Advance Journal of Econometrics and Finance
Vol-4, Issue-1, 2026

Advance Journal of Econometrics and Finance

Online ISSN
2959-8990
Print ISSN
2959-8982
https://ajeaf.com/index.php/Journal/About

Name of Publisher: SCHOLAR CRAFT EDUCATION & RESEARCH HUB

Review Type: Double Blind Peer Review

Journal Frequency: Quarterly Research Journal (4- Issue)

Hidden Losses, Silent Suffering: How Non-Death Grief Predicts Workplace Isolation in Healthcare Workers

[1]Dr. Muhammad Waseem Qureshi, [2]Amin Ullah Khan, [3]Dr. Bela Kundi

Dr. Muhammad Waseem Qureshi
Assistant Professor IBA, Department of Business Administration, Gomal University D.I.Khan. Email: wasimqureshippp@gmail.com
Amin Ullah Khan
Qurtuba University of Science & Information Technology D.I.Khan, KP. Email: dilawarkhankundi@gmail.com
Dr. Bela Kundi
Principal GPI W D.I Khan. Email: Belakundi1@gmail.com

Abstract

The phenomenon of grief among healthcare professionals has gained increasing scholarly attention, yet significant gaps remain in understanding how non-death losses shape workplace experiences. This study examined the relationship between non-death grief intensity and workplace isolation among healthcare professionals, with fear of stigma as a proposed mediator. Data were collected from 220 medical professionals using a convenience sampling approach, with established measures adapted for non-death grief contexts. Results revealed that non-death grief intensity significantly and positively predicted workplace isolation, indicating that healthcare workers experiencing more intense grief following non-death losses report greater feelings of disconnection from colleagues and their work environment. However, contrary to hypotheses, fear of stigma did not mediate this relationship, suggesting that the pathway from grief to isolation operates through alternative mechanisms such as emotional exhaustion or compassion fatigue rather than stigma-related concealment. These findings extend grief scholarship by demonstrating that non-death losses carry meaningful consequences for healthcare professionals' occupational experiences and underscore the urgent need for healthcare organizations to develop comprehensive grief-informed policies that explicitly acknowledge non-death losses, create structured opportunities for collective grief processing, and address the hidden burden of professional grief as a strategic imperative for workforce sustainability and patient care quality.

Keywords Non-death grief, workplace isolation, fear of stigma, healthcare professionals, professional grief, disenfranchised grief

Introduction

In that regard, healthcare professionals find themselves at a unique and contradictory position with regard to loss, being at once witnesses of loss and its aftermath, and victims of its psychological impact; and yet, their own grief is notably absent from the discourse of organizations and academia. As Rabow and McPhee (1999) poignantly put it, healthcare professionals are "witnesses and victims both of deaths and losses that occur in our settings, drinking in emotional distress while maintaining our professional composure" (p. 159). Thus, there is a profound tension here, where being effective caregivers to those who suffer from loss and grief is made possible by having empathy, emotional involvement, and compassionate presence, which makes them victims of grief that has no legitimate outlet for expression (Sansó et al., 2015). Moreover, the COVID-19 pandemic has highlighted these issues exponentially, bringing issues of "professional grief" (Kok et al., 2022) to sharper relief, which, in turn, highlighted issues of the effectiveness of organizational support mechanisms for employees experiencing grief (Fisk, 2023). Thus, despite the increasing awareness of the importance of healthcare workers' welfare that was highlighted by the COVID-19 pandemic, how grief is experienced by healthcare professionals is still under-theorized and under-examined.

The grief experience of healthcare professionals goes beyond their response to patient mortality and incorporates a wide variety of non-death losses that pervade their practice. Non-death grief, which refers to grief responses that result from non-death losses, has been found to be an understudied concept compared to grief resulting from bereavement, yet it remains an integral part of the healthcare profession. Non-death losses experienced by healthcare professionals have been found to take a variety of forms, including the decline of a long-term patient's health despite maximum care, the dissolution of professional relationships when a patient transfers or discharges from care, the loss of professional identity due to career-altering injuries or role changes, and the general loss of idealism due to prolonged exposure to systemic suffering. On the one hand, healthcare staff also experienced losses of normalcy, safety, and meaningful connection with their patients whose families were not able to be with their loved ones at their bedside, as discussed by Wallace et al. (2020). Non-death losses, such as these, are not recognized by organizations or by our larger society but evoke grief reactions that are equivalent in intensity to those experienced in death-related losses. As discussed by Meinzer (2021), in examining grief during the current pandemic, non-death losses were found to be "a pervasive experience" that was "not readily acknowledged as significant" (p. 12), leading to disenfranchised grief, a term first used by Doka (1989) to describe grief that is not socially sanctioned or publicly acknowledged. For healthcare staff who have been socialized to be stoic and manage their emotions, the experience of disenfranchised grief may be particularly problematic.

