Experiences of Grief and the Impacts on Adolescents' Mental Health

Vivências de Luto e os Impactos na Saúde Mental de Adolescentes
Vivencias del Duelo y los Impactos en la Salud Mental de los Adolescentes

RESUMO
Objetivo: Analisar as vivências de luto e os impactos na saúde mental de adolescentes. **Método:** Estudo qualitativo, descritivo e exploratório, realizado em 2024 com 20 adolescentes em situação de vulnerabilidade social pertencentes a uma escola localizada na região noroeste do Rio Grande do Sul. As entrevistas foram áudio gravadas, transcritas e submetidas à análise temática de Braun e Clarke. **Resultados:** A perda pela morte de pessoas significativas ou ruptura de vínculos familiares, geraram intenso sofrimento psíquico e, em casos graves, ideação suicida. Além disso, alguns adolescentes vivenciam a negligência, o que leva ao sofrimento mental, isso corrobora para episódios de automutilação a fim de amenizar o sofrimento emocional. **Conclusão:** O luto na adolescência exige ações intersetoriais e abordagens sensíveis. Frente a isso, é necessário ações de prevenção, programas de apoio a saúde mental de adolescentes e políticas de saúde em prol dessa população.
DESCRITORES: Luto; Saúde Mental; Saúde do Adolescente; Serviços de Saúde na Escola; Enfermagem.

ABSTRACT
Objective: To analyze the experiences of grief and its impact on the mental health of adolescents. **Method:** A qualitative, descriptive, and exploratory study was conducted in 2024 with 20 adolescents in situations of social vulnerability belonging to a school located in the northwest region of Rio Grande do Sul. The interviews were audio-recorded, transcribed, and subjected to thematic analysis by Braun and Clarke. **Results:** The loss due to the death of significant people or the rupture of family ties generated intense psychological suffering and, in severe cases, suicidal ideation. Furthermore, some adolescents experience neglect, which leads to mental suffering and contributes to episodes of self-harm in order to alleviate emotional distress. **Conclusion:** Grief in adolescence requires intersectoral actions and sensitive approaches. Therefore, preventive actions, mental health support programs for adolescents, and health policies in favor of this population are necessary.
DESCRIPTORS: Bereavement; Mental Health; Adolescent Health; School Health Services; Nursing.

RESUMEN
Objetivo: Analizar las experiencias de duelo y su impacto en la salud mental de los adolescentes. **Método:** Estudio cualitativo, descriptivo y exploratorio realizado en 2024 con 20 adolescentes en situación de vulnerabilidad social pertenecientes a una escuela ubicada en la región noroeste de Rio Grande do Sul. Las entrevistas fueron grabadas en audio, transcritas y sometidas a análisis temático por Braun y Clarke. **Resultados:** La pérdida por fallecimiento de personas significativas o la ruptura de lazos familiares generó un intenso sufrimiento psicológico y, en casos graves, ideación suicida. Además, algunos adolescentes experimentan negligencia, lo que genera sufrimiento mental y contribuye a episodios de autolesión para aliviar el sufrimiento emocional. **Conclusión:** El duelo en la adolescencia requiere acciones intersectoriales y enfoques sensibles. Por lo tanto, son necesarias acciones preventivas, programas de apoyo a la salud mental de los adolescentes y políticas de salud a favor de esta población.
DESCRIPTORES: Aflicción; Salud Mental; Salud del Adolescente; Servicios de Salud Escolar; Enfermería.

