case load, you just have to move onto the next patient and carry on with your day. So, I feel that has been hard for me because in my religion and culture you are given that time to grieve. You are not expected to do anything whereas, at work you have to carry on with your day and you only get 5 minutes to maybe gather your thoughts. I feel like sometimes I'm inadequate and I kind of want someone to hold my hand to accompany me to my next ward patient, because my religion and culture says that there is always that support. You want that support with you even if you are at work.*" Line 369-376. Participant 25: "*The death of people around us has always been something where emotion is shared because we all knew the person and we were all involved with the person. Death, from a young age, has been real for me so I think my culture has made it difficult for me in a hospital setting, because there weren't as many people to share my feelings of sadness with or people who could relate to my experience. I mean, of course there were some of my colleagues such as, the other community service therapists and some of the occupational therapists (OTs) but it was almost as if I missed that feeling of a real group mourning or like a real group celebration of*

	the person's life. There wasn't much of that when it came to a hospital setting obviously, I could lean on my colleagues but there still was that level which was missing." Line 341-350.
Conflict with a Higher Power (Being)	Participant 3: "*No matter what religion you follow, you kind of wonder if what you were taught really exists such as, is there really a Higher being and if there is a Higher being then why does he not punish the people who are really evil and why does he take a life of a little child or why does he let this precious life fall into a swimming pool? This guy who drowned was a swimmer but he got caught into one of those whirlpools and he couldn't get himself out. It's in these instances that you start questioning.*" Lines 259-265. Participant 10: "*I think it makes it more difficult because I have these questions like about paediatric patient death-that suffering. I question God.*" Lines 536-537. "*You do feel like why there is so much death ... Why does this person die suddenly at a young age? There are just a lot of questions that I have.*" Lines 543-545. Participant 25: "*Sometimes in the moment of feeling emotionally raw you feel like, 'Why would God take a small child away?' My religion causes a weird confusion.*" Lines 355-356.

Provision of social support	Participant 6: *"When the patient was alive it was about being there for the patient so that he or she felt like he or she had someone who cared about them. Maybe, that was me trying to help and support them when their family could not be there- kind of me being a bridge or someone to check in."* Line 411-413.
No influence	Participant 19: *"...not having a belief system does not make it easier or harder-it is just what it is. The patient is now dead and that is what it is."* Lines 213-214.

Chapter 5: Discussion

All of the participants did grieve during instances of patient death and dying, but their grief processes were unique. The discussion below presents a possible model as to how the ST/As grieved, and this model is presented diagrammatically in Figure 5.1. This proposed model was formulated by mainly taking Wright's (2011) seven stages of grief model into consideration, as participants in this study grief processes seemed to be similar to the some of the stages of grief that are outlined in these seven stages of grief model. When Kübler-Ross' five stages of grief model was closely examined, the researcher was in agreement with Haslam (2018) who said that Kübler-Ross' theory appeared to be structured and concrete. Since, participants also displayed ambivalence when grieving a model which was more flexible in nature needed to be applied to participants' experiences with patient death and dying. "*Whirpools of mixed emotions*" (Participant 25, Line 227) also seemed to be characterised by negative bias, particularly negative differentiation. Furthermore, although Reder (2003) claimed that Worden's (1991) four tasks of mourning model can be used to describe grief, this model seems to only describe mourning practices. Therefore, the researcher did not base the suggested grief model on Worden's (1991) four tasks of mourning, as the ST/As did not necessarily make references to the process of mourning. Similarly, the researcher did not consider the four phases of grief which was suggested by Bowlby and Parkes (1970), simply because the stages offered by these theorists did not completely reflect the ST/As' experiences with death and dying, and was thus rather limiting if it were to be employed. Although other models of grief were not fully considered by the researcher, she did apply features of these theories, when formulating the proposed grief model (Figure 5.1.).

Although the ST/As did not have a universal and standard way of grieving, there were some similarities in their reactions to patient death and dying. Furthermore, the researcher aimed to encapsulate the uniqueness of the ST/As' grief reactions by making a similar claim to Bowlby and Parkes (1970) who maintained that individuals' grief reactions are individualistic in nature. Unfortunately, the researcher could not fully apply the dual process model of coping with bereavement as the ST/As' grief reactions lacked the key feature of oscillation (Strobe & Shut, 1999). For this reason, the researcher took on Wright's (2011) stance whereby she stated that more than one stage can be encountered at a time and do not have to follow a linear nature when experienced, as the ST/As' grief reactions were versatile and they even experienced some of the proposed stages at the same time. Through the adoption of this assertion it allowed for the researcher to present the peculiar features of the ST/As' grief reactions.

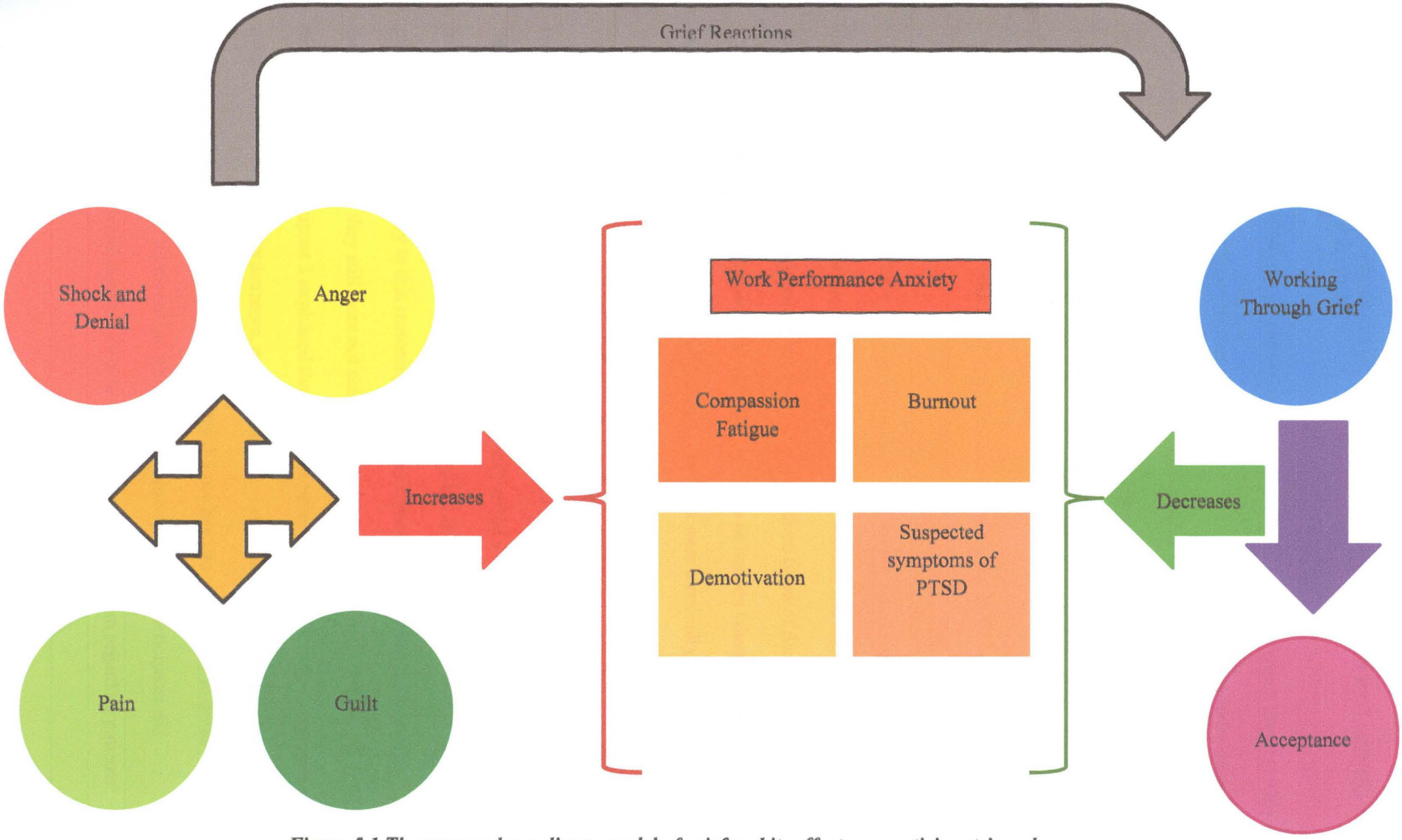


Figure 5.1.The proposed non-linear model of grief and its effects on participants' work performance.

5.1. Shock and Denial

Kübler-Ross (1969) stated that one of the stages of grief is denial, which Freud (1936) considered to be an ego-defence mechanism. Wright (2011) also suggested that individuals may experience denial but coupled it with shock. This stage is considered to be characterised by a "numbed disbelief" (Wright, 2011, para.4). This characteristic would explain why most participants displayed a questioning behaviour and scepticism when they encountered shock and denial as a result of patient death and dying.

Below are situations which led to participants experiencing shock and denial:

5.1.1. Unexpected death. A possible limitation of having asked participants about their experiences with the different types of death namely, sudden and anticipated death was the variability in what participants' perceived constitutes these types of deaths. For instance, some participants deemed terminally ill patients' deaths to be sudden when they passed away prematurely, whereas other participants felt that if patients were terminally ill their deaths were anticipated.

In agreement with studies which have found that anticipatory grief reduces grief reactions after the death occurs (Margolis et al., 1988; Ziberfein, 1999), this study too showed the positive effect of anticipatory grief. From majority of the STAs' reports it may be insinuated that anticipatory grief allowed them to psychological prepare themselves for patients' deaths. Contrary to this reasoning, some participants felt that even in cases where death was anticipated they still were not able to psychologically prepare themselves for patient death, as Participant 5 explained that "*You are never prepared for someone passing away*" (Lines 167-168). Furthermore, most participants stated that anticipated death is not marked by instances of shock and denial, as they did not have an opportunity to build therapeutic interpersonal relationships with patients. However, other participants did encounter shock and denial because they had this unwavering optimism regarding patients'

outcomes despite psychologically preparing themselves for patients' inevitable deaths. Therefore, the denial in these cases may not be a function of the expectedness of the deaths, but rather as a consequence of this false hope which participants displayed. This false hope may be cultivated by participants being bound by the duty of care principle, and as result considered death to be a failure.

Furthermore, when patients' causes of death were unrelated to their medical conditions, due to common illnesses or routine surgeries the ST/As experienced shock and denial. This may be due to these aforementioned factors contributing to patients' deaths being unforeseen. Participants also experienced shock and denial when they felt that terminally ill patients passed away too soon, especially when patients were making progress in therapy. This may due to their optimism being crushed. As a result of the shock and denial which participants experienced, they displayed false hope which is reflected in the following encounter experienced by Participant 6: "*You are just hoping- I mean she was discharged before and would come back a few times. I thought that she might have gone home.*" (Lines 58-59). Therefore, this notion of false hope created a vicious cycle which is highlighted in Figure 5.2.

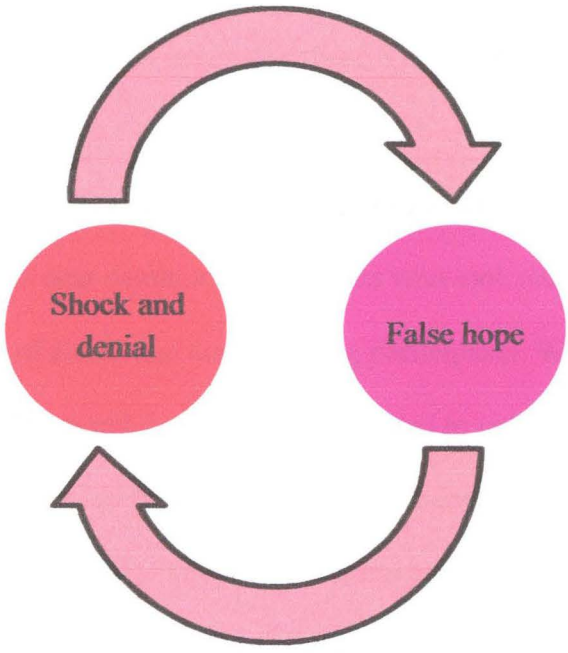


Figure 5.2. The vicious cycle of false hope.

Additionally, the concept of role expectation may have contributed to participants not expecting patients' deaths. For instance, when a participant stereotyped patients to be physically stronger, she considered these patients' deaths to be sudden. As a result of this role expectation phenomenon, it left participants encountering shock and denial when these patients had passed away.

In cases where patient deaths were unexpected, most of the ST/As started grieving from the start of the grief process. This was characterised by them experiencing shock and denial, unlike participants in Wojan (2006) study who reported symptoms of depression in instances of sudden death. Parkes (1975) may have attributed this to the ST/As in this study not having a forewarning of patients' deaths. Since, most of the ST/As in this study considered child death to be unexpected as it occurred out of the "natural order of life", as explained by Participant 17 (Table 4.4.1.) , they were more shocked when a child or young

adult patient had passed away as opposed to when an older patient had passed away. Therefore, some individuals may argue that these ST/As are ageist.

5.1.2. Being present near or at the time of patient death. When participants were with patients who were near death or with patients who took their last breath, it seemed to have elicited feelings of shock and denial among participants. While in a state of shock, some participants encountered moral distress as they wanted to uphold their scope of practice but also wanted to be altruistic, as Participant 6 stated "*I came into the profession because I want to help people*" (Lines 200-201). The moral distress encountered by participants led them to experience helplessness.

Furthermore, participants felt helpless when attempting to wake up a dead patient. These experiences also triggered the reality of mortality which also resulted in them encountering feelings of shock and denial. This may be due to participants not expecting to find themselves in these kinds of situations, especially since participants, such as Participant 13 reported that while completing her undergraduate studies "*The thought of patients dying didn't even exist.*" (Line 167). This will be discussed further under the lack of pre-professional training section.

5.1.3. Magnitude and frequency of patient death. Patient death occurring on a large scale or a number of deaths occurring in such a short-space of time such as three patient deaths in one day also resulted in participants experiencing shock. These situations did not only yield professional anxiety among participants but also death anxiety, as the reality of death set in. A review of the literature to date, has revealed that the following factors have contributed to death anxiety among HCPs: age, gender, culture, and clinical experience in terms of practicing as a HCPs or providing palliative care services (Abdel-Khalek & Tomas-

Sebado, 2005; Braun et al., 2010; Hammett, 2011). The younger the HCPs and the fewer amount of years of clinical experience that these professionals had, the higher the levels of death anxiety did they experience (Braun et al, 2010). Generally HCPs who experienced patient death early on in their practice and practiced within palliative care settings, showed lower levels of death anxiety (Braun et al. 2010). Furthermore, Hammett (2011) stated that female HCPs are most likely to show higher levels of death anxiety in comparison to their male counterparts. Culture was also said to contribute death anxiety among HCPs, as different cultures have ascribed different meanings and beliefs to death (Hammett, 2011).

As mentioned previously, one of the key behaviours that participants' exhibited when they experienced shock and denial was questioning. When their questions were left unanswered they appeared to have experienced anger. However, this is not the only source of anger among participants and thus these causes of anger will be discussed in the section below.

5.2. Anger

Conflict seemed to occur between participants and the medical team, their ST/A colleagues, their patients, patients' significant others, and religious leaders. This seemed to have resulted in participants experiencing anger. Although there is some overlap between the sources of inter-professional conflict proposed by Zeinhom and Hingazee (2015), Merril and Miller (2015) as well as this study, this study also found additional roots of inter-professional conflict between participants and the medical team.

5.2.1. Inter-professional conflict. From participants' reports, the medical team seemed to have employed a utilitarian view whereby they employed therapeutic nihilism. They believed that death was the most positive outcome for the patient. However, there was

one instance where Participant 20 reported that she was angered by the medical practitioner employing a deontological stance when treating the patient "*Aggressively with antibiotics*" (Line 80). Participant 20 felt that the medical practitioner risked upholding beneficence and non-maleficence, as death would have freed the patient from her suffering. Interestingly, this participant also made a situational attribution to the choice of ethical framework employed by the medical team when making decisions regarding patients' treatment regimens. For instance, she stated that in conservative South African communities a utilitarian approach is used to manage patients even if it goes against patient autonomy, unlike in less conservative environments where a deontological approach may be used.

When the ST/As had conflicting ethical views with the medical team; they felt that the medical team was inhumane as patients seemed to have had no QoL when they neared their deaths. Due to systemic challenges, such as rationing of resources, the medical team tended to employ prioritarianism when treating patients. However, the ST/As who applied a deontologist approach when managing patients seemed to be in conflict with the medical team over this, because the medical team implemented the rule of rescue and felt that patients facing death needed to be saved. Furthermore, due to the differing moral views between participants and the medical team, participants often felt deceived and betrayed by the medical team, as the medical team did not follow through with participants' recommendations even though they claimed that they did. There were instances where the medical team would avow to participants after the patient had passed away by stating that participants made the correct diagnoses. This left participants feeling frustrated. More so, participants seemed to feel that deaths caused by aspiration pneumonia, which was the highest cause of patients' deaths (Table 4.1.1.), could have been prevented, if the medical team accounted for participants' recommendations. These aforementioned occurrences may due to the concept of professional hierarchy which led to participants feeling under-valued as

HCPs. These instances also seemed to have threatened participants' collaborative practice with the medical team.

Furthermore, role confusion also seemed to contribute to the lack of collaborative practice between participants and the medical team, because it led to power struggles and role boundary crossing between participants in the nursing staff in particular (Stefors-Hayes & Kang, 2014). This led to contradictory recommendations being made to patients, which may have affected their understanding of their health condition and their management thereof (Stefors-Hayes & Kang, 2014).This could have threatened the ethical principles of non-maleficence and beneficence when these professionals treated patients. As a result of power struggles between participants and the nursing it led to one participant experiencing racial discrimination. Zeinhom and Hingazee (2015) did state that inter-professional conflict can lead to workplace violence, but this study provides evidence which suggests that inter-professional conflict can also result in the use of discriminatory practices within the workplace.

In the case of this study, ineffective communication did not seem cause harm to patients (Mitchell et al., 2012; CRTO, 2017) but to participants. When the medical team or participants' colleagues withheld information from them regarding their patients' deaths participants were frustrated. This lack of information sharing affected the participants' ability to prepare for patients' deaths as well as risked participants seeking social support from the medical team and their colleagues.

Due to a lack of collaboration between participants and the medical team, participants often took responsibility for completing unassigned tasks. This included familiarising the medical team with the patients whose lives the medical team was trying to save. This unfamiliarity with patients among the team maddened participants. At times, participants were even coerced by nurses to take on these unassigned tasks. This sometimes required

participants putting on a façade when interacting with the deceased patients' significant others, which affected the rapport and trust formed between these significant others and participants.

Inter-professional conflict also appeared to have threatened participants working collaboratively with the medical team, as Participant 6 stated: "*We come from a place where we are told to be collaborating but I feel that people are just ignoring us.*" (Lines 493-494). From this quote, it appears as if the ST/As are at risk for developing a learned helplessness (Seligman, 1967). Participants felt that working collaboratively with the medical team is counterproductive. This may jeopardise the quality of PCC especially when proving EOL care to terminally ill patients (Ovretveit, 1993; & Yoder-Wise, 2013).

The ST/As also appeared to perceive the medical team as being inhumane by the medical team displaying dehumanization, as they treated patients with speech-language difficulties unjustly. Furthermore, the medical teams' inhumane behaviour was exhibited in the way in which they treated death. For instance they used dysphermisms like "*Discharged to heaven*" (Participant 6, Line 397) when conveying to participants that their patients had passed away, as well as the ways in which they handled patients' bodies. Some may argue, that these dysphermisms were expressed by the medical team as they were desensitised to patient death or use them as a coping mechanism (Boemer, 1998). Participants also noted that the medical team would employ discriminatory practices, such as ageism which they would use to justify the value in treating patients. It was only through this effort justification that participants also encountered conflict with other allied HCPs as it led to patient neglect. Participants contested to the fact that patients' deaths could have been prevented if their patients were not neglected. When participants reported these instances to hospital management it seemed as if these incidents were never addressed, which resulted in participants' feelings of betrayal being exemplified. This may have led to patient neglect not

being identified and rectified (Reader & Gillespie, 2013). This may have led to participants developing learned helplessness, as they may have perceived that reporting malpractice was pointless. Therefore, it seems that inter-professional conflict between participants and the medical team created a vicious cycle.

Participants also attributed patient neglect to the unequal distribution of resources and believed that if these resources were equally distributed their patients' deaths could have been prevented. Therefore, based on these reports it seems that this challenge which existed in 1994 (van Rensberg & Fourie, 1994) still seems to prevail. If these systemic challenges are overcome it may have assisted in the prevention of avoidable patient deaths (McIntyre et al., n.d.).

Participants also reported that patients' significant others were treated inhumanely by the medical team, in terms of their interaction with these individuals. The medical team would deceive patients' significant others when relaying the causes of patients' deaths to them. For example, when patients had passed away as a result of malpractice they would attribute the cause of death to natural causes. Furthermore, when the medical team were unaccountable for their actions they would often display a buck passing attitude, which did not only displease participants but also affected their ability to work through their grief and attain closure from the death. However, in cases where no party was necessarily at fault for mismanaging patients, participants experienced sadness as opposed to anger when these patients had passed away.

5.2.2. Intra-professional conflict. Intra-professional conflict occurred among participants and their colleagues, who were also ST/As, when these colleagues withheld the news of participants' patients' deaths from participants. However, these colleagues may have withheld information from participants with the intention to protect these participants

emotionally and psychologically. For example, Participant 23 stated that she was frustrated when not being informed of her patients' deaths, but also acknowledged that her ST/A colleagues knew that she was affected by patient death. This differs from the sources of intra-professional conflict among nurses who participated in Zeinhom and Higazee (2015) study.

Furthermore, cultural conflict and lack of supervisory support contributed to intra-professional conflict among participants and their supervisors. However, these factors seemed to have influenced the effectiveness of the social support provided to participants in instances of patient death and dying. These factors will be explored in the social support section.

5.2.3. Religious struggles. As reflected in Table 4.12.2. it appears that through participants experiencing religious struggles and emotional sensitivity, they questioned and were sceptical about a Higher Power's justice. It was almost as if these participants held a Higher Power liable for their patients' deaths particularly in instances of child death. Although Makgahlela (2012) suggested that it's only in the Northern Sotho culture that death elicits a spiritual crisis which is marked by questioning a High Power, in this study experiencing a spiritual crisis was not specific to a religious or cultural group. Worden (1991) adds that when individuals are mourning they may experience a spiritual crisis even if they are spiritual in nature. Furthermore, some participants may have been in a state of numbed disbelief upon discovering that their patients had passed away. This may have led them to question a Higher Power's justice, especially in cases of child death.

Furthermore, although chaplains did not feature in this study, participants did have interactions with priests when they attended their patients' funerals. At times, these interactions aggravated them as priests displayed ageism or ableism- by insinuating that death fixed patients with disabilities.

5.2.4. Conflict with patients and their significant others. Participants who exhibited paternalism when approaching patients were often frustrated with patients who did not follow through with participants' recommendations. This paternalistic approach seemed to threaten patient autonomy. Furthermore, it seemed as if some participants employed somewhat of a materialistic view when approaching patients, as they were angered when patients' emotional labiality disrupted their treatment. The reason as to why the researcher insinuates that this occurrence is a materialistic approach is because of the medical practitioner's account with a patient which was mentioned in Kurapati's (2018) book. The aforementioned approach employed by participants in this study when treating patients, may suggest that participants did not uphold PCC or treat patients within a bio-psychosocial model. This stance may have threatened participants providing holistic care to patients who were nearing the EOL. Furthermore, these instances may suggest that although unintentional, participants did not preserve patient integrity when caring for patients. Additionally, participants also exhibited patient blaming when patients passed away as they blamed patients for bringing death upon themselves, when patients died as a result of them abandoning their self-care. As much as participants were angered by patients in these instances, they also seemed to be saddened by the fact that patients abandoned their healthcare.

