Providing Grief Resolution as an Oncology Nurse Retention Strategy: A Literature Review

Lori Hildebrandt, RN, BN, MN, CON(c)

Oncology nurses play a pivotal role in optimizing care provided to patients at the end of life (EOL). Although oncology nurses commonly provide EOL care and witness deaths of patients that they have maintained long-standing relationships with, they are frequently excluded from grief resolution endeavors. With a worldwide shortage of oncology nurses, retention is paramount to ensuring that the care patients with cancer receive is not jeopardized. Various strategies were identified to resolve grief and increase nurse retention, including creating supportive work environments, debriefing with colleagues, providing EOL and grief education, and altering patient care assignments. Future research on emerging technologies and their effects on oncology nurse coping and retention strategies also was suggested.

Lori Hildebrandt, RN, BN, MN, CON(c), is a nursing instructor in the School of Nursing and Dental Hygiene at the University of Hawaii at Manoa in Honolulu. The author takes full responsibility for the content of the article. The author did not receive honoraria for this work. The content of this article has been reviewed by independent peer reviewers to ensure that it is balanced, objective, and free from commercial bias. No financial relationships relevant to the content of this article have been disclosed by the author, planners, independent peer reviewers, or editorial staff. Hildebrandt can be reached at loricecil2002@yahoo.ca, with copy to the editor at CJONEditor@ons.org. (First submission March 2012. Revision submitted March 2012. Accepted for publication March 30, 2012.)

Background

Grief Terminology

Grief is defined as a consequence to loss (Conte, 2011). Although grief often is referred to in response to a loss, grief also may be experienced in anticipation of a loss (Dunne, 2004) or delayed after a death (Brown & Wood, 2009). Bereavement is the state of experiencing a loss (Buglass, 2010).

Compassion fatigue (CF) is exhaustion that arises from becoming too emotionally attached to patients and families (Aycock & Boyle, 2009). Burnout arises from a cumulative, prolonged
increase in stress (Medland et al., 2004) with symptoms including withdrawal from emotional scenarios at work, anger, and decreased empathy (Lewis, 1999). Chronic compounded grief (CCG) is an accumulation of unresolved grief (Braccia, 2005). Symptoms of CCG mimic burnout, which includes emotional exhaustion and feelings of inadequacy or failure (Bush, 2009), and the symptoms become chronic unless remedied through grief resolution.

**Manifestations of Grief**

Literature was identified and systematically reviewed using the presence of key words. In reviewing the literature, the negative consequences of oncology nurses’ unresolved grief demonstrated a wide array of representations, including CF, burnout, and CCG. The symptoms of those representations may include feelings of helplessness, anxiety (Buglass, 2010), fatigue, and depression (Aycock & Boyle, 2009). Subsequently, patients also are negatively affected as the nurse is unable to provide exceptional care while experiencing those adverse effects. Figure 1 identifies acute symptoms of grief and what the symptoms may lead to if grief remains unresolved.

**Bereavement Task Model**

The experiences of oncology nurses are unique, characterized by long-standing, intimate relationships with patients throughout the illness trajectory, from initial diagnosis to EOL in some cases. That perspective of grief requires a specialized framework.

Saunders and Valente (1994) created the BTM, a pathway specific to oncology nurses’ experiences of grief, which is the only model to isolate the unique characteristics of the oncology role (Brown & Wood, 2009). Saunders and Valente (1994) postulated that oncology nurses generally undertake four tasks to resolve grief when they experience the loss of a patient: (a) finding meaning, making sense of the loss, and questioning what outcome would have been achieved had things been done differently; (b) maintaining and restoring the integrity that may have been injured during the loss of a patient; (c) managing affect, involving the expression of emotions and feelings such as crying, anger, or withdrawing from patient contact; and (d) redefining relationships, identifying the need to mend relationships that may have been impacted by patient loss (Brown & Wood, 2009). Saunders and Valente (1994) ascertained that the time and effort required to work through each stage was influenced by the environment of death, type of death, and whether the nurse was caring for multiple patients who died in a short time. Although the BTM was designed in 1994, it can be translated easily to present day and varied circumstances.

