

Reflection Article/Essay

# Reflections on death and dying<sup>1</sup>

## *Reflexões sobre a morte e o morrer*

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### Abstract

This theoretical essay aims to propose reflections on death and dying through the prism of possible antagonisms, illness and human occupations involved in this process. The antagonisms are put up for discussion obeying the sense of mutual opposition between life and death, birth and death, as well as between their prediction and their negation. Illness is discussed from the perspective of Laplantine's dynamic and ontological models, opening up reflections on the meaning of illness for the patient, who is often expropriated from their dying process. It also addresses how death is currently pushed behind the scenes of social life. Finally, the occupations of death based on the “principles of good death” are approached from the perspective of occupational therapy, discussing funeral preparations and rites developed by the deceased, their social circle and by health professionals, religious people, funeral agents and cemetery workers. We understand that death is a social process.

**Keywords:** Disease, Palliative Care, Funeral Rites, Occupational Therapy.

### Resumo

Este ensaio teórico tem por objetivo propor reflexões acerca da morte e do morrer sob o prisma de possíveis antagonismos, do adoecimento e das ocupações humanas envolvidas nesse processo. Os antagonismos são colocados em pauta obedecendo ao sentido de oposição mútua entre vida e morte, nascimento e morte, bem como entre sua previsão e sua negação. O adoecimento é discutido sob o prisma dos modelos dinâmico e ontológico de Laplantine, abrindo-se reflexões sobre o significado do adoecimento para o doente, muitas vezes se expropriado de seu processo de morrer. Também aborda como a morte é impelida, atualmente, para os bastidores da vida social. Por último, são abordadas as ocupações da morte pautadas nos “princípios da boa morte”, sob o olhar da terapia ocupacional, sendo discutidos os preparativos e os ritos fúnebres desenvolvidos pelo morrente, seu círculo social e pelos profissionais da saúde, religiosos, agentes fúnebres e funcionários de cemitérios. Depreendemos que a morte é um processo social.

**Palavras-chave:** Doença, Cuidados Paliativos, Rituais Fúnebres, Terapia Ocupacional.

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## Introduction

There is no place on Earth where death does not find us  
Even if we turn our heads repeatedly looking in all directions as in a strange  
and suspicious land...  
If there were a way to get shelter from the blows of death – I am not a man to  
shrink from it...  
But it is crazy to think that we can beat it (Rinpoche, 2013, p. 40).

We all experience three inexorable events as human beings: birth, life and death. As we are symbolic beings, say Machado et al. (2016), we conceive and attribute personal, socio-family, cultural, historical, geographic, political, spiritual, philosophical, economic and sexual values and meanings to these events. We are aware (or not) that, based on this attribution, we choose how to relate to life, death and, sometimes, our (re)births.

In the face of death, the way we behave as a society highlights our “collective identity”, as it expresses how we organize ourselves culturally (Reckziegel & Steinmetz, 2016). Kellehear (2016) argues that a fundamental prerequisite when dealing with death is to be aware of it, which makes it possible to see ourselves as “dying people”.

This is corroborated by Gardés et al. (2020, p. 53), when they state that “being aware of one's own finitude is a human gift and, even so, this fact is fiercely disdained, avoided whenever possible by almost everyone”. Elias (2001), in turn, states that the human species is a community of mortals and death is a problem for the living, because the dead have no problems. This author leads us to reflect that it is not death itself, but the knowledge of it that creates problems for human beings (Elias, 2001). However, for what reasons does this knowledge make us see death as a problem, if we all experience this event?

The fact is that anticipating the arrival of death and reflecting on its possible meanings is a challenge for human beings (Kellehear, 2016), regardless of the life cycle, health condition, creed or culture in which they are inserted. Another challenge, raised by Montaigne based on the reinterpretation made by master Rinpoche (2013, p. 40), is the value we attribute to it:

To begin to take from death its great trump card over us,  
Let us take the opposite way to the usual  
Let us deprive death of its strangeness  
Let us frequent it, get used to it  
Let us have nothing but it in mind...  
We do not know where death awaits us: so let us wait for it everywhere.  
To practice death is to practice freedom.  
A man who learned how to die unlearned how to be a slave.

