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Bereavement experiences after the unexpected death of an older family member in the emergency department

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1. Introduction

Unexpected deaths often occur in the emergency department. When a family member dies suddenly in the emergency department, individuals frequently become overwhelmed by extreme sadness and psychological shock [1]. Thus, it is important to offer some degree of support to these relatives [2]. In order to provide emotionally supportive and practical bereavement care for relatives in the emergency department, emergency nurses must understand the bereavement experience from the relatives' perspective. To date, most research on the experiences of individuals who have suffered sudden bereavement in the emergency department has focused on parents whose child has died. In addition, it has typically focused on more practical and emotional aspects in the aftermath of the event. Thus, little is known about the experiences of relatives whose older family member died unexpectedly in the emergency department.

2. Background

When a family member dies suddenly in the emergency department, it can be difficult and often painful for some relatives to accept that death because of the lack of time to prepare for it [3]. These relatives might experience feelings of sadness, fear, shock, and distrust, and might struggle with their emotions [3–5]. Their inability to manage these feelings can lead to the development of a pathological condition, such as depression or post-traumatic stress disorder [3,6,7]. Therefore, emergency nurses must make every effort to reduce these negative outcomes [8].

Understanding families' needs during the end-of-life stage of a patient in the emergency department can enable emergency nurses to provide sensitive and informative bereavement care to the family members after the death of their loved one [9]. There have been several studies focusing on parental bereavement experience after the death of a fetus, newborn, child, or adolescent in the emergency department [1,10,11]. In contrast, there is comparatively little research on the bereavement experience of relatives dealing with the death of an older family member in the emergency department. This is possibly because the death of older adults is considered comparatively predictable [7]. However, there is insufficient evidence to conclude that the death of older family members is necessarily expected or that their death is any less sad than that of a child or spouse. In the United States, about 50% of patients who go into cardiac arrest in the emergency department are over 65 years of age [12]. The death of an older parent causes great sorrow for some adult children, and it can be even more difficult for them to accept the death if it is sudden [13]. To care for someone who is facing or has experienced the death of an older family member in the emergency department, emergency nurses require a thorough understanding of their needs. Specifically, understanding the bereavement experience of these relatives might allow emergency nurses to provide them with appropriate support and mediation at a time when they are most vulnerable. The purpose of this study was to describe relatives' bereavement experience after the death of an older family member in the emergency department.

3. Methods

3.1. Study design

This study used a descriptive phenomenological research design.

3.2. Participants

Potential participants were selected through purposive sampling [14]. A research announcement was posted at a funeral parlor and on a hospital bulletin board from March to November 2016 to recruit participants. The hospital was located in Seoul, the capital city of South Korea. The inclusion criteria were as follows: (1) individuals had experienced the sudden death of an older family member in the emergency department; (2) the age of the deceased family member was 65 years or older; and (3) they were informed of and voluntarily consented to participate in the study.

Eleven potential participants were contacted for this study. One participant was referred by an acquaintance, two participants contacted the authors directly after seeing the research announcement, and eight participants left their telephone number at the information desk of the funeral parlor so that they could be contacted. However, three of them

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Table 1
Characteristics of Participants.

Participants (alias)	Gender	Age	Religious affiliation	Marital status	Relationship to the deceased	Interval between relative's death and interview (months)
Sangmin	M	54	Buddhist	Married	Son	5
Jiwon	M	36	None	Unmarried	Son	5
Yeonhwa	F	81	Catholic	Married	Younger sister	6
Wansik	M	48	Buddhist	Married	Son	5
Yusuk	M	41	None	Married	Son	5
Junsung	M	71	Protestant	Married	Spouse	5
Jaeyoung	M	43	Catholic	Married	Son	6
Daehee	M	33	Buddhist	Married	Son	8

were excluded: one whose family member had died of chronic liver disease, one who had not been in the emergency department at the time of the older family member's death, and one whose family member had died of suicide. The first of these was excluded because the family member had already been preparing for the death of their relative because of the doctor's opinion that the patient was in the end-stage. The third was included at first, but was later excluded because much of the data concerned resentment and guilt about the relative's suicide, which differed strongly from the data of the other participants. The characteristics of the participants are listed in Table 1.

3.3. Ethical considerations

Ethics approval was obtained from the Boramae Medical Center bioethics committee (no. 16-2015-152, date: December 30, 2015). After being informed of the study purpose and procedure (including that the interview would be recorded) and that they had the right to withdraw at any time, all participants voluntarily signed an informed consent form.

