THE GRIEVING RESPONSE OF CERVICAL CANCER PATIENTS IN A REFERRAL HOSPITAL IN BANDUNG CITY

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ABSTRACT

The grief response could affect the treatment process and the condition of cervical cancer patients which directly gives impact on the patients quality of life. The medical practisers are responsible for helping the patients to pass through the grief process to prevent the adverse effects for the patients, thus it is necessary to know the condition of grief response as the data to analyze the problems and to plan the nursing interventions. This study purpose was to identify the grief response in cervical cancer patients at central hospital Dr. Hasan Sadikin Bandung. The research design was a quantitative descriptive by used the questionary of Preparatory Grief in Advanced Cancer Patients (PGAC) with the validity value of 0.823-0.864 and the reliability value of 0.83. The research sample was the patients of cervical cancer with the total number of 50 persons. The technique of sample selection used an Accidental Sampling carried out in the period of two weeks. The research result from 50 patients showed that most respondents (76%) had low grief and a small number of patients (24%) had severe grief which required further intervention. A big number of respondents (60%) had prolonged grief. The grief responses which mostly existed were the response of emotional sadness (58%), meanwhile, the lowest response was religious comfort response (16%). Although the majority of respondents experienced low grief response, there are still existed severe grief response and also experienced prolonged grief. The high response of sadness showed all the patients of cervical cancer needed emotional and spiritual support as the efforts to prevent the low grief become severe grief response and also to overcome the severe grief and it not to be the prolonged grief.
Keywords : Cervical cancer, grief response, preparatory grief.

INTRODUCTION

The incidence and mortality of cervical cancer are still high. According to GLOBOCAN (Global Burden Cancer) (2012), every year 528,000 new cases occur worldwide and 266,000 (50%) of them are declared dead. In Indonesia, cervical cancer has the highest prevalence, which is equal to 98,692 (61%) cases in 2013, with new cases every year as many as 15,000 and 8,000 (53.3%) among them declared dead (Nurwijaya, Andrijono & Suheimi, 2010). As for West Java, cervical cancer ranks first with an incidence of 15,635 cases (Ministry of Health, 2015). The data shows the high incidence of cervical cancer illustrates that many patients will experience loss and death that can cause patients to experience the grieving process.

When someone is diagnosed with cervical cancer, the individual experiences loss, both due to the disease's journey process and the effects of the therapy being undertaken. Losses due to the disease's journey process include physiological loss, sexual function loss (Lubis & Hanida, 2009). These losses are the source of the reason someone experiences grieving process.

Kubler Ross (1969, in Periyakoil, Kraemer & Noda, 2012) mentioned that almost everyone grieved when overcoming loss due to terminal illnesses such as cancer. Based on the results of Olver's study, Eliott, Long, McKinnon, and Rumsby (2012), emotional reactions that most often occur in 57.8% of 38 cancer patients due to side effects of illness or therapy, one of

them is grieving, Periyakoil's research, Creamer and Stain (2012), which states that 81% of 96 cancer patients grieve in overcoming possible losses due to cancer, Palnte (2008) study shows that women who have been diagnosed with gynecological cancer mourn and experience stress and sexual dysfunction.

Grieving is a holistic and multi-dimensional response. Mystakidou (2005) developed a theory regarding the grieving response, namely self-consciousness, disease adjustment, sadness, anger, religious comfort, somatic symptoms, and perceived social support. The perceived response is normally 6-12 months after diagnosis (Kaplan, Sadock & Grebb, 2010).

If the grieving response lasts more than 6 months, it is usually called prolonged grief. This grieving condition affects around 2-3% of the world's population (He, Tang, Yu, Xu, Xie & Wang, 2014). Prolonged grief with a heavy intensity (complicated grief) can cause other psychological problems in patients with cervical cancer itself. Based on the results of Periyakoil, Kraemer, and Noda (2012) study, 35.5% of grieving patients also experienced depression, Mystakidou's study, et al (2008) in 94 patients, grieving was associated with 34% cases of depression, 36.2% cases of anxiety, and hopelessness 57.3%, Hasanah (2015) research conducted in RSHS showed that 12.1% of cervical cancer patients had severe depression, 40.9% moderate depression and 42.4% mild depression, Ramdhani's study (2013) showed that 11.4% of cervical cancer patients experienced severe anxiety, 77.14% moderate anxiety and 11.4% mild anxiety. This shows that in RSHS psychological problems may be caused by grieving that is not resolved and occurs in most cervical cancer patients. In addition, grieving that is not resolved also increases suicide risk and decreases the quality of life for cancer patients (Zhang, El-Jahwari, Prigerson, 2006, in Strada, 2009)

