Heliyon 10 (2024) e40216

Contents lists available at ScienceDirect

Heliyon

journal homepage: www.cell.com/heliyon

Research article

Grief responses during the COVID-19 pandemic: A qualitative study in Spain

Andrea Redondo-Armenteros [a], María Nieves Pérez-Marfil [a,*], Manuel Fernández-Alcántara [b], María Paz García-Caro [c], Francisco Cruz-Quintana [a], María José Cabañero-Martínez [d]

[a] Department of Personality, Assessment, and Psychological Treatment, Faculty of Psychology, Mind, Brain and Behaviour Research Center CIMCYC, University of Granada, Cartuja Campus, 18011, Granada, Spain
[b] Department of Health Psychology, Faculty of Health Sciences, University of Alicante, San Vicente del Raspeig Campus, 03690, Alicante, Spain
[c] Department of Nursing, Faculty of Health Sciences, Mind, Brain and Behaviour Research Center (CIMCYC), University of Granada, Avenida de la Ilustración, 18071, Granada, Spain
[d] Departament of Nursing, Faculty of Health Sciences, University of Alicante, San Vicente del Raspeig Campus, 03690, Alicante, Spain

ARTICLE INFO

Keywords:
Grief
Death
COVID-19
Pandemic
Qualitative research

ABSTRACT

Introduction: The recent COVID-19 pandemic led to a rise in the number of people bereaved by the death of a loved one. There are many pandemic-related stressors that may have further complicated grief in these people. The aim of this research was to conduct an in-depth the experience of illness and death during the pandemic, as well as obstacles to and factors facilitating grief in people who had lost a loved one during this period, whether due to COVID-19 or to natural or sudden causes.

Method: The sample consisted of 42 participants who had lost loved ones to COVID-19 or other causes (both natural and sudden). An inductive approach using grounded theory with open, axial and selective coding was used to analyse the semi-structured open-ended interviews.

Results: The resulting theory was structured around a central category: "Processes of Loss and Grief in Pandemics". The other relevant and related categories were: disease processes during the pandemic, emotional responses to the loss, factors facilitating the grieving process and obstacles to the grieving process. The various analytical categories were then further classified with reference to the Dual Process Model.

Conclusion: This study highlights the main features of grief during the pandemic, including the impact of restrictive measures on disease processes; the funeral rituals performed and subsequent coping; responses such as intense shock, anger, fear or loneliness; and the way in which factors facilitating the grief process were adapted to the circumstances.

1. Introduction

COVID-19 was declared an international pandemic by the World Health Organisation on 11 March 2020. By May 2024, there had

* Corresponding author. Faculty of Psychology, University of Granada, Cartuja Campus, 18011, Granada, Spain.
E-mail addresses: andreara@ugr.es (A. Redondo-Armenteros), nperez@ugr.es (M.N. Pérez-Marfil), mfernandeza@ua.es (M. Fernández-Alcántara), mpazgc@ugr.es (M.P. García-Caro), fcruz@ugr.es (F. Cruz-Quintana).

https://doi.org/10.1016/j.heliyon.2024.e40216
Received 8 July 2024; Received in revised form 22 October 2024; Accepted 6 November 2024
Available online 8 November 2024

been 775 million infections and seven million deaths [1]. It is estimated that each death directly affected an average of nine people [2]. This means that over the years, more than 63 million people worldwide have experienced the loss of a loved one due to COVID-19. The number of people bereaved is even greater when the number of deaths caused by factors such as the postponement of treatment for other illnesses or shorter stays in hospitals is taken into account [3].

Grief is the normal, adaptive response to a significant loss, such as the death of a loved one. In about 10 % of cases, the process of coming to terms with such loss becomes chronic, leading to the onset of prolonged grief [4]. Studies conducted in the early stages of the pandemic showed that those bereaved by COVID-19 experienced more intense acute grief than those who had lost someone to natural causes [5]. For example, epidemiological studies in China have shown that 38 % of people bereaved by COVID-19 met the ICD-11 criteria for prolonged grief [6,7]. However, other studies have found no differences in the intensity of prolonged grief in people who have lost someone to COVID-19 compared with other causes of death, although they did find a high prevalence of people experiencing dysfunctional grief (72 %) [8]. These figures suggest that deaths occurring *during* the COVID-19 period may lead to prolonged grief, presenting similar challenges to those *caused by* COVID-19 deaths. Recent meta-analyses indicate that the overall prevalence of grief symptoms and disorders among people who experienced a loss during the COVID-19 pandemic was 45.1 % and 46.4 %, respectively [9].

The imposition of restrictive measures to prevent contagion is the main reason why the pandemic may have had an impact on the grief of those who lost someone between March 2020 and March 2022. In Spain, as in many other countries, the population was affected by lockdown measures between March and May 2020, limits on the size of gatherings, quarantine following infection or contact with infected people, social distancing requirements and restrictions on movement between municipalities, provinces and communities [10]. For those with loved ones in hospital, this was accompanied by protocols for isolating patients and limiting the number of visits during the first year of the pandemic, with adverse effects on the mental health of patients and their loved ones [11].

The reviews [3,12–15] and qualitative research [16–23] published to date on the experiences of bereaved people during COVID-19 all point to two main obstacles to the development of grief: the inability to say goodbye or be present at the end, and the difficulties and changes in the performance of funeral rituals.

Some of these studies have framed their findings within one of the main theoretical models of grief, the Dual Process Model (DPM) [3,20]. This model holds that there are two approaches to and two types of stressors involved in grieving: those related to processing the loss and those related to restoration and moving on. For example, studies of grief during COVID-19 have looked at both the inability to say goodbye and changes in funeral rituals as stressors associated with grief. These stressors may trigger responses such as anger, guilt [13,20,22] and difficulties in accepting the loss [12,20,24]. In terms of the stressors associated with moving on, this theoretical model suggests that, in the context of the pandemic, these would include restrictions on support systems and social and recreational activities [3,13,15,20]. Among those who lost someone during the pandemic, the most common responses associated with overcoming the situation are loneliness, fear and anxiety [3,12-13,15-16,22].

These findings notwithstanding, the literature provides ample reason to continue to explore the defining characteristics of COVID-19-related grief and loss in general during the pandemic. Most existing qualitative studies fail to account for the differences between COVID-19 losses and those due to other causes of death. Moreover, very few of these studies focus on how factors that facilitate grief have been adapted or on those areas where the pandemic may have had a positive impact [25].

The aim of this study was therefore to explore in-depth of the experience of illness and death during the pandemic, as well as the obstacles to and factors facilitating grief in people who lost a loved one during this period, whether due to COVID-19 or to natural or sudden causes. The research question guiding the study was: "What are the characteristics of the grief experienced by those who lost a loved one during the COVID-19 pandemic?"

2. Method

2.1. Design

This is a qualitative study based on a grounded theory approach. This is described as the systematic process of collecting and analysing data with the aim of developing a theory based directly on the experiences reported by participants [26].

2.2. Participants

We used a purposive sampling approach determined by profiling [27] according to the type of loss (COVID-19 related vs. natural or sudden death) and the sex of the participant (male vs. female). Inclusion criteria were: a) having experienced the death of a loved one between March 2020 and March 2022, b) being of legal age (at least 18 years old) and c) agreeing to participate in the study.

The final sample was made up of 42 participants in total (see Table S1 in Supplementary Material): nine men (21.4 %) and 33 women (78.6 %) aged 18–71 years (Mean = 41.05; SD = 16.91). The age of the deceased family member ranged from eight months to 98 years old (Mean = 67.5; SD = 23.67). The cause of death was COVID-19 in 18 cases (42.9 %), natural death (due to pre-existing conditions such as cancer, demencia, etc.) in 16 cases (38 %), and sudden death (accident, heart attack, stroke) in eight cases (19.04 %). In terms of relationship to the deceased, 22 of the participants lost a parent (52.38 %), eight lost a grandparent (19.05 %), four lost a sibling (9.52 %), three lost a child (7.14 %), two lost a friend (4.76 %) and three lost other relatives (7.14 %).

