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## Working Through Grief and Loss: Oncology Nurses' Perspectives on Professional Bereavement

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### Abstract

**Purpose/Objectives**—To determine facilitators and barriers to managing patient loss from the combined perspectives of oncology nurses and to extract essential components of a supportive intervention.

**Research Approach**—Qualitative, descriptive.

**Setting**—The comprehensive National Cancer Institute–designated cancer center of a mid-Atlantic university teaching hospital.

**Participants**—34 nurses from inpatient and outpatient adult and pediatric oncology units.

**Methodologic Approach**—Focus groups were held with oncology staff nurses to identify challenges regarding work-related bereavement, current support for managing grief and loss, and how to support interpersonal functioning and resiliency.

**Main Research Variables**—Work-related bereavement, bereavement support, and interventions and management strategies for bereavement and loss.

**Findings**—Two primary themes emerged: dimensions of work-related loss and working through bereavement. Participants also provided many concrete suggestions for the creation of a supportive self-care environment.

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**Conclusions**—Support issues were numerous, multilevel, and varied. However, addressing those concerns can improve job satisfaction and decrease compassion fatigue. The findings lay the foundation for appropriate interventions to assist nurses in managing those situations.

**Interpretation**—Administrators, managers, and individuals interested in furthering the multifaceted goals of oncology care, including nurses themselves, are challenged to create and maintain mutually supportive environments for providing optimal care to patients and families.

The global demand for highly skilled, experienced oncology nurses continues to grow because of increased disease incidence and improved cancer survivorship. However, predicted oncology workforce shortages may negatively affect both the quantity and quality of cancer care, including related areas such as research, healthcare access, and survivorship in the 21st century. To date, staff and faculty shortages have decreased the number of nurses receiving specialized oncology education and training (Institute of Medicine, 2009).

In spite of growing evidence that experienced oncology nurses contribute to high-quality cancer care and improved patient outcomes, administrators in oncology settings commonly face multiple challenges to nurse retention, including inadequate staffing levels, high patient acuity requiring complex care delivery, and long work hours (Buerhaus, Donelan, DesRoches, Lamkin, & Mallory, 2001). Caring relationships fostered by oncology nurses also may be associated with emotional burden (Showalter, 2010; Walton & Alvarez, 2010; Yoder, 2010) that can be exacerbated by increased workloads, heightened client acuity and complexity, and repeated contacts with patients who are suffering. This burden may become overwhelming during situations in which nurses lack experience, skills, or sufficient professional and social support to manage their own psychological health (Sabo, 2008). Nurses providing care to patients who are suffering or actively dying also may experience trust issues, loss of independence, and decreased capacity for intimacy, as well as loss of control (Figley, 1995), anxiety, anger, and irritability (Lerias & Byrne, 2003). Stressful events experienced by nurses caring for patients in life-threatening situations also can lead to *intrusive imagery*, defined as “fragments of specific autobiographical events or imaginal extensions of such events that predominantly possess sensory qualities and enter awareness suddenly and unintentionally” (Boelen & Huntjens, 2008, p. 217). Therefore, nurses may relive and re-experience traumatic events repeatedly in their minds. Those psychological disturbances can have personal and professional consequences (Sabo, 2008). Responsibility for delivering therapies that may increase symptoms or negatively affect patients’ quality of life, even temporarily, also can increase stress for nurses and may lead to feelings of powerlessness, helplessness, and hopelessness (Abendroth & Flannery, 2006; Byrne & McMurray, 1997; Medland, Howard-Ruben, & Whitaker, 2004).

Experienced, professional oncology nurses contribute significantly to patients’ well-being and clinical outcomes, in addition to advancing the art and science of oncology nursing. Replacing those nurses during situations in which they are unable to remain in either their specialty or institution is extremely difficult and requires significant amounts of time, effort, and financial resources. Therefore, a better understanding of bereavement and sources of support to bolster individual and communal coping with acute and chronic loss may be important factors in reducing care fatigue and retaining experienced oncology nurses.

Important tasks for nurses who care for dying patients include understanding the process related to bereavement and effective assessment of social support for themselves and for patients and families (Medland et al., 2004). Oncology nurses must be skilled in those tasks while also coping positively with all bereavement-related issues (Medland et al., 2004). Dorz, Novara, Sica, and Sanavio (2003) reported higher emotional exhaustion levels among oncology staff than in those caring for patients with HIV or AIDS. For nursing staff, the difficulty of providing care to dying patients is exacerbated by current and projected increases in the aging population and the fact that extensive care is provided to patients and families at the end of life (Ferrucci et al., 2003; Given & Sherwood, 2006; Vincent & Velkoff, 2010).