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INTRODUCTION

According to the World Health Organization, adolescents are individuals aged between 10 and 19 years. This stage of life is characterized by a complex process of growth and development in the biological, psychological, and social spheres. [1] In the face of these transformations, significant situations such as grief can have impacts that go beyond this phase, directly influencing the emotional structure that will

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accompany the individual into adulthood, since grief is marked by various situations and is considered a difficult process to face due to its complexity of feelings [2]. Although more commonly associated with death, it can also arise in situations such as the end of relationships and the interruption of projects, always involving intense emotional suffering and deep sadness. [3] Grief represents an adaptive response that encompasses psychological, emotional, and social dimensions, varying according to individual factors that can favor healthy coping or generate complications. [4]

The five-stage process of mourning is presented in the theoretical model proposed by Kübler-Ross [5], which discusses the complexity and uniqueness of this experience. The first stage is denial, in which the individual resists accepting the reality of the loss, functioning as a psychological defense mechanism against the initial emotional impact. Next comes the stage of anger, characterized by intense feelings of revolt, injustice, and frustration, often accompanied by existential questions. The third stage corresponds to bargaining, when the bereaved person symbolically seeks to negotiate with the reality of the loss, often through promises or internal pacts with a higher authority. Depression follows this stage, marked by emotional suffering, apathy, social isolation, and sadness, reflecting the perception of the irreversibility of the loss. Finally, acceptance is reached, a phase in which the subject recognizes the reality of the loss and begins to reorganize their life in the face of absence, promoting a more adaptive emotional adjustment. It should be noted that these phases do not necessarily follow a rigid order, so they can occur in an overlapping or intermittent manner, given the nature of grief.

In this same perspective of understanding grief as a dynamic and non-linear phenomenon, the grief therapy proposed by Worden [6]broadens the understanding of the process by conceiving it as a set of tasks to be developed by the bereaved. Initially, the individual must accept the reality of the loss, cognitively and emotionally recognizing the absence of the person. Next, it becomes necessary to work through the emotions and recurring pain of the broken bond, allowing feelings of sadness, guilt, and anger. Worden highlights the importance of reorganizing life in an environment where the deceased is no longer present. In addition, the author describes the task of emotionally replacing the deceased and continuing to live, integrating the loss into one's personal trajectory without breaking the symbolic bond. Like Kübler-Ross, these tasks do not develop in a linear fashion, but constitute an individual process that, when properly supported, promotes adaptation and reduces the risk of complicated grief.

For adolescents, grief is a significant rupture of a structuring emotional bond, the loss of which can trigger a series of emotional and psychological repercussions. This phase is marked by intense processes of identity construction, redefinition of social roles, and the search for emotional autonomy, which makes adolescents particularly vulnerable to experiences of loss. The experience of grief during this period can compromise psychological balance, increasing the risk of mental disorders such as generalized anxiety, major depression, sleep disorders, and even suicidal ideation. [7]

A Brazilian study found that adolescents facing situations of loss and emotional suffering seek out teachers as trusted figures with whom they can vent and share their anxieties. [8] This is consistent with the literature that schools, health professionals, and educators play an essential role in welcoming and supporting bereaved adolescents, acting as key agents in promoting mental health and coping with loss, thus proposing the need for a more humanized educational approach that recognizes grief as a natural phenomenon of life. [9]

A study conducted in the United Kingdom during the pandemic with parents of adolescents who were coping with grief identified that specialized emotional support and assistance offered to adolescents in the school environment were interventions valued by families. Parents emphasized that, in the face of this difficult time, educators played a fundamental role in coping with the situation, especially because they were qualified and prepared to offer adequate support to adolescents. [10]

As such, skilled listening is an essential tool for professionals, as it encourages the expression of emotions, enables ethical and professional support, and contributes to the identification of a specialized support network. [11] In the school context, the perspectives of education professionals regarding grief contribute significantly to the reception of adolescents and to a humanized listening to their singularities in the face of this experience. [12] In this sense, grief in adolescence can impair school performance and emotional development [13] which corroborates the ideas of [8] who points out that significant losses can generate complex grief reactions, affecting mental health, school performance, and social development, in addition to emphasizing the importance of educational actions in school institutions.

Given the above, the question arises: How do adolescents experience grief and what are the impacts on mental health? The relevance of the topic is justified by the intense transformations that adolescents experience when they experience loss or the breaking of bonds. Furthermore,

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studying grief in adolescence can support educational, preventive, and care practices that promote comprehensive care, qualified listening, and emotional support for this population. Thus, the present study aims to analyze the experiences of grief and its impacts on the mental health of adolescents.