**Literature Review**

The literature search was conducted using CINAHL®, MEDLINE®, and PubMed. Key words used were oncology nurse, compassion fatigue, bereavement, grief, burnout, grief resolution, and chronic compounded grief. Articles representing all types of oncologic nursing were accepted for the search, and the reference lists of selected articles were reviewed for the presence of key words and applicability to the topic. Because of the limited number of articles found using the key words, all time frames were accepted for inclusion in the review.

A total of 24 articles were identified using the search terms. All articles comparing nurse burnout and grief to the experiences of other healthcare staff and articles not focused solely on oncology nurses were excluded. Six of the articles that met the key word search were disregarded because two focused on physician grief (Lyckholm, 2001; Papadatou, Bellali, Papazoglou, & Petraki, 2002), one article compared pediatric to adult oncology nurses (Mukherjee, Beresford, Glaser, & Sloper, 2009), two included all cancer professionals (Sherman, Edwards, Simonton, & Mehta, 2006; Trufelli et al., 2008), and one looked at improving oncology care to families of deceased patients (Kaunonen, Aalto, Tarkka, & Paunonen, 2000). Eighteen articles were selected for review: six qualitative studies, five quantitative studies, four journal reports, two descriptions of implemented programs, and one literature review (see Table 1). The author of the current article read, reviewed, and categorized the articles by year of publication and article type, and identified grief resolution strategies.

**Results**

The grief experience usually is not linear, but variable and subjective (Dunne, 2004). As such, a variety of strategies identified in the literature were highlighted. In total, four common themes of grief resolution were identified: creating a positive work environment, debriefing with colleagues, EOL education and grief training, and altering patient-care assignments. The strategies addressed methods to resolve or reduce the incidence of grief, and the goal was to use the identified strategies to work through Saunders and Valente’s (1994) BTM with the aim of grief resolution. By using all four proposed strategies, all steps of the BTM could be completed.

**FIGURE 1. Symptoms and Results of Unresolved Grief for Oncology Nurses**

- Acute symptoms: Anger, Anxiety, Apathy, Depression, Fatigue, Guilt, Headaches, Helplessness, Nausea, Stress
- May lead to: Burnout, Chronic compounded grief, Compassion fatigue, Decreased productivity, High staff turnover, Increased absenteeism
- Increasing the likelihood of leaving the oncology specialty: Resignations, Decreased productivity, High staff turnover, Increased absenteeism
### TABLE 1. Review of the Literature