Prior research has demonstrated that nurses should be aware of the effects their work can have on their own health, as well as the health of their patients (Byrne & McMurray, 1997). Adverse effects on health have been noted among care providers working with patients at the end of life, but little is known about this work in relationship to the psychosocial health and well-being of nurses (Sabo, 2008). Lack of support during periods of this type of job-induced stress has been shown to lead to psychological distress (AbuAlRub, 2004). Concepts such as compassion fatigue and burnout also have been used to describe those phenomena in the literature, although factors distinguishing compassion fatigue from burnout remain controversial (Aycock & Boyle, 2009). *Compassion fatigue* is defined as a severe malaise that results from caring for patients who are in pain or suffering (Sabo, 2006). Maslach, Shaufeli, and Leiter (2001) defined *burnout* as a prolonged response to chronic physical or emotional stressors that results in exhaustion and ineffectiveness. Although other similar concepts with overlapping definitions also have been used in the literature, compassion fatigue most closely reflects the experiences of oncology nurses (Aycock & Boyle, 2009). In those instances, increased absenteeism, loss of productivity, and the choice to leave the workplace (or the specialty of oncology nursing altogether) may occur (Medland et al., 2004). Subsequent losses to institutions, patients, families, and the future of the specialty have been noted (Abendroth & Flannery, 2006). Conversely, a supportive environment, coupled with an understanding of how to recognize and properly manage personal bereavement, can assist nurses to avoid early burnout (Dorz et al., 2003) and compassion fatigue (Abendroth & Flannery, 2006). When supported in time-sensitive and helpful ways, nurses can create a culture of wellness and self-respect that gives them a wider range of interpersonal functioning and greater resiliency.

At the mid-Atlantic university teaching hospital where the current study was conducted, the turnover rate of oncology nurses had been increasing steadily from 13.3% in 2001 to 16.7% in 2004. The use of agency nurses to fill vacant positions over prolonged periods of time had become standard practice for the gynecology-oncology inpatient unit. Nursing administration at the hospital was aware of the fact that staff expended significant physical and emotional energy in caring for their patients. Administrators also were aware that nurses experienced acute or latent feelings of loss, grief, or a perceived loss of meaning in situations with undesirable outcomes including, but not exclusive to, death.

The hospital staff understood that strategies to assist oncology nurses in managing the stress of work-related bereavement should be tailored to specific work settings, and a need existed

to explore factors to build resilience among nurses at risk for compassion fatigue (Sabo, 2008). Therefore, administrators, nursing staff, and faculty from the university teaching hospital's National Cancer Institute–designated comprehensive cancer center and the affiliated school of nursing collaborated on a study designed to inform a planned program of support for oncology nurses encountering situations involving bereavement and loss. The current study was designed using focus groups to identify issues surrounding work-related bereavement, characterize current support, and elicit participant suggestions for supportive interventions for managing bereavement and loss.

## Methods

Focus groups were conducted with a voluntary sample of staff nurses recruited from every inpatient and outpatient adult and pediatric oncology area in the university teaching hospital. In keeping with the specific aims, groups were constructed to help the study team characterize challenges regarding work-related bereavement and nurse perceptions of existing support for managing loss. Participants also were asked to provide suggestions on how to improve existing support in bereavement situations.

Focus groups have become an increasingly popular method for nurse researchers interested in eliciting attitudes and opinions of target populations regarding sensitive or underinvestigated topics (Barbour, 2005). This highlights the ability of focus groups to facilitate efficient data collection and elicit participant views related to experiences involving motivations, feelings, attitudes, and opinions on key issues (Burns & Grove, 2005; Madriz, 2000). Advantages of using focus groups include (a) being less intimidating than one-on-one interviewing but providing more depth than questionnaires, (b) having sensitivity to participants' culture and age by acknowledging participants as experts, (c) obtaining insight into participants' own language and concepts, (d) allowing group interactions, (e) permitting researchers to learn more about the degree of consensus on a topic (Barbour, 2005; Burns & Grove, 2005), and (f) encouraging dialogue and dialectic (i.e., the exchange of ideas, arguments, and counter arguments) between researchers and participants to mutually identify, describe, analyze, and attempt to resolve key issues (Agar, 1999). Those insights can be used to develop programs that strengthen nurses' coping skills to reduce stress, foster supportive work relationships, and reduce burnout (Hellgren, Naswall, Sverke, & Soderfelt, 2003; Shaha & Rabenschlag, 2007).

