How can nurses treat patients who are going through grief situations?

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Grief describes the emotional, cognitive, physical, social, and spiritual responses that can follow the loss of a person, relationship, role, ability, home, health condition, or expected future. In nursing, understanding grief is important because patients and families may experience loss during diagnosis, disability, terminal illness, miscarriage, amputation, separation, death, or major changes in independence. A nurse who notices only physical symptoms may miss the meaning of the loss, while a nurse who assumes that every distressed patient is experiencing the same process may also provide unsuitable care. Effective treatment begins with listening to the patient's account, identifying immediate needs, assessing safety, and recognizing that grief varies across individuals and cultures (National Cancer Institute, 2022).

Grief is usually a natural response rather than a mental disorder. Sadness, yearning, crying, poor concentration, disrupted sleep, and temporary withdrawal can occur without indicating clinical depression or prolonged grief disorder. Nursing care should therefore avoid treating every emotional reaction as pathology. At the same time, some patients develop severe depression, suicidal thinking, traumatic stress, substance misuse, prolonged grief disorder, or an inability to manage essential daily tasks. The nurse must distinguish expected variation from signs requiring urgent medical or mental-health evaluation. This assessment should be compassionate, culturally sensitive, and based on the patient's actual symptoms rather than a rigid timetable for "moving on" (American Psychiatric Association, 2022; National Cancer Institute, 2022).

Literature Review

Grief can follow many forms of loss. The death of a parent, child, sibling, spouse, friend, patient, classmate, or colleague may affect identity and daily routine in different ways. Anticipatory grief can begin before death when a patient or family understands that an illness is likely to be fatal. Ambiguous loss occurs when a person is physically absent without confirmation, or physically present but psychologically changed through dementia, brain injury, or severe illness. Disenfranchised grief occurs when society does not fully recognize the relationship or loss, such as the death of an ex-partner, a same-sex partner in an unsupportive environment, a pregnancy loss, a pet, or a patient cared for by a healthcare worker.

Older stage-based theories sometimes described grief as a fixed sequence through denial, anger, bargaining, depression, and acceptance. These concepts may help some people describe experiences, but modern grief research does not support the idea that every person passes through identical stages in one order. Reactions can overlap, return, or remain absent. A patient may

experience sadness and acceptance together, function effectively at work while struggling at night, or feel relief after a long illness without loving the deceased any less. Nurses should not use a stage model to tell patients how they ought to feel (National Cancer Institute, 2022).

The dual-process model offers a more flexible explanation. Bereaved people may move between loss-oriented coping, such as remembering, crying, and confronting absence, and restoration-oriented coping, such as handling finances, learning new tasks, returning to work, or developing changed relationships. Oscillation between these activities is normal. Continuous confrontation with pain can become overwhelming, while continuous avoidance can prevent adjustment. Nursing support can help patients tolerate this movement without requiring them to choose between remembering the deceased and continuing life (Stroebe & Schut, 1999).

The original essay suggests that grief may become dangerous to society when a bereaved person blames others and seeks revenge. Grief by itself should not be described as a general threat. Most bereaved people do not become violent. A nurse should assess violence risk only when specific evidence exists, such as direct threats, access to weapons, severe agitation, psychosis, intoxication, a history of violence, or stated plans to harm someone. Generalizing danger from anger or grief creates stigma and may discourage patients from speaking honestly. Safety assessment should be individualized and should include the patient's risk of self-harm, because suicidal thinking may emerge in severe depression, traumatic bereavement, or prolonged grief.

Attributes

Grief has several common attributes, although no single set proves that a person is grieving. The original essay identifies forgetfulness, disorganization, lowered tolerance, and lack of motivation. These features are clinically relevant because grief occupies attention and working memory. A patient may forget appointments, misplace keys, overlook medication, or struggle to follow a conversation. Such problems can be frightening, especially when the person worries that they are losing control. The nurse can explain that temporary concentration difficulty is common while also checking for medication effects, sleep deprivation, neurological illness, delirium, depression, or other causes (National Cancer Institute, 2022).