Abandonment of patients and non-adherence to patients' treatment regimens were the roots of conflict between participants and patients' significant others. When patients were abandoned by their significant others, patients seemed to have lost their will to live, and in one case the participant even attributed this abandonment as reason as to why a patient committed suicide. In these instances of abandonment, participants were almost pressed into taking on the unassigned task for caring and being responsible for these patients. Child abandonment which was characterised by child neglect and in extreme cases parents even

wished death upon their children, led to participants feeling relieved when these children had passed away. This may be due participants knowing that these children were not going to be neglected by their parents.

Furthermore, according to participants' attributions it seems that patients' significant others' non-adherence to the patients treatment regimen was a result of them having good intentions but this yielded a perverse result, which in these cases were the deaths of. Therefore, this benevolent behaviour also appears to have led to conflict between participants and patients' significant others. Furthermore, cultural conflict also existed between participants and patients' significant others, as Participant 20 explained that "*The issue of whether you should feed or not feed for me is not culturally or religiously an issue but I have worked with many religious Jewish people for example, for whom not feeding is absolutely not considered.*" (Lines 365-367). Therefore, it may be insinuated that perhaps patients' significant others did not adhere to participants' recommendations due to these recommendations going against patients and their significant others' religious and cultural beliefs. Furthermore, patients' significant others' spiritual practices also seemed to have caused cultural conflict among participants as these beliefs and practices went against participants' own religious and cultural beliefs. Van Keer et al. (2015) discovered that cultural conflict existed between physicians and patients' significant others due to physicians approaching patients within a biomedical model, whereas patients' significant others expected physicians to treat patients within a bio-psychosocial model. However, this study can extend van Keer et al's (2015) conclusions, as it showed that when HCPs' cultural beliefs are in conflict with patients' and patients' significant others' cultural beliefs, it resulted in cultural conflict between these individuals. This conflict may have affected the success of the decision- making process regarding patients' treatment plans.

Role engulfment also appeared to have resulted in conflict between a participant and her family members, in the instance where the participant's patient was her father. This may be due to her role as an audiologist being her dominant role while her role as a daughter underwent role abandonment, which may have led her to experience role conflict.

It appears that due to participants being bound by the duty of care they would experience conflict with patients and patients' significant others. However, at times, their actions led to unintended consequences such as, threats to patient autonomy or employment of a materialistic approach, or even them experiencing role conflict. All of these aforementioned consequences may have risked participants' effectiveness in upholding their duty of care to their patients.

As a result of the conflict which participants experienced with the medical team, religious leaders, patients, patients' significant others, as well as the religious struggles which they were faced with in instances of patient death, it may have led them to encountering moral distress. As a result of this moral distress they appeared to have developed learned helplessness, as a Participant 7 explained that "*You actually have to accept that there is nothing more you can do, as much as you speak to the doctors and the nurses to try and give the best care to your patients, you just have to accept that nothing is going to be done about it and move on.*" (Lines 174-176). This feeling of learned helplessness was further elicited by the nonchalant behaviour that participants had towards patient death given the challenges of the South African context such as, the high mortality rates which are due to: high burden of diseases, high levels of crime and motor vehicle accidents (Radebe, 2014; WHO, 2016; Writer, 2015). This learned helplessness also appeared to have added to participants' feelings of anger and guilt as they are bound by the law of duty of care. Furthermore, this learned helplessness developed by participants seemed to have threatened participants' humanness, which in turn may suggest that perhaps participants did employ the Ubuntu philosophy to

their professional identity as helping professionals (Tutu, 2004). It can further be concluded that this feeling of learned helplessness can create a vicious cycle as represented in Figure 5.3.

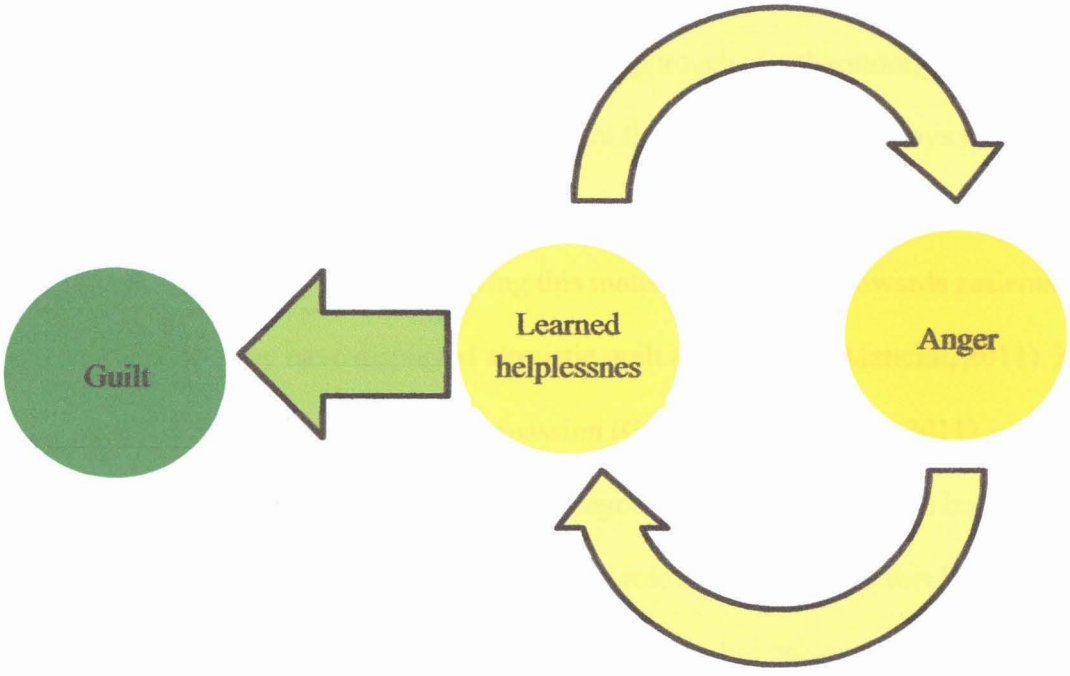


Figure 5.3. The vicious cycle of learned helplessness and its contribution to participants' feelings of guilt.

5.3. Guilt

The seven stages of grief model described pain and guilt as one entity (Wright, 2011). This may be due to feelings of pain associated with the loss of a loved one possibly leading to significant others experiencing remorse. However, in this study the pain experienced by participants did not seem to be linked to the guilt which they experienced (Figure 5.1.), but rather by the depression (not clinical depression) which they may have encountered in instances of patient death and dying. This will be further explored in the section that discusses pain.

Guilt will be discussed in terms of altruistic guilt, deontological guilt, and anticipated guilt.

5.3.1. Altruistic guilt. In cases where participants seemed to have been materialistic in their treatment approach to patients, they displayed a compassionate sense of wonder (Lally, 2018) regarding the demeanour of their treatment. They almost questioned if they were somewhat egocentric in their therapy approach. Furthermore, they reported being self-absorbed in providing therapy to the extent that they were not always empathetic towards patients. They further added that when these patients died, they were overcome by guilt due to their lack of empathy. Employing this materialistic stance towards patients suggests that participants may have displayed altruistic guilt (Gangemi & Mancini, 2011). Moreover, this altruistic guilt did evolve into compassion (Gangemi & Mancini, 2011).

Furthermore, Participant 22 displayed role engulfment when her father was nearing the EOL. She seemed to be engulfed in her role as an ST/A and this led her to experience role conflict. She appeared to have difficulty balancing her personal and professional roles (Katz & Kahn, 1964; Greenhaus & Beutell, 1985). This role conflict may have resulted in her experiencing altruistic guilt, as it seemed that she felt selfish for viewing her father as a clinical case and not as a significant other.

HCPs' are bound by professionalism which actually caused some participants to experience altruistic guilt. When patients had passed away these participants blamed themselves for patients' deaths because they felt that they had disappointed their patients.

Similarly, participants felt that they had let their patients down when they had broken their promises to patients, and were thus overwhelmed by a sense of regret when these patients had passed away. This may be reflected in the following account reported by Participant 14: "*I promised him that I would visit him and I had a complete sense of regret that I hadn't gotten a chance to visit him before he passed on.*" (Lines 130-131). In these

instances, participants seemed to have encountered altruistic guilt, as they felt that they were heartless. In order to overcome this altruistic guilt, participants employed reparative behaviours.

Furthermore, some participants seemed to feel selfish when they felt more pain in instances of personal loss as compared to patient death. This appeared to have led them to experience altruistic guilt. However, participants may have experienced more pain when they had lost their significant others as compared to patients because of the concept of genetic relatedness (Nesse, 2005).

5.3.2. Deontological guilt. The deontological guilt which the ST/As displayed was mostly reflected in them doubting whether or not they practiced within the law of duty of care, to the extent where they blamed themselves for their patients' deaths. This made them feel worthless as therapists. This occurred mostly in: instances of sudden deaths, mass deaths, and a high number of deaths which occurred in a short time period. This may be due to them being in a state of shock and denial in these aforementioned situations. Therefore, this shows that participants were not only sceptical of other HCPs' adherence to the law of the duty of care or a Higher Power's justice, but also doubted their compliance in ensuring good care and justice when caring for their patients. Although the bargaining stage of grief, proposed by Kübler-Ross (1969) in her five stage model of grief did not feature among participants' grief processes, one participant did display features of bargaining as she doubted the treatment which she had provided to the patient to the extent where she critically evaluated her treatment approach. Furthermore, as concluded previously, inter-professional conflict resulted in participants developing learned helplessness. This led them to experience deontological guilt. This caused them to blame themselves for their patients' deaths.

Additionally, participants who displayed paternalism towards patients seemed to have encountered deontological guilt after these patients had passed away. They realised that they did not uphold patient autonomy. Adopting a paternalistic approach may have infringed the "Do not play God" principle (Sunstein, 2005). By breeching this principle it resulted in participants displaying deontological guilt (Gangemi & Mancini, 2011; Mancini & Mancini, 2015). Gangemi and Mancini (2011) added that when individuals have violated the 'Do not play God' principle they expect to be punished. This may explain why Participant 16 who seemed to be paternalistic in her approach towards patients almost yearned to be reprimanded or held accountable so that she could overcome her guilt. However, some may argue that paternalism may have triggered altruistic guilt which is marked by causing unjustified harm (Gangeni & Mancini, 2006). Once participants who displayed paternalism reflected on the patients' deaths, some of them wondered if they were more self-centred than patient-centred in their approach to patients. Furthermore, they doubted whether or not they truly upheld non-maleficence, beneficence, and complied with the law of duty of care when treating their patients as they intended to. They believed that patients died as a result of their paternalistic approach towards them.

Mental incongruity also appeared to have cultivated deontological guilt. For example, if Participant 1's encounter, which is reflected in Table 4.3.1., is examined, it can be seen that the participant employed a deontological approach to the patient as well as aimed to uphold the principles of ethics namely, non-maleficence and beneficence. However, when reflecting on the experience she encountered she realised that she actually risked patient autonomy. This led to her experiencing deontological guilt as she felt that she had violated the "Do not play God" principle. Furthermore, some participants who felt relief after the patients' passing also exhibited deontological guilt which resulted in them experiencing moral disgust, a feature of deontological guilt (Gangemi & Mancini, 2011). This may be due to the mental

incongruity which participants experienced. This may further indicate that these participants displayed negative potency.

5.3.3. Anticipated guilt. When participants' found themselves in similar situations which once elicited feelings of guilt they were able to anticipate guilt. Due to anticipating guilt they seemed to have displayed prosocial behaviour by employing discretionary effort when caring for these patients. A study by Erlandsson et al. (2016) showed that anticipated guilt may motivate an individual to help others, but this study can extend this conclusion by indicating that anticipated guilt appears to mitigate feelings of guilt.

Altruistic and deontological guilt may have been elicited by participants thinking that they had not "put people (patients) first" (KZN DOH, 2013, p. 2). This may have been fostered by participants questioning themselves as to whether or not they upheld the philosophy of Ubuntu and the law of duty of care.

Furthermore, irrespective of whether participants experienced altruistic or deontological guilt they exhibited self-doubt and self-blame (Figure 5.4.). In order to overcome this dilemma and maintain their self-efficacy participants either displayed anticipatory guilt when foreseeing that an instance of patient death may elicit guilt or they sought out esteem support from their colleagues (Figure 5.4.). This will be further discussed under the social support section.

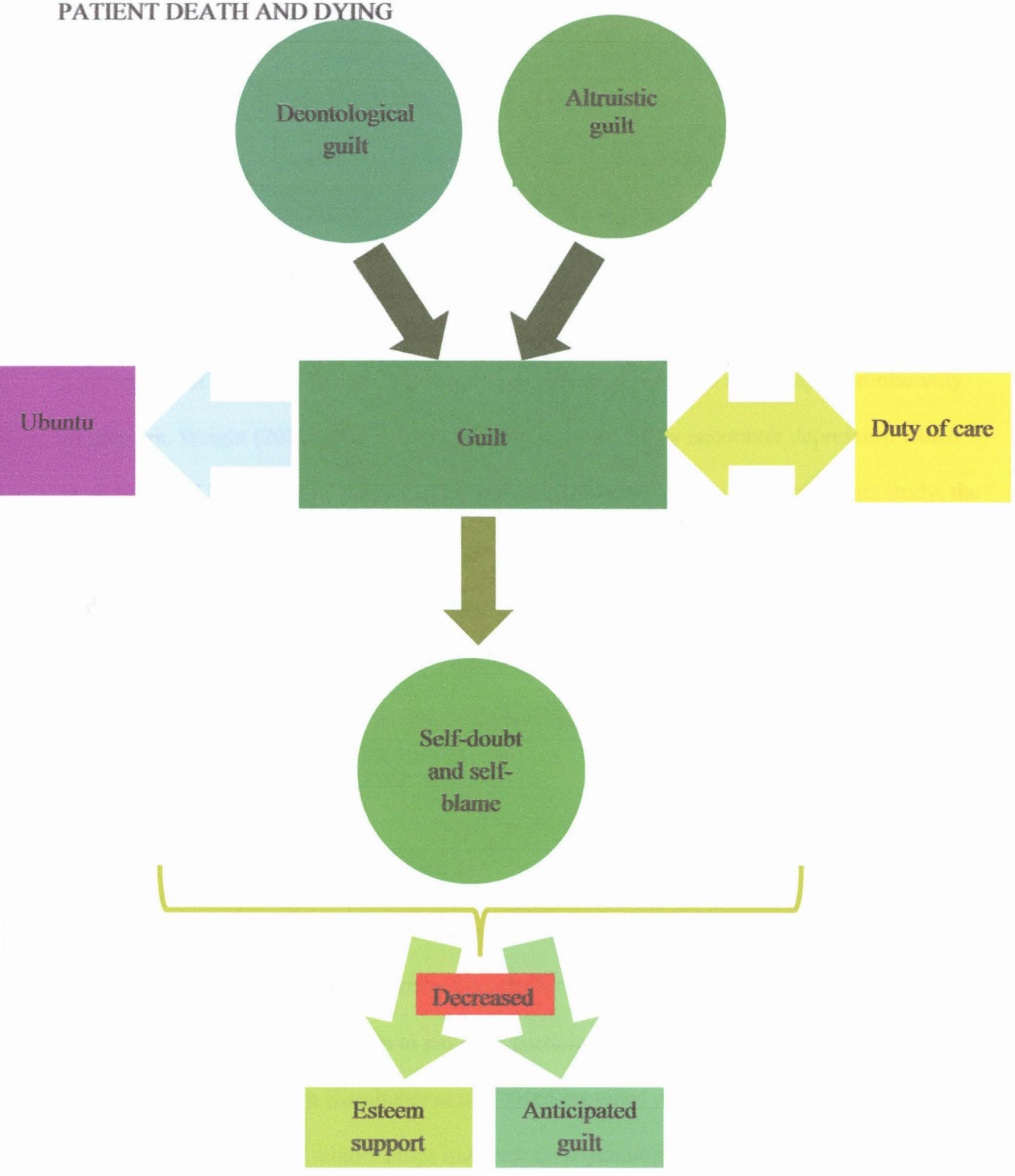


Figure 5.4. The causes, features, and effects of guilt as well as guilt reduction factors.

5.4. Pain

The depression stage of Kübler-Ross' (1969) model of grief appears to describe clinical symptoms of depression. However, participants did not necessarily display these symptoms. Furthermore, unlike, the characteristic of the second task of Wordern's four tasks of mourning, the ST/As in this study only displayed pain emotionally. Therefore, for the purpose study the stage of pain is more in line with the stage of pain described in the seven stage model of grief (Wright, 2011). Wright (2011) stated that pain is displayed emotionally in grievers. Wright (2011) also proposed that the bereaved may encounter depression which is non-clinical in nature and is marked by sadness. However, for the purpose of this study, the stage of depression and pain in the seven stage of mode of grief (Wright, 2011) is combined and labelled pain (Figure 5.1.). This is due to participants' pain being characterised mainly by sadness. The stage of pain will be described according the interpersonal effects of patient death as well as the effects that patient death and dying had on participants' professional identity.

5.4.1. Sadness. It is through therapeutic interpersonal relationships with patients that participants seemed to have encountered heartache when their patients had passed away. While providing care and support to patients, participants became emotionally attached to them. Therefore, although Kornhaber et al. (2016) provided evidence that indicates that therapeutic interpersonal relationships may reduce psychological discomfort in patients, the same may not always apply to HCPs. The findings from this study can extend the aforementioned argument, as in the ST/As' strive to uphold their humanness they did it at the cost of their self-care.

Participants' application of the ideology "a person is a person because of or through others" (Tutu, 2004 p. 25) may explain why participants were overwhelmed by pain when they witnessed their patients' suffering. This suffering also seemed to trigger death anxiety among participants. This correlates with claims made by Peters et al. (2013) and McKay (1991) that when HCPs care for those facing death it makes them conscious of their own death which then triggers death anxiety. Furthermore, while being present during the dying process participants appeared to be engulfed by sadness as they witnessed a loss of dignity among patients. At times, these situations led to participants feeling glum as it triggered emotional and traumatic memories among them who witnessed the same suffering of their significant others.

5.4.2. Helplessness and hopelessness. This stage of pain is also marked by helplessness and hopelessness which was the effect that patient death and dying had on participants' professional identity. Similar, STs who participated in Wojan's (2006) study felt a sense of inadequacy when patients died, so did participants, in this study, as they seemed to have considered death to be a failure. This may be due to participants striving to uphold their duty of care, which is linked to Ubuntu because their care of patients may revolve around their own need to help their patients.

Being present at the time of patients' death or mistakenly attempting to wake up deceased patients resulted in the ST/As experiencing a deep sadness. These situations seemed to have triggered feelings of helplessness among participants. Larsson and Stern (2013, p. 4) refer to this type of helplessness as the "emergency room panic". Furthermore, situations which were beyond participants' control left participants feeling powerless. This

may be due to them feeling that they failed to fulfil their duty of care to patients and their need to help others.

Some instances of child death also seemed to have triggered feelings of helplessness and most participants considered child and young adult death to be more painful than adult death. Therefore, some readers may state that participants displayed jeunism. ST/As who were interviewed rationalised this feeling by stating that child death or young adult death cultivated a loss of hope (hopelessness). Furthermore, participants reported that when patients were a similar age as them they were able to relate to patients. Therefore, it may suggest that participants were able to display cognitive empathy when attending to these patients. This may have resulted in them being overcome by pain because they felt that patients' hopes were crushed.

The ST/As further displayed hopelessness as they felt that their efforts were in vain when their patients died, because their aim of treatment was to improve patients' QoL. Feeling of hopelessness was further induced among the ST/As when they had to continuously adapt their treatment to meet their patients' needs. One participant reported an incident whereby she felt that a patient's treatment indirectly contributed to the patient's death. This seemed to cultivate a sense of hopelessness within the participant. This may either be attributed to participants feeling that they were inadequate in providing duty of care or even that the need to uphold duty of care actually failed them.

The characteristics of this stage of pain namely, sadness, helplessness, and hopelessness seemed to highlight that participants' considered their professional success based on the well-being of their patients. However, their need to uphold the Ubuntu philosophy and their duty of care seemed to have put their self-care under threat and led them to view themselves as helpless helpers (Figure 5.5.).

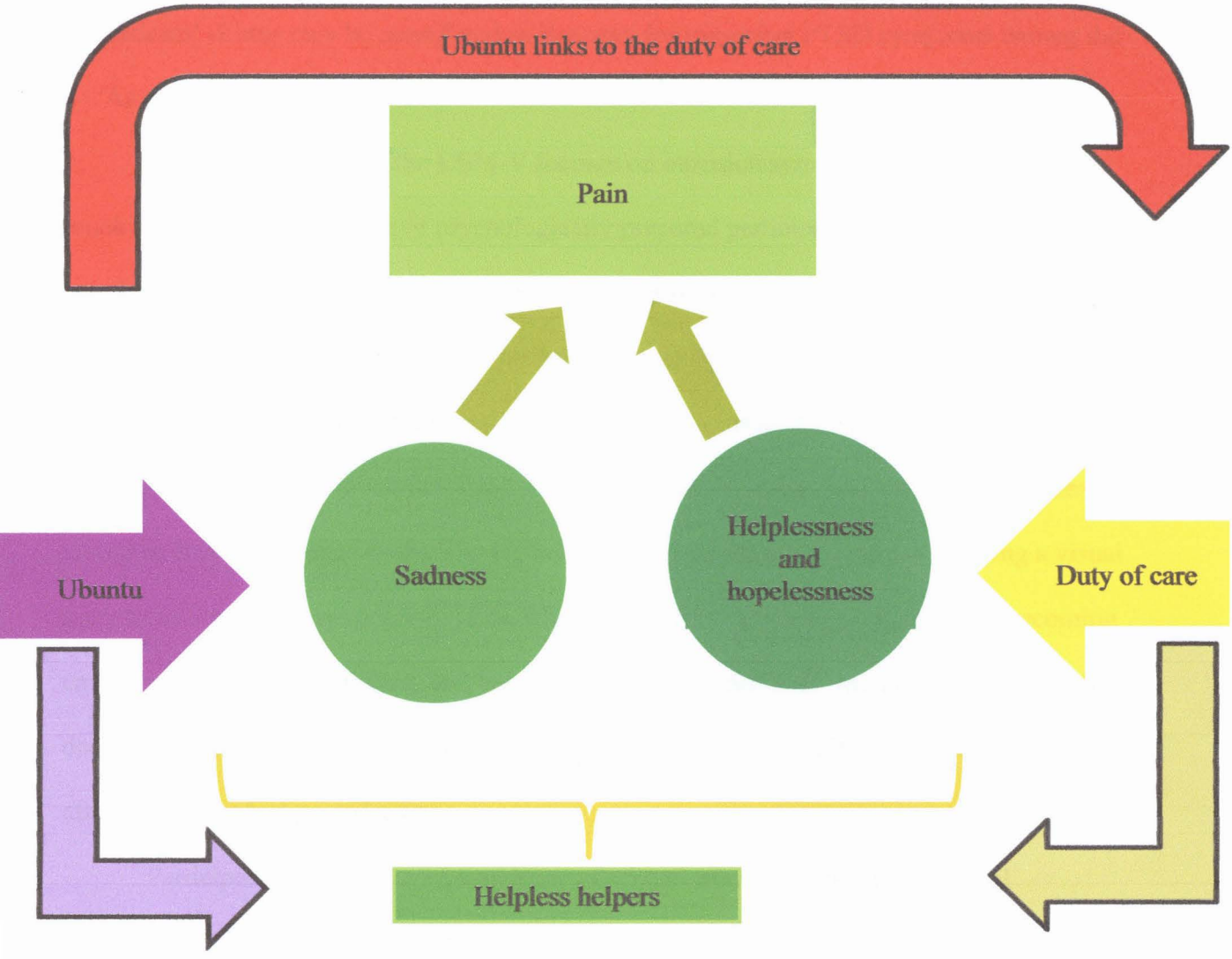


Figure 5.5. The characteristics of pain as displayed by participants and the effect that these facets had on participants' professional identity

5.5. Working Through Grief with the Aim of Reaching Acceptance

As a result of experiences with patient death and dying, participants seemed to have displayed symptoms of PTSD. According to the DSM-V, the first criterion that an individual has to meet in order to be diagnosed with PTSD is having been exposed to a traumatic event or stressor (APA, 2013), which in the case of the ST/As was patient death and dying. In particular, instances of sudden death, frequent exposure to patient death or being present near

the patients' deaths may be considered as stressors for triggering PTSD symptoms among the ST/As.

