Facultad de Ciencias Humanas y Sociales

RITOS, SIGNIFICADOS Y SENTIMIENTOS EN TORNO A LA VIDA Y LA MUERTE

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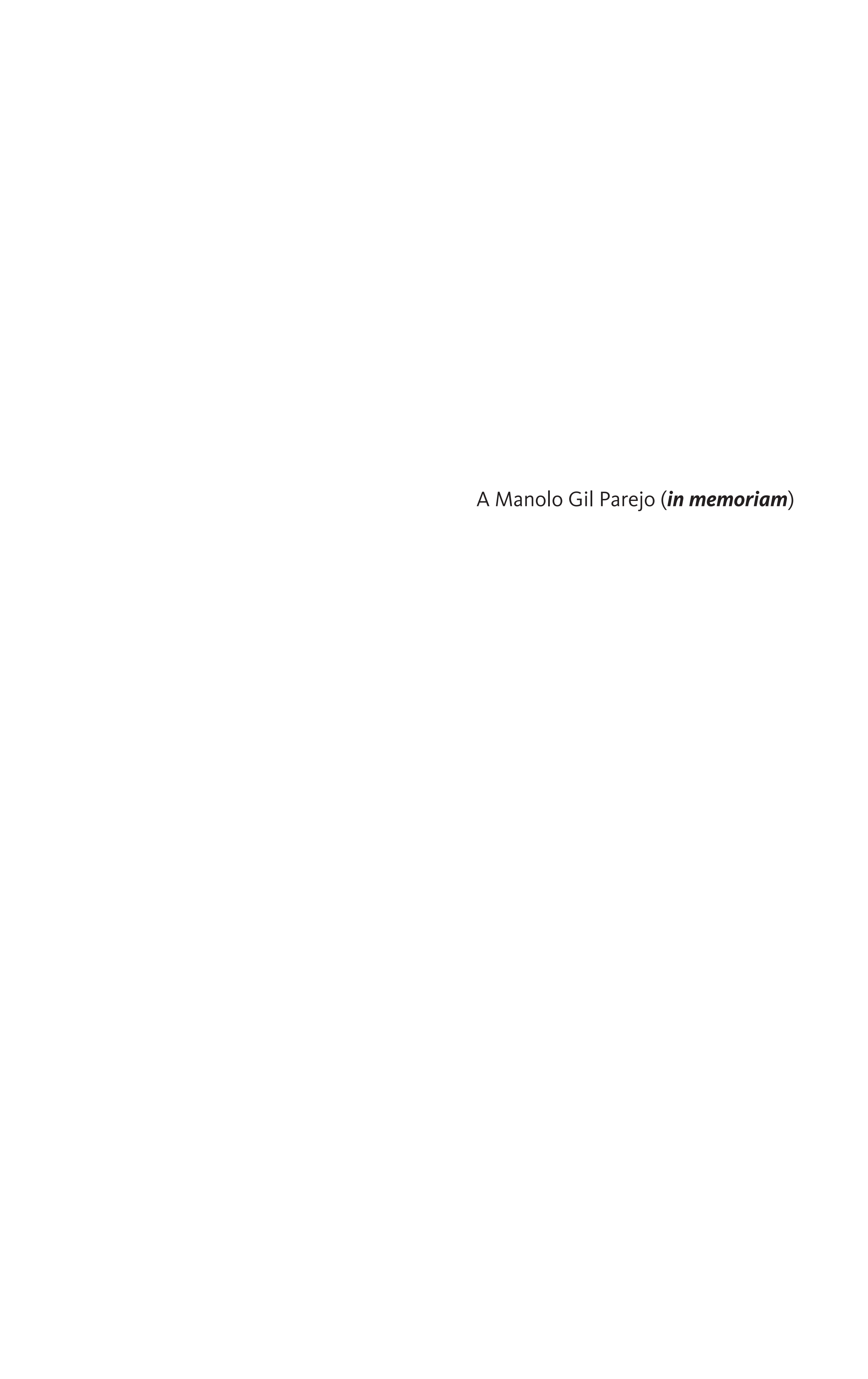

A Manolo Gil Parejo (***in memoriam***)

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ÍNDICE

1. RESUMEN 9

2. ABSTRACT 11

3. INTRODUCCIÓN. 13
3.1. La muerte 13
3.2. El rito 15
3.3. La llegada de la COVID-19. 23
3.4. Preguntas y objetivos de investigación. 25

4. ESTRUCTURA, LÍNEA ARGUMENTATIVA y METODOLOGÍA APLICADA. 27
4.1. Estructura 27
4.2. Motivación 27
4.3. Desarrollo de los artículos 28
4.4. Perspectiva de género y de inclusividad. 31
4.5. Detalle de los artículos y aportaciones de los autores 32

5. CAPÍTULO I: Jugar con la muerte para celebrar la vida. Un estudio etnográfico de la romería de los ataúdes en Santa Marta de Ribarteme, Pontevedra, Galicia 35
5.1. Justificación introductoria. 35
5.2. Artículo 39
5.3. Carta de la revista. 58

6. CAPÍTULO II: I can't believe they are dead. Death and mourning in the absence of goodbyes during the COVID-19 pandemic 59
6.1. Justificación introductoria 59
6.2. Artículo 63

7. CAPÍTULO III: "It is the worst thing that has happened to me": Healthcare and social services professionals confronting death during the COVID-19 crisis 79
7.1. Justificación introductoria 79
7.2. Artículo 83
7.3. Carta de la revista 103

8. CAPÍTULO IV: Nobody should die alone. Loneliness and a dignified death during the COVID-19 pandemic 105
8.1. Justificación introductoria 105
8.2. Artículo 109
8.3. Carta de la revista 130

9. CONCLUSIONES GENERALES E IMPLICACIONES 131
9.1. Conclusiones generales 131

10. REFERENCIAS 135

1. RESUMEN

La muerte es un hecho inevitable que forma parte de la vida de los individuos y las sociedades. La relación de cada comunidad con el fenómeno de la muerte cambia y evoluciona en función del entorno y del contexto en el que esta se produce, así como también varía la forma que tiene cada individuo de afrontar la muerte propia y la de sus seres queridos.

Esta tesis doctoral presenta el estudio sobre algunas formas rituales en torno a la relación existente entre la vida y la muerte en España. Aborda también una investigación sobre los cambios, en determinados sentimientos y significados en relación con la muerte, producidos con la llegada de la pandemia de la COVID-19 y la consecuente limitación para realizar ritos fúnebres y actos de despedida.

Se han realizado dos investigaciones complementarias, con enfoque cualitativo, fenomenológico e interpretativo, mediante trabajo de campo y entrevistas en profundidad en los entornos de Galicia y la Comunidad de Madrid. Fruto de estas investigaciones se han redactado cuatro artículos científicos, cada uno de ellos con objetivos y conclusiones interrelacionados.

Entre los resultados destacan la importancia de los rituales en torno a la muerte como forma de expresión de la relación del ser humano con su propia muerte y la de sus seres queridos, la dificultad de elaborar duelos sanos tras la ausencia de despedidas durante la crisis de la COVID-19, las necesidades de apoyo emocional de muchas y muchos profesionales que fueron testigos de estos fallecimientos, y el deseo de los individuos de estar acompañados en los últimos momentos de su vida, así como de dignificar los ritos de despedida de los difuntos.

Finalmente, se abren itinerarios de amplio recorrido en los caminos de la investigación, la reflexión y la intervención.

2. ABSTRACT

Death is an inevitable occurrence that forms part of life for individuals and society. The relationship each community has with the phenomenon of death changes and evolves depending on the environment and the context in which it occurs. Correspondingly, the way in which individuals cope with their own death and the passing of their loved ones also changes and evolves.

This doctoral thesis presents the study of certain rituals associated with the relationship that exists between life and death in Spain. It also reports on an investigation into changes in certain feelings and meanings related to death that were produced by the arrival of the COVID-19 pandemic, with the consequent limitations on performing funeral rites and formally saying goodbye to loved ones.

Two complementary research studies have been carried out with a qualitative, phenomenological and interpretative approach through fieldwork and in-depth interviews in Galicia and the Community of Madrid. As a result of these investigations, four scientific articles have been written, each with interrelated objectives and conclusions.

The results include: the importance of rituals around death as a form of expressing the relationship human beings have with their own passing and that of their loved ones; the difficulty of proceeding through healthy mourning after the absence of farewells during the COVID-19 crisis; the emotional support needs of many professionals who witnessed COVID-19 deaths; and the desire of individuals to be accompanied in the last moments of their lives, as well as the desire to dignify those who have died with adequate farewell rituals.

Finally, the thesis opens wide-ranging itineraries along the paths of research, reflection and intervention.

3. INTRODUCCIÓN

3.1. La muerte

Si hay un hecho que afecta a todos los seres humanos, y de forma irreversible, es el fenómeno de la muerte; sin embargo, a pesar de que atañe a todos los individuos, la forma personal de entender la muerte y de relacionarnos con ella varía en cada uno de nosotros. Una de las características más distintivas del ser humano es la capacidad de entender el concepto de muerte, de comprender su irreversibilidad y de reaccionar emocionalmente ante ella (Feifel, 1990).

Cada cultura, cada sociedad y cada individuo tienen su forma particular de relacionarse con la muerte y, a pesar de su universalidad, no hay un único modelo que lo abarque todo (Barley, 1997/2012), lo que es seguro es que la muerte está siempre presente a lo largo de la vida de los grupos humanos, y algunos autores incluso han visto en el miedo y en el rechazo a la muerte el origen de toda cultura (Baumann, 1992).

A lo largo de la historia las actitudes ante la muerte sufren continuos cambios, a veces lo hacen de forma más lenta y otras de forma más ágil (Ariès, 1974/2010) pero la manera de interactuar con la muerte se halla constantemente en movimiento.

La muerte propia y, también, la pérdida de un ser querido son una constante, una experiencia inevitable que todo individuo tiene que afrontar, si bien en función del momento histórico, del lugar y de la cultura, se le da a este mismo fenómeno diferentes tratamientos (Bustos, 2007).

Las diferencias en la relación del individuo con la muerte no son solo sociales o culturales sino también psicológicas, no todas las personas afrontan la idea de la muerte de la misma manera, y aunque la ansiedad y el miedo son las respuestas más comunes y las más estudiadas (Gala et al., 2002; Neimeyer & Hogan, 2004) estas reacciones también varían en función de cada individuo y de sus circunstancias, y se pueden manifestar de múltiples y diferentes maneras (Bluck et al., 2008)

Además, los individuos afrontan de forma diferente la idea de la muerte como fenómeno abstracto por un lado, y por otro lado la idea de morir; es decir, la idea de la propia muerte (Spitzenstätter & Schnell, 2020).

La reflexión sobre la propia muerte cuestiona al ser humano sobre la forma que tiene de afrontarla, los miedos e incluso los deseos de evitarla y de huir de ella, especialmente en la época actual. Este deseo de vencer y superar la muerte es el que se manifiesta, de forma extrema, en el Ritual de Santa Marta de Ribarteme, en el que los vivos se meten en un ataúd afirmando, de forma ritual y simbólica, la vida como un valor supremo (Tolosana, 2008) (imagen 1).

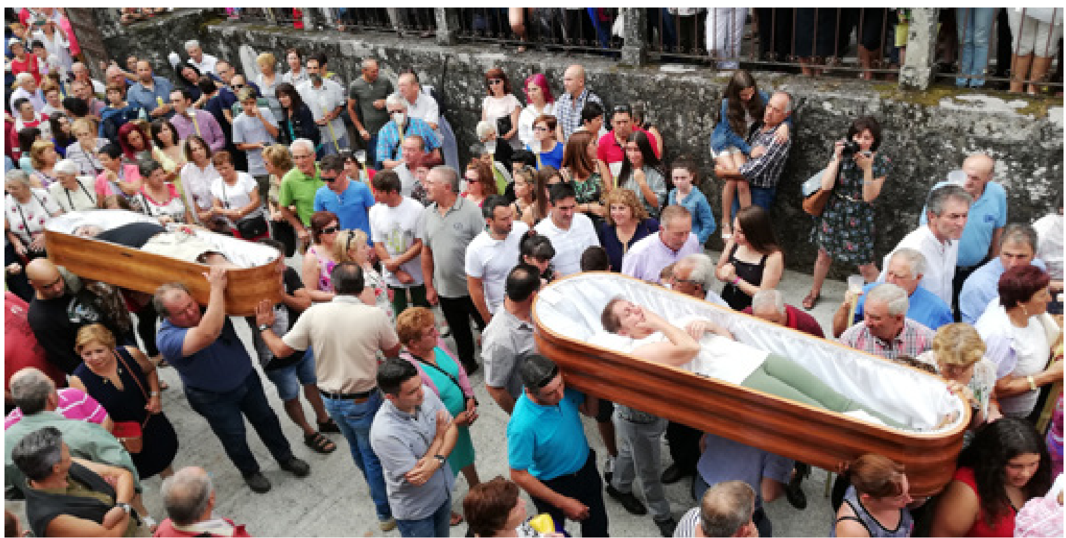

Imagen 1: Romería de los ataúdes en Santa Marta de Ribarteme

Algunos autores afirman que el verdadero miedo del individuo no es tanto a la propia muerte como a la agonía y al sufrimiento que ésta puede provocar (Gala et al., 2002). El individuo contemporáneo se preocupa por morir bien, por morir de forma adecuada. La concepción de una buena muerte o de una muerte correcta es una percepción individual y subjetiva si bien tiene algunos elementos en común tales como la preocupación por el control del dolor y los síntomas, la toma de decisiones clara, la sensación de cierre y despedida, el hecho de ser visto y percibido como una persona, el poder prepararse para la muerte y el poder dejar un legado (Krikorian et al., 2020).

Esta preocupación por una muerte sin dolor y sin sufrimiento ha puesto a la eutanasia en la agenda social y política de muchos países, entre ellos España (Bernal-Carcelén, 2020) en los últimos años, así como ha evidenciado la necesidad de unos cuidados paliativos de calidad.

Desde una perspectiva más social, observamos cómo en la época actual se genera un rechazo generalizado a la idea de la muerte (Thomas, 1991) y a lo que la rodea, debido, en parte, a la racionalidad, la secularización, la medicalización, la individualización y la pérdida del sentido de comunidad (Vaczi, 2019; Walter 2005). Algunos autores afirman que desaparece, así, el diálogo entre la vida y la muerte propio de otras épocas (Sherman, 2014) y que la muerte, en cierto modo, se deshumaniza (Ritzer, 1993) y se aparta de la vida cotidiana. La cultura del éxito, de la felicidad y de la belleza, tan propia de esta época actual, hace que el individuo se centre en alcanzar una vida feliz en la que pensar acerca de la muerte, y el dolor que esta provoca no tiene cabida (Zambrano, 2016). Se llega a lo que Ariés (2011) llama la muerte invertida, una muerte individualizada a la que la comunidad acaba dando la espalda.

Esta evolución de la forma de ver la muerte en España, fruto de la secularización y deshumanización antes mencionadas, se puede ver reflejada en una de sus manifestaciones más características y simbólicas: los ritos.

3.2. El rito

La muerte de un ser humano va casi siempre seguida de un ritual (Mitima-Verloop et al., 2021; O'Rourke et al., 2011) que varía en función del espacio y el tiempo en el que esta se produce. El rito fúnebre, y el propósito de este, difiere en función de la cultura y de la religión en la que se produce (Walter, 2005). Mientras que en Europa asistimos a funerales y entierros sobrios y silenciosos en cementerios monumentales (imagen 2) , en muchas partes de Latinoamérica es común ver a la gente beber alcohol durante el entierro mientras se entona música (imagen 3), o presenciar en algún cementerio

