

Exploring loss and grief during the COVID-19 pandemic: A scoping review of qualitative studies

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ABSTRACT

Introduction: The COVID-19 pandemic has brought about multiple losses to various groups, namely patients, families and healthcare professionals. Grief, which is the reaction to these losses, could cause strain on these individuals' physical and mental health if not identified and managed early. This scoping review analysed loss, grief and how they were managed among these groups during the pandemic.

Method: This scoping review utilised the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Statement extension for Scoping Reviews (PRISMA-ScR) and the Joanna Briggs Institute framework for scoping reviews. Only qualitative studies relating to loss and grief and their management were included. Of 166 studies screened, 69 were included in the study. Qualitative analysis and data coding of each record were conducted through qualitative data analysis software.

Results: Losses included the death of family members, patients, colleagues and others. They also included the loss of usual routines, lifestyles and physical health. The grief experienced was multidimensional, affecting mainly the emotional, physical, social and existential realms. Anger, guilt and fear resulted from unsatisfactory farewells, issues with funerals, social isolation, financial strain and stigmatisation. Management strategies could be categorised into 5 themes: communication, finance, counselling, education and spiritual care.

Conclusion: Loss and grief identification and management among patients, family members and healthcare professionals are critically important during this COVID-19 pandemic. Current operating guidelines have proven insufficient in managing loss and grief. Innovative strategies are essential to tackle the many dimensions of loss and grief. Nevertheless, further research is necessary to better understand the effectiveness of implemented policies.

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INTRODUCTION

As of mid October 2022, the World Health Organization recorded that more than 620 million people worldwide have been infected by SARS-CoV-2, the virus causing COVID-19, while over 6.5 million have succumbed to the disease. Many have lost family members and friends as well as jobs and familiar lifestyles, increasing the prevalence of depression, anxiety and stress. Besides accentuating the pervasiveness of grief during the pandemic, such losses go beyond deaths of loved ones, and encompass many aspects of life.

Loss and grief are multidimensional in nature and should be seen as biopsychosocial constructs. Losses can

be categorised into physical, psychological and social, following the model of George Engel.¹ The grieving process reflects a unique convergence of responses to loss, be it behavioural, emotional or spiritual. Although the pandemic safety measures were well-intentioned, they accentuated the losses by imposing disruptions to the grieving process. These caused significant deleterious effects on the mental and physical health of the suffering individuals. The aim of this paper is to look at loss, grief and the management of grief across 3 groups of individuals most affected by the pandemic, i.e. patients, loved ones of patients and healthcare workers.

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CLINICAL IMPACT

What is New

- This study explored the complex loss and grief that COVID-19 is causing, by underscoring the many challenges encountered in the pandemic.
- The scoping review described the approaches to care for the different groups of stakeholders affected by the pandemic.

Clinical Implications

- The findings can guide collaboration efforts among healthcare institutes and governments for multidisciplinary interventions to reduce the impact of loss and grief.
- The understanding also supports further research on COVID-19 loss and grief, given the pandemic's shift towards becoming endemic.

METHOD

This scoping review utilised the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Statement extension for Scoping Reviews (PRISMA-ScR) and the methods outlined in the Joanna Briggs Institute Evidence Synthesis Manual for scoping reviews: (1) identification of research question(s); (2) identification of relevant studies; (3) selection of studies; (4) data extraction and charting; (5) summarisation and reporting of results; and (6) consultation.

Identifying the review questions

The main research questions were as follows: What were the loss and grief experienced by individuals during the pandemic? What were the interventions to manage the loss and grief of these individuals?

Literature search strategy

To retrieve relevant literature, the following databases were hand-searched: MEDLINE (PubMed), Embase, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsychInfo and Cochrane Library. This was filtered to only include qualitative studies. The retrieval period spanned from establishment of each database to 5 August 2021. Search terms engaged comprised “COVID-19” (MeSH terms), “2019 Novel Coronavirus Disease OR 2019 novel coronavirus

infection OR 2019-nCoV Disease OR 2019-nCoV infection OR COVID-19 pandemic OR COVID-19 pandemics OR COVID-19 virus disease OR COVID-19 Virus infection OR COVID19 OR Coronavirus Disease 2019 OR Coronavirus Disease-19 OR SARS Coronavirus 2 infection OR SARS-CoV-2 infection”, “Bereavement” (MeSH terms), “Grief” (MeSH terms), “bereave OR grief OR mourning OR loss”, “qualitative research” (MeSH terms), and “qualitative study OR qualitative research”.