2.3. Instruments

Data were collected using a single, *ad hoc*, semi-structured, open-ended, one-to-one interview (see Table 1 for a summary; see Table S2 for the complete version). The interview script was structured into three main sections: grief-related experiences and emotions; funeral rituals and symbolic aspects; and factors and variables related to coping with grief.

2.4. Procedure

This study is part of the CO-GRIEF research project (ref: PID2020-119063RB-I00), which consists of both a quantitative (Phase 1) and qualitative phase (Phase 2), with the latter being presented in this paper.

The initial sample for the quantitative analysis was obtained from different bereavement organisations using a variety of contact methods (telephone, email and social networks), through the dissemination of the study by the Universities of Granada and Alicante and using snowball sampling. From these Phase 1 participants, we selected those who had indicated in the quantitative questionnaire that they were willing to participate in the qualitative study and who matched the profile for the sample. They were initially contacted by email to explain the objectives of this second phase of the study and the nature of their participation. If they agreed to take part, they were offered the option of either a face-to-face or online interview. Only three of the interviews were conducted face-to-face at the University of Granada's Mind, Brain and Behaviour Research Centre (CIMCYC). The remaining interviews were conducted via videoconference using the Google Meet tool.

The interviews were conducted by a research team member (ARA) trained in clinical psychology and qualitative research. Written informed consent was obtained from all participants in an earlier phase of the study, and verbal consent was obtained for interviews to be audio-recorded. The interviews were conducted with each participant in a single session between February and November 2022. The duration was between 35 and 150 min. The Google Meet transcription feature was used to transcribe the interviews. The number of interviews was determined by theoretical saturation in the main analytical categories.

The research was approved by the University of Granada's Human Research Ethics Committee (Reference: 2328/CEIH/2021) on 24 November 2021. All data were separated from any identifying elements that could be linked to the participants, in accordance with the provisions of Data Protection legislation.

2.5. Data analysis

An inductive approach using grounded theory [26] was used to analyse the semi-structured open-ended interviews. Using this approach, the emerging theory about the effects of the lived experience on different areas of people's lives can be developed through the organisation of the data. The analysis involves descriptive procedures (micro-analysis and comparison), conceptual ordering (open and axial coding), and theorising (selective coding or the process of refining and integrating theory and matrix development).

The analysis process involved an in-depth reading of each of the interviews in order to gain an overview of their content. The first step was open line-by-line coding. This allowed for the initial generation of the main codes. The process was carried out by one of the researchers (ARA) and supervised by two other team members (MNPM and MFA). Axial coding allowed for the refinement of codes and main categories (see Table 2), as well as the establishment of their interrelationships. Finally, selective coding was used to identify a central category and generate an explanatory theory from the qualitative data [26].

To ensure analytical rigour and reliability, several researchers were involved in the process of generating and integrating the codes and categories. In addition, textual quotations from participants were identified. These were then differentiated in the results from possible interpretations by the researchers. The data were processed using Atlas.ti v7.5 software [28]. The quotes presented were first translated into English and then back-translated into the original language to ensure that the meaning was similar.

3. Results

The analysis of the interviews with the participants identified four main categories: disease processes during the pandemic, emotional responses to the loss, facilitating factors and obstacles during the grieving process (see Table 2). Important differences were also observed in the grief experience of people who had lost someone to COVID-19. This section concludes with a discussion of the theory generated from the obtained results.

Table 1
Semi-structured interview outline.

Areas to be explored	Questions
Grief-related experiences and emotions	What had your loved one's health been like before? Under what circumstances did they die? Were you able to be with them in their final days? What did you feel and/or experience when your loved one died? How has your experience of grief and loss been affected by the COVID-19 situation?
Funeral rituals and symbolic aspects	Were the funeral arrangements in accordance with your loved one's wishes? To what extent were they affected by public health measures and restrictions? How satisfied are you with the final arrangements?
Factors associated with coping with grief	How do you feel you are dealing with the emotions you talked about earlier? What things have helped you to cope with your grieving process? What things do you feel make the grieving and loss process difficult for you? Has your outlook or understanding of life changed since the loss? In what way or in what respects?

Table 2
Main categories and codes post-analysis.

Disease processes during the pandemic	Emotional responses to the loss	Factors facilitating the grieving process	Obstacles to the grieving process
Restrictive hospital protocols	Sadness	Routine, hobbies and self-care	Different grief trajectories
Difficulty or impossibility of saying goodbye	Longing	Introspection techniques	Social disappointment
Healthcare system saturation	Relief	Healthy habits	Internal factors
Overburdening of care	Acceptance	Taking care of others	Restrictive measures to prevent the spread of infection
Conditions in residential care homes	Gratitude	Continuing bonds	Restrictions on or impossibility of funeral rituals
	Intense shock	Psychological intervention and support	Difficulty accepting death
	A sense of loneliness through distance	Personal characteristics and beliefs	Constraints to moving on
	Guilt/Blame	The buffering effect of the circumstances of death	
	Helplessness	Receiving support	
	Anger	Having time and space to spend with their loved ones during COVID-19	
	Fear		

3.1. Disease processes during the pandemic

Regardless of the cause of death, pandemic-related restrictive protocols played a major role in disease processes. They made contact with the sick person difficult due to capacity restrictions, the fear of contagion and concern that the loved one would die alone. The inability to remain close by during the disease processes led to a disinformation effect around the diagnosis and evolution of the patient. Most participants were unable to say goodbye to their loved one at any point in the disease process. Those who were able to say goodbye did so mainly by mobile phone or while the patient was sedated.

> You were blaming yourself, saying "it's just that he's there all alone". If only I could go and see him, even if it's just to be there with him … You know you won't be able to do anything, but at least to see him. There all alone, just to die alone. All you could do was go over and over it in your head …
>
> (P8, female, COVID-19 death, grandparent)
>
> I want to go in, give me PPE, do a PCR, do whatever, any protocol, but I need to see my mother. I have to hold her hand, I have to say goodbye to her … I need it and she needs it too. They wouldn't let me, and I was really angry.
>
> (P28, female, sudden death, mother)

Being able to say goodbye and be with the deceased in their final moments was a great help in the disease process, creating a memory that made it possible for them to accept the death. Another factor that made this acceptance easier was being able to see the body of the loved one after death. The impact of these protocols was also cushioned by the flexibility shown by some hospital staff in terms of their adherence to the rules.

> I think what made us all feel a lot better knowing she didn't die alone, we were there the whole time.
>
> (P13, female, natural death, grandmother)
>
> My mum had to go away for a few days and she didn't want to. I knew she had to go, so I pretended to be her, I took her place, and I was able to be with my aunt …. Not all the time, but I was there for a few days, and on other days the nurses let us sneak in to be with her.
>
> (P 7, female, natural death, aunt)

Participants noted that they had been affected by the saturation of the health system, an issue that had been building for years and was exacerbated by the pandemic. They expressed great dissatisfaction with healthcare professionals during the illness. Reasons included the refusal to provide face-to-face medical care at first contact, in-hospital infection of the deceased, concerns about the quality of care, insufficient or poor quality communication with relatives, direct verbal conflicts and the perceptions that treatment for other illnesses was neglected due to COVID. It is noteworthy that very few participants spoke positively about or expressed gratitude for the work of healthcare workers, although some reported feeling empathy for frontline workers.

> I asked the nurses if the doctor could come out and explain to me what had happened, because we didn't know. The doctor came out and started shouting at me saying: "I've already told your sister on the phone". In my whole life I've never been treated so badly in such a completely vulnerable situation.
>
> (P33, female, COVID-19 death, father)

When participants were primary carers during the disease process, in addition to experiencing intense levels of overload and

isolation, they were faced with the added difficulty of having to decide whether or not to keep their loved one in residential care. Those who chose to do so expressed dissatisfaction with conditions that encouraged infection among residents, the visiting arrangements and the refusal to even allow visits.