<table>
<thead>
<tr>
<th>Study</th>
<th>Design and Sample</th>
<th>Findings and Outcomes</th>
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<tbody>
<tr>
<td><strong>Qualitative</strong></td>
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<tr>
<td>Aycock &amp; Boyle, 2009</td>
<td>231 surveys regarding oncology nurses’ accessibility to grief resolution strategies were sent to Oncology Nursing Society chapters; 103 received</td>
<td>Interventions to cope with grief are provided at some facilities, but not many; however, other facilities should copy existing blueprints.</td>
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<tr>
<td>Conte, 2011</td>
<td>Telephone survey of pediatric oncology nurse educators and managers, representing 78 institutions in the United States</td>
<td>Lack of awareness between patient palliative education and professional nurse grief education; support for oncology nurses needs to be proactive as opposed to reactive.</td>
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<td>Macpherson, 2008</td>
<td>Voluntary questionnaires on peer-supported storytelling; six pediatric oncology nurses</td>
<td>The number of patients who died was less significant than the loss of those considered special.</td>
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<td>Perry, 2008</td>
<td>Phenomenologic, purposive study of seven exemplary oncology nurses</td>
<td>Exemplary oncology nurses do more when faced with difficult patient situations.</td>
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<td>Perry et al., 2011</td>
<td>Descriptive, exploratory study of compassion fatigue (CF) in 19 Canadian oncology RNs who responded through an advertisement in the <em>Canadian Oncology Nursing Journal</em></td>
<td>Physical and emotional stress leads to CF; colleague support improving work-life balance, maturity, and experience lessen the experience of CF.</td>
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<td>Wenzel et al., 2011</td>
<td>Descriptive focus groups consisting of four to eight oncology staff nurses (N = 34)</td>
<td>Two themes were identified: work-related loss and working through bereavement. Effective grief support was not available.</td>
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<tr>
<td><strong>Quantitative</strong></td>
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<td>Barnard et al., 2006</td>
<td>Pilot study, self-report questionnaires given to 101 RNs employed at an Australian oncology specialty hospital</td>
<td>Heavy workloads are a common source of stress. Nursing workloads need to be addressed to reduce nursing stress.</td>
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<td>Feldstein &amp; Gemma, 1995</td>
<td>A grief experience inventory survey completed by 50 of 95 oncology nurses, 52% response rate; responders in four groups were compared statistically.</td>
<td>Nurses who stay in the oncology field and those who leave have above-average ratings of despair, somatization, and social isolation.</td>
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<td>Hinds et al., 1994</td>
<td>Two samples (27 nurses working in pediatric oncology for 2–5 years and 22 pediatric nurses having worked for 6 months–2 years) participated in a grief workshop.</td>
<td>Following one-day workshop, no changes were noted in nurses’ grief symptoms.</td>
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<td>Potter et al., 2010</td>
<td>Descriptive, cross-sectional survey of 153 U.S. healthcare providers.</td>
<td>Baccalaureate-prepared RNs had the highest percentage of scores indicating a high risk for CF. Graduate RNs are at highest risk for burnout.</td>
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<tr>
<td>Quattrin et al., 2006</td>
<td>Descriptive questionnaire given to 100 oncology staff nurses in Italy</td>
<td>Levels of burnout were measured, identifying that 35% of nurses had high levels of emotional exhaustion; increased exhaustion was found in nurses older than 40 with more than 15 years of experience.</td>
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<td><strong>Report</strong></td>
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<td>Braccia, 2005</td>
<td>Report on literature-supported ways to avoid burnout from chronic grief and CF</td>
<td>Literature-supported suggestions range from attending support groups and establishing bereavement councils to helping oncology nurses focus on the positives of facilitating a “good death.”</td>
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<tr>
<td>Bush, 2009</td>
<td>Report on identifying how CF varies from burnout</td>
<td>Oncology nurses are at high risk for CF because of lack of social support and increased workload. Idealistic, highly committed, and motivated nurses are at highest risk for CF.</td>
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<td>Lally, 2005</td>
<td>Review of grief literature, identifying benefits of hospital rounds from the perspective of grieving oncology nurses</td>
<td>Participating in rounds where various healthcare professionals can meet and discuss patient loss in a supportive, respectful environment with like-minded colleagues is beneficial.</td>
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<td>Saunders &amp; Valente, 1994</td>
<td>Review of the literature, clinical experience, and analysis of more than 300 nurses attending bereavement workshops</td>
<td>Bereavement is increased when nurses experience multiple deaths at one time; the bereavement model was developed.</td>
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<td><strong>New Program Implementation</strong></td>
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<td>Lewis, 1999</td>
<td>Successful implementation of a bereavement support group made up of oncology nurses</td>
<td>Attendees reported less stress, better piece of mind, and that the burnout process slowed.</td>
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Creating a Positive Work Environment

Seven of the reviewed studies suggested creating a positive work environment (Braccia, 2005; Brown & Wood, 2009; Feldstein & Gemma, 1995; Macpherson, 2008; Medland et al., 2004; Saunders & Valente, 1994; Wenzel et al., 2011). Wenzel et al. (2011) found that mutually supportive work environments were paramount in optimizing care provided to patients and that instituting a variety of grief resolution strategies in the workplace improved participant job satisfaction and reduced the risk and incidence of CF. In an unsupportive environment where CF and burnout are present, initiatives to facilitate a positive workplace are necessitated. A supportive workplace accepts that nurses will experience grief and emotions and provides accessible, variable grief resolution strategies on a regular basis.