Inclusion criteria

Inclusion criteria for the study were: (1) qualitative studies; (2) individuals with losses and grief during COVID-19; (3) loss and grief management; (4) qualitative findings on experiences of loss, grief and bereavement; and (5) studies reported in the English language.

Study selection and data extraction

The literature retrieval was conducted with reference to the aforementioned inclusion criteria. The full-text articles included on the basis of title and abstract were further reviewed in detail.

Data extracted in this study included types of loss and grief, as well as loss and grief management.

Quality assessment of included studies

For qualitative studies, the Critical Appraisal Skills Programme (CASP) Qualitative Checklist was used for quality appraisal. The tool evaluates studies in 10 domains: (1) clear statement of the aims of the research, (2) appropriate qualitative methodology, (3) appropriate research design for aims of the research, (4) appropriate recruitment strategy for aims of the research, (5) appropriate data collection method for research issue, (6) adequate consideration of the relationship between researcher and participants, (7) consideration of ethical issues, (8) sufficiency of data analysis, (9) clear statement of findings, and (10) value of research (online Supplementary Table S1).

Qualitative analysis

Thematic analysis was conducted on the qualitative data, following a general inductive approach. The included studies were imported into QDA Miner Lite software version 2.0.8 (Provalis Research, Montreal, Canada). Themes and subthemes regarding loss, grief and management were extracted to build a coding schedule.

RESULTS

Literature screening process and results

All searches were performed on 5 August 2021. A preliminary search yielded 166 relevant studies after the removal of duplicates and the final sample size was narrowed down to 69 (Fig. 1).

The sample size for each group of individuals varied from 1 to 20. The most frequently mentioned affected groups were patients (8 studies), family members (17 studies) and healthcare professionals (20 studies). Among these, Dhavale et al. covered both patients and family members.² Others included the general community, religious community, disadvantaged community, students, pregnant women, elderly, and lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ) youths (Table 1). With the exception of 7 studies, the patient demographics of the remaining 62 studies were diverse (online Supplementary Table S1).

Table 1. Summary of included studies

Groups	Number of articles (%)
Patients	8 (11.6)
Family members	17 (24.6)
Healthcare professionals	20 (29.0)
General community	5 (7.3)
Religious community	2 (2.9)
Disadvantaged community	4 (5.8)
Students	5 (7.3)
Pregnant women	6 (8.7)
Elderly	2 (2.9)
LGBTQ youths	1 (1.5)
Total	69

