A Concept Analysis: The Grieving Process for Nurses

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The concept of the grieving process has been explored extensively in families losing a loved one or in a patient grieving over a terminal diagnosis. The patients and families live through this experience one time. What about the nurse who lives it several times a week by caring for these patients and families? How does a nurse grieve? Little publication and research have been done surrounding the grieving process for nurses. This is a concept analysis that clarifies the grieving process for nurses. Clarifying this process will enable further development of nursing research and education, ultimately benefiting nursing practice and retention.

Search terms: grieving process, nurses

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A nurse working in a bone marrow transplant unit admits a 15-year-old female patient for her second allotogenous transplant. The patient will receive her stem cells from her 12-year-old brother, just as she did with her first transplant less than 2 years ago. This young, vibrant, seemingly healthy young woman brought with her hopes of a cure. Unknown to me, that young woman also brought with her a lesson in grieving that I had not experienced in 19 years of employment. The patient died a horrible death, 65 days after her transplant. She endured graft-versus-host disease involving not only her gastrointestinal tract, but also her liver. She developed acute respiratory distress syndrome (ARDS) from an alveolar bleed as a result of the high-dose chemotherapy and her low platelet count. She eventually required mechanical ventilation and then tracheotomy after being on the ventilator for over 3 weeks. Her parents stayed by her side day and night for months. I was the patient’s primary nurse every day that I worked. I was off the day she died. Everyone who knew her grieved for her. The grieving process is a concept that all nurses need to examine, because grief is a phenomenon that every human being will eventually experience.

How do nurses grieve the loss of their patients? Especially nurses who deal with patients who frequently have prolonged suffering with little comfort care in the name of a cure? My personal beliefs are that, too frequently, nurses are expected to “deal with it” or help the family or patient cope. However, who helps the helper? Who assists the nurse who spends hours every working day dealing with the suffering and trying to make it “better” when she or he knows that nothing she or he does would really help make it better? How does the nurse work through such a loss? Clearly, the grieving process needs to be understood among healthcare providers.
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Definitions

According to Walker and Avant (1999), concept analysis allows one to explore the attributes or characteristics of a concept. The purpose of a concept analysis is to distinguish between concepts. Concept analysis is a careful examination and description of a word.

Based on Merriam-Webster’s Online Dictionary (2004), grieving means to cause to suffer, or to feel grief or sorrow. Process is defined as a natural phenomenon marked by gradual changes that lead toward a particular result, a natural continuing activity or function, or a series of actions or operations conducing to an end.

The grieving process is how you reconcile your personal feelings of loss. It is the way one develops a peace with one’s self in relation to a loss, and then moves on with one’s life (Reese, 1996).

Furthermore, Kubler-Ross (1969) defines the grieving process as moving through the five stages of grieving: denial (denying the presence of loss or disease), anger (at the loss or about being ill toward people or God), bargaining (is there another way), depression, and acceptance.

Unlike Kubler-Ross, Stephenson (1985) describes the grieving process in three phases: reaction (involving shock, numbness and anger), disorganization and reorganization (stopping old actions then replacing them with new actions or resuming actions that contribute toward closure of the process), and reorientation and recovery (resolution of previous strong felt emotions).

However, Pessagno (2002) lists four tasks of grief that are described as follows: accepting the reality of the loss, experiencing the pain of the loss, adjusting to the environment from which the deceased is missing, and withdrawing energy from the relationship with the deceased and reinvesting in other relationships.

Clearly, all of the above definitions of the grieving process revolve around an individual feeling of loss or sorrow then working toward a healthy resolution of this loss or sorrow. This process is marked with stages or steps that may vary from individual to individual, but the goal is a healthy resolution of the loss or sorrow so the person can proceed through life.

Literature Review

I searched medical and nursing databases for the concept of the grieving process. Many articles and studies have been written in relation to the nurse helping the patient with his or her grief or the nurse helping the family work through the process of losing a loved one. These articles included studies on what actions by the nurse or physician made the family more comfortable with the patient’s death or impending death. Most of these articles spoke of how the nurse was specially trained to deal with and teach the grieving process to lay persons. I must have missed that semester in nursing school. We as nurses learn how to care for patients in all aspects of life and death, but never have I been in a class that presented how to teach a family or patient to grieve.

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On the other hand, there were very few studies and articles found related to how the nurse deals with the loss of a patient. Papadatou, Bellali, Papazoglou, and
Petraki (2002) explored grief responses of Greek nurses who provided care to children dying from cancer. The researchers found that nurses fluctuated between experiencing and avoiding their grief. Reactions ranged from crying, sadness, anger, and recurring thoughts of the dying conditions (pain and suffering) and the actual death of the child. Support was found from other nursing staff by recalling the positive attributes of the child and discussing positive contributions the nurse had made to make the child’s death more peaceful. Most frequently, the nurse avoided the grief and was noted as saying that a curtain was drawn down and the pain was forgotten, or the pain was placed in a drawer and closed away. The process of working through loss was significantly compromised and led to various degrees of burnout.