Talking about death, challenging us to think about its possible meanings and depriving us of its strangeness, will be part of this theoretical essay article. It aims to propose reflections on death and dying from the perspective of antagonisms, illness and occupations involved in this process. In the first reflection, the possible antagonisms

between life and death, birth and death, as well as prediction and denial of death will be discussed. The second will focus on illness and the proximity of death, as well as the expropriation of the dying individual on this, when death is pushed to the backstage of social life. Finally, in the third reflection, the occupations that permeate the process of death and dying will be raised, based on the principles of a good death, from the perspective of occupational therapy, emphasizing funeral preparations and rites, as well as all the characters involved, from the dying individual and their family, to health professionals, religious, funeral agents and cemeteries employees.

## **Death and its Possible Antagonisms**

Provocation. That is the word when we put antagonism on the agenda to approach death.

We have as a socially established belief that life is antagonistic to death. However, Reckziegel & Steinmetz (2016) argue that life and death cannot be understood in an antagonistic or separate way, as death is the final moment of life and, if we have the right to life, we also have the right to death (if possible, dignified!). So, there are no antagonisms?

According to Maldonado (2021), anthropology describes peoples who celebrate death, dancing and holding banquets, which is corroborated by Kant in his statement: “If it is worth living, and if death is part of life, then dying is also worth it” (as cited in Salviano, 2012, p. 189). On the other hand, in Western culture, we nurture feelings of sadness, fear, loneliness and despair in relation to death (Maldonado, 2021). Are celebration and grief over death antagonisms or two sides of the same coin?

Schopenhauer (2000) states that we live our losses and are sensitive to the losses of other beings, in an expression of compassion and recognition of the suffering generated by them; in the same way, we rebuke those who do not express these feelings, as a sign of not recognizing our humanity (and our fear) or the possibility of the extinction of our race. On the other hand, we wish it to our enemies, to those who have deeply hurt our feelings or who we believe have violated established social norms on which we rely (Schopenhauer, 2000). This author opens up this desire when he says: “[...] The thirst for revenge, in its highest degree, seeks the death of the opponent as the greatest harm to be inflicted” (Schopenhauer, 2000, p. 61). This desire, we infer, is generally restricted to the line of thought and emotions, not generating violent or destructive acts towards the other. This is even necessary, psychoanalytic theories point out, so that the act itself does not occur. Nevertheless, per se, would not this desire be antagonistic to the sacredness of life?

The fear of death will be explored from the perspective of non-being by the same author:

If what makes death seem so terrible to us were the thought of non-being, then we would have to think, with equal shudder, of the time when we were not yet [existent]. For it is undeniable certain that the non-being after death cannot be different from the one before birth, and, therefore, it is also not regrettable (Schopenhauer, 2000, p. 65).

For Schopenhauer (2000), this fear would not make the slightest sense, as we would have to have this same feeling for the time when we were not yet [existent], before our birth: birth and death, therefore, would be experiences of non-being (Lobato, 2018; Salviano, 2012). Based on this assumption, we understand that the antagonism of life in relation to death would make sense, since the first event refers to finitude and being, and the second to infinity and non-being. On the other hand, we infer that, if we look at birth and death as opposites, through the prism of the beginning and end of our history, life would in fact be the experience that unfolds between these two temporal events, over which we have little control. In this way, the antagonism between birth and death would make sense. Lobato (2018), referring to Epicurus, points out another perspective: that death does not belong to us, since, when we are alive, death is not manifest; when we die, life is not manifest.