METHOD

This is a qualitative, descriptive, and exploratory study based on a database linked to a matrix project called "Nursing Care and Health Education with Children and Adolescents at School." Data collection took place in a state public school, a reference for the education of a population living in social vulnerability. The institution provides full-time education and is located in the urban region of a municipality in the northwest of Rio Grande do Sul.

The research involved 20 adolescents between the ages of 10 and 19, enrolled in the aforementioned school, who had presented some behavior of psychological distress associated with grief. Intentional sampling was used, in which the elements of the sample are selected due to the proximity of the representative population to the problem situation of the study.

Data were collected between May and June 2024 through sociodemographic characterization and individual semi-structured interviews, lasting an average of 30 minutes. The data collection script was structured in two stages: initially, a form was applied to characterize the adolescents, followed by an interview consisting of 16 questions. To end the interviews, the data saturation criterion was used, which occurs when the collection does not bring new elements to the research, making it possible to validate the data set without altering the understanding of the phenomenon. The statements were audio recorded and transcribed in full *in Microsoft* Word® for the development of the analysis.

The transcripts were submitted to Braun and Clarke's thematic analysis, which guides the process in six phases. [14] As shown in the table below.

Table 1. The six phases of thematic analysis.

Phase	Description
1. Familiarization with data	Transcribe the data and review it; read and reread the database; note initial ideas during the process.
2. Generation of initial codes	Code interesting aspects of the data systematically throughout the database; gather relevant excerpts for each code.
3. Search for themes	Group codes into potential themes; bring together all data relevant to each potential theme.
4. Review of themes	Check whether the themes work in relation to the extracts and the database as a whole; generate a thematic map of the analysis.
5. Defining and naming themes	Refine the details of each theme and the story that the analysis tells; generate clear definitions and names for each theme.
6. Report production	Provides vivid examples; final analysis of selected excerpts in relation to research question and literature; scientific report of the analysis.

Source: Adapted from Braun and Clarke (2006)

In addition to the analysis of thematic categories, the findings were presented using a word cloud, which allows for a concise and illustrative visualization of the most recurrent terms in the participants' statements, contributing to the understanding of the main emerging thematic axes.

This study is an amendment to a matrix project entitled "Nursing Care and Health Education with Children and Adolescents at School," which was approved by the Research Ethics Committee (CEP) of the Federal University of Santa Maria (UFSM), under opinion No. 7,483,202 and CAAE number 30731320.7.0000.5346, approved on April 2, 2025. The research followed the Consolidated Criteria for Reporting Qualitative Studies (COREQ), which guides the preparation of qualitative research reports, promoting methodological rigor and respect for the rights of participants. For those adolescents who agreed to participate, the Confidentiality Agreement, Assent Form, and Free and Informed Consent Form (FICF) were distributed. The forms were duly signed in duplicate by the researchers, the participants, and their legal guardians, with one copy given to the participant and the other filed with the researchers.

RESULTS

Twenty adolescents participated in the study, 14 females and 6 males, aged between 10 and 16 years, regularly enrolled in the 5th to 9th grades of elementary school. Regarding self-declared race/color, one participant identified as Asian, two as Black, two chose not to declare, four as White, and 11 as Brown.

Regarding self-reported health conditions, one adolescent reported a diagnosis of depression and bipolar disorder, another mentioned anxiety, and a third reported schizophrenia and autism. Three participants reported having asthma or bronchitis, one stated they did not know, and 12 denied having a previous diagnosis of a health condition.