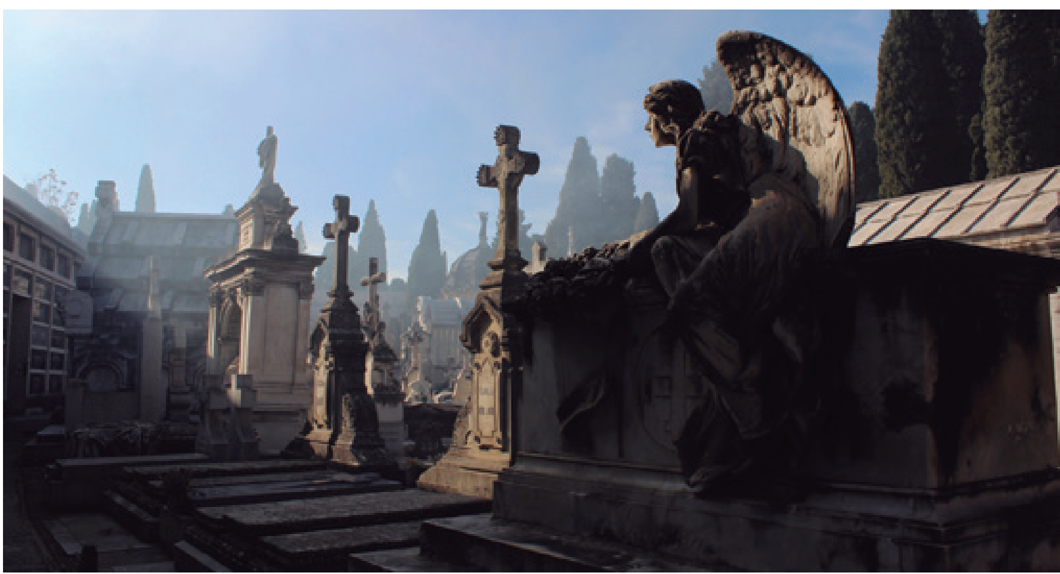

Imagen 2: Cementerio de San Justo en Madrid

Imagen 3: Entierro en un pueblo del norte de Argentina

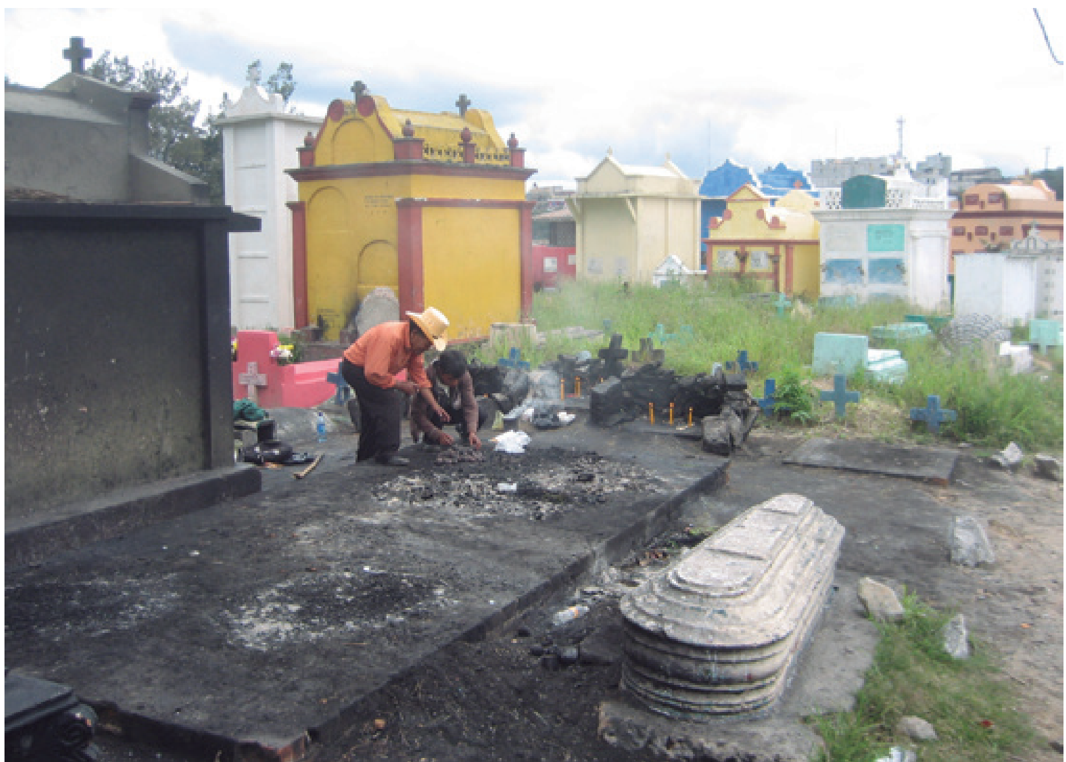

Imagen 4: Ritual en el cementerio de Chichicastenago, Guatemala

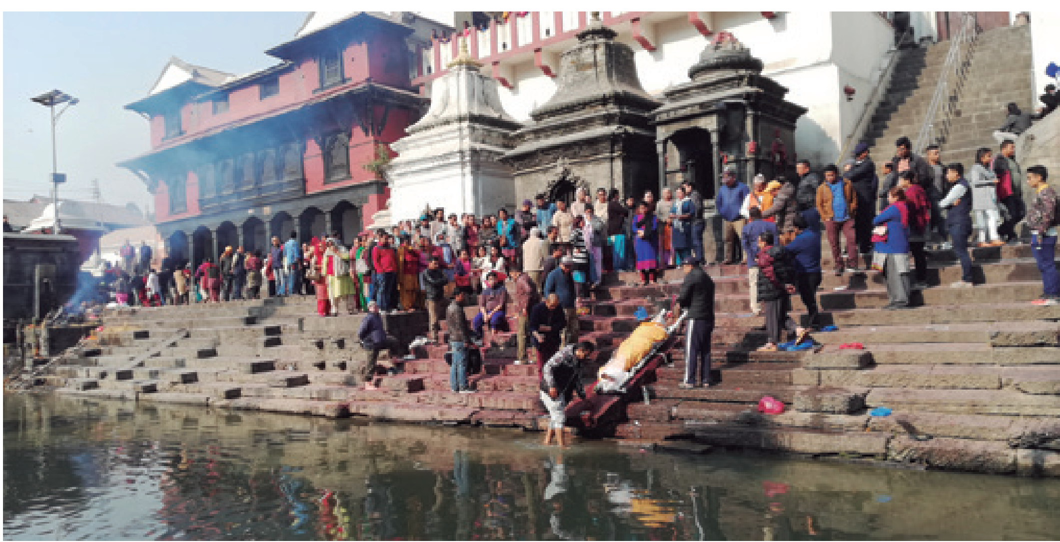

Imagen 5: Preparación de una cremación en Katmandú

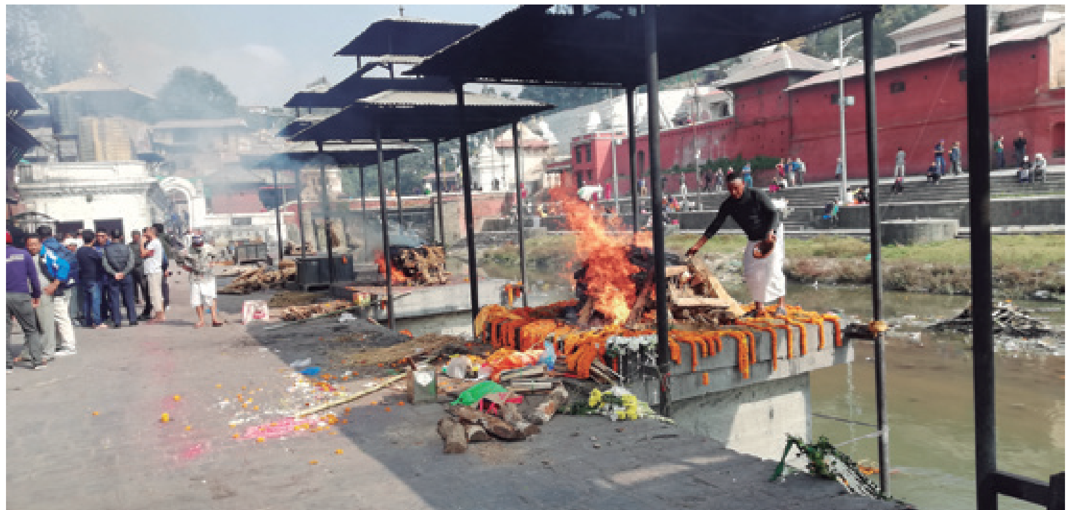

Imagen 6: Ceremonia de cremación en Katmandú

ritos ancestrales fruto del sincretismo religioso (Imagen 4). En Nepal o la India se celebran ceremonias multicolor de cremación junto a los ríos sagrados (imágenes 5 y 6) y también en Indonesia el color naranja caracteriza las cremaciones (imagen 7). En China los velatorios duran varios días y en la cultura árabe se pone el cadáver en contacto con la tierra, siempre en dirección a la Meca (imagen 8).

Los rituales fúnebres han supuesto un aspecto importante en la historia de todos los pueblos, ya que expresan la forma de vivir de estos y su relación con la muerte, una muerte que está en la propia naturaleza y en la cultura de cada sociedad (Veigaza, 2001). Todas las religiones y culturas tienen sus propios rituales, oraciones y creencias relacionadas con el proceso de morir (Roberson et al., 2018). El ritual funerario une, en cierto modo, lo profano con lo sagrado (Durkheim, 2012), (imagen 9).

Imagen 7: Preparación de una cremación en Bali

Imagen 8: Cementerio en un pueblo de Marruecos, todos los cuerpos están enterrados en dirección a la Meca

Imagen 9: Fabrica de ataúdes en una aldea de Tanzania

El rito mortuorio tiene tres funciones principales, por un lado, y desde una dimensión individual a) simboliza el paso del difunto a un nuevo estadio (Gennep, 1969/2008) y b) ayuda a los deudos a conectar con la muerte del ser querido y a comenzar a elaborar la primera de las tareas del duelo (Worden 2008/2013), y por otro lado, desde una dimensión social, c) ayuda a integrar en el grupo la pérdida de uno de sus miembros (Rodríguez, 2001).

La literatura sobre los ritos funerarios aborda tanto la dimensión individual como la función social del ritual (Engelke, 2019), y remarca la importancia de dichos ritos para la continuidad de la vida.

El rito fúnebre es uno de los denominados ritos de paso (Gennep, 1969/2008), el último en la vida del individuo y el único en el que el sujeto protagonista no está presente de forma activa, es decir, no existe como individuo vivo y es la comunidad la que realiza el ritual y, por tanto, la que se beneficia de él (imagen 10).

En muchas culturas, el ritual no se centra en la persona fallecida, sino que tiene como objetivo apoyar a los dolientes frente a su tristeza y ayudarles a aceptar la pérdida (Roberson, et al., 2018). Son ritos que realizan los vivos para los vivos, cuya condición ritual está definida por la vinculación con la persona fallecida (Maillo, 1992), y que supone más un consuelo para los vivos que una ayuda para los difuntos (Agustín, 1995). Lo que sobrevive después de la muerte es aquello que tiene que ver con el propio ritual (Thomas, 1991).

Centrándonos en la tercera de sus funciones, podemos afirmar que el ritual fúnebre se convierte en un elemento importante que ayuda a la elabora-

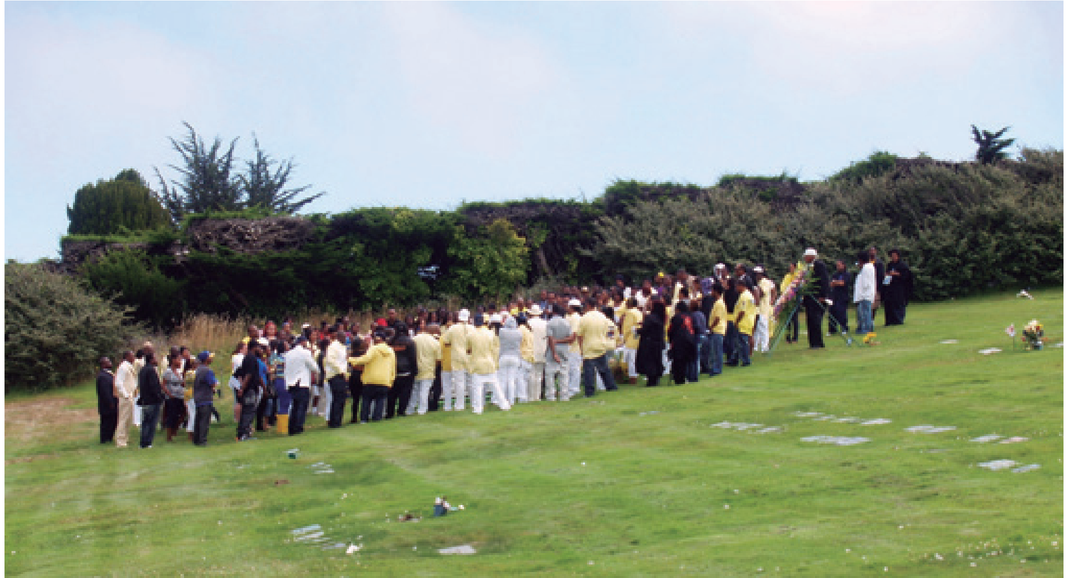

Imagen 10: Entierro de un miembro de la comunidad negra en San Francisco

ción del duelo, o al menos, en el arranque de dicha elaboración. Es decir, aborda la segunda de las preocupaciones ante la muerte: la muerte del otro, la pérdida del ser querido.

Imagen 11: Cadáver a la vista de la comunidad preparado para ser incinerado en Bali

En los primeros momentos de embotamiento e impacto tras la muerte de un ser querido, los ritos sociales y familiares facilitan la resolución del estado de shock e incredulidad (Solano, 2003), favorecen el desprendimiento del ser querido (García & Suarez, 2007) y facilitan al doliente la conexión con la realidad de pérdida. Ver el cadáver ayuda a concienciarse de esta realidad y de la irreversibilidad de la muerte (Worden, 2008/2013) (imagen 11). Los rituales de duelo facilitan el apoyo emocional al doliente por parte de la comunidad (Collins & Doolittle, 2006) y le dan a estos la oportunidad de hablar sobre la persona fallecida y su relación con amigos y familiares (Rushing, 2006).

Algunos autores afirman que la realización del ritual fúnebre y el apoyo de la comunidad que se produce en estas ceremonias constituyen un factor que protege al individuo de sufrir un duelo complicado (Braz & Franco, 2017). Si bien los estudios a este respecto son escasos (Mitima-Verloop et al., 2021), especialmente en España, intuitivamente tiene sentido asumir que una despedida amable y bien elaborada ayuda a aceptar la pérdida (Lensing, 2001).

En algunos trabajos se ha afirmado, sin embargo, que esta protección del duelo no está demostrada de forma clara (Doka, 1995) y tan solo hay evidencias de beneficios directos para la elaboración del duelo a corto plazo (Elaine et al., 2003). Desde una perspectiva psicológica, muy pocos estudios empíricos han examinado el impacto de la realización de rituales en la elaboración del duelo (Castle & Phillips, 2003).

En todo caso los ritos funerales pueden ser útiles para ayudar a los individuos a afrontar la muerte (Stephenson, 1985) y también son parte integrante del sistema de duelo de una cultura, en la que se enmarca un sentido de estructura y de cierre (Collins & Doolittle, 2006; Ladd, 2007).

Al igual que las actitudes del hombre ante la muerte cambian de forma constante (Ariès, 1974/2010), estos rituales fúnebres, que reflejan la visión trascendente de una determinada cultura, están también en constante cambio y evolución.

La muerte en la cultura premoderna era una ocasión natural, siempre pública, colectiva y altamente ritualizada, mientras que en la sociedad moderna occidental asistimos a una pérdida o transformación del rito funerario (Vaczi, 2019). El dolor y el luto modernos se han ubicado progresivamente dentro del marco del individualismo y, por tanto, en el ámbito de la familia inmediata (Angell et al., 2018; Shapiro, 2005). El luto se ha trasladado al ámbito privado (Barley, 1997/2012), la muerte se ve rechazada de la esfera social (Allué, 1998) incluso para las personas que encuentran sentido y consuelo en estas prácticas y rituales (Neimeyer, 1998/2002). Tras la muerte de un individuo, y una vez realizado el rito, los dolientes intentan volver a la normalidad como si nadie hubiese muerto, como si nada hubiese sucedido (Ariès, 1977/2011), lo que, en cierto modo, modifica el significado tradicional del rito.

Estas características propias de la modernización de occidente no se imponen con tanta fuerza en algunas zonas rurales españolas, como en Galicia, donde la tradición y la fuerza del ritual mortuorio cambian a menor velocidad y permanecen en su esencia (Tolosana, 2008). En la tradición rural gallega no solo el ritual fúnebre tiene aún una fuerza colectiva singular, sino que son otros los rituales relacionados con la relación entre el individuo y su propia muerte que, a pesar de los cambios, se mantienen en algunas aldeas (imagen 12).

Imagen 12: Una mujer visita el cementerio en una aldea gallega

En todo caso, en España existen escasos estudios etnográficos sobre la muerte y los difuntos, pero los existentes exponen la realidad de una muerte muy presente en el imaginario popular español y, por lo tanto, de una muerte muy viva (Vaczi, 2019).

Por último, conviene mencionar que, a pesar de la secularización, en España la mayoría de los rituales fúnebres se celebran en el contexto de la religión católica, y los responsos, oraciones y funerales, con o sin cuerpo presente, son en la actualidad los rituales más celebrados.

3.3. La llegada de la COVID-19

Los cambios que se producen a lo largo de la historia en relación a la actitud del individuo, y de las sociedades, con la muerte propia y ajena, y a la forma que tiene cada comunidad de relacionarse con ella son, por tanto, imparables, aunque se producen a distintas velocidades en función del entorno y del momento histórico (Ariès, 1977/2011).

En el último tercio de 2019 y durante 2020 y 2021, esta evolución en la forma de entender tanto la relación con la muerte a través del propio pensamiento individual como la expresión colectiva ritual sufre un revulsivo con la llegada de la pandemia de la COVID-19 que produce millones de muertes en todo el mundo en muy corto espacio de tiempo.

En julio de 2021 habían fallecido 4,2 millones de personas en el mundo debido a esta enfermedad (Statista, 2021). Ochenta mil de estas muertes se registraron en España, que ocupó el puesto número 15 en cifra de muertes absolutas por países. Solo durante la primera ola de la pandemia (entre los meses de enero y mayo de 2021) se calcula que murieron en España más de 45.000 personas debido a la COVID-19 (Instituto Nacional de Estadística).

La mayoría de estas muertes se produjo durante el tiempo que duró el estado de alarma declarado en el país, que limitaba, entre otras cosas, la libre circulación de las personas, sometía a la población a un confinamiento domiciliario y restringía la asistencia a rituales fúnebres.

Se activaron protocolos para los hospitales y residencias de ancianos en los que se prohibían las visitas y el acompañamiento a pacientes por parte de sus familiares. Las personas que murieron en hospitales y residencias fallecieron sin la compañía de sus familias, y aquellas que vivían solas en sus domicilios también murieron en soledad.

Los velatorios y funerales quedaron prohibidos y tan solo se permitió la asistencia de dos familiares al entierro o cremación. La gran mayoría de los españoles no se pudo despedir de sus seres queridos ni en los momentos previos a la muerte ni en los momentos posteriores; desaparecieron los ritos fúnebres casi por completo.

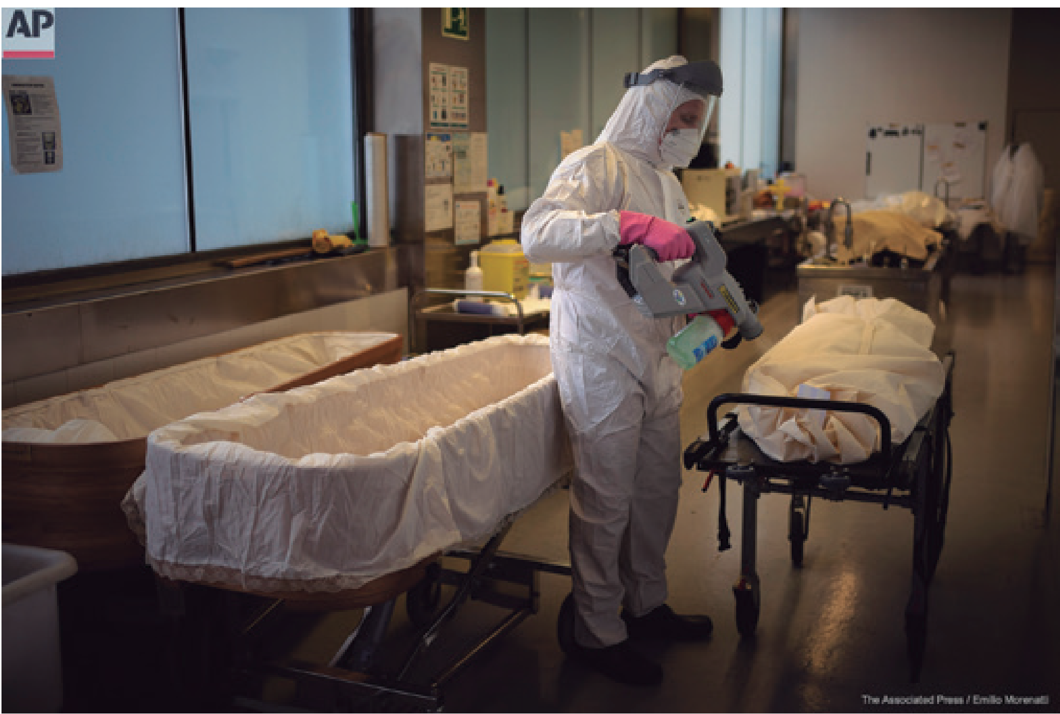

Imagen 13: Un empleado de una funeraria desinfecta el cuerpo de una persona fallecida. Emilio Morenatti

El personal de primera línea (personal sanitario, de funerarias, bomberos, etc.) tuvo que responder ante unas circunstancias extraordinarias, nunca experimentadas hasta el momento, y convivió de forma íntima con un número de muertes desproporcionado (Imagen 13).

