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Review Paper

Grief, Loss, and Bereavement in Cancer Care: A Psycho-Oncological Review

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ABSTRACT

When a patient receives a cancer diagnosis, grief does not wait for death to begin. It starts at that very moment and it extends far beyond the patient themselves, creeping into the lives of their families and caregivers as well. This review looks at grief in cancer care across the full illness trajectory, from the anticipatory grief that begins at diagnosis to the bereavement that can persist for years after a loss. The paper examines this through three theoretical frameworks: The Kübler-Ross Stage Model, the Dual Process Model, and Attachment Theory and how grief shows up differently in patients, families, and caregivers. Drawing on peer-reviewed research published between 2015 and 2026 in journals including JAMA Psychiatry, Psycho-Oncology, Palliative and Supportive Care, Healthcare, and the European Journal of Psychotraumatology. The intervention strategies reviewed include Cognitive Behavioral Therapy, Mindfulness-Based Interventions, bereavement support groups, and Family-Focused Grief Therapy. The review aims to portray that grief in cancer care is central to the experience of illness, and it deserves to be treated that way.

Keywords: *Anticipatory Grief, Bereavement, Cancer Care, Complicated Grief, Prolonged Grief Disorder, Psycho-Oncology, Family-Focused Grief Therapy*

A cancer diagnosis reshapes nearly every aspect of a person's life – their physical health, their roles, their relationships, and their sense of who they are and where they are going. And with that comes grief, often long before any death occurs. According to Bray et al. (2024), cancer accounted for approximately 9.74 million deaths worldwide in 2022 alone. But what is sometimes overlooked is that grief in cancer is not just about death; it begins at diagnosis, it builds through treatment and it lives in the waiting rooms and the scan results as well as the side effects. Weiss et al. (2015) described it well when they noted that cancer-related grief encompasses anticipatory, concurrent, and post-death bereavement, each form carrying its own weight.

What is also striking is how grief in this context is not only the patient's burden but also of the family members watching a loved one deteriorate, caregivers making impossible decisions, and even healthcare professionals, Wandke et al. (2025) found in a scoping

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review published in Psycho-Oncology that oncology staff themselves experience grief following patient deaths.

And yet, Mattson et al. (2025) found in a systematic review in Healthcare that grief is still under-assessed in routine oncological care. Most screening tools look for depression and anxiety. They do not ask about grief specifically. This means that a large number of patients and caregivers who are grieving are not identified, referred, and helped. This review aims bring together the current evidence on what grief in cancer care actually looks like, and what we know about how to address it.

THEORETICAL FRAMEWORKS FOR UNDERSTANDING GRIEF IN CANCER CARE

The Kübler-Ross Stage Model

Most people have heard of Kübler-Ross's five stages of grief — denial, anger, bargaining, depression, and acceptance. First proposed in 1969, this model has shaped how clinicians, patients, and families think about grief for decades. For many people facing loss, being told that what they are feeling has a name and is a recognized part of grief can be genuinely comforting. The framework helped bring the emotional experiences of dying and bereavement into medical and psychological conversations in ways that had rarely been acknowledged before (Kübler-Ross, 1969).

At the same time, contemporary grief research has highlighted important limitations of the model. Grief rarely unfolds in a predictable sequence of stages. People often move back and forth between different emotional states, experience multiple reactions simultaneously, or skip certain reactions entirely. Empirical studies of bereavement show that individuals follow diverse grief trajectories rather than a uniform progression, with patterns ranging from resilience to chronic grief or fluctuating distress (Bonanno et al., 2002; Avis et al., 2021). Scholars have also noted that presenting grief as a fixed sequence can unintentionally make people feel as though they are grieving "incorrectly" when their experiences do not match the model (Avis et al., 2021). As a result, many contemporary researchers describe grief as a dynamic and highly individual process shaped by personal, relational, and contextual factors rather than a set of universal stages.

Seen in this light, the Kübler-Ross framework remains useful not as a strict roadmap but as a language for beginning conversations about loss. When used flexibly, it can help people recognise common emotional reactions while still acknowledging that the experience of grief is complex, nonlinear, and deeply personal (Avis et al., 2021).

The Dual Process Model

The Stroebe and Schut's (1999) Dual Process Model proposes that bereaved individuals move back and forth between two orientations. The first is loss-orientation, sitting with the grief itself, processing the pain, confronting what has been lost. The second is restoration-orientation, dealing with life's practical demands, finding new roles, rebuilding a sense of who you are without the person you have lost.

This model does not treat avoidance as a failure. Stepping away from grief temporarily to manage a household, to go to work, to care for a child is actually part of healthy adaptation. Madsen et al. (2025), in a qualitative study published in Nurse Education in Practice, found that families caring for a dying loved one at home moved back and forth in exactly this way, shifting between processing their grief and getting on with immediate care demands. This oscillation is not a weakness. It is how people cope.