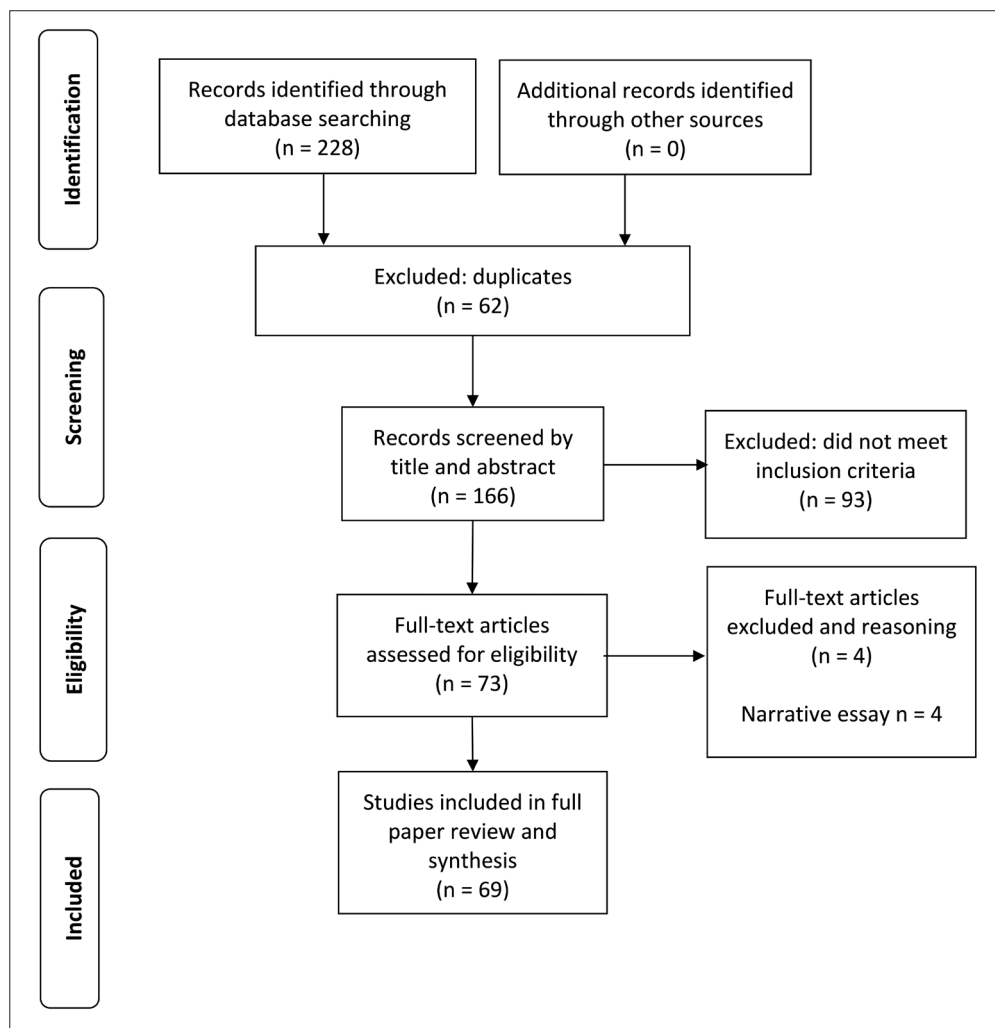


Fig. 1. The process of narrowing down the sample size of studies.

Data analysis

Patients

Eight (11.6%) of the included studies addressed loss and grief among the general patient population, highlighting patients' loss of physical health and the attendant emotional responses.²⁻⁹ Initial symptoms such as fever, cough, anosmia and dysgeusia gave rise to anxiety and fear while social isolation resulted in boredom and loneliness.²⁻⁹ Anxiety revolved around the family's well-being and the risk of transmitting the infection to them.^{2,3} This was compounded by the inability to communicate with medical staff.^{4,7,8} Communication barriers with the latter included language issues, use of medical jargon, lack of updates on the patient's health status and perceived inaccessibility of staff.^{4,7,8} Inadequate communication translated to a sense of lack of autonomy in medical decision-making.^{4,7} Patients felt that their opinions did not matter and were left out of the decision-making process.^{4,7} There was an inequality in the balance of power between patients and staff, where patients face a loss of their "sense of self and autonomy".^{4,7}

The unfamiliarity of the situation brought about by this viral pandemic sparked fear among patients. The changes in healthcare setting raised doubts on the outlook of public health.^{2,6,7,9} Patients are uncertain about their quality of care in healthcare institutes.^{2,6,8} This was exacerbated by misinformation disseminated through social media and other online platforms.³

Regulations barring visitors from healthcare facilities caused loneliness in patients due to physical separation from their families.^{2-4,6-9} When prolonged, this isolation resulted in existential concerns.^{3,4} Patients were afraid of losing their identity, being forgotten by society, and even not remembering their loved ones from cognitive loss.⁴ Upon recovery, patients were worried about hospitalisation costs, their job status and the availability of follow-up care from severely stretched medical facilities.^{2,3,6,9} The uncertainties surrounding their health and the risk of potential relapses caused patients to self-stigmatise and lose confidence in themselves.^{3,9} This was aggravated in some places by the hospitals' inadequate protection of patient identities, resulting in patients being stigmatised and ostracised by society or "social death by the community".³

Family members

Seventeen studies (24.6%) looked at families who suffered the loss of an immediate family member to COVID-19.^{2,10-25} The sense of loss and desolation was exacerbated by strict visiting restrictions that led, in

turn, to reliance on medical staff for updates.^{10,12,14,16,17,23} However, the perceived inadequacy of healthcare such as suboptimal medical intervention, absence of compassion and empathy, unanswered doubts, and contradicting accounts, contributed to the grief.^{10,12,14,16,17,23} Residual feelings of guilt stemming from an unsatisfactory farewell as families were unable to physically accompany patients in their last moments, were also pervasive.^{2,11,12,14-17,19,23,24} Families were also concerned about their own exposure to COVID-19 where logistical barriers to screening left them feeling abandoned by the healthcare system.^{2,21,22}

