A Concept Analysis of Nurses’ Grief

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Background: The psychological and personal well-being of nurses can change the way they care for patients. If nurses’ grief is not properly managed, the nursing shortage will continue to grow. Consequently, a need exists for the identification of nurses’ grief and effective interventions to manage grief to ensure the successful development and growth of the nursing profession.

Objectives: This concept analysis sought to properly define nurses’ grief and the role it plays in the day-to-day requirements of nurses.

Methods: A review of the literature was conducted using CINAHL®, BioMed, EBSCOhost, and MEDLINE® and the following key words: nurse, grief, and patient loss. Articles included provide information about nurses’ grief, outcomes resulting from grief, and interventions to manage nurses’ grief.

Findings: Nurses’ grief must be incorporated into the nursing curriculum and addressed by employers. In particular, facility leaders should help promote a healthy work environment and address the need for proper grief management. Educators, managers, and nurses can benefit from acknowledging the current gap in managing nurses’ grief.

When an individual dies, that person’s family and friends begin experiencing grief caused by the loss of a loved one. Grief varies depending on the individual. Personal and job-related factors, as well as outside relationships, can affect how a person grieves (Wenzel, Shaha, Klimmek, & Krumm, 2011). The same is true for nurses, who are often left to individually manage their grief. If not properly supported, nurses’ grief can affect factors outside of work (e.g., personal relationships, emotions, feelings of worth, eating habits) (Dougherty et al., 2009; Wenzel et al., 2011). The purpose of this concept analysis is to clarify the meaning of nurses’ grief using Walker and Avant’s (2011) model. This model is used as a foundation to fully explore the concept of nurses’ grief, including its antecedents, attributes, consequences, purpose, and uses. Such clarification may allow facility leaders to better support nurses with grief management.

Leaders engaged with facility support services should first identify those areas in which nurses may encounter grief more frequently. For example, a nurse working in an oncology unit may experience patient death on a weekly basis; he or she may also experience feelings of perceived loss by sending patients to the end of life to be cared for by hospice. A high rate of turnover in nursing staff is seen when nurses’ grief is not adequately acknowledged and when few resources are provided to adequately assist those who are grieving (Dougherty et al., 2009; Medland, Howard-Ruben, & Whitaker, 2004; O’Connor, Watts, Bloomer, & Larkins, 2010; Wenzel et al., 2011). If nurses’ grief is better understood and supported, retention rates and job satisfaction may rise. The goal of this analysis is to provide findings to inform the implementation of new programs or the adjustment of existing resources to assist nurses who may be experiencing grief related to patient loss.

Professionalism requires an understanding of what is appropriate within a profession and specific situations that may arise. Gerow et al. (2010) used Miller’s (1990) work to help define a professional relationship as “previously set and agreed-upon services provided to the client” (p. 124). Even while maintaining professionalism, nurses may become overly invested in their patients, and they may build close relationships with individual patients and their family members. Gerow et al. (2010) explained that increased grief felt by a nurse for a deceased patient may be related to the relationship they developed (e.g., general friendship, bonding spiritually, caring relationship with patient and family). However, a professional stigma exists among nurses. Some nurses may view grieving as unacceptable and expect their colleagues to remain strong and supportive for patients’ families while maintaining professional distance (Chan, Lee, & Chan, 2013; Charalambous...
Antecedents

To fully comprehend the meaning of nurses’ grief, understanding the term “grief” is essential. Grief is defined as experiencing a loss or perceived loss (Merriam-Webster, Inc., 2015). Perceived loss is included within the criteria of nurses’ grief because the patient does not have to be deceased for nurses to experience grief (Dunne, 2004). In nursing, perceived loss is the idea of a situation not leading to a positive outcome for a patient and usually ending in death. Antecedents defining nurses’ grief include the individual being a licensed registered or practical nurse, as well as the primary nurse for a patient; experiencing a loss or a perceived loss of a patient; and having developed a relationship with a patient and his or her family before the patient’s death.

Unlike other more concrete antecedents, the antecedents of relationships and perceived losses are abstract and more difficult to measure. A formed relationship can be as simple as the relationship created by a nurse’s professionalism when caring for a patient. However, this relationship is often stronger and develops over time with continued care. Individuals may form a bond through similarities in their life experiences, backgrounds, common interests, and care practices (Gerow et al., 2010). To truly determine if a nurse-patient relationship has been established during the time of care, directly asking the nurse is necessary.

