

I can't believe they are dead. Death and mourning in the absence of goodbyes during the COVID-19 pandemic

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Abstract

The circumstances surrounding the deaths during the COVID-19 pandemic and the subsequent mourning process transpired in completely atypical conditions. This study analyses the experience of losing a loved one without traditional, culture-specific rituals for saying goodbye, explores the different factors affecting the onset of mourning by family members and studies the existence of complicating risk factors associated with grief from this distinct type of loss. A qualitative, phenomenological and interpretive research study was undertaken through in-depth interviews of 48 informants, key and general, in the autonomous Community of Madrid. The interviews were conducted between July and November of 2020 and were followed by an interpretive categorical qualitative analysis. The principal results include (a) the finding that deaths caused by the pandemic are, due to their characteristics, a complicating factor for bereavement, (b) evidence that the professionals who supported these deaths with a holistic approach, facilitating the process for the family members, have been a determining factor in enabling the beginning of the mourning process and reducing anguish for the family members and (c) the conclusion that a need exists for a resignification of the funeral rite. Finally, before future crises, it is recommended that access protocols be developed for relatives, including methods that permit them to say goodbye to their loved ones, no matter the situation.

KEYWORDS

COVID-19, death, farewell, grief, loss, mourning, ritual

1 | INTRODUCTION

Worldwide over 2,500,000 people died from COVID-19 between the end of 2019 and March 2020 (Dong et al., 2020). The pandemic has affected the entire world population, and in the first months of 2020, the number of infections and deaths was especially high in Italy and Spain.

In Spain, 152,230 deaths from illnesses occurred between the months of March and May 2020, a 44.80% increase in deaths compared to 2019, of which 45,684 were caused by the COVID-19 virus (INE, 2020).

Most of these deaths occurred during the period of the state of emergency declared in the country, which limited, among other

things, the free movement of people, subjected the population to home confinement and restricted attendance at funeral services.

Protocols were activated for hospitals and senior residences prohibiting visitors as well as eliminating the possibility for family members to accompany patients through any required healthcare treatment. The people who died in hospitals and residences passed away without their families by their sides, and those who lived alone also died in solitude.

Wakes and funerals were prohibited, and only two family members were permitted to attend a burial or cremation. The great majority of Spaniards could not say goodbye to their loved ones, in either the moments before or the moments after death. These were, therefore, deaths without farewells.

The pandemic produced a significant number of unexpected deaths with very special circumstances and consequently, a similar quantity of bereavements that came to be in very special circumstances (Menichetti et al., 2021), many to date unaccounted for, and that have the potential to have devastating effects on individuals and society in the short and long term (Wallace et al., 2020).

The reality of not being able to see the cadaver or identify the body, can result in profound ambiguity (Imber-Black, 2020), and the perception of not having seen the person right before the death, or after the passing, makes it difficult to rationalise the loss, evokes a sense of disbelief that the loved one has actually died (Field & Filanosky, 2009), and therefore complicates the process of coming to terms with and accepting the death.

Unresolved losses (Lazare, 1989) triggered by a sensation of disbelief from not having seen the loved one in their last moments, nor seeing the body in the moments after the death, can make it impossible to experience a normalised grieving process (Worden, 2009). A corresponding absence of the farewell rite or end of life celebration further promotes the loss into the category of so-called ambiguous losses (Boss, 1999) that are fraught with uncertainty and freeze the mourning process or make it difficult to progress through.

Ambiguous losses occur when the deceased is physically absent, but a psychological presence continues (Boss, 2010). This type of loss generates a complication for grief in response to stressors that naturally obstruct the acceptance of the loss (Hollander, 2016).

The theory of ambiguous loss has been applied in a novel way by Scheinfeld (Scheinfeld et al., 2021) to the situation that the COVID-19 pandemic has placed the world in.

Among other factors complicating grief, Worden (2009) highlights the circumstances surrounding the loss, the type of death and the absence of a social support network, as well as underlying social challenges with speaking openly about death.

During the COVID-19 pandemic, a concurrence of these factors has existed. The circumstances surrounding deaths have been extraordinary with a completely unfamiliar situation for mourners and the support of a social network has been greatly reduced by the impossibility of accessing the deceased's relatives to offer condolences. In a literature review, Mason et al., (2020) also highlight the location of death (hospitals and senior residences) and the absence of emotional support during mourning, as complicating factors. Complicated grief can become pathological when it deviates from the expected course, and this can have detrimental health consequences for the bereaved (Middleton et al., 1993). Pathological grief is characterised by a notably intense emotional response, which is prolonged and that prevents the elaboration and performance of normal daily tasks (Echeburúa & Herrán Bolx, 2007).

For Scheinfeld (2021), the benefits of farewell rituals with helping a return to normality have not been realised due to the limitations of the online format that has occurred during the pandemic, which, while useful, cannot replace the close support and physical contact that is so necessary at the beginning of the grieving process. Throughout the pandemic, the mourning process for families has been hindered by an absence of traditional rituals where there can

What is known about this topic:

- The circumstances surrounding a loss and an absence of social support are complicating factors of mourning
- Ambiguous losses provoke a freeze in the grieving process
- The act of saying goodbye to the deceased facilitates coming to terms with and accepting the loss

What this paper adds:

- The losses that have occurred during the COVID-19 pandemic have elements similar to ambiguous loss
- Not being able to say goodbye to a loved one who dies, before and/or after the passing, is a complicating risk factor for bereavement
- The role of professionals is fundamental to facilitate a normalised mourning process

be direct, physical contact with the decedent's loved ones (Burrell & Selman, 2020).