3.4. Data collection

The data were collected through in-depth individual interviews. We conducted between one and three interviews with each participant. The additional interviews were conducted to obtain sufficient data and to clarify points in the first interview that were obscure. The authors of this study comprise an emergency nurse with 10 years of experience and a researcher with expertise in qualitative research. One author (the emergency nurse) conducted all the interviews. The location of the interview was selected by the participants (e.g., a hospital counseling room, the entrance to a mountain trail, a church, the participant's workplace or home, or a café near their workplace). Recalling the death of a family member could be an emotionally challenging task; therefore, it was necessary to offer some support (e.g., holding the participant's hand) for the bereaved relative and sometimes pause the interview, particularly in cases where the participant experienced great sorrow.

The interview began with the question: "How have you been since your father (mother/spouse) died?" Subsequently, the interviewer asked several open-ended questions, such as "Please tell me about the situation when your father (mother/spouse) died" or "Please tell me about what you experienced in the emergency department when your father (mother/spouse) was being resuscitated." Examples of further questions included "Please tell me about your experience when you learned of his/her death from the doctor" and "Please tell me about your experience with the nurses while you were in the emergency department." Each interview lasted for 25–180 min, with an average of 50 min. Each interview was recorded with the participant's permission.

3.5. Data analysis

This study used Giorgi (2009)'s descriptive phenomenological approach [15] to obtain a qualitative understanding of the experiences of bereaved relatives following the sudden death of an older family member. The audio-recorded interview data were transcribed verbatim by one of the authors. To ensure participants' privacy and confidentiality, each participant was given an alias throughout the study.

Giorgi (2009) suggested a three-tiered analysis. First, the transcripts were read and re-read to grasp the overall meaning of what the participants said. Each author read them independently. In the second step, meaningful statements were generated by identifying meaning units and underlining the sentences or phrases relevant to the phenomenon under study. Each author did the work in the second step individually. In the third step, each meaning unit—in the participants' own words—was transformed into "phenomenologically psychologically sensitive expressions" [15]. To generate these psychologically sensitive expressions, each author summarized the meaning units using third-person expressions and labeled each concept. The authors then categorized these concepts into themes based on similarities of meaning. The authors met several times to review the list of themes and discuss how each could be conceptualized into more abstract themes.

3.6. Trustworthiness

To ensure the trustworthiness of this study, we tried to describe the procedures of data collection and analysis in as much detail as possible, and the participants were asked to review the analyzed data and confirm the accuracy of the contents of the data they had provided. This participant review process helps to ensure the credibility of the interpretation of the qualitative data. Several participants confirmed that the results were consistent with their experience.

4. Results

The bereavement experience of persons whose older family members died in the emergency department consisted of four themes: "lack of control of emotions," which occurred when they first witnessed the family member's cardiac arrest, and "enduring fear in a desolate emergency department," which focused on the period when the family member was in the resuscitation room. Subsequently, after death had been declared, participants responded with "denial or silent acceptance"; thereafter, some experienced a feeling of emptiness that we characterized as "living with longing for the deceased in everyday life."

4.1. Lack of control of emotions

All participants experienced great shock when they first became aware of their older family member's unexpected cardiac arrest. Most participants could not control their emotions during this period. Some reported experiencing a feeling of dissociation from the reality of the event, as if in a dream, and felt helpless. *"My wife and kids just screamed and broke down. I could not believe it happened so suddenly. I did not know whether it was a dream or a real situation." (Sangmin, 54, son).*

One of the participants, Jaeyoung, received a call from the emergency department that his mother was being resuscitated and could not control his emotions while driving to the hospital. *"I was working … I heard that my mother was going to die. I was driving on my own, and I could*

not see ahead as the tears flowed, and my emotions could not be restrained. It was surprising that I arrived at the hospital without a traffic accident."(Jaeyoung, 43, son).

4.2. Enduring fear in a desolate emergency department

When their older family member underwent cardiopulmonary resuscitation, all participants felt uncontrollable fear and sadness and were forced to wait in anxious uncertainty for information. One participant said that the experience in the emergency department was like being left alone in the middle of a desert. *"I was alone in the corridor in front of the resuscitation room while my wife was receiving resuscitation. I was just crying alone. At that time, I felt like I was standing in the middle of a desert. I was very scared and it was painful." (Junsung, 71, husband).*

Most participants were unaware of the progress of the resuscitation during this period. They feared that there was no hope of the family member surviving. *"I was waiting outside and I was so scared and frustrated because I could not see inside the resuscitation room. The medical staff did not say anything, and I just kept waiting. I just cried in the hallway and waited. My wife was pregnant, but she kept standing and waiting." (Daehee, 33, son).*