Attachment Theory

Research in psycho-oncology and palliative care similarly highlights how attachment relationships shape psychological responses to serious illness. When cancer threatens the continuity of close relationships, attachment processes become activated, influencing how patients and caregivers experience distress and provide support to one another (McPherson & Devereaux, 2024). Within this context, family members often begin to grieve even before death occurs. Caregivers frequently experience anticipatory or pre-loss grief as they witness the progression of illness and the gradual changes in the person they love (Lee et al., 2025; Klikovac et al., 2024), and relatives commonly report grieving the expected loss while the patient is still alive (Sørensen et al., 2024).

Coelho et al. (2020), in a qualitative study in Qualitative Health Research, described anticipatory grief in family caregivers of terminal cancer patients as involving two overlapping forms of distress: traumatic distress from being exposed to life-threatening illness, and separation distress from facing permanent loss. Both of these map directly onto what Bowlby described. And from a clinical perspective, this matters, because how a person is attached may predict how they will grieve. Research suggests that a person's attachment style may shape the way they experience and process grief, with insecure attachment often associated with greater emotional distress and a higher likelihood of complicated bereavement (Fraley & Bonanno, 2004; Meier et al., 2013). Assessing attachment style early could help clinicians identify who is at greatest risk for complicated bereavement.

GRIEF EXPERIENCES ACROSS THE CANCER TRAJECTORY

Anticipatory Grief in Patients and Families

Anticipatory grief is the grief that begins before a loss occurs. In cancer care, it often starts at diagnosis. Walbaum et al. (2024) conducted a systematic review and meta-analysis of 31 studies involving 5,558 family caregivers of patients with advanced cancer, published in Psycho-Oncology, and what they found was that among caregivers, pooled prevalence of pre-loss grief was 24.0% (95% CI [18.0–30.0]). Death anxiety was even more prevalent, at 57.0% (95% CI [37.8–76.2]). And hopelessness was present in 35.2% (95% CI [28.2–42.2]). More than half of caregivers in these studies were experiencing death anxiety. That tells us something important about the scale of the need.

Li et al. (2023), in a study published in Frontiers in Psychology using Structural Equation Modelling with 624 caregivers of elderly cancer patients in China, found that caregiver burden directly increased anticipatory grief, and that this relationship was partly explained by reduced family functioning and resilience. In other words, when the burden is too heavy and the family is struggling to cope, grief gets worse. This suggests that if we want to reduce anticipatory grief, we need to reduce caregiver burden and that improving family resilience is not just a nice idea but a clinical necessity. Madsen et al. (2025) found something similar; families caring for a dying loved one at home quietly set aside their own needs, realising there was no hope of recovery, while continuing to provide care. Their grief was happening in the background, unspoken and unaddressed.

Grief in Cancer Patients

Cancer patients grieve the loss of their health, their identity, their plans, and sometimes their sense of a future at all. Mattson et al. (2025) reviewed 15 observational studies of cancer patients in Healthcare and found that grief was a consistent and significant burden with PGAC scale scores ranging from 26.7 to 44.5 and clinically significant prolonged grief

scores of 23.8 to 24.3 on the PG-12 and PG-13 in young adults with advanced cancer. These are patients who are still alive but already grieving deeply.

And yet, Mattson et al. (2025) also found that grief-specific screening is almost entirely absent from routine oncology care. Most psychosocial pathways focus on depression and anxiety in patients, and reserve grief interventions for bereaved relatives. This means that patients grieving their own illness,their own future are often missed entirely. That is a gap that needs to be closed.

Grief in Family Members and Caregivers

Family caregivers often absorb the emotional weight of cancer alongside the patient. As Weiss et al. (2015) described, caregivers experience loss and grief in their everyday lives while still providing care. They are grieving while the person is still there. Teo et al. (2025), in a prospective study published in Psycho-Oncology tracking 192 informal caregivers of terminal cancer patients from six months before death through six months after, found that elevated anxiety and depression during caregiving were significant predictors of poor bereavement adjustment later. This suggests that waiting until after a patient dies to offer psychological support may simply be too late for many caregivers.

After the patient dies, a different kind of grief sets in. The caregiving role which had given structure, purpose, and meaning to everyday life disappears almost overnight. What follows is not just grief for the person but grief for the self that existed in relation to them. Bartley et al. (2025), in a systematic review of 64 international bereavement care models published in Omega, found that only 14 of those 64 models included any formal assessment of complex grief. Most relied on bereavement packs, condolence cards, and one follow-up call. That is not enough and the data shows it.