In the first moments of shock and numbness after the death of a loved one, social and family rituals facilitate the resolution of the state of shock and disbelief (Vargas, 2003). Funeral rites encourage detachment from the loved one (García & Suarez, 2007) and facilitate the mourner with connecting to the reality of the loss. Seeing the cadaver helps with becoming aware of the reality and the irreversibility of death (Worden, 2009). The performance of the funeral rite and the community support that occurs during this ritual is a factor in protecting the individual from suffering a complicated bereavement (Braz & Franco, 2017).

For Worden (2009), the first task in healthy mourning is to become conscious of the reality of the loss, a task that is slowed down or even blocked when there are no goodbyes or subsequent farewell rituals.

This study explores and describes the experience of losses during the worst months of the pandemic, from the point of view of the mourners and of the professionals that have been direct witnesses to the deaths (healthcare workers, funeral directors, firefighters, etc). Specifically, the aim is to: (a) describe the experience of the loss of a loved one without the culturally determined rituals for the farewell, (b) explore how the grief process experienced by family members is initiated under the conditions generated by the pandemic and (c) study the existence of factors complicating grief that are associated with this type of loss.

2 | METHODOLOGY

2.1 | Design

This work is based on a qualitative, phenomenological and interpretative approach through in-depth interviews. A deep exploration of

the experiences of the participants who faced a critical situation due to COVID-19, such as the death of a family member, was conducted, collecting their feelings, perceptions and thoughts, and observing how they gave meaning to what they experienced. The interview offers a contextualised view of the experience, allowing one to historically and socially frame personal experiences and thus understand the social processes that may underlie subjective evaluations or interpretations (Finkel et al., 2008).

2.2 | Recruitment and sampling

The study was carried out in Madrid, one of the largest cities of Spain and the one most affected by the pandemic. Forty-eight informants of different types (general informants and key informants) were interviewed, both relatives of the deceased as well as professionals involved with these deaths (Table 1). The criteria for selection were as follows: (a) First or second-degree relatives of a deceased person (General informants). People with different types of kinship and close relationship to the deceased were included in the sample. All interviewees contacted agreed to participate in the study; (b) In the case of the professionals (key informants), informants were selected who had different roles and worked in distinct types of institutions. Social workers were the most reluctant to participate. All participants were contacted by telephone, the project was explained, and their collaboration was requested. The interviews were carried out progressively, following, to some extent, theoretical sampling (Glaser, 1967), utilising the constant comparison between each type of informant (general and key), and seeking distinctive aspects in newly selected informants, or to augment central analysis categories that required greater depth; finally, the research questions and objectives guided the inquiry process and the search for new observations and interviewees. When the information received was repeated over and over, the information required to fulfil the objectives was considered to have reached a saturation point. Interviews were conducted between July and November 2020. One of them was conducted in writing and seven by videoconference due to pandemic restrictions, the rest were conducted in person. An interview of a social worker that was broadcast on national media included information relevant to the study and was therefore included (IP08). The interviews were approached as a conversation, following Kvale (2006), around three dimensions: The circumstances and process of the loss, the farewell rituals or absence thereof and the acceptance of the loss and/or beginning of the mourning process. All the interviews were recorded digitally and transcribed verbatim.

2.3 | Ethical considerations

Considering the sensitivity of topics involved in this research, compliance with the appropriate ethical requirements was maintained, under the supervision of the University Ethics Committee, who

issued a report of approval. All participants were informed of the objectives of the research study, the sources of financing and the planned use of the results. Informed consent was solicited, and informants were notified that their participation was voluntary. Permission for audio recording was also requested. Anonymity was guaranteed through a confidentiality agreement.

2.4 | Data analysis

After the verbatim transcription of all the interviews, the analysis began with the support of the Nvivo 12 plus program, which facilitated categorisation and codification. The analysis was carried out in three phases: exploration and discovery phase, categorisation and codification and interpretation (Taylor & Bodgan, 1987). The participants' discourses were examined via a categorical analysis that considered both content and discourse analysis (Cheek, 2004). First, the language used was explored, taking into account the words and phrases used and the sentiment associated with them (Hsieh & Shannon, 2005). Second, the analysis focused in on the meanings associated with death and the farewell to close relatives. The development of the analytical categories and the codification of the interviews were central to this stage (Ryan & Bernard, 2003) (Tables 1 and 2). The last step of analysis was the interpretation and association of meanings with the circumstances and contexts in which they took place. The main strategies of rigour and quality criteria associated with qualitative research were applied (Lincoln & Guba, 1985). Reflexibility was used in the data collection process, as well as content saturation and key categories; to prevent biases in the first author's interpretations, the second author reviewed the results and analysis for dependability and confirmability (Darawsheh, 2014).

3 | FINDINGS

During the state of emergency decreed by Spain, between March and May of 2020, thousands of people died without the company of their loved ones and without the possibility of saying goodbye because of confinement.

Families had to begin to mourn under totally extraordinary and unprecedented circumstances.

(The following results are illustrated with excerpts from the interviews shown in Table 3).

3.1 | I couldn't say goodbye to her. I felt like it was a kind of kidnapping

For these families, the loss began at the moment that family members said goodbye to the loved one as they left for or entered the hospital, without being aware in many cases that they would not see their loved one again, neither alive nor after they had passed.