None of the participants in this study were allowed in the resuscitation room while their family members underwent resuscitation, even though most wanted to be in the room to observe the situation. They were afraid to wait outside and wanted to comfort their family member in the last few moments before death. *"I was trying to open the door to enter the resuscitation room, but the medical staff kept closing it. I did not mean to interrupt … The staff simply did not let me in." (Sangmin, 54, son).*

Some of the participants strove to understand why relatives were not allowed to enter the room. They thought it was hospital policy, and that the presence of guardians would burden medical staff. Nevertheless, they said that they would have gone into the resuscitation room if the doctor or other medical staff had asked if they wanted to be present. *"I really wanted to go into the resuscitation room. But I did not want to get in the way of the medical staff. … Then I thought, 'Would they mind if I did a little bit to save my mother?'" (Jaeyoung, 43, son).*

Most participants said that the medical staff in the emergency department did not offer sufficient explanation. They were also disappointed by the attitude of these staff, such as their matter-of-fact manner of speaking. *"At that time, the medical staff were not interested in the caregiver. There was no chair in front of the resuscitation room. Even when I asked, the doctors did not make eye contact and only replied in a businesslike manner" (Yusuk, 41, son).* On the other hand, some participants were greatly appreciative of the medical staff's efforts to save their family members and of staff members who offered them a cup of water.

4.3. Denial or silent acceptance

There were two main responses of the family after the death declaration: denial or silent acceptance. After resuscitation failed, the relatives were told of their family member's death. Most did not accept this sudden separation from their family member and began to scream or blame the medical staff. "*I could not believe it. My mother had gone for a walk that morning and she was with me until just before she died, so I could not accept her death. I was so sad then, and on the other hand, I was scared … So, I just yelled and resented the doctor. My sister fell right onto the floor." (Sangmin, 54, son)*

Some participants accepted the death of the older family member even though it was unexpected. These participants tended to think that they had fulfilled their moral obligation as a child or spouse to care for the family member when they were alive. *"I think I had done my best as a husband. So, I could stand it at that time." (Wansik, 48, son).* However, most participants felt frustrated because they were not given an explanation of the direct cause of death. *"Why did my father die? What is the reason for the cardiac arrest? So, I asked the doctor. But the doctor did not answer clearly. It's frustrating. Actually, I still wonder." (Sangmin, 54, son).*

After hearing the doctor's declaration of the death of the older family member, some participants appealed to medical staff to leave the family member in a separate location in the emergency department. *"I wanted to be able to stay with my mother for a while in a separate room after the doctor's death declaration. I wanted [them] to give me a little space and time so that I could touch my mother's face, hold her hand, and let all the family members cry." (Jaeyoung, 43, son).*

4.4. Living with longing for the deceased

Participants struggled in the wake of their older family member's death. Some turned to alcohol to alleviate their suffering, while others pretended that the family member was still alive. They exhausted themselves in longing for their family member and regretted that they had not done more for them when they were still alive. Some used somatic metaphors to express this, such as: *"I felt exactly half gone, like just half of my body was gone. At that time, I accepted it a little bit like this, but since it's been some time, I think of it more and it makes me sadder day by day. Just thinking about it makes me cry."* (*Junsung, 71, husband).*

As their grief persisted, some participants began to experience somatic reactions such as insomnia, indigestion, and chest tightness. *"I have not been able to sleep for almost a month since my father's funeral. I can't sleep because I drink alcohol." (Sangmin, 54, son).* Over time, their loneliness and unhappiness changed into feelings of regret and guilt. Nevertheless, some participants appreciated the fact that the death had been quick and had not placed an undue burden on the surviving family members. *"I was grateful that my father passed away without pain. Most older people die over a long time in the hospital. But my father passed away right away without any such thing. Thank you for that." (Jiwon, 36, son).* Some participants who adhered to a religion said that their religious beliefs helped them quickly adapt to reality and escape from the distress of bereavement.

5. Discussion

This study explored the bereavement experience of relatives who faced the sudden death of an older family member in the emergency department. Participants in this study were shocked by the experience of sudden bereavement, a reaction noted in several previous studies [3,5]. When individuals experience the sudden bereavement of a family member, they might not initially acknowledge the death but instead continue to believe that their loved one is alive [16]. When relatives fail to manage their feelings following a bereavement, they can develop pathological conditions such as physical illness, depression, and post-traumatic stress disorder [3,11]. Therefore, if nurses engage in supportive behaviors, such as holding their hand, speaking words of kindness, listening to them in a quiet space, or offering them a cup of water; these acts can help relatives accept the reality of their bereavement [1,17].

However, emergency nurses often have difficulty in caring for relatives because of a lack of space and time [18]. In addition, some emergency nurses are reluctant to approach bereaved relatives expressing extreme sadness, anger, or distrust [19,20]. Many of the participants in this study perceived a lack of support from emergency department staff or believed that the patient's condition had not been well explained. Furthermore, most participants felt disappointed when emergency nurses began trying to clean up the resuscitation room or sent the deceased to the mortuary soon after their death.