Likewise, Lenart, Bauer, Charise, Brighton, Johnson, and Stringer (1998) found that nurses mainly repressed grief and that their support systems were mainly from other nurses. Some nurses reported grief responses such as fatigue, sleep disturbances, anxiety, sorrow, moodiness, and difficulty concentrating. All being documented unresolved grief responses.

Contrarily, Puckett, Hinds, and Milligan (1996) presented an article where an oncology nurse experiencing the loss of a patient receives assistance from the beginning of the patient’s diagnosis. The support is continued through to the death of the patient. This approach used a support group for nurses, which involved a multidisciplinary team to assist nurses through the stages of grieving until acceptance was reached.

Just as important, Brosche (2003) established a Grief Care Plan for the nurse to assist the nurse through the grieving process. The diagnoses used for this plan were shock, denial, disorganization, volatile reactions, guilt, loss and loneliness, relief, and, finally, reestablishment.

**Antecedents**

Antecedents are the events that need to take place prior to the occurrence of the concept (Walker & Avant, 1999). In order to experience the grieving process, the nurse must experience a loss or perceived loss. The nurse must not repress his or her grief for the sake of looking strong or in the name of looking professional. The nurse must work through the stages of the grieving process until a healthy resolution and acceptance of the loss is obtained.

**Defining Characteristics/Attributes**

Defining attributes are a list of characteristics of a concept that appear over and over again when reviewing the literature. They help you name the occurrence of the concept as differentiated from a similar concept (Walker & Avant, 1999). The grieving process has the defining characteristic of being a loss that causes grief. The loss is then processed to acceptance or resolution of this loss through stages such as denial, anger, disorganization, reorganization, and depression. The resolution or acceptance of the loss results in the individual being able to establish or invest in other relationships and move on in a healthy fashion throughout the rest of his or her life. Resolution enables the nurse to be fully present for his or her patient (Furman, 2002).

**Consequences**

According to Walker and Avant (1999), consequences are the events or incidents that occur as a result of the occurrence of the concept. As Brosche (2003) tells us, the consequences of not going through the grieving process for the nurse can range from burnout to potentially harmful addictions, such as alcohol and drugs or even to thoughts of suicide. Furthermore, staff morale and delivery of patient care can be affected. The consequences for the hospital can lead to high turnover and decreased customer service and satisfaction. The nationwide consequence being an even larger nursing shortage.

Similarly, Furman (2002) states that helping nurses deal with death and process grief guards against burnout, maintains a therapeutic presence, and, in return, leads to better patient care.
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Model Case

A model case is constructed to illustrate the concept of the grieving process. This case, which includes all the defining attributes and no other attributes, is an absolute instance of the concept (Walker & Avant, 1999). I was the patient’s primary nurse. I delivered her chemotherapy. I taught her and her family the routine and not-so-routine side effects of her treatment and prepared everyone involved for the possibly rocky road ahead. I was working the days when she was developing ARDS. One day, the patient’s mother started to cry as she asked me if her daughter would live. I held her as she wept and became angry because I could not tell her “yes” anymore. I cried with her and her daughter as they said goodbye to each other before the patient was sedated then intubated. No one knew if she would ever wake up again.

I often found myself unorganized or disheveled especially at home as I wondered how my patient was doing. In my prayers, I prayed for her recovery and I swore I would never complain about working too hard or being understaffed again. As time proceeded, I became depressed. It became hard to even go to work. I felt a lump in my throat every time I had to go into her room and face the agony she and her family were experiencing. I was present the day the doctor had the “end of life and do not resuscitate (DNR)” talk with the patient’s family. I remember her mother discussing with me if she made the right decision by making her daughter a DNR. I was present the night the patient had a massive myocardial infarction then went pulseless. I cried with her parents and said goodbye to her before she died. After the patient’s death, I attended a grieving support program for nurses at the hospital. I went through the grieving process and, as a result, maintain close relationships with patients. They, in return, received excellent nursing care.

Borderline Case

A borderline case is a case that contains some of the defining attributes of a concept but not all of them (Walker & Avant, 1999). Jennifer was not my patient’s primary nurse, she was my orientee when I cared for the patient. She assisted me when I delivered the patient’s chemotherapy. Jennifer was present when I taught the patient and her family the routine and not-so-routine side effects of her treatment and prepared everyone involved for the possibly rocky road ahead. We were working the days when the patient was developing ARDS. I knew my patient was taking a turn for the worse and I made sure Jennifer also knew this. I saw Jennifer start to try to block out her feelings. One day, the patient’s mother started to cry as she asked me if her daughter would live. I held her as she wept. When I left the room, Jennifer was waiting for me and said that she was not sure she could do this job. I tried to discuss her feelings, but she just walked away. She started to find herself unorganized at work. As time proceeded, Jennifer showed signs of being depressed. She told me that sometimes it was even hard for her to come to work. She changed preceptors so she did not have to take care of my patient. When Jennifer did have to work with me, which meant taking care of my patient, she did only immediate patient care, limiting her personal presence in the room so conversations could not get too in-depth. Jennifer was not working the night my patient died. She sent a sympathy card to the family for closure. She also attended the grieving support group at the hospital. I notice, however, that when our unit gets an especially young patient, Jennifer
tries very hard to avoid taking care of that patient. When she does take care of these patients, she gives excellent nursing care, but stays distant.