Prolonged Grief Disorder

For some people, grief does not follow a healing trajectory. It becomes stuck. Prolonged Grief Disorder now formally recognised in the DSM-5-TR and ICD-11 is characterised by persistent yearning for the deceased, difficulty accepting the death, and significant functional impairment lasting beyond twelve months. LaPlante et al. (2024), in a systematic review and meta-analysis published in Behavior Therapy, estimated PGD prevalence between 9.8% and 34.3% in bereaved populations. The wide range likely reflects differences in how grief was assessed and when, but even the lower estimate is clinically significant.

People bereaved by cancer are at particular risk for PGD. Smith et al. (2025), in a service evaluation published in the European Journal of Psychotraumatology across five cohorts of 68 individuals bereaved by cancer, noted that the cancer illness trajectory with its terminal prognosis, visible deterioration, and often intense caregiving demands creates conditions that make complicated grief more likely. At intake into their group programme, symptoms of PGD, PTSD, depression, and anxiety were all significantly elevated. Teo et al. (2025) found that elevated psychological distress during caregiving was a key predictor of PGD later. Catching this early, through a simple screening tool like the PG-13 at oncology intake, could make a real difference.

Intervention Strategies for Grief in Cancer Care

No single intervention fits everyone. What works for a bereaved spouse in her sixties may look very different from what helps a young adult caregiver or a patient still undergoing

treatment. The four approaches reviewed in this paper have strong evidence behind them but choosing among them requires clinical judgment, not just evidence checklists.

Cognitive Behavioral Therapy (CBT)

CBT is the most thoroughly evaluated psychological treatment for grief, particularly for Prolonged Grief Disorder. At its core, CBT for grief works by identifying the thoughts that are keeping a person stuck; self-blame, catastrophizing, the sense that grief will never end and gradually replacing them with more realistic and adaptive ones. Alongside this, behavioral strategies like activation (re-engaging with meaningful activities) and gradual exposure help people face what they have been avoiding. LaPlante et al. (2024) reviewed 30 randomised controlled trials and found CBT to be the most frequently studied and effective modality, adaptable across individual, group, and online formats.

Lacasta and Cruzado (2024) tested Cognitive-Behavioral Group Therapy in a randomised controlled trial with 249 relatives of deceased cancer patients, published in Palliative and Supportive Care. The results were significant across the board improvements in complicated grief, depression, anxiety, hopelessness, and general health compared to a psychoeducational control group, at post-treatment, six-month, and twelve-month follow-ups.

Bryant et al. (2024) directly compared grief-focused CBT with mindfulness-based cognitive therapy in 100 adults with PGD, published in JAMA Psychiatry. Both produced significant reductions in grief severity. But grief-focused CBT was statistically superior at the six-month follow-up. Smith et al. (2025), in their five-cohort service evaluation in the European Journal of Psychotraumatology, reported effect sizes of $d = 0.65$ for PGD symptoms and $d = 0.53$ for self-compassion at three-month follow-up in cancer-bereaved individuals.

Mindfulness-Based Interventions (MBI)

Where CBT works by changing the content of thoughts, mindfulness works by changing one's relationship to them. The idea is not to eliminate grief but to sit with it without being consumed by it; to observe thoughts and feelings without getting pulled into cycles of rumination. D'Antoni, Mattiussi, and Crescentini (2026), in a systematized narrative review published in Healthcare, found that MBSR and MBCT both produced improvements in grief-related distress, depressive symptoms, and psychological well-being. Particularly notable was the consistent reduction in rumination across studies and rumination.

D'Antoni et al. (2026) concluded that MBIs work best alongside other grief-specific treatments rather than as stand-alone approaches for clinical PGD; a view supported by Bryant et al.'s (2024) RCT, which found CBT to be more effective at six-month follow-up.
Johns et al. (2024) found in a pilot RCT in BMC Palliative Care that a group-based mindfulness programme for patient-caregiver dyads improved quality of life and reduced avoidant coping. Patients and caregivers together, learning to be present.

Bereavement Support Groups

Support groups remain one of the most commonly sought forms of help after bereavement. When you are grieving a loss to cancer, sitting with others who have been through the same thing offers a kind of understanding that even the most empathetic clinician cannot always provide. The shared experience matters.

However, LaPlante et al. (2024) made an important point: simply attending a group where grief is discussed is not enough. To produce meaningful reductions in PGD, groups need

therapeutic structure. This was corroborated by Smith et al. (2025), whose structured CBT-based group produced significant improvements that a waitlist control group did not. The group format works but only if what happens in the group is more than shared distress.

Bartley et al. (2025) reviewed 64 international bereavement care models and found that structured follow-up support was associated with better outcomes for bereaved family members. But only 17 of 64 models considered culturally and linguistically diverse populations.