The families' grief was accentuated during the immediate post-death and mourning period as a result of inconsistencies in the burial ceremonies, which caused anger at times.^{13,15} They were either altered to "abnormal or unreligious burials" that lacked meaning, or worse, absent altogether.^{11,14-16,19,21,22,24} Families thought these "incomplete ceremonies" were the product of "unjustified government policies" dehumanising their loved ones.^{2,14,19,21} They were critical of the government for treating their loved ones as statistics in a system rather than as human beings.^{14,21}

The loneliness of mourning in isolation, the desolation from multiple losses of family members dying in quick succession, and an inability to fully commit towards work and family, translated to a lack of closure.^{13,15,16,19,20,22,24} The cancellation of social events, and difficulty in accessing formal counselling services denied people of outlets for their emotions, further prolonged this grieving process.^{15,16,18,20} Beyond this, families were worried about their future.^{11,13,24} In specific countries, government policies based on culture sparked instabilities within the family, especially when the deceased was the father of the household.^{2,11,13,15,20,25} This was borne out by widows losing custody of the child and having to leave the household upon remarriage.¹¹ Financial burdens from unpaid medical bills and job losses from retrenchments aggravated existing difficulties in earning a livelihood and continuing the children's education.^{2,11,13,15,20,25} Families of COVID-19 victims too were concerned about stigmatisation and feared that the community might be afraid to interact with them, causing social isolation.^{11,15,24} Alternatively, these families might be labelled as pitiful or miserable, complicating the already limited social interactions available to them.^{11,24}

Healthcare professionals

Twenty studies (29.0%) reported on healthcare professionals (HPs) who incurred a loss of routine, social connection and medical personal protective equipment (PPE).²⁶⁻⁴⁵ Iheduru-Anderson²⁶ highlighted a shortage

of PPEs that had HPs feeling vulnerable due to the potential loss of physical health and grievance towards the “betrayal by employers”.^{26-29,31,35,40,45} They were angry at this perceived injustice and felt like the proverbial sacrificial lamb.^{26,27,35} Paradoxically, donning PPE made them feel guilty of depriving others of protection.^{26,27} Some other findings included the following: meetings with patients were limited or stopped altogether; there were no operating guidelines and healthcare facilities appeared to lack clear direction; information at workplaces was unreliable; and decision-making by departments was conflicting.^{26-29,31,33,40,41,43,45} HPs were thus negatively impacted by these disruptions in normal work life. In addition, the loss of multiple patients simultaneously also left many feeling demoralised and inadequate.^{26,27,35,40} Moral distress with ethical dilemmas was prevalent as autonomy and informed consent were forsaken to expedite decision-making processes.^{26-28,41,43}

HPs found work physically and mentally draining as insufficient manpower gave rise to work overload, while off-days were replaced by stacked shifts.^{26,27,34,36,37,43,45} Despite feeling exhausted, HPs felt the pressure to forego rest in order to adapt to the rapidly changing circumstances.^{26,28,31,35,37} Repeated discussions about death with families and watching loved ones say goodbye to dying patients left many HPs overwhelmed, while some believed that hospital protocols were bereft of compassion and humanity.^{26,27} HPs also feared contracting COVID-19 and transmitting the disease to their family.^{26-28,31,32,34,38-40} In some countries, the unreliable screening process and slow results translated into HPs “social distancing” alone at home for longer periods.^{35,39,43,45} This inadequate social contact wore down their mental well-being.^{28,29,31,33,37,41,42} The fear of possibly losing their lives left HPs suffering from insomnia.^{27,29,31,35,36,45} Stigmatisation by the general public further worsened the situation as some demonise HPs for spreading COVID-19.^{26,28,29,36,40}

Others

Some studies described the experiences of specific groups such as the general community, elderly, disadvantaged, religious communities, students, LGBTQ youths and pregnant women. There were similarities with the above groups except for some unique observations.