In addition to the psychological impact, grieving could influence physiological conditions that would affect the body's system. According to the research of Buckley, Sunari, Marshall, Bartrop, McKinley, and Tofler (2012), there was an increase in adrenocortical activity by 30% in the group that experienced grieving compared to the group that did not experience grieving. The increased adrenocortical activity could increase the hormone cortisol. Research on 154 cancer patients showed high cortisol secretion was an independent factor associated with poor prognosis (Abiven, Coste, Groussin, Amract, Tisser, Legmann, Pousset, Bettagha & Bertherat, 2006). High cortisol had been identified as a potential mechanism for the initiation of ovarian cancer, cancer cell failure to performed cell death (apoptosis), and resistance to chemotherapy (Schrepf, Clevenger, Christensen, DeGeest, Bender, Ahmed, Goddheart, Dahmoush, Penedo, Lucci, Azar, Mendez, Markon, Lubaroff, Thaker, Slavich, Sood & Lutgen, 2012). In addition, natural killer cells, which are important defense agents against tumors and viral infections, also experienced a

reduction in the group that experienced grieving with high levels of depression and insomnia (Buckley, et al, 2012).

Other impacts also occurred in the cardiovascular system. The effects could be seen from clinical signs and symptoms such as changes in pulse and blood pressure. Based on the Carber (Cardiovascular Health in Bereavement) study results, an increase in pulse rate was associated with an increased in anxiety and cortisol (Buckley, et al, 2012). In addition to the pulse, a study conducted by Buckley, et al (2012) in 80 grieving individuals and 80 individuals who did not grieve showed that the grieving group had a higher systolic blood pressure than the not grieving group (130.3 mmHg vs. 127.5 mmHg). Increased pulse and blood pressure in grieving individuals significantly contributed to the increased risk of other health problems, such as the risk of cardiovascular problems (coronary artery plaque rupture and increased risk of coronary disease) and mortality in 14% of participants after controlling for other risk factors (Klzillbash, Daviglus & Dyer, 2008).

Bad effects that occurred due to the intensity of heavy grieving in the long term could be prevented by nurses. Nurses play an important role in reducing the grieving intensity in cervical cancer patients. One of the roles of nurses is as a caregiver. The caregiver is responsible for increasing comfort, providing emotional and social support and patient advocacy (Stajduhar & Cohen, 2009). The research results conducted by Ray, Block, Friedlander, Zhang, Mciejewski, and Prigerson (2006) state that the high acceptance phase and low grief in patients related to caregiver services were seen from the results of the quality of life context after grieving. In addition, nurses also act as educators. As a nurse educator helps explain to patients and families about the characteristics of pathological grieving responses, the grieving process inhibitors, and ways to reduce grief with therapies such as logotherapy and psycho-religious (Yosep & Sutini, 2009).

Based on Lacey's study results (2011), increasing the alertness of health workers to anticipating grief in cancer patients has the potential to reduce prolonged grief disorder and long-term morbidity. This can be achieved if nurses can correctly identify the response to the patient grieving, the possibility of prolonged grief disorder, and provides appropriate intervention in accordance with the patient's condition. But, in Indonesia, the grieving problem in patients has not been recognized as important and has not received attention properly, both in terms of research and care. In fact, in other countries such as America and Europe, grieving is a concern both in the field of research or care. American and European cultures tend to hide their emotional expressions and be more individualistic in overcoming grief. This is contrary to Indonesian culture, which tends to live in a way that is social, family or ethnic (Potter & Perry, 2010). These cultural differences can affect

how grieving responses in cervical cancer patients. Therefore, researchers conducted a study on "The grieving response of cervical cancer patients in a referral hospital in Bandung city ".

METHODS

The type of research used in this study was quantitative descriptive. In this study, researchers discover the grieving response in cervical cancer patients at Hasan Sadikin Hospital Bandung. The research approach used in this study was a cross-sectional approach where the researcher only took data once from each respondent.

The population of this study was all cervical cancer patients in Hasan Sadikin Bandung Hospital, which numbered 100 people in the last 1 month. The sample in this study were productive age women who had been diagnosed with cervical cancer. The sample selection method used by researchers in this study was non-random sampling or non-probability sampling with accidental sampling method. This sampling took place within 2 weeks. The minimum number of samples in this study was determined using a cross-sectional sample formula, namely binomial proportions with Solvin formula with a minimum number of samples of 50.