> If anything, my point is what is happening in the nursing homes, if there are more infections, it's because the conditions aren't what they should be. In my sister's nursing home there are bedrooms with three and four people sleeping in the same room.
>
> (P5, female, COVID-19 death, sister)

3.2. Emotional responses to the loss

Many of the emotional responses to loss reflect feelings that were not directly affected by the COVID-19 situation. These include feelings of sadness and hopelessness, longing for the loved one, relief (especially after long periods of illness or suffering for the patient), moments of acceptance (helped by the advanced age of the deceased and the progressive deterioration of health) or experiences of gratitude towards the deceased, one's own circumstances, or other loved ones.

However, the pandemic seems to have shaped a number of emotional responses, many of which are nuanced and differentiated (see Table 3). In the first instance, the feeling of disbelief and shock is more intense and persistent over time, potentially lasting for months. This may be due to not having been able to see the sick person, say goodbye or see the body. Secondly, those grieving experienced increased loneliness as a result of social distancing, which exacerbated perceptions of lack of support and understanding. Thirdly, the COVID-19 protocols put in place throughout the process also evoked emotions such as guilt/blame and helplessness or anger towards the measures themselves, the people responsible for implementing them, the sense of injustice or the healthcare staff. Finally, participants also often talked about fear and anxiety, mainly associated with the risk of death of other loved ones, but also with the risk of contagion or their own death.

3.3. Factors facilitating the grieving process

Participants recognised few factors specifically facilitating the grieving process during the pandemic. They highlighted aspects such as focusing on routines, pursuing hobbies and self-care activities (physical activity, reading, self-help resources and new professional or educational challenges), establishing new healthy habits, getting out and about or caring for others. In particular, some participants talked about their strategies for maintaining contact with the deceased or continuing bonds, which had to be adapted to the circumstances surrounding the pandemic. This involved maintaining the link with their loved one virtually through messages and photographs or by posting on social networks and communication channels. Other ways of maintaining the link with the deceased included shared activities or things that the deceased would have wanted them to do, visiting the grave when measures allowed, tributes such as tattoos or artistic creations and getting involved in social causes related to the death. Finally, we highlight introspection techniques such as meditation, reflection or writing, which served as an alternative way of saying goodbye and having conversations with the deceased for those who did not have the opportunity to do so before death.

> I got a tattoo done for him, because he always told me to "enjoy life" when he took me to school. I have it tattooed here, and since this happened it's become more like my motto in life, when I maybe don't feel like doing something I look at it and say "he would want me to do it".

Table 3
Quotations in Relation to the Category "Emotional Responses to the loss".

Codes	Quotations
Intense shock	*In shock. Not seeing him dead, not being able to say goodbye, or even see him when he was ill, made me dream about my father … It's like you see in the movies, that he'd been taken away and wasn't really dead, and then he suddenly appeared. I've been having these dreams for a long time. It's as if my brain hasn't really taken in the fact that my father is dead.* (P33, female, COVID-19 death, father)
A sense of loneliness through distance	*A sense of loneliness due to distance. For not being able to say a proper farewell to her, for COVID. Not being able to have the same kind of contact with people as before the pandemic, everything feeling very remote, as if from a great distance.* (P29, female, COVID-19 death, grandmother)
Guilt/Blame	*With hindsight, I thought, "Why didn't you try harder? Why didn't you go?" But I was there; I got the info, I tried to find out on what days I could visit, and how … "Until he's on the ward, until he's negative, we can't let you in …" I went along with the reasoning at the time. It's afterwards, when you lose the person, that you get that little voice saying "You could have done more. Why didn't you think about it? Why didn't you … ?"* (P11, female, COVID-19 death, father)
Helplessness	*I felt an overwhelming sense of helplessness. Firstly, because I couldn't say goodbye, and secondly, because of the way things were handled. Knowing that this was malpractice. If things had been done differently, if action had been taken, or if my father had been taken away when my grandmother came back from hospital. More than anything it's the helplessness.* (P2, female, COVID-19 death, father)
Rage	*Very angry that this is how things happened and not some other way. For not being able to talk to him, for not speaking to each other. More than anything else, it's that anger that affects me the most. And saying, "Damn, he could have had a happier ending".* (P6, female, natural death, father)
Fear	*It's still going on; I'm still really scared. I've never been afraid of death and now I'm panicking that something might happen to me, to my partner, to my family. I adopted a cat and she looks so tiny, innocent and fragile that sometimes I'm so scared of being left without her and of her dying.* (P41, female, COVID-19 death, mother)

(P25, female, COVID-19 death, father)

Psychological support (often online, allowing them to unburden themselves and learn to express their feelings), personal qualities (resilience, personal strength or the will to move on) or their own beliefs were also very helpful in the grieving process.

> I buried my father's ashes and started giving classes to almost 100 students, 2 h online. The student rep knew what had happened and asked me if I didn't want to teach the class, but I needed to because if I hadn't connected with those almost 100 students online for 2 h, I would have gone crazy. I think I used it as a survival tool at the time.
>
> (P38, female, natural death, father)

Some of the interviewees felt that the circumstances surrounding the death acted as a buffer for their later grieving. These included the deceased passing away at home, in their sleep or without pain; having no unfinished business with the deceased; the age of the deceased or their desire to die; and the anticipation of the death.

> I want to remember the look on my father's face when I saw his body, just a few hours after he died, at peace and with a smile on his face. I would like to think that everything went well and that he was able to go in peace and without suffering, which is the last thing he wanted; he didn't want to suffer.
>
> (P11, female, COVID-19 death, father)

One factor that facilitated the grieving process was the availability of social support. This, however, was severely limited by the pandemic situation. The support most valued by participants was the availability of a grief support network (expressing feelings of grief, sharing experiences with other bereaved people with the same or a different loss, getting to know the deceased through the eyes of others, joining support groups and associations), as well as the possibility of distraction or practical help. Measures such as lockdown, social distancing or restrictions on gatherings and activities, as well as changes to funeral rituals, inevitably affected the way in which such support was delivered. The use of social networks, phone and video calls, and alternative symbolic rituals to make up for those that could not be performed were some of the ways in which people were able to overcome these restrictions. For some people, the pandemic has increased their appreciation of the efforts of those who showed their support (e.g. by attending funerals despite social distancing or fear of contagion).

> I was always like "you can't do anything about death, but with my grandmother I can, she's very ill, what can I do?" And I did whatever I could: called her, sent her things, "look grandma, I'm going to do such and such, I'm going to video call you in the meantime". I said to her: "Grandma, don't worry, if grandpa is watching us he must be enjoying it because I'm doing whatever …"
>
> (P8, woman, COVID-19 death, grandparent)

Lastly, for some participants, lockdown provided an opportunity to spend more time with the deceased before they died, as well as to become closer to their family members by being forced to share more time and space with them. In some specific instances, participants were even grateful that the pandemic had made it possible to celebrate funeral ceremonies with a smaller, more intimate circle, as opposed to large ceremonies with crowds of people. It also led to the creation of online support groups that are still in place today.

> In such circumstances, you get worse and worse with each family member who comes to hug you … So I don't know if, in the middle of all this, it might even have been a good thing that there weren't so many people around, at that moment in the funeral home, which is so sad, right? In my case, and I think in my mother's case too, I get the feeling, it helped a bit that there weren't so many people.
>
> (P32, male, sudden death, father)
>
> This pandemic has brought us closer together as a family, my mother, my brother, and I, I mean the original family circle.
>
> (P14, female, COVID-19 death, sister)

3.4. Obstacles during the grieving process

As with the facilitating factors, many of the obstacles encountered were not directly influenced by the pandemic. The bereaved were therefore affected by social factors such as differences in the grief experience of individual family members (sometimes involving conflict with other bereaved people over issues such as care during illness, disagreements about inheritance or perceived lack of sensitivity to the interviewee's grief) or social disappointment (associated with misunderstanding and external judgements about the circumstances of the illness, the death or how they managed their grief). Participants reported that their grief was also negatively influenced by internal factors such as emotional blocking (due to academic or caregiving responsibilities, conscious avoidance or the perception of an environment hostile to emotional expression), not having anticipated the death, a loss of motivation, difficulties during significant dates associated with the deceased and the feeling that the world continued to function as usual despite the significance of their loss.