The findings were organized into thematic categories called: "Adolescents' experiences of grief," "Duali-

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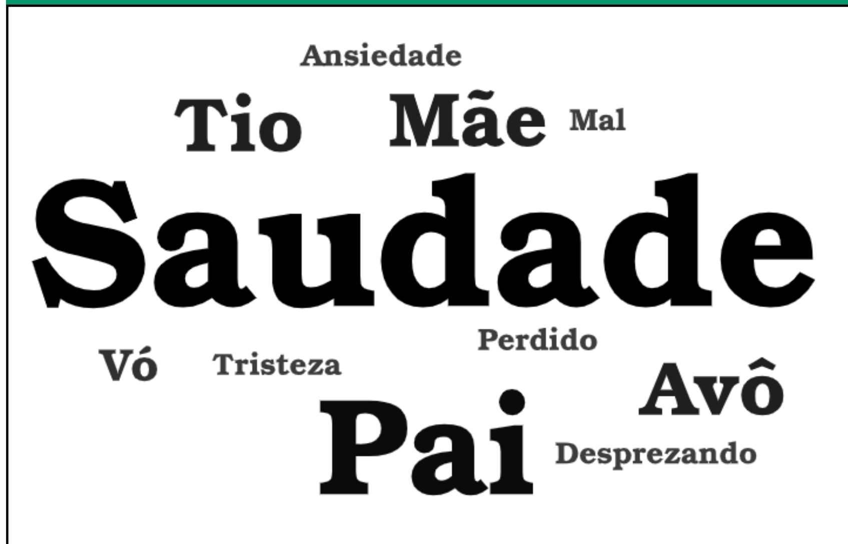
ty in adolescents' emotional support relationships," and "Self-harm and its impacts on adolescents' mental health."

ADOLESCENTS' EXPERIENCES OF GRIEF

The figure below shows a word cloud illustration of the most frequently mentioned statements.

Figure 1. Word cloud of the category experiences of grief among adolescents.



Source: Constructed by the authors, 2025.

The adolescents participating in the study have experienced significant emotional loss, especially in the context of unresolved grief. The narratives highlight the profound emotional impact resulting from the absence or breakdown of bonds with parental and family figures, expressing feelings of longing and helplessness in their experiences of grief.

I miss my grandfather a little... [...] (A1)

It had been three days since I lost my uncle, he was like a father to me, I was alone, I thought about killing myself! (A5)

I miss someone, it was my grandmother... I lived with her. I called her mother, and one night I was lying with her, and she died beside me. (A7)

I am very sad because my father died when I was 7 years old. (A12)

When asked about how they experienced grief, the adolescents expressed difficulties and, in some cases, the desire to take their own lives. Suicidal ideation was even present in some cases, demonstrating the emotional impact of the loss of family members and loved ones.

I tried to hang myself. It's very difficult for me because I loved her since I was little, I love her! It was very difficult to see her die by my side. (A7)

When I am very sad because my father died, I feel like killing myself because I feel this sadness and longing for my father. (A12)

When I lost my grandfather, one day I took a knife and thought about cutting myself all over... another day I was coming home from school and kept crossing the street back and forth, waiting for a car to come and run me over! (A19)

It was also observed that grief is also present as a result of the breakdown of family ties, including those weakened by the separation of parents, the loss of role models for adolescents, or even broken romantic relationships, all of which contribute significantly to mental suffering.

I miss my mother because my father won't let me see her! (A1)

They were about to separate, and I didn't like that situation because all the blame fell on me, and I started to self-harm. (A4)

My father was never present in my life, and I've had a lot of anxiety disorders because of him. (A5)

Look, I never had a father's true love. I feel bad, I remember my uncle, everyone despising me, everything... I'm not well. (A8)

I felt bad, like, because of a girl! Because of something I did, then we stopped talking, and that's how it ended up. (A11)

My father, he lives in another city, and I have no contact with him. (A15)

The study's findings reveal that grief, in its many forms, whether due to physical death, broken bonds, or emotional absence, causes suffering in adolescents. The loss of significant people and the rupture of emotional bonds constitute experiences of pain and emotional instability, which can contribute to suicidal ideation as a way to end suffering. Thus, grief impacts mental health, revealing the need for supportive approaches in the school context.

DUALITY IN EMOTIONAL SUPPORT RELATIONSHIPS FOR ADOLESCENTS

The figure below illustrates the most frequently mentioned statements using a word cloud.