Supporting relatives is an exceedingly important aspect of care because it helps them manage their grief and avoid social crises [21,22]. Supporting families in this way requires professional knowledge and experience [2,23]. Emergency nurses need education and training in order to fully understand and support families who are experiencing the

pain of bereavement [2,17,18,24]. On the whole, family members of patients tend to be nervous, anxious, irritable, and restless when waiting during an indefinite period of resuscitation [25,26]; participants in this study similarly reported being very scared during the resuscitation of their family member. In addition, as reported in a previous study [9], participants retrospectively expressed their wish to observe the resuscitation efforts and to be with their relative during the last moments of their lives, but they were not allowed.

Family presence during resuscitation remains controversial [25,27,28]. According to a study [27] in Jordan, health professionals tend to fear that family members will interfere with their work (e.g., verbal and physical attacks during resuscitation) or that their efforts will have an adverse psychological effect on family members. A qualitative study [28] in Iran showed that family presence during resuscitation can be both destructive (e.g., can interfere with resuscitation or generate traumatic mental images in the relatives' mind) and supportive (e.g., improves trust in the resuscitation team, improves family satisfaction, reduces conflict with the resuscitation team) for resuscitation team members. A survey [29] in southern Taiwan reported that the hospital units did not have a written policy for family presence during resuscitation (74.8%), and only 11 (1.5%) medical staff members were actually aware that family were present during resuscitation. The 2015 American Heart Association Guidelines note that health care providers should consider allowing family presence during resuscitation from both scientific and ethical standpoints [30].

Despite concerns regarding family presence during resuscitation [25,31], permitting family presence is consistent with the principle of autonomy and might reduce anxiety, post-traumatic stress disorder [31], and bereavement-induced suffering among relatives by allowing them to participate and support their family member in the last moments of life [32]. Most relatives desire at least the option of being present in such critical moments [9,32], and in line with this, most participants in this study wanted to be present with their family member during resuscitation. Therefore, hospitals should create policies regarding family presence during resuscitation and, if possible, emergency nurses should confirm whether family members want to be present during resuscitation based on that policy.

Participants reported experiencing great sorrow from the absence of the deceased and searched for places that they had frequently visited with the loved one in order to alleviate feelings of guilt and sadness. Some participants depended on religion to overcome the pain of bereavement. In a study in Norway [33], religion was acknowledged as a critical resource for coping with bereavement after the sudden and unexpected death of family member. An attachment to God was also associated with lower depression and grief and increased stress-related growth among bereaved relatives [34]. Thus, emergency nurses should respect relatives' religious beliefs. The support of family and social networks is also helpful for relatives in dealing with the bereavement [35]. Overall, bereaved relatives might need immediate support and continuous follow-up care in order to adapt to life after bereavement [36].

This study is significant in that it examines the sudden bereavement experiences of relatives whose older family member has died. Despite its significance, the study has some limitations. First, there might have been differences in the experiences of each participant in this study depending on their relation to the deceased (e.g., spouses, parents, or children); however, we did not analyze this confounder in detail. Second, because of the difficulty in recruiting participants, the data were insufficient for determining whether the themes were saturated. Finally, all participants except one were male; therefore, women's bereavement experiences might not have been fully described in this study.

6. Conclusion

This study applied a phenomenological research method to explore the experiences of a small sample of relatives after the sudden death of an older family member. This study has high face validity because it reports on the emotional anguish and sorrow associated with the sudden death of a loved one in an authentic way. The words and phrases expressed by participants provided a clear indication of the social value of the deceased person. This study is also meaningful in that it describes the bereavement experience from the viewpoint of relatives who witnessed the sudden death of an older family member.

The bereavement experiences of relatives in the emergency department were intense and their pain, fear, and sorrow were arguably exacerbated by feelings of alienation from emergency medical staff during resuscitation. Families in these circumstances require emergency nurses' support, particularly a good explanation of the situation and words of kindness and comfort. Relatives might feel disillusioned with emergency nurses who want to quickly send the deceased to the mortuary after the death declaration. Relatives might need time to be with the deceased family member in a quiet private space after the death declaration. Overall, emergency nurses should provide compassionate care to relatives faced with sudden bereavement in the emergency department.

7. Declaration of conflicting interests

The authors declare that there are no conflicts of interest.

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Ethical statement

- The name of the ethics committee: Seoul Metropolitan Government-Seoul National University Boramae Medical Center Institutional Review Board
- The approval number: 16-2015-152
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