**Contrary Case**

A contrary case is a clear example of what the concept is not (Walker and Avant, 1999). Sue was my patient's other primary nurse. She took care of my patient during the days I was not working. She knew that the patient’s prognosis was poor from the very beginning. She mentally tried to block out any caring or link between herself, the patient, and patient’s family. Seeing the patient decline in status and develop ARDS, Sue became angry. She said phrases like, “They all die anyway. Why even try?” Sue displaced her anger on the other nurses and became confrontational with even the slightest disagreement. She left the room when the patient’s parents cried because she just could not deal with the emotion. When the patient died, Sue shed no tears. She left the room while the family viewed the body. Sue left the floor so she did not have to say goodbye to the patient’s parents.

Sue eventually became depressed and felt worthless. She hated her job and everything about it. She refused to talk about her feelings with anyone, including her husband. She eventually quit bedside nursing altogether and now works at an insurance company.

**Related Case**

Related cases are instances of concepts that are similar to the concept being studied but do not contain the critical attributes (Walker & Avant, 1999). The following is a related case on sadness. My son is in his first year of coach pitch baseball. He is the only 6-year-old on the team. The rest of the boys are aged 7 to 9. My son is very tender hearted. He asked his coach to play pitcher during one of the biggest games the team had this year. All the kids on the other team were aged 9. Therefore, they hit the ball much harder than the other teams did. The other team was also undefeated.

The coach told my son that he could not play his usual position because the team needed someone bigger on the pitcher’s mound so that if they got hit by a ball, they would not get hurt. My son was crushed. He told me after the game with tears in his eyes that he was sad. I told him that when he gets older and bigger, he will be the one hitting the ball hard, making the smaller kids go to the outfield because he will hit the ball even harder than any of the other kids on his team. My son looked at me and smiled and said, “I will hit a home run every time and show coach that I am not a baby! I’m not sad anymore, Mommy.” My son had worked through his sadness by reasoning that he would also be big someday. By the way, his next game he went three for three and hit a triple over the third baseman’s head.

**Invented Case**

According to Walker and Avant (1999), an invented case is a case that uses the ideas of the concept but outside our own experience. The following is an invented case. An Indian chief who had ruled his tribe for many decades dies from old age. The tribe must go through the grieving process in relation to his death. During the cremation of the leader, the women cry while the men chant and beat drums. The medicine man speaks to the Great Spirit and tells him that if the great leader could come back, even in another form, to lead their people, he would do anything that the Great Spirit asks of him. The chief’s son becomes angry and confrontational with anyone who even mentions his father’s name. The son is distracted and cannot even hunt because he cannot shoot his bow straight enough to hit his prey. During a time of chanting, the chief’s son receives a message from the Great Spirit that his father’s spirit will be by his side through all his decisions as new chief. The young son tells the medicine man of his premonition. After the tribe hears of the promise of hope, the tribe rejoices. The chief will live on in his son’s actions and deeds. The tribe says goodbye to their leader, and every year on the anniversary of his death, they sing his praises. The son becomes a great and decorated leader as his father was.
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Implications for Nursing

As nurses, we will all experience the loss of a patient at some time in our career. For nurses who work in settings that revolve around patient diagnoses that have poor prognoses, the repetitive loss of patients puts not only a physical, but also mental and spiritual burden on us not only as nurses, but also as humans. Recognizing that nurses need to work through the grieving process and come to a healthy resolution with a patient's death is the first step to helping maintain physical, mental, and spiritual health. As a result, maladaptive grieving can lead to emotional distancing and depression, non-caring, anger, and burnout. This maladaptive grieving results in the loss of nurses to other professions or nurses who give poor nursing care (Brosche, 2003). At a time when we live with a continuing nursing shortage, we need to take care of ourselves so we can survive and thrive in our environment.

Nursing needs to stand up and say, “Hey, we hurt too.” Hospitals need to recognize the need for grieving support groups where multidisciplinary teams are involved to include nursing, physicians, pastoral care, and psychology. Three to four times a year, memorial services need to be held for the ones that have passed, either in the chapel or in a church. These memorial services need to be mandatory for anyone not working that day. After the short service, all people present, including the deceased patient’s family members and staff, need to have time to eat, drink, laugh, tell stories, and just have some closure together. The results would be less burnout and less unhappy non-caring nurses, with the final result of fewer nurses leaving the field. This intervention may not completely cure the nursing shortage, but it is a very healthy start.

Conclusion

In summation, the concept of the grieving process as presented in this paper is related to nurses who experience the loss of a patient. The grieving process involves going through steps to arrive at a resolution or acceptance of the loss or death. The grieving process needs to be recognized by nursing and health administration as a necessity for good health, including not just physical but mental and spiritual as well.

“...it’s okay for you to grieve too.”

I believe Reese (1996) says it all when he wrote, “It’s only human to hurt, to cry, to grieve, when a person who’s influenced you in some way has died. Please cry with your patients and their families; it’s okay for you to grieve too.”

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References