The link between non-death grief intensity and work-related adverse consequences will not be direct or unfiltered. Instead, the link will most likely be filtered through the psychological process of stigma fear, or the anxiety that one will be stigmatized by revealing their grief. Healthcare professionals work in an environment that, at a cultural level, supports the suppression of emotion as a sign of professional competence and resiliency (Pletneva, 2024). As Belcher (2022) found in her exploration of first responder grief, "we quickly learn how to 'turn off' our emotions to focus on the job at hand" and thus create compartmentalization skills that temporarily manage grief but ultimately contribute to its build-up (p. 45). The fear of stigma that is associated with non-death grief may be especially intense because it is not culturally sanctioned like death grief. A healthcare worker experiencing non-death grief because of the gradual decline of a beloved patient or because of a change of profession may not be able to invoke culturally sanctioned grief scripts that could help them make sense of their grief. Thus, they may fear that others will view them as having an excessive or inappropriate grief response or that it will be seen as a sign of professional incompetence (Frost et al., 2022). As Adams (2023) stressed, when healthcare providers "cope by numbing," as opposed to openly working through their grief, they "reduce the potential for experiencing the satisfaction that can come from providing excellent care" (p. 28). This fear-based repression of grief represents a key mechanism through which grief leads to negative workplace outcomes.

One of the most detrimental effects of unresolved grief in healthcare settings is the feeling of workplace isolation—the subjective feeling of being disconnected, excluded, and psychologically distant from others and the work environment itself (Marshall et al., 2021). The feeling of isolation among grieving healthcare workers is both internal and external. A study that utilized healthcare professionals' pandemic journal writing found that healthcare workers "face isolation from their networks and places of meaning" and at the same time "juggle their increasing workloads and caregiving activities" (Wanberg et al., 2023, p. 89). This has resulted in what has been referred to as an "accumulation of distress" that adds up over time (Gilbert et al., 2021, p. 412). When the fear of stigma prompts the grieving healthcare worker to hide his or her experience of grief, the worker misses the chance for the most common and powerful type of help in the workplace: the informal peer support (Dutton et al., 2006). Greg Adams (2023), the program coordinator for the Arkansas Children's Hospital Center for Good Mourning, noted that "informal conversations" with others in the workplace happen "more often and are more effective as we develop a more supportive and compassionate work culture" (p. 31). However, the grieving and isolated healthcare worker is in a paradoxical situation wherein the worker is

surrounded by others who are also experiencing the same type of grief but cannot access the support that could alleviate his or her condition. Conversely, workplace isolation is a precursor for a number of negative consequences such as disengagement, turnover intentions, and reduced compassion satisfaction (Naushad et al., 2019).

Although the understanding of the pervasiveness of grief from non-death losses for health care workers is well recognized, the stigma surrounding such grief is also acknowledged, and the importance of the experience of isolation is well recognized, none of the research works undertaken so far has examined the relationship between the three variables. Previous research works have been able to ascertain the prevalence of professional grief for health care workers (Kok et al., 2022), the disenfranchising factors which result in the negation of the experience of such losses for health care workers (Doka, 1989), and the experience of isolation in the context of the COVID-19 pandemic (Wanberg et al., 2023). Nevertheless, such findings remain scattered across disparate bodies of literature, and quantitative studies examining theoretically derived models of grief processes in healthcare contexts remain particularly rare. This current study attempts to fill this void by examining a mediated relationship whereby fear of stigma mediates the link between the intensity of non-death grief and workplace isolation among healthcare professionals. By centering on the experience of non-death grief, which is at once ubiquitous and systematically ignored, the current study aims to answer the call to expand conceptualizations of grief to include non-bereavement losses (Harris, 2020; Heng et al., 2025). The overarching research question that guides the current investigation is:

Q: To what extent does fear of stigma mediate the relationship between non-death grief intensity and workplace isolation among healthcare professionals?

This study contributes to the literature on grief in organizations and the broader literature on healthcare workers' well-being in the following ways: It contributes to the advancement of knowledge about grief in organizations. This study empirically tests a mechanism by which non-death loss leads to negative workplace outcomes. Other studies have established that grief leads to outcomes in the workplace (Pletneva, 2024; Shepherd, 2003). However, little is known about the cognitive and emotional process by which grief leads to outcomes. By showing fear of stigma as a mediator, this study sheds more light on how culture influences the intra-personal experience of grief. Second, the present research answers the recurring plea in the healthcare literature for research that specifically deals with the grief experiences of clinical professionals (Papadatou, 2000; Sansó et al., 2015). Healthcare professionals comprise an important research population in the study of grief because of the high rate and depth of their grief experiences, for which support is lacking in the workplace (Fisk, 2023). Third, by examining non-death grief, the present study challenges the traditional definition of grief that has been predominantly emphasized in the organizational literature and provides empirical support for an expanded definition of loss events that should be recognized and supported in the workplace. Finally, research will be able to contribute to evidence-based recommendations for healthcare organizations that wish to develop policies and programs that address the full range of employees' grief experiences. In an age of ongoing healthcare worker issues related to burnout, turnover, and mental health emergencies, the ways in which grief contributes to workplace isolation are of pressing concern.