General community

Several studies found the general community fearful and critical of government guidelines around social distancing and isolation.⁴⁶⁻⁵⁰ Despite self-adherence to these guidelines, lack of adherence by others triggered a lack of trust in governmental enforcement efforts.⁴⁶

Religious community

Religious communities reported divine struggles, losing faith in God due to their expectations not being met.^{51,52} Some expressed doubts in the existence of God or forgot their connection with God entirely due to fear and anxiety towards the pandemic.⁵²

Disadvantaged community

Disadvantaged communities highlighted fear due to the impracticality of social distancing and over-burdening of infrastructure.⁵³⁻⁵⁶ The population size of such communities did not allow proper social isolation due to the limited size of their living quarters.^{53,55,56} Stay-home orders also placed more burden on mobile toilets in these places, causing people to use nearby bushes as make-shift toilets without proper sanitation, thereby further lowering hygiene standards.⁵⁵

Students

Students reflected concerns over ineffective learning environments due to a sudden transfer to virtual learning, where they were unable to retain information and connect with people.⁵⁷⁻⁶¹ Potential technological breakdowns led to time wastage waiting for system recovery, while being constantly online gave rise to worries about work-life balance.^{58,60} The lack of physical teaching and supervision also led to the fear of their inability to complete course requirements.^{58,60,61}

Pregnant mothers

Expectant mothers were fearful of catching COVID-19, especially near their delivery date, due to a lack of information about the birth and risk involved.⁶²⁻⁶⁷ They also felt robbed of important life moments as they were unable to celebrate milestones, such as holding baby showers.^{62,65}

Elderly

The elderly population indicated greater anxiety due to social isolation measures.^{68,69} The perceived isolation and social disconnectedness predisposes them to anxiety disorders, especially in times of crisis.⁶⁸

LGBTQ youths

LGBTQ youths, on the other hand, reported a loss of safe space.⁷⁰ They were anxious about staying home with unsupportive parents and lacking access to school support networks. These youths were also worried about judgemental parents overhearing their telephone conversations.

Interventions to manage loss and grief

Suggested interventions were multidisciplinary and multipronged. They involved multiple domains such as communication, finance, counselling, education, spiritual care and preparedness.

Communication

Communication should involve patients, family members and HPs. Daily updates should be provided to patients and families. The healthcare team must simplify their language, avoid medical jargon, and reassure patients and families that the former are receiving optimal care. Engaging patients and families in medical decision-making, and allowing them to express their concerns in an open, honest and respectful manner would relieve their worry. Although telecommunication technology could bolster family support and care, HPs should still check communication preferences and ensure digital literacy. They could be trained to communicate better with patients and families on end-of-life issues. Better communication between HPs could lead to teambuilding, companionship and better organisational rapport between supervisors and peers.

Finance

Financial aid was relevant for patients and families. Many have lost their jobs and sources of income due to the pandemic. Self-employed individuals closed down their businesses and lost all that they worked for. The downturn in market, social distancing and lockdown measures led to a sharp decline in consumerism. Those in the food and beverage or aviation industry were especially affected, facing massive layoffs. When coupled with the medical bills that follow hospital admission due to the virus, financial burdens were at an all-time high. Government subsidies and grants would go far in resolving medical bills, living expenses and child education for these groups of individuals.

Counselling

Counselling was cardinal in “encouraging constructive processing of negative feelings”.⁷ The first step was for HPs to pay more attention to the mental status of patients and family members. Programmes and protocols needed to be developed to protect their psychological well-being. These could include counselling sessions for individuals to vent their feelings or concerns, regular follow-up phone-calls, or the provision of social support networks. Social media could garner community support for collective mourning, thus promoting emotional relief. For HPs, building resilience to counterbalance loss and trauma should be nurtured. Condolence or bereavement

meetings to acknowledge patient death and debrief should be held regularly. Peer support and professional psychologists should be on standby as part of crisis intervention programmes. Policies protecting work-life balance and ensuring sufficiency of equipment should be established for HPs.