Forgetfulness

Forgetfulness during grief may involve missed tasks, difficulty retaining new information, repeated questions, or an inability to remember why one entered a room. The mind may return repeatedly to the loss, reducing the attention available for ordinary activities. Nurses should provide instructions in simple steps, repeat important information, use written reminders, and involve a trusted support person with the patient's permission. When the patient manages medication independently, a pill organizer, alarm, or follow-up call may reduce risk. Persistent or worsening cognitive changes require further assessment rather than being attributed automatically to grief.

Disorganization

Disorganization can appear when routines previously shared with the deceased must be rebuilt. A spouse may not know how bills were paid, a parent may struggle to maintain household tasks after a child's death, or a patient facing disability may need to reorganize transportation and self-care. The person may complete tasks more slowly or fail to prioritize. Nurses can help by identifying the most urgent needs, connecting the patient with social work, and breaking complex plans into manageable actions. The goal is not to take over every decision but to restore a sense of control.

Lowered Tolerance

Bereaved patients may become impatient, sensitive to noise, easily frustrated, or unusually angry. Fatigue and emotional overload can reduce tolerance for ordinary demands. Anger may be directed toward clinicians, relatives, the deceased person, religious beliefs, or oneself. Nurses should not respond defensively or insist that anger is inappropriate. They can acknowledge the emotion, set limits on abusive behavior, and explore what the anger communicates. Statements such as "This feels unfair" or "You have had to manage too much at once" can validate distress without agreeing with harmful conduct.

Lack of Motivation

Loss can reduce interest in work, social activity, food preparation, exercise, and self-care. The original essay describes this as laziness, but that label is inaccurate and potentially harmful. Low motivation may reflect sadness, exhaustion, disrupted sleep, depression, medication effects, or the loss of a shared purpose. Nurses should assess the degree of impairment and ask what activities still feel possible or meaningful. Small, realistic goals—taking a shower, eating one balanced meal, walking briefly, or calling one person—may be more useful than demanding an immediate return to previous functioning.

Consequences

Grief can affect the body, mind, relationships, work, and spiritual life. Reactions are influenced by the circumstances of the death, closeness of the relationship, previous losses, trauma history, culture, religion, social support, financial pressure, and health. Sudden or violent deaths may produce intrusive images and traumatic stress. A long anticipated death may still create intense grief, though some families also experience relief that suffering has ended. Nurses should ask rather than assume which consequence is most important (National Cancer Institute, 2022).

Physical Effects

Physical effects can include fatigue, headache, muscle tension, chest tightness, appetite change, gastrointestinal disturbance, sleep disruption, nightmares, restlessness, and a temporary sense of weakness. Some patients become less active, while others remain constantly busy to avoid painful thoughts. Hyperactivity should be understood in context rather than treated as a universal symptom. Bereavement can also worsen existing medical conditions because medication routines, nutrition, sleep, or healthcare appointments are disrupted.

Insomnia is common and can intensify emotional distress and cognitive difficulty. Nurses can assess sleep habits, caffeine and alcohol use, pain, medication, and nighttime fears. Basic sleep support may include regular wake times, reduced late-night stimulation, and medical review when insomnia is severe. Sedating medication should not be offered automatically, particularly when the patient has substance-use risk or must remain alert for caregiving responsibilities.

Suicidal ideas are not merely a physical effect, as the original list implies; they are a serious psychological and safety concern. Nurses should ask directly when warning signs are present or when the patient expresses hopelessness, burdensomeness, a wish to die, or inability to continue. Direct questioning does not create suicidal thoughts. Assessment should examine intent, plan, means, previous attempts, substance use, protective factors, and immediate support. A patient at imminent risk should not be left alone and requires urgent escalation according to clinical policy.