To create a positive workplace that encourages mental wellness, Potter et al. (2010) posited analyzing for the presence of CF and burnout. Some indicators for CF and burnout may be increased absenteeism, decreased productivity (Conte, 2011; Medland et al., 2004), and high turnover (Feldstein & Gemma, 1995; Medland et al., 2004; Wenzel et al., 2011). Patient satisfaction surveys also may be indicators, as the level of care may inadvertently decrease as a result of nurse CF and burnout.

Four studies indicated that oncology nurses felt displays of mourning were not permitted in their workplace (Aycock & Boyle, 2009; Brown & Wood, 2009; Feldstein & Gemma, 1995; Saunders & Valente, 1994). In a supportive work environment, outward displays of grief should be expected and acceptable. Saunders and Valente (1994) referred to this step as managing affect.

Debriefing With Colleagues

Eleven of the articles identified subject matter pertaining to debriefing with colleagues (Aycock & Boyle, 2009; Barnard, Street, & Love, 2006; Brown & Wood, 2009; Bush, 2009; Conte, 2011; Feldstein & Gemma, 1995; Lewis, 1999; Macpherson, 2008; Medland et al., 2004; Saunders & Valente, 1994; Wenzel et al., 2011). Medland et al. (2004) found increased staff retention following the attendance of a psychosocial wellness retreat. Peer-supported storytelling and sharing were other identified strategies found to be effective in mitigating the experience of grief (Macpherson, 2008). Macpherson (2008) explained that sharing grief experiences with colleagues is effective, as they can relate to similar experiences. In addition, that practice keeps nurses from bringing grief home and sharing it with their loved ones, who may not be able to relate to nurses’ experiences and feelings. Macpherson (2008) established that nurses must listen to others’ stories as well as share their own.

End-of-Life Education and Grief Training

Nine of the articles demonstrated subject matter about providing additional education such as strategies to enhance nurse coping and how to best care for patients at EOL (Brown & Wood, 2009; Conte, 2011; Feldstein & Gemma, 1995; Hinds et al., 1994; Lewis, 1999; Macpherson, 2008; Medland et al., 2004; Saunders & Valente, 1994; Wenzel et al., 2011). By providing additional EOL education and grief support to oncology nurses, they will be better prepared to attend to patient needs during EOL, as well as their own (Conte, 2011). Unfortunately, the majority of oncology nurses do not receive additional EOL care training, grief education, or coping strategies in their nursing education or professional orientation (Brown & Wood, 2009; Conte, 2011).

Feldstein and Gemma (1995) contended that not only is the EOL care training important, but the content is, too. Currently, the majority of EOL education surrounds care of the patient and family, pain management, and symptomology, with little or no emphasis on grief (Conte, 2011). To optimize the care provided to patients, grief training needs to be incorporated in EOL education.

The education must be timely. To be effective, EOL and grief training needs to be provided prior to oncology nurses’ exposure to grief. The strategies also should be studied to ascertain whether students who receive grief training are enabled to deal better with grief and when best to initiate that training.

Altering Patient-Care Assignments

Four of the articles’ themes pertained to altering patient-care assignments (Brown & Wood, 2009; Lewis, 1999; Medland et al., 2004; Saunders & Valente, 1994). Those articles emphasized that
the experience of grief may be worsened by nurses’ repeated exposure to death, particularly if nurses had shared a special relationship with dying individuals (Hinds et al., 1994; Lally, 2005; Lewis, 1999; Macpherson, 2008; Medland et al., 2004; Wenzel et al., 2011). One coping strategy suggested limiting the number of deaths oncology nurses are exposed to by altering patient assignments, so that nurses do not provide EOL care to multiple patients simultaneously (Brown & Wood, 2009; Saunders & Valente, 1994). Saunders and Valente (1994) posited that by reducing nurses’ exposure to death, they will be set to complete the steps of bereavement more efficiently. Providing time off the unit following a patient’s death also was identified as a measure to allow affected nurses time to grieve immediately following the loss (Medland et al., 2004).