The instrument or measuring tools used to measure the grieving response in this study was a standard questionnaire, Preparatory Grief in Advanced Cancer Patients (PGAC) compiled by Mystakidou, Tsilika, Parpa, Katsoudan, Sakkas and Saldatos (2005) which was used in Athens, Greece in in 2005 and 2008 and in America in 2014. The instrument was in English and later translated into Indonesian with the procedure of back translation by 2 experts to prevent interpretation errors occurrence.

The type of questionnaire used was a closed questionnaire using a Likert scale, namely each question had four possible answers, namely strongly agree (SA) had a score of three (3), agree (A) had a score of two (2), disagree (D) had a score of one (1), strongly disagree (SD) had a score of zero (0) for negative questions and vice versa for positive questions. In this questionnaire, there were 31 questions. This questionnaire had 7 subscales namely self-consciousness, disease adjustment, sadness, anger, religious comfort, somatic symptoms, and perceived social support.

Validity test was done in two ways, namely Content Validity and Construct Validity. Content validity in this study was conducted by consulting each item in the instrument to the lecturers in Nursing Faculty of Padjadjaran University.

The construct validity instrument test results were valid with a validity value of 0.823-0.864. In addition, researchers conducted face validity to 10 people who had the same sample characteristics as the study sample to find out whether the questionnaire was understandable or not. Face validity was done at Dr. RSUP Hasan Sadikin Bandung. The results of face validity showed

that there were some questions that were not being understood, so the researcher added or changed the information without changing the meaning of the question.

The reliability test of the PGAC questionnaire was carried out using the Alpha Cronbach reliability coefficient and the result of its reliability value was 0.71 - 0.83 in each subscale so that this instrument could be said reliable.

The implementation phase included data collecting, data processing, data analyzing and concluding the results. The researcher has conducted a Proposed Examination then the researcher submits the requirements to conduct the research, the requirements were a research proposal, a research permit letter from the Nursing Faculty of Padjadjaran University. After the researcher obtained research permission from Dr. RSUP Hasan Sadikin Bandung, the researcher conducted research at Dr. RSUP Hasan Sadikin Bandung on May 18, 2016, until June 1, 2016.

Before the questionnaire sheet was distributed, the researcher explained the purpose and objectives of the research, the benefits, and the desired form of participation, the impacts, and possibilities that could occur during the research, the research benefits for the respondents and estimated time spent to fill in the questionnaire. After the respondent understood, the researcher asked for approval whether the patient was willing or not, the patient had the right to refused to participate in this study if the patient was willing, the researcher submitted the respondent's consent sheet to be signed. After signing the approval sheet, the researcher explained how to fill out the questionnaire to the respondents. The questionnaire answering was done by the respondent or assisted by the researcher by reading the question and marked the respondent's answer if the patient could not fill the questionnaire. Filling out the questionnaire took 10-20 minutes. Each filling out questionnaires was always accompanied by researchers to prevent misunderstanding and reduce bias in research. Researchers conducted this study without any secondary researchers. After the questionnaire was filled out by the respondent, the researcher examined the completeness of the answers so that if there was an unanswered or unclear question it could be confirmed immediately. This data collection was conducted at Dr. RSUP Hasan Sadikin Bandung.

RESULT AND DISCUSSION

Table. 1 Level of Grieving in Cervical Cancer Patients (N=50)

Category	f	%	Mean	Range	Standard Deviation
Light grieving	38	76			
Severe grieving	12	24	30,68	6-57	12,230

Based on table 1, it was discovered that most cervical cancer patients experienced light grief (76%), only a small proportion experienced severe grieving and required further intervention to overcome it (24%).

The grieving condition could be influenced by several factors including age, education level, socioeconomic status, duration of grieving, culture, surgery or therapeutic treatment, religion and belief, and family status or family support (Kozier, 2010).

Table 2 Characteristics of Respondents and the Level of Grievance in Cervical Cancer Patients (N = 50)

Characteristic	F	%	Light grieving		Severe grieving	
			f	%	f	%
Age						
18-40	11	22	4	8	7	14
41-65	38	76	33	66	5	10
>65	1	2	1	2	0	0
Education level						
Do not attend school	8	16	8	16	0	0
Elementary School	22	44	17	34	5	10
Junior High School	5	10	5	10	0	0
Senior High School	14	28	7	14	7	14
College	1	2	1	2	0	0
Job						
No	39	78	29	58	10	20
Yes	11	22	9	18	2	4
Cancer Stages						
Early (I-IIA)	15	30	14	28	1	2
Advanced (IIB-IV)	35	70	24	48	11	22
Diagnosis duration						
1-6 month	20	40	16	32	4	8
6-12 month	21	42	17	34	4	8
> 12 month	9	18	5	10	4	8
Surgery						
No	15	30	10	20	5	10
Yes	35	70	28	56	7	14
Radiation						
No	25	50	22	44	3	6
Yes	25	50	16	32	9	18
Chemotherapy						
No	23	46	18	36	5	10
Yes	27	54	20	40	7	14
Combination therapy (>1 therapy)	25	50	21	42	4	8
No	25	50	17	34	8	16
Yes						

