Oncology Nurses’ Grief: A Literature Review

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The oncology practice setting can be a highly emotional workplace because nurses provide care to many of the same patients and their families over time. Comparing and contrasting nurses from different clinical settings would provide insight into the more common themes of nursing grief and might give guidance on how to educate nurses about this in different practice settings. One way in which management could support the grieving nurse is by limiting the number of comfort care patients one nurse is assigned.

In 2009, 562,340 people in the United States were expected to die of cancer (American Cancer Society, 2009). Cancer deaths affect patients, families, and the oncology nurses and others who care for them. Although the area of patient and family grief has been studied extensively, little is known about the grieving process that oncology nurses experience when one of their patients dies. This article will summarize literature on how nurses working in oncology practice settings as well as other practice settings grieve.

Grief is the “emotional suffering caused by or as if by bereavement” (Merriam-Webster, 2004, p. 138). When a person grieves, he or she feels sorrow related to the loss (Merriam-Webster). Grief is frequently described as a process. In a landmark study, Lindemann (1944) found that grief from acute loss may appear soon after the death, be delayed, or appear that the person does not grieve at all.

Theoretical Conceptualizations of Grief

A review of the literature revealed that many theorists have conceptualized the grief process as stages, points, tasks, or themes. Given the complexity of grief, perhaps it is presented in such a way for ease of understanding. Linde mann (1944), one of the first to publish on the topic of grief, conceptualized “points of grief.” The points consist of “somatic distress, preoccupation with the image of the deceased, guilt, hostile reactions, and loss of patterns of control” (p. 142).

Kubler-Ross’s (1969) theory on the stages of grief is one of the most recognized theories and is taught by many schools of nursing. Kubler-Ross presented her pioneering work on grief in five stages “denial and isolation, anger, bargaining, depression, and acceptance” (p. 9). One of the reasons that Kubler-Ross’s theory is used so frequently is because her theory is applicable to the dying and the bereaved.

Carter (1989), a nurse researcher, based her grief research in nursing experience and expertise and developed a theory consisting of themes of grief. The themes include “being stopped, hurting, missing, holding, seeking, change, expectations, inexpressibility, and personal history” (pp. 355–357).

Worden’s (1991) theory is used by clinicians all over the world. Worden, a psychologist, presented the Tasks of Grief Model in his book Grief Counseling and Grief Therapy. The tasks of the grief are “accepting the reality of the loss, to process the pain of grief, to adjust to a world without the deceased, and withdrawing emotional energy from the deceased and reinvesting it in another relationship” (pp. 39–50).

In general, the theories imply that the bereaved person is working through the grief process. All of the theories also are guidelines because people are not expected to experience the emotions of the tasks, points, themes, or stages in a linear fashion. Some similarities and differences exist among them. Kubler-Ross’s and Worden’s theories include the idea that the bereaved will eventually come to accept the death. Lindemann describes hostile reaction as one of his five points, which is similar to Kubler-Ross’s anger stage. The major difference among the theories is that Kubler-Ross’s theory may be applicable to the person who is dying and those who are bereaved. In contrast, Lindemann, Carter, and Worden’s theories are directed toward those who have experienced the death of a loved one.

In 1994, Saunders and Valente developed a task model describing how oncology nurses grieve. The Bereavement Task Model proposes four tasks that oncology nurses generally undertake when experiencing the loss of a patient. The four tasks are “finding meaning,
restoring and maintaining integrity, managing affect, and realigning relationships” (Saunders & Valente, p. 320). The authors submit that the depth and breadth to which a nurse would work through these stages are related to the environment of the death, the type of death the patient had, and whether the nurse had to care for many clients who died in a short span of time. The Bereavement Task Model is one of very few grief models developed for the oncology practice setting.

General Themes of Nursing Grief

An examination of how nurses in a variety of practice settings, including pediatrics, obstetrics and gynecology, and critical care, experience the grief process demonstrates several common themes. First, most nurses feel that more education and support from supervisors are needed to assist nurses as they care for bereaved individuals (Chan et al., 2008; Hallgrimsdottir, 2004; McCreight, 2005; Weir, 2005). Limiting the number of comfort care patients a nurse is assigned is one way to address this issue (Saunders & Valente, 1994). Management also can help by allowing nurses a break after the patient and family have left the facility to speak to a counselor, clergy, or a peer (Macpherson, 2008; Saunders & Valente).

Another common theme is that education related to bereavement is lacking in nursing curricula and in organizations where nurses work (Chan et al., 2008; Engler et al., 2004). Education in bereavement care should be integrated into undergraduate and graduate education (Chan et al.; Engler et al.). Organizations may educate nurses by providing in-services, workshops, and continuing education classes in the area of death, dying, and grieving (Chan et al.; Engler et al.). Engler et al. found that nurses older than 40 years and those who had more than five years of experience had more positive feelings about providing bereavement care.