## Study Procedures

Electronic, written, and verbal communications were used to encourage nurses to volunteer for the focus groups. Staff nurses were encouraged to notify their nurse managers of their desire to participate. Nurse managers also identified potential staff nurse participants for each focus group based on unit staffing needs and nurses' years of oncology nursing experience. The latter criterion was essential to ensure that the stresses and support needs of oncology nurses were appropriately identified across the full spectrum of experience. Participants were allowed to count focus group attendance as work hours and were paid commensurately, with assurance from their nurse managers that staffing would be provided to allow for group participation. Sign-up sheets posted in work areas were helpful for

estimating focus group size, although signing up was not considered binding. A reminder notification system for all participating units also was implemented; however, some nurses who signed up did not attend.

The seven focus groups that were held consisted of four to eight participants each (N = 34) and included staff nurses with varied levels of skill and experience from every inpatient and outpatient unit of the cancer center. Optimal group times were soon before or after shift changes, in the early afternoon, and around lunch or dinner time. A light meal was served as a small incentive. On arrival, participants received an oral consent and a copy of the focus group interview guide. Oral consent was obtained following procedures approved by the institutional review board. As part of the oral consent process, permission was sought from all participants to tape-record the focus groups. Sufficient time was provided to allow all participants to carefully read through the consent document and to ask questions before the start of focus groups. To ensure confidentiality, study team members who were not likely to be in direct contact with participants were selected to lead the groups. Participants self-selected pseudonyms that were used throughout the focus groups.

Study assistants met prior to the focus groups to strategize group procedures and to assign primary responsibilities for running the sessions. Specific procedures and steps followed throughout the study have been detailed elsewhere (Shaha, Wenzel, & Hill, 2011). In this way, the study members were prepared for and able to appropriately manage issues that arose through having nurse participants talk about difficult experiences of loss.

During the focus groups, the moderator began by asking participants to describe a patient situation in which they experienced either grief or a sense of loss. Next, participants were asked to describe what was helpful and what was less helpful in managing the bereavement issue. Finally, the moderator asked participants to describe what they believed would be the essential components of a program to help nurses in a similar situation. The moderator supplemented each major question by using transition and clarifying, challenging, and probing questions to yield more accurate and in-depth responses. Open-ended comments also were solicited from participants at the completion of each group. Focus groups lasted about 45 minutes to one hour, excluding a 10-minute warm-up.

## Data Analysis

Content analysis frequently is applied to focus group data and allows for quantitative assessments in conjunction with categorical descriptions of the major ideas and opinions expressed (Burns & Grove, 2005; Curtis & Redmond, 2007; Mansell, Bennett, Northway, Mead, & Moseley, 2004; Mayring, 2002, 2007). After focus group data were recorded and professionally transcribed verbatim, open and selective coding was applied to identify categories and themes related to the burden of everyday nursing care (Kean, 2000; Rabenschlag & Shaha, 2007; Shaha & Rabenschlag, 2007). Data analysis included the use of ATLAS.ti and Folio Views<sup>®</sup> software packages. Thematic analysis then was applied to focus group transcripts to obtain a better understanding of all concepts and issues identified by nurse participants. Field notes were maintained to record study team members' observations and perceptions of participants and events as well as insights related to each of the focus groups. Pairing content analytic approaches with thematic analyses allowed the

study team to effectively extract themes emerging from the focus group data (Cutcliffe & McFeely, 2001).

## Findings

Analysis led to the identification of two themes. The first, dimensions of work-related loss, was divided into three categories: losing life and hope, job-related factors that exacerbate bereavement and loss, and outsider misperceptions and misunderstandings. The second theme, working through bereavement, represented resources and relationship issues as being subsumed into three categories: individual strongholds, team strength in debriefings and dialogues, and renewal through patient and family relationships. Those themes and related categories have been presented in order of predominance and emphasis by participants across focus group discussions. Finally, participants' recommendations for improving organizational levels of support were provided (see Table 1).

### Dimensions of Work-Related Loss

**Loss of life and hope**—The oncology nurse participants acknowledged that work at a large teaching facility was personally, physically, and psychologically demanding (see Figure 1). They also perceived that aspects of the care environment were insufficiently supportive to meet those higher demands. According to the nurses, patient situations could be stressful and demanding and they did not always perceive effective support to be available or accessible. Rapid deterioration of a patient's health condition or sudden death was particularly difficult for nurses to accept and manage. Nurses' descriptions of situations in which they experienced patients' rapid deterioration of health conditions were rife with feelings of helplessness and frustration. In those situations, negative emotional states were exacerbated by limited time to process and manage feelings of loss. Time typically was limited by the pressing needs of other patients and the unit, which could be especially difficult to balance because of nurses' preexisting sense of loss. In addition, nurses experienced a loss of hope and feelings of discouragement when patients were diagnosed with recurrences. If untempered, those emotional losses were described as negatively affecting nurses' ability to remain positive in subsequent patient-related situations. One nurse said, "It is hard to be this person that offers hope in the beginning. . . . It gets harder and harder to offer that."