Essential Attributes

Once a nurse begins to develop these relationships and experiences a loss or perceived loss, he or she then begins to go through a grieving process—the defining characteristic of nurses’ grief. To assist in measuring this abstract concept, theorists have created grief models. The most widely known of these is Kübler-Ross’s (1969) five stages of grief, but theorists are beginning to consider different models to better fit individuals working within health care. Saunders and Valente (1994) created a model for oncology nurses that involves four tasks: finding meaning and sense to the loss, restoring what may have been lost or injured as a result of the patient dying, managing the effects, and redefining relationships.

Many models have been adapted to nursing, but because of different circumstances surrounding nurses’ grief, their accuracy must be questioned. For example, grief can be recurring. In particular, nurses may move through stages of grief and then re-experience these stages when another loss occurs; they may feel as though they are moving backward in the stages of grief because of the recurrences. One patient may bring up the memories of a past patient, leading to grieving for the current patient and the past patient. Further research is needed to analyze and compare multiple patient losses and regression in the grief stages of non-nurses versus nurses to accurately state the variances in nurses’ grief.

Consequences

Although many nurses eventually feel resolution or balance after the loss of a patient, some nurses continually progress through the stages of grief with no resolution. The primary consequence of nurses’ grief is their reaction to stages within a model of grief. Depending on the individual, these stages can lead to positive or negative outcomes. Based on a review of the literature, these consequences have been categorized into three groups: unit-based factors, educational opportunities, and personal-emotional factors.

Unit-Based Factors

Unit-based factors can alter an individual’s reaction to a loss, and they include staffing shortages, high patient acuity, and long work hours. A nurse cannot be allowed to spend time off of the floor to grieve if insufficient nurses are available to staff the unit (Wenzel et al., 2011). However, patient assignments can be adjusted to allow the nurse to spend time with the patient’s family and process the loss. Having conversations with colleagues about the deceased patient and sharing personal feelings have been found to be helpful (O’Connor et al., 2010). Providing sufficient support to nurses can assist with increasing their morale and job satisfaction (O’Connor et al., 2010). In addition, meeting nurses’ needs fosters work-life balance, preventing the continuous recurrence of negative consequences (e.g., burnout, turnover, prolonged stages of grief, work-related stress) (Dougherty et al., 2009; Medland et al., 2004). Because of a lack of assistance in preventing these negative consequences, nurses can lose sight of the positive consequences that make their role rewarding (e.g., palliative care support, family and patient advocate and care provider, job satisfaction and fulfillment) (Dougherty et al., 2009; Medland et al., 2004; Wenzel et al., 2011).

Educational Opportunities

Further staff support could include providing educational opportunities. Many nursing students have mentioned deficits in grief education, as well as the need for end-of-life care training (Brown & Wood, 2009; O’Connor et al., 2010). Education outside of the hospital environment is necessary to prepare those who will one day join the ranks of nurses. Studies focusing on nursing students and their preparedness have showed that many are ill prepared in the clinical and classroom settings to work with patients at the end of life (Sadala & da Silva, 2009). Because of the lack of training in the education setting, facility leaders must develop programs to fill this gap for nurses already in the workforce. However, based on review of the literature, nurses are seeking more unit-based activities (see Figure 1), not a universal solution (Shorter and Stayt, 2010; Wenzel et al., 2011). Each environment and the nurses working within it are different. As such, facility managers must reach out to their employees and properly assess whether the resources provided are meeting nurses’ needs.

Personal-Emotional Factors

The personal-emotional factors of the individual may strongly influence his or her ability to successfully grieve a patient loss.
Individuals may be unable to outwardly express their emotions because of a fear of ridicule or not being accepted on the unit (Brown & Wood, 2009; Gerow et al., 2010). Ineffective coping can lead to job dissatisfaction, increase in job turnover, compassion fatigue, frustration, and feelings of helplessness (Gerow et al., 2010; Wenzel et al., 2011). These emotional factors need to be addressed by facility leaders to support their staff in managing responses to loss.