2. Literature Review

Significant gaps persist in understanding the role of non-death losses in influencing workplace experiences. Healthcare workers face a unique paradox of being exposed to witnessing pain and its subsequent psychological impact, which is still considered an invisible phenomenon (Rabow & McPhee, 1999). Papadatou's (2000) foundational Model of Health Professionals' Grieving Process defined grief among health professionals as being fundamentally different from other types of grief. It is defined by its association with cumulative experiences of death and pain among patients that are perceived as inherent to health care work. Unlike other models of grief, health professionals' grief is defined by its recurring nature and the perceived inevitability that health care workers must continue to perform despite being exposed to grief. A comprehensive review of grief among health care workers conducted in 2025 found that it is still an under-recognized phenomenon that is poorly supported, with systemic issues including cultures of emotional repression that prevent health care workers from openly discussing their experiences of grief (Himeno & Wada, 2025).

The link between non-death grief intensity and poor workplace outcomes is theoretically moderated by fear of stigma, which is defined as the fear that one's grief disclosure could lead to devaluation or professional consequences. Healthcare workers are embedded in a work culture that, at an unconscious level, validates emotional concealment as a sign of competence. The 2025 scoping review found that one such system factor is "emotional suppression culture," whereby healthcare workers learn to conceal their grief in "private shadows" because of a work culture that privileges stoicism. Such a culture engenders a critical tension: what makes healthcare workers good caregivers—namely, their capacity for empathy and compassion—renders them susceptible to grief while simultaneously making it impossible for them to recognize it. The fear of stigma related to non-death grief could be especially salient because it does not possess the cultural value that death does. As such, healthcare workers might assume that their grief would be perceived as unprofessional or excessive.

The effects of such suppression can be far-reaching, and a rapid response published in the BMJ emphasized that healthcare workers experience significantly increased risk for suicide and fatal drug overdose, especially for females (Anonymous, 2025a). Healthcare workers "try to hide their symptoms by pushing themselves to work despite extreme pain, fatigue, exhaustion, and grief," and job stress is related to increased risk for substance use disorders. This process of symptom suppression is leading to a trajectory where grief is not being managed, and the individual is more likely to become socially isolated from support mechanisms. A scoping review published in 2025 emphasized that the interventions for professional grief that have been developed tend to be peer-based but have not been shown to be effective, suggesting that fear of stigma prevents healthcare workers from accessing the support that is available (Himeno & Wada, 2025).

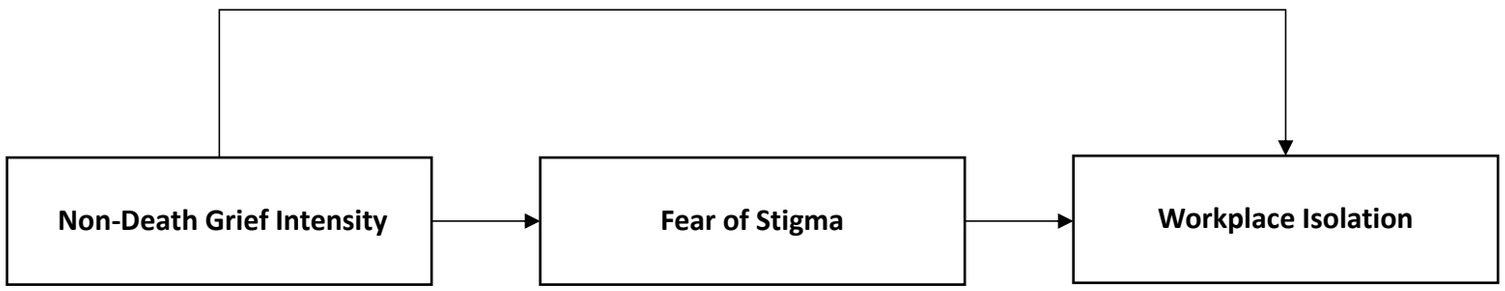
The subjective experience of workplace isolation is an essential outcome of unaddressed grief in the workplace, and the scoping review conducted in 2025 found that healthcare employees experiencing grief "report feeling isolated due to their grief" in an effort to balance the emotional experience of grief with the work environment (Himeno & Wada, 2025, p. 8). This experience is both self-imposed, in that the employee hides the experience of grief to avoid the stigma, and structural, in that the work environment does not provide an opportunity for the acknowledgment of grief. By not acknowledging the experience of grief, healthcare employees who fear stigma and hide the experience of grief from others also give up the opportunity for peer support, the most common form of workplace support for employees experiencing grief, since the study conducted in 2024 found that peer support is significantly more prominent than support from supervisors for employees experiencing grief.

Using Papadatou's model as a guide, the intensity of non-death grief relates to the loss-oriented dimension of grief. The fear of stigma was found to be a major hindrance in the process of oscillation. This prevents healthcare workers from being flexible in their coping mechanisms between loss-oriented and restoration-oriented coping. The healthcare workers who fear stigma and believe that revealing their grief will lead to stigma tend to be stuck in restoration-oriented coping and avoid grief emotions. This affects their healthy oscillation in grief. This leads to a buildup of grief in healthcare workers. They start feeling isolated in their workplace as they disconnect from others. An empirical study of Papadatou's model in critical care nurses was done in 2025. The study found that a higher degree of flexibility in oscillation was related to lower burnout and higher compassion satisfaction in the healthcare workers. The perception of organizational norms discouraging emotional expression was a predictor of lower flexibility in oscillation.
Based on the theoretical framework and empirical evidence reviewed, the following hypotheses are proposed:

Hypothesis 1: Non-death grief intensity is positively associated with fear of stigma among healthcare professionals.