Psychological Effects

Psychological reactions may include sadness, yearning, disbelief, guilt, anger, anxiety, numbness, relief, fear, loneliness, and temporary experiences of sensing the deceased person’s presence. A bereaved person may hear the deceased’s voice briefly or feel that the person is nearby without having a psychotic disorder. Nurses should explore the experience, its cultural meaning, level of distress, and whether reality testing remains intact. Persistent hallucinations accompanied by disorganization, dangerous commands, or severe impairment require mental-health evaluation.

Depression and grief overlap but are not identical. Grief often arrives in waves connected with reminders and may include positive memories or moments of connection. Major depression is more likely to involve persistent low mood or loss of pleasure, pervasive worthlessness, hopelessness, and broader impairment. A bereaved person can meet criteria for depression and should receive appropriate treatment; clinicians should not withhold care because sadness followed a death. Panic attacks and severe anxiety may also require intervention, especially when the patient begins avoiding necessary healthcare or daily activities (American Psychiatric Association, 2022).

Prolonged grief disorder involves persistent, intense yearning or preoccupation with the deceased together with significant distress and impairment beyond the expected cultural context and duration.

Diagnosis should not be made simply because grief continues. Continuing bonds with the deceased, anniversaries, and occasional sadness can remain normal for years. The clinical concern is persistent inability to reengage with life, severe identity disruption, emotional numbness, avoidance, or meaninglessness that causes substantial impairment (American Psychiatric Association, 2022; World Health Organization, 2022; Shear, 2015).

Social and Occupational Effects

The original essay correctly notes that grief can reduce enjoyment, create distance from relatives, and impair performance at work. Friends may avoid the bereaved person because they do not know what to say, while others may pressure the person to recover quickly. Family members can grieve the same death differently, leading to misunderstanding. One person may want to discuss the deceased repeatedly, while another copes through work or silence. Nurses can explain that different styles do not necessarily indicate lack of love.

Employment can provide routine and social support, but concentration and energy may be reduced. Where possible, flexible scheduling, temporary workload adjustments, leave, or a gradual return can help. Nurses and social workers can provide documentation or connect patients with relevant services. The patient's privacy should be respected, and employers need only the information necessary to arrange support.

Empirical Referents

The original essay states that there are no major instruments for measuring grief and suggests blood pressure or "brain working level." Blood pressure may rise because of stress, pain, medication, or many other conditions and cannot quantify grief. Brain imaging is not a routine clinical grief measure. Grief is assessed primarily through conversation, observation, functional history, cultural context, and validated questionnaires when appropriate.

Empirical referents are observable signs or measures that indicate the concept is present. These can include self-reported yearning, sadness, avoidance, sleep disturbance, functional impairment, social withdrawal, inability to accept the death, or persistent preoccupation. Instruments such as the Inventory of Complicated Grief and the Prolonged Grief Disorder measures can support structured assessment. Depression, anxiety, trauma, and suicide-risk tools may also be used, but no questionnaire should replace a clinical interview (Shear, 2015).

Nurses should ask about the relationship and circumstances of the loss, current daily routine, sleep, appetite, substance use, support, spiritual concerns, safety, and what the patient wants from care. Cultural assessment matters because mourning practices, expected duration, emotional expression, and family roles vary. A reaction should not be classified as abnormal merely because it differs from the nurse's personal experience.

Nursing Assessment

The nurse begins by creating a respectful environment and allowing the patient to tell the story without interruption. Open questions may include: “Who or what have you lost?” “What has been hardest today?” “How are you sleeping and eating?” “Who is available to support you?” and “Have you had thoughts that life is not worth living?” The nurse should listen for guilt, trauma, conflict, practical needs, and signs of severe impairment.

Physical assessment remains important because grief can coexist with acute illness. Chest pain, severe shortness of breath, dehydration, uncontrolled diabetes, medication interruption, or other symptoms require medical evaluation rather than being dismissed as emotional. Older adults and medically fragile patients may be particularly vulnerable after a loss because the deceased person previously helped with medication, meals, transportation, or communication.