Education

Education was about providing timely and reliable information. This could present as pandemic awareness programmes and health promotion campaigns. Society should be encouraged to refrain from stigmatising and discriminating against patients, their families and HPs. Dissemination of accurate and up-to-date information about the disease helped to provide proper expectations of health outcomes and management. Patients could be taught self-help physiotherapy, or to incorporate technology such as virtual reality into their rehabilitation process. For HPs especially, healthcare facilities needed to provide clear guidelines and policies on palliative care to support the staff and reduce inconsistencies.

Spiritual care

Spiritual care went beyond rallying belief in a faith system and finding substance in a greater being. Governments could respect the preferences and religious identities of patients and their families without judgment. Funerals should be conducted in accordance with religious burial rites as far as possible, and in the company of family and friends. Otherwise, rituals were to be adjusted to balance patient and family needs while conforming to safety policies. To build on this, the government could provide education and referrals for families struggling with the logistics of special funeral arrangements. Objects with symbolic meaning could also be installed to remember victims.

DISCUSSION

The COVID-19 pandemic gave rise to an influx of articles that highlighted the loss and grief experienced by specific groups of individuals, while exploring pre-existing interventions and proposing new ones to tackle the issues at hand. Some of these articles approached the topic through thematic analysis as well. However, these existing studies were notably of narrower scope in terms of groups studied. Our analysis found that across all the literature reviewed, a few overarching themes regarding loss, grief and interventions could be identified and categorised: communication, finance, counselling, education and spiritual care. Our study also found that these 5 themes could be further harmonised into 3 approaches for application: communication, reassurance and preparedness.

Communication

In this study, we found that high-quality communication was paramount. This encompassed communication of understandable information addressing the availability of staff, medical care plan, inclusion of patients and families in care, and information dissemination to HPs. Inadequacies in communication induced emotional responses such as anxiety and frustration, which led to dissatisfaction and a lack of confidence among all stakeholders. These findings have implications for healthcare systems that wish to improve their care during the COVID-19 pandemic and beyond. Study findings emphasised the importance of effective strategies targeting the improvement in quantity and quality of communication. There should be regular training for HPs on elements of communications that patients and families favour for better rapport and satisfaction. These can come in the form of workshops, where HPs practise communication skills with simulated patients and are provided feedback at the end. Healthcare leaders could support everyone with clear instructions and regular updates. Daily updates on the latest protocols could be emailed to every HP, while scheduling briefings for everyone at the start of a new week or when there is launching of new protocols.

Despite the expansion of telecommunication, not everyone has the required equipment and digital literacy. Governments and healthcare institutes need to collaborate to overcome barriers to digital inclusion—social support, collaborative learning and provision of equipment. A multidisciplinary taskforce can be set up to assess each region's digital literacy, and free digital literacy workshops provided to those regions flagged out. In the setting of stretched social support manpower, creation of videography materials or brochures could also be a fall-back to educate patients and families on realistic expectations and resources for self-help. Current standard operating protocols could be updated to bolster efforts in orchestrating clear consistent messaging on the aforementioned levels. Collaborative efforts between the government and healthcare institutions are necessary to plan the processes of the new protocols. A separate committee of auditors could be established to ensure proper implementation that reaches all strata.

Reassurance

Our study highlighted the importance of reassurance in one's future. Worries about the impact of COVID-19 on lives were a recurrent theme in our findings. These were general concerns about physical health, financial difficulties, stigmatisation and more targeted concerns

about the learning environment. COVID-19 aroused fear of the unknown and anxiety from unpredictable and uncontrollable situations, affecting the well-being of individuals due to their focus on negative emotions. For physical health, the authorities could streamline the screening process to resolve worries about exposure and relapses. Release of the definitive results of the screening could be prioritised, with the detailed medical report provided later. The government could establish financial benefit packages to support jobs and finances. The masses can be incentivised to patronise small businesses through the introduction of subsidies to ease living expenses, while helping to sustain the livelihood of small businesses as well. Data protection education to prevent leakage of personal data must be regularly held within institutes. Frequent campaigning through physical brochures or televised advertisements can promote awareness in limiting stigmatisation. As for students, the promotion of adaptability was vital to their engagement. Institutes need to reassure students of the continuity of their education with concrete schedules and timetables. Introduction to digital learning through crash courses and digital literacy assessments will lower students' dependency on physical delivery and heighten their confidence.

Preparedness

Lastly, our findings urged preparedness in both aspects of preventing loss and combating grief.