TABLE 1 Data sheet of the subjects interviewed and categories

Interviews of professionals	Role	Corresponding categories	Main contributions
Hospital employees			
IP01	Medical Director	A,C,D,F,G,I	Overview of death in hospitals. Facilitation of farewells to the dying despite healthcare protocols. Some relatives avoid saying goodbye.
IP02	Psychologist	A,B,C,D,G,I,J,K	Narration of cases. Importance of saying goodbye for grief progression.
IP08	Patient Experience Department Representative	A,B,C,D,F,G,H,I,J	Facilitation of farewells to the dying despite the healthcare protocols. Reactions of family members to death. Management of personal effects.
IP09	Nurse	A,B,C,D,E,F,G,I,J	Reactions of family members to death. Importance of saying goodbye for grief progression.
IP35	Nurse	A,C,D,F,	Absence of goodbyes in the ICU. Personal fears.
IP40	Doctor	A,C,D,F,G,I	Goodbyes in the Emergency Department. Limitation of the healthcare protocols with regard to goodbyes.
IP41	Doctor	A,B,C,D,F,G,I	Facilitation of farewells to the dying despite the healthcare protocols. Reactions of family members when facing the death of a loved one.
IP42	Social worker	F	Her role was not related to the deaths but with the organisation of patients and facilitating contact with families.
IP15	Chaplain	A,B,C,D,E,F,J	The importance of goodbyes for proceeding with grieving. Reactions of family members to death. Importance of ritual performance and spiritual transcendence.
Senior residence employees			
IP04	Director and Owner	A,B,C,D,F,G,I,J	Overview of death in senior residences. Reactions of family members to death. Limitations of the healthcare protocols with regard to goodbyes. Absence of farewells and mourning.
IP05	Orderly	A,C,D,E,F,G,I	Absence of goodbyes and absence of connection with family members. Narratives about the deaths.
IP06	Social Worker	B,C,D,F,G,I	Absence of goodbyes and absence of connection with family members
IP07	Psychologist	B,C,E,D,F,G,H,I,J	Grief and family member reactions. Grief and reactions of family members. Unexpected deaths and the effects.
IP11	Communication Director	A,B,C,D,E,F,G,H,I,J,K	Overview of death in senior residences. Limitations of the healthcare protocols. Reactions of family members to death. Substitute rituals. Some relatives avoid saying goodbye.
IP12	Social Worker and Sales Manager	A,B,C,F,H	Reactions of family members. Reactions on personal belongings of the deceased. Grief.
IP13	Orderly Coordinator	A,C,E,F,G	Moments of dying alone. Unexpected deaths. Reactions of family members.
IP14	Orderly	A,C,D,E,F,G,H,J	Moments of dying alone. Unexpected deaths. Reactions of family members.
IP32	Director of Residence	A,C,J	Overview of death in senior residences. Absence of goodbyes and reactions of family members. Substitute rituals.
IP33	Orderly	A,C,F,G	Absence of goodbyes and reactions of family members
IP18	Chaplain	A,C,E,I,J	Absence of religious rituals, importance for some families.
Funeral services professionals			
IP16	General Secretary and Secretary of the Board of Directors	A,B,C,F,H,I,J,K	Overview of the organisation of farewell rites. Absence of these rites. Importance of the rite in bereavement. Contextualisation of the work in a funeral home.
IP17	Quality Assurance Manager	B,C,J	Importance of ritual in mourning. Organisation and absence of rituals. Resignification of the funeral rite.

(Continues)

TABLE 1 (Continued)

Interviews of professionals	Role	Corresponding categories	Main contributions
IP19	Sales	A,C,F,I,J,K	Reactions of family members after deaths. Organisation and limitation of rituals.
IP20	Sales Director	A,B,C,F,I,J,K	Reactions of family members after deaths. Organisation and limitation of rituals. Resignification of the funeral rite.
IP21	Hearse Driver and Mortician	A,C,F,I,J,K	Reactions of families after deaths at home. Narration on funeral rites during the pandemic.
IP22	Head of Coordination and Control	C,I,	Limitations in the protocols for the collection of corpses and their accompaniment.
IP23	Customer Service Representative	A,B,C,F,J	Family reactions. Initiation of the mourning process in the face of ritual limitations.
IP24	Public Relations Representative	A,B,C,F,J	Family reactions. Initiation of the mourning process in the face of ritual limitations.
IP25	Human Resources Manager	A,B,C,	Additional information on the organisation of the funeral service and the functions of the funeral professionals.
IP26	Communications Manager	A,B,C,F,J	Importance of funeral rites for mourning. Narratives on how funeral services professionals approached communication with family members and society. Resignification of the funeral rite.
IP27	Assistant to the Business Director	A,C,F,J	Additional information on the organisation of funeral service operations
IP10	Chaplain	A,C,E,I,J	Importance of ritual for bereavement. Religious rituals and family reactions at the cemetery.
IP34	Public Relations Representative and Crematorium Technician	A,B,C,E,F,I,J	Reactions of the families at the cemetery. How the funeral rites have been conducted under the established protocols.
IP38	Undertaker	A,C,F,I,J	Reactions of the families at the cemetery. How the funeral rites have been conducted under the established protocols.
IP39	Public Relations Representative	A,C,F,J	Family reactions. Initiation of the mourning process given ritual limitations.
Emergency services professionals			
IP30	Doctor	A,C,E,F,G	Reactions of families to deaths at home. Farewells and their importance.
IP31	Nurse	A,C,D,F	Reactions of families to deaths at home. Farewells and their importance.
Emergency social workers			
IP36	Volunteer Social Worker	C	No cases related to bereavement and death were assigned to her, she attended to other requests related to social services or social assistance.
IP37	Volunteer Social Worker	A,B,C,I,	Importance of goodbyes. Requests from mourners for social services support. Start of the beginning of mourning.
Others (collection of corpses)			
IP28	Firefighter	A,C,F,G,I	Impressions on the absence of farewells. Protocols for the treatment of corpses.
IP29	Firefighter	A,C,F,I	Impressions on the absence of farewells. Protocols for the treatment of corpses
IP03	Priest Improvised Morgue	A,B,C,E,F,G,I	Absence of rituals and substitute rituals, including online. Rituals and mourning. Funerals after the state of emergency. Religious meaning of rituals. Resignification of the funeral rite.