Family-Focused Grief Therapy (FFGT)

FFGT works at the level of the family system, addressing the communication patterns, conflicts, and cohesion deficits that can prevent a family from grieving together. And crucially, it starts before the patient dies during palliative care rather than waiting until bereavement begins.

Kissane et al. (2016), in a randomised controlled trial published in the Journal of Clinical Oncology, screened 1,488 patients and relatives at Memorial Sloan Kettering Cancer Center and enrolled 170 families into a three-arm trial. Among families who received 10 sessions of FFGT, only 3.3% developed Prolonged Grief Disorder at 13 months of bereavement. In the standard care arm, that figure was 15.5%. The families who benefited most were those with low communication and high conflict, exactly the families who are hardest to reach and most at risk.

Masterson et al. (2013), reviewing the model in Bereavement Care, described its core components as promoting open family communication, creating space for shared grief expression, and working through relational conflict. This matters especially in South Asian families, where the structure of joint family systems, and cultural norms around expressing grief openly, may make family-level intervention both more challenging and more necessary.

DISCUSSION

- **Grief in Cancer Patients:** Mattson et al. (2025) showed that patients themselves are experiencing clinically significant grief throughout their illness and most oncology services are not asking about it. Integrating a brief validated measure like the PG-13 into standard psychosocial assessment seems like a minimal and achievable change that could make a real difference.
- **Early Intervention:** Both Teo et al. (2025) and Walbaum et al. (2024) showed that how caregivers cope during the illness period predicts how they will cope after death. Kissane et al. (2016) showed that family-level intervention before death can reduce PGD incidence from 15.5% to 3.3%. The evidence is clear: waiting until bereavement to offer support is waiting too long.
- **CBT:** Bryant et al. (2024) in JAMA Psychiatry and Lacasta and Cruzado (2024) in Palliative and Supportive Care both found grief-focused CBT to be significantly effective. For clinicians working with bereaved cancer populations, this is the intervention with the strongest and most consistent evidence base.
- **Equity Gap:** Bartley et al. (2025) found that only 17 of 64 international bereavement care models consider culturally and linguistically diverse populations. For South Asian contexts where grief is expressed, shared, and managed differently this means most of the evidence base needs to be adapted rather than directly

applied. This is not a minor caveat; it is a significant challenge for clinical practice in settings like ours.

Future Research Directions

There are several areas where the field could require more research:

- Longitudinal studies that follow grief from diagnosis all the way through bereavement. Most current studies capture only a slice of this process. Understanding how anticipatory grief evolves into post-death grief and what factors shape that trajectory is essential for designing better care (Walbaum et al., 2024).
- Grief in cancer patients as distinct from their caregivers. Mattson et al. (2025) highlighted how little we know about how to assess and address it. Patient-specific grief protocols are largely absent from the literature.
- Digital and internet-delivered grief interventions are promising but evidence remains preliminary (D'Antoni et al., 2026). Larger, adequately powered RCTs with longer follow-up are needed before these can be recommended as standard care.
- The cultural adaptation of CBT, FFGT, and mindfulness programmes for non-Western populations is a priority. Bartley et al. (2025) found that 47 of 64 bereavement care models worldwide were not designed with culturally diverse populations in mind. Research examining grief in the context of cancer within India remains limited in the international literature. While a small number of studies have explored the psychosocial experiences of patients, caregivers, and bereaved family members, the broader psychological processes of grief and bereavement in Indian cancer populations remain relatively under-researched.
- Finally, the role of spiritual and religious beliefs in shaping grief particularly in South Asian contexts warrants serious academic attention. For many patients and families in India, faith is not peripheral to how they grieve. It is central.

CONCLUSION

Grief is not a complication of cancer care. It is an inherent part of it. It begins at diagnosis, runs through treatment, and continues long after a death has occurred — sometimes becoming so severe and so persistent that it becomes a clinical disorder in its own right. What I hope this review has shown is that we now have real, robust evidence about what grief in cancer care looks like and what actually helps.

The frameworks – DPM, Attachment Theory, Kübler-Ross – help us understand. The intervention – CBT, mindfulness, support groups, FFGT – help us act. But the evidence also shows us where we are falling short; we are not screening for grief in patients, we are not supporting caregivers early enough, and we are not designing care with cultural diversity in mind.

Changing that does not require an overhaul of the entire system. It requires a shift in how grief is seen not as something separate from cancer care, but as something at the very heart of it. Every patient grieving their own illness, every caregiver quietly falling apart while still showing up, every family trying to hold together in the face of loss they all deserve care that is designed with their grief in mind.

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Conflict of Interest

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