The nurse should also assess strengths. Religious faith, family connection, community involvement, previous coping skills, meaningful routines, creativity, and willingness to seek help can support adaptation. Care should build on resources the patient already values instead of imposing a universal coping method.

Nursing Interventions

Therapeutic presence is one of the most important interventions. Nurses do not need to produce a perfect comforting statement. Honest phrases such as “I am sorry,” “I can stay with you,” or “Tell me about the person” are often more helpful than clichés. Statements that the loss was “meant to happen,” that the deceased is “in a better place,” or that the patient should be strong can invalidate grief unless they reflect the patient’s own beliefs.

Education can normalize common reactions while identifying warning signs. The nurse can explain that concentration, sleep, appetite, and emotional intensity may fluctuate and that grief does not follow a fixed schedule. Written information should include how to access urgent help, counseling, bereavement groups, spiritual care, hospice services, or primary care. Referrals should match the patient’s preference; not every person wants group support, and some may prefer cultural or faith-based resources.

Practical assistance may be as important as emotional discussion. A newly bereaved patient may need help arranging transport, medications, food, childcare, funeral information, benefits, or communication with employers. Social workers, chaplains, psychologists, physicians, and community organizations can collaborate. Nursing care is strongest when it recognizes that grief occurs within material circumstances.

Cultural and Spiritual Care

Mourning rituals can include prayer, washing and preparing the body, specific clothing, food, music, silence, gatherings, or restrictions on handling the deceased. Nurses should ask families what practices are important and accommodate them whenever they are consistent with safety and law. They should not assume that every member of a cultural or religious group follows the same tradition.

Spiritual distress may involve anger toward God, loss of meaning, fear about death, or conflict with a faith community. The nurse can invite discussion and offer a chaplain or chosen spiritual adviser without pressuring the patient. Nonreligious patients may find meaning through relationships, nature, art, service, or memory. Spiritual care is broader than promoting religion.

Support for Nurses

Nurses themselves experience grief after patient deaths, especially in oncology, intensive care, emergency, pediatrics, hospice, and long-term care. Repeated loss can contribute to moral distress, compassion fatigue, or withdrawal. Professional boundaries do not require emotional absence. Debriefing, peer support, reflective practice, supervision, and adequate staffing can help nurses process difficult cases.

The original conclusion correctly states that grief care requires more than telling nurses what to do during a terminal phase. Education should combine communication practice, ethics, cultural care, symptom assessment, safety planning, and supervised clinical experience. Simulation can allow nurses to practice conversations before facing them in high-pressure settings. Feedback should focus on listening, clarity, and respect rather than memorized phrases.

Conclusion

Nurses treat patients going through grief by recognizing the loss, listening without imposing a timetable, assessing physical and psychological safety, supporting practical needs, and connecting patients with appropriate resources. Forgetfulness, disorganization, reduced tolerance, low motivation, fatigue, insomnia, anxiety, sadness, and social withdrawal can occur, but each patient's pattern is different. Grief should not be described generally as dangerous to society, and unusual reactions should be interpreted through individualized assessment (National Cancer Institute, 2022).

Empirical assessment relies on clinical conversation, observation, function, cultural context, and validated grief measures rather than blood pressure or brain activity alone. Nurses should distinguish normal grief from depression, trauma, prolonged grief disorder, psychosis, and imminent suicide risk. Effective care combines compassion with clinical judgment (American Psychiatric Association, 2022; Shear, 2015).

Grief education benefits both patients and nurses. It provides a framework for communication, encourages feedback, reduces avoidable stigma, and supports the mental health of staff who repeatedly encounter death and loss. The goal is not to remove grief, because grief reflects the significance of what was lost. The goal is to help the person remain safe, supported, and able to adapt while preserving meaningful memories and relationships.

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