TABLE 1 (Continued)

Interviews of Family Members	Role	Corresponding Categories	Main Contributions
Daughters			
IF02	Daughter of deceased	A,B,C,D,E,I,J,K	Narratives on the mourning process. Feelings associated with the absence of goodbyes and the importance of being able to perform rites.
F03	Daughter of deceased	A,B,C,D,F,J,K	Narratives on the mourning process. Feelings associated with the absence of goodbyes and the importance of being able to perform rites. Emotions related to a missing corpse. Freezing of grief.
IF05	Daughter of deceased	A,B,C,D,F,G,J	Narratives on the mourning process. Feelings associated with the absence of goodbyes and the importance of being able to perform rites. Emotional attachment to the living. Ambiguous loss. Need for closure.
IF07	Daughter of deceased	A,B,C,D,E,F,H,J,K	Narratives on the mourning process. Feelings associated with the absence of goodbyes and the importance of being able to perform rites. Need for closure.
Granddaughter			
IF01	Granddaughter of deceased	A,B,C,D,F,J,K	Narratives on the mourning process. Feelings associated with the absence of goodbyes and the importance of being able to perform rites. Need for closure.
Widow			
IF06	Wife of deceased	A,B,C,D,E,G,J,K	Narration of death at home with the possibility to say goodbye and to sit vigil with the corpse. Initiation of the mourning process.
Friend			
IF04	Resident in a Senior Residence	A,B,C	Experiencing the death of fellow residents. Focused more on their fears than on grieving for the loss.

TABLE 2 Categories

Indicator	Category	Description
A	Goodbyes	Narratives about the last goodbyes or the absence of these, both before and after the death of the loved one.
B	Grief	Explicit or implicit comments about the beginning of the mourning process or the prospects of how it will proceed.
C	Emotions	Expressions of emotions and feelings experienced before death and illness, both in family members and professionals.
D	Moment of Death	Narratives explaining the moment of death and the circumstances surrounding it.
E	Spirituality	Comments and expressions of religious or transcendental feelings associated with loss and death.
F	Informing Family Members	The professionals tell how they informed the relatives about the aspects related to the death of the loved one or about the treatment of the corpse, and how family members reacted. Family members talk about receiving the news.
G	Unexpected Death	Verbalisations about sudden and unexpected deaths and the reactions of the bereaved.
H	Deceased's Belongings	Explains the attachment after the death of some mourners to objects belonging to the deceased.
I	Healthcare and Mortuary Protocols	Refers to the protocols established by the authorities that prevented or allowed the farewells, or to sit vigil with the corpse, as well as the occasions in which they were not complied with.
J	Rites	Reference is made to funeral rites or the absence thereof.
K	Sitting Vigil with the Corpse or Ashes	Narratives about the possibility or impossibility of accompanying the corpse or even the ashes of the corpse and associated sensations.

In some cases, this last goodbye occurred in the hospital emergency room prior to admission (VF1), in other cases it took place at home when the ambulance took the patient away (VF2).

In senior residences, the ban on visits was implemented suddenly, which in many cases meant people never saw their loved ones again (VP1).

TABLE 3 Verbatim interviews transcripts - professionals (VP) and family members (VF)