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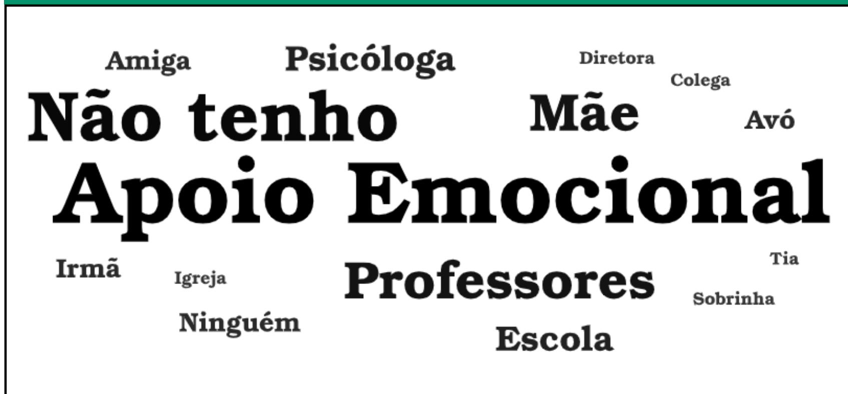
Figure 2. Word cloud of the category duality in emotional support relationships among adolescents.



Source: Constructed by the authors, 2025.

The findings in this category reveal the duality of the supportive relationships experienced by adolescents: while some networks are sources of care and acceptance, others are marked by neglect and emotional abandonment, increasing emotional vulnerability and the risk of psychological distress.

The person who helps me is a specific teacher; she talks to me and calms me down. At home, I have support from my aunt and grandmother. (A1)

Only my teacher, but my mom also talks to me. (A2)

I have my best friend here at school, you know? And she always supports me [...] My teacher asked her daughter, who is a psychologist, to help me, but my mom said it was silly, that I didn't need that [psychologist]. (A4)

Here at school, I feel more welcome than at home. Here at school, I usually talk to my teacher or my classmate. (A7)

Yes, my grandmother. The teachers I tell things to. (A9)

I like coming to school because people make me feel good, but sometimes I feel excluded, you know? But it passes! [...] when I go to church, it gets a lot better. (A17)

I have my friends here. Once, the principal called my mom and talked to her. (A19)

The statements also reveal situations of fear of reporting their feelings, expressing their mental health condition.

No, no one has ever seen me cutting myself, my sister must have noticed, but she never came to talk to me about it. (A3)

It's just my mom, but she'll yell at me a lot, you know? So I'd rather start crying and punch things. (A8)

No, not even with my teachers... I've tried talking to my sisters, but they start calling me crazy. (A10)

I don't talk to anyone. (A11)

I prefer to keep things to myself because if I talk about them, they'll say it's just drama. Once I told my sister, but she doesn't spend much time with me, my mom isn't home [...] everything ends up in a fight in the end. (A15)

I don't trust anyone because there was a time when I told everything to a girl, and then she went and told everyone. Then my mom found out, and she said I had to trust only her because she was my best friend, but when I told her things [sighs] I don't know... if I tell her things, it seems like she ignores me and doesn't have time. (A18)

Some statements refer to psychological and emotional support, to the need to talk about feelings as a strategy to alleviate psychological suffering.

I wanted to go to a psychologist, but now I think I don't need to anymore because it will bother my mom. (A4)

I went to a psychologist for two years, but I stopped because I wanted to. She didn't want me to stop going, but I didn't want to take strong medication anymore. I didn't want to be dependent on medication. (A5)

I talk to my niece, who doesn't understand anything, so I vent to her. [...] the only teacher I trust at school, but I don't always talk to her. I think I could, but I'm not close enough to her. (A12)

When my mother sees me like this, she comes and talks to me. Then I stay quiet and calm down. (A14)

The duality of the presence or absence of emotional support plays a decisive role in the mental health of adolescents. Especially in fragile or broken family contexts, it is possible to observe suffering that aggravates susceptibility to self-destructive thoughts. However, adolescents who have a structured support network may feel safer and more welcome to experience adverse situations.

SELF-HARM AND ITS IMPACT ON THE MENTAL HEALTH OF ADOLESCENTS

The figure below illustrates the most frequently mentioned statements using a word cloud.