During situations in which disease progression occurred and patients were perceived to be at the end of life, nurses described conflicting feelings regarding perceptions of what one nurse referred to as "last-ditch effort(s)." She explained, "They want to try everything they can." Another nurse stated, "I think there's always that little bit of extra optimism—that little bit of extra hope." Prolonged attempts to sustain the lives of acutely ill patients near death, whether directed by the patients themselves, family, or providers, clearly were draining for nurse participants, created conflicting feelings about the care delivered, and were associated with feelings of dissatisfaction related to patients' experiences at the end of life.

The last-ditch efforts provoked moments of feeling helpless or overwhelmed for the nurses. For example, one nurse recalled, "I think what was difficult in my situation was that we were unable to give him [help]. You know, stopping the chemo[therapy] and sending



someone home for a week or two before they die, or helping them through the dying process.” One nurse’s statement appeared to capture the overall sentiment of those discussions: “I felt kind of helpless in a way.”

Close attachments that developed when caring for patients over time also enhanced feelings of grief and loss. When nurses developed close relationships with patients and their families, they found it much more difficult to accept the end or to move on to the next patient. In remembering a particular patient, one nurse said, “I think everyone had gotten so attached to him—we really did feel a loss.” Some nurses reported trying to avoid close attachments. Another nurse echoed, “Usually I don’t do that, because it’s not good to get so attached all the time.”

**Job-related factors that exacerbate bereavement and loss**—Nurses perceived specific challenges and enhanced burden related to working at a large teaching facility and caring for very ill patients, many of whom were at the end of life and still receiving chemotherapy and radiotherapy. One nurse said, “Working in a tertiary university institution is stressful and demanding. Little time remains for respite or recreational breaks.”

Coupled with those demands, nurses often reported days that were so busy that they could barely find time for a break. One nurse said, “The unit is just so busy that it’s like you don’t have time to even sit down and be upset about something and process it.” They described how this lack of time to “defuse” and the inability to find the necessary time or space to rest exacerbated difficulties related to bereavement. A nurse said, “It would help . . . to have, like, time during the day.” Another added, “On the average day, I think people should be allowed to leave and not feel guilty.”

Collaborating with ancillary staff and other healthcare professionals within the organization occasionally was perceived to be burdensome. One participant explained, “The unfortunate part about the ancillary staff is they’re not—they don’t get to see the patients and the families and have the humbling experience it is to take care of somebody who is dealing with something like a chronic illness.” Nurses believed that improvement in system-level processes and interactions with ancillary staff would increase their own work satisfaction and decrease frustrations, particularly while simultaneously balancing patient needs and self-managing work-related losses.

Participants identified nursing care issues involving other healthcare professionals. In one nurse’s words, “I think it’s frustrating, too. Sometimes you’re dealing with other departments, and you sit there and you think: ‘Do we all work for the same place?’” Participants believed that the high demands on their job were not necessarily conducive to an efficient and effective work environment. Added worry and time spent to resolve those issues was perceived as an additional burden that was detrimental to helping nurses find balance between loss and the ever-present demands of caring for patients with cancer.

Although nurses recognized the caring intent of other healthcare professionals, they also identified difficulties in communicating with personnel outside of nursing, particularly

medical colleagues. Physicians often were perceived to be distant from the nurses' environment and perspectives, which resulted in misunderstandings and potential conflicts.

**Outsider misperceptions or misunderstandings**—Overall, nurses found it difficult to unburden themselves outside the hospital. Many did not believe that “outsiders” could really understand the issues that they had to face at work. In the participants' experiences, outsiders often depicted oncology as alien and extraordinary. In addition, the actual amount of work that nurses had to complete and the kind of work they did all day often were difficult for others to understand. One nurse explained, “I think it's more frustrating to talk to—it makes me more upset to talk to people who don't get this.” Another added, “Or they say—oh, you work with kids, you play with kids all day.” Therefore, nurses' ability to effectively communicate their experiences with others outside of the profession constituted a deficit of support in their personal lives.

### Working Through Bereavement

In spite of numerous barriers to effective management of bereavement issues, oncology nurse participants also identified a number of perceived facilitators of support. (see Figure 2).

**Individual strongholds**—The first category encompassed all individual measures that nurses in the study described as beneficial. The nurses' daily routines constituted a high work load with little time left for critical reflection. Lack of time to ponder certain issues was considered by some nurses to be beneficial and supportive to their coping.