Verbatim transcripts	
VF1	"They put him on oxygen and then suddenly everything was like chaos. I remember they would yell code, code, they were taking him to be resuscitated. They laid him down, they grabbed him, with like a spoon, from the wheelchair, the thing is I didn't get to see his face again because he turned around from me, neither a goodbye nor anything. I stayed...like this. And me, code would reverberate in my head and I would think darn, resuscitation is for people who are dying, or who are having a stroke, who need to be resuscitated, what do I know." (IF04 Daughter of Deceased)
VF2	"And well, me, the goodbye... that is, I didn't see him physically since the day I called the doctor. I never saw him again." (IF03 Daughter of Deceased)
VP1	"And there are [relatives] that came in February or the first weekend in March and they haven't seen their relatives again, they haven't been able to see, nor have they been able to go to the hospital, nor could they come in here, nothing at all." (IP13 Psychologist in a Senior Residence)
VP2	"Unfortunately, we have seen that there have been a lot of cases of people who presented with mild symptoms for a few days, even without having a fever, and who suddenly in a period of two, three hours, all of a sudden would begin to have a very, very, very high fever. They would start saturating, they would start with respiratory problems and they would die in two, three hours." (IP14 Communication Director for Chain of Senior Residences)
VP3	"To be talking with them and they drop dead, and that patient five minutes earlier had been on the phone with their family, and then telling their family member that the patient was dead, and they would tell me: 'Doctor, that is impossible.' And me: 'Well no... the patient is dead' and they would tell me: 'That is impossible.' And the truth is, ugh..." (IP07 Doctor)
VP4	"You would call a relative and you would say...: 'Look I am so sorry, your dad has passed away,' and the daughter would say to me: 'but what hospital are you calling me from?'; 'from Santa Cristina' and she would tell you: 'That can't be, my father was admitted to the Príncipe de Asturias, in the ER, he walked in there on his own to be admitted, with a little shortness of breath, a low grade fever and 'well my daughter I will see you later, bye-bye.' What that daughter doesn't know is that in the fervor of the battle that father in the ER had worsened, and in a rush, they had brought him to our hospital, in our hospital he had been admitted, he kept worsening, he had been intubated, and finally he had died. And no one in that process had had time to call the daughter." (IP04 Nurse)
VP5	It's not the same to be told: 'hey'; Than when you know you have a relative who is sick with an illness, you see how they deteriorate, you are by their side and keep them company, you talk to the doctors and see it coming, you can prepare... to suddenly, like in this case, leave a person with a mild cough and a low grade fever.... And this person is gone in two days and you can't see that person, you can't talk to a doctor, you can't get a hold of anyone." (IP30 Funeral Home Communications Manager)
VP6	"Another one asked me for the earrings, and I mailed them because they needed to know that it was their mother and the only way to know was the earrings." (IP14 Communication Director for Chain of Senior Residences)
VP7	"And in that regard that it was the condolence message to the family, it caught my attention how they couldn't believe that their relative had passed, that they would ask more questions: 'Libertad, I need to know if he died with his mouth open,' and I would say: 'Well, if you need it, I will go the doctor and ask him,' or 'Who was there in that moment, who closed his eyes?' Very specific questions about death that shocked me, and I say, 'Good heavens, the mouth open...'" (IP15 Social Worker in Chain of Senior Residences)
VF3	"I needed, let's see. I hadn't been able to talk to my father and say to him 'How are you feeling? What do you feel, are you scared? Or, do you feel bad? Do you feel well?' Thus, I had the need to read everything. I even read how he had died and well that he had an IV in his femoral, then in the jugular or there were things, well, very hard that you don't want anyone to go through, much less your own father. Thus, well I think I have a pretty big trauma that I will need to treat, no doubt, because when I start thinking about it, I start to have a panic attack and no one should touch me, no one should stress me." (IF04 Daughter of Deceased)
VF4	"Another really hard thing was to not be able to speak with him. A friend of my boyfriend, his dad was hospitalised, and he is young, and of course he had his mobile phone, but my grandfather didn't know how to use his mobile, actually he didn't even take it with him, and also, he was going to the hospital and I didn't think like 'take your mobile, take it to keep us informed.'" (IF05 Granddaughter of Deceased)
VP8	"The thing is she called us almost daily, it was these daughters who called their father every morning and afternoon, and when he passed, they continued calling: 'Well it's as if he hasn't died, Higinia, and we are simply calling to know how you are doing because it seems as if you gave us a bit of strength and such...'" (IP10 Director in Senior Residence)
VF5	"And then I started having conversations with his roommate. He would tell me he was doing terribly, that he had two kids, that he was scared of dying. And there I was cheering him up and I said to him 'well, you will both go on, - I say- you'll see, do you mind if I call you more often?' And he said: 'no, no, as often as you'd like!'" (IF03 Daughter of Deceased)
VF6	"And in fact, I think of his voice a lot, if there is a day that it's blurrier, I call him, because I didn't want to cancel.... See? These are things that I'm the only one who refuses, and I call him to hear his voicemail." (IF04 Daughter of deceased).
VP9	"They couldn't see him in those twenty days, nor later when we were taking him away, nor later when he was buried, nor when he was incinerated..." (IP25 Hearse Driver)
VP10	"It's just not possible, you don't see a certain something that you can start to come to terms with, you haven't even seen your loved one deceased, thus he is, and he isn't, and they return..." (IP02 Hospital Psychologist)
VF7	"They took him away, they put him in, well, I didn't go, but my father went, and he said he couldn't see the box or anything else, that is he immediately signed to pay later and well the estimate, and then, nothing else." (IF05 Granddaughter of Deceased)

TABLE 3 (Continued)