Las personas con profesiones sociosanitarias fueron los únicos acompañantes y testigos de los fallecimientos. Los sistemas de gestión de cadáveres se desbordaron y las funerarias se vieron saturadas (González-Fernández et al., 2020), se crearon morgues improvisadas y se movilizó a militares y bomberos para realizar la recogida de cadáveres (Imagen 14).

Al restringirse de forma radical la asistencia a los rituales funerarios, los capellanes de tanatorios, cementerios y morgues improvisadas tuvieron que realizar anómalos ritos fúnebres sin la participación comunitaria que los define. El ritual, tal y como se conocía, desapareció durante algunos meses. Algunas familias decidieron realizar estos ritos de forma virtual, se realizaron así celebraciones que, si bien ayudaron a tomar conciencia de las pérdidas, no pudieron reemplazar el apoyo cercano y el contacto físico propios de un ritual tradicional (Scheinfeld et al., 2021).

Ante esta situación, algunos autores adelantan que la ausencia de estos rituales tradicionales dificultará el proceso de duelo de las familias (Burrell & Selman, 2020).

Si los cambios en la forma de tratar con la muerte en España y en el mundo se producían de forma continua, marcados por la secularización, el postcapitalis-

Imagen 14: Bomberos preparando los furgones para salir a recoger cadáveres. Foto cedida anónimamente

mo y la individualización, la llegada de la pandemia acelera y agudiza estos cambios de forma disruptiva. Este nuevo paradigma generaba muchos interrogantes y cuestiones que había que abordar desde la investigación en ciencias sociales.

3.4. Preguntas de investigación

Al pensar en la relación del ser humano con la muerte, y en los ritos que ponen de relieve esta relación, y teniendo en cuenta esta irrupción repentina de la enfermedad que ha provocado un volumen de muertes hasta ahora solo conocido en guerras y catástrofes, y al que nos hemos tenido que enfrentar como individuos, como familia y como sociedad en su conjunto, cabe realizar ciertas preguntas. Las respuestas a estas preguntas se van dando a lo largo de los artículos que conforman esta tesis doctoral y en las conclusiones que figuran al final de este trabajo.

1) ¿Qué actitud tiene el individuo ante la muerte y cómo se refleja dicha actitud en determinados rituales?
2) ¿Cómo se expresa la relación de la comunidad con la muerte en la cultura y las tradiciones populares?
3) ¿Cuál es la función del rito funerario para la comunidad y para los individuos en la sociedad actual española?

4) ¿Qué relación tienen los ritos de despedida premortem y postmortem con la elaboración del duelo?
5) ¿Cómo ha sido la experiencia de la pérdida del ser querido sin los rituales culturalmente determinados para la despedida durante la pandemia de la COVID-19?
6) ¿Cómo ha cambiado la pandemia de la COVID-19 la forma de relacionarse con la muerte de las y los profesionales que más acostumbrados estaban a tratar con ella (personal sociosanitario y de primera línea)?
7) ¿Cómo ha afrontado el personal sociosanitario la exposición a un volumen de muertes desproporcionado y desorbitado?
8) ¿Qué significado han tenido para familiares, dolientes y profesionales sociosanitarios, las muertes producidas en soledad durante los meses más críticos de la pandemia de la COVID-19 y cómo se relaciona dicho significado con la percepción de una buena muerte?
9) ¿Existe relación entre el rito funerario y la percepción social de dignidad de la muerte?
10) ¿La despedida de un ser querido guarda relación con lo que socialmente se considera una buena muerte o una muerte digna?
11) ¿Despedirse de un ser querido es un factor de protección de duelo complicado?
12) ¿Es posible resignificar el ritual funerario?

Los objetivos generales de esta tesis doctoral son:

1. Estudiar la existencia de rituales en torno a la vida y la muerte que se celebran en algunas regiones españolas y tratar de entender su evolución y sus significados.
2. Investigar los cambios producidos en torno a la relación del ser humano con el fenómeno de la muerte fruto de la irrupción de la pandemia de la COVID-19.

4. ESTRUCTURA, LÍNEA ARGUMENTATIVA Y METODOLOGÍA APLICADA

4.1. Estructura

El siguiente trabajo está estructurado en cuatro capítulos, cada uno de ellos corresponde a cada uno de los artículos científicos publicados, o en proceso de publicación, que conforman la unidad científica de esta tesis doctoral. Por tanto, cada uno de los capítulos contiene sus propios apartados de introducción, metodología, discusión y resultados y están estructurados tal y como fueron publicados o como se enviaron a las revistas correspondientes.

Cada uno de los artículos va precedido en esta tesis doctoral de una justificación introductoria que presenta la motivación para incluirlo en este trabajo, explica algunos aspectos de la investigación que, por falta de espacio, no se incluyeron en el propio artículo, y aporta una visión más humana y emocional sobre el desarrollo del estudio. Estas justificaciones tratan de dar una continuidad en la línea argumentativa de la tesis para entender la unidad científica del trabajo y los elementos comunes a los cuatro estudios.

Finalmente, estos cuatro capítulos se complementan con unas conclusiones generales y con unas implicaciones que dan sentido al compendio y, sobre todo, pretenden tener una utilidad práctica ya que incluyen recomendaciones de intervención y prevención que deberían tenerse en cuenta en el mundo académico, profesional y de los poderes públicos.

4.2. Motivación

Se ha elegido la presentación de la tesis por compendio de artículos por diversos motivos:

En primer lugar, considero que es una obligación ética del investigador el dar a conocer y divulgar los frutos de la investigación, especialmente cuando los resultados y sus implicaciones pueden repercutir en el bien común o en una

vida más saludable para los seres humanos. Los artículos científicos tienen una mayor difusión que las tesis doctorales y facilitan el hecho de ser consultados por personas con intereses muy concretos sobre una materia de estudio.

Los artículos que componen esta tesis poseen ese enfoque, que pretende aportar conocimiento y sugerir acciones de prevención para mejorar el bienestar del ser humano y su salud mental, se preocupan de la dimensión ética, y se alinean, de esta manera, con el tercero de los Objetivos de Desarrollo Sostenible y la Agenda 2030, que pretende garantizar una vida sana y promover el bienestar para todos en todas las edades. Tres de los cuatro artículos presentados tienen implicaciones y recomendaciones de intervención acordes con este objetivo de los ODS.

Por otro lado, la publicación por artículos da mayor flexibilidad al investigador. En un entorno VUCA (Volátil, Incierto, Cambiante y Ambiguo), cuyos retos aumentan con la pandemia (Noda, 2020) la flexibilidad es un imperativo esencial para poder adaptarse a los continuos cambios del entorno, y la comunidad científica no debe mantenerse ajena a ello. Uno de estos cambios radicales ha estado marcado por la aparición de la pandemia mundial provocada por la COVID-19. La presente investigación tuvo que adaptarse rápidamente a la nueva situación, cambiando el plan previsto en un primer momento, y gracias al formato de artículos científicos esta adaptación se realizó de una forma menos traumática para el investigador y más efectiva para los objetivos de la investigación.

En tercer lugar, existe una creciente tendencia en el mundo académico a realizar este tipo de tesis por compendio de artículos. Esta tendencia pone en contacto al investigador con la comunidad científica y asegura una mayor calidad en el trabajo final, ya que, previamente a su defensa pública, este trabajo habrá sido evaluado anónimamente por profesionales del mundo de la investigación, de forma objetiva, con sistemas de doble ciego y con un enfoque internacional. Los artículos se han enviado a revistas con altos índices de impacto en las materias que aborda esta tesis.

4.3. Desarrollo de los artículos

Todos los artículos se han redactado a partir de investigaciones de tipo cualitativo. El primer artículo, así como su investigación correspondiente, está realizado antes de la aparición de la pandemia de la COVID-19. Es un artículo de carácter etnográfico y se ha desarrollado a partir del trabajo de campo, de la observación participante, y de entrevistas semiestructuradas y entrevistas informales no estructuradas. Así mismo, cuenta con documentación gráfica.

El resto de los artículos están realizados inmediatamente después de la llamada primera ola de la pandemia de la COVID-19, y los tres son fruto de una única recogida de datos y un mismo tratamiento metodológico que se expone

en dichos artículos. El instrumento principal de la recogida de datos fue la entrevista en profundidad semiestructurada. Como se describirá al presentar cada uno de los artículos, todas las entrevistas se realizaron bajo unas condiciones emocionales muy duras para los entrevistados y en un entorno de mucha incertidumbre.

Para el análisis de datos en los cuatro artículos se ha contado con el apoyo del software NVIVO 12 que ha ayudado a la investigación en el análisis y categorización de dichos datos.

Si bien los requisitos para la tesis doctoral exigen un compendio, al menos, de tres artículos, he considerado muy positivo introducir un cuarto artículo (el correspondiente al primer capítulo, sobre el ritual de Santa Marta) que aporta esa visión ritual sobre la muerte, previa a la pandemia, y que posee una importancia especial desde la perspectiva de los cambios ocurridos en la relación del individuo con la muerte en España.

Consideraciones éticas y uso de imágenes

Considerando la sensibilidad que conllevaba esta tesis doctoral se procedió a cumplir los requerimientos éticos oportunos que fueron supervisados por el Comité de Ética de la Universidad Pontificia Comillas con su informe favorable. Todos los informantes fueron advertidos de los objetivos de la investigación, las fuentes de financiación y el uso de los resultados. Se solicitó el consentimiento informado y se informó de la voluntariedad en la participación. También se solicitó permiso para la grabación en audio. Se garantizó mediante compromiso de confidencialidad y anonimato.

Las figuras incluidas en el primer artículo forman parte de este y se han enviado a la revista correspondiente. El resto de los artículos se enviaron sin imágenes.

Sin embargo, he decidido ilustrar algunas partes de este trabajo con fotografías que reflejan de forma visual los contenidos expuestos en él, y además tratan de ser un elemento más de sensibilización acorde con las líneas de intervención y prevención que figuran al final de la tesis. De ahí que algunas imágenes puedan resultar de gran dureza.

Las imágenes en las que no figura el nombre del autor o del propietario son propiedad del investigador; en el resto de las imágenes se nombra al autor o al organismo que las ha cedido. Todas las imágenes cuentan con permiso de sus propietarios para ser publicadas en esta tesis doctoral. En caso de aparecer personas en las imágenes se ha velado porque estas sean irreconocibles, y en el caso de pacientes, el fotógrafo obtuvo permiso de estos o de la familia para su divulgación.

Artículos

- El primer artículo, ***Jugar con la muerte para celebrar la vida. Un estudio etnográfico de la romería de los ataúdes en Santa Marta de Ribarteme, Pontevedra, Galicia***, describe etnográficamente un ritual en un entorno rural, que, sin ser un rito fúnebre, utiliza símbolos y elementos propios de las celebraciones funerarias. Este artículo habla de la relación de las personas con la muerte, de sus temores y de su deseo de evitarla, y de cómo esta huida se puede manifestar en un anómalo ritual comunitario.
    - o El artículo está actualmente enviado a la revista Etnográfica.

- El segundo artículo, ***I can't believe they are dead. Death and mourning in the absence of goodbyes during the COVID-19 pandemic,*** habla de la ausencia de despedidas y rituales fúnebres tras los meses más duros de la pandemia de la COVID-19 y evidencia la relación entre el rito funerario y el proceso de duelo.
    - o El artículo fue publicado en Health and Social Care in the Community el día 7 de agosto de 2021.

- El tercer artículo, ***"It is the worst thing that has happened to me": Healthcare and social services professionals confronting death during the COVID-19 crisis,*** muestra cómo ha sido la forma de afrontar la sobreexposición a un elevado volumen de fallecimientos del personal que habitualmente más acostumbrado está a tratar con el fenómeno de la muerte, desde profesionales sociosanitarios de emergencias, hospitales y residencias de ancianos hasta profesionales de primera línea como bomberos o personal de funerarias.
    - o El artículo está actualmente enviado a International Journal of Public Health.

- El cuarto artículo, "***Nobody should die alone". Loneliness and a dignified death during the COVID-19 pandemic,*** describe lo que ha supuesto para la comunidad afrontar e interiorizar el hecho de que las muertes se hayan producido en solitario durante parte de la pandemia de la COVID-19, profundiza en el significado de la buena muerte y estudia la relación de los rituales con la percepción de muerte digna.
    - o El artículo fue aceptado en Omega: Journal of Death and Dying**,** el 6 de septiembre de 2021 y está en proceso de publicación

4.4. Perspectiva de género y de inclusión

Si bien la perspectiva de género puede aparecer de forma transversal en esta tesis, es justo reconocer que no se aborda de una forma específica en estas investigaciones, y esto pudiera suponer una limitación a la hora de interpretar algunos resultados.

Abordar el estudio desde esta perspectiva hubiese supuesto un enfoque sumamente interesante; sin embargo, entre los objetivos principales de la investigación no se encontraba el entender la diferencia de los roles de género a la hora de relacionarse con la muerte o de vivir un duelo. La limitación marcada por el tiempo, y por el uso de palabras en los artículos, provocó que se priorizasen otros objetivos. Si bien esta línea de investigación está siempre abierta y creo que puede ofrecer resultados enriquecedores, especialmente para estudiar y entender el reparto de roles en una familia tras la muerte de un ser querido, y cómo dichos roles pueden ir evolucionando a lo largo de cada una de las fases de la elaboración del proceso de duelo.

A la hora de seleccionar las muestras se procuró tener en cuenta ambos sexos para ser incluidos en ellas, en cada una de las investigaciones realizadas para esta tesis. Sin embargo, en la redacción de los artículos no se detalló el sexo, a no ser que lo pidieran los revisores, al igual que no se detalló el género o, por ejemplo, la edad, o la procedencia, ya que esta no iba a ser una variable representativa para el estudio. La prioridad fue que las personas entrevistadas cumplieran los requisitos de inclusión y, sobre todo, en una investigación tan complicada desde el punto de vista emocional y en un contexto de emergencia social y sanitaria, que accediesen libre y voluntariamente a las entrevistas.

Por otro lado, algunos de los roles de los entrevistados imponían el sexo del sujeto que se incluía en la muestra; por ejemplo, los sacerdotes son siempre de sexo masculino. Otros roles no imponían directamente que la persona entrevistada perteneciese a uno de los dos sexos; pero lo condicionaba bastante, ya que las funciones correspondientes estaban desempeñadas mayoritariamente por uno de estos sexos, por ejemplo, las auxiliares de residencias de ancianos o trabajadoras sociales son en su mayoría mujeres y los enterradores en su mayoría hombres.

En ambas investigaciones se intentó que hubiese un número suficientemente representativo tanto de hombre como de mujeres, si bien no fue sencillo equipararlo, y como he comentado antes tampoco era un requisito imprescindible de cara a conseguir los objetivos de los estudios. Finalmente, en la primera investigación, la correspondiente al primer artículo, se entrevistó a cinco hombres y siete mujeres, y en la segunda investigación se entrevistó a 18 hombres y 31 mujeres.

En otro orden de cosas y respecto a otros criterios de inclusividad, se intentó también incluir algún sujeto que procediera de fuera de España en la muestra, aunque esto no fue prioritario. En la primera investigación se entrevistó de

manera informal y no estructurada a un sacerdote angoleño (la entrevista no fue grabada) que participaba esos días en el ritual, y en la segunda investigación se entrevistó a una persona procedente de República Dominicana que vive en Madrid como inmigrante y que perdió a su madre en España durante la pandemia de la COVID-19. Al igual que con la perspectiva de género, no se profundizó en las diferencias y se abren líneas de investigación que contesten cuestiones como, por ejemplo, cómo se vive la acumulación del duelo migratorio con el duelo por muerte por COVID-19, o cómo aparecen en nuestra sociedad el sincretismo y la integración de rituales funerarios celebrados por extranjeros que viven en España.

4.5. Detalle de los artículos y aportaciones de los autores

1.

Hernández-Fernández, Carlos

Jugar con la muerte para celebrar la vida. Un estudio etnográfico de la romería de los ataúdes en Santa Marta de Ribarteme, Pontevedra Galicia

Enviado a Etnográfica.

Aportaciones:

Carlos Hernández-Fernández, que figura como único autor, ha realizado la totalidad del artículo, incluyendo la recogida de datos y el trabajo de campo.

Dra. Carmen Meneses-Falcón ha realizado las tareas de orientación supervisión y triangulación.

2.

Hernández-Fernández, C., & Meneses-Falcón, C. (2021).

I can't believe they are dead. Death and mourning in the absence of goodbyes during the COVID-19 pandemic. Health & Social Care in the Community, 00, 1–13. https://doi.org/10.1111/hsc.13530

Publicado.

Aportaciones:

Carlos Hernández-Fernández: Conceptualización, recogida de datos, investigación, análisis formal, administración del proyecto, administración de recursos, visualización, redacción del borrador original, redacción de la revisión y edición.

Dra. Carmen Meneses-Falcón: Metodología, supervisión, validación y soporte a la redacción de la revisión.

3.

Hernández-Fernández, C., & Meneses-Falcón, C.

“It is the worst thing that has happened to me”: Healthcare and social services professionals confronting death during the COVID-19 crisis.

Enviado a International Journal of Public Health.

Aportaciones:

Carlos Hernández-Fernández: Conceptualización, recogida de datos, investigación, análisis formal, administración del proyecto, administración de recursos, visualización, redacción del borrador original, redacción de la revisión y edición.

Dra. Carmen Meneses-Falcón: Metodología, supervisión, validación y soporte a la redacción de la revisión.

4.

Hernández-Fernández, C., & Meneses-Falcón, C.

Nobody should die alone. Loneliness and a dignified death during the COVID-19 pandemic.

Aceptado en Omega: Journal of Death and Dying, el 6 de septiembre de 2021

Aportaciones:

Carlos Hernández-Fernández: Conceptualización, recogida de datos, investigación, análisis formal, administración del proyecto, administración de recursos, visualización, redacción del borrador original, redacción de la revisión y edición.

Dra. Carmen Meneses-Falcón: Metodología, supervisión, validación y soporte a la redacción de la revisión.

5. CAPÍTULO I: JUGAR CON LA MUERTE PARA CELEBRAR LA VIDA. UN ESTUDIO ETNOGRÁFICO DE LA ROMERÍA DE LOS ATAÚDES EN SANTA MARTA DE RIBARTEME, PONTEVEDRA, GALICIA

5.1. Justificación introductoria

Antes de abordar en esta tesis un estudio a fondo de los rituales funerarios en España, abordaje cuyo planteamiento se vio, posteriormente, modificado por la pandemia de la COVID-19, me pareció interesante detenerme a estudiar alguno de los escasos rituales en el mundo en el que, sin ser fúnebres, se usasen los símbolos y signos propios de un entierro o funeral. Este tipo de rituales, nada habituales y llenos de simbología, aportan muchos datos sobre la relación del ser humano con la muerte en determinados entornos y en un contexto concreto.