> Since he died, I've always felt that a part of me has shut down my feelings. I've felt that I've blocked out grieving a little bit by having to be responsible for other things and having practically no time to mourn. You can't give in because someone is depending on you; you basically don't get a break.
>
> (P33, female, COVID-19 death, father)

However, many of the other obstacles mentioned by the bereaved can be traced directly to the pandemic situation. The measures put in place in Spain to prevent the spread of the virus, which affected the bereaved regardless of the cause of death, are of particular importance in this regard. It is important to bear in mind that the exact time of death and the level of infection at that point conditioned the impact and severity of these measures. The obstacle associated with the measures that most affected those interviewed was not being able to count on face-to-face support from other bereaved people. This obstacle was exacerbated by not being able to see their loved ones until well after death and not being able to support older people who were grieving on their own. These issues were more pronounced in those who lost someone during lockdown (in particular, the inability to escape from their reality and the associated rumination, the feeling that time is not passing and the days are all one and the same, conflicts with other cohabitants and not being able to collect the deceased's remains). Also affected by perimeter lockdown were those bereaved people living in a different municipality to their loved ones. This was even more the case for those living abroad. Most respondents felt that the support received via electronic channels was insufficient and sometimes disagreeable.

> I mostly think about the issue of being alone, coming to terms with it alone. In today's society, we are used to socialising and being with people. I'm just saying that he died in March and the first time we saw my grandmother was by breaking the restrictions on Mother's Day. So imagine her grieving alone from March to May.
>
> (P8, female, COVID-19 death, grandparent)

Funerals were one occasion when these measures had the greatest impact. Many interviewees spoke of not being able to attend the funeral, having to postpone it or being unable to attend in person, thus missing the opportunity to share their grief with other mourners. Many felt that postponement made the funeral services less meaningful, and that people became less interested in attending them. At times they had to wait due to surges in the number of infections, sometimes delaying the process for more than a year. As they were not able to hold these ceremonies or invite everyone, they also noted the fact that people found out about them gradually over time, which they felt prolonged their grief.

> At first, everyone called, I had a list of people to reply to on WhatsApp. When you go to a funeral you see everyone in the funeral home, you get a hug and everyone goes home. But you get that sense of being embraced. Not here, here everyone wanted to hear about it, everyone wanted to talk to you. I was on the phone for an hour with an uncle I hadn't heard from in years. Then, complete exhaustion, all the people calling in the pandemic.
>
> (P14, female, COVID-19 death, sister)
>
> As the date drew nearer, family members said "no, there are restrictions; leave it for later, and we'll see if we can go, it's too complicated now". And I said "well, let's leave it for later". And a year later I said "whoever wants to come, come and whoever doesn't, don't come, I don't care".
>
> (P23, male, COVID-19 death, father)

Difficulties in coming to terms with the death led many bereaved individuals to regularly ask themselves whether the death could have been prevented by different actions on their part or on the part of others, particularly healthcare workers or those who had infected the deceased. Several also said that they would have found grieving much easier if the death had not occurred during the pandemic.

> I think that emotionally she also felt very lonely and that also played a part. The nurses said "it's just she gets agitated, she takes off her oxygen". If things had been different, if we had been able to be with her more, or if the staff had been able to be with her more, maybe she would have been calmer and things wouldn't have gone so badly.
>
> (P5, female, COVID-19 death, sister)

Some of the participants felt hindered in moving on because of other losses in a short space of time, problems at work (they lost their job or found it difficult to find work due to the pandemic) and with university (some students perceived a lack of flexibility towards their situation on the part of their universities or were put at a disadvantage by the online format of the classes).

> I had an exam critique and said I couldn't go because my father was in the ICU. The teacher didn't reply and failed me. It was like my world came to a standstill, but everybody else's kept going. I said: how can my life be ruined right now and yet everything really goes on the same. You have to carry on with your own stuff because you can't make it stop.
>
> (P25, female, COVID-19 death, father)

3.5. Differences in the grieving processes for deaths caused by COVID-19 vs. other causes

Most of the differences found between grieving processes caused by COVID-19 and other causes of death are illustrated by the

quotations (see Table 4).

When it came to disease processes during the pandemic, some experiences were unique to those who had lost someone to COVID-19 as opposed to other causes. Firstly, in relation to disease processes, participants expressed their dissatisfaction at feeling that their sick relatives had been treated differently because of their advanced age or disability. They also highlighted the impact that uncertainty about the symptoms and evolution of the virus had on their experience of the disease processes, especially those with loved ones who became infected in the early months of the pandemic. On the other hand, those with relatives who died from other causes expressed dissatisfaction that the treatment of other non-COVID-19 conditions had been neglected because of the pandemic.

In terms of emotional responses to the process, those bereaved by COVID-19 reported feeling anger more often than other bereaved groups, who highlighted other emotions such as acceptance, relief or gratitude. They were also the only ones to cite the death of a loved one as a key reason for their fear, and the trivialisation of the virus as a reason for their anger (pointing to the reckless non-compliance of others, COVID-19 denialism and its effects, as well as the anti-vaccine movement). The other groups of bereaved people identified more varied and individualised triggers for this type of emotion.

There were no differences in the facilitating factors; however, there were differences in the obstacles to the grieving process, with the greatest of these depending on the cause of death. Firstly, most of those who reported not being able to have a funeral had lost a loved one to COVID-19, whereas those who had lost a loved one to other causes were mostly able to do so, even if they were otherwise affected by the restrictive measures. Furthermore, those bereaved by COVID-19 were not allowed to see the body or choose how the remains were to be handled (with cremation being obligatory in many cases). These deficiencies in the process, which were not perceived by other bereaved groups, made it difficult to acknowledge the death and begin the grieving process.

Moreover, those who lost a loved one to COVID-19 mentioned societal-related obstacles more frequently, such as feeling misunderstood and let down by society (including the feeling that the pandemic has been forgotten over time), not being able to embrace other loved ones and experiencing the effects of lockdown. Although the other bereaved groups were also affected by such obstacles, they referred to them much less often, reporting more varied experiences and finding comfort more easily in the buffering effect from the circumstances surrounding the death.

Another problem unique to COVID deaths was the occurrence of simultaneous infections following the first death, causing the bereaved to be confined in the early days of grief or concerned about the health of other infected family members. The speed of the process between infection and death was stressed by many. Lastly, they also mentioned that, while grieving, they were affected by the constant reminders of the virus in the media and in everyday conversations.

> My mother at home alone, thinking she was infected, despairing. My brother very sick. I came back without seeing my mother or brother, after losing my sister, imagining that I was going to lose them too.
>
> (P14, woman, COVID-19 death, sister)

Table 4
Comparative Quotations between those Bereaved by COVID-19 and those Bereaved by Other Causes.