Participants reported accessing various coping resources, such as religion and faith or sports. In one nurse's words, “I'm also religious and like, I know that [the patient is] going to a better place and isn't suffering so much.” Another stated, “I take a lot of baths. Just other things to pamper myself. I do, like, massages and things like that, and just relax. And I do have quiet time.” Nurses also reported other coping strategies, such as limiting the amount of time spent talking about work at home.

**Team strength in debriefings and dialogues**—For all nurses, the healthcare team was a potential resource for managing bereavement. “So, yeah to have people who are in your same situation is very, very helpful,” said one nurse. Another reported, “I had a lot of team support, like our unit and everything.” Not only did colleagues experience the same situations together, but they also benefited from discussing those events with one another, which allowed them to debrief and reduce their collective stress. One participant stated, “I have certain people on my unit that I find easier to talk to that I can kind of vent.”

On every unit in this particular cancer center, each nurse had an assigned preceptor or mentor. The mentor was another member of the team whom the nurse could turn to for guidance and support. The role was considered by some nurses to be beneficial in dealing with the rigors and stress of oncology nursing. Nurses also commented on the advantages of the multidisciplinary team.



Debriefing sessions with a psychiatric liaison nurse or members of the pastoral care team were another helpful source of support identified by some nurse participants. One participant stated, “We also have unit debriefings whenever someone passes away. We have our bereavement coordinator and things that come and we sit and we talk.”

Depending on the unit, nurses would request pastoral care or ask the psychiatric liaison nurse to arrange a debriefing session following a loss. In particular, the psychiatric liaison nurse would sometimes hold rounds. During those rounds, nurses were able to bring up discussion topics of their own. One participant shared, “I know many years ago we had, like, a regular opportunity to have what we used to call psychosocial rounds, and we had a regular time and a regular person who used to come to the unit. And I think we all looked forward to it.” However, the usefulness of this strategy was individually determined, as participants recognized that not everyone found those opportunities to be helpful. Debriefing sessions and psychosocial rounds were considered helpful, as described by a nurse who said, “It was phenomenal . . . just knowing you would have that outlet [psychosocial rounds] on a weekly basis, I just thought that was really valuable. I would love to see something like that started again.”

**Renewal through patient and family relationships**—Nurse participants believed that their relationships with patients helped them put their work into perspective and supported their ability to derive some meaning from those difficult situations. Nurses also experienced support from patients’ families, particularly when the families maintained contact with the nursing staff. As one nurse pointed out, “I mean some parents try to keep in touch, and some people, some families keep in touch for years.” Another stated: “Even after the family member has passed on, the family will come back to the unit.” Those nurses described enjoying close associations with the patients and their families.

The nurses also faced certain difficult expectations from patients. A participant said, “They want that kind of exuberance and crazy optimism [from you].” Patients did not always want a completely realistic presentation of the future from their nurse. Nurses reported the challenge of having to be empathetic, supportive, and nonjudgmental while also maintaining a sense of the realistic outcomes.

Close attachments to patients fostered relationships. “I think the helpful thing is that you know them really well,” said one nurse. Another participant described such a relationship: “Just a nice person, close to my age, you know, I think you often put yourself in that position and think how you would respond.”

Nurses identified that they were committed to “do the best job” for patients. Their work experiences with patients and families reinforced the commitment and also gave nurses positive feedback. One nurse said, “I felt like I was the right person there at the right time, and I just felt that I did my best job.” Another asserted, “You know you want to give [the patient] a positive feeling.” One nurse said, “I think we kind of get our internal kudos by the job itself.” Nurses were clear about their motivations, which they described as being a part of what attracted them to the specialty and also allowed them to remain in oncology despite the hardship of managing professional bereavement and loss.

### Suggestions to Implement or Supplement Organizational Support

Participants also were asked to describe various measures of support that the organization should provide or that were already in place and perceived to be helpful (see Figure 3). The suggestions ranged from individualized support and patient services to the creation of meditation rooms or quiet spaces on nursing units. Some nurses suggested that development of an inpatient hospice unit would be therapeutic for nursing staff, patients, and families.

Nurses also promoted having a regular opportunity to take a break and leave the floor. “I eat and I sit—I try and go outside. I clear my mind, I don’t think about things,” said one participant. Those opportunities were not always possible, but they were appreciated. “Last week, they [nurse colleagues on the unit] said they finally got off the unit—they were all excited—must have been about four or five of them, they were able to go to lunch,” a nurse shared. Some nurses took deliberate action to create breaks from the unit. Nurses identified currently existing support from the organization with regard to their education and careers; they also appreciated opportunities to attend conferences.