An additional theme is that nurses frequently feel a need to outwardly grieve their patient’s death but are reluctant to do so because of how the patient’s family or their peers might react to their emotional display (Halcomb, Daly, Jackson, & Davidson, 2004; McCreight, 2005; Weir, 2005). Nurses may be reluctant to show emotion such as crying because the family and their peers may view them as unprofessional. Their peers also may think that they have become too emotionally involved with their patients. Two studies found that nurses suffer prolonged mental anguish when caring for dying patients and their families (Engler et al., 2004; Halcomb et al.).

Grief in the Oncology Practice Setting

Oncology nursing is different from other practice settings because many patients are terminally ill (Mok & Chiu, 2004). Nursing as a whole shares a primary goal of holistic care that includes health promotion and maintenance. Oncology nurses are concerned with holistic care; yet, often the primary goal they have for their patients is comfort (Mok & Chiu). Knowing that a patient’s death may be untimely, quality of life usually is a major consideration in oncology nurses’ treatment plans. Given the highly emotional setting, oncology nurses often provide care to the patient’s entire family (Boyle, 2000). Oncology nurses care for patients with some degree of chronicity because of the treatment regimens they are on or because of exacerbation of symptoms (Feldstein & Gemma, 1995).

Studies investigating grief in the oncology setting have found that oncology nurses expressed a variety of concerns. Deficits in education related to bereavement care (Medland et al., 2004; Redinbaugh, Schuerger, Weiss, Bruفسky, & Arnold, 2001; Saunders & Valente, 1994) and feelings of inadequacy in ability to provide quality end-of-life care were commonly expressed concerns. The inadequacy often was closely related to staffing shortages (Papadatou, Bellali, Papazoglou, & Petraki, 2002).

Another theme identified in several studies was that a paradox exists in oncology nursing. Many nurses suppress outward expression of grief in front of patients, families, and peers (Boyle, 2000; Feldstein & Gemma, 1995; Medland et al., 2004; Papadatou, Bellali, et al., 2002; Papadatou, Martinson, & Chung, 2001; Saunders & Valente, 1994). The paradox is because nurses encourage patients and families to express their feelings about the impending death or the death that has occurred but do not give themselves the same privilege (Boyle). The nurses repress their feelings in most cases to uphold what they or their peers believe to be a professional affect (Papadatou et al.). Many nurses are socialized into believing that by crying or showing emotion they are unprofessional and are too involved with the patient and family (Feldstein & Gemma; Saunders & Valente). Nurses also may repress their feelings because they do not have time to grieve simply because of staffing shortages. Constant suppression of feelings may lead to compassion overload and workplace burnout (Saunders & Valente).

Implications for Future Research and Nursing Practice

A pervasive theme, regardless of practice setting, suggests that more education needs to be provided for nurses who are caring for the dying and bereaved. Another universal suggestion is that assistance needs to be provided to oncology nurses so that a healthy grieving process may be facilitated. Ways in which a healthy grieving process could be implemented are by attending funerals, holding staff “wakes” (events for staff to share memories about their patients), finding meaning in the death, attending counseling sessions and support groups, meeting with clergy, and journaling (Desbiens & Fillion, 2007; Saunders & Valente, 1994; Vachon, 1998).

Macpherson (2008) found that peer-supported storytelling may be cathartic and a way to find meaning in death, particularly for oncology nurses who have lost a patient for whom they cared. Peer-supported storytelling is conducted by two oncology nurses meeting...
face-to-face and sharing stories of patients they have cared for who have died (Macpherson).

Almost every article included in this review suggested the need for future research on grief of nurses in a variety of practice settings. Further research should include qualitative, quantitative, and mixed-method studies. One researcher suggested that the development of a tool to measure oncology nurses’ grief would be useful for pre- and post-intervention studies (Macpherson, 2008). Another area would be to explore the role of culture on grief. Although understanding grief on a multidisciplinary level is important, currently little is known about differences in how RNs, nursing assistants, licensed practical nurses, doctors, and other providers grieve their patients. Comparing nurses from different clinical settings also might provide insight to nursing grief and guidance on how to develop and implement interventions for different practice settings.

Conclusion

The importance of learning how oncology nurses grieve patient loss cannot be underestimated. As the national shortage continues to worsen, the number of nurses choosing oncology as a practice setting will inevitably decrease, which may be related to burnout (Medland et al., 2004). The themes in the literature imply that some oncology nurses may not be grieving effectively. Oncology nurses who do not effectively grieve patients may be at high risk for burnout (Medland et al). The Bereavement Task Model provides an example of how oncology nurses can grieve in a healthy way. Effective grief may be facilitated through peer-supported storytelling, staff wakes, attendance at patient funerals, counseling, and clergy assistance (Saunders & Valente, 1994).

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References


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