Code	COVID-19	Other Causes
Disease processes during the pandemic	*One comment from the doctor "with your sister's illness, the average lifespan is between 50 and 60 years, she is already 57". It was like saying "she has already lived as long as she should have". He didn't know how long she might have lived if it hadn't been for COVID, some people have lived much longer. I think that there is still a social stigma that either because of age or because of the type of illness, it's not worth the bother.* (P5, female, COVID-19 death, sister)	*[My grandmother] wasn't infected [with COVID-19] at any time. But maybe because of the situation things weren't so well monitored by primary care, so I will always have the thought in my head that maybe if it had been at another time she wouldn't have become so unbalanced.* (P4, male, sudden death, grandmother)
Rage	*Two things make me really angry. The first is when things began to open up and people gathered together outside, which wasn't possible at the time. I felt very angry, it was like "my father is dead and you're all here being complete idiots". I also feel angry about other stuff like "COVID doesn't exist", "your dad didn't die because of that" and so on.* (P33, female, COVID-19 death, father)	*It tugs at your heartstrings because you go right back to what my father had been like before the pandemic, he was in a good place to die. And it makes you angry, saying: what an easy death he could have had, that he could have had, and what a shame he had to die in such an awful way.* (P38, female, natural death, father)
Fear	*We were scared to death for the people who were sicker and whatnot. My father was also going through chemo, so I was, like, already thinking, "Oh, hell, I wonder if my dad is going to get infected and die as well".* (P27, female, COVID-19 death, best friend)	*I've never been afraid, but now I'm aware of any noise. As the only thing I want is to see my parents, I think at night one of them is going to come and tell me something. That's what I feel, as if I'm waiting for something. So any noise scares me.* (P10, female, natural death, both parents)
Obstacles	*There was no wake or burial, she was cremated, and for 15 days we didn't know where her ashes were. On the day she died, my mother was lying in the living room for 8 h before the funeral home came to take her away. In other words, everything was lacking. Because you're alone, you are cooped up.* (P19, female, COVID-19 death, mother) *I'll never forget that they brought out the coffin all covered in yellow tape, which couldn't be opened. At that time I was thinking "I'd like to see my mum, to see that she's in there". The feeling the whole time was like my mother had disappeared. And somehow that feeling hasn't gone away, having not been able to see her, not having been able to hold a vigil for her.* (P41, female, COVID-19 death, mother)	*There was a large capacity for the Mass and anyone who had ever known my aunt and wanted to remember her was able to attend. At the funeral home it was a more limited group, but everyone important, everyone who wanted to be there was able to come and it was no problem. I know that at other times it wasn't even possible to have a funeral, but in our case it went more or less smoothly.* (P7, female, natural death, aunt) *I always said "don't let my parents die because of COVID". I wouldn't have been able to cope with leaving them in hospital and them calling me and saying "come and collect the ashes". I was like, "I don't know what I'll do the day they tell me that". Thanks to God, they died during the pandemic, but not in those circumstances.* (P10, female, natural death, both parents)

3.6. Theory generated

The theory generated can be seen in Fig. 1. Following the analysis, the central category to emerge was "Processes of Loss and Grief in Pandemics", reflecting the unique features of the disease processes and subsequent grieving in the wake of the extraordinary measures taken due to COVID-19. The theory generated from the results obtained clearly shows the four main categories identified from the analysis of the interviews with the participants. The first category, "Disease Processes during the pandemic", can be broken down into two relevant factors: the saturation of the healthcare system (which caused the care system to become overloaded and the lack of information) and the restrictive hospital protocols (which in turn created challenges around saying goodbye and the conditions in residential care homes). These factors have also influenced the subsequent category "Processes of Loss and Grief" by prolonging the initial shock reaction following the loss and complicating the perception of a good death, understood as a facilitating factor for the families of the deceased. Both factors have a negative relationship with acceptance of the loss. This second category also included other responses such as guilt, fear, loneliness and anger. Anger was frequently triggered by a sense that the virus was being trivialised, which in turn was associated with social disappointment. Both causes of anger belong to the category "Obstacles to the Grieving Process". Another fundamental obstacle was the restrictive measures during the grieving process, which also made it difficult to access a key facilitator, namely social support. Finally, changes in funeral rituals made it more difficult to maintain continuing bonds, which are additional facilitators in the grieving process. All of these factors were interrelated and had an impact on the aforementioned responses of loneliness and intense shock.

This theory leads us to conclude that certain emotional responses and obstacles were modified and directly influenced by social restrictions and the associated public reaction, while other factors remained consistent with what would be expected during bereavement under normal circumstances. Furthermore, while the facilitating factors were those typical of any grieving process, some needed to be adapted to the circumstances of the pandemic, while others came about or were intensified as a result of the pandemic. Moreover, losing someone to COVID-19 as opposed to other causes of death also had an impact on the grief experience, both during the period of illness and later bereavement. This specifically refers to factors such as fear, anger, trivialisation of the illness (and the consequent social disappointment), perceptions of a good death and changes to funeral rituals.

4. Discussion

The aim of this study was to conduct an in-depth exploration of the experience of illness and death during the pandemic, as well as the obstacles and facilitating factors during the grieving process in people who had lost a loved one during this period, both to COVID-19 and to natural or sudden causes. The findings identified the central category of "Processes of Loss and Grief in Pandemics" and four associated categories: disease processes during the pandemic, emotional responses to the loss, facilitating factors and obstacles to the grieving process.

The findings of this study can be explained by reference to the Dual Process Model, especially the latest theoretical review conducted by the authors following COVID-19 [3]. That paper categorised the risk factors associated with the pandemic into loss-oriented and coping-oriented stressors and responses. The current study identified several stressors associated with loss, including challenges in being physically present with the person, misinformation about the diagnosis and its evolution, difficulty or inability to say goodbye,

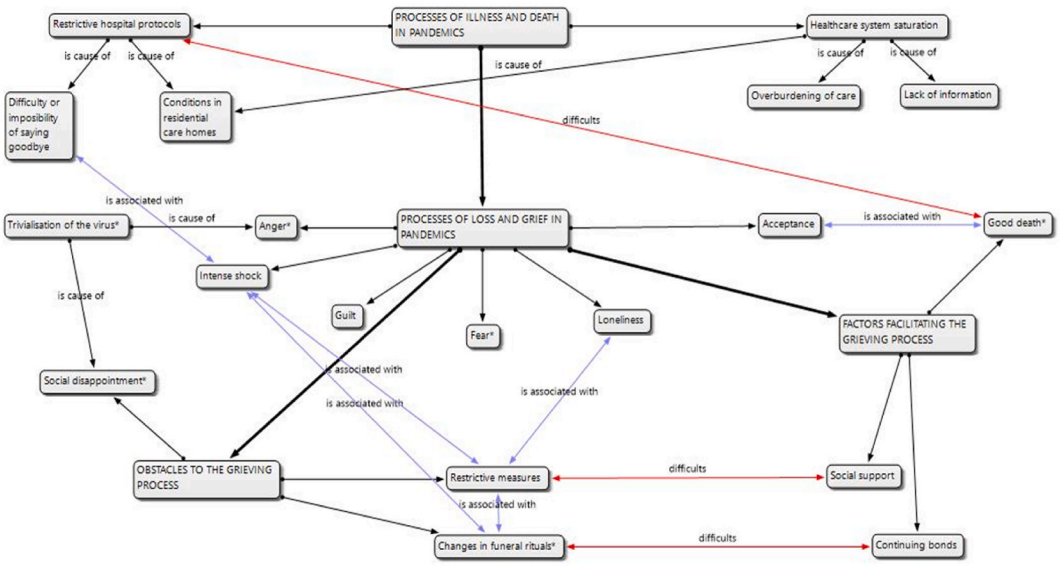

Fig. 1. Theory Generated Around the Central Category "Processes of Loss and Grief in Pandemics"; legend: Asterisks indicate those categories where there were differences in the experience depending on the cause of death.

changes in funeral rituals (time and capacity restrictions, forced cremations, bans on ceremonies) and lack of opportunities to give and receive physical and social support. All of these circumstances have been reported in previous studies [12–24] and are particularly well illustrated in the study by Lee and Neimeyer [29], which obtained very similar quantitative results to those presented in this qualitative research. However, other previously unmentioned stressors have been identified, such as concerns about the quality of care, caregiver overload, conditions in residential care homes, saturation of the healthcare system and clashes with healthcare staff.