Based on the table above, it can be seen that the respondents grieving rate in early adulthood, which is aged 18-40 years was more severe (14%) compared to patients who were older (10%). This is in accordance with the theory which stated that younger age tends to experienced heavier grieving than the older age (Kozier, 2010). At the age of 18-40 years which is the productive age is where a person is able to perform reproductive functions such as pregnancy and childbirth (Rasjidi, 2009) therefore it is possible for women of productive age have a greater burden due to the demand for obtaining a child from both the family and themselves. Whereas cervical cancer treatment can reduce the possibility of pregnancy without risk such as miscarriage and premature, and even infertility (Beiner & Covens, 2007). These things can be a big stressor for women of reproductive age with cervical cancer, therefore, are likely to cause more severe grieving response compared to women with older age.

Patients who had higher education showed a more severe grieving response (14%) compared to those with low education (10%). Education related to people's understanding of their health condition. Patients with low education might not understand the impact or prognosis of the disease, so the respondent did not know how his health was. This ignorance is likely to cause patients with low education to experience lower grievances compared with patients with higher education who understand their health conditions. This is not in accordance with the theory put forward by Potter & Perry (2010) which stated that low socio-economic conditions accompanied by low education increase demands on those who experience loss (grief). This may be due to other factors that can affect one's grieving response, one of which is socioeconomics.

Based on socioeconomics, patients who did not work experienced more severe grieving (20%) compared to patients who worked (4%). This is related to the patient's income if the patient is not working the economic status of the patient is low. Financial loss is one of the losses that most cancer patients feel (Lubis & Hanida, 2009). The financial loss followed by a low economic status is likely to be a stressor for patients in addition to the physical stressors experienced. This is line with what Kozier (2010) stated that someone who is faced with heavy losses and economic difficulties may not be able to overcome their grief.

Based on the physical characteristics of the disease, patients who are at an advanced stage experience more severe grieving (22%) than those at the initial stage (2%). This may be due to cervical cancer associated with changes in the female reproductive organs that cause women to experience sexual loss. Losing the ability to have sexual relations is a fear felt by women who have cervical cancer (Villafuerte, et al, 2007), this can cause women to lose their role as wives. In addition, based on the results of Susanti's research, Hamid & Afiyanti, et al (2011), it was discovered that complaints of physical weakness, dizziness, and frequent blood released were obstacles for participants to carry out the roles they had been carrying out. The role of mother, wife, and role in managing the household must be left to others. The problem of functional impairment of this role is felt like a problem that threatens women's identity as well as losing the function of sexuality (Otto, 2007). Therefore, the higher the stage suffered by patients the more loss due to the effects of the disease, the more severe the grieving felt. This is in accordance with the results of Park, et al (2007) which stated that the process of chronic disease, progressive and side effects of treatment in advanced cervical cancer causes a decrease in physical, psychological and social function that will affect the quality of life. The quality of life of patients is one indicator of the high and low levels of grieving someone (Ray, et al, 2006).

The longer the patient suffering from cervical cancer shows the patient had prolonged grief (> 6 months). This shows that there are patients who experienced a prolonged grief disorder. The

problematic condition can occur due to grieving problems was not addressed properly in the early period so that the grieving response occurred in a protracted manner. This is in accordance with Kaplan's theory, Sadock and Grebb (2010) stated if the grieving response lasted more than 12 months, it is called a prolonged grief disorder. This is a problem because it can lead to worse psychological problems, namely the high risk of major depressive disorder, posttraumatic disorder, and generalized anxiety disorder, suicide, functional disability and decreased the quality of life (Prigerson & Maciejewski, 2008).