La relación del individuo y de la comunidad con la muerte en las sociedades rurales españolas varía notablemente en función de la zona geográfica en la que nos encontremos, y por supuesto es muy diferente a la existente en las sociedades más urbanas. También varían los ritos funerarios que se realizan en la actualidad; por poner un ejemplo, en Madrid la misa funeral se celebra normalmente pasados unos días desde el óbito, mientras que en muchos pueblos y ciudades pequeñas se celebra de cuerpo presente previamente al entierro.

Algunos antropólogos como Cátedra (1988), Gondar (1999) o Tolosana (1991, 2008, 2016) se han preocupado por estudiar esta relación entre algunas comunidades rurales y el fenómeno de la muerte en diferentes zonas geográficas, así como sus significados, pero en general el tema de la muerte en España ha sido muy poco estudiado por ciencias sociales tales como la sociología o la antropología (Vaczi, 2019) y existe poca literatura al respecto. Quizá con esta falta de estudios se confirma que la muerte en la modernidad se convierte en un tabú al que le damos la espalda (Ariès, 1977/2011) incluso en la comunidad científica.

Se encuentran estudios especialmente interesantes en el norte de España, sobre todo en Galicia, a la que algunos investigadores describen como la zona en la que habitan los muertos (Tolosana, 1991) refiriéndose a la relación especial de esta región con el mundo de los difuntos. En toda Galicia podemos encontrar, en la tradición, en la cultura y en el arte, símbolos y rituales que nos hablan de la especial relación entre la vida y la muerte que existe en el noroeste español.

Algunas de estas tradiciones rituales están en retroceso e incluso en vías de desaparición. Por este motivo me parecía interesante analizar, desde un punto de vista etnográfico y descriptivo, la llamada Romería de los Ataúdes, que se realiza en Santa Marta de Ribarteme, en la provincia de Pontevedra, y en la que personas vivas se introducen en ataúdes y desfilan en procesión por la aldea para agradecer, paradójicamente, estar vivos. (Imagen 15)

Esta romería apenas está documentada en la literatura científica, y tan solo encontramos aisladas referencias a ella en material de divulgación reciente de la propia parroquia (Rodríguez & Araujo, 2018), en alguna breve referencia en los estudios sobre antropología gallega de Tolosana (1991, 2008 y 2016), en pequeñas obras de divulgación (Quiben, 1951) o en literatura narrativa (Cela, 1952); en estos últimos casos, además, las referencias son de mediados del siglo XX, por lo que se puede concluir que no hay una documentación sistemática actual de este ritual tan singular. Sin embargo, sí que encontramos multitud de entradas en prensa e incluso en reportajes de televisión, como veremos en el artículo, un hecho este que revitaliza el ritual pero que también lo resignifica y modifica al globalizarlo y ofrecerle un escaparate de difusión al mundo. (Imagen 16)

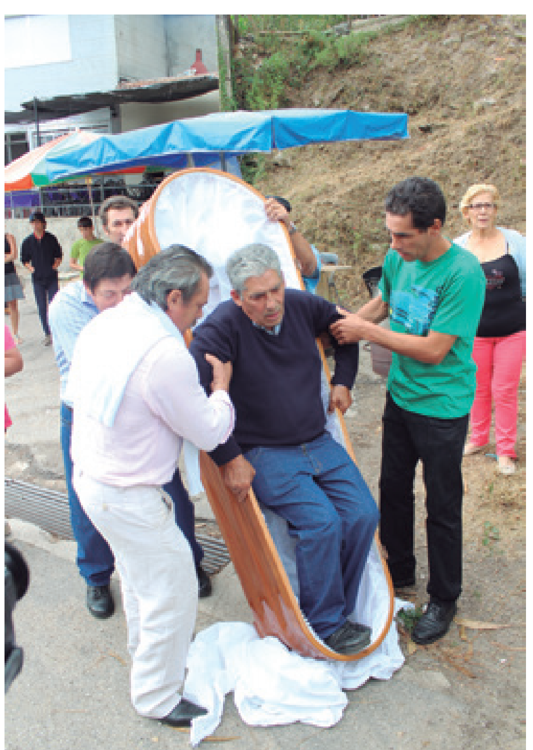

Imagen 15: Un devoto de Santa Marta se introduce en el ataúd con ayuda de sus amigos.

Por este motivo he considerado interesante documentar esta romería que, como afirma el artículo que se presenta a continuación, evoluciona constantemente sin que haya dejado plasmada su presencia en la literatura de carácter académico, y que posee un futuro incierto, más aún tras la exis-

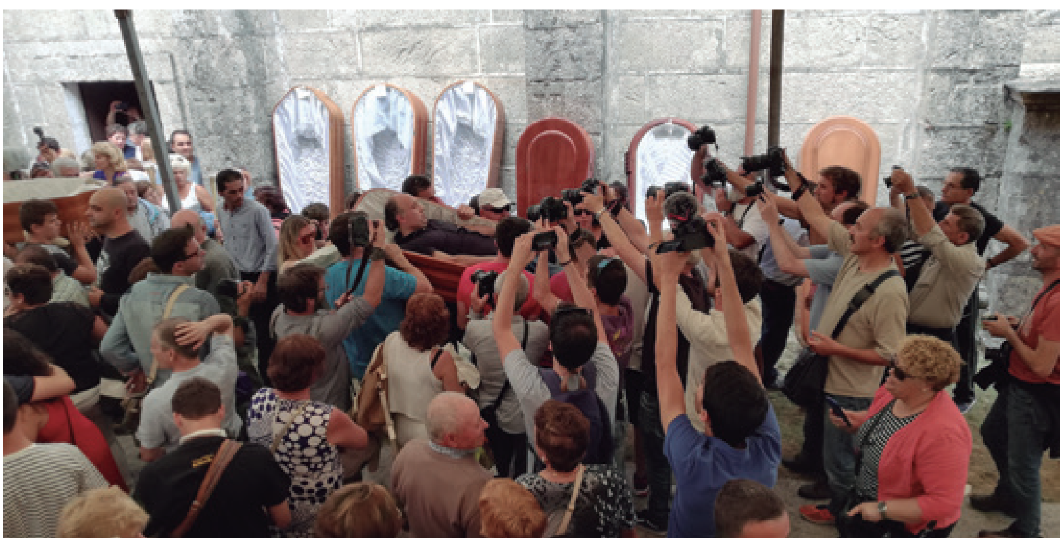

Imagen 16: Nube de fotógrafos en torno a uno de los ataúdes de Santa Marta de Ribarteme

tencia de la pandemia que ha obligado a que sea suspendida durante los dos últimos años (2020 y 2021).

Con dicho estudio, además de explorar esta curiosa relación del individuo y sus miedos con la muerte y los tabúes que la rodean, he pretendido dejar constancia del patrimonio cultural y simbólico de una parte de España que, a pesar de su riqueza, es muy desconocido. De hecho, posteriormente a la realización de la investigación la romería de Santa Marta fue declarada de interés turístico por la Xunta de Galicia en su Consello de 27 de febrero de 2020.

Tras participar varios años como observador de la romería y tener la oportunidad de hablar con muchos vecinos implicados en la fiesta, en 2019 adopté el rol de investigador y me sumergí en ella tratando de entender su complejidad y, sobre todo, los significados. Fue un trabajo enriquecedor e interesante en el que descubrí las peculiaridades del trabajo del etnógrafo, tal y como se reflejan con humor en las obras de Barley.

El esquema de este artículo es ligeramente diferente al del resto de los artículos que componen la tesis. Se trata de un artículo de carácter más descriptivo y cien por cien etnográfico. Una vez expuestos los resultados no se realiza una discusión, ya que el objetivo no ha sido comparar la romería con otras romerías, ni tan siquiera con otros rituales, sino describirla y tratar de narrar su evolución y la de los significados con las escasas referencias encontradas. De esta forma aposté por realizar unas reflexiones sobre el ritual y su significado en lugar de una discusión, teniendo en cuenta que no existía literatura sobre el propio ritual, con la que sí que hubiese sido interesante realizar ese diálogo en caso de haber existido.

Este artículo aporta a la unidad científica de la tesis una mirada diferente al mundo de la muerte, una visión más religiosa y quizá más mágica o supersticiosa que el resto de los artículos, una visión que refleja el miedo que el ser humano tiene a su propia muerte, en especial cuando sus significados se asocian a consecuencias de carácter negativo para el individuo (Cicirelli, 2010). (Imagen 17)

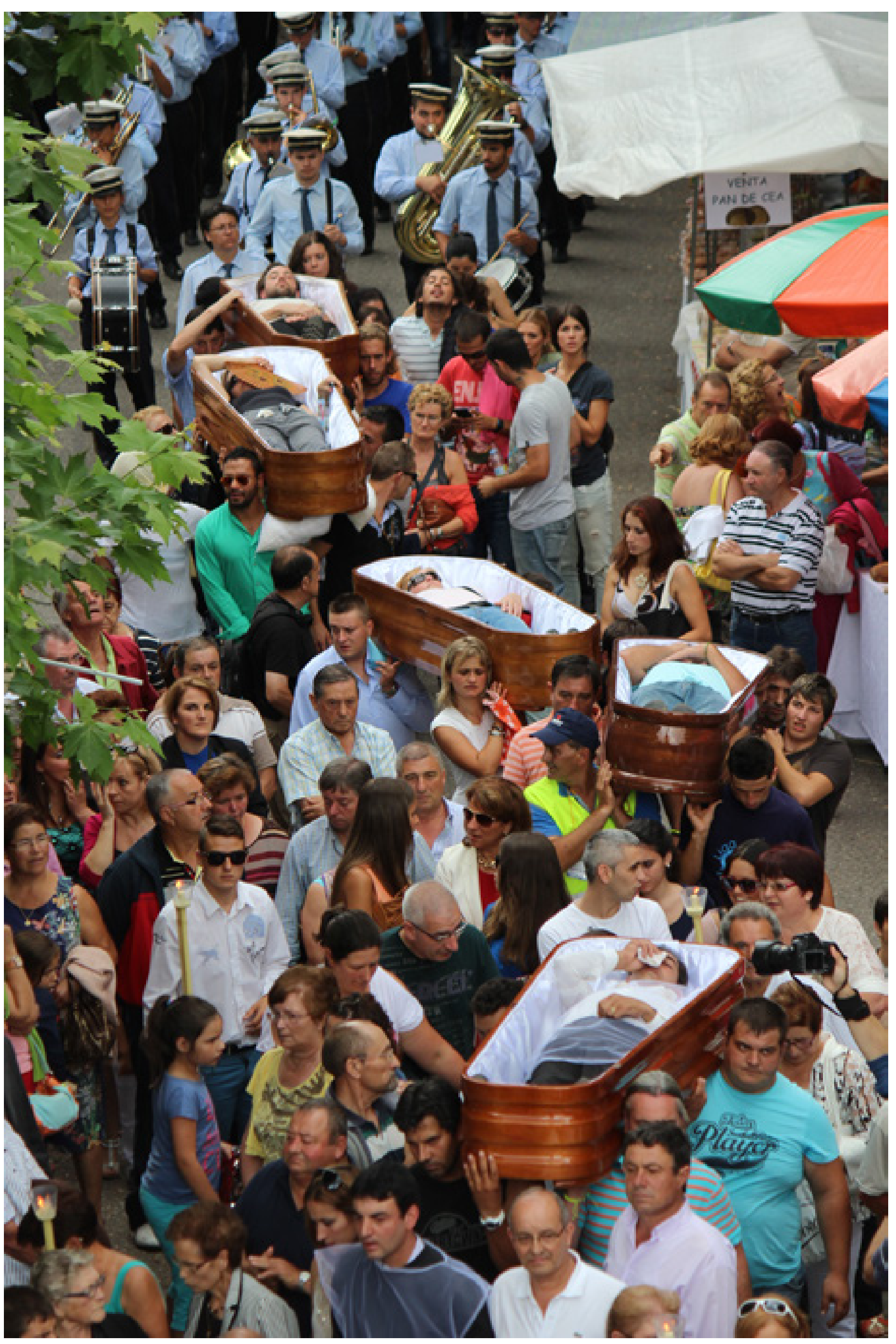

Imagen 17: Procesión de féretros en Santa Marta de Ribarteme

5.2. Artículo: Hernández-Fernández, Carlos. Jugar con la muerte para celebrar la vida. Un estudio etnográfico de la romería de los ataúdes en Santa Marta de Ribarteme, Pontevedra, Galicia

Resumen

Este estudio describe y analiza, desde una perspectiva social y antropológica, el ritual denominado popularmente romería de los ataúdes, que se celebra cada 29 de Julio en la localidad de Santa Marta Ribarteme, en Galicia. Se profundiza en un rito del que existen escasas publicaciones a pesar de la riqueza de significados y contenidos, y se cubre, así, el vacío existente en la literatura. Se parte de un trabajo etnográfico realizado desde 2013 a 2019, mediante observación participante, entrevistas y análisis de documentos gráficos y escritos sobre esta celebración. Los resultados indican que esta romería es la única en España, y quizá en el mundo, que posee los símbolos propios de un entierro y en el que algunos peregrinos procesionan introducidos en un ataúd, mientras mantiene, a su vez, los elementos simbólicos comunes en cualquier romería religiosa de carácter festivo. La fe en los milagros, la desesperación producida por la enfermedad y el miedo a la muerte constituyen la esencia de este rito religioso y profano a su vez, en continua evolución, que nos habla del dialogo entre la vida y la muerte propio de la condición humana.

Palabras clave

Ritos funerarios, romería, entierro, ritual, procesión

JUGAR CON LA MUERTE PARA CELEBRAR LA VIDA. UN ESTUDIO ETNOGRÁFICO DE LA ROMERÍA DE LOS ATAÚDES EN SANTA MARTA DE RIBARTEME, PONTEVEDRA, GALICIA

TO PLAY WITH DEATH TO CELEBRATE LIFE. AN ETHNOGRAPHIC STUDY OF THE PILGRIMAGE OF THE COFFINS IN SANTA MARTA DE RIBARTEME, PONTEVEDRA, GALICIA

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Abstract

This study analyzes the sociological and anthropological implications of the ritual commonly known as the casket pilgrimage, which takes place every July 29 in the northwest of Spain in the town of Santa Marta Ribartemente, Galicia. The study highlights and delves into a ritual that has been rarely covered in publications despite its wealth of meaning and substance and it therefore fills a void in the literature about funeral rituals. The starting point is the ethnographic work done between 2013 and 2018, including participant observation, interviews and analysis of illustrated material and written documents about this ritual. Results indicate that this is the only pilgrimage in Spain, perhaps even in the world, that possesses the symbols of a burial and during which some pilgrims choose to participate while inside a casket, while simultaneously maintaining common symbols of any festive religious pilgrimage. Faith in miracles, the despair caused by illness and the fear of death are essential to this religious and profane ritual, which is constantly evolving and illustrates the dialogue between life and death that is so typical of the human condition.

Palabras clave

Ritos funerarios; romería; entierro; ritual; procesión;

Key words

Funerary rituals; pilgrimage; burial; ritual; procession Introducción

Introducción

La muerte, como fenómeno con dimensión individual y social, está presente a lo largo de toda la existencia del ser humano. En función del momento his-

tórico, del lugar y de la cultura, se le ha dado diferentes tratamientos (Caycedo 2007).

Los rituales fúnebres suponen un aspecto importante en la historia de los pueblos, ya que expresan su forma de vivir y su relación con la muerte, una muerte que está en la propia naturaleza y en la cultura de cada pueblo (Acosta 2001).

La literatura sobre los ritos funerarios aborda esta doble dimensión (Engelke 2019), y remarca la importancia del rito para la continuidad de vida. Todas las religiones y culturas tienen sus propios rituales, oraciones y creencias relacionadas con el proceso de morir (Roberson, Smith y Daveson 2018).

En muchas culturas, el ritual no se centra en la persona fallecida, sino que tiene como objetivo apoyar a los dolientes frente a su tristeza y ayudarles a aceptar la pérdida (Roberson, Smith y Daveson 2018). Son ritos que realizan los vivos para los vivos, cuya condición ritual está definida por la vinculación con el muerto (Velasco Maillo 2013). Lo que sobrevive después de la muerte es aquello que tiene que ver con el propio ritual (Thomas 1991).

Estos rituales fúnebres que reflejan la visión cosmológica de una determinada cultura están en constante cambio y evolución. La muerte en la cultura premoderna y no-occidental era una ocasión natural, siempre pública, colectiva y altamente ritualizada, mientras que en la sociedad moderna occidental, asistimos a una pérdida o transformación del ritual mortuorio (Vaczi, 2019).

En la modernidad se observa un rechazo a la idea de la muerte (Thomas 1991) y a lo que le rodea, incluyendo los rituales, debido a la racionalidad, la secularización, la medicalización, la individualización, y la pérdida del sentido de comunidad (Vaczi, 2019 y Walter 2005). Cuando alguien muere los deudos intentan volver a la normalidad como si nadie hubiese muerto, como si no hubiese sucedido nada (Ariès 2011). El luto se privatiza (Barley, 2012), la muerte se ve rechazada de la esfera social (Allué 1998) incluso para las personas que encuentran sentido y consuelo en estas prácticas y rituales (Neimeyer 2002).

A pesar de estas tendencias simplificadoras, en algunas aldeas de Galicia, sobreviven ritos de una notable fuerza comunitaria en los que, teniendo como protagonista a la muerte, no existe difunto sino que son protagonizados por vivos y en su realización confrontan la relación entre la vida y la muerte, o el bien y el mal, y afirman de forma ritual y simbólica, la vida como un valor supremo, con el deseo de vencer o superar la muerte (Lisón Tolosana 2008).

Es el miedo a la muerte (Lurker 1998) el que da sentido a estos rituales protagonizados por vivos que han vivido experiencias cercanas al propio fallecimiento o al de sus seres queridos, y que simbolizan el triunfo de la vida sobre la muerte como símbolo de éxito o sabiduría (Mariño 1987).

En estos rituales podemos ver, por un lado, una especie de cortejo fúnebre y por otro, una banda de música tocando melodías compuestas para bailar, destacando así la eterna lucha del dolor

con alegría, y de la fe con la indiferencia (Otero, Cuevillas y Taboada 1980).

Este tipo de manifestaciones no sólo se celebran en España, aunque sólo se encuentran de forma aislada en otros lugares. En Corea del sur, desde 2012, se celebran falsos funerales colectivos en los que personas vivas se introducen en un ataúd con el objetivo de reflexionar y afrontar la vida de otra manera (ABC 2019) y en Portugal, se celebraba hasta 1994 en la Romería da Senhora da Aparecida una procesión de ataúdes con personas vivas dentro (Carvalheiras 2006) con algunos parecidos a la que es objeto de este estudio.

Las romerías gallegas

Las romerías son celebraciones que se realizan en honor de Jesucristo, algún santo o alguna advocación de la virgen María venerada en la zona. En la romería se acude al santuario a pedir favores, dar gracias o pedir perdón por algún pecado (Mariño 1987). Estas advocaciones se materializan en imágenes de devoción que se encuentran en iglesias o capillas y que constituyen un territorio de gracia, un espacio geográfico en el cual extienden su influencia milagrosa (Christian 1978). Se realizan en todo el territorio español, aunque en cada región tienen sus elementos diferenciadores y reflejan así la relación existente entre religiosidad, ritual y territorio.

