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Jeffrey Sarnoff, MD

Thomas Jefferson University Hospital

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CARING FOR SURVIVORS OF SUDDEN DEATH IN THE EMERGENCY WARD

JEFFREY SARNOFF, M.D.

Acute grief is a definite syndrome with psychological and somatic symptomatology (1).

Frequently, emergency physicians have to interact with family and friends of persons who have died suddenly, often unexpectedly. These interactions are in complex ways difficult for both emergency ward (EW) staff and for survivors of sudden death. It may be that the way in which this crisis is managed will be a major determinant in how these survivors will remember the incident of sudden death, and how they will cope with it psychologically and physiologically.

The literature on grief—its psychodynamics, its manifestations, and its treatment—begins, in the modern era, with Sigmund Freud's *Mourning and Melancholia*. Freud wrote that:

Mourning is regularly the reaction to the loss of a loved person, or to the loss of some abstraction which has taken place of one, such as fatherland, liberty, and ideal, and so on. As an effect of the same influences, melancholia instead of a state of grief develops in some people, whom we consequently suspect of a morbid pathological disposition. . . . The distinguishing mental features of melancholia are a profoundly painful dejection, abrogation of interest in the outside world, loss of the capacity to love, inhibition of all activity and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-reviling, and culminates in a delusional expectation of punishment. . . . The fall in self-esteem is absent in grief, but otherwise the features are the same (2).

Later, Bowlby wrote more on the psychodynamics of grief, particularly childhood grief (3, 4). He asserted that when a child grieves, the grief evolves through three stages: an attempt to recover the lost object (manifested by weeping and anger), psychological disorganization (manifested by depression), and finally, a stage of reorganization.

In the 1940's Erich Lindemann wrote about the grieving process, and made major contributions with regard to the manifestations and effects of grief and sudden loss (1, 5). The infamous Coconut Grove fire that occurred in Boston in 1942 provided Lindemann and the staff at Massachusetts General Hospital with over four hundred deaths that were sudden and unexpected. At that time, the Massachusetts General Hospital was engaging in preparations for the eventuality of treating disaster situations related to World War II.

Lindemann noted characteristics that he termed pathognomonic for grief:

Dr. Sarnoff is a second-year resident.

somatic distress, guilt, hostile reactions, and loss of patterns of conduct. Lindemann speculated on another characteristic, "the appearance of traits of the deceased in the behavior of the bereaved, especially symptoms shown during the last illness, or behavior which may have been shown at the time of the tragedy" (1). Whereas the above descriptions apply to normal grief, Lindemann went on to describe two aberrations of normal grief, the morbid grief reactions of the delayed and the distorted type. Lindemann asserted that morbid grief reactions could, if recognized and treated appropriately, be transformed into normal grief reactions; if identification and treatment of symptoms of morbid grief reactions is not successful, the bereaved person would be at risk for increased incidence of mental and physical illness. The role of loss of a loved object in the psychopathology of depression is well known (6, 7).

C.M. Parkes has studied bereavement as a cause of mental and physical illness by conducting longitudinal studies on the health records of widows (8, 9, 10). He wrote that widows under the age of 65 consulted their medical doctor for psychiatric symptoms three times as frequently during the half-year after bereavement than they had done in a control period before their bereavement. Both younger and older widows increased their consultation rate to physicians for physical symptoms by nearly fifty percent in the first six months of bereavement.

Whether or not the initial management of acute grief in the emergency ward setting is a major determinant in the success of the grieving process has yet to be determined. Jones has reported on a follow-up survey of survivors of sudden death who were seen in the EW of Crittendon Hospital in Michigan (11). Survivors were interviewed regarding their subjective experiences in the EW. The results enabled Jones and subsequent writers to examine what could be perceived by survivors as effective treatment.

The necessity of applying crisis theory to the suddenly bereaved was addressed by Dubin (12) and Aguilera (13). Aguilera described three variables that contribute to the crisis situation that can be utilized in the treatment of acute grief in the EW: distorted perception of the event, inadequate external supports, and inadequate psychological coping mechanisms.

Elizabeth Kubler-Ross, writing in the 1960's and 1970's, described five stages that dying people go through, and brought the subject of death and dying to the medical literature after little had appeared since Lindemann's work of the 1940's (14). Hershowitz, in 1973, described four stages that occur in people who are mourning: impact, recoil-turmoil, adjustment, and reconstruction. Impact covers the time sequence from notification of the death through approximately 48 hours; recoil-turmoil covers approximately 48 hours to one to four weeks after the death, and is characterized by rage, anxiety, depression, guilt and shame. The adjustment period occurs over the next several weeks to months and is characterized by decreased pain and a shifting in the survivor's attention from the past to the future. The final stage, reconstruction, is characterized by pragmatic problem-solving and new hope.