The next criterion, of the DSM-V focuses on intrusion symptoms (APA, 2013). As much as personal loss may have psychologically prepared participants for death, patient death may have elicited emotional and traumatic memories of personal loss. This may have caused emotional distress among participants in their personal lives. Furthermore, participants reported having dreams about their patients, especially in instances where they were present near patients' deaths, or when they built therapeutic interpersonal relationships with patients who then suddenly passed away. The former instance may be due participants having a visual representation of patients nearing death, while the latter may be due to participants becoming emotionally attached to patients and being in denial about patients' deaths. As a result of the denial experienced by participants, they would also instinctively walk to patients' beds even after the patient had passed away.

Participants also displayed avoidance of related stimuli through professional detachment, professional avoidance, or resigning from trauma-induced work environments. This is the third criterion of the DSM- V for diagnosing PTSD (APA, 2013). Furthermore, participants avoided trauma related stimuli through sublimation. Participants displayed sublimation by not becoming fixated on patients' deaths and continuing to manage their other patients almost immediately after they discovered that their patients had died. However, some may argue that this defence mechanism may have resulted in participants experiencing disenfranchised grief. From participants reports it may be insinuated that their grief was disenfranchised because their work environments did not recognise or support their grief (Selby, 2007). This claim talks to the fourth criterion of DSM-V when diagnosing PTSD in individuals (APA, 2013). As previously mentioned, participants experienced: denial, anger, self-blame, self-doubt, and feelings of hopelessness and helplessness, with the latter at times,

being learned in nature. This learned helplessness may actually be considered to be an alteration in participants' reactivity. Participants displayed features of the fifth criterion by not wanting to collaborate any longer with the medical team due to the medical team's approach to patient death and dying. This may affect the quality of care provided to patients.

Patient death seems to have caused a functional impairment (seventh criterion of the DSM-V for diagnosing PTSD) among participants as it resulted in participants' experiencing work performance anxiety, demotivation, burnout, and compassion fatigue. As a result, participants seemed to have developed a learned helplessness behaviour which was displayed through effort justification when they managed patients. It should be noted that it was this effort justification which the medical team employed that angered participants in this study. Therefore, in participants attempt to emotionally protect themselves from traumatization, they seemed to have been setting themselves up to become "*apathetic robots*"? Participants', in this study, calling-vocation match seemed to filter into their zest for work. However, these concepts were disrupted by patient death as it triggered feelings of: moral distress, burnout, compassion fatigue, negative dominance, and symptoms of PTSD. All of which seemed to have resulted in participants having a low job satisfaction.

Furthermore, the self-tuning process of self-care, which was proposed by Vinje and Mittlemark (2007) as well as Bakibinga (2013), may be applied to the techniques implemented by the ST/As to maintain their work performance. The self-tuning process of self-care also seemed to have assisted participants in working through their grief reactions with the aim of them accepting their patients' deaths.

In this study, introspection, sensibility, and reflection was marked by self-talk; a characteristic of self-reflection which is key to self-nurturance (Rew, 2009). Therefore, self-reflection allowed participants to utilise active coping mechanisms, some of which improved their work performance while others aided them in accepting patients' deaths. A common

self-reflection technique used letting go of negative emotions. This was similar to nurses who participated in Bakibinga's (2013) study. Additionally, for most ST/As their religious beliefs also seemed to have influenced the introspection, sensibility, and reflective process as it mitigated their feelings of helplessness and guilt. Furthermore, for these participants religious practices were a form of active coping in instances of patient death and dying.

5.5.1. Religion and cultural practices. Most participants reported that religious beliefs and practices allowed them to accept their patients' deaths. This correlates with the findings obtained by Wojan (2006) as she too discovered that those STs who had religious affiliations accessed their beliefs to get closure from patients' deaths. For participants who did not necessarily have a religious affiliation, they felt that not having to conform to religious practices allowed them to work through their patients' deaths in their own manner.

Some participants further explained that their religious beliefs aided them in receiving closure from patients' deaths, whereas their cultural beliefs influenced the way in which they displayed their grief. However in some instances, participants experienced cognitive dissonance due to the mismatch between participants' cultural and religious beliefs. Interestingly, being exposed to the multiculturalism in South Africa seemed to be a dissonance reduction factor, and allowed participants to successfully work through their grief. Multiculturalism in South Africa seemed to allow participants being exposed to various ways of grieving (Drenth, 2008). Therefore, it seems that participants did not need to be bound by their cultural beliefs when working through patient death, instead they could have actually employed grieving practices which best suited them to reach the acceptance stage.

However, at times, participants' religious and cultural beliefs and practices did lead to participants' experiencing disenfranchised grief as there was limited social support available in their work setting or their grief was not acknowledged.

5.5.2. Social support. Since, participants encountered grief, they were in need of social support. This was to possibly reduce the possible psychological distress induced by these experiences (Martz & Livneh, 2007).

5.5.2.1. participants receiving social support. Participants seemed to belong to a social network which consisted of the following members: allied HCPs, fellow ST/As, supervisors, and individuals with whom they shared interpersonal relationships with. Due to inter-professional conflict, participants did not deem medical practitioners and nurses as being effective social support providers. Principle five of RRT may explain this perception. It is only in cases where participants had interpersonal relationships with members of the medical team, did they consider these social interactions to be supportive.

Unlike the medical team, most participants chose allied HCPs as social support providers. This may be due to the inference made by principle four of RRT; through successful collaboration supportive interactions can be cultivated. The types of social support provided by allied HCPs were mainly: emotional support, esteem support, and information support.

Emotional support was provided through debriefing. As a result of participants engaging in shared activities through collaboration and shared experiences with allied HCPs, participants, and allied HCPs displayed emotional mimicry, affective empathy, and emotional contagion. Therefore, Schafer et al.'s (1981) definition of social support can further be expanded and can include emotional mimicry, affective empathy, and emotional contagion. As facets which constitute emotional support. It is through these facets that participants preferred informal debriefing. Through these informal debriefings and shared activities between participants and allied HCPs, participants were able to regulate their affect, behaviour, and cognitions during instances of patient death (Lakey & Orhek, 2014).

However, in instances where participants were social support providers, and due to the emotional contagion phenomena participants displayed emotional exhaustion and vicarious trauma. This in turn led to depersonalization between participants and their colleagues (Shumaker & Brownell, 1984). Although the emotional contagion may be able to regulate the social support recipient's affect, behaviour and cognition, it may actually contribute to burnout among social support providers.

In addition to emotional support, the allied healthcare team also provided participants with esteem support when participants displayed reassurance seeking. Therefore, allied HCPs were able to encourage participants that they did not mismanage patients. This aided in participants' feelings of guilt being mitigated (Schaefer et al., 1981). Additionally, some participants felt that through esteem support it ensured that they upheld patient autonomy. Furthermore, through information sharing between other HCPs and participants, participants were able to determine how to approach patients and possibly psychological prepare themselves for these patients' inevitable deaths (Schaefer et al., 1981).

It further appears as if social support may lead to a mutual symbiotic relationship between the social support recipient and provider. Participants did not only receive support from members of the allied team but also supported them in instances of patient death. However, some participants were socially undermined by allied HCPs which resulted in them feeling abandoned. This is due to allied HCPs displaying effort justification when managing patients. Furthermore, experienced allied HCPs were not perceived to be effective social providers, as they were habituated to death. In instances when participants felt socially undermined by the allied healthcare team, they viewed their fellow speech therapy and audiology colleagues to be more effective in providing social support. Some of these participants preferred to seek support from their fellow speech therapy and audiology colleagues, as they shared interpersonal relationships with them. This may be due to

participants feeling that their fellow speech therapy and audiology colleagues have more intimate knowledge and are more familiar with them (Vaux, 1990). However, in accordance with principle six of RRT, some participants stated that they sought social support from both the allied healthcare team and their speech therapy and audiology colleagues, because their fellow speech therapy and audiology colleagues could understand the type of treatment which they were able to provide to patients, whereas the allied healthcare team could understand the extent to which the patient could be managed (Lakey & Orhek, 2014). Additionally, principle six can further be applied to participants who debriefed with their significant others and friends. Participants felt social undermined by these individuals because these individuals tended to employ a sympathetic approach rather than an empathetic approach. Therefore, participants stopped debriefing to these individuals. Through these dynamic adaptions participants were able to regulate their affect (Lakey & Orhek, 2014). Since, participants were able to shift their social providers based on their needs. It shows that they placed emphasis on the quality of the social support provided. This is in accordance with stress-buffering hypothesis model (Cohen & Wills, 1983).

Participants did encounter social support through shared experience which alleviated the risk for participants experiencing disenfranchised grief. However, not all participants felt comfortable to debrief with their supervisors and preferred to debrief with their speech therapy and audiology colleagues who had the same experience level as they did, this may be in line of principle two of RRT (Lakey & Orhek, 2014).

Furthermore, not all participants had access to social support, particularly those who practiced within rural areas. This was due to them having: a lack of supervision and collegial support, experiencing cultural conflict with their supervisors, and their supervisors displaying a lack of empathy. Similarly, supervisors felt abandoned as they were unable to debrief to their subordinates. Due to the lack of variability in support providers, participants may have

had difficulty in regulating their moods, emotions, behaviours, and thoughts (Lakey & Orhek, 2014; Vaux, 1990). In doing so participants may have been able to protect themselves against the negative effects of being socially undermined: poor mental health being and an increase in stress levels (Vinokur & van Ryn, 1993).

The types of social support did not necessarily vary depending on the type of death. Participants received emotional, esteem, and information support in instances of sudden and anticipated death.

Although mixed encounters of social support were reported from participants, it seemed that it was the quality of social support provided rather than the quantity of social support and the social environment that influenced the success of participants being able to regulate their emotional and psychological states. Through perceived support participants realised that for them to be able to regulate their affect and behaviour, the type and characteristics of social support must occur in the way in which the recipient needs and wants it's to be (Lakey & Orhek, 2014).

5.5.2.2. participants providing social support, or lack thereof. Limited interaction with patients' significant others may have put these individuals at risk for experiencing abandonment (Kaunonen, 2000). Limited family interaction may be due to systemic challenges: language barriers, defaulting family counselling sessions, incurring financial constraints, travelling long distances, and fulfilling work-related responsibilities.

However, it was not only these systemic barriers which threatened social support being provided to the significant others of patients; the cognitive and emotional dissonance which some participants experienced led to moral distress. This also jeopardized the effectiveness of the social support being provided. Furthermore, participants who built interpersonal therapeutic relationships with patients and the patients significant others, also

seemed have experienced a loss of words when interacting with the significant others after patients' deaths. These significant others may have not felt emotionally supported, as parents in Finlay's and Dallimore's (2014) study reported loneliness and lack of emotional support by professionals who they had built a rapport with. This limited provision of social support resulted in the ST/As experiencing guilt, unlike the doctors who avoided communicating with patients' significant others after patients had passed away (Brody, 2010). Some of the ST/As avoided contacting patients' significant others as they suspected that they would be at a loss for words when communicating with patients' significant others. Additionally, in order to maintain self-preservation participants employed the ego-defence mechanisms namely, repression and suppression as well as a sympathetic approach when interacting with patients' significant others. Failure to have contacted patients' significant others, after patients had passed away, may have come across as the ST/As not being concerned about patients' significant others' losses. Additionally, it may have contributed to these significant others experiencing complicated and prolonged grief (Brody, 2010).

Nonetheless, some participants did have opportunities to interact with patients' significant others. They provided social support through: telephonic calls, emails, text messages, and consoling presence. A common way that participants displayed consoling presence was by attending patients' funerals. This did not only allow for the provision of social support to significant others of patients, but granted participants the opportunity to affirm their relationships with patients and show their humanness. Furthermore, a few of the participants also felt responsible for providing emotional support to patients when patients' significant others were not present. This may be due to these participants' cultural beliefs, which place emphasis on family support. However, interestingly, Participant 6 who made mention of this did not provide social support to patients' significant others after patients had passed away, but she attributed this to her wanting to maintain self-perseveration.

Some of the participants social interaction with patients' significant others after the passing away of the patient resulted in emotional mimicry between participants and the patients' significant others. This seemed to have brought comfort to participants. The same may be applied to the emotional contagion experienced by participants when they had interacted with patients' significant others, however this was not true in all cases. The emotional contagion phenomena seemed to have led to pain among participants when they saw patients' significant others grieving. Therefore, given the infectious nature of emotion contagion, social support at times may lead to emotional exhaustion among participants (Shumaker & Brownell, 1984).

Through the concept of countertransference, participants appeared to be able to provide social support to terminally ill patients, these patients' significant others, and at times their colleagues. This type of social support was characterised by emotional and information support. This correlates with Heinmann's (1950) and Little's (1991) interpretation of countertransference, as they too believed that the phenomena led to clinicians displaying empathy towards patients.

Furthermore, Katz (1990) explained that through countertransference patients could serve as role- models and could thus assist clinicians in overcoming their own fears. Some participants did engage in vicarious learning where they learned from the challenges experienced by their patients who were facing death. Through vicarious learning they were able to psychologically prepare themselves for their eventual death and reduce their death anxiety. When one of the participants encountered personal loss she employed the charitable behaviour that her patients' significant others would when their loved one had passed away. Through vicarious learning she noticed that when her patients' significant others donated their loved ones' hearing aids they would receive closure from their loved ones' deaths. Giving charity also seemed to have assisted this participant in accepting her father's death.

Participants reported that through role integration of their professional and family roles they were able to provide emotional social support through affective empathy when interacting with significant others. It seems that through positive carryover of experiences and skills in one role, which in this case is being a mother, it enhanced their roles of being supportive providers to bereaved parents.

There appeared to be more social interaction between the ST/As, patients and patients' significant others in instances of anticipated death. This was characterised by information sharing and care. Participants attributed providing information support to patients' significant others to expecting their patients' death, and them being informed by members of the MDT. This enabled participants to better prepare patients' significant others for the patients' inevitable death. This correlates to the deductions made by Warnock et al. (2017), as these authors found that a lack of communication between members of the healthcare team contributed to them having difficulty sharing information about patients health condition with patients' significant others. Furthermore, given the role of the ST/As in EOL care (Grant, 2015), it may explain why participants provided social support to patients' significant others while patients were still alive. However, other participants stated that they displayed false hope and withheld information from patients' significant others in instances of anticipated death. This may have resulted in patients' significant others perceiving the ST/As as being unethical, uncompassionate, and distrustful (Adams et al., 2014). Whereas, in instances of sudden death the ST/As appeared to be more honest and displayed more professional integrity.

Participants maintained that in private practice more social support was available to patients' significant others. Although this was not examined further, the opportunities to provide social support may be greater in private healthcare settings due to more resources

being available, as per participants' reports. Therefore, the concept of the person-environment fit may be applied to this occurrence (Shumaker & Brownell, 1984).

The provision of social support to patients' significant others resulted in mutual nurturing between participants and patients' significant others (Boston, Fultz and Schoenader, 1984), and in participants' accepting their patients death. At the same token, not providing social support resulted in participants not receiving closure from patients' death, and they experienced guilt and feelings of ambiguity.

5.5.3.Organisational support. As mentioned under the social support section, most of the ST/As maintained that seeking social support (informal) was more effective in ensuing their emotional well-being. However, limited organisational support did seem to contribute to compassion fatigue and burnout among participants. Furthermore, a lack of organisational support seemed to be triggered by the culture of the institution, particularly the culture of the hospital. This may be due HCPs being considered to be resilient to patient death and dying. Due to a lack of organisational support participants experienced disenfranchised grief. Therefore, these participants requested for formal debriefing sessions to aid them in working through their grief.

Some participants were provided with organisational support through having mortality and morbidity meetings. However, these meetings functioning as a form of organisational support were dependent on the nature of the institution. Furthermore, in cases of deaths of children who were attending special needs schools, some schools made provisions to support the staff, whereas other schools did not know how to approach death. This may be attributed to schools not expecting to face death. Additionally, making use of organisational support facilities was compulsory when practicing in palliative care facilities. These institutions aided participants in preserving quiet reflection by providing staff with a

private room where they could engage in reflective practice and recharge themselves. Some participants felt that the provision of organisational support was rather dependent on how the manager of the institution or team approached patient death and dying.

As mentioned previously, not all participants in this study considered their supervisors to be effective social support providers. However participants who did view their supervisors as being supportive, reported that their supervisors equipped them with active coping mechanisms, or allowed them to informally debrief with them. Furthermore, participants who were supervisors believed that their staff should access EWP to debrief about patient death. This may due to EWP being considered as being beneficial in facilitating health and well-being among employees (Universal Healthcare, 2018). However, participants felt that their staff did not feel comfortable to access EWP services, as their staff felt that their cultural and age needs were not going to be met. Furthermore, due to inefficiencies within the EWP system participants preferred not to access EWP. They felt that counselling sessions were counterproductive. Participants also seemed to prefer to seek out external counselling services because they did not want to self-disclose information to their colleagues due to the fear of encountering public self-consciousness (Gould & Barak, 1988). Some participants reported that they did not access EWP as they were not made aware that these services existed, or because they were unsure of the extent of the type of information which could be disclosed during consultations.

Therefore, these participants requested to have mourning reports (Field, 1997). If these mourning reports were provided after the patients had passed away, it could have aided participants in achieving acceptance of their patients' deaths as well as increase their effectiveness of providing social support to patients' significant others. Furthermore, participants simply asked for institutions to give them an opportunity for their grief to be

acknowledged. If it was provided it may have alleviated the risk of participants experiencing disenfranchised grief.

Some participants reported that some institutions provided organisational support to patients' significant others. This seemed to have aided these significant others in working through their grief. The type of organisational support provided included: memorials, commemorations, and aiding in the preservation of quiet time for grieving families.

5.5.4. Work-life balance and leave. As participants reported, patient death and dying contributed to them experiencing job stressors. Therefore, participants took time off from work and employed the concept of work-life balance by separating their work lives from their personal lives. This practice is in line with recommendations made by Lagndon and Langdon-Starr (2014, p. 294) and Papir-Bernstein (2018).

5.5.5.Relaxation and physical activities as well as self-soothing behaviours. Based on Lagndon's and Langdon-Starr's (2018) suggestion, it may explain as to why participants nurtured themselves through relaxation and physical activities. Furthermore, similar to the student nurses who participated in Niederriter (2009), participants too displayed self-soothing behaviours such as, crying when working through their grief. This may act as a mood enhancement behaviour (Gračanin et al., 2014). Additionally, similar to STs who participated in Wojan (2006), participants' too employed gallows humour in instances of patient death and dying.

5.5.6. Personal loss. The relationship between personal loss and patient death seems to be a mutual symbiotic relationship For some participants who experienced loss in their personal lives, it seemed to serve as mastery experiences with death and mitigated death

anxiety (Bandura, 1994; Shokri & Akbari, 2016). Thus, encounters with personal loss appeared to have psychologically prepared participants for patient death. Confrontations with personal loss also seemed to improve participants' self-efficacy in tackling their grief processes as they utilised coping mechanisms, which they acquired from experiencing personal loss. However, it must be remembered that personal loss did trigger emotional and traumatic memories for other participants, which contributed to them displaying possible symptoms of PTSD. Therefore, there is a risk that personal loss can increase death anxiety among participants.

5.5.7. Resilience and desensitisation. Through the frequency of exposure to patient death and experience with personal loss, participants acquired more active coping mechanisms which they employed across experiences. This allowed them to develop resilience to patient death and dying and mitigated their death anxiety.

Furthermore, most participants reported that due to the high mortality in SA they became desensitised to death. However, being desensitised to death meant that they were apathetic in instances of patient death which raises the question proposed by Participant 6: "*Are we set up to become these apathetic robots…*?" (Lines 357-358)

5.5.8. Negative coping mechanisms. A few of the participants utilised negative coping mechanisms. These coping mechanisms constituted of withdrawal and distraction. In line with Roter's (2017) conclusions, the employment of these coping mechanisms may have somewhat assisted participants in overcoming patient death, but it also affected their work performance.

5.5.9. Pre-professional training. As reflected in Table 4.2.1. participants stated that their undergraduate studies did not prepare them for approaching and dealing patient death. Additionally, not all participants knew how to communicate and console patients and patients' bereaved significant others after the patients had passed away. As discussed previously, this affected the social support provided by participants. Additionally, participants were unsure how to make ethical decisions about facilitating QoL when providing EOL. This is reflected in a statement made by Participant 11.

Death education does not seem to feature in the medical curricula due to death being viewed as a failure of HCPs' expertise (Field, 1997). However, in this study some of the participants attributed the lack of pre-professional training to the speech therapy and audiology education community wanting to safeguard them from experiences which may have caused them psychological and emotional distress. Participant 20 who was mentoring a student even confessed to this: "*I had a youngster job shadowing me a while ago. We had popped into the ward to see one of the patients and I could see that he was dying. I had to hustle her out because I thought I cannot expose this kid to that.*" (Lines 283-285). However, this protection may be counter-productive because when participants began practicing as therapists they actually experienced emotional and psychological distress when their patients had died.

Participants urged that undergraduate speech therapy and audiology departments include instruction on death and on communicating with patients and their significant others particularly, after the patient has died. Participants suggested that they would also prefer if these lectures were conducted by a ST/A together with a psychologist, as Participant 7 explained that "*You (the researcher) could even do a lecture together with psychology, they could give you the situation and you can give the relatable speech therapist and audiologist experience that we can identify with.*" (Lines 386-389). Furthermore, this suggestion may be

motivated by Vygotsky's (1978) theory of ZPD where lectures conducted by ST/As who have explored patient death and dying and psychologists may scaffold ST/As in dealing with these instances of patient death and dying. This instruction may equip ST/As with strategies to deal with patient death and dying and interact with terminally ill patients and their significant others. It should be noted that participants did complete psychology modules while completing their undergraduate programmes, but none of these modules were clinical psychology modules which participants felt would have provided them with the necessary techniques to be able to face patient death and dying (Ishi & Muramatsu, 2009).Therefore, by including clinical psychology into the speech therapy and audiology programme it may ensure that ST/As provide holistic EOL care to patients as well as allow them to work through their own grief holistically (APA, 2008; Wahass, 2005).

Furthermore, Participant 17 took the onus upon herself to attend workshops which tackled death and dying due to her having experienced personal loss. She felt that by attending these courses it assisted her in being prepared to approach patient death and dying. Therefore, it seemed as if participant 17 recommended that CPD workshops which address patient death and dying be made available to ST/As. If ST/As do attend these CPD courses it may aid them in becoming competent in attending to patient death and dying, especially since, CPD activities aim to develop and enhance individuals' professional knowledge and skills (CPD, 2014).