Las romerías tienen un origen eminentemente religioso, aunque poseen numerosos elementos de carácter profano y festivo que se acaban fundiendo en un todo (Lison Tolosana 2008).

Son varias las romerías gallegas en las que se encuentran símbolos y ritos mortuorios, si bien tienden a desaparecer. Algunos ejemplos son las de A Franqueira en A Cañiza, la del Nazareno en A Pobra do Caramiñal (que aún se celebra), la de los Milagros de Amil en Maraña, la del Santo Cristo de Xende en A Lama, o la que será objeto de este estudio de Santa Marta de Ribarteme en As Neves (González Pérez 1975). Muchas de ellas han sido documentadas gráficamente por la fotógrafa Cristina García Rodero entre los años 1975 y 1998 (García Rodero 2010). También se encuentran referencias a la muerte y a los muertos en la Romería de San Andrés de Teixido donde *vai de morto quen non foi de vivo*[1] y en la que es habitual visitar el cementerio para interpelar el alma de los muertos (Saavedra 2015). «Un exvoto sorprendente que se podía ver antiguamente, usual en las romerías gallegas, es el ataúd que se encuentra colgado de una viga del santuario de San Andrés de Teixido. Los que, por accidente o enfermedad, se vieron a las puertas de la muerte y la esquivaron gracias a la ayuda del santo, le ofrecían el féretro en que iban a ser enterrados« (Saavedra 2015: 146)

1 Dicho popular que afirma que a San Andrés de Teixido va de muerto quien no fue de vivo, en referencia a que, si no se realiza el peregrinaje durante la vida, el alma tendrá que acudir al santuario tras la muerte reencarnado en un animal.

La relación de Galicia con la muerte es especial, «en el norte viven los muertos» afirma Lisón Tolosana (1991: 15). En algunos lugares la tradición aún habla de la Santa Compaña, una procesión de ánimas del purgatorio condenadas a vagar eternamente, en otros se habla de señales que avisan de la muerte o de apariciones de difuntos (Gondar 1989) y en Vila García de Arousa se ha descrito un antiguo ritual funerario llamado la danza del *abellón*[2] (Alonso 2000). Son numerosos los elementos rituales diferenciales en la celebración de entierros y funerales en las aldeas gallegas (Lisón Tolosana 1991 y Gondar 1989).

En las Rías Baixas, región en la que se enmarca este estudio, son varias las huellas culturales del culto popular a la muerte reflejadas en el arte, como los petos de ánimas, pequeños monumentos de piedra labrada situados en cruces de camino, que tenían como función recoger ofrendas para las almas del purgatorio. En ellos se concentran las ideas sobre la muerte y la asociación comunal de los parroquianos y aldeanos ante el tema de las ánimas (Pellón Revuelta 1997).

En definitiva, como dicen los devotos de Santa Marta, los gallegos miran a la muerte de frente (Autor 2013).

La romería de Santa Marta de Ribarteme

En este espacio común que comparten estas fiestas con símbolos y ritos de carácter mortuorio encontramos la Romería de Santa Marta de Ribarteme, en la que durante la procesión desfilan dentro de ataúdes personas que quieren pedir favores o agradecerlos a la «virgen Santa Marta».

Es un ritual de origen católico que se celebra cada 29 de julio, día de Santa Marta, en la parroquia de San José de Ribarteme en el concello de As Neves, en la provincia gallega de Pontevedra.

De origen incierto, la aparición de los ataúdes en la romería no está documentada hasta el siglo XX. (Rodríguez y Araujo 2018). Lis Quiben (1951) cuenta como resulta

> «de intensa emoción el ver acudir por los caminos que confluyen a la iglesia de San José de Ribarteme, a lo que constituye un verdadero cortejo fúnebre, porque si bien se nota la ausencia del sacerdote y la cruz parroquial, esto se ve compensado y sustituido por la presencia de un ataúd destapado, llevado a manos y por la asas, con un niño o persona mayor dentro» (Lis Quiben 1951: 6).

y Cela (1952) describe también en su obra este peregrinaje de ataúdes

> «El vagabundo, entre romeros portugueses, mendigos variopintos y carpazonas de rojo sayal, marcha, corredoira arriba, camino de Santa Marta de Ribarteme, en el campo de Las Nieves, por el monte pontevedrés.
>
> El vagabundo andaba con la salud a vueltas y había prometido un

2 Abejorro.

ataúd a la santa si la santa lo libraba del ataúd. [...]

Como el vagabundo no tiene ni amigos ni parientes ni, por no tener nada, ni un perrito que le ladre, lleva, por entre las madreselvas y los tojos del camino, su ataúd a la cabeza, igual que una cesta de frescas manzanas de esperanza». (Cela 1952: 15).

A raíz de estas escasas descripciones surgen una serie de preguntas: ¿Qué elementos rituales posee la Romería de Santa Marta que son diferenciadores de otras romerías?; ¿Tiene el mismo significado la romería y sus símbolos fúnebres para los nativos que para los forasteros?; ¿Cuál es su evolución con respecto al pasado? Para responderlas se plantea describir y analizar este ritual, desde una perspectiva social y antropológica, atendiendo a sus elementos propios y diferenciales.

Apuntes Metodológicos

Situado en una perspectiva de investigación cualitativa, se ha realizado trabajo de campo de orientación etnográfica con el fin de describir el ritual y entender los significados actuales de la romería. Los principales instrumentos de recogida y análisis de la información han sido la observación participante y la entrevista en profundidad semiestructurada.

Observación participante

Se trata de la técnica más idónea para este objeto de estudio, pues permite un análisis desde la perspectiva de la gente que está implicada (Jankowsky y Wester 1993) y no sólo desde los ojos del mero observador.

Se realizó observación participante no estructurada durante la celebración de la Romería de los años 2013, 2015, 2016, y 2018, documentada gráficamente, con la utilización de diarios de campo, y recogida de observaciones, conversaciones y entrevistas informales.

De una manera más intensiva se realizó el trabajo de campo durante la romería del año 2019, asistiendo a todos los acontecimientos que la fiesta ofrece: novena, preparativos, misas, procesión, subasta, etc, tanto los días previos como los posteriores, produciéndose una integración del investigador en la vida cotidiana de los participantes.

Entrevista en profundidad semiestructurada

Desde el trabajo de campo contactó con multitud de informantes que condujeron hacia una entrevista más en profundidad o semiestructurada. Esta técnica ofrece una visión contextualizada de la experiencia ya que permite enmarcar histórica y socialmente las experiencias personales y comprender así los procesos sociales que pueden subyacer a valoraciones o interpretaciones de carácter subjetivo (Finkel, Parra y Baer 2008)

Se entrevistó a 14 participantes con distintos roles, tal y como se detalla en la tabla 1. El proceso de selección de informantes parte del trabajo etnográfico y de dos instrumentos correspondientes al muestreo teórico, la comparación

constante y la saturación de contenidos (Glaser y Strauss 1967). Los acontecimientos e informaciones recogidas eran contrastadas con otros informantes, que orientaba la búsqueda de nuevas observaciones y entrevistas. Cuando al seguir recogiendo información esta empezaba a reiterarse se consideraba saturada la información necesaria para cubrir los objetivos. Por otra parte, se recurrió a la auditabilidad como medida de rigor y calidad, siendo supervisado tanto en el trabajo de campo como en el análisis por un investigador externo.

Se realizó un análisis categórico de contenido guiado por los objetivos y preguntas de investigación, que fue apoyado por el programa informático Nvivo v12. (Tabla 1)

Descripción Etnográfica de la Romería de Santa Marta Ribarteme: Una Celebración Ritual de la Vida con Símbolos Fúnebres

La preparación de la romería

La novena de santa Marta se desarrolla del día 19 al día 27 de julio en la iglesia de San José de Ribarteme. Participan en la novena en torno a cincuenta personas. A medida que se aproxima la fiesta del 29 de julio el número de devotos que asisten a estos actos se incrementa. En su mayoría se trata de vecinos del pueblo o alrededores, sobre todo mujeres, y también algunos emigrantes que pasan en la comarca las vacaciones de verano.

Algunos visten una especie de hábito, llamado mortaja, y portan una vela. Lo hacen porque tienen alguna promesa, pero desconocen el significado y el origen de esta especie de túnica.

> «No, no sabemos lo que significa, siempre se llevó. [...] Como siempre lo hemos visto pues... Tú al final te pones lo que has visto, entonces te pones el hábito y lo llevas» (E07a)

Si bien el nombre hace referencia a la sabana con la que se envuelve un cadáver, su significado no parece estar asociado a este hecho. Llevar la mortaja es una forma visible de comunicar a la comunidad que se está en penitencia. Significa una especie de confesión pública. Es uno de los signos que se van perdiendo con el paso de los años, en un entorno con mayor poder adquisitivo resulta más cómodo realizar una ofrenda económica, sin tener que exponer en público la condición de ofrecido.

> «Creo que la vela e incluso el hábito está no en retirada, pero sí en cierta decadencia, ya no se ven tantos. Ahora lo que se ofrece mucho es el cirio pequeño porque la gente busca cosas prácticas» (E05).

Algunos lo visten durante la novena, pero la mayoría de los que lo visten lo harán el día de la romería.

El día 28 se realizan los preparativos para la romería y comienzan a aparecer en la aldea los primeros curioso y devotos.

Tras la misa, se realiza la procesión de San Benito. La iglesia permanece abierta durante una buena parte del día. La imagen de Santa Marta ocupa un lugar principal en el lateral derecho de la

Tabla 1. Relación de informantes entrevistados

Entrevista	Rol	Sexo	Relación con el pueblo
E01	Alcalde de As Neves	Varón	Vecino del concello
E02	Devota que sale en la romería dentro de un ataúd	Mujer	Forastera, vecina de Vigo
E03	Miembro de la comisión de fiestas	Varón	Vecino
E04	Devota que ofreció salir en ataúd pero que finalmente no lo hace	Mujer	Forastera, vecina de Vigo
E05	Miembro de la asociación de patronos del santuario	Varón	Emigrante que regresa a la aldea los veranos
E06	Párroco desde 2010 a 2019	Varón	Forastero, vecino de un concello limítrofe
E07a	Devota	Mujer	Vecina, que emigró y regresó al pueblo tras su jubilación
E07b	Devota, hermana de E07a	Mujer	Vecina, que emigró y regresó al pueblo tras su jubilación
E08a	Devota que ha ofrecido un ataúd vacío por la salud de su hijo	Mujer	Forastera que vive en un concello limítrofe
E08b	Hijo de E08a, no creyente	Varón	Forastero, emigró a Argentina y regresó. Vecino de Vigo
E09a	Devota que ha realizado diferentes promesas a lo largo de los años	Mujer	Vecina del concello
E09b	Hija de E09a. Ha realizado diferentes promesas a lo largo de los años	Mujer	Vecina del concello
E10a	Devota que ha salido en procesión en el ataúd en dos ocasiones	Mujer	Vecina
E10b	Devota, amiga E10b, que ha hecho diferentes promesas a lo largo de los años	Mujer	Vecina

iglesia. Los fieles comienzan a pasar delante de ella en un desfile incesante que se mantendrá de forma constante durante dos días. Los devotos tocan la imagen, depositan donativos, colocan flores o ponen exvotos de cera que representan distintas partes del cuerpo humano.

> «Los exvotos aquí, no sé en otras partes de España, pero aquí son muy comunes, no es raro» (E04).

Por la tarde la sacristana, junto con algunos vecinos, trasladan los ataúdes desde una casa cercana llamada la casa de la santa, hasta el templo.

Por la noche hay baile y orquesta hasta altas horas de la mañana. Es la fiesta profana, muy ligada a la romería. Sería difícil de entender la existencia de la una sin la otra, como comenta el alcalde.

> «Y hay que tener también muy claro que esto significa muchas cosas, que es algo poliédrico y que hay esa dimensión de fe, de entrega y tal, pero que también hay esa dimensión lúdica y ese saber convivir entre dos cosas. Todo esto es una construcción social, no es solamente un ritual ni un rito antiguo que se queda solamente en eso, esto evolucionó afortunadamente y seguirá evolucionando. Y creemos que la sabiduría de ese sincretismo está en todas partes y todavía pervive» (E01)

El párroco sin embargo mira con recelo la celebración nocturna que desvincula de la celebración de fe.

> «Y después la fiesta profana es fiesta profana, muchas veces más de ofensa a Dios que otra cosa, porque en todo el año no pisan la Iglesia para nada y no van a la novena por supuesto» (E06).

La romería

El día 29 el pueblo se llena de peregrinos y curiosos desde las siete de la mañana. Algunos llegan andando como antiguamente, pero la mayoría lo hace en coche.

Los ataúdes están expuestos fuera de la iglesia, cada uno de ellos tiene un papel pegado con el nombre de la persona que lo va a ocupar en la procesión. Hay siete ataúdes abiertos y uno cerrado.

La sacristana se ocupa de la reserva de los ataúdes y de que estos *cadaleitos*[3], estén preparados para la procesión. Los peregrinos ya no vienen con ellos desde sus hogares como hacían antaño.

> «Yo recuerdo que cuando venía un ataúd los romeros iban detrás, (...) Entonces te decía cuando se acercaba al Santuario un ataúd pues venían esos romeros detrás y tocábamos a difunto la campana, y era un poco el anuncio de que venía un difunto. Y hoy alquilan el ataúd y se meten dentro cuando se inicia la procesión» (E05).

Hace unos años se pedía la voluntad, ahora hay un precio fijo de cien euros, pero el devoto deberá de realizar más desembolsos económicos. Si no encuentra amigos o familiares que porten el féretro, tendrá que pagar a porteadores.

> «Pues mira, vienen cinco porteadores y cada porteador me cobra 100 euros. 500 euros, más 100 euros del cajón, más otros 100 euros que le di a una chica peluquera porque yo no sabía de ningún porteador y ella sí que conocía a uno. O sea, haz cuentas, 700 euros en total». (E02)

La dimensión económica de la fiesta es importante, propio de un sistema capitalista más desarrollado que lo mercantiliza todo y de un mayor poder adquisitivo. Las donaciones económicas, en dinero o especie, ofrecidas a Santa Marta, son continuas. En muchos casos la ofrenda se reduce a lo económico. Hace unos años se hacía una mayor ostentación de estos donativos, ahora la iglesia intenta que, visualmente, cobren menos protagonismo.

3 Ataúdes.

> «Antes sí, antes le ponían un lazo desde arriba hasta abajo y ahí se le iba colgando el dinero, y había como 3 o 4 parejas de la Guardia Civil alrededor, para que no robaran. Y después hubo un año que estaba ya Don Manuel [párroco desde 1978 hasta 2010], que hizo una hucha que está delante de la Virgen y allí ya se va metiendo el dinero, ya no lo lleva la Virgen y ya no se sabe cuánto da cada uno. Yo un año, aunque me costó mucho ganarlas, metí 250.000 pesetas que fue cuando mi hija quedó con la boca torcida» (E09a)

Los beneficios económicos de la romería son indudables, pero la iglesia, acorde con lo que se espera de ella en los nuevos tiempos, intenta eliminar la imagen mercantilista en una celebración tan mediática, y que los que más tienen la utilicen en su beneficio.

Antiguamente se subastaba quiénes serían las personas que portarían la imagen a la entrada y a la salida del templo. Actualmente no se realiza esa subasta, aunque se sigue observando que son las personas con más poder económico, a menudo nativos que emigraron, los que sacan e introducen la imagen en la iglesia.

> «Yo recuerdo de haber visto un año, una vez que subastaban los banzos, los palos de llevar a la Santa. Y pues una persona decía 'voy a hacer una promesa de meter el brazo izquierdo' y luego iba y estaba ya otro allí y entonces lo subastaban para ver quién lo llevaba. Y vi dos señores allí subastando y el resto de la gente callada escuchando a ver cuánto ofrecía cada uno, dieron hasta 350.000 pesetas o vacas y bueyes. Pero para mí la gente que no pague nada para eso y que sea mejor cristiano. La Iglesia suprimió eso, la subasta, para todos los sitios porque es anti todo, y sólo los ricos son los que podían hacerlo porque el pobre no puede». (E06)

La dimensión económica de la fiesta es un elemento importante, y está latente en comentarios y discusiones entre vecinos.

Tras la misa mayor de las 12:30 comienza la procesión (Figura 1). La comitiva se abre con un pendón de Galicia, seguido de una cruz de plata y de un estandarte de Santa Marta, todos ellos donaciones, posteriormente las imágenes de San José, San Benito, y, finalmente, Santa Marta. Tras ello saldrán los ataúdes, ocupados por los ofrecidos (Figura 2). Detrás, la banda de música, y a continuación los fieles y devotos que lo desean, algunos descalzos, otros, los menos, de rodillas, portando velas y con la llamada mortaja.

La procesión dura aproximadamente una hora, y resulta especialmente curioso el contraste del desfile de ataúdes entre las atracciones de feria. No es extraño captar la imagen de estos ataúdes, ocupados por personas cuyo sufrimiento los ha llevado hasta ahí, desfilando junto a un hinchable de Bob Esponja o junto a unas camas elásticas donde unos niños saltan ajenos a esta procesión de vivos que camina al ritmo de las marchas fúnebres de la banda de música (Figura 3).

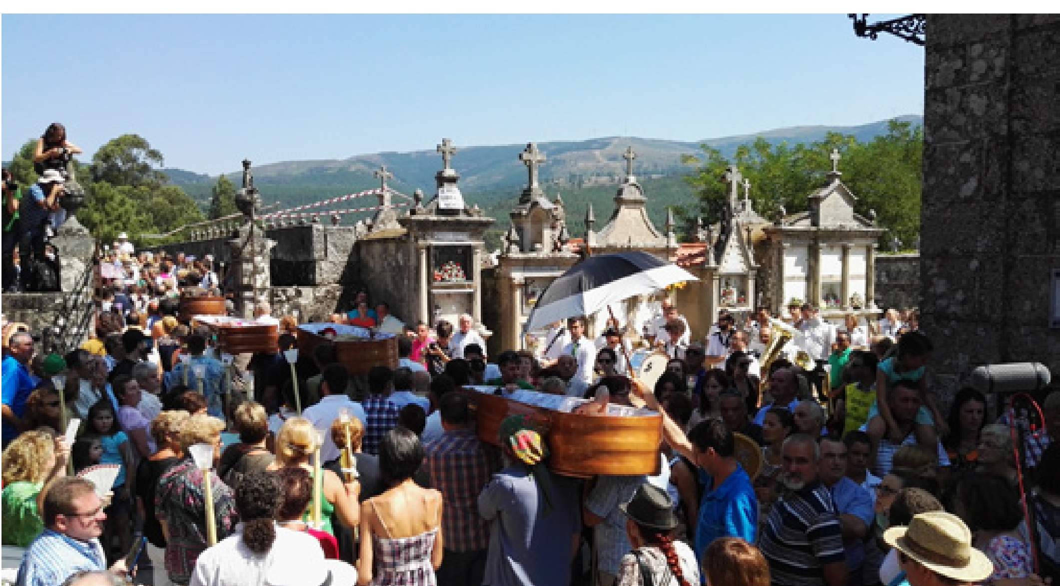

Figura 1 Los féretros salen de la iglesia en procesión

Figura 2 Devoto en un ataúd tras la Imagen de Santa Marta en la Romería de 2013

Significados rituales

Es difícil encontrar a alguien, en el pueblo, que nos diga el significado concreto del ataúd. Según narra el párroco, Santa Marta, en los evangelios es la hermana de Lázaro, y Lázaro para los católicos significa la resurrección, pero esto parece más bien una explicación atribuida a posteriori para darle al símbolo un significado desde la lógica católica.