**Concept in Nursing**

Grief is experienced by nurses in different ways depending on their specialty, but it all revolves around a loss. Some nurses may never see a patient’s family members or form a relationship with the family. A patient’s unconscious state prevents the formation of a relationship outside of feeling empathy and placing oneself in his or her situation. Not all nursing units regularly experience patient losses—some may not experience them at all—creating the idea that such losses may affect nurses very minimally. However, not experiencing patient losses may leave nurses unprepared to handle such situations. Some facilities provide continuing education regarding coping strategies for patient loss and the grief process (Schmidt, 2011), whereas others may be unaware of the effects of grief on nurses and the hospital as a whole.

Nursing can be a taxing career, particularly for individuals involved with direct patient care. Many new nurses change careers not long after assuming their first professional nursing position (Medland et al., 2004). Job dissatisfaction and increased workload have been attributed to decreased retention rates (Medland et al., 2004; Wenzel et al., 2011), as well as to nurses’ inability to grieve properly (Charalambous & Kaite, 2013; Medland et al., 2004). Providing grief support to nurses who experience patient loss allows for the development of positive consequences to the concept of nurses’ grief.

**Concept in Oncology Nursing**

Many oncology units see a varied population of patients with different diagnoses, stages of disease, symptoms, and treatments. Although each situation is unique, grief may be experienced and managed differently. For nurses, providing hope for patients and their families can become more challenging when patients have been in and out of the hospital for an extended period of time and continue to deteriorate. Maintaining a positive attitude may also become more difficult after years of caring for patients and experiencing losses (Braun, Gordon, & Uziely, 2010). Some nurses remember negative experiences more than positive, successful ones. These lasting memories further support the need for awareness of nurses’ grief, as well as strategies to assist nurses with grief support and management.

**Exemplary Cases**

To fully illustrate the concept of nurses’ grief, the use of exemplary cases is beneficial. In the model case, the situation fully explains the explored concept as defined by Walker and Avant (2011). The borderline case presents some, but not all, of the attributes of the concept, whereas the contrary case lacks attributes of the defining concept of nurses’ grief. These cases are useful in helping nurses to gain a deeper understanding of the concept.

**Model Case**

K.C., a patient known to the nurse, was diagnosed with stage IV liver cancer. The cancer was metastasizing too rapidly for doctors to recommend any further treatment other than palliative care. When arriving for shift change, the nurse received the news of K.C.’s diagnosis. She was emotional and overwhelmed because she had cared for and bonded with this patient. After two weeks of fighting, K.C.’s health began to rapidly decline, and members of K.C.’s family came to the hospital from all parts of the state to say their goodbyes. Tears were shed, and stories were shared. K.C. died three hours after the nurse’s shift. Because the nurse had cared for K.C. for almost a month, a relationship had developed. Two months later, K.C.’s daughter returned to the unit to thank everyone and tell them the family was doing well. This model case shows the attribute of a nurse losing a patient for whom she is the primary care nurse. She begins the grieving process in her own way: developing a relationship with the patient and her family, caring for the patient at the end of life, and providing emotional support. In this scenario, the positive aspects of grief include telling stories and sharing memories with the family, which allow the nurse to grieve in her own way. When the patient’s family came back to the hospital to thank the staff, this act provided closure. This model case shows how the nurse participated with the family in the grieving process, illustrating the attributes of nurses’ grief.

**Borderline Case**

A nurse with extensive oncology nursing experience was asked how she remains in the specialty with frequent patient deaths. She stated, “I don’t think about it anymore, and I just...”

**FIGURE 1. Grief Management Suggestions for Facility Leaders**

*Note. Based on information from Dougherty et al., 2009; Medland et al., 2004; Wenzel et al., 2011.*

- Provide a quiet space for staff.
- Offer training and support for grief management in individual and group settings.
- Allow time for closure and to spend with patients’ family members immediately after death.
- Follow up with patients’ families (e.g., attend funerals, send cards to family members).
- Have an annual service to recognize patients who have died (e.g., memorial service, candlelight service).
- Acknowledge nurses’ contributions to patients’ care.
- Create a balanced work schedule.
- Supply support groups, retreats, and mentors to incoming staff, as well as grief counselors to come to the unit after patient deaths.
- For a brief period of time, block off rooms where patients have died, and mark them with roses or ribbons in honor of those patients.
don’t let it affect me.’ When approached about the topic, the nurse was acting as the primary nurse for J.P., a patient undergoing palliative care. As she cared for J.P., she maintained an emotional distance, preferring not to become involved with J.P.’s family or provide extensive emotional support outside of empathy. Although the nurse ensured J.P.’s comfort and answered any questions, she did not spend time helping J.P. or his family cope with the diagnosis. When J.P. died, the nurse had no reaction and viewed his death as another patient death. This nurse meets parts of the attribute (loss and primary care nurse status), but J.P.’s death was not a loss that caused the nurse grief; the nurse maintained separation and did not form a relationship with the patient.