However, some participants maintained that it was only through clinical experiences that they were able to prepare for patient death and dying. Field (1997) said that exposure to patients with advanced illness and their significant others may improve HCPs' provision of EOL care. These experiences may also aid the student ST/As in developing resilience to patient death and dying prior to practicing as clinicians.

Furthermore, participants suggested that universities should allocate sessions during which student ST/As can share their encounters with patient death and dying, because not all participants were exposed to patient death and dying during their undergraduate training, but some of their peers were. This may provide personal insights with providing EOL care to patients particularly those who they have built therapeutic interpersonal relationships with (Field, 1997). This may be particularly important because participants reported being unsure on how to build rapport with their patients. Through sharing these narratives, loss, grief, and ST/As approach to significant others of patients who have passed away can be discussed (Field, 1997). Sharing narratives about experiences regarding patient death and dying may ensure that these professionals do not employ a paternalistic and materialistic approach when managing patients (ABIM, 1996).

Additionally, the ST/As stated that they would have appreciated engaging in role-play activities, as similar to participants in Tolle et al. (1989) study felt that role-play would allow them to practice approaching patients' significant others after the patients have died. Through role-play student ST/As may be more comfortable in approaching patients' significant others and ensure that they work through their grief.

As previously mentioned, there appears to be a high incidence of burnout and compassion fatigue among participants. Therefore, in addition to pre-professional training, participants requested that there should be professional guidelines and policies in place regarding self-care among ST/As. To date there are guidelines and policies regarding wellness strategies devised by organisations, such as SAMHSA (2016) for HCPs. However, these guidelines need to be made specific to each healthcare profession due to these professions having different scope of practices. Furthermore, some ST/As may also be governed by educational boards as they practice within school settings. These education councils also need to cater for ST/As wellness needs, especially since some of the

participants did experience patient death within a school setting and it seems that schools did not always know how to support the ST/As.

Professional bodies, such as ASHA (2009) and the HPCSA (2008) mention that ST/As will need to provide EOL to patients but do not provide self-care strategies to these professionals. Furthermore, these professional bodies seem to focus more on HCPs' provision of good care to patients (ASHA, 2009; HPCSA, 2008), but not how they should take care of themselves.

Furthermore, participants attributed this lack of training on self-care due to the speech therapy and audiology education community focusing on patient management. By not being equipped with self-care strategies in undergraduate studies, it may have contributed to them experiencing disenfranchised grief. One of the participants even admitted that by not allowing herself to grieve for patients it may have contributed to her being diagnosed with depression.

Participants appeared to be at risk for developing complicated grief, particularly when they had difficulty working through their grief processes. If participants' experiences with patient death and dying were closely examined it may be noted that the encounters which striked them the most were those which resulted in them experiencing complicated grief. Simply because they did not have the coping mechanism in place to work through their grief and accept their patients' deaths.

Although experience with death has assisted participants in developing resilience to patient death, it has also seemed to have desensitised them to patient death. This seems to be attributed to participants not being aware as to how to approach patient death, which causes them to fear that they, as Participant 6 questioned, "*Are set up to become these apathetic robots...?*" (Lines 357-358).

Chapter 6: Conclusions

ST/As who participated in this study seemed to adhere to the HCPs' code of conduct and medical ethics as stipulated by the HPCSA (2008) when providing care to patients. Although this study did not focus on the care that these professionals provided to their patients, based on the results obtained it seems as if this factor influenced their experience with patient death and dying. In striving to uphold the duty of care principle, it has either created these helping professionals to be helpless helpers.

Furthermore, given the humanistic nature of the Ubuntu philosophy, it may be thought that by HCPs adopting this concept into their clinical practice they may experience emotional pleasure (Tutu, 2004; Ncama, 2015; Broodryk, 2005; Vinje & Mittlemark, 2007). This may contribute to them having a high job satisfaction. However, this study showed that when ST/As are faced with patient death and dying, the Ubuntu philosophy may have a converse effect on these HCPs.

Figure 6.1. highlights that in ST/As need to uphold their duty of care to patients and the Ubuntu philosophy, it may have contributed to them experiencing grief. This may have led to the ST/As developing job stress and symptoms of PTSD. Failure to overcome this grief may have led to them encountering complicated grief. Therefore, in the ST/As' obligation to uphold their professional code of conduct and their desire to maintain their calling-vocation match, it has caused them to sacrifice their duty of care to themselves. This in turn has affected them upholding the ethic of care principle. The ethic of care may serve as a mediating factor in ensuring that the ST/As maintain a balance in caring for their patients and caring for themselves (Close, 2019).

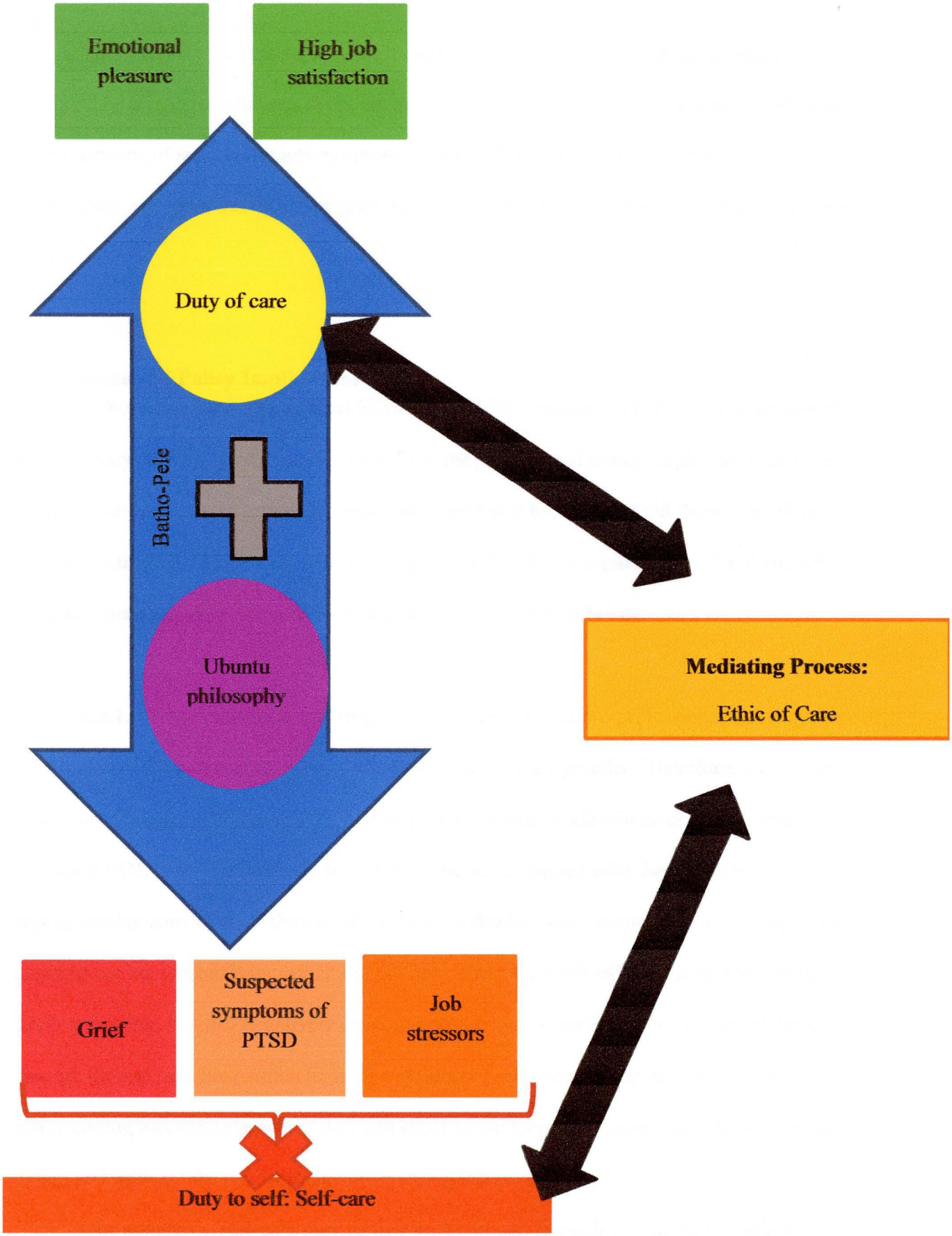


Figure 6.1. The counter effect of upholding the Ubuntu philosophy and duty of care that is mediated by the ethic of care

6.1. Theoretical Implications

This study may add to theoretical frameworks of grief, specifically grief process exhibited by ST/As in instances of patient death and dying. Furthermore, this study indicates the importance of self-care practices among HCPs so that they can sustain their job engagement and work through their grief. In doing so they may be able to maintain their ethic of care.

6.2. Practice and Policy Implications

It should be remembered what Silva et al. (2009) stressed to HCPs- if they are unwell how can they care for their patients? Therefore, the practice and policy implications devised from this study are based around recommendations made to ST/As, to aid them in working through their grief. This is to ensure that they do not develop complicated grief and are able to sustain their self-care. These recommendations are discussed below:

6.2.1. Pre-professional training. In addition to limited pre-professional training, the ST/As did not even expect to encounter patient death in their practice. Therefore, they were unsure how to approach these patients' deaths and at times tackle ethical decisions when providing EOL care. Furthermore, the ST/As were not equipped with the necessary active coping mechanisms to work through these patients deaths. Some participants even employed negative coping mechanisms, which did not only affect their self-efficacy in tackling patient death and dying, but also negatively impacted on their work performance. Therefore, perhaps through didactic teaching which highlights models of self-care, ST/As may be equipped with active coping mechanisms, which they can apply to aid them in overcoming patient death and dying, and mitigate the risk of them encountering job stressors.

Discussions on self-care may further be facilitated through student ST/As sharing narratives of their experiences with patient death and dying. Through these shared

experiences student ST/As may be able to psychologically prepare themselves for patient death and dying, because just as ST/As who participated in Rivers et al. (2013) study did not experience patient death and dying neither did most participants who participated in this study encounter death when they were students. However, some of their peers did, and so if there was a forum where student ST/As could share their narratives regarding their experiences with patient death it may psychologically prepare their peers who haven't experienced patient death in their pre-professional training.

As mentioned previously, some participants reported that it was only through clinical exposure to death that they were able to psychologically prepare themselves. Therefore, undergraduate training should include ST/As receiving clinical exposure to hospice facilities and palliative care centres. By managing terminally ill patients, it may reduce the risk ST/As employing a paternalistic and materialistic approach when providing EOL to their future patients. Field (1997) may have contested to this as he stated that by including these aforementioned types of practicals into student HCPs' undergraduate programmes it provided HCPs with a better view on how terminally ill patients should be managed.

One of the reasons as to why participants seemed to have approached patients paternalistically and materialistically may be due to them being moulded by the medical education community to provide good care as well as this community considering death to be a failure (Field, 1997). Therefore, when patients passed away participants were overcome by feelings of hopelessness and helplessness. However, by having an opportunity to treat patients who are facing death in their undergraduate studies, it may assist ST/As in realising that good care in these instances is not marked by saving a life, but rather by providing comfort care and ensuring that the ethical principles are being upheld. Furthermore, the implementation of this realisation may alleviate any feelings of guilt when patients pass away.

Field (1997) stated that when student HCPs provide EOL care to patients they were able to have a deeper awareness of not only the patients' concerns but also the worries of these patients' significant others. Therefore, by managing these patients who are nearing the EOL, it may provide student ST/As with the opportunity to practice interacting with these patients' significant others, as well as ensure that once qualified these ST/As do not shun away from providing social support to patients' significant others. Additionally, role-play activities, which take models of communication into account, may be utilised to demonstrate how ST/As could possibly approach patients' significant others in instances of patient death.

Field (1997) showed that collaborative education between HCPs at an undergraduate level or during continuing professional activities may cultivate HCPs who are able to participate in multidisciplinary patient care. Therefore, collaborative education activities may reduce inter-professional conflict and promote collaboration as each professional may have a better understanding of the others' professions. These collaborative education opportunities may also cultivate a mutual symbiotic relationship, between professions, whereby each healthcare profession is providing social support to each other. Collaboration will further be discussed in the organisational support section.

6.2.2. Organisational support. According to participants' experiences, it seems that limited organisational support has cultivated disenfranchised grief among participants. This may lead to complicated grief (Shear, 2012).

6.2.2.1. collaboration. CoPs seem to cultivate organisational culture. The MDT can be considered a CoP. If the collaboration between these team members is successful it can be assumed that a supportive organisational environment may be fostered. These types of

environments may aid HCPs, such as ST/As in providing quality EOL care and approaching patient death.

As outlined on numerous occasions, inter-professional conflict resulted in a lack of collaboration between participants and the medical team, which did not only result in these professionals being poor social support providers to each other but also affected the quality of care provided to patients. Therefore, it is recommended that these professionals develop conflict resolution skills which is said to be the foundation of successful collaboration (Jehn, 1995). Although Gardner (2005) acknowledged that literature recommends that conflict resolution skills may be the foundation of successful collaboration, he disputes this fact. However, Gardner (2005) argues that conflict resolution is related more to the concept of dominance. Therefore, Gardner (2005) suggested that goodwill power, a concept proposed by Gardner (1998), be applied to collaborative work. This approach indicates that mutual respect is needed between professionals to ensure successful collaboration, and that professional hierarchy systems should not exist, because it feeds into inter-professional conflict thus threatening collaboration.

Due to these professional hierarchy systems participants felt undervalued and as a result developed learned helplessness. They preferred to no longer collaborate with the medical team.. Therefore, in order to cultivate successful collaboration, ST/As need to maintain their clinical competence while being attentive to other team members' rationales for managing patients in a certain manner (Gardner, 2005).

The medical team and ST/As seemed to have employed different ethical frameworks when managing patients. If these professionals communicated with each and developed a shared treatment plan in providing care for patients, it may have mitigated the conflict between these professionals (Cooperrider and Srivasta, 1987). Furthermore, ST/As are encouraged to engage in dialogue where information is shared between them and other

members of the MDT team. Participants mentioned and Gardner (2005) contested to information sharing providing insight on how patients should be managed by each member of the MDT.

ST/As are encouraged to engage in clinical rounds, MDT meetings and in-service trainings with other members of the MDT. These forums serve as an opportunity to develop collaborative relationships with the other members of the MDT (Gardner, 2005). These interactions allow for opportunities for information sharing, education, and devising plans for patient care.

In order to get closure from patients' deaths institutions where ST/As are employed at, should consider offering mourning reports. These mourning reports may not only function as a learning opportunity for HCPs in providing EOL care, as proposed by Field (1997), but also may assist them in working through their patients' deaths.

It must be remembered that collaboration does not always have to occur within these organisational practices it can happen spontaneously, as HCPs do engage in vicarious learning with each other unknowingly, especially during casual interactions (Gardner, 2005). Furthermore, Gardner (2005) described the collaborative process as a journey, and so ST/As must remember that collaboration is a lengthy process that is constantly evolving.

6.2.2.2.EWP. Since, participants experienced job stressors, they may benefit from EWP. EWP which offers formal debriefing services may prevent job stressors as well as promote self-care. Self-care may further be cultivated by partaking in activities which promote active coping mechanisms (Bakibinga, 2013), with the aim of improving employee workplace performance. Therefore, it is suggested that organisations, where ST/As are employed at should consider offering the counselling services or get these professionals to engage in EW activities.

6.2.2.3. Group debriefing. Based on the conclusions obtained from Hanna and Romana (2000), it may be implied that if ST/As engage in group debriefing when experiencing patient death or even being present during patients' dying process, they will not encounter disenfranchised grief. Through group debriefing individuals may share their coping mechanisms with each other (Hanna & Romana, 2007). Therefore, ST/As may attain active coping mechanisms from their colleagues to help them overcome patient death and dying. This may even contribute to them developing resilience to these incidences.

6.2.2.4.Guidelines. As mentioned previously, international and national professional boards do not offer guidelines stipulating how ST/As should ensure self-care. It is almost as if these professional boards are more concerned about good care being provided to patients that they fail to recognise that these carers need to take care of themselves, in order to provide good quality care to patients. Therefore, guidelines regarding self-care need to be formulated by these professional boards or at least be uploaded onto these professional boards' websites, so that ST/As can access them easily.

6.2.2.4.Continuing professional education. It seems that continuing professional education programmes can also aid in preparing HCPs for patient death and dying. Field (1997) stated that these programmes can also aid HCPs in being efficient in providing EOL care to patients and patients' significant others. Furthermore, Field (1997) added that medical research has an increased focus on the provision of EOL care, but perhaps medical researchers should also explore the effect of providing EOL on HCPs.

To date research, such as by Field (1997),which has advocated for pre-professional training regarding patient death and dying has focused more on providing quality EOL care to patients, but not on how HCPs should care for themselves. Therefore, the above mentioned

recommendations highlight the need for including instruction on and promotion of self-care. This may assist ST/As to work through their grief and have a good workplace performance. This in turn can ensure that they are providing good care to patients (Figure 6.1.).

6.2.3. Social Support. Almost all of the participants who participated in this study appeared to have considered social support (informal debriefing) as being beneficial in working through their grief. However, not all of these participants had access to effective social support providers during their experiences with patient death. This left them feeling abandoned and contributed to them possibly having experienced disenfranchised grief.

6.2.3.1. Online social support services. Online social support services have been deemed to be effective in facilitating social support as they cater for asynchronous communication, and allow for social support to be provided without needing to overcome geographical and transportation limitations (White & Dorman, 2001). It may even allow for ST/As to discuss sensitive topics with ease, given that these services can be accessed anonymously (Ferguson, 1997).

Therefore, it is recommended that professional bodies, which ST/As are governed by provide online support services or even have blogs and online discussions regarding these professionals' experiences with patient death and dying, especially since blogs have been shown to be an effective means in receiving and providing social support. Furthermore, since blogs involve sharing common encounters with a particular incident, and as implied by the fourth principle of RRT individuals who may require social support may seek out social support providers who share similar experiences (Lakey & Orhek, 2014), it may be assumed that if ST/As, as a professional entity, have a blog which is dedicated to them discussing their

experiences with patient death and dying their emotional distress, behaviour, and cognitive concerns may be mitigated.

6.2.3.2. supporting bereaved significant others. It may be suggested from participants' experiences, that providing limited support to patients' significant others hampered the ST/As in accepting their patients' deaths. Furthermore, if patients' significant others received limited support from the ST/As it may have negatively influenced patients' significant others' bereavement outcomes (Cortezzo et al., 2015; van Baarsen, 2002; Kaunonen, 2000). Therefore, it is recommended that ST/As uphold the continuity of care principle by having debriefing sessions with these individuals (Cortezzo et al., 2015). This may somewhat contribute to ST/As ethic of care.

6.2.4. Data collection procedures. This study showed that narratives do not need to be used only for clinical reasoning (Mattingly & Lawlor, 2000), but can be used to obtain insight into professionals' meaning-making, beliefs, behaviours, and their experiences as helping professionals.

Furthermore, this study showed that in the digital age research involving interviews can be conducted using telecommunications applications, such as Skype. By using these types of telecommunications, the success of conducting interviews as a data collection procedure may not be hindered by geographical barriers.

6.3. Critical Evaluation of the Study

6.3.1. Strengths of the study. Prior to conducting the main study I conducted a pilot study. By piloting the study it gave me an opportunity to practice conducting narrative interviews, which aided me in alleviating the risk of interview bias. Based on the feedback provided by the participant it allowed me to refine the clarity and rigour of the questions asked. It also ensured that the questions were posed in a coherent manner. Furthermore, I also sought feedback on the usefulness of the participant distress protocol. The participant did not make any amendments as she deemed the participant distress protocol to be useful.

I would like to consider the findings obtained to be trustworthy in nature. I employed the member checking technique to ensure credibility, verisimilitude, and utility of the results obtained. Furthermore, by creating an audit trail it ensured that the findings obtained were dependable. Therefore, the trustworthiness of the study was further enhanced. Additionally, the findings may be considered to be reliable as participants grief reactions were described in light of theoretical models of grief.

A possible limitation of utilising narratives was that results cannot be generalised to the population being studied (Ziebland, 2013). However, findings from this study yielded information on participants' grief reactions in instances of patient death. Grief reactions are viewed to be unique among individuals (Buglass, 2010; Sprang & McNeil, 1995). Therefore, participants' grief reactions do not necessarily apply to the greater speech therapy and audiology population. However, there were similarities among the 25 ($n=25$) participants' grief reactions. Thus the recommendations made to work through grief may aid the population to overcome patient death and dying.

6.3.2. Limitations of the study. Although narratives were obtained, they were analysed using thematic analysis. Perhaps, future studies should look into analysing the

narratives obtained using narrative analysis. This may provide a different perspective regarding the ST/As' encounters with patient death and dying.

Participants did display correspondence bias (Jones & Gilbert, 1986) whereby they made assumptions about other HCPs and significant others approach to patient death. To mitigate this attribution error it is recommended that this study be replicated across other healthcare professions. This may even alleviate inter-professional conflict among HCPs. Furthermore, given the difference in the medical culture between SA and international healthcare systems, other South African HCPs' encounters regarding patient death and dying should be investigated.

Additionally, research should explore patients' significant others experiences when interacting with ST/As, particularly after the patient has passed away. There appeared to be limited social support provided by participants to these significant others in these instances.

Despite literature showing that social desirability may contribute to how males and females may report their grief process, studies by Yoost & Crawford (2015) as well as Sansone and Sansone (2012) have shown that males and females do grieve differently. Therefore, some readers may feel that since all participants were female, interpretations, and conclusions made about participants' experiences with patient death and dying cannot further be applied to male ST/As's encounters with these incidences. Furthermore, although this study did not look at how race influences grief reactions, majority of the participants were white. Therefore, future studies should explore how this factor may impact ST/As experiences regarding patient death and dying.

References

Abbaszadeh, A., Ehsani, S.R., Begjani, J., Kaji, M.A., Dopolani, F.N., Nejati, A., & Mohammadnejad, E. (2014). Nurses' Perspectives on Breaking Bad News to Patients and their Families: A Qualitative Content Analysis. *Journal of Medical Ethics, 18*(7), 5-22.

Abdel-Khalek, A.M., & Tomas-Sabado, J. (2005). Anxiety and Death Anxiety in Egyptian and Spanish Nursing Students. *Death Studies, 29*, 157-169.

Adams, , J.A., Anderson, R.A., Docherty, S.L., Tulsky, J.A., Steinhouser, K.E., & Bailey, D.E. (2014). Nursing Strategies to Support Family Members of ICU Patients at High Risk of Dying. *Heart & Lung: The Journal of Critical Care, 43(5),* 406-415.

Albino, I.N, & Deliwe, C.N. (2017). The Republic of South Africa. In M.L. Wehmeyer & J. R. Patton (Eds.), *The Praeger International Handbook of Special Education* (3st ed., pp. 332-351). New York, NY: Routledge.

Albrecht, T.L., & Adelman, M.B.(1987). *Communicating Social Support.* Newbury Park, CA: Sage.

Altinay, L., Paraskevas, A., & Jang, S.S. (2016). *Planning Research in Hospitality and Tourism* (2nd ed.). New York, NY: Routledge.