El hecho de que los ofrecidos ya no vengan desde sus domicilios con

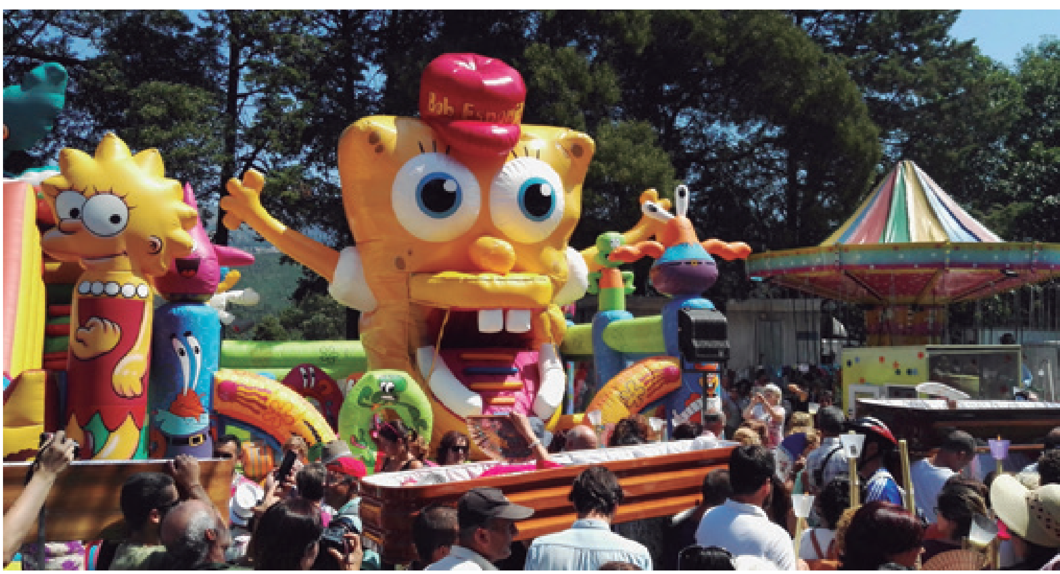

Figura 3 Los féretros pasan delante de la zona destinada al ocio

el ataúd supone un cambio muy significativo. De nuevo encontramos la razón en la comodidad y la practicidad. Con el actual sistema funerario nadie compra su ataúd hasta el momento del entierro, por lo que resulta mucho más cómodo alquilarlo en la parroquia. Esto cambia notablemente el significado, ya que el ataúd deja de ser la ofrenda, la ofrenda ahora es la propia persona que promete procesionar dentro de él. Antiguamente el hecho de cargar con él suponía un sacrificio, ahora el sacrificio es introducirse dentro venciendo el tabú y la aprensión de hacerlo.

> «Antes no iba la gente dentro. Esto de la gente fue desde que estuvo Ermenegildo [párroco desde 1964 hasta 1978], antes la gente lo ofrecía, pero tapado» (E09a).

Normalmente los ofrecidos son personas de origen gallego y de la zona, si bien cada vez viene gente desde más lejos, atraídos por los medios de comunicación que contribuyen a extender la fama milagrosa de Santa Marta.

En la aldea son muchas las personas que a lo largo de los años han salido en el ataúd, incluso en varias ocasiones. Para ellos es algo que forma parte de lo habitual.

> «Bueno pues yo fui dos años en el cajón, las dos veces fue una por mi cuñado y otra por mi suegra». (E10a)

Dentro o fuera del ataúd, andando o de rodillas, descalzos o con la mortaja, se encuentran dos motivos principales por los que estas personas realizan esta ofrenda ritual: a) la devoción a Santa Marta y/o b) la desesperación por la vivencia de experiencias cercanas a la muerte. (Figura 4)

Por un lado, la enorme devoción a Santa Marta y la confianza en sus milagros, a la que le atribuyen un poder que está, incluso por encima de Dios.

> «Para mí fue Santa Marta, todo Santa Marta. (...), para mí Santa Marta

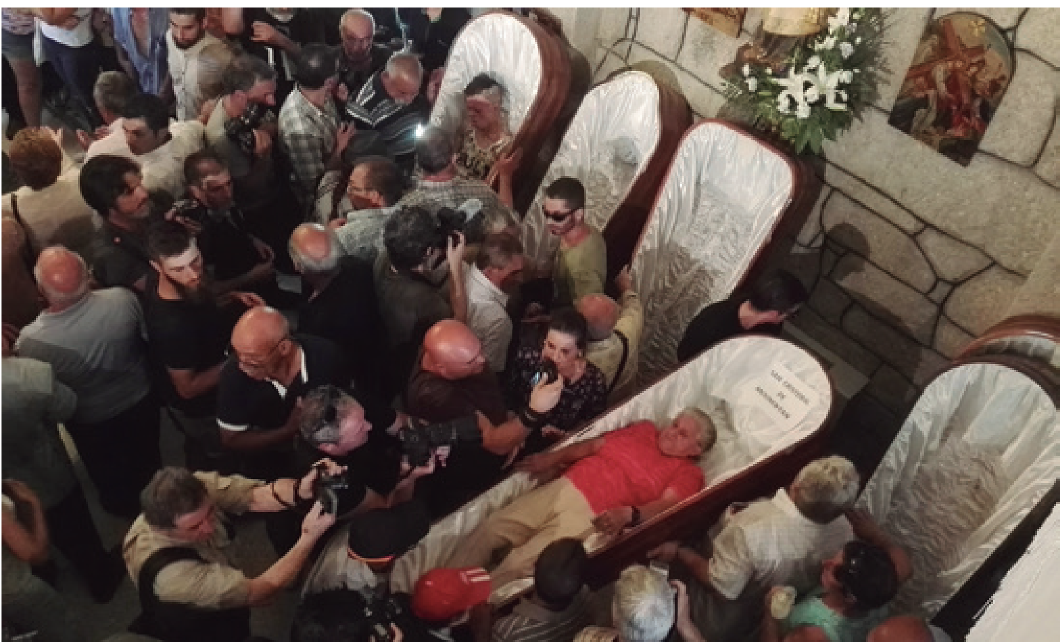

Figura 4 Devota en ataúd dentro de la iglesia al finalizar la procesión

> es todo, yo voy con mi devoción, doy lo que puedo, ayudo en lo que puedo con la Virgen y es para mí Santa Marta. Todos los Santos, pero como Santa Marta... yo no lo sé si es porque he escuchado ya de los antepasados o no lo sé, yo sé que tengo mucha devoción a Santa Marta. Yo para mí Santa Marta es todo, yo hago lo que puedo y si Santa Marta me ayuda voy toda la procesión» (E09a)
>
> «Yo le tengo mucha fe a Santa Marta, y dicen que hay que pedir a Dios, pero yo no le pido nada a Dios» (E10b)

Por otro lado, la desesperación que produce una situación límite. En el caso de los forasteros muchas veces no existe la devoción a la santa, y es la fama de sus milagros es la que produce esta especie de efecto llamada.

> «Se lo pedí de todo corazón y después de pedírselo pensé '¿Cómo me voy a meter yo en un ataúd?' y además yo no le tengo devoción a Santa Marta ni a ningún Santo, porque es curioso ¿no? Pero fue aquello que me vino» (E02).

El símbolo del ataúd, que refleja la singularidad única de este ritual, es para los vecinos sólo un símbolo más de esta fiesta y no el centro de ella. Pero es lo que capta la atención de turistas, curiosos, y periodistas que hacen que el pueblo esté lleno este día. La romería cada tiene más repercusión mediática en medios nacionales y extranjeros[4].

Esta mediatización de la fiesta preocupa a algunos vecinos y a sacerdotes, que temen que pueda convertirse en un

4 En 2001 se hace eco el diario británico The Guardian, que la catalogará en 2008 como la segunda

mero negocio, o en un simple atractivo turístico y morboso, despojándola del profundo significado religioso.

> «No es necesario eso de llevar un cajón, es más por el morbo y se contamina con el dinero que hay de por medio. Yo si fuera Obispo lo prohibía eso. ¿No puedes ir a agradecerle a la Virgen o a Santa Marta sin llevar el cajón? Hombre, eso es un negocio puro y duro». (E08b)

Lo cierto es que durante la procesión se observa muchísima carga emocional. Es habitual ver personas llorando y las expresiones de sufrimiento de los que ofrecen algún sacrificio.

> «Nosotros aquí valoramos mucho esas actitudes. A ver, yo un día le explicaba a alguien que para que una persona se ofrezca a ir en una caja tiene que tener un motivo». (E03)

A pesar de ser un ritual comunitario los significados y motivaciones tienen un marcado carácter individual, no todos le encuentran el mismo sentido.

«Me gusta la romería porque te llama la atención y valoro la gente que se mete dentro ¿eh? Hasta el día de hoy si he hecho algo es porque mi madre me ofreció y me dijo 'si quieres póntelo porque yo lo pedí por ti, si no quieres me pongo yo un hábito'. Lo otro no lo veo normal, que tenga que ir descalza un día de calor para que me ardan los pies. [...]. ¿Algo hay? Sí. ¿Yo sufro para que tú me sanes? ¿Me sacaste el sufrimiento y ahora sufro yo por ti? No lo veo normal». (E09b)

Otra evolución importante de significado es que, si hace años el hecho de introducirse en un ataúd suponía haber estado muy cerca de la muerte, hoy hay quien se ofrece por la salud de una mascota, por enfermedades leves, o por otro tipo de promesas que no tienen que ver con la salud. Es como si el milagro fuese más accesible y se pudiera pedir todo tipo de favores en una especie de intercambio con la imagen milagrosa

> «Porque yo recuerdo a mi suegra que me lo contaba, o sea, es cuando alguien se está muriendo y pides por ella. Pero bueno ahora a nivel general todos piden por lo mínimo, o sea, por ejemplo, mi caso con mi hermana, una operación de mandíbula». (E10a)

> «O sea, me vino a la mente Santa Marta y yo le dije 'Santa Marta, no te pido más, pero por favor concédeme un año de vida para este animal y que no muera, porque no estoy preparada ahora para que se muera'. Se lo pedí de todo corazón y después de pedírselo pensé '¿Cómo me voy a meter yo en un ataúd?'». (E02)

Aunque cada devoto tiene su relación de fe particular, Santa Marta es la santa que venera el pueblo, aunque no sea su patrona, Es la que está presente en forma de estampa o imagen en cada casa, a la que recurren constantemente a lo largo del año y de sus vidas, y no sólo en la romería. La

fiesta más extraña del mundo. En 2013 un reportero de The National Geographic se introdujo en un ataúd y realizó la procesión para la serie Outsiders. Y en 2017 la romería aparece en The New Yok Times.

santa es el nexo común que une a la comunidad cuando hay que apagar un incendio en el templo o pedir por una buena cosecha.

Al finalizar la procesión la multitud se dispersa, la mayoría de los vecinos celebran la fiesta con su familia almorzando en sus casas, los forasteros comerán pulpo y churrasco en los restaurantes provisionales instalados para la fiesta, y a las pocas horas, tras la celebración de una subasta de animales donados para tal fin, la aldea quedará prácticamente vacía hasta el siguiente año.

Reflexiones

En España, tan sólo en Galicia, es posible encontrar alguna romería que use símbolos y ritos de carácter fúnebre, y tan sólo en Santa Marta de Ribarteme se mantiene, desde hace años, la tradición de que algunos ofrecidos procesionen dentro de su ataúd simulando su propio entierro[5].

Si bien es cierto que la relación entre ritual religioso y el territorio debe de ser repensada, ya que el rito se descentraliza cada vez más (García Pilan 2011), esta forma de ritualización en forma de entierro refleja de forma inequívoca la vinculación del pueblo gallego con la antropología de la muerte y sus rituales (Lisón Tolosana 1991). No sería posible encontrar una celebración similar fuera de Galicia.

Con el paso de los años la romería experimenta una globalización, debido a su carácter exótico y mediático. Cada vez acuden más forasteros y curiosos que introducen en el rito cambios en su significado más profundo y en sus formas.

Las formas de realizar este ritual han sufrido cambios con respecto a las escasas descripciones que encontramos del siglo XX (Rodero 2010, Liz Quiben, 1951, y Lison Tolosana, 2016), como el alquiler de ataúdes, la discreción en los donativos, la desaparición paulatina de las mortajas, la disociación entre fiesta ritual y profana, o la motorización del peregrinaje.

El ritual está en cambio permanente y sufre una transformación severa fruto, también, del deseo de revitalización de la fiesta desde algunos colectivos implicado. Esta revitalización de rituales que podrían estar en peligro de extinción, fruto de la lógica de la modernidad, aseguran su eficacia como activadores de identidades (Jimeno Salvatierra, 2002) pero puede poner en peligro su carácter religioso y tradicional más íntimo.

La difusión en medios de comunicación, que son capaces de reconstruir la tradición, puede, por otro lado, despersonalizar el ritual (García Pilan 2011 y Thomsom, 1996). De no cuidarse en sus aspectos esenciales podría quedar reducido a una mera procesión de ataúdes para disfrute de los turistas.

5 Si bien existen otras romerías en las que podemos encontrar que algunas personas también se introducen en el ataúd a modo de ofrenda cómo en la Romería del Cristo de Xende, la presencia de los féretros es algo de tipo irregular en proceso de recuperación y no mantenido en el tiempo.

La fe en Santa Marta y en sus poderes milagrosos, y la desesperación producida por la cercanía de la muerte es lo que motiva a los devotos a procesionar en un ataúd, si bien cada vez se encuentran motivos de menos gravedad para realizar este sacrificio.

El ataúd simboliza en el origen el juego entre la vida y la muerte, aunque existe una banalización del símbolo que puede transformar su significado hacia un simple elemento de intercambio con la santa.

Existen diferencias entre la forma de vivir la fiesta entre los vecinos del pueblo y los foraneos. En su conjunto, es vivida con mayor intensidad por los autóctonos. La devoción a Santa Marta está presente en su discurso y se encuentran imágenes y estampas en locales y domicilios. Para los vecinos la ofrenda de ataúdes es algo normalizado con lo que han convivido desde niños. Los forasteros participan sólo en la misa y en la procesión. Acuden al evento, curiosean, o cumplen su promesa, y regresan a casa sin experimentar la romería con tanta intensidad emocional como los nativos.

Algunos parroquianos y sacerdotes consideran que el uso de los féretros no debería constituir el elemento principal de la romería. Que un acto de fe sea conocido por la “procesión de los ataúdes” es cuestionado por el obispado y algunos curas, que son los que tendrían la posibilidad de modificar de forma sustancial esta procesión. Se cuestiona, en este sentido el tratamiento sensacionalista de algunos medios de comunicación.

Donativos, subastas y ofrendas constituyen una importante fuente de ingresos cuyo destino incierto se comenta en conversaciones informales y puede convertirse en un motivo de discordia entre los distintos agentes implicados: vecinos, asociaciones, iglesia y concello.

En futuros trabajos se deberá profundizar más en el análisis de cada una de las dimensiones de la romería, así como en la evolución de un ritual que cada vez atrae a más curiosos y que cambia de forma constante adaptándose a los nuevos usos y costumbres. Cabe preguntarse si es posible retornar al sentido más religioso de la romería en una sociedad cada vez más secularizada (Walter, 2005)

Vaczi (2019) y Cátedra (1988) afirman que en España existen pocos estudios etnográficos sobre la muerte y los difuntos. Este estudio refleja como los vivos pretenden burlar a la muerte por medio del uso de su simbología ritual y de la fe en las imágenes de devoción (Christian 1978). Estudiar y analizar estos ritos permite conocer más sobre nosotros mismos como sociedad y sobre nuestros deseos individuales y comunitarios de supervivencia y transcendencia.

En resumen, este trabajo contribuye a mantener el patrimonio social y cultural de tradiciones y rituales relevantes que, en sus dimensiones individual y comunitaria, reflejan la relación existente entre la percepción de la vida y la muerte en algunas sociedades rurales, y se cubre, así, la carencia de documentación en la literatura sobre la romería de los ataúdes de Santa Marta de Ribarteme.

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5.3. Carta de la revista

carlos@dosabrazos.com

De:	Etnográfica <revistaetnografica@gmail.com>
Enviado el:	lunes, 7 de junio de 2021 17:35
Para:	'José Carlos Hernández Fernández'
Asunto:	RE: Artículo para Publicación

Caro José Hernández Fernández,

Confirmamos a recepção do artigo "**JUGAR CON LA MUERTE PARA CELEBRAR LA VIDA. UN ESTUDIO ETNOGRAFICO DE LA ROMERÍA DE LOS ATAUDES EN SANTA MARTA DE RIBARTEME, PONTEVEDRA, GALICIA**", bem como dos anexos das imagens e da tabela. Notamos que o artigo deve ser inédito (e não estar em avaliação em nenhum outro periódico), requisito obrigatório conforme a norma editorial publicada em https://journals.openedition.org/etnografica/387.

O artigo será lido pelos membros da comissão editorial da *Etnográfica* e, se julgado adequado ao perfil da revista, será então encaminhado para avaliação por pares em anonimato bilateral, sendo de esperar uma resposta ao longo de seis meses a partir da data de submissão. Contudo, fazemos a ressalva de que temos tido um elevado número de propostas. Voltaremos a contactá-lo para comunicar a decisão.

Com os melhores cumprimentos,

Mónica Rodrigues
[assistente editorial / editorial assistant]
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De: José Carlos Hernández Fernández <jhernandezf@comillas.edu>
Enviada: 4 de junho de 2021 16:04
Para: etnografica@cria.org.pt
Assunto: RE: Artículo para Publicación

Buenas tardes,

El miércoles 2 de junio envié un artículo para valoración.

Les ruego me confirmen su recepción. Había varias figuras y me da miedo que por el peso no haya llegado.

Aprovecho para preguntar si tienen alguna estimación de plazos en la toma de decisiones.