Verbatim transcripts	
VP11	"And we have seen how people would jump on the coffins, even trying to open them, because they didn't trust that the body was in there, that is very important." (IP09 Hospital and Mortuary Chaplain).
VF8	"And all this without us knowing where, and because he [my brother] went and said 'Hey, it is my mother, and I want to know where the body is, because my mother passed and we don't know anything, we haven't been able to cry for her, nothing.'" (IF02 Daughter of Deceased)
VP12	"Some families did ask (that you open the coffin), although they knew the answer was no. 'Is there no way to see him? Of course, because, well, 'my father has been hospitalised for a month, he passed and simply, so we know that it is my dad, I am not asking for anything, just for you to open it.' But the answer was always negative. It was impossible. Due to protocol, of course, more than anything else." (IP33 Public Relations Representative at Funeral Home)
VP13	"Because with no rite there is no mourning. Let's see, if there is no rite the mourning doesn't begin. The mourning begins when you go back home without your loved one, that is the beginning of mourning no matter how you look at it, no matter what anyone says." (IP09 Hospital and Mortuary Chaplain)
VP14	"Then there has been no proper mourning. That means this is the worst thing about this illness, there isn't mourning, you haven't seen that person, you haven't said goodbye." (IP06 Social Worker in a Senior Residence)
VP15	"Here grief isn't comparable with normal grief, it has nothing in common, it is completely different, as in, I have seen... I have spent a lot of time in the street and in hospitals, 29 years, and in those 29 years easily 25 I have been in the street and therefore I am used to seeing reactions from relatives. From families who came with their grief in a very advanced phase, who are already in the phase, in cancer grief for instance, they arrive already in the complete acceptance phase, they have already cried as much as they needed to, the denying is behind them, the anger is behind them, and they are just in the acceptance part, accepting this is this way and such. I have also encountered those who become furious, as if I had, I was responsible, which is also quite common... you see all that, but in this case, it was really strange, because you didn't know how to face it." (IP24 Sales Director at Funeral Home)
VF9	"But I think that this is a process, for me and the millions of families there are, which is going to be very traumatic to deal with, maybe me, my sister, my mother, I don't know. But I know I will need lots of work. Truth be told, not just a chat but also mental work or that they help me forget...about that, I don't want to forget either. (IF04 Daughter of Deceased).
VF10	"It is that I am like gutted that until we are able to bury him, to me it's not... but if it was up to him, he wouldn't have wanted to end this way (...)." (IF05 Granddaughter of Deceased)
VF11	"Yes, yes, yes, it put me at ease enough, it has put me at ease enough. I don't know how to explain it. As in, in a way... generally speaking I felt as if something was missing, right? Also, that something was owed to him in a way, in a way and well, and that day, well yes, it is true that considering all the measures and everything, seeing people does wonders, it does wonders. Seeing relatives too, well, it had been a while we hadn't seen, people close to us, people that well, who really loved him and who were there that day." (IF01 Daughter of Deceased)
VF12	"Well look, I have to be extremely grateful that I have mourned through this, at that time of chaos in Madrid's life, all over Spain, I have to be grateful that I had time to grieve because I have been privileged that I could... (...) Well, my brother Fernando called the funeral home and they told him there was no problem, just that it would take a long time for them to take the body, that they might show up at 5 a.m. or something like that, that they couldn't come pick him up, which I was thankful for because I wanted to be with him. And then, fortunately, that's what they said. Then, well, we had enough time to be with him a little while, to pray for him." (IF06 Wife of Deceased)
VP16	"I told the girls 'give him a complete PPE' and told them to let him go in the room, I didn't care, let someone come tell me that I have violated the protocols. That is, morally here we did have an option A and option B." (IP01 Hospital Director)
VP17	"When the patient was really sick, they were forbidding us as well from allowing their relatives to come see the deceased, and I refused (...) and then I refused, and I said that relatives had to see the deceased." (IP07 Doctor)
VP18	"Everything we could do to make that grief at the end a little more bearable, we have tried to do, because it could happen to any of us, it could have happened to us, but it happened to them and in some cases very... excessively quick, and families here inconsolable laying on the floor crying, laying on the floor simply crying because their dad was hospitalised two days ago and... and he was now gone, two days, he died in 48 hr. I imagine that must be really hard. You cannot tell that family 'say goodbye in 15 min and leave'..." (IP03 Hospital Patient Experience Department Representative)
VF13	"But of course, it was... You cannot get close. That is, my father was where you are and me, in fact, they had to sit me down, I couldn't touch him, I couldn't do anything I couldn't touch myself either. If you touched yourself, they would scream so that you would not... that is, they had to wash you, you had to be like a robot. Of course, it was so cold, because I would talk to my Dad, but I needed to feel him, I just didn't care." (IP05 Nurse)
VP19	"There were families that were completely dominated by fear and who didn't want to come near the hospital under any circumstances. Then, 'So my father, my aunt, or my grandmother has passed? Well then, great. Tell me what to do or when to come pick up their belongings.'" (IP01 Hospital Director).
VP20	"But there have been some families that have declined the possibility of being there in the last moment so that a priest could be there instead." (IP14 Communication Director of Chain of Senior Residences)

(Continues)

TABLE 3 (Continued)

Verbatim transcripts	
VF14	"I got back in touch with the medical team, and I told them: 'I won't come to say goodbye, I am a high risk person and I am scared.' That was the end, that was the end. (,,,) I feel gutted about going to see him, because then I got sick, well, at that time I already had COVID, but I didn't know." (IF03 Daughter of Deceased)

The common element in all these farewells is that they were quick goodbyes, without physical contact and without awareness of irreversibility. The family members who said goodbye did not know they were saying goodbye for the last time.

For these families, a process full of uncertainty began, in which contact with the patient was limited and sometimes non-existent, and which ended with a call from a physician to report the passing of their loved one.

Many of these deaths could have been foreseen because the patient was in the ICU or their condition had deteriorated, but many other deaths occurred suddenly, without an apparent worsening of the patients' state of health (VP2).

The interviewed healthcare workers reported how these almost sudden deaths caused disbelief in the families and great difficulty coming to terms with the unexpected news (VP3).

Sometimes, the death was communicated after the patient had been transferred to another hospital but before the family could be told the patient had been transferred, leaving the relatives in a total state of bewilderment (VP4).

The absence of a final goodbye, sudden death or the uncertainty caused by not knowing where a loved one is, were elements that provoked a complete sense of disbelief and unreality in the mourners, making it difficult to adequately digest and come to terms with the news.

3.2 | I need to know if he died with his mouth open

These losses began, therefore, by giving the mourners the sensation of something absolutely surreal. They had said goodbye to their loved one a few days before, without being aware of the irreversibility of the farewell, in some cases they could have spoken to him or her by videoconference or telephone. They had received news from the doctor once a day and then suddenly received a call informing them of the death. Without visits to the hospital or the senior residence, without seeing their relative's condition worsen and without being able to say goodbye, the relatives had to accept a death for which they had no tangible proof (VP5).