Another manifest antagonism is the prediction and denial of death. What generates more anxiety: predicting it or denying it? Forecasting moves people into defensive anticipatory reactions, such as the desire to predict its arrival by identifying the causative risks, and, thus, repel it (Kellehear, 2016). On the other hand, it generates acceptance processes, such as learning about, preparing for and planning for death (Kellehear, 2016). The desire to predict it motivates the search for knowledge about the course of diseases, in addition to the desire to seek a cure, avoiding death (Kellehear, 2016). The identification of the risks and the desire to repel them stimulate us to technological innovation, the development of military defense policies and warning systems against attacks by other peoples, the development of weapons that kill remotely, in addition to the search for safe living places (Kellehear, 2016). Learning, preparation and planning permeate the historical observation of records on the death of peoples who preceded us, as well as our current reality, with regard to rites, rituals, art and culture, development of religious and scientific organizations, development of technologies and science (Kellehear, 2016). Mbembe, quoted by Tranquilin-Silva (2020), reiterates that we can postpone (anticipating) or escape death, and that this is a power for us, but it is not absolute, because we depend on other people.

In turn, what is the denial of death if not the producer of the shield of immortality or of each one's hero's journey? Remen (1998, p. 96) states, "the denial of death is the way in which we usually all assemble our version of life". Kovács (2021, p. 3), in turn, points out that the topic of death became prohibited in the 20th century (extending to the present day), due to a communication disorder called "conspiracy of silence", that is, we so vehemently deny death that talking about it has become a prohibited act in most family, social and institutional contexts. Corroborating this statement, Pinto & Baia (2013, p. 9) reiterate that, "in current times, death must be concealed; the true state of health is hidden from the patient, since they must die in ignorance of their own death". Would prediction and denial be antagonistic or complementary behaviors?

## **About Illness and Death**

Disease, from the point of view of Laplantine, discussed by Sarti (2010), follows two models that are not necessarily excluding: the ontological model, which refers to medicine centered on disease, based on the physical body, as a "being" of the disease; and the relational or dynamic model, concerning medicine centered on the subject,

which considers the internal dynamics of the organism and its relationship with the environment. The ontological model, predominant in contemporary Western society, separates body and subject, causing strangeness, as this separation makes the body autonomous into a biological body (Sarti, 2010), with a clear exclusion of our identity and narrative, which expropriates us from the illness and death process.

We infer that illness diverts us from what we took for granted and programmed in the course of life: living without major mishaps (preferably happy and healthy), getting old and dying (preferably without suffering).

Undoubtedly, getting sick, especially for those seriously ill, is a frightening and sometimes lonely experience, imposing reflections on the course of life, its meaning, the severity and lethality of the disease, whether it will remain in its acute presentation or even become chronic, if it will bring functional losses, if there will be destitution of its independence and autonomy, if it will be abandoned (Kovács, 2014, 2021). Added to this, there is often the isolation of the patient due to the fear of contagion, the distance from family and friends (and their resentment for the distance), in addition to the fear of pain, other unpleasant symptoms, degeneration and loss of control of life itself (Kovács, 2021). It is noticed that there can also be a manifestation of the veiled, but real, envy of the healthy, the shudder in the relationship with their divine, exhaustion when the condition is prolonged or becomes chronic and, in many cases, the imminence of death. It is unbearable to get sick!

Another aspect to be observed is that the sight of a similar person who is sick naturally distances us from them (we build walls), as it shakes the fantasies about our own immortality, being a fertile ground for the development of the loneliness of that person (Elias, 2001).

In the field of health, one of the difficulties is that institutions (and teams) are commonly guided by the conventional biomedical model, reducing the subject (patient) to the disease, evading the full, integral human being, excluding biopsychosocial care (Baère et al., 2017).