American Board of Internal Medicine. (1996). *Caring for the Dying: Identification and Promotion of Physician Competency: Educational Research Documents.* Retrieved from: http://www.abim.org

American Counselling Association. (n.d.). *Vicarious Trauma.* Retrieved from: http://www.counselling.org

American Nurses Association. (2016). Nurses' Roles and Responsibilities in Providing Care and Support at the End-of-Life (Position Statement). ANA Board of Directors Website: http://www.nursingworld.org

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders: DSM-V* (5th ed.). Washington, DC: Library of Congress Cataloguing-in-Publication Data.

American-Speech-Language-Hearing Association. (2009). *End-of-Life Issues in Speech-Language Pathology*. Retrieved from: http://www.asha.org/slp/clinical/endoflife

Anxiety and Depression Association of America. (2010). *Posttraumatic Stress Disorder (PTSD)*. Retrieved from: http://www.adaa.org

Anxiety and Depression Association of America. (2018). *Anxiety and Stress in the Workplace* Retrieved from: http://www.adaa.org

Appel, D.L. (2011). *Narratives on Death and Bereavement from Three South African Cultures* (Masters dissertation). University of South Africa, Department of Psychology, Pretoria, South Africa.

Aronson, E., & Mills, J. (1959). The Effect of Severity of Initiation on Liking for a Group. *Journal of Abnormal and Social Psychology, 59*, 177-181.

Ashforth, B.E., Kreiner, G.E., Fugate, M. (2000). All in a Day's Work: Boundaries and Micro Role Transitions. *Academy of Management Review, 25*, 472-491.

Association for Death Education and Counselling. (2010). *Code of Ethics*. Retrieved from: http://www.adec.org.

Atherstone, D. (2011). *Pastoral Care in a Clinical Setting: The Role of Hospital Chaplaincy Plays as Part of a Broader Medical Team* (Masters dissertation). South African Theological Seminary, South Africa.

Bakibinga, P. (2013). *The Experience of Job Engagement and Self-care among Ugandan Nurses and Midwives* (Doctoral Thesis). University of Bergen, Department of Health Promotion and Development, Bergen, Norway.

Bakker, A.B., Demerouti, E., & Schaufeli, W.B. (2005). Crossover of Burnout and Work Engagement among Working Couples. *Journal of Human Relations, 58*(2), 661-689.

Balasubramanian, C., Subramanian, M., Balasubramanian, S., Agrawal, A., Raveendran, S., & Kaliaperumal, C. "Thanatophobia" Physician's Perspective of Dealing with Patients with Fear of Death. *Journal of Natural Science, Biology, and Medicine, 9*(1), 103-104.

Balk, D.E. (2011). *Helping the Bereaved College Student*: New York, NY: Springer.

Balk, D.E.(2014).*Dealing with Dying, Death, and Grief during Adolescence*. New York, NY: Publishers.

Baloyi, L. (2014). The African Conception of Death: A Cultural Implication. International Association for Cross-Cultural Psychology, 40(2)-232-242.

Bam,N .E., & Naidoo, J. R. (2014). Nurses Experiences in Palliative Care of Terminally-ill HIV Patients in a Level 1 District Hospital. *Journal of Democratic Nursing Organization, 37*(1), 1200-1209.

Bamberg, M. (2007). Narrative Analysis and Identity Research: A Case for "Small Stories". *Theory and Psychology, 21*(9)28-33.

Bananno, G.A.,& Burton, C.L. (2013). Regulatory Flexibility: An Individual Difference Perspective on Coping and Emotion Regulation, *Psychological Science, 8*(6),591-612.

Bananno, G. A. Wortman, C.B., Lehman, D. R., Tweed, R.G., Haring, M., Sonnega, J .,...Nesse, R.M. (2002). Resilience to Loss and Chronic Grief: A Prospective Study from Pre-loss to 18 months Post-loss. *Journal of Personal Social Pyshcology,83*(5), 1150-1164.

Bandura, A. (1994). Self-Efficacy. In V.S. Ramachaudran (Ed.), *Encyclopaedia of Human Behaviour* (4th ed., pp. 71-81). New York: Academic Press.

Baumeister, R.F., Dale, K., & Sommer, K.L. (1998). Freudian Defence Mechanisms and Empirical Findings in Modern Social Psychology: Reaction Formation, Projection, Displacement, Undoing, Isolation, Sublimation, and Denial. *Journal of Personality, 66* (6), 1082-1095.

Beauchamp, T.L., & Childress, J.F. (1994). *Principles of Biomedical Ethics* (4th ed.) UK: Oxford.

Bentham, J.(2000). *An Introduction to the Principles of Morals and Legislation.* New York, NY: Batoche Books.

Berger, J.T. (2014). Moral Distress in Medical Education and Training. *Journal of General Internal Medicine, 29* (2), 395-398.

Bickham, A. M. (2009). *Distress in Nurses following Patient Death: A Local Response to the Need for Debriefing.* (Masters dissertation). Montana State University, Department of Nursing, Montana, USA.

Biddle, B.J. (1986). Recent Developments in Role Theory. *Annual Review Sociology, 12,* 67-92.

Biermann, J. (2017). South Africa's Healthcare under Threat. In P. Stevens (Ed.), *Fighting The Diseases of Poverty* (1st ed., pp. 20.33). New York: NY; Routledge.

Boemer, M.R. On Death and Dying (3rd ed.). Brazil: Ribeirão Preto.

Boston, C.D., Fultz, J., & Schoenrade, P.A. (1984, November 12-13). *Distress and Empathy: Two Qualitative Distinct Vicarious Emotions with Different Motivational Consequences.* Paper Presented at the Annual Meetings of the American Psychological Association, Toronto, Canada.

Bowlby, J., Parkes, C.M. (1970). Seperation and Loss within the Family. In E.J. Anthony (Ed.), *The Child in His Family* (1st ed., pp. 197-216). New York, NY: Wiley.

Bowlby, J. (1980). *Attachment and Loss: Loss, Sadness and Depression* (2nd ed.). New York, NY: Basic Books.

Braun, M., Gordon, D., & Uziely, B.(2010). Associations between Oncology Nurses' Attitudes Toward Death and Caring for Dying Patients. *Oncology Nursing Forum, 37*, 43-49.

Braun, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Brody, L. (2009).*Gender, Emotion and the Family*. UK: Harvard University.

Broodryk. J. (2005). *Ubuntu Management Philosophy*. Randburg: Knowres.

Brown, S.L., Nesse, R. M.,Vinokur, A.D., & Smith, D.M. (2003). Providing Social Support may be More Beneficial than Receiving it. *Psychological Sciences,14(4)*, 320-327.

Brunhofer, M. O (2011).Loss and Mourning: A Life Cycle Perspective. In J.R. Brandell (Ed.), *Theory & Practice in Clinical Social Work*.(2nd ed., pp. 665-693). New York, NY: Sage.

Bryan, W.V. (2014). *Multicultural Aspects of Human Behaviour: A Guide to Understanding Human Cultural Development* (3rd ed.). Springfield, Illonis: Charles C Thomas.

Bryant, C.D. (2003). *Handbook of Death and Dying*. Thousand Oakes, CA: Sage.

Buglass, E. (2010). Grief and Bereavement Theories. *Nursing Standard, 24* (41) 44-47.

Burhansstipanov, L., Shockeny, L.D., & Gentry, S. (2018).History of Oncology Patient and Nurse Navigation. In L. Shockney (Ed.), *Team-Based Oncology Care: The Pivotal Role of Oncology Navigation* (3rd ed., pp. 13-43).Baltimore, MD: Springer International.

Campbell, M.L.(1995). Breaking Bad News to Families of Hospitalized Patients. *Michigan Family Review, 1*(1),39-46.

Carcary, M. (2009). The Research Audit Trial-Enhancing Trustworthiness in Qualitative Inquiry. *Journal of Business Research Methods, 7*(1), 11-24.

Carter, R.E.,& Lubinsky, J.(2015).*Rehabilitation Research: Principles and Applications* (5th ed.). St. Louis, Missouri: Elsevier.

Caswell, G., Pollock, K., Harwood, R., & Porock, D. (2015). Communication between Family Carers and Health Professionals about End-of-Life Care for Older People in the Acute Hospital Setting: A Qualitative Study. *BioMedical Central Palliative Care*, 86(10), 15-20.

Central Intelligence Agency. (2014). *Country Comparison: Death Rate*. Retrieved from: http://www.cia.gov

Chase, E. (2017). Enhanced Member Checks: Reflections and Insights from a Participant-Researcher Collaboration. *The Qualitative Report, 22*(1), 2689-2703.

Clandinin, J., Caine, V., Estefan, A., Huber, J., Murphy, M.S., & Steeves, P. (2015). Place of Practice: Learning to Think Narratively. *Narrative Works, 5*(10), 20-25.

Clark-Carter, D. (2012). *Quantitative Psychological Research: A Students Handbook.* New York, NY: Psychology.

Clayton, P.J., Halikas, J.A., Maurice, W.L., & Robins, E. (1973). Anticipatory Grief and Widowhood. *British Journal of Psychiatry, 122*, 47-51.

Close, C. (2019). *Introduction to the Ethic of Care (Working Paper)*. Retrieved from Cabrillo College website: http://www.cabrillo.edu

Cohen, S., & Hoberman, H. (1983). Positive Events and Social Supports as Buffers of Life Change Stress. *Journal of Applied Social Psychology, 13(2),99-125.*

Cohen, S., & Pressman, S. (1994). *Stress Buffering Hypothesis*. In N.B. Anderson (Ed.), *Encyclopedia of Stress Behaviour* (2nd ed.,pp. 257-280). Thousand Oakes, CA: Sage

Cohen,S., & Wills, T.A. (1985). Stress, Social Support, and the Buffering Hypothesis. *Psychological Bulletin, 98(2), 310-357.*

College of Respiratory Therapists of Ontario. (2017). *Collaborative Care Principles and Best Practices*. Retrieved from: http://www.crto.on.ca

Committee on Hospital Care and Institute for Patient- and Family-Centred Care. (2012). Patient- and Family-Centred Care and the Paediatrician's Role. *American Academy of Paediatrics, 129*(2), 3-9

Continuing Professional Development. (2014).*The Importance of Continuing Professional Development*. Retrieved from: http://www.continuingprofessionaldevelopment.org

Coon, D., & Mitterer, J.O. (2010). *Introduction to Psychology Gateways to Mind and Behaviour* (12th ed.). Belmont, CA: Wadsworth Cengage Learning.

Cooperrider, D.L., & Srivastva, S. (1987). Appreciative Inquiry in Organisational Life. *Research in Organisational Change and Development,1*, 129-169.

Corr, C.A. (1998). Enhancing the Concept of Disenfranchised Grief, *Omega, 38(1)*,1-20.

Corr, C.A., & Corr, D.M. (2013). *Death & Dying – Life & Living* (7th ed.). Belmont, CA: Wadsworth Cengage Learning.

Corso, M., Giacobbe, A, & Giacobbe, A. (2009). Designing and Managing Business Communities of Practice, *Journal of Knowledge and Management, 13*(1), 73-89.

Cortezzo, D.E., Sanders, M.R., Brownwell, E.A., & Moss, K. (2014). End-of-Life Care in the Neonatal Intensive Care Unit: Experiences of Staff and Parents. *Perinatal Journal, 32*(8), 713-724.

Creswell, J.W. (2009). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* (3rd ed.). Thousand Oakes, CA: Sage.

Creswell, J.W., & Miller, D. (2010). Determining Validity in Qualitative Inquiry. *Theory Into Practice, 39(3)*, 124-130.

Cryder, C.E., Springer, S., & Morewedge, C.K. (2012). Guilty Feelings, Targeted Actions. *Personality & Social Psychology Bulletin, 38*(5), 607-618.

Currall, S., & Towler, A. (2003). Research Methods in Management and Organizational Research: Toward Integration of Qualitative and Quantitative Techniques: In A. Tashakkori & C. Teddlie (Eds.), SAGE Handbook of Mixed Methods in Social & Behavioural Research. (1st ed., pp.513-526). Thousand Oakes, CA: Sage.

Deelstra, J. (2000). *The Downside of Social Support.* (Masters dissertation). University of Tampere, Department of Medicine, Vammalan, Finalnd.

Delaney, L.J. (2018). Patient-Centred Care as an Approach to Improving Healthcare in Australia. *The Australian Journal of Nursing Practice, Scholarship and Research, 5*(2), 2-10.

Demmer, C.(2006). Confronting AIDS-related Loss and Grief: An Exploratory Study of Professional Caregivers in Kwa-Zulu Natal, South Africa. *African Journal of AIDS Research*, 5(2), 97-107.

Dennis, D. (2009). *Living, Dying, Grieving*. Clarkville, TN: Jones and Bartlett.

DePoy, E., & Gilson, S.F. (2012). *Human Behaviour Theory and Applications: A Critical Thinking Approach.* Thousand Oakes, CA: Sage.

De Vaus, D.A.(2001). *Research Design in Social Research.* UK: Sage.

Dingley, C., Daugherty, K., Derieg, M.K., & Persing, R. (2008). Improving Patient Safety Through Provider Communication Strategy Enhancements. In K. Henriksen, J.B. Battles & M.A. Keyes (Eds.), *Advances in Patient Safety: New Directions and Alternative Approaches* (3rd ed., pp. 10-34). Rockville, Maryland: Agency for Healthcare Research and Quality.

Draucker, C.B., Martsolf, D.S., & Poole, C.(2009). Developing Distress Protocols for Research on Sensitive Topics. *Psychiatry Nursing Archives,23*(3),343-350.

Drenth, C.M. (2008). *Complicated Grief in the South African Context-A Therapeutic Intervention Program* (Master's dissertation). North-West University, Department of Social Work, Potchefstroom, South Africa.

Druder, E. (2010). New-found Football Fans. In T. Chari & N. Mhiripiri (Eds.), *African Football, Identity Politics and Global Media Narratives: The Legacy Of the FIFA 2010 World Cup* (1st ed., pp. 93-106). New York, NY: Routledge.

Dworkin, G. (1975). Paternalism. *The Monist, 56*(1), 64-84.

Erlandsson, A., Jungstrand, A.Å., & Västfjäll. (2016). Anticipated Guilt for Not Helping and Anticipated Warm Glow for Helping are Differently Impacted by Personal Responsibility to Help. *Frontiers in Psychology, 7*, 1475-1536.

Evans, A. N., & Rooney,B.J.(2013).*Methods in Psychological Research* (3rd ed.). Thousand Oakes, CA: Sage.

Evans, L. (2010). To What Extent has Psychological Theories Informed our Understanding of Response to Loss and/or Adjustment to Dying. *Journal of Anthropology,12*(9), 1-5.

Farlex Legal Online Dictionary. (2005). Retrieved from: http://www.medical-dictionary.thefreedictionary.com

Farlex Medical Online Dictionary. (2012). Retrieved from:

http://www.medical-dictionary.thefreedictionary.com

Feifel, H. (Ed.). (1977). *New Meanings of Death* (2nd ed.). New York, NY: McGrwall-Hill.

Ferguson, T. (1997). Healthcare in Cyberspace: Patients Lead a Revolution. *Futurist, 31*(6), 29-34.

Ferrante, J (Ed.). (2014). *Sociology: A Global Perspective* (9th ed.). Stamford, CT: Cengage Learning.

Festinger, L. (1957). *A Theory of Cognitive Dissonance*. Stanford, CA: Stanford University.

Field, M.J. (1997). *Educating Clinicians and Other Professionals Approaching Death: Improving Care at the End of Life*. New York, NY: National Academies.

Fraley, R.C., & Shaver, P. R. (2002). Loss and Bereavement: Attachment Theory and Recent Controversies concerning "Grief Work" and the Nature of Detachment. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of Attachment: Theory, Research, and Clinical Applications* (1st ed., pp. 735-760). New York, NY: The Guilford.

Freud, A. (1936). *The Ego and the Mechanisms of Defence*. Germany: Karnac Brooks.

Freud, S. (1926). Inhibitions, Symptoms & Anxiety. *Psychoanalytic Quarterly,4*(4),616-625.

Freud, S. (1959). Future Prospects of Psychoanalytic Psychotherapy. In J. Stachey (Ed.). *The Standard Edition of the Complete Psychoanalytic Works of Sigmund Freud* (20th ed., pp.87-172). UK: Hogarth.

Freud, S. (1961). *Beyond the Pleasure Principle*. Mineola, NY: Leverringht.

Freud, S. (2013). *The Neuro-psychoses of Defence*. UK; Red Books Ltd.

Freudenberger, H.J. (1974). Staff Burnout. *Journal of Social Issues, 30*, 159-165.

Fulton, A. (2012). Dealing with Client Death and Dying: A Letter to Social Work Practicum Students. *Journal of Social Work Education, 18*(2), 69-76.

Gangemi, A., & Mancini, F. (2011). Guilt and Guilts. In R. Trnka, K. Balcar, & M. Kuška (Eds.), *Re-constructing Emotional Spaces; From Experience to Regulation* (1st ed., pp.169-188). Prague: Prague College of Psychological Studies.

Gardner, D.B. (1998). Effects of Conflict Types and Power Style Use among Health Professionals in Interdisciplinary Team Collaboration. UK: University of Microfilms International.

Gardner, D.B. (2005). Ten Lessons in Collaboration. *The Online Journal of Issues in Nursing, 10*(1), 1-10. Doi:10.3912/OJIN.

Garvis, S. (2015). *Narratives Constellations*. Netherlands: Sense.

Gerber, I., Rusalem, R., Hannon, N., Battin, D., & Arkin, A. (1975). Anticipatory Grief and Aged Widows and Widowers. *Journal of Gerontology, 30*(2), 225-229.

Gibson, A., & Foster, C. (2007). The Role of Self-talk in the Awareness of Physiological State and Physical Performance. *Sports Medicine, 37*(12), 1029-1044.

Gilbert, D.T., & Jones, E.E. (1986). Perceiver-Induced Constraint: Interpretation of Self-Generated Reality. *Journal of Personality and Social Psychology, 50*, 269-280.

Gillian. (2010, July 21). Representative Sample [Blog Post]. Retrieved from: http://www.psychcentral.com/encyclopoedia/

Gilligan, C. (1982). *In a Different Voice: Psychological Theory and Women's Development*. Cambridge, MA: Harvard University.

Glick, I.O., Weiss, R.S., & Parkes, C.M. (1974). *The First Year of Bereavement*. Canada: John Wiley and Sons.

Goldberg, J. (2016). *Stages of Grief: How to Cope with Grief and Loss*. New York, NY: Page.

Goldstein, E. (1995). *Ego Psychology and Social Work Practice* (2nd ed.). New York, NY: The Free.

Gottlieb, B. (2000). Selecting and Planning Support Interventions. In S. Cohen, L. Underwood., & B. Gottlieb (Eds.), *Social Support Measurement and Intervention* (3rd ed.,pp.195-220). London: Oxford University.

Gould, J.S., & Barak, B. (1988). Public Self-Consciousness and Consumption Behaviour. *The Journal of Social Psychology, 128*(3), 393-400.

Gračanin, A., Bylsma, L.M., &Vingerhoets, A.J.J.M. (2014). *Is Crying a Self-Soothing Behaviour? Frontiers in Psychology, 5*, 502-507.

Grady, M.P. (1998). *Qualitative and Action Research: A Practitioner Handbook: A Practitioner Handbook.* Thousand Oakes, CA: Phi Delta Kappa Educational Foundation.

Grant, M. (2015). Introducing Palliative Care. In C. Dahlin, Coyne, P.J., & B. R. Ferrell (Eds.), *Advanced Practice Palliative Care* (2nd ed.,pp. 371-378). New York, NY: Oxford University.

Green, S. (2000). *Research methods in Health, Social and Early Years Care.* UK: Nelson Thornes Ltd.

Greenhaus, J., & Beutell, N.J. (1985). Sources of Conflict between Work and Family Roles. *The Academy of Management Review, 10*(1), 76-88.

Guwande, A. (2014). *Being Mortal Medicine and What Matters in the End* New York, NY: Metropolitan Books.

Hahn, S.E. (2000). The Effects of Locus of Control on Daily Exposure, Coping and Reactivity to Work Interpersonal Stressors: A Diary Study. *Personality and Individual Differences, 29(1)*, 729-748.

Hall, J.M., & Powell, J. (2011). Understanding the Person through Narrative. *Nursing Research and Practice,* 18(2), 322-333.

Hammett, F.S. (2012, March 10-11). *Death Anxiety among HCPs*. Paper presented at the Ninth Inaugural Commonwealth Nurses Conferences, London, United Kingdom. Retrieved from: http://www.commomwealthnurses.org

Hanna, D.R., & Romana, M. (2007, August). Debriefing After a Crisis: What's the Best Way To Resolve Moral Distress? Don't Suffer in Silence. *Nursing Management, 114* 39-47.

Harvard Medical School. (2011, December 12). Beyond the Five Stages of Grief [open letter]. *Harvard Health Publishing*. Retrieved from: http://www.heath.harvard.edu.

Haslam, N. (2018, October 28). *The Five Stages of Grief are not Fixed Steps. The Sydney Morning Herald*. Retrieved from: http://www.smh.com.au

Health Professions Council of South Africa. (2008). *Guidelines for Good Practice in the Health Care Professions*. Retrieved from: http://ww.hpcsa.co.za

Health Professions Council of South Africa. (2016).*Statistics*. Retrieved from: http://www.hpcsa.co.za

Health Professions Council of South Africa. (2017). *Organisational Structure*. Retrieved from: http://www.hpcsa.co.za

Health Professions Council of South Africa. (2018). *Professional Boards*. Retrieved from: http://www.hpcsa.co.za

Health Systems Trust. (2007). *Private Hospitals*. Retrieved from: http://www.hst.org.za

Heather and Christol. (2009, April 1). Defence Mechanisms: Neuroscience meets Psychoanalysis [Blog Post]. Retrieved from: http://scientificamerican.com.

Heigham, J., & Sakui, R. A. (2009). Ethnography. In J. Heigham, & R. A. Crocker (Eds.), *Qualitative Research in Applied Linguitsics: A Practical Introduction* (1st ed. pp.91-112). New York, NY: Palgrave Mcmillian.

Heimann, P. (1950). On Countertransference. *International Journal of Psychoanalysis, 31* 81-84.

Hess, U., & Fischer, A.(2014) Emotional Mimicry. *Social and Personality Psychology Compass, 8(2)*, 45-57.

Hillier, S.M.,& Barrow,G.M. (2014).*Aging, the Individual and Society* (10th ed.). *Aging, the Indvidual and Society*. Australia: Cengage Learning.

Hobbs, J.R., & Agar, M.H. (1982). The Coherence of Incoherent Discourse. *Journal of Language and Social Psychology, 4*(3), 213-231.

Hobson, A. (2004). *The Oxford Dictionary of Difficult Words* (25th ed). UK: Oxford University.

Hochschild, A. (1983). *The Managed Heart: Commercialization of Human Feeling.* Berkley: University of California.

Hoffman, M.L. (1982).Development of Prosocial Motivation: Empathy and Guilt. In N. Eisenberg (Ed.), *The Development of Prosocial Behaviour* (1st ed., pp. 218-231). New York, NY: Academics.

Holtz, C., & Elsway, I. (2016).Developing Countries: Egypt, China, India, and South Africa. In C. Holtz (Ed.), *Global Health Care: Issues and Policies* (3rd ed., pp.65-110). Boca Raton, FL: Jones Bartlett Learning.

Houser, J. (2013). *Nursing Research: Reading, Using and Creating Evidence* (3rd ed). Burlington: Jones & Bartlett Learning.

Huffman, J.C., & Stern, T.A. (2003). Compassionate Care of the Terminally Ill. *Primary Care Companion to the Journal of Clinical Psychiatry, 5*(3), 131-136.