Families asked healthcare workers for proof of the death, a photo or a personal effect, the death certificate, or they asked for concrete details about the moment of death (VP6 and VP7). They expressed the need to know the details about the last moments of their loved one's life so that they could structure a logical narrative of the facts and accept what had happened (VF3).

3.3 | It's as if he hasn't died

Family members wanted to be connected to their loved ones in the moments before the death, but this was not always achieved and resulted in great hardship (VF4).

Once the family member has passed away, this need for connection transitions into a search for objects or people that can link them to their loved one. The families continued calling the senior residence although the resident has already died (VP8) or they continued speaking with their loved one's roommate (VF5) or even calling the telephone of the deceased to listen to their voice on the voicemail (VF6).

Relatives also could not see the body (VP9), increasing the feeling of disbelief and difficulty with accepting the reality of the loss (VP10 and VF7).

The mourners doubted the body that was buried or cremated was that of their relative, so they asked for proof the cadaver that was to be buried or cremated was indeed that of their loved one (VP11 and VP12). This feeling was heightened when funeral homes took days or weeks to deliver remains (VF8).

3.4 | I organised a memorial and for me it was a relief. For me it was, it was like a balm, a little bit of tranquility

The professionals who were interviewed confirmed that the absence of a last goodbye both before and after death have negative repercussions for the grieving process (VP13 and VP14), especially since the circumstances endured in the pandemic could not be compared to anything that had been previously experienced (VP15).

The mourners themselves, aware of the difficulty of processing these losses, recognised the need for psychological help for the correct processing of grief (VF9).

The families needed a final goodbye that would allow them to close out one phase and begin another (VF10). Those who were able to perform some ritual act afterwards, recognised the relief that the celebration brought them (VF11). Relief was also experienced by people whose family members died at home and were able to watch over them before the funeral home arrived to pick up the body (VF12).

3.5 | I imagine that for them 10 min to say goodbye was enough

Some professional healthcare workers, in hospitals and senior residences, decided to sidestep the protocols established by the

authorities with the goal of facilitating a last gathering for the families (VP16), including allowing a last visit with the body to say goodbye after the death (VP17).

Aware of the legal circumvention that this entailed, they decided to allow these exceptions to minimise the negative psychological effects caused by not being able to say goodbye and possible ongoing complications with mourning (VP18). Nevertheless, these were perceived as incomplete goodbyes since the family members were not allowed to touch or get close to the deceased (VF13).

Not all families who had the opportunity wanted to say goodbye, usually for fear of infection (VP19). Others declined in order to allow a priest in to administer last rites (VP20). Relatives who had the opportunity to say goodbye but did not use it, subsequently felt regret and guilt about the decision (VF14).

4 | DISCUSSION

The lack of a final farewell before and after the deaths, and the absence of funeral rituals situated the mourners before a bereavement process that unites complicating risk factors already described in the literature (Mason et al., 2020) but never contemplated in these circumstances.

As anticipated by Wallace et al., (2020) the families have had difficulties coming to terms with and processing the losses due to the limitations of home confinement that, in and of itself was an abnormal situation, and prevented them from connecting with the reality of the worsening health and subsequent death of their family member. Sudden deaths, such as many of those that have occurred during the pandemic, are more difficult to accept (Parkes, 1975). Uncertainty, disbelief and surreal feelings were constants in the losses that occurred during the state of emergency. And it is these feelings of disbelief that have made it difficult to come into full awareness about the reality of death and to begin the mourning process (Worden, 2009).

This study shows that the concept of ambiguous loss developed by Boss (1999) which refers, above all, to missing persons, soldiers killed in battles, or deceased whose bodies are never found, is perfectly applicable to this situation, where the relatives do not become cognizant of the reality of the loss until the celebration of some funeral ritual can take place, which, moreover, in the era of the pandemic, even when it has been possible to perform, has proven to be insufficient.

Although Sheinfeld et al. (2021) use the concept of ambiguous loss to refer to multiple losses during the pandemic, they do not explicitly refer to bereavement losses, but do apply it to other types of loss caused by confinement or social and psychological distancing between loved ones, among other factors. This study, however, demonstrates that bereavement losses occurring during this period should also be explicitly included in the category of ambiguous loss.

A feeling of ambiguity about a loss causes a freezing of grief that prevents, in many cases, a normalisation of the mourning process

(Boss, 2010). While the stages model of grief described by Kübler-Ross (1969) or the phases model (Bowlby, 1980; Parkers, 2009; Sanders, 1999) are not to be considered linear, they are more difficult to apply from the extraordinary perspective of the pandemic. Mourners felt they could not begin the grieving process, so especially in the first few weeks it was difficult to identify the recognised phase or stage.

According to the task model described by Worden (2009), and in describing the tasks that a mourner must perform to adapt to a loss, it was found that the subjects of this study had difficulty completing the first task: recognising the reality of the loss, which blocked the progression of the rest of the tasks. This process, according to Worden (2013), must follow a certain order, and until one accepts that the loss is real and irreversible, it is difficult to undertake the rest of the tasks: to process the pain, to adapt to a world without the deceased and to establish a new lasting connection with the loved one.

These losses, without the possibility of saying goodbye or seeing the corpse, produce a freeze in the process of mourning, in which behaviours of searching for the loved one are often found.

In looking at the complicating factors also described by Worden (2009) and reviewed by Mason et al. (2020), several of the situations described in this study are seen to have converged, including a lack of social support, the circumstances of the death, an unexpected death or multiple losses.