### Discussion

Oncology care offers rewarding challenges and the opportunity to develop meaningful relationships with patients and families, but the rewards are coupled with the reality that some patients eventually will pass away (Maree & Wright, 2008; Sehlen et al., 2009). Oncology care focuses on providing cure whenever possible, as well as comfort and palliative care in cases in which cure is not achievable (Bakitas et al., 2009; Goelz et al., 2010). In particular, the dilemma of cure and end-of-life care has been found to influence oncology nurses and contribute to high burden and stress (Rohan & Bausch, 2009; Sehlen et al., 2009). Nurses and other healthcare professionals operate in a high-technology environment where they encounter advances in medical and other research on a daily basis, which can be both exciting and stressful (Mukherjee, Beresford, Glaser, & Sloper, 2009). For all nurses, collaborative relationships with other healthcare professionals must be maintained to provide the best and most appropriate care for patients and their families, and those interfaces can become another source of stress. For nurses in the current study, the stress and difficulty of managing bereavement professionally was offset by their recognition of the importance of providing essential assistance to patients and families at critical times. However, study participants also commented on the amount of turnover and burnout they had witnessed in oncology settings, as well as the detriments to cancer care that occur when continuous professional bereavement and loss are not well managed.

Perceived deficits in support emerged as one finding, highlighting the fact that oncology nurses’ levels of support may be too low to manage bereavement. Therefore, the participants experienced distress and discomfort that paralleled findings from previous studies (Mukherjee et al., 2009; Rodrigues & Chaves, 2008; Turner et al., 2007b; Williamson, 2008). A national survey e-mailed to Oncology Nursing Society chapter presidents (N = 103) found that the most common form of on-site professional resource for oncology nurses was an employee assistance program (60%), followed by the availability of pastoral care (50%) and access to a counselor or psychologist (22%) (Aycock & Boyle, 2009). However, 17% of survey respondents indicated an absence of on-site professional resources for

nursing staff. Among respondents who indicated resources were present at their institutions, many reported limitations to use or barriers to access. The finding suggested that even when professional resources are made available, institutions may need to ensure that nursing staff are aware of them and able to access them when needed (Aycock & Boyle, 2009).

Nurse participants in the current study also emphasized high personal and peer expectations for themselves and the quality of care they provided. Those definitions were inferred from the nurses' perceptions of their employing institution. Although the employer does not provide a generalized nursing mission statement, the institution has a high ranking in the United States. Focus group participants' elevated expectations for themselves were not a surprise given that the nurses worked at an institution globally recognized for its oncology care. Although a paucity of research has focused on nurses' individual perceptions and expectations of care delivery and its influence on burnout or resiliency, nurses in the current study perceived multiple internal and external pressures to perform. Treatments generally necessitate regular visits to the treatment centers, together with regular follow-ups, usually across five years. When patients experience recurrence, follow-up visits and treatment sequences can extend for long periods of time, and close relationships between patients, families, and healthcare professionals often result. In addition, end-of-life care fosters close attachments among patients, families, and healthcare providers, independent of time.

Despite the advances in cancer care, oncology healthcare providers are aware that cure and patient survival can be limited. A large number of patients encountered by oncology professionals will pass away at some point. Therefore, the transitory nature of life is highlighted in oncology (Kearney, Weininger, Vachon, Harrison, & Mount, 2009; Lee, Cohen, Edgar, Laizner, & Gagnon, 2006; Quinal, Harford, & Rutledge, 2009; Rohan & Bausch, 2009; Sinclair & Hamill, 2007; Turner et al., 2007a, 2007b, 2008, 2009). However, issues of loss and bereavement continue to be insufficiently addressed in the oncology workplace. The inclusion of death and dying and content on grief and bereavement has been recommended for nursing curricula (Byrne & McMurray, 1997); the current study's findings support the importance of emphasizing those issues for nurses. Despite the recommendations, Aycock and Boyle (2009) found that 45% of nurse respondents indicated they had not received education or skill-development opportunities addressing work-related coping. In addition, only 30% of respondents indicated they had received periodic in-services related to workplace coping, the most common type of education offered. Although End-of-Life Nursing Education Consortium (ELNEC) courses are considered a mandatory requirement for preparing new nurses, no survey respondents indicated that the courses were mandatory at their workplaces, and only 17% reported that optional ELNEC courses were available. Therefore, nurses across the United States appear to experience a lack of educational resources that address their concerns related to workplace coping; the current study's participants also discussed this problem.

Nurses' experiences with work-related bereavement and grief are complex and different from other forms of grieving (Gerow et al., 2010). As demonstrated by the current study's findings, the deficits of support for nurses dealing with loss and bereavement issues in oncology settings are numerous, multilevel, and varied. However, evidence shows that addressing concerns similar to those described in the current study can improve job

satisfaction and decrease the health-impairing consequences of compassion fatigue, such as burnout (Quinal et al., 2009).