Muchas gracias

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6. CAPÍTULO II: I CAN'T BELIEVE THEY ARE DEAD. DEATH AND MOURNING IN THE ABSENCE OF GOODBYES DURING THE COVID-19 PANDEMIC

6.1. Justificación introductoria

Con la llegada de la pandemia de la COVID-19 a España, y especialmente a Madrid, se produce un aumento espectacular del número de personas fallecidas diariamente, en unas condiciones hasta ahora desconocidas para todos. Las noticias sobre los fallecimientos ocupan titulares en prensa y televisión durante varias semanas, y el temor a la muerte, junto con los miedos propios de la pandemia, se convierte en tema de conversación en los hogares españoles. (Imagen 18)

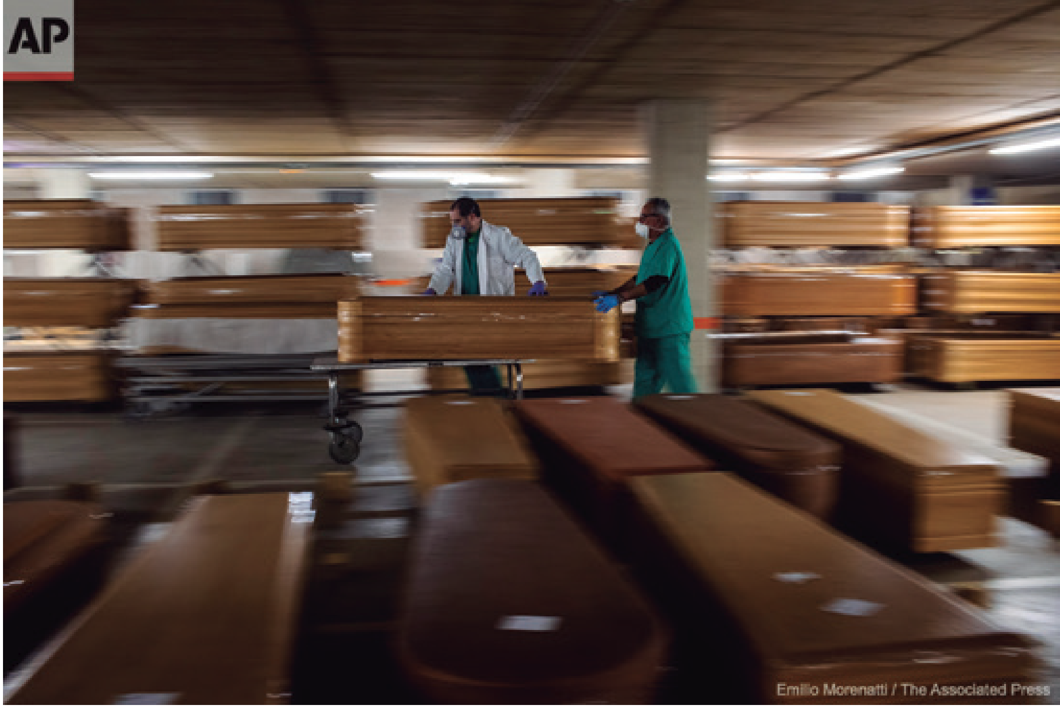

Imagen 18: Personal de una funeraria preparando ataúdes durante la pandemia. Emilio Morenatti

El volumen de fallecimientos, en sí mismo, no tendría por qué suponer un cambio significativo en la elaboración de los duelos individuales y familiares; sin embargo, las circunstancias en las que se producían sí que apuntaban a un importante impacto en la forma de percibir la muerte de un ser querido y el posterior duelo que las familias tendrían que elaborar.

Entre estas circunstancias se daba una muy especial, y es que la gran mayoría de las muertes se producían sin posibilidad para el familiar de despedirse de su ser querido, ni antes de producirse el fallecimiento ni después. En el mejor de los casos los últimos contactos con el moribundo se habían producido a través de un móvil o una tablet, gracias a la voluntad del personal sanitario. Aun así eran contactos breves que carecían del tiempo y del espacio adecuados para realizar un buen acompañamiento o mantener conversaciones trascendentes (Imagen 19).

Era la primera vez en la historia de la democracia en España en la que, por medio de un estado de alarma, se prohibían las visitas en los hospitales y residencias y en la que se vedaba la asistencia a velatorios, entierros y funerales.

Se puede pensar que cualquier fallecimiento repentino, como por ejemplo los producidos por accidentes de tráfico, se producen de esta manera, sin una posibilidad de despedida, y por tanto que el objeto de estudio del siguiente artículo no ofrecía ninguna novedad. Sin embargo, hay importantes diferencias entre esas muertes imprevistas y el tema que nos ocupa; la más importante, o una de las más visibles, es que ante un fallecimiento repentino casi siempre se permite ver el cadáver si este no está muy deteriorado y, en todo caso, siempre que haya cadáver, se permite hacer uno o varios rituales de despedida, especialmente los correspondientes a velatorio, entierro o cremación; y en caso de no haber encontrado el cuerpo de la persona fallecida se pueden hacer funerales o actos de despedida en el que honrar al difunto y recibir, de esta manera, el cariño físico de las personas queridas y de la red de contactos.

Tan solo cuando el cuerpo de la persona no aparece, y por tanto, ni siquiera se puede dar legalmente por fallecida, desaparece todo acto de despedida dando lugar a una sensación de pérdida ambigua (Boss, 1999/2001) que dificulta notablemente la elaboración del duelo (Worden, 2008/2013).

Por primera vez en la historia reciente nos encontrábamos ante esta situación de ausencia de despedidas de familiares fallecidos de los que sí que existía un cadáver, pero que no podía ser visto ni homenajeado por sus seres queridos, lo que producía en los deudos una sensación de incredulidad y de incertidumbre tremenda. (Imagen 20)

Por otro lado, tampoco se puede equiparar la ausencia de acompañamiento en la enfermedad de la COVID-19 a la que se produce ante las muertes repentinas, ya que en este caso el familiar sí que se encontraba enfermo, en una residencia o en un hospital, y aunque el fallecimiento no fuese siempre esperado,

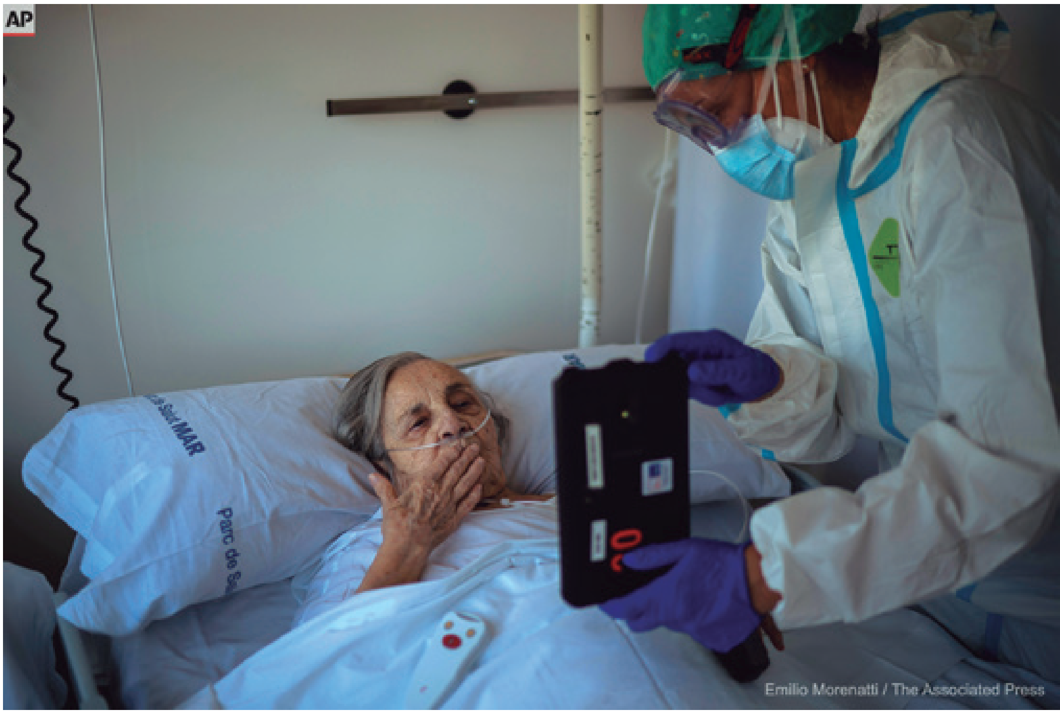

Imagen 19: Una paciente habla con su familiar por medio de una Tablet con ayuda de una sanitaria. Emilio Morenatti

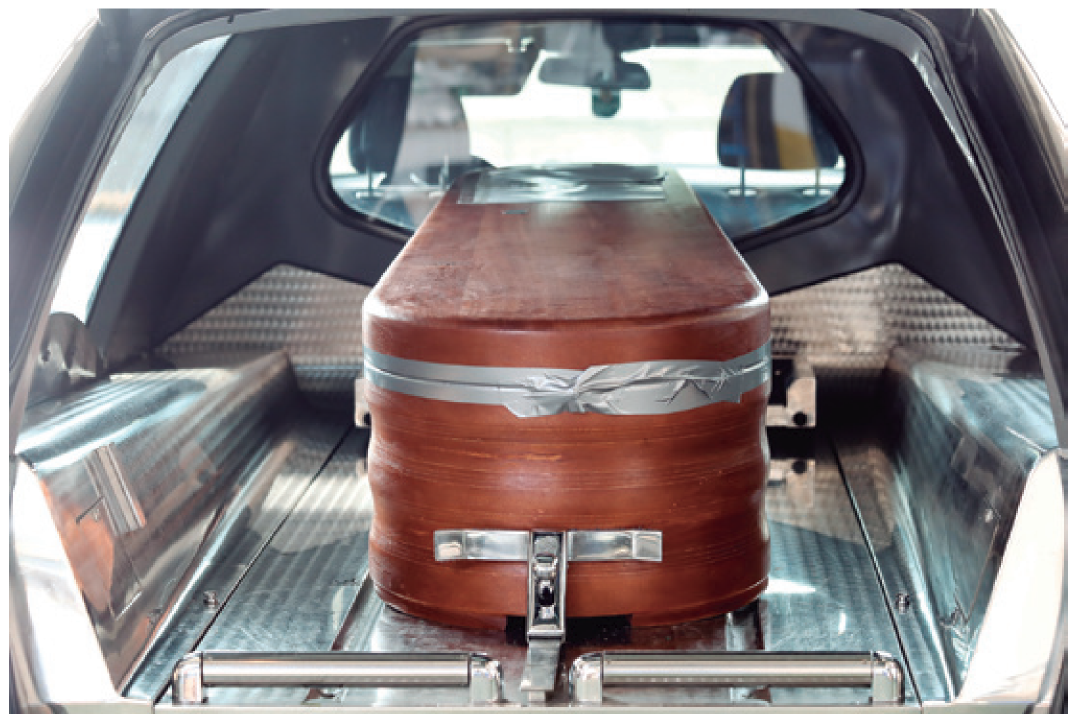

Imagen 20: Un ataúd precintado durante la pandemia en un coche fúnebre sin coronas ni flores Cedida por SFM

podía ser previsible, y fueron el sistema sanitario y el estado los que impedían acceder a visitar y acompañar a la persona enferma, y no la circunstancia de la enfermedad o la muerte como tal.

En este artículo abordo en esas circunstancias tan particulares, cuál ha sido la experiencia de los familiares y de los profesionales, y profundizo en su vivencia para investigar hasta qué punto se puede equiparar el arranque del proceso de duelo al que se produce ante una pérdida ambigua. Las pérdidas ambiguas son definidas por Boss (1999/2001) como aquellas en las que el individuo no está presente físicamente, pero sí psicológicamente porque no se tiene una constancia clara de su muerte.

Por supuesto, la literatura sobre este tema concreto referido a la pandemia no existía hasta 2020, año en que se empiezan a publicar estudios en diversos países, si bien ninguno de los estudios consultados se aborda con el mismo enfoque que el estudio que se expone a continuación. El presente artículo supone por tanto una novedad en la investigación sobre rito funerario y duelo.

Para la elaboración del estudio, y ante la imposibilidad de realizar una observación participante debido, precisamente, a las restricciones impuestas por el estado de alarma, opté por realizar entrevistas en profundidad, no solo a familiares, sino a profesionales que fueron considerados testigos de excepción en esta situación tan anómala.

Opté, con grandes dudas, por incluir a pocos familiares en la muestra, debido a lo delicado del tema, a la tremenda emocionalidad que surgía en las entrevistas y a la dificultad de contactar con las familias en momentos tan complicados para ello. Aplicar criterios éticos en esta investigación tan especial era para mí un imperativo fundamental. Aun así, considero que la saturación de los contenidos está satisfecha.

Por otro lado, y en el aspecto más humano de la investigación, todas las entrevistas tuvieron una cierta función terapéutica para las personas entrevistadas, y a este investigador le supusieron una lección de vida y le hicieron crecer como persona.

Aun así he tratado de evitar el sesgo que el impacto emocional de las investigaciones sobre la muerte produce en el investigador (Visser, 2017) sin olvidar, siguiendo a Publio Terencio Africano, que "soy humano y nada de lo humano me es ajeno" (Africano, 1961).

Espero que artículos como este sirvan para que no se repitan episodios similares en un futuro y desde el sistema público de bienestar social se asegure que, en cualquier situación, todo el mundo pueda despedirse de su ser querido si así lo desea.

6.2. Artículo: Hernández-Fernández, C., & Meneses-Falcón, C. (2021). I can't believe they are dead. Death and mourning in the absence of goodbyes during the COVID-19 pandemic. Health & Social Care in the Community, 00, 1–13. https://doi.org/10.1111/hsc.13530

Resumen

Las circunstancias de los fallecimientos durante la pandemia de la COVID-19 y los duelos asociados se produjeron en circunstancias totalmente excepcionales. Este estudio analiza la experiencia de la pérdida del ser querido sin los rituales culturalmente determinados para la despedida, explora cuáles son los factores diferenciales en el comienzo del proceso de duelo experimentado por los familiares y estudia la existencia de factores de complicación del duelo asociado a este tipo de pérdidas. Se ha realizado una investigación con enfoque cualitativo, fenomenológico e interpretativo mediante entrevistas en profundidad a 48 informantes, básicos y clave, en el entorno de la comunidad de Madrid. Las entrevistas se realizaron entre julio y noviembre de 2020 y se procedió a un análisis cualitativo, interpretativo categórico. Entre los resultados principales destacan:

a) La constatación de que las muertes producidas por la pandemia suponen, debido a sus características, un factor de complicación del duelo.

b) Se evidencia que los profesionales que han acompañado estas muertes con un enfoque holístico, facilitando el proceso a los familiares, han supuesto un factor determinante para facilitar el comienzo del proceso de duelo y disminuir la angustia.

c) Se concluye que existe una necesidad de resignificación del rito funerario.

Finalmente se recomienda la elaboración de protocolos de acompañamiento a familiares ante futuras crisis, así como medidas que permitan acompañar las despedidas de los seres queridos en cualquier circunstancia.

Palabras clave

Duelo, pérdida, muerte, COVID-19, despedida, rito, ritual

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ORIGINAL ARTICLE

WILEY

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

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Abstract

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

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

1 | INTRODUCTION

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

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

Most of these deaths occurred during the period of the state of emergency declared in the country, which limited, among other things, the free movement of people, subjected the population to home confinement and restricted attendance at funeral services.

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

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

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

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

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

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

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

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

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

For Scheinfeld (2021), the benefits of farewell rituals with helping a return to normality have not been realised due to the limitations of the online format that has occurred during the pandemic, which, while useful, cannot replace the close support and physical contact that is so necessary at the beginning of the grieving process. Throughout the pandemic, the mourning process for families has been hindered by an absence of traditional rituals where there can be direct, physical contact with the decedent's loved ones (Burrell & Selman, 2020).

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

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

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

What is known about this topic:

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

What this paper adds:

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

2 | METHODOLOGY

2.1 | Design

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

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

2.2 | Recruitment and sampling

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

2.3 | Ethical considerations

Considering the sensitivity of topics involved in this research, compliance with the appropriate ethical requirements was maintained, under the supervision of the University Ethics Committee, who issued a report of approval. All participants were informed of the objectives of the research study, the sources of financing and the planned use of the results. Informed consent was solicited, and informants were notified that their participation was voluntary. Permission for audio recording was also requested. Anonymity was guaranteed through a confidentiality agreement.

2.4 | Data analysis

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

3 | FINDINGS

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

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

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

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

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

TABLE 1 Data sheet of the subjects interviewed and categories

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

(Continues)

TABLE 1 (Continued)

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

(Continues)

TABLE 1 (Continued)

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

TABLE 2 Categories

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

In some cases, this last goodbye occurred in the hospital emergency room prior to admission (VF1), in other cases it took place at home when the ambulance took the patient away (VF2). In senior residences, the ban on visits was implemented suddenly, which in many cases meant people never saw their loved ones again (VP1).

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

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

(Continues)

TABLE 3 (Continued)

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

(Continues)

TABLE 3 (Continued)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 | DISCUSSION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 | LIMITATIONS

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

6 | IMPLICATIONS

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

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

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

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

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

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

7 | CONCLUSION

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

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

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

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

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

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CONFLICT OF INTERESTS

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

AUTHORS' CONTRIBUTIONS

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

DATA AVAILABILITY STATEMENT

Data available on request due to privacy and ethical restrictions.

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7. CAPÍTULO III: "IT IS THE WORST THING THAT HAS HAPPENED TO ME": HEALTHCARE AND SOCIAL SERVICES PROFESSIONALS CONFRONTING DEATH DURING THE COVID-19 CRISIS

7.1. Justificación introductoria

El segundo de los artículos que forma parte de la investigación sobre muerte y COVID-19 (y tercero en esta tesis) se centra en los profesionales que tuvieron algún tipo de relación directa con las muertes, y estudia su forma de afrontarlas.

Por un lado, el personal sociosanitario de hospitales, residencias de ancianos, emergencias o atención psicosocial, y por otro lado, el personal cuya función estuvo relacionada con el manejo de cadáveres y/o los rituales posteriores; es decir, profesionales de funerarias, bomberos, y capellanes de cementerios y morgues. En esta última categoría se podría haber incluido también a los militares, pero el acceso a ellos se hacía excesivamente burocrático y consideré que, al ser su función durante la primera ola de la pandemia, similar a la de los bomberos, su inclusión en la muestra no sería significativa.

Todos estos profesionales sufrieron una presión asistencial totalmente desproporcionada y nunca experimentada en nuestro país. Las situaciones recientes más comparables, en España, habían sido catástrofes como la de los atentados terroristas del 11M, en los que fallecieron 191 personas, o el accidente aéreo de un avión de Spanair en el aeropuerto de Barajas. Sin embargo, la presión y saturación generada por estas dos catástrofes no duró más de 48 horas, mientras que la primera ola de la COVID-19 en España, y especialmente en Madrid, se extendió durante más de seis semanas. (Imagen 21)

Aunque en los medios de comunicación las noticias no mostraban imágenes de moribundos, ni de personas fallecidas, los datos hablaban de cientos de muertos diarios y había testimonios que hablaban de cadáveres hacinados en hospitales y residencias por falta de espacio y capacidad de respuesta.(Imagen 22). Era habitual ver a profesionales sociosanitarios llorando de impotencia ante las cámaras de las televisiones.

