Anticipatory Grief in Patients With Cancer

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Patients and their loved ones often experience anticipatory grief when learning of a diagnosis of advanced or terminal cancer. Anticipatory grief can be a response to threats of loss of ability to function independently, loss of identity, and changes in role definition, which underlie fear of death. Dealing with multiple losses is a primary task that the dying patient must face. When an oncologist delivers bad news, the patient and family members often hear the same discussion through different filters, which can lead to conflict and dysfunction. By providing a supportive and safe environment, oncology nurses can help patients and their loved ones understand that their feelings are common and are experienced by others in similar situations and assist them with developing coping strategies and in redefining their roles within the family and in the outside world. In addition, an important goal at this time is to help the patients reframe “hope” realistically so they may have the opportunity for personal growth as well as reconciliation of primary relationships toward the end of life.

The terms grief, mourning, and bereavement often are used interchangeably when discussing loss experienced by family and friends when a loved one dies (Rando, 1984). However, grief, mourning, and bereavement also may be experienced when patients with cancer and their loved ones are anticipating functional losses and possible death. Anticipatory grief is described as a “range of intensified emotional responses that may include separation anxiety, existential aloneness, denial, sadness, disappointment, anger, resentment, guilt, exhaustion, and desperation” (Cincotta, 2004, p. 325). Dealing with multiple losses is the preeminent coping task faced by a dying patient (Block, 2001). Oncology nurses working with patients who have received a diagnosis of advanced or terminal cancer are in a position to help patients and families cope during this time.

Case Study

E.H. was a 59-year-old married woman who was diagnosed with locally advanced non-small cell lung cancer. She and her husband had two children, a married daughter who was expecting her first child and a son who was in his junior year in college. After a long career as a reporter, E.H. had landed a dream job at a public radio station, working long hours but loving the challenge and stimulation.

Following an extent of disease work-up, E.H. and her husband met with her medical oncologist to discuss treatment options. When pressed about E.H.’s “chances,” the oncologist was realistic, explaining that the chance of a cure was small, but also held out the hope that, with chemotherapy and radiation, control might be possible. E.H. said that she would be willing to try “chemo,” but that, if it were not working, she would not wish to continue futile treatments. At that point, E.H.’s husband became emotional and insisted that she needed to “beat this disease,” and so E.H. agreed to begin the recommended chemotherapy regimen.

After a few courses of chemotherapy, E.H. arrived at the infusion center in emotional distress and reported having severe anxiety and not being able to sleep for more than a few hours per night. The oncology nurse asked the oncology social worker to come to the unit and together they sat with E.H. and asked her to share her feelings. E.H. related how she finally felt fulfilled and appreciated in her work, but was now unable to meet the demands of the role because of the effects of chemotherapy.

She had little energy available to spend on her husband or on social engagements. She had been anticipating the arrival of her first grandchild and was looking forward to the day when her son would graduate college, but now was consumed with feelings of nausea and exhaustion that limited all but the most basic of activities of daily life.

Experiencing Grief

What E.H. experienced was grief in response to multiple losses (see Figure 1). Her body had been betraying her and she felt exhausted, depressed, and immobilized. Her identity changed in several meaningful ways: as a professional who felt competent and appreciated at her workplace, as a woman who could share in welcoming a new grandchild, and as a mother who was looking forward to seeing her son graduate from college.

Although her distress was obvious, E.H. had not voiced her concerns to her husband. Her marriage had been a strong one, but, since her diagnosis, she had felt increasingly isolated and alone. She felt that her husband was not realistic about

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her situation and was focused solely on her continued fight. According to Rolland (1990), the conversation about diagnosis and prognosis is highly emotional and the patient and family are very vulnerable. When the oncologist sat down with E.H. and her husband to discuss her diagnosis and treatment options, they each reacted very differently. Family members in this situation often hear the same discussion through different filters, which can later lead to conflict and dysfunctional patterns of coping (Rolland, 1990).

Interpersonal Strategies

Often patients and their family members try to shield each other from their grief when, in fact, they would derive benefit and feel relief by sharing their true feelings with each other (Block, 2001). When meeting with E.H., the oncology nurse and social worker provided a non-judgmental, supportive environment that enabled E.H. to put into words her underlying feelings about her situation. Acknowledging these feelings makes the experience more accessible and less charged for the patient (Levine & Karger, 2004). Having someone who was able to listen and acknowledge her feelings was important to E.H. as she was not able to get this kind of support from family and friends, who had their own fears of losing her and were insisting that she “fight” for a cure. By helping E.H. understand that her feelings were common, the oncology nurse and the social worker helped E.H. feel less anxious and depressed and gave her the chance to express her ambivalence about hope for a cure and her underlying feelings of mortality.

The oncology nurse and social worker approached the difficult issue of mortality by helping E.H. to define what “hope” meant to her. Through their discussion, E.H. was able to realize that, although cure was unlikely, many reasons existed for her to maintain hope. She resolved to find more meaningful ways to communicate with her husband and children. The benefits of better communication between E.H. and her family would include acknowledging the possibility of permanent loss, would sustain and possibly reframe hope, and would build flexibility into planning for the future (Rolland, 1990).

Family members have several tasks to fulfill to manage their anticipatory grief in a healthy way (see Figure 2); therefore, the oncology nurse also set up a few appointments to meet separately with E.H.’s husband to explore his fears and to provide support while she was receiving her chemotherapy treatments. The social worker was present when available. With gentle reassurance, E.H.’s husband was able to acknowledge his anger about being abandoned by his wife, to express his anxiety about the possibility of caring for his wife’s physical and emotional needs as her disease progressed, and to share his concerns about filling the roles of father and mother when she was gone. He even began to touch on his own fears of death. Being able to express these fears brought E.H.’s husband closer to acceptance of the possibility that E.H.’s cancer would not be cured and to move beyond his need for his wife to fight the disease at all costs. He began to be more responsive to her needs and they were able to share intimate thoughts.

A key component in adapting to and coping with the crisis of terminal illness is the flexibility of family functioning and the ability of members to take on additional roles when a loved one can no longer fulfill their traditional role within the family (Kissane & Block, 1994). In E.H.’s family, although both spouses had solid employment, providing nurturing and emotional care clearly fell on E.H. After meetings with the oncology nurse, E.H.’s husband was able to acknowledge his feelings of inadequacy around emotional caregiving and was willing to be referred to a therapist to work toward acceptance.

Conclusion

Patients who have received a diagnosis of terminal cancer will most likely exhibit manifestations of anticipatory grief, which include responses to the various losses that they are experiencing. Early on, the losses may include loss of functioning, identity, and role definition. Underlying all of this is the ultimate loss, death. By allowing patients and their loved ones to express their feelings about each of these losses, the oncology healthcare providers can help them to deepen their relationships and to experience growth, even at the end of life.

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