In addition, we have the civilizing impulse, which pushed death to the backstage of social life, both as a process and as a mnemonic image, causing the sick to also be isolated and pushed backstage and condemned to loneliness (Elias, 2001). We infer that it is not uncommon for these backstages, or contexts of illness and death, to be masked (or disguised) in our society, in the back room, the aedicule at the end of the land on the main house, in long-stay institutions or the hospital. Illness, but mainly death, ceased to be community, public experiences, to become silent, solitary, aseptic and technical, with little or no possibility of expressing our humanity (Kovács, 2014, 2021; Menezes, 2004). The expression of feelings, desires, anxieties and concerns of patients and their families, especially those with a life-threatening illness, is not allowed in most of these contexts (Reckziegel & Steinmetz, 2016; Kovács, 2014; Menezes, 2004). It is observed that, under the yoke of Cartesian science, a deafness and a relational blindness are commonly established between these characters and the health team, politely disguised by language and technical knowledge, excess of tasks, standardization of conducts and, mainly, by the ingrained culture of healing the physical body, in which death is seen as failure or technical incompetence (Kovács, 2021; Kellehear, 2016; Menezes, 2004; Elias, 2001). Kovács (2014, p. 95) mentions that:

Death can become a solitary event, with no space for the expression of suffering or rituals. The caricature that represents it is the patient who cannot die, with tubes in orifices in the body, with pointers and the noise of machines for company, expropriated from their own death.

The expropriation of death redefines the scenario and the roles played by the actors involved. The context is no longer the production of life and the dying person loses the leading role to become a supporting role in death itself (Menezes, 2004; Elias, 2001). Negative and positive coping strategies are developed by the characters involved in order to deal with the problem, the first being negative strategy related to the abandonment of the patient by family members, friends and their community, delegating care and responsibility over their life and death behind the scenes, especially in the hospital context (Kovács, 2014, 2021; Elias, 2001). The second, we infer, portrays the passive acceptance of the supporting role by the patient, with a clear abandonment of himself, deprived of his rights and duties, behaving as a “patient”, that is, one who resignedly waits.

As for the positive strategies, the humanization of care for those with life-threatening diseases has been implemented, as a result of the paradigm shift by health professionals, the scientific community, family members and by the patients themselves about health care in the face of the modern hospice movement and to advances in Palliative Care (Kovács, 2021; Perezim & Camargo, 2018; Reckziegel & Steinmetz, 2016; Floriani, 2013; Esslinger, 2013; Menezes, 2004). Another aspect is related to the patient's ability to empower themselves, when they are able to arrogate their role and their rights and duties in this experience.

Corroborating the idea of empowering the sick, as a positive coping strategy, Esslinger (2013, p. 30) mentions, “[...] for the sick person, death is their death, and it is natural to claim the right to have control over it, according to their own needs, individual convictions and values they believe in”. Seeing oneself as a dying person and being aware of one's own death is an essential requirement of the dying process (Kellehear, 2016). The recognition that the end is approaching inaugurates a mental cycle of reflections usually permeated by the analysis of life, clarification of values, mediations about gains and losses, experiences of crisis and negotiations around sadness, loneliness, personal fear or giving meaning (Kellehear, 2016). Consequently, the freedom to talk about death becomes an act of respect for one's own identity, freedom and compassion for the patient's biographical and narrative being (Esslinger, 2013). Talking about death is talking about life: it is reflecting on “quality of life” during the dying process (Esslinger, 2013); those who allow themselves to say “I am going to die” can also be the actor in their departure, organizing it (Menezes, 2004).

The dying process can be experienced in different ways by the patient, according to the meanings attributed, and it largely depends on how much they feel that their life was meaningful and fulfilled or frustrated and meaningless (Elias, 2001; Menezes, 2004). We may suppose that for those who feel fulfilled, death is easier; for those who feel like failures, more difficult. In addition, there are those who, despite the success of their lives, feel that their way of dying, in itself, makes no sense (Elias, 2001). Therefore, each dying being dies imbued with their meanings, as well as with the current social-historical meanings, which should allow the protagonism to be exercised, in fact, by the

dying person (Kellehear, 2016). Saunders (as quoted in Floriani, 2013, p. 401), when addressing an audience at the British Medical Association, explained with absolute lucidity:

Speaking of acceptance of death when its approach becomes inevitable is not mere resignation or fragility on the part of the patient, nor is it defeat or negligence on the part of the doctor [health professionals]. For both, it is [precisely] the opposite of doing nothing. Our work, then, is to alter the character of this inevitable process so that it is not seen as a defeat of life, but as a positive achievement in the dying process; an intensely individual heroic feat for the patient.