It is important to highlight the healthcare systems' inability to cope with the pandemic situation due to severe patient overcrowding, especially during the first wave of infections. What is more, the healthcare situation in Spain during COVID-19 was clearly affected by the austerity measures put in place following the 2008 crisis [30]. This lack of material and human resources, the excessive workload and reduced rest periods placed added pressure on healthcare workers, leading to serious ethical dilemmas regarding the allocation of available resources [31]. In addition, a wide range of mental health problems are reported in healthcare professionals, including depressive symptoms, sleep disturbance, anxiety, stress and anger [32–34]. It is not surprising that the particularly stressful circumstances and resulting effects may have had an impact on the treatment of patients and their families. This lack of resources and investment also affected conditions in residential care homes, where an excess mortality rate of 43.5 % was recorded [35]. The main causes include the neglect of and discrimination against the residential population caused by the aforementioned lack of human and material resources, and by the apparent failure of the regional administrations to control the situation at the beginning of the crisis [36]. These figures, combined with restrictions on movement and visits in an effort to reduce them, have had a significant adverse impact on the well-being of residents and family members, as documented in one international review [37].

Common responses to loss-oriented stressors acknowledged by participants in the present study include guilt/blame, loneliness and anger towards the system, which is consistent with previous studies [3,12–16,20,22]. Intense shock and prolonged grief were also evident in our analysis. One possible hypothesis is that both aspects may have been influenced by the difficulty of coming to terms with death, due to the disruption to the fundamental stages of the process (accompaniment, farewell and funeral rituals). The literature has traditionally associated attendance at funerals with an easier grieving process [38], fewer depressive symptoms and better social adjustment during the first weeks after the loss [39]. Burrell and Selman's review [40] showed that the benefit of after-death rituals does not depend on whether or not they can be performed, but on the ability of the bereaved to shape these rituals in a way that is meaningful for them. During the pandemic, many practices could not be tailored to the wishes of the bereaved or the deceased, and the measures were even more severe if the deceased was infected with COVID-19. As such, factors such as not being able to see the body of the loved one, or the choice between cremation and burial, may have directly affected the meaning that such practices, if carried out at all, had for the loved ones, resulting in a perceived lack of control over the event.

As in previous work, stressors associated with moving on point to the inconvenience of lockdown or restricted mobility [17] and the erosion of typical coping strategies such as social support [13,15,20]. On the other hand, anxiety and fear of the death of other loved ones also appear in the present study as the most common responses, in line with previous research [12,16,22]. Factors such as social disappointment or difficulties in adapting to the new circumstances associated with the pandemic (e.g. new academic conditions related to online formats, lack of flexibility on the part of universities, loss of job or difficulty in finding a job) also emerged in this research. These two conditions could be interrelated through the influence of a third, the absence of physical contact. Physical contact has been shown to have positive effects on social well-being and is associated with the emotional depth of attachments [41-42], as well as with prosocial behaviour [43]. The physical aspects of communication were completely disrupted during this pandemic, potentially leading to a reduction in the perceived emotional depth of relationships (and the support linked to them) [44] and predisposing people to less prosocial behaviour towards others. This could be directly related to the social disappointment generated in the bereaved by the failure to live up to expectations placed on the people around them.

The present study has also considered possible differences in the experiences of those bereaved by one cause of death or another, and has analysed these experiences in relation to different points in time in the experience of illness, death and bereavement, something not focused on by previous studies. In terms of loss-related stressors, we first highlight the differences in concerns about the quality of care. While the origin of these concerns in those bereaved by COVID-19 was differential treatment due to advanced age or disability, those bereaved by other causes perceived that other diseases had been neglected in the prioritisation of COVID-19. Both perceptions are supported by the fact that the processes of prevention, diagnosis and treatment of non-COVID-19 pathologies were affected in all care settings [45]. Also noteworthy are the ethical recommendations for decision-making during the pandemic drawn up by the Spanish Society of Intensive Care Medicine, Critical Care and Coronary Units, which reflected that the allocation of medical resources during COVID-19 took into account factors such as age or comorbidities with other diseases [46]. People bereaved by COVID-19 found it more difficult to perform funeral rituals. Greater prohibitions were imposed depending on the cause of death. This, together with the impossibility of seeing the body or deciding what to do with the remains, could lead to feelings of ambiguous loss similar to those experienced by families of missing persons [47]. Responses to loss were also affected in these participants, particularly in terms of anger and the underlying reasons for it, particularly the various ways in which others downplayed the virus. This minimisation and even denial of the cause of death may have led to feelings of denial of grief associated with COVID-19 [22,48]. Such disempowerment could contribute to the emergence of a sense of social disappointment, causing individuals to feel misunderstood by those around them. This may distance them from other people more than the preventive measures themselves, making it more difficult for them to access one of the most important buffers against the negative effects of stressors, namely social support [49].

One of this paper's main contributions has been to identify the strategies that bereaved people used and adapted to the pandemic to cope with these stressors, as well as to discuss them alongside theoretical models such as the DPM [3]. Firstly, the people bereaved have largely used virtual means to cope with the loss. This seems to have had both positive and negative effects, providing opportunities to connect with other loved ones at a distance, but also hindering the adjustment to a new life without the deceased person [50]. Secondly, there is insufficient evidence on the impact of various alternative funeral rituals on grief. Burrell and Selman's review [40]

suggests that active involvement in arranging funerals and adapting them in ways that make sense to the bereaved may be beneficial. Both virtual media and alternative rituals facilitated the provision of social support and support networks among those grieving [44, 51]. Finally, the support groups and psychological interventions that enabled participants to express and normalise the emotions associated with their grief would often not have been possible without the use of virtual support. The review by Zuelke et al. [52] provides evidence of the effectiveness of these online interventions for symptoms of prolonged grief.

The main limitations of this study relate to the representativeness of the sample selected. Although an effort was made to include a fairly wide range of ages and sexes, as in most studies, the number of female participants exceeded the number of male participants. Furthermore, the data collected represent a number of situations and protocols that have been designed primarily in the context of Spain. This makes it difficult to extrapolate and generalise the findings to other countries where the impact of the pandemic or the measures taken have been different. The ability to control the conditions under which the interviews were conducted was limited by the fact that the interviews were conducted online, even though this did allow for a sample of different locations and contexts. Finally, the analysis of the results did not take into account differences according to the time of death, either in terms of the duration of grief or the existence of different restrictions.

5. Conclusions

This qualitative study brings together a wide range of experiences in an attempt to reflect what the disease processes, death and grieving has meant for those who lost a loved one during the two years of the pandemic. The most notable aspects of the study include the effect of restrictive measures on the disease processes, the funeral rituals performed and how grief was then dealt with, the identification of the most common responses such as intense shock, anger, fear or loneliness, as well as the way in which some of the factors facilitating the grieving process were adapted to the circumstances. Other worthwhile observations include differences in the grief experience of those who lost a loved one to COVID-19, such as perceptions of differential treatment of the patient due to advanced age or disability; greater inconvenience in funeral rituals; anger caused by the minimisation of the virus; social disappointment; or fear of the death of others. It is essential that the obstacles and needs raised by all those affected are taken into account at a societal level for any future health crises or emergencies. Future research could focus on how to specifically address these aspects in clinical practice and grief treatment programmes, as well as analyse the effectiveness of such interventions on bereaved people.

Funding

This project has been funded by the Ministry of Science and Innovation within the 2020 Proyectos I+D+I programme (Ref. PID2020-119063RB-I00). ARA is funded by a grant from the University Teacher Training Programme of the Ministry of Universities (FPU21/01029).

CRediT authorship contribution statement

Andrea Redondo-Armenteros: Writing – original draft, Visualization, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization. **María Nieves Pérez-Marfil:** Writing – review & editing, Validation, Supervision, Resources, Project administration, Methodology, Investigation, Funding acquisition, Conceptualization. **Manuel Fernández-Alcántara:** Writing – review & editing, Visualization, Validation, Supervision, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization. **María Paz García-Caro:** Writing – review & editing, Validation, Supervision, Methodology, Conceptualization. **Francisco Cruz-Quintana:** Writing – review & editing, Validation, Supervision, Resources, Methodology, Investigation, Conceptualization. **María José Cabañero-Martínez:** Writing – review & editing, Validation, Supervision, Methodology, Conceptualization.