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Figure 3. Word cloud of the category self-harm and its impacts on the mental health of adolescents.

Source: Authors' construction, 2025.

The adolescents participating in this study brought up the act of hurting themselves as a means of emotional self-regulation, allowing them to shift the impacts on their mental health to physical, concrete, and transferable pain. In this way, self-harm functions as a ritual of relief from mental suffering.

I feel a little relief from this anger when I cut myself, I manage to calm down a little. (A1)

I was feeling bad, so to relieve my pain, I cut my vein and thought about killing myself... that's why I cut my vein. (A2)

I get very angry, so I cut myself. Then when I cut myself like that, I just focus on the physical pain, and I start to stop crying. (A3)

I need to relieve my emotional pain, so I cut myself, it relieves my pain, because then I can focus. (A4)

It's more to relieve the pain of longing I feel, so I cut myself. (A7)

It's after they yell at me, I start shaking, like a rage attack... and I start biting myself to try to calm down, so I don't try to kill myself or cut myself! (A10)

Self-harm is a strategy for expressing psychological suffering and an attempt to deal with intense emotions. The statements reveal a silent cry in the face of the inability to symbolize suffering or find spaces for listening and acceptance.

DISCUSSION

Adolescence is a phase marked by intense biopsychosocial transformations, which makes this period vulnerable to the emergence of mental suffering. Worldwide, about 14.3% of adolescents suffer from mental health problems. [15] At the national level, research shows that about 17.1% of adolescents have some mental disorder and 88.5% of adolescents who participated in the survey have self-harmed [16], highlighting the high rate of self-harm among adolescents, which reinforces the need for interventions aimed at promoting the health of this population. In Rio Grande do Sul, the situation is no different. According to an epidemiological bulletin, adolescents in Rio Grande do Sul have the highest rate of self-harm notifications and the highest suicide rates in the country. [17] It should be emphasized that the findings of this study reveal self-harm among adolescents and suicidal ideation.

Based on the statements of the adolescents in the study, it was identified that experiencing some type of significant loss during development, whether due to the death of a family member or loved one, is one of the most impactful experiences on the mental health of these adolescents. The impact of parental loss was the risk factor with the most negative consequences. When unaccompanied, such experiences can trigger symptoms such as self-harm and suicidal ideation, because these adolescents are unable to express their feelings, becoming emotionally vulnerable. Not talking about these losses can generate feelings of sadness, triggering depression and anxiety. Discussing the subject has a significant impact on the grieving process, as it is a long-term strategy. [18] This highlights the need to develop strategies for coping with grief in the early stages in order to reduce possible symptoms that increase pain and suffering. [19]

Based on the adolescents' statements, fragmented family relationships were identified, in which there is a lack of attentive listening and acceptance. Given this, the school, teachers, and the entire school network emerge as one of the main sources of support for this population, since they spend most of their time in this space. This finding is corroborated by the literature, which shows that, in many situations, the role played by the school is more important than that played by the family, transforming the school environment into the main emotional and social support network for adolescents. [20] A study conducted with adolescents in Southern California identified that school is the main promoter of adolescent care [21], highlighting the relevance of school in promoting health, with an emphasis on adolescent care and support.

In view of this, teachers play a fundamental role in providing emotional support, and addressing grief and

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mental health in schools provides a space for protection and care. In this context, the School Health Program (PSE), an intersectoral strategy of the Ministry of Health in partnership with the Ministry of Education, is fundamental for building a welcoming environment, in addition to enabling the training of educators to deal with issues associated with death and the grieving process. Schools play an essential role in identifying signs of emotional distress and providing adequate support. Thus, school actions strengthen the promotion of emotional health and contribute to the prevention of negative outcomes related to grief in adolescence.