### **Death as the Ultimate Human Occupation**

We are occupational beings by nature, since we carry out daily activities, produce material and immaterial goods, we are in constant movement, we exercise family and social roles, we write our history and compose that of others, we relate to each other through our usefulness and we prepare ourselves for death as the ultimate occupation (Costa et al., 2017; Mills & Payne, 2015). Etymologically, the word occupation comes from the Latin root “*occupatione*” and its meaning is linked to the time dedicated to accomplishing something, to everyday tasks, to an action in a given time and space (Costa et al., 2017). It is considered a basic human need, with a strong influence on people's health and well-being (Costa et al., 2017; Salles & Matsukura, 2016), including in their active death process. Under this occupational therapeutic prism, we will discuss the preparations that involve death.

Dying is a biological and social process, an occupation experienced not only by the dying person, but also by their social circle, health professionals, religious, funeral directors and cemeteries workers (Kellehear, 2016; Elias, 2001). It is, therefore, an interpersonal journey that includes material, religious, financial, medical and family preparations and/or rites, as well as tests, trials, and often unexpected social experiences that involve other people (Kellehear, 2016). With the exception of sudden, tragic deaths and, in a way, resulting from pandemics or epidemics due to infectious diseases, as is the case of the current SARS-CoV-2/Covid-19 pandemic - when we are restricted or prevented from the experience of preparations for dying and death –; in other situations, these preparations are present. The expression of suffering generated by this impediment is portrayed by Tranquilin-Silva (2020, p. 31): “Our ancestors die. Our collective, affective memories are gone. The depositaries of our love are gone in the midst of our despair”. Elias (2001) states that people unite when their rites and ideas about death are common, and separate when they diverge.

The occupations of dying, understood as preparations and rites (these go beyond action and are full of symbols), have varied enormously over time and space, but their structural patterns are well recognized everywhere (Kellehear, 2016). Historically, many authors have investigated and described death (and its occupations), from the High Middle Ages to the 21st century (Phillip Ariés; Marcel Mauss; Geoffrey Gorer; Michel Foucault; Norbert Elias; Barney Glaser; Anselm Strauss; David Sudnow; Claudine Herzlich; Cicely Saunders; Marie de Hennezel; Ira Byock; Tony Walter; Nicholas

Albery; Stephanie Wienrich), and organized it into models called “traditional death”, “modern death” and “contemporary death” (Menezes, 2004). Regarding traditional death, it is a set of models present from the High Middle Ages to the 18th century. In this period, birth and death had a public character and were experienced by the entire community; their rites were accepted and carried out, without excessive dramas or gestures of emotion. Death was simply accepted and the dying person was the agent of their own process (Combinato & Martin, 2017; Menezes, 2004). In the 19th century, modern death emerged from the establishment of the family as the central nucleus and the subject's social value, added to the consolidation of hospital institutions. These contexts began to offer a death managed and controlled by medicine, and became central references regarding life, health, illness and death. In this model, the concealment of the truth to the patient about their state of health occurred and still occurs (Combinato & Martin, 2017; Menezes, 2004). Modern death, for Moritz (as cited in Medeiros & Lustosa, 2011, p. 206), seen as an adversary, is genuinely characterized by:

Prolonged act generated by technological development, a scientific fact generated by the improvement of monitoring, a passive fact since decisions belong to doctors and family members, not the patient, a profane act for not meeting the patient's beliefs and values and finally an act of isolation, since the human being dies socially in solitude.