Given the ambiguity of the loss and the concurrence of several risk factors for complicated grief, it is understood that deaths occurring during this pandemic, and especially during the months of confinement, were more likely to provoke grief that evolves as complicated, and even pathological.

Burke et al. (2019) note the lack of institutional and informational support in the hospital or residence where death occurs as a complicating risk factor. This assertion is confirmed in this study. It is considered, however, that the fact that some social and health-care professionals applied a holistic approach to their interventions, breaching protocols and facilitating farewells to ensure the well-being or at least providing some psychological and social relief to the families, will have a healthy impact on these mourners, reducing the possibility of complicated or pathological grief.

On the other hand, while there are authors that affirm that funeral rites are in a process of deritualisation and designification (Neimeyer, 2002) and that many people in modern society tend to react to death as if it does not exist (Ariès, 2011), the results of this study indicate that farewell rituals in the face of death, whether before or after the passing, help to give meaning to the reality of death and a recognition of the loss. Therefore, this study questions this loss of significance, although it considers that the meanings and forms of the funeral rite have undergone changes in recent years and the resignification should be studied.

Many mourners have recognised what a relief it would have been for them to have been able to perform some kind of ritual tribute that would have helped them close out one life phase and begin another. It is noted that the funeral rite would have been a normalising

element in the first days after the loss, and a therapeutic element in the medium term (Delgado, 2005) and in such special circumstances it would have also been a means of supporting mental health (Cardoso et al., 2020) as some authors have already pointed out.

The online services that occurred in some cases, or the rare last goodbyes that took place in hospitals or senior residences, brought mourners a small amount of relief, but they lacked the elements of a complete farewell (physical contact, a suitable venue, social support, etc).

In their exhaustive literature review on complicating and protective factors in bereavement, Mason et al (Mason et al., 2020) do not make references to farewells or memorial rituals. Nevertheless, one can conclude that in light of the data obtained in this study, the absence of both premortem and postmortem farewells is a risk factor for complicated bereavement. Consequently, the adequate effectuation of farewell and funeral rituals constitutes a protective factor against the complication or pathologisation of grief.

In this regard, a review by Burrell & Selman conducted during the pandemic highlights the importance of meaningful and supportive memorial services for the bereaved (Burrell & Selman, 2020).

5 | LIMITATIONS

The main limitations derive from the sample selected and the exceptional circumstances in which the data were collected. The interviews were conducted immediately after the most intense months of the pandemic. Access to the informants was complicated and some relatives did not want to participate in the study due to their state of mind and distress. This type of informant could have provided vital information for the study since they were the ones who, a priori, presented with the greatest difficulty in beginning the mourning process. Therefore, it is possible that the diversity of informants was not maximised, something that is fundamental in qualitative research.

6 | IMPLICATIONS

In a situation of absolute chaos, healthcare and social workers, with some exceptions, have focused on managing the health crisis. This has been to the detriment of holistic interventions, focused on companionship, that is, providing adequate support to families throughout the process, which would have been helpful to bereaved family members. In some hospitals and residences, the scope of work of psychosocial staff has been reduced to purely basic interventions in the face of the chaos and a lack of personnel.

In addition to the existing protocols on safety and standard of care, additional protocols should be added that ensure social and healthcare personnel provide adequate and accurate communication and companionship of family members. Communications about a death in these circumstances should not be limited to informing about the physical process of the exitus but should also address the needs of relatives in these moments.

Appropriate medical assistance should not prevent that, in parallel, adequate psychosocial support of relatives be provided to help them come to terms with the reality of the death. The role of psychologists and social workers is essential to accompany and inform families in these first moments and to foresee or at least detect signs of complicated bereavement. It is necessary to create teams that provide multidimensional support to patients and families (Kangasniemi et al., 2021) and that could be well-led by social workers.

In anticipation of future crises, protocols should also be added that allow for an adequate goodbye, both before and after the death, with all necessary safety measures, as some hospitals and senior residences have demonstrated, is perfectly feasible.

The processes of mourning are long and future longitudinal research will reveal how these processes evolve over time and whether there is a real increase in cases of complicated and/or pathological grief.

Post-pandemic resilience skills training programs (Walsh, 2020) will help society and the bereaved to breathe new hope into their lives and to learn to live with their losses.

7 | CONCLUSION

Amid the abnormal situation of confinement and generalised stress caused by the COVID-19 pandemic, many families began a mourning process, similarly atypical, caused by the loss of one or more loved ones.

The absence of a farewell to a loved one, both before and after the death, is a complicating factor in grief, as it is associated with disbelief, denial and a lack of acceptance and coming to terms with the loss.

In some institutions, the social and healthcare professionals, in a humanising effort, and despite the difficulty, also attended to the psychological and social needs of the families and made it possible to carry out acts of farewell that reduced feelings of anguish and disbelief, which was a facilitating element to begin the mourning process.

On the other hand, the absence of funeral rituals has caused mourners, and society in general, to reflect on the need for these ceremonies and to give them new meaning.

It is also necessary to reflect on what has happened and work to ensure that in future health crises both a dignified farewell to the deceased occurs along with adequate, humanising, psychosocial assistance for families.

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CONFLICT OF INTERESTS

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

AUTHORS' CONTRIBUTIONS

Carlos Hernández-Fernández: Conceptualisation, data curation, investigation, formal analysis, project administration, resources, visualisation, writing—original draft, review and editing. Carmen Meneses-Falcón: Methodology, supervision, validation and writing—review and editing.

DATA AVAILABILITY STATEMENT

Data available on request due to privacy and ethical restrictions.

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