Based on the patient's treatment therapy, it was found that patients who performed surgery experienced more severe grieving (14%) than those who did not performed surgery (10%). Similarly, patients who did radiation therapy experienced more severe grieving (18%) than those who did not do radiation therapy (6%). Likewise, patients who performed chemotherapy experienced more severe grieving (14%) than who did not perform chemotherapy (10%). Patients who took combination therapy (more than one therapy) experienced more severe grieving (16%) than patients took only one therapy (8%). This is because when a person is diagnosed with cervical cancer, the individual will experienced loss due to the therapy they were performing (Lubis & Hanida, 2009). The loss as a result of therapy includes loss of physiological functions, namely fertility and sexual function due to changes in the vagina (Lubis & Hanida, 2009). This is likely to cause the more therapy done by the patient, the more side effects and losses that are experienced so that the patient's grieving rate is higher.

Table 3 Grieving Responses to Cervical Cancer Patients (N = 50)

Grieving Responses	Items	Mean	Total		Severe grieving		Light grieving	
			F	%	F	%	F	%
Self-consciousness								
Low	8	7,92	25	50	1	2	24	48
High			25	50	11	22	14	28
Disease Adjustment								
Low	6	6,1	30	60	0	0	30	60
High			20	40	12	24	8	16
Sadness								
Low	3	6,56	21	42	1	2	20	40
High			29	58	11	22	18	36
Anger								
Low	4	3,02	26	52	0	0	26	52
High			24	48	12	24	12	24
Religious Comfort								
Low	3	1,02	34	68	3	6	31	62
High			16	32	9	18	7	14
Somatic Symptoms								
Low	3	3,78	23	46	3	6	20	40
High			27	54	9	18	18	36
Perceived Social Support	4	2,28	31	62	2	4	29	58
Low			19	38	10	20	9	18
High								

Table 3 shows that the majority of the respondents tend to experience grieving responses, namely sadness (58%). While religious comfort was the lowest response felt by respondents (16%), this shows that the patient's spiritual strength was strong so that the worshipping process was not disturbed and the patient's belief in their God. This is consistent with the study of Vergo, Whyman, Kestel, and Rector (2014) and Mystakidou, et al (2008), the aspect of sadness was the highest response felt by cancer patients. This is also in accordance with the theory of Videbeck (2008) who stated that aside from anger, sadness is the dominant emotional experience felt when someone is facing loss.

If the emotional response is a response that tends to be in a high intensity, then the spiritual response experienced by most respondents tends to be low. The results of the study showed that the religious comfort felt by patients was the lowest response (32%), this shows that the patient's spiritual strength is strong so that the worship process is not disturbed and the patient's belief in his God. Religious comfort is a spiritual dimension that supports cognitive and affective dimensions which form the basis of beliefs giving meaning and purpose to one's life. Grieving individuals can respond like anger and disappointment to God. If an individual can find meaning about the loss faced through spiritual beliefs then grieving will give a positive response to the individual. This can be shown based on the results of research that religious comfort tends to be lighter felt by patients with mild grieving rates (14%) compared with patients with severe grief (18%). This might be because people who have a close relationship with their God are more able to accept the reality of the disease and surrender to the fate that they experience. This is in accordance with Susanti's research, Hamid & Afiyanti, et al (2011) stating that belief in the power of God makes patients resign, sincere, and accept the destiny given by God. The grieving response has entered the acceptance period if the individual has accepted the conditions and consequences they experienced (Ulrich, 2008).

Based on the table above shows that respondents with a degree of severe grief experience a high response in all aspects. All patients experienced a high response to disease adjustment (24%) and anger (24%), while the lowest was in the religious comfort (18%) and somatic symptoms (18%). Respondents with mild levels of grieving tend to experience a low response in all aspects and responses, the highest experienced by respondents are sadness (36%) and somatic symptoms (36%), while the lowest is in the religious comfort aspect (14%).

CONCLUSION AND RECOMMENDATION

Based on the results of research that has been done to cervical cancer patients can illustrate that the majority of respondents experience grief with a light intensity but there are still a small

number of respondents who experience grief with a severe level that requires further intervention to overcome it.

The grieving response that has the greatest tendency experienced by respondents was sadness. While the grieving response that has the smallest tendency experienced by respondents was religious comfort. The grieving response in the grieving group tends to experience severe grieving responses in all aspects while the grieving group tends to experience mild grieving responses in all aspects.

Factors that influence the level of grieving in this study were seen from the religious comfort and perceived social support aspects. The high negative aspects of religious comfort and perceived social support responses cause severe grief, and vice versa if the negative aspects of religious comfort and perceived social support tend to be low, the grieving response that feels will be lighter.

Efforts to help cervical cancer patients go through the stages of grieving until reaching acceptance, preventing grieving, and overcoming grieving need to be given emotional and spiritual support by nurses and families.

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