In contrast to this managed, controlled and solitary death, since the second half of the 20th century, contemporary, humanized death, also called “good death”, has emerged, widely discussed by the Palliative Care approach and by the modern hospice movement (Floriani, 2013; Combinato & Martin, 2017; Baère et al., 2017). This recent model is based on multidisciplinary, interdisciplinary and transdisciplinary actions, which aim to improve the quality of life of the patient's residual time, aiming at a socially shared, smooth dying, with coping strategies that give meaning to death (Floriani, 2013; Baère et al., 2017; Dourado & Cedotti, 2021). Its propositions are that dying is free of avoidable burden (such as heroic measures and therapeutic obstinacy), with minimal suffering for the patient and their families, that the patient's wishes and desires are respected within the feasible and that it is congruent with the current clinic, culture and ethics (Floriani, 2013). We suggest here to broaden the vision of this model beyond the sick, encompassing all dying people.

In 2000, the British magazine *British Medical Journal* - BMJ published an article describing the 12 principles of a good death, translated to Portuguese by Menezes (2004):

- 1) knowing when death is coming and understanding what to expect;
- 2) being able to maintain control over what happens;
- 3) being able to have dignity and privacy;
- 4) having control over pain relief and other symptoms;
- 5) having the possibility of choosing and controlling the place of death (at home or elsewhere);
- 6) having access to information and specialized care of any kind that may be needed;



- 7) having access to all kinds of spiritual or emotional support, if requested;
- 8) having access to palliative care anywhere, not just in the hospital;
- 9) having control over who is present and who shares the end of life;
- 10) being able to decide on directives that ensure that their rights are respected;
- 11) having time to say goodbye and to have control over other aspects; and
- 12) being able to leave when the time comes, so that life is not prolonged indefinitely (Menezes, 2004; Smith, 2000; Floriani, 2013).

We infer that these principles aim at the appropriation of death and its occupations by the dying person (and must anticipate a possible loss of consciousness), with the effective involvement of the other characters. From this perspective, the dying subject becomes the main actor, performing occupations that he considers significant and crucial in his case (Kovács, 2021; Souza et al., 2019; Combinato & Martin, 2017; Mills & Payne, 2015). Among these, the exercise of autonomy through discussion with the team and family about: how the patient wants their treatment and symptom control to be done; how to arrogate and practice their rights and duties; how to develop their advance directives of will or even the codicil (Kovács, 2021; Combinato & Martin, 2017; Machado et al., 2016; Mills & Payne, 2015); the execution of dreams, if they wish so; the satiety of desires related to food and self-care; the reception or not of visits; leisure and hobby activities; the expression of their faith and the preparation of funeral rites, which permeate the mortuary toilet, the choice of the urn, place of burial or scattering of their ashes, in addition to identifying the people who they wish to be present at their funeral (Combinato & Martin, 2017; Mills & Payne, 2015; Kovács, 2014). Still within the preparations, saying goodbye to people, pets, significant objects, their home and the places that marked their history or visiting the ones they want to know; through face-to-face encounters, hugs, kisses, touching, producing meaningful gifts, writing letters, recorded farewell messages or producing live streams and logbooks (Mills & Payne, 2015; Kovács, 2014). It is fundamental to recognize that those who die say goodbye to everything they know, including their own history and image.

Additionally, there are pending issues of a legal, financial, social, affective, emotional, relational and spiritual nature, which the deceased can resolve, if desired. Legal and financial pending issues refer to retirement, pension and bank accounts, as well as legal issues such as assets, properties, guardianship of children, guardianship of animals, among others. Social pending issues refer to the reorganization, organization and recognition of the social roles developed by the subject, production of autobiography and organization of rites, such as baptism, marriage, blessings and graduation. The affective, emotional and relational ones belong to the act of asking for forgiveness or forgiving someone and loving in time their own. In terms of spirituality and religiosity, they can ask forgiveness or forgive someone who transcends themselves, experience religious rituals, produce and/or keep religious objects with them and express their spirituality through readings, reproduction of religious music and visits to religious temples (Menezes, 2004; Floriani, 2013; Baère et al., 2017; Kovács, 2014).