Discussions with nurse participants concerning perceived deficits of support resulted in a number of concrete suggestions to improve the management of bereavement at multiple levels. The participants were notably more focused on enhancing personal resources and on the general work environment in their recommendations for managing bereavement than on educational interventions. Not surprisingly, end-of-life and palliative care issues were a distinct and important component of oncology nurses' discussions in the context of their care.

### Limitations

Participants were not individually evaluated or followed over time. Therefore, interpretations based on the particular bereavement and loss situations related to each participant should be interpreted with some caution. The study had potential for differential recall bias among participants because conducting all groups immediately following or at the time of a grief or bereavement experience was not possible. Despite limitations to the overall sample size, data saturation was observed. Pairing content analytic approaches with thematic analyses allowed the study team to effectively extract themes emerging from the focus group data (Cutcliffe & McFeely, 2001). The current study focused on the nursing staff of one large U.S. teaching hospital, which may differ considerably from other healthcare environments. No objective measures of participants' levels of bereavement or underlying depressive or mood distress were collected during the study, but screening for underlying depressive or mood disorders should be considered by researchers investigating similar topics in the future. Demographic information was not collected to increase confidentiality for the nursing staff, which limited opportunities to comment specifically on issues such as years of oncology experience, age, and level of education. The inability to create groups separated by specialty because of recruitment challenges and limited sample size increased diversity in the group discussions but also prevented the authors from drawing comparisons between specialties (e.g., differences between pediatric and adult oncology care settings). However, although services available might have differed across settings, bereavement and loss experiences were very similar in the way they were described by participants. In addition, the inclusion of participants from all areas increased the transferability of the findings.

### Conclusions and Implications for Nursing Practice

The current study's findings enhance the understanding of the loss and bereavement experiences of oncology nurses and lay a foundation for designing appropriate interventions to assist nurses in managing those situations. Overall, information from the current study may assist nurses, organizations, and policymakers by facilitating a better understanding of the challenges and competing issues involved in managing bereavement and loss in oncology nursing staff. The current study also specified the types of support nurses should be encouraged to access in an effort to pursue professional and life goals while simultaneously providing competent and compassionate care to patients, families, and communities. Nurses, administrators, managers, and all individuals interested in providing

the highest standards of oncology care are challenged to create and maintain mutually supportive environments.

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**Loss of Life and Hope**

To see [a patient] lose that [life] and to struggle to try and hold on to it and not be able to . . . you know, was the hardest part for me. We really didn't—weren't prepared for [death]. And he had a disease that we thought he was going to be able to recover from.

I think what we experience regularly, unfortunately, is people getting the news that their hopes are being dashed, because they're being told that their follow-up shows that their cancer has recurred.

There's nothing else we can do. . . . You know, make sure that their pain is under control. Just make sure their symptoms [are under control]. If they're going to hospice, make sure they're going to a good place. Or if they're going home, that they have things set up for them when they're at home.

**Job-Related Factors That Exacerbate Bereavement and Loss**

Realizing that you know [at the hospital], we have some of the sickest patients and so keeping that in perspective—that not everyone with cancer dies.

I think one of the problems we had on our unit—someone had passed away . . . take the person to the morgue; and you come back and you have an admission—put a person in the same room. You didn't even get over [the patient's death].

Sometimes I eat my lunch [outside the unit]. [I] used to go to the second floor cafeteria. That was good. But everyone is talking so loudly there that it's not very peaceful.

You want to give this medication, it's not there, so you have to call the pharmacy and then in half an hour it's still not there. You have to call them and you have to call the blood bank about this and just all these things. You can't just check it off your list a lot of times. And that's really frustrating to me.

I just feel like [physicians] are in their own little world, and we have our own little world. You know we can work together. That's fine. But it's not like we can sit down and talk about things.

**Outsider Misperceptions or Misunderstandings**

I don't [know] about anyone else's family, but I talk to my husband and he has no idea what I am talking about.

They'll say, "I don't understand why you do it." They'll say that, and I hate that. . . . They'll say, "I can't believe you do it. I could never do that." And you really don't want to hear that, either.

**Figure 1.**  
Quotes From Oncology Nurses on Dimensions of Work-Related Loss

### **Individual Strongholds**

But then I feel like that sometimes that [being busy] helps to shelter me from having to deal with that emotional—you know—on a day-to-day basis, and it kind of like helps me . . . being busy, helps me to just focus on my work and not think about what's actually happening to this person.