Albrizio synthesized a new model, delineating a five-stage process in the survivors of sudden, unexpected death: impact, shock/disbelief, protest, disorganization and reorganization (16). Impact describes the brief, yet intense sequence of events

immediately preceding and including the notification of death. Albrizio notes that the survivor is called to unfamiliar surroundings in most cases, and this, coupled with the nature of the news, makes it essential that the person notifying the survivor of the death keep certain specific notions in mind.

When making contact with the survivor, the caller should promptly identify himself, and establish from the outset his relationship to the deceased. Ideally, one will communicate the seriousness of the situation without causing more alarm than necessary. Refraining from actual notification of death over the telephone is indicated; however, if the survivor probes the caller, it may well be appropriate to notify the survivor that death has actually occurred. First, the stability of the survivor should be assessed. Furthermore, it should be ascertained whether there are any adults in the company of the survivor at the time of the first communication. The caller should consider how the survivor will travel to the hospital—it is good policy to caution that the survivor not travel alone—and to ensure that no children, sick, or disabled people will be left alone while the survivor travels to the hospital. If the death happens to be sudden but not unexpected, one may plan to prepare for it by maintaining regular, supportive contacts between hospital staff and anticipated survivors (including frequent visits to the hospital). According to Albrizio, how the news of death is communicated is more important than who communicates it (16). Factors to assess in delegating the responsibility for this communication include: staff availability, comfort with this role, ability to empathize, ability and willingness to remain with the survivors, degree of technical/medical material that needs to be explained, and convention within the given emergency ward (11). It is essential that the person who is to notify survivors of the death have a clear sense of how he feels about death and dying in general and about the deceased patient's death in particular, in order to maximize his empathy, compassion, warmth, and effectiveness without conveying his own anxiety, guilt, or other uncomfortable feelings (14). When communicating the news of the death, one should gauge the hierarchy of the survivors present and pick one of the survivors as the principal person who will be directly communicated with. With regard to communication of news of death, hospitals have a medical-legal responsibility to inform immediate family before informing anyone else. The hospital may in fact require release forms signed by the family of the deceased before releasing any information to telephone callers.

Jones wrote that survivors, when interviewed some time after the death of someone important to them, commented favorably upon certain practices instituted during the impact stage, for example, being greeted immediately upon arrival by someone from the hospital staff who could inform them without delay of the patient's condition (11). A common mistake made during the impact stage is to request that survivors complete paperwork before being adequately informed about the nature of the situation and what was done for the patient.

Albrizio described a second stage that occurs concurrently with the impact stage, shock and disbelief. This lasts for hours to days after the notification of death, and is characterized by a sense of numbness, bewilderment, unreality, frank denial, blunted affect and tears (16). Physically, this stage can be manifested by choking, shortness of

breath, gastrointestinal upset, and a sense of tightness in the throat. It is also frequently manifested by an obsessional review of the acute events surrounding the death, the telling of anecdotes about the life of the deceased, repetitive questions regarding the circumstances around the death, and use of the incorrect verb tense, for example, "the deceased has an appointment tomorrow."

During this stage the survivor often seeks from medical staff reassurances regarding the death, specifically wanting to know if the death was a painful one and if everything possible was done for the deceased. One must assess how much the survivors are able to assimilate. To gauge this, one can listen for use of the present verb tense which, as mentioned above, is a manifestation of the survivor's denial that should not be undervalued nor undermined as a defense mechanism.

There are times when the stresses of this type of work or the realities of emergency ward time schedules make it difficult or impossible for one staff member to treat one group of survivors through their entire stay in the emergency ward. When this occurs, it is helpful to employ several staff members, working together, in a "tag-team" manner. Also, it can be useful to both survivors and emergency ward staff to mobilize additional supports in managing these crises, for example, clergy or trained grief counselors. There is often much practical work to be done, such as notifying other survivors, finding their telephone numbers, directing them to the hospital, and gathering police or ambulance reports.