However, the lack of listening and spaces for dialogue about mental health can compromise the outcomes of adolescents, some of whom end up seeking self-destructive means of expression, as well as self-harming behaviors. [23] In the findings of the present study, the participating adolescents reported resorting to self-harm as a way of dealing with intense emotions, seeking to relieve pain, regulate stress, and express feelings that they are unable to verbalize. Data from a survey of approximately 72,000 Brazilian adolescents aged 12 to 17 identified that 17.1% had mental disorders. This reality is concerning, considering that, in Brazil, between 2011 and 2022, suicide rates among adolescents increased by 3.7%, while cases of self-harm grew by 21%. [20]

In light of these findings, it can be observed that grief and emotional breakdowns emerge as triggers for emotional instability, and the loss of significant bonds, whether through death, parental separation, or emotional absence, weakens adolescents, making them more vulnerable. Thus, emotional support becomes a determining factor in how adolescents deal with suffering. While some find support at school, from teachers, or from friends, others experience emotional isolation within the family unit. The absence or fragility of emotional support becomes a link between experiences of grief and self-harm practices, because when faced with the impossibility of symbolizing emotional pain due to a lack of someone to listen, many adolescents resort to self-harm as a strategy for emotional regulation, transforming psychological pain into physical pain.

Thus, grief and emotional loss weaken emotional balance, and the absence of adequate support culminates in suicidal behavior. The findings of this study indicate that grief is particularly complex and that, in order to better understand how to deal with it, care must focus on the adolescent. In addition, there is a need to reinforce the urgency of integrated interventions between school, health, and family, based on humanized listening, strengthening bonds, and promoting safe spaces for dialogue and emotional expression for these adolescents. In view of this, the importance of the PSE as an essential strategy for addressing the vulnerabilities experienced by adolescents is evident, since the expansion and strengthening of the PSE allows the school environment to become an even more prepared space to welcome, identify, and refer situations involving psychological distress. Among its potentialities, the possibility of nurses playing a mediating role in training education professionals so that they are prepared to intervene, at least at the primary level, stands out[25]

When educators are able to recognize early signs such as behavioral changes, isolation, and mood swings in adolescents, care ceases to be fragmented and becomes more timely and assertive, with the school assuming a strategic role as a listening ear, functioning as a sensitive and active observer of adolescents' daily lives. Thus, it is reaffirmed that joint action between education and health is a way to protect and care for the mental health of adolescents, promoting a comprehensive, humanized, and continuous approach.

CONCLUSION

This study analyzed the experiences of grief and its impacts on the mental health of adolescents, revealing that loss, whether due to death, the breakdown of emotional bonds, or emotional absence, is an experience marked by pain, fear, insecurity, and feelings of abandonment.

The adolescents' narratives reveal that grief, regardless of its origin, has significant repercussions on mental health, including sadness, anxiety, hopelessness, suicidal ideation, and self-harming behaviors.

The findings show that some adolescents experience these situations alone, due to fragile family ties, a lack of listening, and, at times, judgment and emotional invalidation. In these contexts, school emerged as the main place of refuge, where teachers, classmates, and professionals act as a source of emotional support.

Furthermore, the role of nursing stands out, especially in the context of Primary Health Care and intersectoral actions promoted by the PSE. Nurses are strategic professionals in the early identification of psychological distress, the creation of spaces for qualified listening, and the development of educational interventions that promote healthy coping with grief. In addition, they can act in welcoming adolescents who show signs of risk, promoting referrals, follow-ups, and comprehensive care strategies for this population.

Despite its contributions, this study has limitations, such as being conducted in a single school, which restricts the generalization of the findings to other sociocultural contexts.

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In addition, as it is a previously constructed database, it was not possible to expand or adjust questions according to emerging needs during data collection.

The findings highlight the need for new studies that explore different school realities, expand the sample, and delve deeper into specific aspects of the grief experience. Thus, there is an urgent need for new research investigating grief trajectories in adolescence, emotional regulation strategies, and interventions in care, health education, and psychosocial follow-up.

It is concluded that grief in adolescence is a complex and multidimensional phenomenon that requires sensitive, humanized, and intersectoral approaches. The recognition of the school as a place of belonging and of nursing as a protagonist in care reaffirms the importance of preventive actions, emotional support programs, and structured policies that minimize the impacts of grief and promote the well-being and mental health of adolescents.

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