Contrary Case

An emergency department (ED) nurse was caring for E.O., a patient presenting with fever, cold sweats, fatigue, cough, and generalized weakness. Because of the time of the year and E.O.’s symptoms, the nurse requested an influenza test. The results came back positive. E.O. was told that she could not return to work for at least seven days or until 24 hours after her fever broke. However, E.O. had no paid time off or sick leave available. Nervous about paying for the ED visit and making up for a week without pay, E.O. became anxious. The nurse reassured E.O., stating that her getting well was most important. E.O. received fluids and a prescription, and she was sent home. The nurse cleaned the room and moved on to taking care of the next patient. This case meets no attributes of the concept. The nurse experienced no form of loss because she simply completed her duties and sent the patient home to improve.

Empirical Referents

Empirical referents for nurses’ grief allow the observer to seek out those who may not be processing their grief properly or further support those who are grieving. The most common form of measuring grief is through observing the stages of grief or coping mechanisms. Conte (2011) noted that the manifestations of working through the stages of grief (i.e., denial, anger, bargaining, depression, and acceptance) vary depending on the individual, and they may include fatigue, burnout, anxiety, emotional disassociation, helplessness, loss of job productivity, and decreased concentration. However, nurses who are able to work through the grief process are likely to experience individual growth and continued personal and job satisfaction (Dunne, 2004). One difficulty is assessing whether an individual is experiencing the stages of grief without asking; some may internalize their grieving process. Running parallel to the stages of grief are the effects that may occur during these stages (e.g., job satisfaction or dissatisfaction, spiritual growth or disconnection, interference or development with personal relationships, psychological symptoms). The end goal is the formation of a resolution—a tool of measurement in the individual’s process of grief. A resolution shows that the individual is completing the grieving process and has come to terms with the loss, as well as made adaptations in his or her life to manage without the deceased.

Implications for Practice

- Increase employer-supported resources to adequately reinforce the psychological and personal well-being of nurses in the areas of grief and loss.
- Provide outlets or opportunities for nurses to express their emotions and experiences in a safe environment that is away from the bedside (e.g., debriefings, retreats).
- Ensure that nurses feel supported when providing care to patients who are actively dying; this can be accomplished through interactions with coworkers and/or provision of adequate supplies to care for these patients.

Recommendations for Change

Nurses do not often have closure in the way that family and friends do when a patient dies. Instead, they have to do without attending a funeral and continuing relations with the family to discuss memories and celebrate the patient’s life. Often, the patient is moved, and the room is cleaned and immediately assigned to another patient. In certain units, experiencing multiple deaths in a short period of time is common.

However, over time, these experiences can affect nurses’ psychological and personal well-being. Considerations need to be made and resources provided to assist nurses with properly managing grief. These considerations and resources can include retreats, pastoral or chaplaincy visits, unit debriefings, programs to maintain contact with families of deceased patients, and employee assistance counseling (Schmidt, 2011; Shorter & Stayt, 2010; Wenzel et al., 2011). As long as some form of assistance is maintained and nurses feel comfortable—not stigmatized—pursuing it, this is a step in the right direction. Such efforts may lead to the development of a positive and growing nursing profession in all specialties, including those with a higher potential for loss and the grief that may accompany it.

Conclusion

The literature clearly demonstrates that nurses’ grief is a common occurrence and one that greatly affects job satisfaction, turnover rates, personal and professional relationships, and employee engagement (Dougherty et al., 2009; Gerow et al., 2010; O’Connor et al., 2010; Wenzel et al., 2011). Antecedents of the concept of nurses’ grief include but are not limited to the loss or perceived loss of a patient, primary nurse status, and personal relationships developed between the nurse and patients and their family members. The process of grief management is a pivotal attribute of nurses’ grief. Consequences of improper grief management may lead to a lack of closure. A greater understanding of nurses’ grief through exploration of exemplary cases can lead to educational strategies and the development of resources for nurses. After obtaining a greater understanding of nurses’ grief, the nursing profession can effect positive changes in nursing environments, leading to improvements in nurses’ grief management.
References