Data and code availability

The data that has been used is confidential.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.heliyon.2024.e40216.

References

[1] World Health Organization (WHO), Coronavirus Disease (COVID-19), World Health Organization, 2024 May 19 [accessed 2024 Jun 6]. Available from: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/.
[2] A.M. Verdery, E. Smith-Greenaway, R. Margolis, J. Daw, Tracking the reach of COVID-19 kin loss with a bereavement multiplier applied to the United States, Proc. Natl. Acad. Sci. U. S. A. 117 (30) (2020) 17695–17701, https://doi.org/10.1073/pnas.2007476117.
[3] M. Stroebe, H. Schut, Bereavement in times of COVID-19: a review and theoretical framework, Omega J. Death Dying 82 (3) (2021) 500–522, https://doi.org/10.1177/0030222820966928.
[4] M. Lundorff, H. Holmgren, R. Zachariae, I. Farver-Vestergaard, M. O'Connor, Prevalence of prolonged grief disorder in adult bereavement: a systematic review and meta-analysis, J. Affect. Disord. 212 (2017) 138–149, https://doi.org/10.1016/j.jad.2017.01.030.
[5] M.C. Eisma, A. Tamminga, G.E. Smid, P.A. Boelen, Acute grief after deaths due to COVID-19, natural causes and unnatural causes: an empirical comparison, J. Affect. Disord. 278 (2020) 54–56, https://doi.org/10.1016/j.jad.2020.09.049.
[6] World Health Organization (WHO), 6B42 prolonged grief disorder. ICD-11 for Mortality and Morbidity Statistics, 2024 Jan [accessed 2024 Jun 6], https://icd.who.int/browse/2024-01/mms/en#1183832314.
[7] S. Tang, Y. Yu, Q. Chen, M. Fan, M.C. Eisma, Correlates of mental health after COVID-19 bereavement in Mainland China, J Pain Symptom Manage 61 (6) (2021) e1–e4, https://doi.org/10.1016/j.jpainsymman.2021.02.016.
[8] L.J. Breen, V.O. Mancini, S.A. Lee, E.A. Pappalardo, R.A. Neimeyer, Risk factors for dysfunctional grief and functional impairment for all causes of death during the COVID-19 pandemic: the mediating role of meaning, Death Stud. 46 (1) (2022) 43–52, https://doi.org/10.1080/07481187.2021.1974666.
[9] C.Y. Kustanti, H.J. Jen, H. Chu, D. Liu, R. Chen, H.C. Lin, et al., Prevalence of grief symptoms and disorders in the time of COVID-19 pandemic: a meta-analysis, Int. J. Ment. Health Nurs. 32 (3) (2023) 904–916, https://doi.org/10.1111/inm.13136.
[10] Gobierno de España, Crisis sanitaria COVID-19: Normativa e información útil, Gobierno de España, 2023 Jul 5 [accessed 2024 Jun 6], https://administracion.gob.es/pag_Home/atencionCiudadana/Crisis-sanitaria-COVID-19.html.
[11] A. González-Rodríguez, J. Labad, Salud mental en tiempos de la COVID: reflexiones tras el estado de alarma, Med. Clin. 155 (9) (2020) 392, https://doi.org/10.1016/j.medcli.2020.07.009.
[12] M. Firouzkouhi, N. Alimohammadi, A. Abdollahimohammad, G. Bagheri, J. Farzi, Bereaved families views on the death of loved ones due to COVID 19: an integrative review, Omega J. Death Dying 0 (0) (2021) 1–16, https://doi.org/10.1177/00302228211038206.
[13] X. Tao, C.C. Yu, J.A. Low, Exploring loss and grief during the COVID-19 pandemic: a scoping review of qualitative studies, Ann Acad Med Singap 51 (10) (2022) 619–628, https://doi.org/10.47102/annals-acadmedsg.2021460.
[14] T. Van Schaik, M.A. Brouwer, N.E. Knibbe, H.J. Knibbe, S.C. Teunissen, The effect of the COVID-19 pandemic on grief experiences of bereaved relatives: an overview review, Omega J. Death Dying 0 (0) (2022) 1–34, https://doi.org/10.1177/00302228221143861.
[15] P.P.B. Sola, C.D. Souza, E.C.G. Rodrigues, M.A.D. Santos, É.A.D. Oliveira-Cardoso, Family grief during the COVID-19 pandemic: a meta-synthesis of qualitative studies, Cad. Saúde Pública 39 (2023), https://doi.org/10.1590/0102-311XEN058022.
[16] A. Aguiar, M. Pinto, R. Duarte, A qualitative study on the impact of death during COVID-19: thoughts and feelings of Portuguese bereaved adults, PLoS One 17 (4) (2022) e0265284, https://doi.org/10.1371/journal.pone.0265284.
[17] V. Buscemi, M. López, O.B. de la Rosa, S. Crespo, X. Costa, E.S. Persentili, C. Noguera, Aprendiendo de la experiencia del duelo en el contexto de la pandemia por COVID-19 [Learning from the grief experience during the COVID-19 Pandemic], Med paliat 28 (3) (2021) 166–176, https://doi.org/10.20986/medpal.2021.1243/2021.
[18] M. Guerra-Ramirez, I. Rojas-Torres, J. Tafur-Castillo, Significado del duelo frente al COVID en estudiantes y profesores de enfermería [Meaning of grief during COVID-19 in nursing students and professors], Rev Cienc Cuid 19 (3) (2022) 56–66, https://doi.org/10.22463/17949831.3375.
[19] J.R. Hanna, E. Rapa, L.J. Dalton, R. Hughes, T. McGlinchey, K.M. Bennett, et al., A qualitative study of bereaved relatives' end of life experiences during the COVID-19 pandemic, Palliat. Med. 35 (5) (2021) 843–851, https://doi.org/10.1177/02692163211004210.
[20] A. Torrens-Burton, S. Goss, E. Sutton, K. Barawi, M. Longo, K. Seddon, et al., 'It was brutal. It still is': a qualitative analysis of the challenges of bereavement during the COVID-19 pandemic reported in two national surveys, Palliat Care Soc Pract 16 (2022) 1–17, https://doi.org/10.1177/26323524221092456.
[21] F. Koliouli, L. Canellopoulos, I. Stasinopoulou, C. Risvas, L. Sani, M.F. Bacqué, Experiences of grief and mourning practices of Greek bereaved adults during the pandemic: a qualitative approach, Death Stud. (2024) 1–13, https://doi.org/10.1080/07481187.2024.2309451.
[22] M. Asgari, M. Ghasemzadeh, A. Alimohamadi, S. Sakhaei, C. Killikelly, E. Nikfar, Investigation into grief experiences of the bereaved during the covid-19 pandemic, Omega J. Death Dying 0 (0) (2023) 1–22, https://doi.org/10.1177/00302228231173075.
[23] C. De Vincenzo, G. Biancalani, L. Sani, M.F. Bacqué, L. Novelletto, D. Scussolin, et al., The impact of COVID-19 on grief: a quantitative and qualitative analysis in Italy, OMEGA (Westport) 0 (0) (2024), https://doi.org/10.1177/00302228241248534.
[24] P.V. Antezana, A.A.I. Bravo, E. Malvaceda-Espinoza, O. Mamani-Benito, R.F.C. Esteban, Percepción del duelo de adultos que han perdido a un familiar durante la situación de pandemia en Lima Metropolitana [Perception of Grief in Adults Who Have Lost a Family Member During the Pandemic Situation in Metropolitan Lima], Rev. Colomb. Psiquiatr. (2022), https://doi.org/10.1016/j.rcp.2022.09.003.
[25] L. Reitsma, C. Killikelly, H. Müller, L. Larsen, P. Boelen, L. Lenferink, Prevalence and correlates of positive and negative psychological effects of bereavement due to COVID-19: a living systematic review, F1000Res 12 (2023) 237, https://doi.org/10.13140/RG.2.2.30746.11202.
[26] A. Strauss, J.M. Corbin, Grounded Theory in Practice, Sage, 1997.
[27] U. Flick, Introduccion a la investigación cualitativa [Introduction to Qualitative Research], Ediciones Morata, Madrid, 2012.
[28] ATLAS.ti scientific software development GmbH. ATLAS.ti [software], Versión 7.0. Berlín: ATLAS.ti Scientific Software Development GmbH (2023). Available from, http://www.atlasti.com/es.
[29] R.A. Neimeyer, S.A. Lee, Circumstances of the death and associated risk factors for severity and impairment of COVID-19 grief, Death Stud. 46 (2022) 34–42, https://doi.org/10.1080/07481187.2021.1896459.
[30] H. Legido-Quigley, L. Otero, D. la Parra, C. Alvarez-Dardet, J.M. Martin-Moreno, M. McKee, Will austerity cuts dismantle the Spanish healthcare system? BMJ 346 (2013) https://doi.org/10.1136/bmj.f2363.
[31] L. Otero-García, J.T. Mateos, A. Esperato, L. Llubes-Arrià, V. Regulez-Campo, C. Muntaner, et al., Austerity measures and underfunding of the Spanish health system during the COVID-19 pandemic—perception of healthcare staff in Spain, Int J Environ Res Public Health 20 (3) (2023) 2594, https://doi.org/10.3390/ijerph20032594.
[32] A. Lozano-Vargas, Impacto de la epidemia del Coronavirus (COVID-19) en la salud mental del personal de salud y en la población general de China [Impact of the Coronavirus epidemic (COVID-19) on the mental health of health workers and general population in China], Rev. Neuro Psiquiatr. 83 (1) (2020) 51–56, https://doi.org/10.20453/rnp.v83i1.3687.
[33] L.A. Williams, D. Accardo, J. Dolgoff, A. Farrell, T. McClinton, E. Murray, et al., A mixed methods study: the grief experience of registered nurses working on the frontlines during the COVID-19 pandemic, J. Clin. Nurs. 33 (1) (2024) 344–356, https://doi.org/10.1111/jocn.16579.
[34] S. Burm, S. MacDonald, C. Melro, E. Kennedy, P. Tran-Roop, F. Kilbertus, et al., The burden of grief: a scoping review of nurses' and physicians' experiences throughout the COVID-19 pandemic, Death Stud. (2024) 1–10, https://doi.org/10.1080/07481187.2024.2306461.
[35] J. Oliva, L.M. Peña-Longobardo, Impacto de la COVID-19 en la atención sociosanitaria: el caso de las residencias, Informe SESPAS 36 (2022) S56–S60, https://doi.org/10.1016/j.gaceta.2022.02.003 [Impact of COVID-19 on long term care: the case of residential facilities. SESPAS Report 2022]. Gaceta Sanit. 2022.
[36] B. Deusdad, El COVID-19 y la crisis de las residencias de mayores en España: Edadismo y precariedad [COVID-19 and Care Homes and Nursing Homes Crisis in Spain: Ageism and Scarcity of Resources], Res Ageing Soc Policy 8 (2) (2020) 142–168, https://doi.org/10.17583/rasp.2020.5598.
[37] D.C. Thompson, M.G. Barbu, C. Beiu, L.G. Popa, M.M. Mihai, M. Berteanu, et al., The impact of COVID-19 pandemic on long-term care facilities worldwide: an overview on international issues, BioMed Res. Int. 2020 (2020), https://doi.org/10.1155/2020/8870249.
[38] S. Zisook, R.A. DeVaul, Grief, unresolved grief, and depression, Psychosomatics 24 (3) (1983) 247–256, https://doi.org/10.1016/S0033-3182(83)73227-5.