Hulley, S.B.,Cummings, S.R.,Browner, W.S.,Grady, D.G.,& Newman, T.B.(Eds.). (2007). *Designing Clinical Research* (3rd ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Institute of Medicine. (2015). *Committee on Approaching Death: Addressing Key End-of-Life Issues*. New York, NY: National Academies.

Institute for Patient and Family-Centred Care. (2012). *Patient- and Family- Centred Care.* Retrieved from: http://www.ipfcc.org

Ishi, H., & Muramatsu, H. (2000). Student Nurses' Views on the Usefulness of Psychology. *Shinrigaku Kenkyu, 71*(2), 136-143.

Izard, C.E. (1997). *Human Emotions*. New York, NY: Plenum.

Jahn, W.T. The 4 Basic Ethical Principles that Apply to Forensic Activities are Respect for Autonomy, Beneficence, Non-maleficence, and Justice. *Journal of Chiropractic Medicine, 10*(3), 225-226.

Jehn, K.A. (1995).A Multi-method Examination of the Benefits and the Detriments of Intragroup Conflict. *Administrative Science Quarterly, 40*, 256-282.

Jemmings, B., Gemmil, C., Bohman, B., & Lamb, K. (n.d.). *Kübler-Ross and other Approaches* [PowerPoint]. Retrieved from: http:///www.uky.edu.

Joinson, C. (1992). Coping with Compassion Fatigue. *Nursing, 22*(4), 116-120.

Jones, L. (2018, July). The Digital Age: Are We Losing Human Connection-The Impact of Digital Technology. *Thrive Global, 12*, 23-26.

Jouybari, L.M., & Sasnagoo, A. (2013). *The Nurses' Experiences of Breaking Bade News to the Patients. Iranian Journal of Medical Ethics, 7*(24), 11-39.

Kaltman, S., & Bonanno, G.A. (2003). Trauma and Bereavement: Examining the Impact of Sudden and Violent Deaths, *Journal of Anxiety Disorders, 17*(3), 131-147.

Kastenbaum,R.J.(2015).*Death, Society, Human Experience* (11th ed.). UK: Routledge.

Katz, R.S. (1990). Using our Emotional Reactions to Older Clients: A Working Theory. In B. Genevay and R.S. Katz (Eds.), *Countertransference and Older Clients* (1st ed., pp.17-20).UK: Sage.

Katz, D., & Kahn, R.L. (1966). The Social Psychology of Organisations. New York, NY: John Wiley & Sons.

Kaunonen, M. (2000). *Support for a Family in Grief* (Masters dissertation). University of Tampere, Department of Medicine, Vammalan, Finalnd.

Khomba, J.K. (2011). *Redesigning the Balance Scorecard Model: An African Perspective* (Doctoral Thesis). University of Pretoria, Pretoria, South Africa.

Khumalo, R.S. (2017). The Changing Landscape of South Africa and Implications for Practicing Ubuntu. In J. Dreyer, Y. Dreyer, & E. Foley (Eds.). *Practicing Ubuntu Practical Theological Perspectives on Injustice, Personhood and Human Dignity*, (20th ed., pp. 22-34). Zurich: Lit Verlag.

King (2013, January 19). The Importance of Research Design [Blog Post]. Retrieved from: http://www.universalteacher.com

King, L.M. (2013). In Discourse-Towards a Pan-African Psychology: Drum Rolls for a Psychology of Emancipation. *Journal of Black Psychology, 29*, 223-231.

Knowles, O. (2013). *Facebooking for Social Support: An Experimental Test of Relational Regulation Theory* (Master's dissertation). Utah State University, Department of Psychology, Utah, USA.

Knudsen, L.V., Leplante-Lévesque, A., Jones, L., Preminger, J.E., Nielson, C., & Lunner, T. (2012). Conducting Qualitative Research in Audiology; A Tutorial. *International Journal of Audiology, 51*, 83-92.

Ko, H.C., Wang, L.L., & Xu, Y.T. (2013). Understanding the Different Types of Social Support Offered by Audience to A-List Diary-Like and Information Bloggers, Cyberpsychology Behaviour. *Social Networking, 16(3)*, 194-199.

Kosciulek, J.F. (2007). The Social Context of Coping. In E. Martz & H. Livneh (Eds.), *Coping with Chronic Illness and Disability* (3rd ed., pp. 73-89). New York, NY: Springer Science and Business.

Konigsberg, R.D. (2011, January). New Ways to Think About Grief. *Time Magazine, 24*, 11-15.

Kornhaber, R., Walsh, K., Duff, J., & Walker, K. (2016). Enhancing Adult Therapeutic Interpersonal Relationships in the Acute Healthcare Setting: An Integrative Review. *Journal of Multidisciplinary Healthcare, 9*, 537-546.

Kroeber, T. (1963).The Coping Functions of the Ego Mechanisms. In R. White (Ed.), *The Study of Lives* (1st ed., pp. 178-198). New York, NY: Atherton.

Kübler-Ross, E. (1969). *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy & Their Own Families* (41th ed.). New York, NY: Scribner.

Kübler-Ross, E. & Kessler, D. (2001). *Life Lessons: Two experts on Death and Dying Teaches us about the Mysteries of Life and Living.* New York, NY: Scribner.

Kuo, D.Z., Houtrow, A.J., Arango,P., Kuhlthau, K.A., Simmons, J.M., & Neff, J.M. (2011). Family-Centred Care: Current Applications and Future Directions in Paediatric Healthcare. *Maternal and Child Health Journal, 16*(2), 297-305.

Kuo, B.C.H. (2014).Coping, Acculturation, and Psychological Adaption among Migrants: A Theoretical and Empirical Review and Synthesis of the Literature. *Health Psychology and Behavioural Medicine, 2*(1), 16-33.

Kurapati, R. (2018). Physician: How Science Transformed the Art of Medicine. New York, NY: Greenleaf Book Group.

KwaZulu-Natal Department of Health. (2013). *Batho Pele: People First.* Retrieved from: http://www.kznhealth.gov.za

Lakey, B., & Orhek, E. (2011). Relational Regulation Theory: A New Approach to Explain the Link Between Perceived Social Support and Mental Health. *Psychological Review, 118(3),* 482-485.

Lally, J.R. (2018). *A Compassionate Sense of Wonder*. San Francisco, CA: West Ed.

Lange, M., Kline, T.M., & Kline, N.E. (2008). Assessing Nurses' Attitudes Toward Death and Caring for Dying Patients in a Comprehensive Cancer Center, *Oncology Nursing, 35*(9), 955-959.

Larsson, E.W., & Stern, T.A. (2013). Helplessness in the Helpers: Aetiology and Management. *Primary Care Companion for CNS Disorders, 15*(6), 1-19.

Lave, J., & Wenger, E. (1991). *Situated Learning: Legitimate Peripheral Participation.* Cambridge: Cambridge University.

Lehto, R.H., & Stein, K.F. (2009). Death Anxiety: An Analysis of an Evolving Concept. *Research and Theory for Nursing Practice, 23*(1), 23-41.

Leon, A.C., Davis, L.L.,& Kraemer, H.C.(2011). The Role and Interpretation of Pilot Studies in Clinical Research. *Journal of Psychiatric Research, 45*(5),626-629.

Lewis, H.B. (1971). *Shame and Guilt in Neurosis*. Madison: International University.

Lewis, S.L., Heitkemper, M.M., & Dirksen, S. R. (2004). *Medical-Surgical Nursing: Assessment and Management of Clinical Problems*. Canada: Elsevier Saunders.

Liblich, A. (2014). *Narratives of Positive Aging Seaside Stories*. UK: Oxford University Series.

Liddiard, K.(2017). *The Intimate Lives of Disabled People*. New York, NY: Routledge.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage.

Lindermann, E. (1944). The Symptomology and Management of Acute Grief. *American Journal of Psychiatry, 7*(4), 1-28.

Linton, A.D. (2015). *Introduction to Medical-Surgical Nursing* (6th ed.). Canada: Elsevier Saunders.

Little, M. (1951). Countertransference and the Patient's Response to It. *International Journal of Psychoanalysis,32*, 32-40.

Loh, J. (2013). Inquiry into Issues of Trustworthiness and Quality in Narrative Studies: A Perspective. *The Qualitative Report, 18*(33), 1-15.

Lonetto, R., & Templer, D.I. (1986). *Series in Health Psychology and Behaviour Medicine: Death Anxiety*. New York, NY: Hemisphere

Lydall, A. (2004). *Give Sorrow Words: The Meaning of Parental Bereavement* (Master's dissertation). University of Johannesburg, Department of English, Johannesburg, South Africa.

Maciejewski, P.K., Zhang, B., Block, S.D., & Prigerson, H.G. (2007). An Empirical Examination of the Stage Theory of Grief. *American Medical Association, 297* (7), 216-723.

Macnee, C.L., & McCabe, S. (2008). *Understanding Nursing Research: Using Research in Evidence-Based Practice*. New York, NY: Lippincott Williams & Wilkins.

Makgahlela, M.A. (2016). *The Psychology of Bereavement and Mourning Rituals in a Northern Sotho Community* (Doctoral thesis). University of Pretoria Faculty of Humanities, Pretoria, South Africa.

Malkinson,R., Rubin,S.,& Witzum,E.(2000).*Traumatic and Non-traumatic Loss and Bereavement: Clinical Theory and Practice. Madison*: Psychosocial.

Mancini, A., & Mancini, F. (2015). Do Not Play God: Contrasting Effects of Deontological Guilt and Pride on Decision-Making. *Frontiers in Psychology, 6*, 1251-1289.

Mandal, J., Ponnambath, D.K., & Parija, S.C. (2016). Utilitarian and Deontological Ethics in Medicine. *Tropical Parasitology, 6*(1), 5-7.

Maple, M., Edwards, H., Plummer, D., & Minichiello, V. (2010). Silenced Voices: Hearing the Stories of Parents Bereaved Through the Suicide Death of a Young Adult Child. *Health & Social care in the Community, 18*(3), 241-248.

Margolis, O.S., Kutscher, A.H., Marcus, E.R., Raether, H.C., Pine, V.R., Seeland, I.B., & Cherico, D.J. (Eds.). (1988). *Grief and the Loss of an Adult Child.* New York, NY: Praeger.

Marshall, P.A. (2007). *Ethical Challenges in Study Design and Informed Consent for Health Research in Resource-Poor Settings.* Geneva, Switzerland: WHO Liberty Cataloguing Data.

Martin,S. (2009,Novemeber). Coping with the Emotional Aspects of a Client's Death. *The New Social Worker,318*, 5-6.

Matson, M., & Hall, J.G. (2011). *Health as Communication Nexus: A-Service Learning Approach.* Dubuque, Iowa: Kendall Hunt

Mattingly, C., & Lawlor, M. (2000). Learning from Stories: Narrative Interviewing in Cross-cultural Research. *Scandinavian Journal of Occupational Therapy, 7*, 4-14.

McIntyre, D., Bloom, G., Doherty, J., & Brijlal. (n.d.). Health Expenditure and Finance in South Africa (Report). Retrieved from Health Systems Trust and the World Bank website: http://www.hst.org.za

McKay, R.C. (1991).Working with Dying People: Crisis and Compensations. *Curationis, 14*(4), 1-5.

Medeiros, K. D. (2013). *Narrative Gerontology in Research Practice.* New York, NY: Springerfield.

Mediclinc. (2016). *Mediclinic Annual Report-Market Overview.* Retrieved from: http://www.annualreport2016.mediclinic.com

Mental Health Commission. (2006). Multidisciplinary Team Working: From Theory to

Practice (Discussion Paper). Retrieved from Mental Health Commission website: http://wwwmhcirl.ie

Mermann, A.C., Gunn, D.B., & Dickinson, G.E. (1991). Learning to Care for the Dying: A Survey of Medical Schools and a Model of Course. *Academic Medicine, 66*(1), 35-38.

Miller, A.J. (2011). Don't blame the Patient! . *Texas Heart Institute Journal*, 38(6), 620-623.

Miller, C.B. (2013). *Moral Character: An Empirical Theory*. UK: Oxford University.

Miller, M.C., & Segal, J. (2010). ***When a Loved one is Terminally-Ill: Talking about Death and Making End-of-Life Decisions*** [e-book]. Retrieved from: http://www.helpguide.org

Mills, A.J.,Durepos, G., & Wiebe,E. (2010). *Case Study Research.* Thousand Oakes, CA: Sage.

Merrill, L., & Miller, E. (2015). ***Interprofessional Conflict Management Study in a Hospital Setting*** (Master of Social Work). California State University, Sacromento, USA.

Misslebrook, D. (2013). Duty, Kant, and Deontology. *The British Journal of General Practice: The Journal of the Royal College of General Practitioners, 63*(609), 211.

Mitchell,J.T.,& Everly, G.S.(2001).*Critical Incident Stress Management: Basic Group Crisis Interventions*. New York, NY: Cambridge University.

Mitchell, P., Wynia, M., Golden, R., McNellis, B., Okun, S., & Webb, E.C.,... von Kohorn, I. (2012). *Core Principles & Values of Effective Team-Based Health Care* (Discussion Paper). Retrieved from Institute of Medicine of the National Academies website: http://www.iom.edu/tbc

Monteith, M.J. (1993). Self-Regulation of Stereotypical Responses: Implication for Progress in Prejudice Reduction. *Journal of Personality & Psychology, 65*, 469-485.

Mooney, D.C. Tactical Reframing to Reduce Death Anxiety in Undergraduate Nursing Students. *American Journal of Hospice and Palliative Care, 22*, 427-432.

Morris, S., & Page, W. (2004). Humour in Cancer and Palliative Care: An Educational Perspective. In L. Foyle & J.Hostad (Eds.), *Delivering Cancer and Palliative Care Education* (1st ed., pp.173-189). New York, NY: Radcliff.

Mosher, D.L. (1965). Interaction of Fear and Guilt in Inhibiting Unsuccessful Behaviour. *Journal of Consulting Psychology, 29*, 161-167.

Murrow, G.B., & Murrow, R. (2015). A Hypothetical Neurological Association between Dehumanisation and Human Rights Abuses. Journal of BioSciences, 29(1), 1-15.

Muylaert, C.J., Sarubbi, V., Gallo, P.G., Neto, M.L.R., & Reis, A.O.A. (2014). Narrative Interviews: An Important Resource in Qualitative Research. *Journal of Psychology, 48*(2), 184-189.

Naik, S.B. (2016). Death in the Hospital: Breaking Bad News to the Bereaved Family. *Indian Journal of Critical Care, 17*(3), 178-181.

Nakajima, S., Masaya, I., Akemi, S., & Takako, K. (2012). Complicated Grief in Those Bereaved by Violent Death: The Effects of Post-Traumatic Stress Disorder on Complicated Grief. *Dialogues in Clinical Neuroscience, 14*(2), 210-214.

National Cancer Institute. (n.d). *Definition of Social Support*. Retrieved from: http://www.cancer.gov

Navare, S. (2008). Counselling at Work Place: A Proactive Human Resource Initiative. *Indian Journal of Occupational and Environmental Medicine, 12*(1), 1-6.

Ncama, B.P. (2015). Ubuntu-Guiding Philosophy of Care for Children with HIV/AIDS in Nigeria, *African Journal for Physical Health Education, Recreation and Dance, 21*(4), 1457-1468.

Nemcek, M.A. (1987). A Concept Analysis of Self-Nurturing. Journal of the *American of The Association of Occupational Health Nurses Journal, 35*(8), 349-352.

Nesse, R.M. (2005). An Evolutionary Framework for Understanding Grief. In D. Carr, R.M. Nesse, & C.B. Wortman (1st ed., pp.195-226). Evolution and Human Behaviour New York, NY: Springer.

Newman, L. (2004). Elisabeth Kübler-Ross. *British Medical Journal, 329*(7466), 627-633.

Nguyen, K.(2012).Exploring Patient Perspective at End-of-Life: Qualitative Interviews with Terminally Ill Patients. *Yale Medicine Thesis, 46*(17), 66-70.

Nia, H.S., Lehto, R.H., & Ebadi, A., & Peyrovi, H. (2016). Death Anxiety among Nurses And HCPs: A Review Article. *International Journal of Community Based Nursing and Midwifery, 4*(1), 2-10.

Niederriter, J. E. (2009). *Student Nurses' Perception of Death and Dying* (Doctoral thesis). Cleveland State University, School of Urban Education, Cleveland, USA.

Nyatanga, B., & de Vocht, H. (2006). Towards a Definition of Death Anxiety. *International Journal of Palliative Nursing, 12*, 410-413.

Oakley, J., & Cocking, D. (2004). *Virtue Ethics and Professional Roles*. UK: Cambridge University.

O'Daniel, M., & Rosenstein, A.H. (2008). Professional Communication and Team Collaboration. In R.G. Hughes (Ed.), *Patient Safety and Quality: An Evidence-Based Handbook for Nurses* (1st ed., pp.2-31). Rockville, Maryland: Agency for Healthcare Research and Quality.

Ogden, K., Barr, J., & Greenfield, D. (2017). Deterring Requirements for Patient-Centred Care: A Participatory Concept Mapping Study. *BioMed Central, 17*(1), 780-716.

Olivia. (2016, December 19). What is Trustworthiness in Qualitative Research [Blog Post]. Retrieved from: http://www.statisticssolutions.com

Omdahl, B.L. (2014). *Cognitive Appraisal, Emotion, and Empathy*. New York, NY: Psychology.

O'Reilly, M., & Kiyimba, N. (2015). *Advanced Qualitative Research: A Guide to Using Theory*. Thousand Oakes, CA: Sage.

Osterweis, M., Solomon, F.,Green, M.(1984). *Bereavement: Reactions, Consequences and Care*. New York, NY: National.

Ovretveit, J. (1993). *Health Service Quality: An Introduction to Quality Methods of Health Services*. UK: Blackwell.

Oxfam. (2012). *Conducting Semi-structured Interviews*. Retrieved from: http://www.alnap.org

Palmer, A. (2008). *Coping with Death and Dying. American Association of Nurse Anaesthetists Journal, 73*(5), 26-30.

Pamela. (2015, March 25). Heart-wrenching Photo of Doctor Crying Goes Viral: Here's Why [Blog Post]. Retrieved from: http://ww.idealmedicalcare.org

Pannucci, J.,& Wilkins,E. G. (2011).*Identifying and Avoiding Bias in Research. Plastic and Reconstructive Surgery, 126*(2),619-625.

Papri-Bernstein, W. (2018). *The Practitioner's Path in Speech-Language Pathology: The Art of School-Base Practice*. San Diego, CA: Plural.

Parkes, C.M., & Weiss, R.S. (1983). Recovery from Bereavement. In H.M. Chochinov, & B. William (Eds.)., *Handbook of Psychiatry in Palliative Medicine* (1st ed., pp. 321-334). New York, NY: Oxford University.

Pargement, K., & Rye, M.S. (1998). Forgiveness as a method of Religious Coping. In E.L. Worthington (Ed.), *Dimensions of Forgiveness: Psychological Research and Theological Perspectives* (1st ed., pp. 59-78). Philadelphia, PA: Templeton Foundation.

Patterson, W. (2013).Narratives of events. Labovian Narrative Analysis and its Limitations. In Andrews, C. Squire & M. Tamboukou(Eds.), *Doing Narrative Research* (2nd ed., pp.2-31). UK: Routledge Taylor & Francis Group.

Pearlman, L.A., & Saakvitne, K.W. (1995). Trauma and the Therapist: Countertransference and Vicarious Traumatisation in Pyschotherapy with Incest Survivors. *American Journal of Clinical Hypnosis, 38*(4), 289-299.

Peeters, G. (1971). The Positive-Negative Asymmetry: On Cognitive Consistency and Positivity Bias. *European Journal of Social Psychology, 1*(1), 455-474.

Peng, A.C., Dimotakis, N., Ilies, R. (2011). Work-Family Balance, Role Integration and Employee Well-Being. *Creating Balance*, 10(1), 121-140.

Peters, L., Cant, R., Payne, S., O'Connor, M., McDermott, F., Hood, K...Shimoinaba, K. (2013). How Death Anxiety Impacts Nurses' Caring for Patients at the End of Life. *Open Nurses Journal, 23*(2), 14-21.

Picker Institute. (2017). Principles of Patient-Centred Care. Retrieved from: http://www.pickerinstitute.org

Piers, G., & Singer, M. (1971). *Shame and Guilt: A psychoanalytic and Cultural Study.* New York, NY: Norton.

Pitney,W.A., & Parker,J.(2009).*Qualitative Research in Physical Activity and the Health Professions*. Bournemouth, UK: Human Kinetics.

Planalp, S. (2001). *Communicating Emotion: Social, Moral and Cultural Processes*. New York, NY: Cambridge University.

Plante,J., & Cyr,C. (2011). HCPs' Grief after the Death of a Child. *Paediatrics & Child Health,16*(4),213-216.

Polit, D.F.,& Beck,C.T.(2008). *Essentials of Nursing Research: Appraising Evidence for Nursing Practice* (8th ed.). New York, NY: Lippincott Williams & Wilkins.

Prasad, P. (2015), *Crafting Qualitative Research: Working in the Post-positivist Traditions.* New York, NY: John Wiley & Sons.

Profetto- McGarth, J., Polit, D.F., & Beck, C.T. (2010). *Canadian Essentials of Nursing Research.* Ontario, Canda: Lippincott Williams & Wilkins.

Radebe, L. (2014, December).SA's Mortality Rate at its Lowest in Over a Decade. *Brand South Africa, 2,* 212-213.

Ramsay, R.F. (2001, February 8-10). Revisiting the Working Definition: The Time is Right to Identify a Conceptual Framework for Social Work. Paper presented to the Kentucky Conference on Social Work and Education, Kentucky, United States of America. Retrieved from: http://www.ucalgary.ca

Ranmuthugala, G., Plumb, J.J., Cunningham, F.C., Georgiou, A., Westbrook, J.I., & Braithwaite, J. (2011). How and Why are Communities of Practice Established in the Healthcare Sector? A Systematic Review of the Literature. *BioMed Central Health Services, 273*(11), 15-19.

Ray, E.B., & Miller, K.L. (1994). Social Support, home/work stress, and burnout: Who can help? *Journal of Applied Behavioural Science, 30(1),* 357-373.

Reader, T.W., & Gillespie, A. (2013). Patient Neglect in Healthcare Institutions: A Systematic Review and Conceptual Model. *BMC Health Service Research, 156* (13), 1-47.

Reblin, M., & Uchino, B.N. (2008). Social and Emotional Support and its Implication for Health. *Current Opinion in Psychiatry, 21(2),* 201-205.

Reder, E. A. (2003). Grief and Bereavement. In J.F. O'Neil, P.A. Selwyn & H. Schietinger (Eds.), *Critical and Creative Methodologies in Social Work.* (1st ed., pp.1-23). New York, NY: Routledge.

Reismann, C. (1993). *Narrative Analysis.* Thousand Oakes, CA: Sage

Reismann, C.K. (2008).*Narrative Methods for the Human Sciences*. Thousand Oakes, CA : Sage

Rejnõ, Å., Berg, L., & Danielson, E. (2013). The Narrative Structure as a Way to Gain Insight into Peoples' Experiences: One Methodological Approach. *Scandinavian Journal of Caring Sciences, 4*(2), 12-20.

Rew, L. (2009). Self-Reflection. In B. Dossey & L. üeegan (Eds.), *Holistic Nursing: A Handbook for Practice* (5th ed., pp. 195-207). Sandbury, MA: Jones and Bartlett.

Reynolds, F. (2006). How Doctors Cope with Death. *Archives of Disease in Childhood, 91*(9), 727-783.