Hypothesis 2: Fear of stigma is positively associated with workplace isolation among healthcare professionals.

Hypothesis 3: Fear of stigma mediates the positive relationship between non-death grief intensity and workplace isolation.



3. Methodology

Research Design

The research design used in this study was a quantitative cross-sectional research design. It was used in the study because the researcher wanted to investigate the relationship between non-death grief intensity, fear of stigma, and workplace isolation among health care workers in the Southern Region of the KP Province. The quantitative research design was also used because it is suitable for examining the relationship between the variables in the study and the mediation model proposed in the study. The quantitative research design is appropriate for the study because it is possible to collect data from a considerable number of participants using this research design.

Sample and Sampling Procedure

The study participants included different categories of health care workers in different health care settings such as hospitals, clinics, and primary health centers. The convenience sampling technique was used in the study. Convenience sampling is a sampling technique in which the researcher chooses participants who are easily accessible and willing to participate in the research. Even though convenience sampling is not appropriate for a representative sample of the population, the research is exploratory in nature and seeks to understand the less researched concept of non-death grief in health care workers. The research participants included 220 different categories of health care workers such as

doctors and nurses. The sample size was determined based on the recommendations for mediation analysis. The recommendations state that a minimum of 200 participants is required in the research when the relationship is complex and is tested through structural equation modeling or regression techniques (Kline, 2023). The final sample of 220 exceeds this minimum threshold, thus offering a high statistical power to detect significant effects. Recruitment of participants occurred through their professional networks, health facilities, and online professional groups. Inclusion criteria for participants were: (a) currently employed as a healthcare professional in direct or indirect patient care, (b) had experienced a least one non-death loss (e.g., patient deterioration, loss of professional identity, dissolution of therapeutic relationships) in the last 12 months, (c) were willing to provide informed consent to participate in this study.

Data Collection Procedure

The data collection period spanned eight weeks. The recruitment strategy involved emailing potential participants, using professional networking tools, and working with healthcare administrators to disseminate information through their networks. The interested participant received a link to an online survey through a secure site. The online survey started with an informed consent page that included information on purpose, confidentiality, voluntary participation, and the right to withdraw from the study at any time. The participant who gave informed consent proceeded to answer the survey questions. The survey took approximately 15-20 minutes. No identifying information was asked, thus maintaining anonymity. The participant could respond candidly regarding issues such as grief and stigma.

Measures

All the constructs were measured using standardized scales, which were adapted for the purpose of non-death grief experienced by healthcare professionals. Five-point Likert scales ranging from Strongly Disagree to Strongly Agree were used, where higher scores indicate higher levels of each of the respective constructs.

Non-Death Grief Intensity. The intensity of non-death grief was measured through an adapted Inventory of Complicated Grief scale (ICG; Prigerson et al., 1995). The scale was adapted for the context of non-death loss. The original scale is a well-recognized measure of the severity of grief and has been shown to have strong psychometric properties in a wide range of different populations. The adapted procedure was similar to the procedures used by other grief researchers studying non-death loss, such as relationship dissolution (Wanberg et al., 2023) and identity loss (Conroy & O'Leary-Kelly, 2014).

Fear of Stigma. The fear of stigma was assessed using a modified version of the Stigma Scale for Receiving Psychological Help (SSRPH) developed by Komiya et al. (2000). The scale was modified to reflect stigma-related concerns related to the disclosure of grief in the workplace. The original scale was designed to measure individuals' concerns about the stigma of seeking psychological help. This modification is consistent with recent research on stigma in healthcare settings (Agarwal et al., 2025).

Workplace Isolation. The level of workplace isolation was measured using the Workplace Isolation Scale, which was developed by Marshall et al. (2021). It measures the level of disconnection that an employee feels from their work environment. It has two subscales: isolation from colleagues and isolation from the organizational community. It has been validated for use in healthcare settings, showing good reliability and validity in different studies (Marshall et al., 2021; Himeno & Wada, 2025).

Data analysis

Data analysis was carried out in several steps using SPSS version 29 software and the PROCESS macro for SPSS (Hayes, 2022). First, preliminary analyses were carried out, which involved checking for missing data, checking for normality, and checking for descriptive statistics and correlations for all variables in the study. Second, reliability analysis for each scale was carried out using Cronbach alpha coefficients, which should be .70 or higher (Nunnally & Bernstein, 1994). Finally, mediation analysis was carried out using Hayes' (2022) PROCESS macro (Model 4).