[39] D.W. Kissane, S. Bloch, D.P. McKenzie, Family coping and bereavement outcome, Palliat. Med. 11 (3) (1997) 191–201, https://doi.org/10.1177/026921639701100303.
[40] A. Burrell, L.E. Selman, How do funeral practices impact bereaved relatives' mental health, grief and bereavement? A mixed methods review with implications for COVID-19, Omega J. Death Dying 85 (2) (2022) 345–383, https://doi.org/10.1177/0030222820941296.
[41] B.K. Jakubiak, B.C. Feeney, Affectionate touch to promote relational, psychological, and physical well-being in adulthood: a theoretical model and review of the research, Pers. Soc. Psychol. Rev. 21 (3) (2017) 228–252, https://doi.org/10.1177/1088868316650307.
[42] J.T. Suvilehto, L. Nummenmaa, T. Harada, R.I. Dunbar, R. Hari, R. Turner, et al., Cross-cultural similarity in relationship-specific social touching, Proc. Biol. Sci. 286 (2019) 20190467, https://doi.org/10.1098/rspb.2019.0467, 1901.
[43] A. Gallace, C. Spence, The science of interpersonal touch: an overview, Neurosci. Biobehav. Rev. 34 (2) (2010) 246–259, https://doi.org/10.1016/j.neubiorev.2008.10.004.
[44] L. Dahlberg, Loneliness during the COVID-19 pandemic, Aging Ment. Health 25 (7) (2021) 1161–1164, https://doi.org/10.1080/13607863.2021.1875195.
[45] D. Cura-González, E. Polentinos-Castro, M. Fontán-Vela, J.A. López-Rodríguez, J. Martín-Fernández, What Have We Missed Because of COVID-19? Missed Diagnoses and Delayed Follow-Ups. SESPAS Report 2022, vol. 36, Gaceta Sanit, 2022, pp. S36–S43, https://doi.org/10.1016/j.gaceta.2022.03.003.
[46] Sociedad Española de Medicina Intensiva, Crítica y Unidades Coronarias (SEMICYUC), Recomendaciones éticas para la toma de decisiones en la situación excepcional de crisis por pandemia COVID-19 en las unidades de cuidados intensivos [Ethical recommendations for decision-making in the exceptional situation of the COVID-19 pandemic crisis in intensive care units] [accessed 2024 Jun 6]. Sociedad Española de Medicina Intensiva, Crítica y Unidades Coronarias (SEMICYUC), https://semicyuc.org/wp-content/uploads/2020/03/Ética_SEMICYUC-COVID-19.pdf, 2020 Mar.
[47] J.W. Worden, Á. Aparicio, G.S. Barberán, El tratamiento del duelo: asesoramiento psicológico y terapia [Grief Counseling and Grief Therapy, fourth ed., Paidós, Barcelona, 2013.
[48] S. Albuquerque, A.M. Teixeira, J.C. Rocha, COVID-19 and disenfranchised grief, Front Psychiatry 12 (2021) 638874, https://doi.org/10.3389/fpsyt.2021.638874.
[49] W. Stroebe, M. Stroebe, G. Abakoumkin, H. Schut, The role of loneliness and social support in adjustment to loss: a test of attachment versus stress theory, J. Pers. Soc. Psychol. 70 (6) (1996) 1241, https://doi.org/10.1037//0022-3514.70.6.1241.
[50] K.R. Rossetto, P.J. Lannutti, E.C. Strauman, Death on Facebook: examining the roles of social media communication for the bereaved, J. Soc. Pers. Relat. 32 (7) (2015) 974–994, https://doi.org/10.1177/0265407514555272.
[51] H. Prime, M. Wade, D.T. Browne, Risk and resilience in family well-being during the COVID-19 pandemic, Am. Psychol. 75 (5) (2020) 631, https://doi.org/10.1037/amp0000660.
[52] A.E. Zuelke, M. Luppa, M. Löbner, A. Pabst, C. Schlapke, J. Stein, et al., Effectiveness and feasibility of internet-based interventions for grief after bereavement: systematic review and meta-analysis, JMIR Ment Health 8 (12) (2021) e29661, https://doi.org/10.2196/29661.