Preparedness applies to healthcare resources, protocols and government directives. Healthcare facilities needed to assign store managers to maintain an appropriate stockpile of equipment for emergencies. At the same time, regular business continuity planning is required to address foreseeable causes of equipment shortage.

Being ill-prepared predisposed individuals to complicated grief. Inability to adapt after loss delays the transition from acute to integrated grief, which can result in prolonged grief, as well as separation and traumatic distress (recurrent painful emotions and sense of disbelief). There should be training for HPs to identify distress and assist in the grieving process, with a support network of psychiatrists on standby. Some healthcare facilities do have welfare committees and counselling services readily available, but there is a lack of spiritual care protocols in place. Healthcare institutes could address this by setting up pastoral services to provide better engagement with religious groups. The pandemic makes it impractical to hold extended wakes or have large attendances but alternatives do exist. Relevant services could prepare alternatives such as virtual platforms instead of physical wakes, where the event is live-

streamed to overcome social distancing measures. No matter which option, uniform application of selected regulations across the nation is key. It is essential to craft relevant healthcare protocols and government directives for pandemics beforehand and ensure proper enforcement throughout. These should include the guarantee of reliable information, work-life balance, and burial processes. Clear and consistent instructions that integrate the perspectives of the masses inspires confidence and security. This ties back to the aspect of communication, where the necessity of these directives must be clearly explained to the masses, i.e. not to trivialise death, but to curb the spread of the pandemic and ensure everyone's safety.

Psychological interventions in the form of cognitive behavioural therapy (CBT) and mindfulness-based cognitive therapy (MBCT) can help to prepare individuals for acute grief. CBT can prevent poor coping behaviour such as avoidance and antagonistic confrontation, while challenging cognitive biases. Stress management is enhanced, improving psychological outcomes through inhibiting the prolongation of grief. MBCT utilises various mindfulness meditation practices to cultivate non-judgemental awareness. To cross physical boundaries, MBCT can be hosted on virtual platforms, which will prove beneficial to those in quarantine or in isolation facilities without access to mental health professionals. Virtual platforms are also an avenue for mutual peer support to cultivate resilience and foster companionship.

Strengths and limitations

To our knowledge, this review is the first in Singapore to synthesise evidence regarding broad principles of loss, grief and their management in the context of the COVID-19 pandemic. In addition, the quality of evidence of this study is high as evidenced by the CASP tool.

Nonetheless, this review was limited by the exclusion of non-English language reports that might be relevant, thus diminishing the scope of the study. In addition, the qualitative nature of the studies rendered the reported findings subjective, leaving grounds for dispute on the validity of our data. Furthermore, this review might not have achieved data saturation as not all plausible themes might have been captured. Given COVID-19's fast-changing development, this study only reflects a specific point in time of the pandemic. However, we believe our findings are still applicable to the general population as our sample size is relatively large for a qualitative evaluation (n=69). At the point of writing,

the pandemic is still evolving rapidly, challenging healthcare systems and becoming endemic with the rollout of vaccination programmes in many countries. Many more people will be experiencing loss and grief in the near future. Studies must examine the experiences of these individuals during as well as after the pandemic is controlled. The effectiveness of the suggested system-level interventions should also be explored. Differences in cultural contexts will lead to significant variations in the implementation and effectiveness of system-level interventions. The specific intricacies could be further studied when more evidence citing cultural contexts is published. Further research can also be conducted for translating the suggested interventions proposed in this study to real clinical settings.

CONCLUSION

The COVID-19 crisis has caused many to suffer losses and experience grief. To maintain the biopsychosocial well-being of the people, governments and healthcare systems need to identify the demographics facing such conditions. The results of the present study show that patients, families and HPs are the main groups suffering from multifaceted losses and grief. Moreover, the impact of COVID-19 and current societal restrictions filled those afflicted with fear for their future, which further aggravated their emotional and psychological well-being.

In response, we propose collaborative efforts between the government, welfare organisations and healthcare systems to raise public awareness and establish guidelines to ensure the physical and psychological well-being of society. Healthcare officials and government policy-makers can use the findings of the present study to provide comprehensive and holistic support (physical and financial-social), and minimise psychological and spiritual distress to those suffering grief during this pandemic.

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