I know a lot of people that use like physical exercise and things as an outlet. Some people get something out of going to the gym—running, doing things like that to kind of try to relieve stress.

I allow myself 10 minutes to talk about work when I get home. Because if I don't, and often my husband really instilled this, but it probably is good because I could go on forever and not leave work at work. It's hard to do that. I force myself to talk about it with my husband and whatever happened during the day for 10 minutes and then that's it. And then we move on with what's going in our personal lives. I try to exercise, I try to play with my dog, I try and focus on positive things in my life.

### **Team Strength in Debriefings and Dialogues**

I can just think about having a group and talking about it and validating each others' feelings and giving you a sense that what you were doing is meaningful and does help people.

We had a very good support between the social worker that was on our floor [and] another nurse that was working. I felt like the three of us really worked well as a team. We had good physician support in this case.

Well, the social—I like our social worker—he's good . . . I think we use a lot of humor . . . at least between us and some other people on the unit to help lighten situations.

We had a pastoral counselor come in and talk to us after that particular [event] that I'm talking about, and people didn't like it. And I asked them why, and I think it's because they didn't know the person that came to lead the discussion. They didn't feel comfortable—they said that they would rather have just a group and because we all work together it would be everyone that you knew and then you could talk about it, and they said that they would get more out of that than having someone come that they didn't know.

### **Renewal Through Patient and Family Relationships**

This one man, he had Hodgkin's and got treatment, and then I think he was good for like a year. And then he got acute myeloid leukemia from the chemo associated with the Hodgkin's, and he came back in. And I was there with him for his first bone marrow biopsy and he's just so wonderful, and his family was so wonderful and supportive.

**Figure 2.**  
Quotes From Oncology Nurses on Working Through Bereavement

I would love someday for [the hospital], for us to have our own inpatient hospice that these people could transition to that we would be able to follow through, at least go and visit or rotate to even work in that area certain times.

You know, we actually set up something. Our unit went through a renovation and we actually moved over to another unit, and while we were on that other unit, we had set up a little room, in the back of the locker room.

Physical resources that we have access to, you know, so many things now that we have a minute's notice on the Internet and that kind of thing. You know if you express the desire to go to a conference or just do some things.

**Figure 3.**

Quotes From Oncology Nurses on Improving Organizational Support

**Table 1****Participant Suggestions for the Management of Nurse Bereavement**

| <b>Suggestions for Nursing Support</b>   | <b>n</b> |
|--|----------|
| <b>Creating time and space for staff self-care (N = 43)</b>  |          |
| Reinforcement and support for breaks to get away   | 16       |
| Recognition, training, and support for individualized coping methods (e.g., defense building, outside activities, nurse or family support, physical exercise, faith or religion) | 12       |
| Unresentful coverage without invoking guilt  | 7        |
| Comfort space proximal to but off the unit   | 6        |
| Contact with nature, going outdoors on breaks, and sun lamps to promote natural light  | 2        |
| <b>Counseling or communicating with others who understand (N = 28)</b>   |          |
| Support from other team members and talking with fellow nurses on the unit   | 15       |
| Unit debriefings with a bereavement coordinator, pastoral counselor, or social worker  | 9        |
| Psychosocial rounds and availability of counselors   | 4        |
| <b>End-of-life issues and hospice or palliative care (N = 26)</b>  |          |
| Interdisciplinary teams and improved collaborations  | 14       |
| In-hospital hospice units or communication between hospital and hospice after discharge (care continuity)  | 4        |
| Supporting patients' positive attitudes while maintaining reality of impending death   | 3        |
| Acceptance of patient or family decisions regarding treatment  | 3        |
| Time to grieve immediately following a loss  | 1        |
| Better understanding or acceptance of personal perspectives related to death   | 1        |
| <b>Quality time with patients and families (N = 19)</b>  |          |
| Streamlining paperwork and improving staff collaboration to provide quality time with patients and families  | 15       |
| Proximity and time to see patients in follow-up, care continuity, and better health  | 4        |
| <b>Acknowledgment and reinforcement of nurses' special efforts (N = 12)</b>  |          |
| Opportunities to follow patients (e.g., patient newsletters, obituaries, cards, funeral attendance if desired)   | 10       |
| Annual tribute services for patients who have died   | 1        |
| Thanks and acknowledgment from institution for nurses' contributions to care   | 1        |
| <b>Work structures, work processes, and organization (N = 8)</b>   |          |
| Tangible support offered by cancer center (e.g., National Nurses Week recognition, massages)   | 4        |
| Increased nurse control over schedules (e.g., regularity, predictability, getting off work on time)  | 2        |
| Building knowledge infrastructure through the Internet, reading environments, and access to evidence-based practice resources and research                                       | 2        |