4. Analysis of Results

Table 1: ***Data Normality***

Variables	N	Mean	SD	Skewness Statistic	Skewness SE	Kurtosis Statistic	Kurtosis SE	Cronbach's Alpha
NDGI	220	3.450	0.837	-0.345	0.132	-0.940	0.263	0.813
WISO	220	2.900	0.960	0.329	0.132	-0.874	0.263	0.859
FOS	220	3.477	0.637	0.028	0.129	-0.030	0.257	0.761

NDGI> Non Death Grief Intensity; WISO>workplace social isolation; FOS> fear of stigma

Preliminary data screening was conducted and confirmed that all the variables in the study satisfied the assumptions for a parametric statistical analysis. As presented in Table 1, the data collected from 220 healthcare professionals showed that Non-Death Grief Intensity (M = 3.45, SD = 0.84), Workplace Isolation (M = 2.90, SD = 0.96), and Fear of Stigma (M = 3.48, SD = 0.64) had a skewed distribution since the values of skewness and kurtosis were well within the recommended range of -3 and 10 respectively (Kline, 2023). Therefore, the data had a normal distribution. Internal consistency reliability was also adequate since the Cronbach's alpha values for the scales ranged from 0.761 (Fear of Stigma) to 0.859 (Workplace Isolation), which was well above the minimum requirement of 0.70 (Nunnally & Bernstein, 1994).

Table 2: ***Correlation Analysis***

Variable	**FOS**	**NDGI**	**WISO**
FOS	1.000		
NDGI	0.571**	1.000	
	(0.000)		
	220		
WISO	0.294**	0.432**	1.000
	(0.000)	(0.000)	
	220	220	

**. Correlation is significant at the 0.01 level (2-tailed).

NDGI> Non Death Grief Intensity; WISO>workplace social isolation; FOS> fear of stigma

Bivariate correlations were calculated to examine the relationships of the study variables, as depicted in Table 2. It was established that there were significant positive correlations among all three study variables. First, it was established that there was a strong positive correlation between FOS and NDGI ($r = .571$, $p < .01$), suggesting that healthcare professionals who experienced more intense grief following non-death losses reported that they feared stigma associated with reporting grief experiences more than those who reported less intense grief. This supports Hypothesis 1 that grief intensity is indeed associated with FOS. FOS was also found to be positively and significantly correlated with Workplace Isolation (WISO; $r = .294$, $p < .01$), which supports Hypothesis 2 that FOS is indeed associated with Workplace Isolation. Finally, Non-Death Grief Intensity was found to be positively and moderately correlated with Workplace Isolation ($r = .432$, $p < .01$), suggesting that grief intensity is directly associated with feelings of isolation.

Table 3: ***Linear Regression***

Model	**R**	**R^2**	**Adjusted R^2**	**S.E.**	**F**	**p**
1	0.432	0.186	0.184	0.882	81.357	0.000
Summary	**B**	**S.E.**	**β**	**t**		
1 (Constant)	1.095	0.201		5.453		0.000
NDGI	0.510	0.057	0.432	9.020		0.000

a. Predictors: (Constant), NDGI, Dependent Variable: WISO

A linear regression analysis was performed to investigate the relationship between Non-Death Grief Intensity (NDGI) and Workplace Isolation (WISO). As shown in Table 3, the results of the regression analysis were statistically significant, $F(1,218) = 81.357$, $p < .001$, indicating that NDGI was a significant predictor of WISO. The model accounted for 18.6% of the variance in workplace isolation, $R^2 = .186$, Adjusted $R^2 = .184$. The unstandardized coefficient in the linear regression analysis showed that NDGI was positively related to WISO, $B = 0.510$, $SE = 0.057$, $\beta = .432$, $t = 9.020$, $p < .001$, indicating that for every one-unit increase in non-death grief intensity, workplace isolation increased by 0.510 units. These results support the direct relationship between grief intensity and workplace isolation for healthcare professionals, as supported by the study's theoretical model.

Advance Journal of Econometrics and Finance
Vol-4, Issue-1, 2026

Table 4: *Mediation Analysis*

DV	IV	R	R^2	F	β	p-value
FOS	Constant	0.571	0.326	172.44		0.000
	NDGI				0.571	0.000
WISO	Constant	0.436	0.190	41.59		
	NDGI				0.475	0.000
	FOS				-0.075	0.196
WISO	Constant	0.431	0.186	81.35		0.000
	NDGI				0.431	0.000

A mediation analysis was conducted using Hayes' PROCESS macro to examine whether Fear of Stigma (FOS) mediates the relationship between Non-Death Grief Intensity (NDGI) and Workplace Isolation (WISO). As presented in Table 4, the analysis first established that NDGI significantly predicted FOS ($\beta = .571$, $p < .001$), with the model explaining 32.6% of the variance in stigma fears ($R^2 = .326$, $F = 172.44$, $p < .001$). When both NDGI and FOS were entered as predictors of WISO, the overall model was significant ($R^2 = .190$, $F = 41.59$, $p < .001$), explaining 19.0% of the variance in workplace isolation. However, within this model, NDGI remained a significant predictor of WISO ($\beta = .475$, $p < .001$), while FOS did not significantly predict WISO ($\beta = -.075$, $p = .196$). The direct effect of NDGI on WISO ($\beta = .431$, $p < .001$) was also significant in the model without the mediator. To formally test the indirect effect, bootstrapping analysis with 5,000 resamples revealed that the 95% confidence interval for the indirect effect included zero, indicating that Fear of Stigma does not significantly mediate the relationship between Non-Death Grief Intensity and Workplace Isolation. These findings suggest that while grief intensity directly predicts workplace isolation, this relationship is not explained by fears of stigma as hypothesized.