Viewing the body has been reported by many survivors to be beneficial (11), provided that certain conditions are met. Survivors should be given a place to view the body that is as private as possible; they have reported that when this area is not only private, but also large and open they are better able to cope with the situation. The process can be initiated by saying something like, "We would like to give you some time to be alone with your loved one." The survivors need to be informed—before viewing the body—of the physical condition of the deceased, and it is good management to drape disfigured, traumatized portions of the body. The presence of a small amount of medical and surgical equipment serves to reinforce the notion that medical care was in fact instituted and everything that could have been done was done. However, too much medical equipment has been described by survivors as overwhelming.

Even though the matter of viewing the body might well be addressed with the implication that survivors are to be *alone* with their loved one, it is necessary that at least one member of the emergency ward staff accompany the survivors into the viewing area and remain with them in an unobtrusive manner. Survivors have reported that they have been comforted by the presence of a staff member. In fact, survivors report that supportive touching by the staff, and the expression by the staff member of his or her own emotion, such as shedding of tears, can be perceived as a validation of the feelings of the survivor (11). Survivors have also reported that viewing the body is helpful because it transforms the experience from a dream-like awareness of the situation into more of a reality.

The final part of the shock/disbelief phase that occurs in the emergency ward setting is the concluding process. One must ensure that all necessary papers have been

signed. Survivors should be given photocopies of the signed documents, since it has been found that they are rarely able to recall the nature of the forms they have signed. Personal effects of the deceased must be claimed; emergency ward staff must appreciate that the taking of these personal effects is an integral part of the grieving process and should be encouraged. The matters of autopsy and organ donation must be addressed. If an autopsy is required, it is useful to explain why this is so, what it involves, and that it does not signify mutilation or disfigurement. The question of how the body will be transported out of the hospital should be discussed. Usually survivors will introduce this matter by asking, "What will happen with the body now?"

The staff member that has been treating the survivors should give a referral for follow-up care in the grieving process. Most often this referral is made to either: clergy; groups specializing in the grieving process; a psychiatrist, psychologist, or social worker; or a community mental health center. The clinician should accompany the survivors to the exit door of the emergency ward and actually grant them permission to leave the premises, thereby alleviating possible problems of guilt over leaving prematurely. In the days following the death, it is good practice to make several follow-up telephone calls to the survivors to assess their progress in the grieving process.

After the survivors have left the hospital, it is useful to convene the staff that participated in the care of both the deceased and the survivors, to conduct a re-hash of the events that took place, and to address how the staff feels about what has taken place. Emergency ward staff commonly experience intense feelings of anger, guilt, frustration, and sadness to name but a few, and the opportunity to express their feelings can be helpful.

REFERENCES

1. Lindemann E: Symptomatology and management of acute grief. *Am J Psych* 101: 141-148, 1944
2. Freud S: Mourning and Melancholia, in *The Complete Works of Sigmund Freud, Standard Edition*. XIV: 243-258, 1957
3. Bowlby J: Childhood mourning and its implications. *Am J Psych* 118: 481-498, 1961
4. Bowlby J: Processes of mourning. *Int J Psychoan* 42: 317-361, 1961
5. Cobb S, Lindemann E: Management of the Coconut Grove burns at the Massachusetts General Hospital: neuropsychiatric observations. *Ann Surg* 117: 814-824, 1943
6. Rochlin G: Loss and restitution. *Psychan St Ch* 8: 288-309, 1953
7. Rochlin G: The loss complex. *J Am Psychan Ass* 7: 299-316, 1959
8. Parkes CM: Effects of bereavement of physical and mental health—a study of the medical records of widows. *Br Med J* 2: 274-279, 1964
9. Parkes CM: Recent bereavement as a cause of mental illness. *Br J Psych* 110: 198-204, 1964
10. Parkes CM: The first year of bereavement. A longitudinal study of the reaction of London widows to the death of their husbands. *Psych* 33: 444-467, 1970
11. Jones WH: Emergency room sudden death: what can be done for the survivors. *Death Ed* 2: 231-245, 1978

12. Dubin WR, Wolman T: Evaluation and management of the grief reaction. *Penn Med* 19-22, July 1979
13. Aguilera D, Messick J: Crisis Intervention: Theory and Methodology, 4th edition. St. Louis, C.V. Mosby, 1982
14. Kubler-Ross E: On Death and Dying. New York, MacMillan, 1969
15. Hirshowitz RG: Crisis theory: a formulation. *Psych Ann* 12: 33, 1974
16. Albrizio M: The client who is bereaved, in Practice and Management of Psychiatric Emergency Care. Edited by Jorton JG, Partridge R. St. Louis, C.V. Mosby, 1982