Rivers, K. O., Perkins, R.A., Carson, C. P. (2009). Perceptions of Speech-Pathology and Audiology Students Concerning Death and Dying: A Preliminary Study. *International Journal of Language & Communication Disorders, 48*(1), 98-111.

Roberts,P.,Priest, H.,& Traynor,M. (2006).Reliability and Validity. *Nursing Standard,44*(20), 41-45.

Robbins, S.P., & Coulter, M. (2005). *Organisational Culture* (11th ed.). New Jersey, NJ: Pearson.

Robinson, R. (2004). Counterbalancing Misrepresentations of Critical Incident Stress Debriefing and Critical Incident Stress Management. *Australian Psychologist,39*(1), 29-34.

Rolland, J.S. (1990). Anticipatory Loss: A Family Systems Developmental Framework. *Family Process, 29*(3), 229-244.

Rose, S., Bisson,J., Churchill, R.,& Wessely, S.(2009).Psychological Debriefing for Preventing Post Traumatic Stress Disorder (PTSD).*Cochrane Review,9(2)*,45-47.

Roter, A.B. (2017). *Understanding and Recognising Dysfunction Leadership: The Impact of Dysfunctional Leadership on Organizations and Followers.* New York, NY: Routledge.

Rozin, P., & Royzman, E.D. (2001). Negativity Bias, Negativity Dominance, and Contagion. *Personality and Social Psychology Review, 5*(4), 296-320.

Rubab, U. (2017). Impact of Work-Family Conflict on Burnout and Workplace Deviant Behaviour: Mediating Role of Stress. *Jinnah Business Review, 5*(1), 1-10

Rückert, K. (1998). Helpless Helpers? *Krankenflege Journal, 26*(10), 446-447.

Rural Rehabilitation South Africa. (2017). *About Us*. Retrieved from:www.ruresa.com

Salmons, J. (2015).*Qualitative Online Interviews*. Thousand Oakes, CA: Sage.

Sanchez, J.R. (2007).Revisiting Elizabeth Kübler-Ross: Pastoral and Clinical Implications of the Death and Dying Stage Model in the Caring Process. *Pastoral Theology1*(1), 5-10.

Sansone, R.,A.,& Sansone, L.A.(2012).Physician Grief with Patient Death. *Innovations in Clinical Neuroscience,9*(4), 22-26.

Schaefer, C., Coyne, J.C., & Lazarus, R.S. (1981).The Health-Related Functions of Social Support. *Psychological Health Medical 4(4)*, 381-406.

Scheunemann, L.P., & White, D.B. (2011). The Ethics and Reality of Rationing in Medicine. *Chest, 140* (6), 1625-1632.

Schroeter, K. (2008). Duty to Care Versus Duty to Self. *Journal of Trauma Nursing*, 15(1), 3-4.

Schur, E.M. (1971). *Labelling Deviant Behaviour: It's Sociological Implications*: New York, NY: Harper & Row.

Selby, S. (2007). Disenfranchised Grievers: The GP's Role in Management. *Australian Family Physician, 36*(9), 768-770.

Seligman, M.E.P. (1967). Learned Helplessness. *Annual Review Medicine, 23*(4), 408-412

Setsiba, T. H. S. (2011). *Mourning Rituals and Practices in Contemporary South African Townships: A Phenomenological Study* (Doctoral thesis). University of Kwa-Zulu Natal, Department of Psychology, Durban, South Africa.

Shabbar, F. (2016). Storytelling as a Research Method: Iraqi Women Narrating Their Life Stories.In L. Bryant (Ed.), *Critical and Creative Methodologies in Social Work* (1st ed., pp.2-31). New York, NY: Routledge.

Shear, M.K. (2012). Grief and Mourning Gone Awry: Pathway and Course of Complicated Grief. Dialogues in Clinical Neuroscience, 14(2), 119-128.

Shkedi, A. (2005). *Multiple Case Narrative: A Qualitative Approach to Studying Multiple Populations*. Amsterdam: John Benjamin.

Shokri, S., & Akbari, B. (2016). Relationship of Self-Efficacy with Life Expectancy and Death Anxiety in Elders over 60 years old of Resident in Nursing Homes of Rasht City. *Electronic Journal of Biology, 12*(3). Retrieved from: http://www.ejbio.imedpub.com

Shumaker, S.A., & Brownell, A. (1984). Toward a Theory of Social Support: Closing Conceptual Gaps. *Journal of Social Issues, 40(4),* 11-36.

Sikkema, K.J., Hansen, N.B., Kochman, A., Tate, D.C., & Difranceisco, W. (2004). Outcomes from a Randomized Controlled Trial of a Group Intervention for HIV Positive Men and Women Coping with AIDS-Related Loss and Bereavement. *Death Studies, 28*(3), 187-209.

Silva, I.J., de Oliveira, M.F.V., da Silva, E.D., Polaro, S.H.I., Radūnz, V., dos Santos, E.K.A., & de Santana, M.E. Care, Self-Care and Caring for Yourself: A Paradigmatic Understanding Thought for Nursing Care. *Revista da Escola de Enfermagem da USP, 43*(3), 690-695.

Silverman, P.R. (1974). Anticipatory Grief from the Perspective of Widowhood. In B. Schoenberg, A.C. Carr, A.H. Kutscher, D. Peretz & Goldberg, I.K. (Eds.), *Anticipatory Grief* (1st ed., pp. 320-330). New York, NY: Columbia University.

Simon, M.K. (2011). Validity and Reliability in Qualitative Studies. Philadelphia, PA: Lippincott Williams & Wilkins.

Sinclair, S. (2011). Impact of Death and Dying on the Personal Lives and Practices of Palliative and Hopsice Care Professionals. *Canadian Medical Association Journal, 183*(2), 180-187.

Singh, A., Singh, D., & Nizamie, S.H. (2003). Death and Dying. *Mental Health Reviews, 39*(2), 801-803.

Skeleton, L. (2016). Ethical theories and Perspectives on End-of-Life Decisions. *Dialogue & Nexus, 4* (3), 1-7.

Sneddon, A. (2013). *Autonomy*. UK: Bloomsbury.

Snyder, B., Dwyer, L.J., Moxham, H., Parker, P., & Stanley, R.S. (2014). *Koizer and Erb's Fundamentals of Nursing* (3rd ed.). Australia: Pearson.

South African Association of Audiologists. (2017).*South African Association of Audiologists.* Retrieved from: http://www.audiologysa.co.za

South African History Online. (2016). *Race and Ethnicity in South Africa*. Retrieved from: http://www.sahistory.org.za

South African Neurodevelopmental Therapy Association. (2009). *Sandta-Home*. Retrieved from: http://www.sandta.org.za

Southern African Neurological Rehabilitation Association. (2012). *Welcome to SANRA.* Retrieved from: http://www.sanra.orgSouth African Speech Language Hearing Association. (2016). *Code of Ethics.*

South African Speech Language Hearing Association. (2017). *Overview.* Retrieved from: http:www.saslha.co.za

Sprang, G., & McNeil, J. (1995). *The Many Faces of Bereavement: The Nature and Treatment of Natural, Traumatic and Stigmatized Grief.* Philadelphia, PA: Bruner/Mazel.

Statistics South Africa. (2017). Mortality and Causes of Death in South Africa. Retrieved from: http://www.statssa.gov.za

Stenfors-Hayes, T., & Kang, H.H. (2014). Boundaries, Gaps, and Overlaps: Defining Roles in a Multidisciplinary Nephrology Clinic. *Journal of Multidisciplinary Health, 147*(7), 471-477.

Stephens, C., & Long, N. (2000). Communication with Police Supervisors and Peers as a Buffer of Work-related Traumatic Stress. *Journal of Organizational Behaviour, 21 (2)*, 407-424.

Stroebe, M., & Schut, H. (1999). The Dual Process Model of Coping with Bereavement: Rationale and Description. *Death Studies, 23*(3),197-224.

Stroebe, M., Schut, H.,& Boerner, K. (2017). Cautioning Health-Care Professionals: Bereaved Persons Are Misguided Through the Stages of Grief. *Journal of Death & Dying, 74*(4), 455-473.

Stroebe, W., & Stroebe, M.S. (1987). *Bereavement and Health: The Psychological and and Physical.* New York, NY: Cambridge University.

Substance Abuse and Mental Health Service Administration. (2016). *Behavioural Health is Essential to Health, Prevention Works and Treatment is Effective*. Retrieved from: http://www.samhsa.gov

Suinn, R.M. (1969). The STABS, a Measure of Test Anxiety for Behaviour Therapy: Normative Data. *Behaviour Research and Therapy, 7*(3), 335-339.

Sunstein, C. (2005). Moral Heuristic. *Behavioural and Brain science, 28*, 531-573.

Sutton, J., & Austin, Z. (2015). Qualitative Research: Date Collection, Analysis, and Management. *The Canadian Journal of Hospital Pharmacy, 66*(3), 226-231.

Suzanne. (2010, May 1). When Doctors Need Doctoring [Blog Post]. Retrieved from: http://www.pyschologytoday.com

Swartwood, M. R. (2014). *Who should I bring?A Qualitative Examination of the Rule of the Support Person in Cancer Genetic Counselling Appointment* (Thesis). University of University, Department of Graduate Studies, Minnesota, USA.

Tariq. (2015, December 7). *Professional Avoidance*. [Blog Post] Retrieved from: http://www.outofthefog.com

Tazelaar, F. (1980). Mental Incongruities-Social Restrictions-Behaviour. *A Study on the Labour Force Participation of Married University-Educated Woman* [Doctoral Thesis]. University of Utrecht, Utrecht, Netherlands.

Thorson, J.A., & Powell, F.C. (1988). A Revised Death Anxiety Scale, *Death Studies, 16*, 507-521

Tolle, S.W., Cooney, T.G., & Hickam, D.H. (1989). A Program to Teach Residents Humanistic Skills for Notifying Survivors of a Patient's Death. *Academic Medicine, 64*(9), 505-506.

Tolmie, A.,Muijs,D.,& McAteer, E.(2011).*Quantitative Methods in Educational and Social Research*. New York, NY: Open University.

Tonetta-Stanker, S. (2009). Providing Patient-and Family-Centred End-of-Life Care in the ICU. *Nursing Critical Care, 4*(5), 54-55.

Toner, M.A., & Shadden, B.B. (2012). End-of-Life Care for Adults What Speech-Language Pathologists Should Know. *Topics in Language Disorders, 32*(2), 107-110.

Tsai, S., Crawford, E., & Strong, J. (2018). Seeking Virtual Social Support Through Blogging: A Content Analysis of Published Blog Posts Written by People With Chronic Pain. *Digital Health, 4*, 1-36.

Tse, M.M.Y., & Wan, V.T.C. (2011). Physical Exercise: Does it Help in Relieving Pain and Increasing Mobility among Older Adults with Chronic Pain. *Journal of Clinical Nursing, 20*, 635-644.

Toner, M.A., Shadden, B.B. (2012). End-of-Life Care for Adults: What Speech-Language Pathologists Should Know. *Topics in Language Disorders, 32*(2), 107-110.

Tornøe, K.A., Danbolt, L.J., Kvingne, K., & Sørlie, V. (2014). The Power of Consoling Presence-Hospice Nurses' Lived Experience with Spiritual and Existential Care for the Dying. BioMed Central, 13(25),Doi.org/10/10.1186/1472-6955

Treatment Action Campaign. (2012). The Gauteng Health System in Crisis. Retrieved from: http://www.politicsweb.gov.za

Trochim, W.M.K., & Donnelly, J.P. (2006).*Research Methods Knowledge Base* (3rd ed.). Massachusetts, Boston: Cengage Learning.

Turber-Cobb, J., Bloor, L.E., Wittemore, A.S., West, D., & Spiegel, D. (2006). Disengagement and Social Support Moderate Distress among Women with a Family History of Breast Cancer. *The Breast Journal, 12*(3), 7-15.

Tutu. D. (2004). *God has a Dream: A Vision of Hope for our Time*. New York, NY: Doubleday.

Universal Healthare. (2018). *Corporate Health and Wellness Services*. Retrieved from: http:/www.universal.co.za

University of California. (2014).*Research Ethics:* Retrieved from: http://www.universityofcalifornia.edu

University of Nottingham. (n.d.). *Research Ethics: Information Sheet and Consent Form Checklist*. Retrieved from: http://www.nottingham.ac.uk

van Baarsen, B. (2002). Theories on Coping with Loss: The Impact of Social Support and Self-Esteem on Adjustment to Emotional and Social Loneliness Following a Partner's Death Later in Life. *Social Sciences,57(1),* 33-42.

Van Keer, R., Deschepper, R., Fancke, A.L., Huyghens, L., & Bilsen, J. (2015). Conflicts between HCPs and Families of a Multi-Ethnic Patient Population During Critical Care: An Ethnographic Study. *Critical Care, 19*(10), 441-444.

Van Rensberg, H.C.J., & Fourie, A. (1994). Inequalities in South African Healthcare. *South African Medical Journal, 84*(20) ,95-99.

Vaux, A. (1990). An Ecological Approach to Understanding and Facilitating Social Support. *Journal of Social and Personal Relationships, 507*(7), 507-518.

Veacht, R. (1997). Medical Ethics: An Introduction. In R. Veacht (Ed.), *Medical Ethics* (2nd ed. pp. 1-25). CA: Jones and Bartlett.

Vinje, H.F., & Mittelmark, M.B. (2007). Job Engagement's Paradoxical Role in Nurse Burnout. *Nursing and Health Sciences, 9,* 107-111.

Vinokur, A.D., & van Ryn, M. (1993(. Social Support and Undermining in Close Relationships: The Interdependent Effects on the Mental Health of Unemployed Persons. *Journal of Personality and Social Psychology, 65(2),* 350-359

Vygotsky, L.S. (1978). *Mind in Society: The Development of Higher Psychological Processes*. Cambridge, MA: Harvard University.

Wagner, R.E., Hexel, M. , Bauer, W.W., & Kropiunigg, U. (2000). Crying in Hospitals: A Survey of Doctors', Nurses', and Medical Students' Experiences and Attitudes. *Medical Journal of Australia, 166*(12), 13-16.

Wahass, S.H. (2005). The Role of Psychologists in Health Care Delivery. *Journal of Family Community Medicine, 12*(2), 63-70

Walton, E. (2015). Working Towards Education for All in Guateng. In F. Maringe & M. Prew (Eds.), *Team Physician Manual* (2nd ed., pp. 210-228). Gauteng: African Minds.

Wang, X. (2011). The Role of Anticipated Guilt in Intentions to Register as Organ Donors and to Discuss Organ Donation with Family. *Health Communications, 26*(8), 683-690.

Warnock, C., Buchanan, J., Tod, A., Soreny, C., & Foster, J. (2017). The Difficulties Experienced by Nurses and Healthcare Staff Involved in the Process of Breaking Bad News. *Journal of Advanced Nursing, 11*(10), 132-135.

Watson, K. (2011). Gallows Humour in Medicine. *Journal of Medicine, 41*(5), 37-45.

Watts, J.H.(2008).Emotion, Empathy and Exit: Reflections on Doing Ethnographic Qualitative Research on Sensitive Topics. *Medical Sociology,3*(2),3-14.

Webster, L., & Mertova, P. (2007). *Using Narrative Inquiry as a Research Method: An Introduction to using Critical Event Narrative Analysis in Research on Learning and Teaching*. New York, NY: Routledge .

Weismann, A.D. (2000). *On Death and Denying; A Psychiatric Study of Terminality.* New York, NY: Behavioural Publications.

Weiss, G.L., & Lonnquist, L.E. (2015). *The Sociology of Health, Healing and Illness* (8th ed.). New York, NY: Pearson Education.

Wemmer, K. (2007). *Educating Audiologists in South Africa: Internationally Recognized Specialists or Locally Relevant Generalists* (Master's dissertation). University of Witwatersrand, Department of Speech and Hearing Therapy, Johannesburg, South Africa.

Wertheim, E.H., & Schwartz, J.C. (1983). Depression, Guilt, and Self-Management of Pleasant and Unpleasant Events. *Journal of Personality & Social Psychology, 45*, 884-889.

White, M., & Dorman, S.M. (2000). Receiving Social Support Online: Implications for Health Education. *Health Education Research, 16*(6), 693-707.

White, S.J. (2008). Using Self-Talk to Enhance Career satisfaction and Performance. *American Journal of Health-System Pharmacy, 65*(6), 514-519.

Williams, P., Barclay, L., & Schmied, V. (2004). Defining Social Support in Context: A Necessary Step in Improving Research, Intervention, and Practice. *Qualitative Health Research, 14*(7), 942-960.

Wilson, R., & Veale, D. (2009).*Overcoming Health Anxiety: A Self-help Guide using Cognitive Behavioural Techniques*. UK: Robinson.

Wojan, J. D. (2006). *Dealing with Loss; Perceptions of Speech-Language Pathologists* (Masters dissertation). Miami University, Department of Speech-Language Pathology and Audiology, Miami, USA.

Woken, M.D. (n.d.). *Research Paper Tips.* Springfield, Illonis: Springfield.

Wolfram, W. (2015).Coping with the Death if a Child in the ED. *Academy of Emergency Medicine,5*(3),242-246.

Woo, J. A., Maytal, G., & Stern, T.A. (2006). Clinical Challenges to the Delivery of End-of-Life Care. *Primary care Companion to the Journal of Clinical Psychiatry, 8*(6), 367-372.

Wood, D.J., Bruner, J.S., & Ross, G. (1976). The Role of Tutoring in Problem Solving, *Journal of Psychiatry and Psychology, 17*, 89-100.

Worden, J. W. (1991). *The Four Tasks of Mourning. Grief Counselling and Grief Theory: A Handbook for the Mental Health Practitioner* (2nd ed.). UK: Routledge.

World Health Organization. (2016) *The Burden of Road Traffic Crashes, Injuries and Deaths in Africa.* Retrieved from:http:///www.who.int

Wright, (2011). J. *7 Back to Life: Your Personal Guidebook to Grief Recovery.* [e-book]. Retrieved from: http://www.recover-from-grief.com

Wright, J.,& Sim,C.(2000). *Research in Health Care: Concepts, Designs and Methods.* UK: Test.

Writer, S. (2015, June).South Africa is the Second Worst Country in the World for Gun Deaths. *BusinessTech, 11*, 30-32.

Yoder- Wise, P.S. (2013). *Leading and Managing in Nursing* (5th ed.). Canada: Elsevier.

Yoost, B.L., & Crawford, L.R. (2015). *Fundamentals of Nursing.* Evansville, Indiana: Elsevier Ziebland, S (2013). Narrative Interviewing. In S. Ziebland, A. Coulter, J. D. Calabrese & L. Locock (Eds.), *Understand and Using Health Experiences: Improving Patient Care* (1st ed., pp. 38-48). UK: Oxford.

Zielberfein, F. (1999). Coping with Death: Anticipatory Grief and Bereavement. *Generations,23* (1), 69-75.

Zeinhom, A., & Higazee, A. (2015). Types and Levels of Conflicts Experienced by Nurses in Hospital Settings. *Health Science Journal, 42* (2), 90-96.

APPENDICIES

Appendix A: Model of Grief: The Dual Process of Coping with Bereavement

Buglass (2010) reflected on theories of grief and concluded that although stage theories may yield common patterns in human behaviour, which may provide comfort to bereaved individuals as they know that their experiences are shared by others. These stage models of grief do not indicate that grief is unique and complicated process. Therefore, critiques of these stage models of grief such as Buglass (2010) as well as Sprang and McNeil (1995) favour the dual process model of coping with bereavement which was proposed by Stroebe and Schut (1999).This framework of grief is thought to indicate that grief is a dynamic process. Given the flexible nature of the coping with bereavement model (Figure 7.1.), it may be employed to grief reactions and practices of various cultures (Stroebe & Schut, 1999).

Loss-orientated factors of the dual process model of coping with bereavement focuses on individuals encounters with death and is characterised by grief work that involves the bereaved individual being preoccupied with the death, reminiscing, and longing for the deceased (Stroebe & Schut, 1999). Whereas, the restoration-orientated factors focuses on making the necessary adjustments to an individual's life in order to overcome the death (Stroebe & Schut, 1999). However, a key factor of the dual-process model of coping with bereavement is oscillation (Stroebe & Schut, 1999). Oscillation involves moving back and forth between the loss-orientated facets and restoration-orientated facets of the model (Stroebe & Schut, 1999). During the process of oscillation bereaved individuals, at times, will be reminded of their loss while at other times they will avoid these emotional and traumatic memories through distraction or placing their focus on other activities (Stroebe & Schut, 1999). According to Stroebe and Schut (1999), the process of oscillation is fundamental for coping with bereavement.



Figure 7.1. The dual process model of coping with bereavement adopted from Stroebe and Schut (1999).

Appendix B: Ten Lessons to Reduce Conflict

The ten lessons to reduce conflict as outlined by Gardner (2005) are outlined below:

- Lesson 1: As part of individuals' individualistic nature as people, they tend to function within a mental model, which comprises of preconceived ideas, values and expectations. This mental model allows individuals to conceptualise their surroundings by zoning on information that is based on their expertise and experiences. When collaboration begins each professional brings their own unique mental model to the team. Therefore, for collaboration to become a shared mode, each team member needs to form partnerships so that they can iron out their expectations of collaboration. In order for successful collaboration among team members to be ensured, each individual within the team has to have insight into their own values and goals, as well as to externalise these factors.
- Lesson 2: Collaboration requires a joint focus of the task at hand and interpersonal relationships. These relationships can be formed mainly through effective communication. Therefore, Cooperrider and Srivastva (1987) stated that this effective communication can be fostered through appreciation inquiry. This theory places emphasis on focusing on the possibilities of working together and creating an organisational culture, which is marked by individuals within an organisation developing mutual and shared goals and visions, despite their differences in their mental maps (Robbins & Coulter, 2005).
- Lesson 3: As mentioned by Jehn (1995), conflict resolution is pivotal in ensuring effective collaborative practice. Collaborative leaders need to address task-related conflict by allowing each member in the team to express their mental maps i.e. their perspectives. In cases, where conflict has an emotional cause these team leaders need to redirect this conflict towards task related conflict. Group

intervention should only occur if emotional conflict continues to disrupt team work.

- Furthermore, dialogue which is characterised by information sharing can form the basis of effective communication among individuals within a team. It allows for the discussion about each individual's mental maps and tries to form connections between these unique mental maps so that shared mental maps can be created.
- Lesson 4: Conflict resolution tends to attend to the concept of dominance. Therefore, conflict resolution may lead to power struggles between team members and thus adds to inter-professional conflict. Therefore, Gardner (1998) recommends the concept of goodwill as an alternative to conflict resolution strategies. The premise of this concept focuses on shifting individuals focus in seeing other team members' noble intentions and respecting these team members.
- Lesson 5: Interpersonal and organisation skills are needed for successful collaboration, as Zeinhom and Higazee (2015) showed that when these two factors are not in play they result in inter-professional conflict. Imperative interpersonal skills include: self-confidence, assertiveness, clinical competence, co-operation, and flexibility. Whereas, organisational skills are based on the integration of system and contextual factors, as well as their influence on collaborative practice.
- Lesson 6: Collaboration is a journey; team members need to understand this. Thus, successful collaboration requires time, which may be a challenge in trying to facilitate interactions and resolve collaborative concerns.
- Lesson 7: These interactions can lead to shared decision-making. These interactions can either happen through face-to-face interactions, ward rounds or MDT meetings. These interactions allow for information sharing, learning and planning for patient management.