The social circle, made up of family members and friends, in turn, takes care of the dying person by offering emotional support; healthcare and well-being, including bathing, feeding, bed organization, supply of medication; and assistance in preparing

for death (Kovács, 2021; Mills & Payne, 2015). Furthermore, this circle performs the funeral rite, which, for Bayard, quoted by Souza & Souza (2019, p. 3)

Funeral rites begin with agony and coincide with the initial phase of mourning. The segment takes place with the wake, funerals, condolences, and public mourning (for prominent people), social (as in the case of the use of a specific color of clothing) and psychological (the feeling of loss), extending with the cult of the dead or the visit to the cemetery, as occurs on the day of the dead.

The rites of oblation are also offered, demonstrated by the zeal with the deceased, such as, for example, the mortuary toilet or the seventh day mass. Rites of passage are also performed, in which there is exaltation of the separation between the dead and the living, ensuring the inclusion of the dead in a post mortem status (Kovács, 2021; Souza & Souza, 2019).

In turn, professionals, including health teams, the religious, funeral directors and cemeteries employees, are also widely involved in occupations with death. Health teams are mainly concerned with the active process of death, with clinical, comfort, pharmacological, psychological, social, religious and spiritual assistance (according to Law No. 9.982 of 2000) of the dying person, as well as supporting, active listening, passing bad news and preparing the body in the post mortem (Saad et al., 2018; Dourado & Cedotti, 2021; Baère et al., 2017). They accompany family members in the recognition of the body and release the death certificate (Américo, 2012; Hermes & Lamarca, 2013). Religious and their assistants take care of the religious and spiritual assistance intended for the dying, as well as their social circle, through body care, dressing of the mortuary toilet, extreme unction, blessings and prayers, conducting obsequies and services/masses (Pereira, 2013). Funeral agencies, through their funeral directors and preparation assistants, take care of the transferring of the body, perform thanatopraxy, organize urns and decorate the wake rooms, welcome family members and conduct the burial (Neves & Damo, 2016). Cemetery employees are also responsible for digging the ground, driving the car to transport the body to the grave, lowering the urn by using ropes, in addition to covering it with earth or placing it in a graveyard (Classificação Brasileira de Ocupações, 2021).

That said, we infer that death is a social process composed of many characters and occupations with cultural, ethical-moral, religious, political, historical and geographical significance.

## **Final Considerations**

Human beings are aware that death exists and usually see it as a problem. This problem can be transposed if the acts of talking about it and experiencing it in everyday life become a social and cultural habit, welcoming it as an experience inherent to human existence. It is necessary to emphasize that welcoming is the antithesis of trivializing it, in the face of political, economic and social violence to which we are all exposed, especially in our country.

Politics, culture, current morals, customs and occupations that permeate not only the dying subject (ill or aged), but their social cycle and all the professionals involved (we draw the attention of the occupational therapist in particular) point out that this experience should not be seen only as a biological process, but as a social and occupational process.

Effectively, few times in history has there been so much talk about death as now, during the SARS-CoV-2/Covid-19 pandemic. We reaffirm death as a problem when as a result of necropolitics applied in numerous countries, mass deaths and the imposition of severe restrictions on the expression of occupations involved in death and dying, especially funeral preparations and rites. Today, these restrictions do not only refer to the direct and indirect victims of this virus, but have been extended to all who die for other reasons at this time.

The changes resulting from these restrictions, necessary for the containment of the virus, have increased hospitalization and the mechanization of deaths. The deceased usually dies in solitude or with the feeling of having been abandoned by his social circle, when he does not understand the situation. For their social circle, in turn, not being able to say goodbye in person, receiving the body of their loved one wrapped in a plastic bag, making it impossible to see them, suffering a reduction in the period of time to watch over them, having a decrease in the number of people who may be present to support and welcome them, in addition to collective mourning to the detriment of the individual (since there is no space for it) are modifications of preparations and rituals that are very severe and impacting for all involved, generating occupational changes. The result of this disturbing experience will only be visualized in the future. At that moment, we will have the chance to move forward or backward in terms of how we relate to death and dying, as a personal and social experience.

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### Author's Contributions

Both authors were responsible for the conception and writing of the text, organization of sources, review and approval of its final version.

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