A variety of grief resolution strategies are available (see Figure 2). By adopting the strategies, altering patient-care assignments, and limiting the number of patients at EOL that nurses care for, oncology nurses will be better able to complete the steps of the BTM. Establishing an improved work-life balance also was identified as a means of trying to prevent or limit the grief experienced by oncology nurses; suggestions included engaging in physical activity, asking for help when needed, sustaining adequate sleep and nutrition, and engaging in pleasurable activities (Aycock & Boyle, 2009; Bush, 2009; Lally, 2005; Quattrinin et al., 2006).

Discussion

Limitations

The limited number of articles reviewed demonstrated the gap in literature on the topic and the generalizability of the findings. The emphasis on literature pertaining to pediatric oncology nurses (Conte, 2011; Hinds et al., 1994; Macpherson, 2008) was identified as another shortcoming. Mukherjee et al. (2009) identified that pediatric oncology nurses experience additional work stressors compared to those working with adult patients; therefore, the grief experience of pediatric oncology nurses may be heightened. As a result, the usage and variability of adopted coping strategies may differ from adult oncology nurses to pediatric oncology nurses.

The inclusionary criteria for the choice of key words were to ensure that the focus of the selected articles remained on grief coping strategies and oncology nurses; however, with the large number of key words used, the focus of the articles differed substantially. Although the articles selected did provide grief resolution strategies, they often were not the main focus. As such, the efficacy of the strategies remains to be demonstrated.

Areas for Future Research

Of the 18 articles reviewed, 11 were research projects, 9 conducted after 2000. Since 2000, substantial changes have taken place in health care. Technologic advances, namely the use of electronic medical records, have changed nurses’ roles in myriad ways, including documentation and the way patient histories are conducted and reviewed. The changes frequently amount to additional time away from the bedside while nurses adapt to the new technology, impacting the care that patients receive (Demeris, Parker Oliver, & Wittenberg-Lyles, 2011).

The Internet has contributed to increased access to medical materials so patients and families are better informed (Demeris et al., 2011). The commitment to patient- and family-centered care also has been growing (Institute for Patient- and Family-Centered Care, 2011). As a result of these changes, patients are making their own decisions regarding health care, including their choices for EOL (Demeris et al., 2011).

The role of oncology nurses inevitably has evolved along with technologic advances and change in patient-care focus (Demeris et al., 2011). New research on oncology nurses’ experiences of grief and preferred grief-resolution strategies are a continual need. Suggestions for future research include examining the impact of using Web-based approaches to facilitate grief resolution for oncology nurses, identifying the impact of hospital technologies on oncology nurses’ experiences with grief, and comparing the usage and type of grief resolution strategies among adult and pediatric oncology nurses. In addition, research aimed at identifying the efficacy of the proposed coping strategies is needed.

Conclusion

The literature review demonstrated that providing grief resolution strategies to oncology nurses increases retention, highlighted by articulating the consequences of not grieving, including CF, CCG, and burnout. Grief resolution strategies were provided from the literature search and categorized as creating a positive work environment, debriefing with colleagues, providing

**FIGURE 2. Grief Resolution Strategies for Oncology Nurses**

- Attend funerals.
- Send sympathy cards.
- Light a candle to signify the loss of a patient.
- Create a memory board.
- Visualize own mortality.
- Create a will.
- Write an epitaph.
- Host an annual get together for families in honor of their loved ones.
- Develop a bereavement brochure for families of patients who died.
- Seek counseling with the help of a psychiatric professional.

Not grieving is detrimental to the oncology nurse, negatively impacting the care that is provided to patients. By providing workplace grief resolution strategies, an increase in oncology nurse retention will occur.
grief training and EOL education, and altering patient-care assignments. By adopting coping strategies from these categories, oncology nurses may be able to complete the steps of Saunders and Valente’s (1994) BTM, aiding in grief resolution. In addition, oncology nurses need to engage in grief resolution strategies on a frequent basis. By doing so, they are more likely to stay in the specialty, ensuring that patients with cancer continue to receive optimized care.

The author gratefully acknowledges Melissa Campbell, RN, BScN, MN, NR; Pearl Chin, RN, BN, MN, Cheryl Crocker, BSc, MEd, PhD, and Parneet Hara, RT, BScN, MHS, for their substantive support throughout the development and editing of this article.

References

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