- Lesson 8: This interaction may be viewed to be quite structured in nature, but collaboration can also occur spontaneously. Therefore, it is recommended that spontaneous collaboration be appreciated as it can cultivate learning opportunities among team members.
- Lesson 9: Collaborative practice needs to meet the personal needs and needs of other team members. These two concepts are fostered through co-operation and assertiveness, respectively.
- Lesson 10: Collaboration is not always required for each decision. It is only required for complex and challenging tasks.

Appendix C: A Model for Communicating Bad News to Terminally-ill Patients' Significant Others

The model for communicating bad news to bereaved significant others of terminally ill patients, as proposed by Warnock et al. (2017) is discussed below:

Situational factors can further be divided into three branches: complex events, unexpected deaths, and method employed to communicate the news (Warnock et al., 2017). Complex events were based on the fact that participants reported that family feuds had created a negative ambience around the patients. This made it difficult for HCPs to deliver distressing news to significant others of the terminally ill patients (Warnock et al., 2017). Although it may not be the HCP's responsibility to resolve family rivalries, he or she is obligated to inform all of the patients' significant others of the patients' poor prognosis, and should involve patients' significant others in the decision-making and treatment plan processes (Osterweis, Solomon & Green, 1984).

Unexpected death interlinks with the method used to communicate news (Warnock et al., 2017). These branches stemmed from the fact that when the terminally ill patients significant others visited the patient and noted improvements in the patients' conditions, but soon after the patients had passed away. HCPs found it challenging to notify these patients' significant others telephonically of the patients' deaths (Warnock et al., 2017). These significant others tended to display denial on hearing the news (Warnock et al., 2017). This correlates with Kübler-Ross' (1969) observations, which also showed that significant others of terminally ill patients may exhibit denial when HCPs notified them of the patients' impending deaths. However, it should be noted that Kübler-Ross (1969) did not comment on the method used to inform these patients' significant others. Furthermore, in her study, she did not include patients who had suddenly passed away (Kübler-Ross, 1969). Naik, (2016)

also noted that significant others of patients who passed away unexpectedly appear to exhibit denial, irrespective of the way in which the bad news was communicated to them.

Furthermore, situational factors feed into and overlap with the branch of the model that focuses on patients and their significant others. It looks at aspects such as family dynamics and patients' significant others' responses to bad news (Warnock et al., 2017). In addition to these aspects, it also focuses on communication barriers, and patients' significant others not agreeing the patients' treatment plan (Warnock et al., 2017). Similarly, Van Keer, Deschepper, Francke, Huyghens & Bilsen (2015) discovered that due to linguistic differences, significant others may have difficulty understanding the patients' prognoses and this can negatively impacts on the medical decision- making of the treatment programme (Van Keer et al., 2015).

As previously mentioned, Warnock et al. (2017) stated that due to patients' significant others not agreeing with the HCPs proposed care plan for the patients, they may experience conflict with HCPs. However, unlike Van Keer et al. (2015), Warnock et al. (2017) did not take into account that the patients' and their significant others' religious beliefs and ethno-cultural norms and values. These factors may influence the decision-making process of the patients' treatment plans. Van Keer et al. (2015) discovered that HCPs appeared to be more concerned about patients' biological needs as opposed to the patients' significant others who were also about patients' religious, social, and psychological needs. This may lead to cultural conflict between HCPs, patients, and patients' significant others.

In Warnock et al.'s (2017) discussion of the organisational branch of the proposed model, they stated that allied HCPs particularly felt that due to work demands and inadequate staffing that they were unable to co-ordinate events, such as debriefing sessions with significant others of patients who had passed away. Nonetheless, Osterweis et al. (1984) recommended that HCPs should adopt the principles of continuity of care, as their

experiences with patient death and dying and their rapport with patients' significant others may aid in alleviating personal distress which the bereaved may experience.

However, identically to Warnock et al. (2017), Abbaszadeh et al. (2014) found that medical practitioners tended to avoid communicating information to the terminally ill patients' significant others and relied on nurses to communicate this news. This resulted in nurses working beyond their scope of practice. Furthermore, this may raise ethical concerns as medical practitioners are responsible for conveying news regarding patients' conditions and treatment plans to caregivers (Caswell, Pollock, Harwood & Porock, 2015; Jouybari & Sasnagoo, 2013). In these instances the nurses' role is only to support patients' significant others (Caswell et al., 2015).

Not only are there challenges that occur between HCPs and significant others of patients, but also between HCPs treating these patients (Warnock et al., 2017). Dingley, Daugherty, Derieg and Persing (2008) discovered that ineffective and insufficient communication between team members may lead to caregiver dissatisfaction. Similarly, Warnock et al. (2017) also found that poor communication between various HCPs led to them experiencing difficulty in communicating information to the terminally ill patients' significant others. This may also lead to patient safety being compromised as there may be: lack of critical information being communicated, misinterpretation of information, and overlooked changes in the patients' health statuses (O'Daniel & Rosenstein, 2008).

Appendix D: Definitions of Social Support

Albrecht and Adelman (1987) define social support as communication which alleviates uncertainty about a situation. This may enable the individual to feel as if he or she has more control over a situation. As Matson and Hall (2011) point out, this definition of social support is limiting, as it states that supportive communication must reduce uncertainty. Through the following example, Matson and Hall (2011) highlight that supportive communication may not necessarily reduce apprehension. For example, an individual who consoles a friend whose parents have passed away may be providing social support, but this support does not reduce the uncertainty or feelings of possible powerlessness that the friend may be experiencing.

The National Cancer Institute (NCI, n.d.) provides an alternative definition of social support which explains that the support network, which constitutes of family, friends, neighbours, and community members provide psychological, physical, and financial assistance, when necessary. According to Vaux (1990), who proposes an ecological viewpoint on social support, states that a large support network is more beneficial because more members can be more easily accessible. Therefore, they can provide more effective social support. Diversity within a support network has shown to provide wider range of instrumental and information support (Vaux, 1990).

Appendix E: Participant Information Sheet for Inviting Participants to Participate in the Study

Participant Information Sheet for Participating in the Research Study

Study title: Exploring speech therapists' and audiologists' experiences regarding patient death and dying

Dear: Speech Therapist and/or Audiologist

My name is Nabeelah Nagdee,

I am currently completing my MA in Audiology. My project aims to explore speech therapists' and/ audiologists' experiences regarding patient death and dying. There is not a lot of research which explores speech therapists' and audiologists' perceptions concerning death and dying both internationally and locally, but there appears to be a need for further research into this area in South Africa. I am hoping that you will assist me with information that I wish to obtain.

I am therefore inviting you to participate in my research study. In order to participate in the study you would have needed to have experienced patient death. This is to ensure that your experiences regarding patient death is accurately reflected in the study.

My study involves conducting audio-recorded narrative interviews. You may have the option to either be recorded face- to- face or over Skype to ensure that no time is taken away from you completing your clinical duties. Additionally, if you do not reside in the Gauteng Province then the interview will need to be conducted over Skype. The interview will take approximately 30 minutes to complete. Once the results from the interviews have been

transcribed, the interview transcriptions will be emailed to you. It would be appreciated if you could review the transcriptions and comment on their accuracy. This will improve the credibility of the findings obtained and my interoperation thereof.

If you are interested in participating in my study, please contact me either telephonically or via email. Furthermore, it would be appreciated if you could inform your colleagues about my research study and provide them with my contact details, if they are willing to participate in my study. My contact details are below:

Name: Nabeelah Nagdee

Cell: 078 694 3518

Email: nabeelahnagdee@gmail.com

Kind regards

Nabeelah Nagdee

Listed below are the contact details of my research supervisor should you require any additional information, clarification or wish to report any information related to my research study:

Name: Dr Victor de Andrade

Work Tel: 011 717 4570

Email: Victor.DeAndrade@wits.ac.za

Listed below are the contact details for the HREC (non-medical) chair and administrator

should you have any complaints or wish to report any problems related to the research study:

HREC (non-medical) Chair:

Name: Professor Jasper Knight

Tel: (011) 717 6508

Email: Jasper.Knight@wits.ac.za

HREC (non-medical) Administer:

Name: Shaun Schoeman

Work Tel: (011) 717 1408

Email: shaun.schoeman@wits.ac.za

Your participation in my study will be highly appreciated.

Kind regards

Nabeelah Nagdee

Appendix F: Participant Information Sheet and Consent Form for Participating in the Narrative Interviews (Pilot Study)

Participant Information Sheet for Participating in the Narrative Interviews and Consent Form for Participating (Pilot Study)

Study title: Exploring speech therapists' and/or audiologists' experiences regarding patient death and dying

Dear: Speech Therapist and/or Audiologist,

My name is Nabeelah Nagdee,

I am currently completing my MA in Audiology. My project aims to explore speech therapists' and audiologists' experiences regarding patient death and dying. There is not a lot of research which explores speech therapists' and audiologists' perceptions concerning patient death and dying both internationally and locally, but there appears to be a need for further research into this area in South Africa.

My study involves conducting narrative interviews with participants. The interviews will provide me with a deeper understanding of participants insights' and experiences regarding the death and dying process of their patients. I intend to pilot the interviews as this may aid me in addressing any limitations which I may encounter during the interview process prior to conducting the research study. In order to participate in the pilot study you would have needed to have experienced patient death. The pilot interview will take approximately 30 minutes to complete. Please note that your participation in the pilot study is entirely voluntary. You may wish to withdraw from the pilot interview at any point. Your answering

to questions posed is entirely voluntary and if you do not wish to answer certain questions, your decision will be respected. Furthermore, results from the pilot study will be excluded from the main study

Discussing death and dying is may possibly lead to possible emotional distress. Therefore, if you do encounter distress during the interview please refer to the distress protocol or contact a counsellor or psychologist who form part of the South African Depression and Anxiety Group (SADAG) on (011) 2344837 or 08000205026.

Please be assured that your confidentiality will be maintained to the fullest of my potential. Data collected will be encoded and kept under lock and key in order to maintain confidentiality. Your identity will only be known to me and my research supervisor. However, personal information may be disclosed if required by the law and if the University of Witwatersrand Human Research Ethics Committee (HREC-medical) wishes to inspect or record information for the purpose of updating their records.

Listed below are my contact details should you require any additional information in relation to my research study:

Name: Nabeelah Nagdee

Cell: 078 694 3518

Email: nabeelahanagdee@gmail.com

Listed below are the contact details of my research supervisor should you require any additional information, clarification or wish to report any information related to my research study:

Name: Dr Victor de Andrade

Work Tel: 011 717 4570

Email: Victor.DeAndrade@wits.ac.za

Listed below are the contact details for the HREC (non-medical) chair and administrator **should you have any complaints or wish to report any problems related to the research study:**

HREC (non-medical) Chair:

Name: Professor Jasper Knight

Tel: (011) 717 6508

Email: Jasper.Knight@wits.ac.za

HREC (non-medical) Administer:

Name: Shaun Schoeman

Work Tel: (011) 717 1408

Email: shaun.schoeman@wits.ac.za

THE EXPERIENCES OF SPEECH THERAPISTS AND AUDIOLOGISTS REGARDING PATIENT DEATH AND DYING

Title of Study: Exploring speech therapists' and audiologists' experiences regarding patient death and dying

Researcher: Nabeelah Nagdee

If you would like to participate in the study please complete the section below:

I, _____ agree to participate in this pilot research study. I understand the purpose of the pilot research study as well as participation requirements in this research study.

Please circle

I agree that my participation will remain anonymous YES/NO

I agree that the interview may be audio recorded YES/NO

Date: _____

Signature of participant: _____

Signature of researcher: _____

Kind regards

Nabeelah Nagdee

Appendix G: Interview Guide and Feedback Form (Pilot Study)

Questions

Section I : Biographical Information

1) Gender:

a) Female b) Male

2) Age: _____

3) Race and Ethnicity: (*circle one*)

a) White/Caucasian b) African/Black c) Indian

d) Coloured e) Other:_____

4) Please state your religious affiliation?

a) Christian b)Hindu c) Jewish

d) Muslim e) Other_____

5) Designation

a) STA b) ST c) A

6) How long have you be practicing in the profession? _____

7a) Where were you practicing in the past?

7b) Where are your currently employed?

Section II: Patient Death and Dying

8a) Please recount a particular episode during which one of your patients has died?

8b) Why does this specific encounter stand-out?

8c) What was most difficult about this experience?

9) In your experience, recount your encounters with bereaved significant others after the passing on of the patient?

Section III: Coping with Death and Dying

11) What coping mechanisms did you employ to aid you in overcoming the death of your patients?

12) In your experience, if any, what provision in your work setting was made to help you cope with the death and dying process of your patients?

FEEDBACK FORM

Please provide feedback on the following

- **Overall conduction of the narrative interview:**

_____

_____

- **Posing and probing of questions:**

_____

_____

- **Facilitators usage of non-verbal communication to acknowledge and encourage participation**

_____

_____

- **Did the questions asked address the concepts being explored? If not, provide suggestions on how this can be improved:**

_____

_____

- **Do you think that the participant distress protocol may aid you in overcoming possible distress which you may have experienced during the interview. If not, provide suggestions on how this may be improved:**

_____

_____

_____

- **Additional Comments:**

_____

_____

Appendix H: Participant Information Sheet and Consent Form for Participating in the Narrative Interviews (Main Study)

Participant Information Sheet and Consent Form for Participating in the Narrative Interviews (Main Study)

Study title: Exploring speech therapists' and/or audiologists' experiences regarding death and dying

Dear: Speech Therapist and/or Audiologist

My name is Nabeelah Nagdee,

I am currently completing my MA in Audiology. My project aims to explore speech therapists' and audiologists' experiences regarding death and dying. There is not a lot of research which explores speech therapists' and audiologists' perceptions concerning death and dying, both internationally and locally, but there appears to be a need for further research into this area in South Africa. I am hoping that you will assist me with information that I wish to obtain.

I am therefore inviting you to participate in my research study. In order to participate in the study you would have needed to have experienced patient death. This is to ensure that your experiences regarding patient death is accurately reflected in the study.

My study involves conducting narrative interviews with participants who volunteered to participate in the research study. The interviews will provide me with a deeper understanding of your insights and experiences regarding the death and dying process of your patients. The interview will take approximately 30 minutes to complete. Furthermore, once the results from the interviews have been transcribed, the interview transcriptions will be emailed to you. It

would be appreciated if you could review the transcriptions and comment on their accuracy, as this will improve the credibility of the findings obtained and my interoperation thereof.

Please note that your participation in my research study is entirely voluntary. You may wish to withdraw from the study at any point. Your answering to the questions posed is entirely voluntary and if you do not wish to answer certain questions, your decision will be respected.

It would be beneficial for me to audio-record the interview session so that I am able to obtain accurate results for analysis. If you would not like to be audio- recorded please inform me before the commencement of the interview. You may also request for the audio recording to cease during the interview.

Discussing death and dying is may lead to possible emotional distress. Therefore, if you do encounter distress during the interview please refer to the distress protocol or contact a counsellor or psychologist who form part of the South African Depression and Anxiety Group (SADAG) on (011) 2344837 or 08000205026.

Results from my research study will be made available to you once the study is complete. The results may assist you in finding ways or improving your responses to patient death and dying.

Please be assured that your confidentiality will be maintained to the fullest of my potential. Data collected will be encoded and kept under lock and key in order to maintain confidentiality. Your identity will only be known to me and my research supervisor. However, personal information may be disclosed if required by the law and if the University of Witwatersrand Human Research Ethics Committee (HREC-non-medical) wishes to inspect or record information for the purpose of updating their records.

Listed below are my contact details should you require any additional information in relation to my research study:

Name: Nabeelah Nagdee

Cell: 078 694 3518

Email: nabeelahanagdee@gmail.com

Listed below are the contact details of my research supervisor should you require any **additional information, clarification or wish to report any information related to my research** study:

Name: Dr Victor de Andrade

Work Tel: 011 717 4570

Email: Victor.DeAndrade@wits.ac.za

Listed below are the contact details for the HREC (non-medical) chair and administrator **should you have any complaints or wish to report any problems related to the research study:**

HREC (non-medical) Chair:

Name: Professor Jasper Knight

Tel: (011) 717 6508

Email: Jasper.Knight@wits.ac.za

HREC (non-medical) Administer:

Name: Shaun Schoeman

Work Tel: (011) 717 1408

Email: shaun.schoeman@wits.ac.za

THE EXPERIENCES OF SPEECH THERAPISTS AND AUDIOLOGISTS REGARDING PATIENT DEATH AND DYING

Title of Study: Exploring speech therapists' and audiologists' experiences regarding patient death and dying

Researcher: Nabeelah Nagdee

If you would like to participate in the study please complete the section below:

I, _____ agree to participate in this research study. I understand the purpose of the research study as well as the participation requirements in this research study.

Please circle

I agree that my participation will remain anonymous	YES/NO
I agree that the researcher may use anonymous quotes in her research report	YES/NO
I agree that the interview may be audio recorded	YES/NO
I agree that the information I provide may be used anonymously by other researchers following this study	YES/NO

Date: _____

Signature of participant: _____

Signature of researcher: _____

Appendix I: Interview Guide (Main Study)

Questions

Section I : Biographical Information

4) Gender:

b) Female b) Male

5) Age: _____

6) Race and Ethnicity: (*circle one*)

a) White/Caucasian b) African/Black c) Indian

d) Coloured e) Other:_____

4) 4) Please state your religious affiliation?

a) Christian b)Hindu c) Jewish

d) Muslim e) Other_____

5) Designation

b) STA b) ST c) A

6) How long have you be practicing in the profession? _____

7a) Where were you practicing in the past?

7b) Where are your currently employed?

Section II: Patient Death and Dying

8a) Please recount a particular episode during which one of your patients died?

8b) Why does this specific encounter stand-out?

8c) What was most difficult about this experience?

9) In your experience, recount your encounters with bereaved significant others after the passing on of the patient?

Section III: Coping with Death and Dying

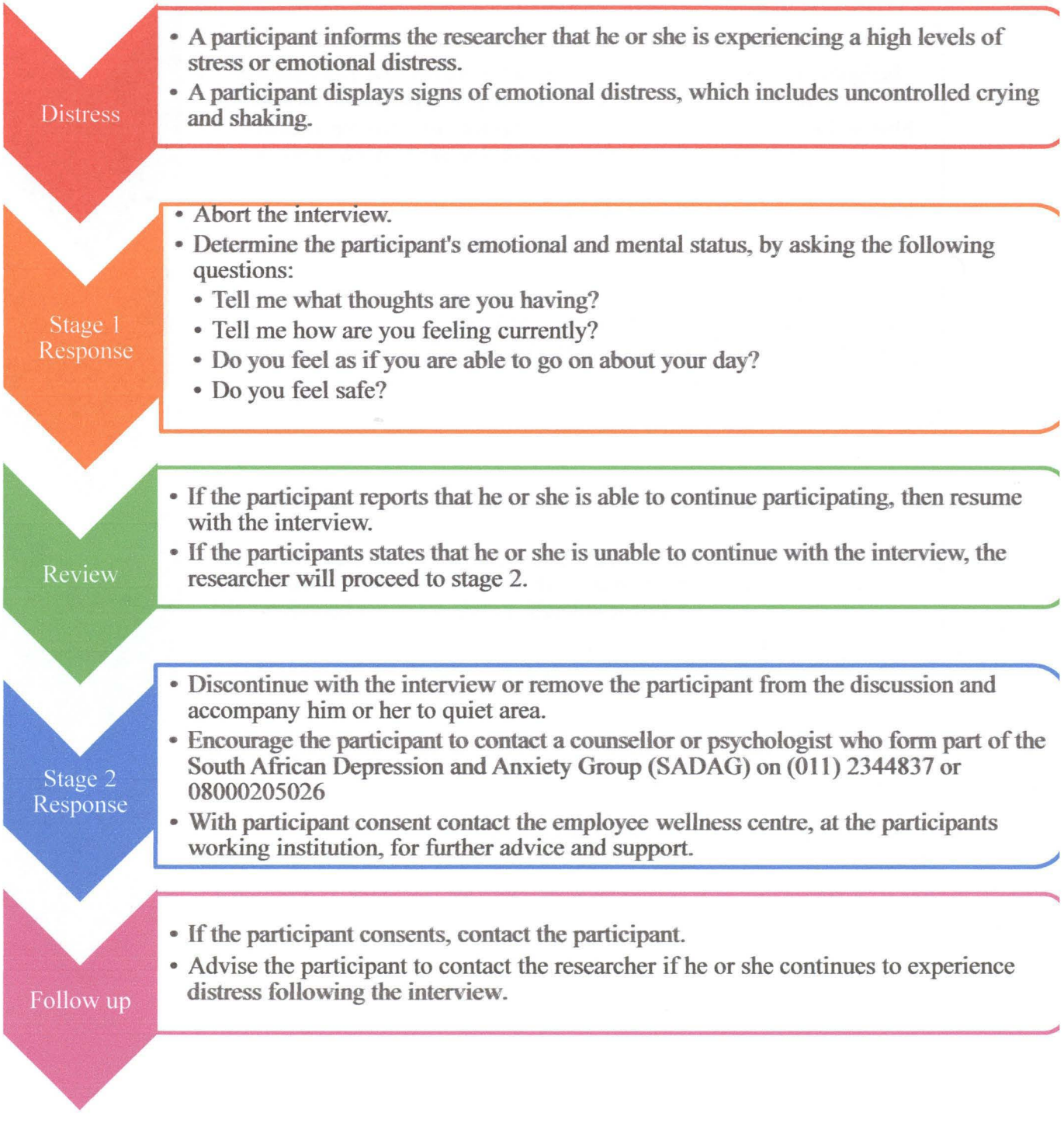
11) What coping mechanisms did you employ to aid you in overcoming the death of your patients?

12) In your experience, if any, what provision in your work setting was made to help you cope with the death and dying process of your patients?

Appendix J: Participant Distress Protocol

Distress Protocol for Research Participants

The figure below outlines the protocol which the researcher will implement if participants experience distress during the narrative interviews:



Appendix K: Researcher Distress Protocol

Distress Protocol for the Researcher

The figure below outlines the protocol which the researcher will implement if she is encountering emotional distress during the data collection and/or analyses processes:



Appendix L: Ethics Clearance Certificate (Non-Medical)

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Nagdee

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H17/11/42**
PROJECT TITLE	Exploring speech therapists' and audiologists' experiences regarding patient death and dying
INVESTIGATOR(S)	Miss N Nagdee
SCHOOL/DEPARTMENT	Human and Community Development/
DATE CONSIDERED	17 November 2017
DECISION OF THE COMMITTEE	Approved
EXPIRY DATE	12 December 2020

DATE 13 December 2017 **CHAIRPERSON** pp (Professor J Knight)

cc: Supervisor : Dr V de Andrade

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University. Unreported changes to the application may invalidate the clearance given by the HREC (Non-Medical)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**

Signature

12 / 12 / 17
Date

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

Appendix M: Audit Trail Components

COMPONENTS OF AUDIT TRAIL			
Instrumental development information	Pilot study	Communication (emails)	
		Consent forms (participation and audio recording of the interview)	
		Interview transcription (written and typed)	
		Completed Feedback form	
Raw data	Communication (emails)	Organisations	South African Speech-language Hearing Association
			South African Association of Audiologists
			South African Neurodevelopmental Association Therapy
			South African Neurological Rehabilitation Association
			National Black Speech, Language and Hearing Association
			Rural Rehabilitation of South Africa
		Participants	
	Consent Forms	Interview participation consent forms	
		Audio-recording consent forms	
	Audio Files	Audio recording of interviews	
Data reduction, analyses, reconstruction, synthesis	Interview Transcriptions	Written transcriptions	
		Typed transcriptions	
		Tabulated extracts from transcriptions (codes)	
		Tabulation of themes	
		Feedback from member checking	