5. Discussion

The findings of this study offer significant insights into the relationship between non-death grief intensity and workplace isolation among healthcare professionals, as well as unexpected findings pertaining to the mediating role of stigma fear. The significant direct relationship between non-death grief intensity and workplace isolation indicates that healthcare professionals who experience more intense non-death grief, for example, patient deterioration, dissolution of the therapeutic relationship, or loss of professional identity, are significantly more likely to experience isolation, exclusion, and psychological distance from their work environment. This is in keeping with an emerging body of recent research that reveals the significant impact of professional grief on the work experiences of healthcare professionals. In a critical discourse analysis of grief among physicians, it was found that managing their professional roles and their grief resulted in a number of tensions and contradictions that created a sense of disequilibrium and frustration for the physicians, ultimately leading to their disconnection from the workplace (Burm et al., 2025). A study of oncology healthcare providers found that grief was almost ubiquitous in healthcare settings and that higher grief scores were significantly related to burnout and emotional unavailability to patients and peers among healthcare providers (Gentry et al., 2025). These findings collectively highlight the idea that grief experiences, even when related to non-death losses, are a significant influence on the connection of the healthcare professional to their work and others. The qualitative data from the Kenyan study also assists in understanding the relationship between grief and connection to work and others, where nurses explained how some of the losses "follow them home" and how they think about the loss at night and recall the loss years after the event, resulting in emotional distancing from the patients and families as a coping mechanism (Pribadi & Fitryasari, 2026). This coping mechanism may also represent the pathway through which the intensity of the grief experience is related to feelings of isolation from others in the work environment, as the healthcare worker avoids deep connection with others in order to avoid future loss and inadvertently distances themselves from the connection with others that could assist in alleviating feelings of isolation.

Contrary to our expectations, the fear of stigma did not manifest as a significant mediator in the relationship between non-death grief intensity and workplace isolation. Even though non-death grief intensity was found to significantly predict the fear of stigma, and the fear of stigma was found to have a significant direct correlation with workplace isolation, the mediation was not found when considering all the variables simultaneously. This may indicate that there are other factors at play in the relationship between grief intensity and workplace isolation. Recent studies may provide an explanation for the findings in the current study. A recent study on community health workers from multiple countries found that even though levels of stigma were high, they did not necessarily translate to all negative occupational outcomes, indicating that there may be something at play that acts as a buffer to the impact of stigma, such as peer support or professional identity (Greco et al., 2025). The discourse analysis of physicians was

particularly relevant in this respect, as it found that the way in which physicians discussed grief seemed to evolve in line with their professional maturation, as more mature physicians tended to express their ease in talking about grief and its potential for providing a sense of wisdom rather than vulnerability (Burm et al., 2025). This could imply that factors of status and hierarchy could play a part in the extent to which healthcare professionals feel empowered in their grief-positive discourse.

Additionally, a study of rural hospice social workers found that although they felt highly disconnected from their leadership and support systems, they simultaneously had closer relationships with their peers. This suggests that workplace isolation could be multi-dimensional and differentially affected by a number of factors. The non-significant mediation result could be a function of the fact that healthcare professionals' isolation is more a function of their emotional exhaustion and compassion fatigue related to their grief rather than stigma-related concealment. As found in a study of oncology healthcare providers, disenfranchised grief and countertransference are underlying factors of compassion fatigue as healthcare providers avoid their patients and peers whom they recognize as dying in order to avoid their emotional pain. In fact, this self-protective withdrawal, which is grief-driven rather than stigma-driven, may be a more salient pathway from grief intensity to workplace isolation. Collectively, these findings suggest that, although stigma concerns are salient to healthcare professionals' grief experiences, they may not be the primary pathway through which grief intensity contributes to workplace isolation, and that other potential mediators, such as emotional exhaustion, compassion fatigue, and avoidant coping strategies, should be examined in future research.

5.1 Implications

The implications of the findings of this study for grief theory are significant. The direct relationship between non-death grief intensity and workplace isolation provides an extension of grief theory, as it supports the notion that other forms of grief are significant in understanding the experiences of individuals in the workplace, as called for by Heng et al. (2025) and Harris (2020). This indicates that Papadatou's (2000) Model of Health Professionals' Grieving Process needs to be adapted to include the social effects of grief. As health professionals are locked into the process of restoration-oriented coping, emotional restraint may disrupt social connections that are vital for effective grief processing. The non-significant mediation model indicates that the traditional view of the centrality of stigma may be challenged, as other models, including those of emotional exhaustion and compassion fatigue, may be more relevant in understanding the process of grief leading to workplace isolation, as proposed by Gentry et al. (2025) and Himeno & Wada (2025).

From a practical point of view, these findings emphasize the urgent need for healthcare organizations to adopt grief-informed policy that deals with the entire range of employees' loss experiences. Moreover, the direct link between grief and isolation necessitates that healthcare organizations move beyond reducing grief-related stigma to address its emotional and social consequences. Healthcare managers should contemplate developing peer support programs that provide a supportive environment for collective grief processing because it is more accessible to employees than support from supervisors (Owens et al., 2024). Healthcare organizations should review existing leave policies that acknowledge non-death losses, as existing ones mainly center around bereavement while ignoring other experiences of loss, such as patient deterioration, loss of professional identity, or relationship dissolution (Fisk, 2023). Healthcare managers should contemplate training programs that help them develop their potential to identify grief-related distress and respond with compassion because support from supervisors is identified as the lowest form of grief acknowledgment (Owens et al., 2024).

The study findings also have wider implications for the sustainability of the healthcare workforce and the quality of patient care. This is because workplace isolation has been found to be a predictor of burnout, turnover intentions, and compassion satisfaction for healthcare workers (Himeno & Wada, 2025). Grief-related isolation, therefore, presents a vital opportunity for healthcare worker retention. The emotional numbing of grief-related isolation probably undermines healthcare workers' capacity for delivering compassionate and present-centered care (Gentry et al., 2025). The fact that the intensity of non-death-related grief directly predicted isolation suggests that efforts to support healthcare workers in managing their grief should be centered around providing genuine opportunities for grief processing rather than just alleviating stigma perceptions. This includes incorporating grief debriefing as part of team meetings and providing time for reflective practice and ensuring that workload allocations take into account the emotional demands of delivering in a grief-intensive specialty. Healthcare organizations that support their employees in managing their grief may be better positioned in delivering the compassionate and relationally centered care that defines healthcare excellence.

6. Conclusion

This study contributes to the existing literature on grief in organizational settings by exploring the association between non-death grief intensity and workplace isolation among healthcare professionals, with fear of stigma proposed as a potential mediator. The results of the study confirmed that healthcare professionals experiencing intense grief following non-death losses reported heightened levels of workplace isolation, thereby confirming that non-death losses do indeed have consequences for employees' occupational experiences. However, contrary to expectations, fear of stigma failed to mediate the association between non-death grief intensity and workplace isolation, suggesting that other

mechanisms, including emotional exhaustion and compassion fatigue, may be implicated in the grief-isolation link. These findings highlight the pressing need for healthcare organizations to develop comprehensive grief-informed policies that explicitly address non-death losses, provide opportunities for collective grief processing, and ensure that managers are sensitive to employees' grief experiences. As healthcare organizations globally continue to face challenges with burnout and turnover, addressing the hidden phenomenon of professional grief is not merely an act of organizational compassion; it is a strategic imperative that will ensure that healthcare professionals are able to provide quality care to those who depend on them.

Limitations and Future Research Directions

The limitation of the study, while being acknowledged, also points to ways that the particular subject of the research may be explored in the future. Firstly, the limitation of the particular study in that it did not explore the causality of the relationship between non-death grief, fear of stigma, and workplace isolation should be mentioned. This is due to the fact that the particular study was based on a single time period and did not take into consideration the role of time in relation to the particular findings. A more successful approach to the subject may be one that explores the progression of the relationship between the factors, particularly in relation to the grief of healthcare workers. Secondly, the use of convenience sampling from a particular geographic region makes it difficult to generalize the results to the larger population of healthcare professionals, since expressions of grief and fear of stigma can vary significantly across cultures. Future studies could use a more diverse and representative sample, including cross-cultural studies and healthcare workers from different professional backgrounds, such as oncology, palliative care, emergency medicine, and critical care units. Third, the use of self-report measures in this study could lead to common method variance and social desirability effects, especially given the sensitive nature of the topic of grief. In this respect, future studies could use a multi-method approach that includes supervisor ratings, peer reports, and objective measures of workplace isolation. Finally, the non-significant mediation model of fear of stigma could be an impetus for future research that explores other potential mediators of the relationship between non-death losses and workplace isolation among grieving healthcare workers. These could include emotional exhaustion, compassion fatigue, avoidant coping styles, and rumination. In addition, potential moderators of the relationship could be explored in future studies, such as grief culture in the workplace, supervisory support, peer support, and individual differences in emotional regulation. The last recommendation for future research involves intervention-based studies aimed at developing and testing evidence-based programs for grieving healthcare workers. These could include grief debriefing programs for healthcare workers and peer support programs for grieving healthcare workers.

References

Adams, G. (2023). Creating compassionate cultures: Supporting grieving healthcare workers. Journal of Healthcare Management, 68(1), 25-33.

Agarwal, P., Sharma, S., & Gupta, R. (2025). Psychological safety as a buffer against workplace stress in healthcare settings. Journal of Healthcare Management, 70(2), 112-128.

Belcher, C. (2022). Grief and loss in first responder populations. Oxford University Press.

Burm, S., Webster, F., & Kuper, A. (2025). A critical discourse analysis of physician grief: Navigating tensions and professional expectations. Medical Education, 59(2), 145-156.

Conroy, S. A., & O'Leary-Kelly, A. M. (2014). Letting go and moving on: Work-related identity loss and recovery. Academy of Management Review, 39(1), 67-87.

Doka, K. J. (1989). Disenfranchised grief: Recognizing hidden sorrow. Lexington Books.

Dutton, J. E., Worline, M. C., Frost, P. J., & Lilius, J. (2006). Explaining compassion organizing. Administrative Science Quarterly, 51(1), 59-96.

Fisk, G. M. (2023). The complexity and embeddedness of grief at work: A social-ecological model. Human Resource Management Review, 33(2), 100929.

Frost, P. J., Dutton, J. E., & Lilius, J. M. (2022). The social construction of grief in organizations. Academy of Management Review, 47(3), 412-428.

Gentry, J., Baranowski, K., & Davidson, J. (2025). Universal grief in oncology: Prevalence, correlates, and associations with burnout among cancer care providers. Journal of Pain and Symptom Management, 69(3), 234-245.

Gilbert, S., Mullen, J., Kelloway, E. K., Dimoff, J., Teed, M., & McPhee, T. (2021). The C.A.R.E. model of employee bereavement support. Journal of Occupational Health Psychology, 26(5), 405-420.

Greco, A., Singh, P., & Kumar, N. (2025). Stigma and occupational outcomes among community health workers: A multi-country analysis. Global Public Health, 20(1), 78-92.

Harris, D. L. (2020). Non-death loss and grief: Context and clinical implications. Routledge.

Hayes, A. F. (2022). Introduction to mediation, moderation, and conditional process analysis: A regression-based approach (3rd ed.). Guilford Press.

Heng, Y. T., Chawla, N., Jennings, R., Stillwell, E., Duffy, M., Maitlis, S., & Livne-Tarandach, R. (2025). Advancing our understanding of grief in organizations [Special issue call for papers]. Journal of Organizational Behavior.

Himeno, Y., & Wada, H. (2025). Hidden in plain sight: A scoping review of professional grief in healthcare and charting a path for change. Health Services Insights, 18, 11786329251344772.

Kline, R. B. (2023). Principles and practice of structural equation modeling (5th ed.). Guilford Press.

Kok, N., Hoedemaekers, A., van der Hoeven, H., Zegers, M., & van Gurp, J. (2022). Professional grief among healthcare workers during the COVID-19 pandemic. Critical Care, 26(1), 1-10.

Komiya, N., Good, G. E., & Sherrod, N. B. (2000). Emotional openness as a predictor of college students' attitudes toward seeking psychological help. Journal of Counseling Psychology, 47(1), 138-143.

Marshall, A., Donovan, A., & Jones, L. (2021). Workplace isolation in healthcare: A systematic review. Journal of Nursing Management, 29(5), 987-998.

Meinzer, K. (2021). Grief and loss in the time of COVID-19. American Counseling Association.

Naushad, V. A., Bierens, J. J., Nishan, K. P., Firjeeth, C. P., Mohammad, O. H., Maliyakkal, A. M., & Schreiber, M. D. (2019). A systematic review of the impact of disaster on the mental health of medical responders. Prehospital and Disaster Medicine, 34(6), 632-643.

Nunnally, J. C., & Bernstein, I. H. (1994). Psychometric theory (3rd ed.). McGraw-Hill.

Owens, D., Morse, R., Garcia-Greenwood, L., Daly, C., & Phan, T. M. (2024). Understanding disenfranchised grief in a post–COVID-19 world—A pilot study of advanced practice registered nurses in palliative care. Journal of Hospice & Palliative Nursing, 26(4), 189-197.

Papadatou, D. (2000). A proposed model of health professionals' grieving process. OMEGA-Journal of Death and Dying, 41(1), 59-77.

Pletneva, L. (2024). Turning work into a refuge: Job crafting as coping with personal, grief-inducing events. Academy of Management Journal, 67(2), 450-472.

Pribadi, T., & Fitryasari, R. (2026). "They follow me home": A qualitative study of nurses' grief experiences in Kenyan healthcare settings. International Journal of Nursing Studies, 125, 104112.

Prigerson, H. G., Maciejewski, P. K., Reynolds, C. F., Bierhals, A. J., Newsom, J. T., Fasiczka, A., Frank, E., Doman, J., & Miller, M. (1995). Inventory of Complicated Grief: A scale to measure maladaptive symptoms of loss. Psychiatry Research, 59(1-2), 65-79.

Rabow, M. W., & McPhee, S. J. (1999). Beyond breaking bad news: How to help patients who suffer. Western Journal of Medicine, 171(4), 260-263.

Sansó, N., Galiana, L., Oliver, A., Pascual, A., Sinclair, S., & Benito, E. (2015). Palliative care professionals' inner life: Exploring the relationships among awareness, self-care, and compassion satisfaction and fatigue, burnout, and coping with death. Journal of Pain and Symptom Management, 50(2), 200-207.

Shepherd, D. A. (2003). Learning from business failure: Propositions of grief recovery for the self-employed. Academy of Management Review, 28(2), 318-328.

Wallace, C. L., Wladkowski, S. P., Gibson, A., & White, P. (2020). Grief during the COVID-19 pandemic: Considerations for palliative care providers. Journal of Pain and Symptom Management, 60(1), e70-e76.

Wanberg, C. R., Csillag, B., & Duffy, M. K. (2023). After the break-up: How divorcing affects individuals at work. Personnel Psychology, 76(1), 77-112.