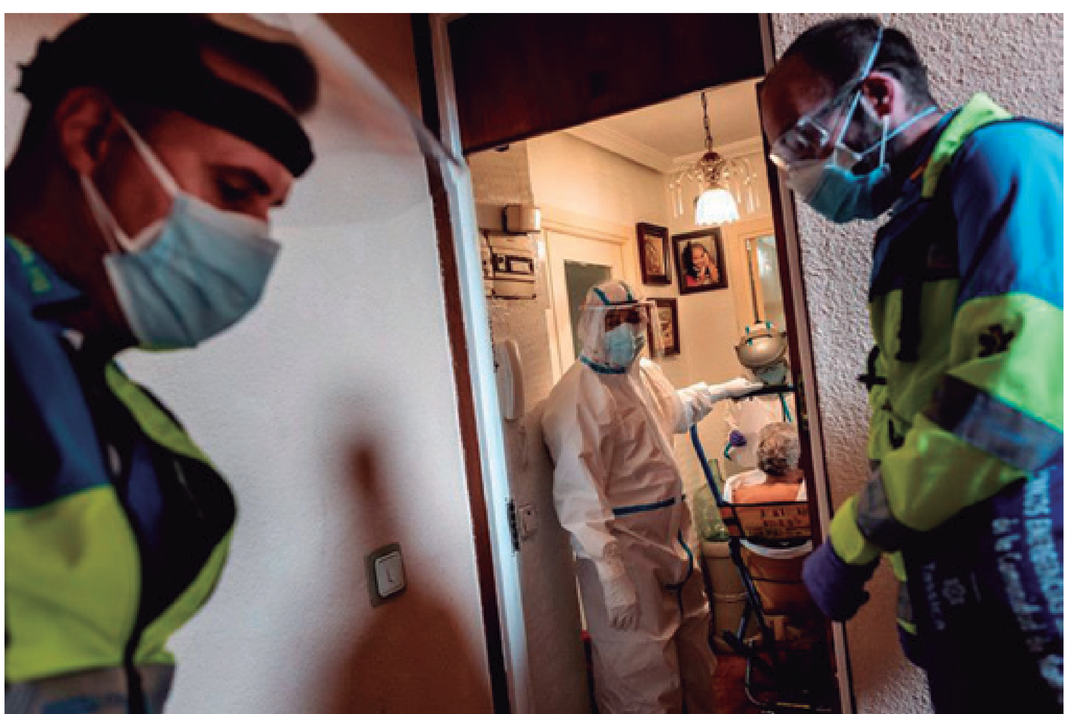

Imagen 21: Personal sanitario interviene en un domicilio durante la pandemia. Rafa Cucharero

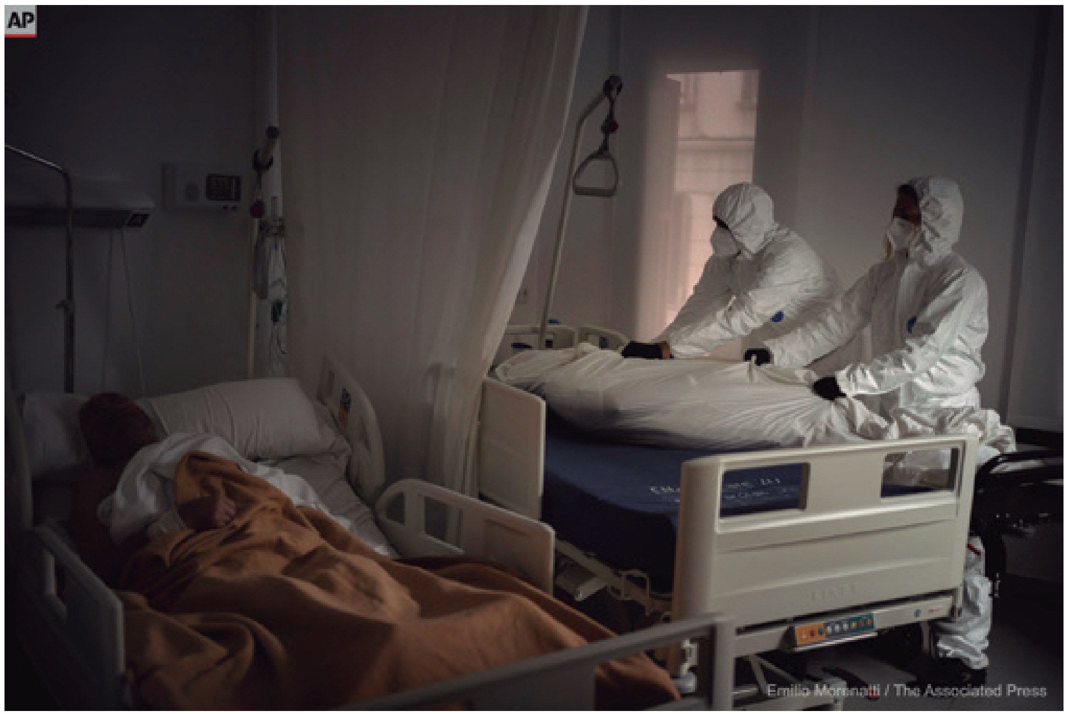

Imagen 22: Personal sanitario cubre un cadáver al lado de un enfermo por COVID-19. Emilio Morenatti

Se hacía, pues, necesario investigar cómo estaban afrontando y soportando los profesionales esa carga física y emocional, y qué les estaba suponiendo tratar con el fenómeno de la muerte de una forma tan desproporcionada y a diario. (Imagen 23)

El artículo resultante pretende estudiar cómo se relacionan con la muerte estos profesionales, y cómo esta relación y sus estrategias de afrontamiento les ayudaron o no para afrontar el volumen de muertes ante el que se encontraban a diario, así como los posibles efectos psicológicos resultantes, como la denominada ansiedad ante la muerte (Tomer et al., 1996) o el trastorno de estrés postraumático.

Era interesante también comprobar si el hecho de trabajar en servicios en los que se acostumbra a ver morir, como por ejemplo en urgencias o unidades de paliativos, podía ayudar a afrontar, de una forma más sana, lo que estaba sucediendo en la pandemia y proteger al profesional emocionalmente.

Por otro lado, era importante, también, ver las diferencias entre la forma de afrontar la exposición al número desorbitado de fallecimientos de los profesionales que acompañan a las personas hasta la muerte (personal sociosanitario) y

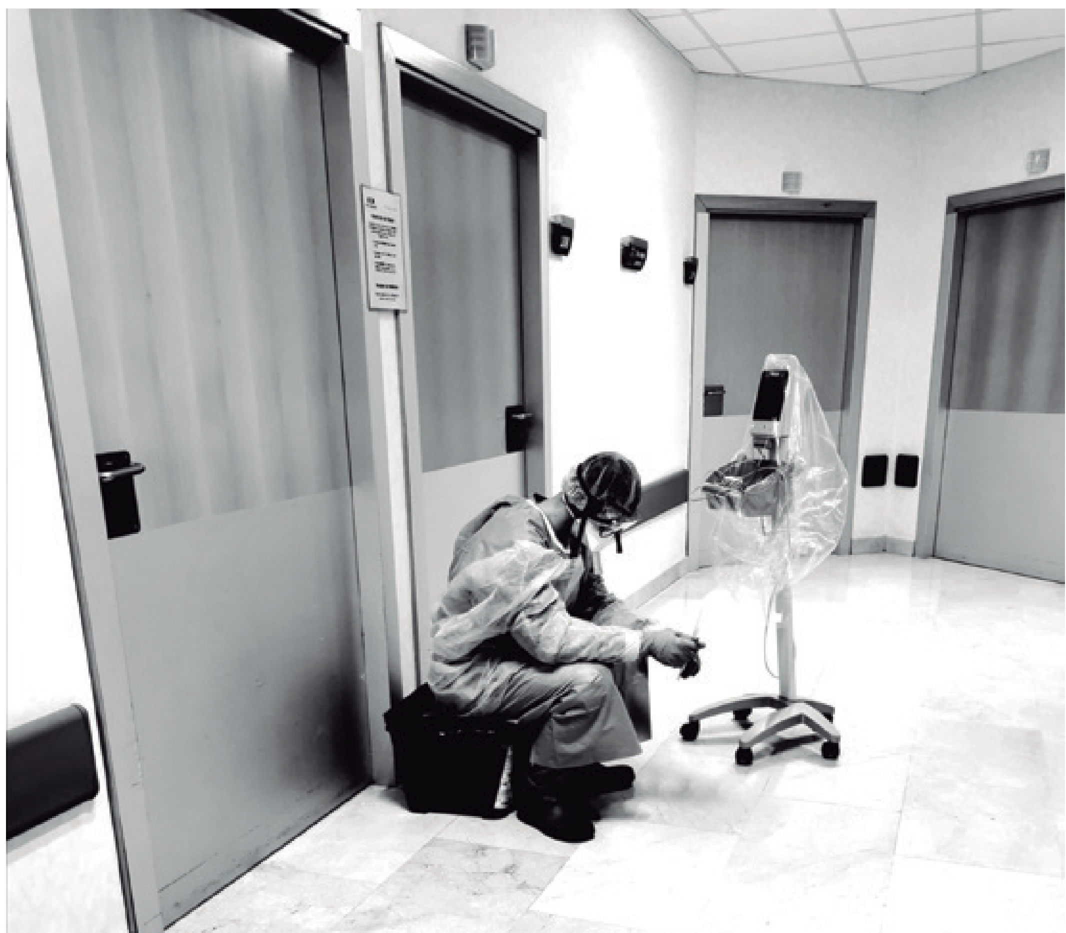

Imagen 23: Profesional sanitario abatido en un hospital. Yoyo Jiménez

del personal que trabaja solo con el cuerpo de la persona ya fallecida (personal de funerarias, bomberos y capellanes). Se pretendía comprobar si los estilos de afrontamiento y la forma de vivir emocionalmente la experiencia difería entre unos y otros.

Las entrevistas con los profesionales se abordaron en la misma etapa que las entrevistas con los familiares, puesto que además todas se usaron para la totalidad del estudio y la redacción de los tres artículos resultantes. En algunos casos pude acceder a dichos profesionales a través de una institución que me abrió las puertas -un hospital, una residencia o una funeraria- y en otros casos accedí de forma directa por medio de contactos personales.

Mentiría si dijese que estas entrevistas fueron menos duras o difíciles que las realizadas a familiares y dolientes. Muchas de ellas tuvieron una importante carga emocional, tanto para el entrevistado como para el investigador, y es de agradecer la generosidad con la que muchos profesionales revivieron para este estudio, entre lágrimas que recogió la grabadora, los momentos vividos durante los peores meses de la pandemia. La comunicación no verbal hablaba en muchos casos de la angustia que, en el momento de las entrevistas, aún estaban viviendo los profesionales, especialmente el personal sociosanitario. Aun así, ninguna de las personas con las que contacté se negó a participar en el estudio

Uno de los aspectos que me interesaba estudiar era la repercusión que esta exposición desorbitada a la muerte podría tener para su salud mental, y aunque la investigación se abre a estudios de corte longitudinal que deberán medir los efectos de dicha exposición, y la aparición de trastornos como el de estrés post traumático, o la ansiedad, el artículo adelanta ya algunas conclusiones que nos deben hacer pensar en cómo la sociedad española debería cuidar a los que nos cuidan ante futuras catástrofes.

7.2. Artículo: Hernández-Fernández, C & Meneses-Falcón, C “It is the worst thing that has happened to me”: Healthcare and social services professionals confronting death during the COVID-19 crisis

Resumen

Objetivos:
Este estudio analiza el impacto emocional que las muertes por COVID-19 han causado en los profesionales sociosanitarios y de funerarias, observa las diferentes implicaciones entre uno y otro tipo de profesionales y analiza si los profesionales más acostumbrados a los fallecimientos de sus pacientes han desarrollado mejores estrategias de protección.

Métodos:
Se ha realizado una investigación con enfoque cualitativo, fenomenológico e interpretativo mediante entrevistas en profundidad a 48 informantes, básicos y clave, tanto profesionales de la salud como de residencias de ancianos y de funerarias, así como familiares de fallecidos en el entorno de la comunidad de Madrid. Las entrevistas se realizaron entre julio y noviembre de 2020 y se procedió a un análisis cualitativo, interpretativo categórico.

Resultados:
Los profesionales sanitarios se vieron sobrexpuestos a una gran cantidad de muertes producidas en unas circunstancias dramáticas. Muchos profesionales tienen dificultades para procesarlo y manifestaron necesidad de ayuda psicológica. El hecho de trabajar previamente en servicios o residencias con alto índice de mortalidad no supuso un factor de protección. Existen algunas diferencias de afrontamiento entre profesionales sociosanitarios y profesionales dedicados al tratamiento y recogida de cadáveres.

Conclusión:
La sobreexposición a las muertes en las circunstancias en las que se produjeron durante el estado de alarma causó en los profesionales un alto impacto emocional que puede derivar en problemas de salud mental a medio plazo.

Palabras clave

Muerte, COVID-19, Profesionales sociosanitarios, Burnout, Ansiedad ante la muerte

Títle

"It is the worst thing that has happened to me": Healthcare and social services professionals confronting death during the COVID-19 crisis

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Carmen-Meneses-Falcón: Methodology, supervision, validation.

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This research project was approved by the Ethical Committee of the Comillas University de Madrid on 15th June 2020.

ABSTRACT

Objectives: This study analyzes the emotional impact COVID-19 deaths have had on healthcare, social services, and funeral services professionals, observes the different implications, and analyzes whether professionals who are more accustomed to patient deaths have developed better protection strategies.

Methods: This work is based on a qualitative, phenomenological, and interpretative approach through in-depth interviews of 49 informants, including professionals, as well as family members of those who died from COVID-19 in Madrid. The interviews were processed through a qualitative, interpretative, categorical analysis.

Results: Healthcare professionals were overexposed to a significant number of deaths under dramatic circumstances. Many professionals had difficulties processing their experiences and expressed the need for psychological help. The fact that certain professionals previously worked with exposure to high mortality rates was not a protective factor. Some coping differences were seen between health care professionals and professionals dedicated to the treatment of the deceased.

Conclusion: The overexposure to death with the circumstances that existed during the state of emergency had a significant emotional impact on the professionals that can lead to mental health problems in the near term.

KEY WORDS

Death, COVID-19, Social Services and Healthcare Professionals, Burnout, Death anxiety

INTRODUCTION

Worldwide over 2,500,000 people died from COVID-19 between the end of 2019 and March 2020.[1] The number of infected and deaths was especially high in Italy and Spain.

In Spain 152,230 deaths from illnesses occurred between the months of March and May 2020, of which 45,684 were caused by the COVID-19 virus,[2] a 44.8% increase in deaths compared to 2019.

Hospitals were overflowing and had to convert operating rooms into ICUs and common spaces, like gyms and waiting rooms, into treatment areas.

Protocols were activated for hospitals and senior residences prohibiting visitors and preventing family members from accompanying their loved ones. Healthcare and social services workers were the only companions and witnesses to the deaths of their patients.

The systems for managing the deceased broke down and funeral homes were overflowing.[3] Improvised morgues were created, and military and fire service personnel were mobilized to transport bodies.

Front-line professionals had to respond in extraordinary circumstances, never previously experienced, and lived intimately with an inordinate number of deaths. These professionals, and not re-

latives, were the last ones to see patients alive[4] so they also had to provide emotional support[5] and accompany patients through death to the extent possible.

Some healthcare and social services workers who were not used to witnessing deaths, either because of their specialty or usual patient type, were newly exposed to death and dying in a dramatic way.

The death anxiety described by Tomer et al.[6] and that is frequent, for example, in palliative care professionals accustomed to witnessing the death of patients, now appears in many other health care professionals, generating burnout, stress and emotional fatigue (Melo & Oliver, 2011).[7] It is also possible to find medium and long term effects such as those described in reviews on the intervention of professionals in humanitarian catastrophes.[8,9]

As COVID-19 is an infectious disease, with which the professionals must co-exist, they also experienced a far greater fear of death, both their own and that of their family members,[10] as well as stress caused by fear of the deterioration and death of their patients.[11]

This study aims to a) analyze the emotional impact that COVID-19 deaths have had on healthcare, social services and funeral services professionals, b) observe the different implications for one type of professional versus another, and c) analyze whether professionals who regularly work in places with higher incidences of death have developed better protection strategies.

METHODS

Design

This work is based on a qualitative, phenomenological, and interpretative approach through in-depth interviews. The experience of the participants who had to face, in one way or another, situations of death during the state of emergency is explored in depth, collecting their feelings, perceptions, and thoughts, and observing how they gave meaning to what they experienced. The interview offers a contextualized view of the experience, allowing one to historically and socially frame personal experiences and thus understand the social processes that may underlie subjective evaluations or interpretations.[12]

Recruitment and sampling

The study was carried out in Madrid, a city with one of the highest demands for emergency services and healthcare provision between March and May 2020. To ensure a diversity of perspectives was acquired, 49 informants of different types were interviewed incorporating: a) nine hospital employees including doctors, nurses, social workers, psychologists and chaplains; b) eleven senior residence employees including management, psychologists, social workers, chaplains and orderlies; c) two emergency services professionals, one a doctor and the other a nurse; d) sixteen funeral services professionals across all functions including management, office administration, sales, customer service, transport, chaplains, crematorium technicians,

and undertakers; e) two firefighters; f) six relatives of the deceased; g) two emergency social worker and h) one resident of a senior residence. (Table 1) All participants were contacted by telephone, the project was explained, and their collaboration was requested. The interviews were carried out progressively, following the theoretical sampling model of Glaser and Strauss,[13] utilizing the constant comparison between each type of informant, and seeking distinctive aspects in newly selected informants, or to augment central analysis categories that required greater depth; finally, the research questions and objectives guided the inquiry process and the search for new observations and interviewees. When information received was repeated over and over, the information required to fulfill the objectives was considered to have reached a saturation point. Interviews were conducted between July and November 2020. One of them was conducted in writing and seven by videoconference due to pandemic restrictions. The rest were conducted in person, and all were recorded. The interviews were approached as a conversation, following Kvale,[14] around three dimensions: a) the impact of being overexposed to death, b) their experience with the deaths compared to previous stages of their lives, and c) how they assimilated and processed the experience.

Ethical considerations

Considering the sensitivity of topics involved in this research, compliance with the appropriate ethical requirements was maintained, under the supervision of the university Ethics Committee, who issued a report of approval. All participants were informed of the objectives of the research study, the sources of financing and the planned use of the results. Informed consent was solicited, and informants were notified that their participation was voluntary. Permission for audio recording was also requested. Anonymity was guaranteed through a confidentiality agreement.

Data Analysis

After the verbatim transcription of all the interviews, the analysis began with the support of the Nvivo 12 plus program, which facilitated categorization and codification. The participants' discourses were examined via a categorical analysis that considered both content and discourse analysis. First, the language used was explored, taking into account the words and phrases spoken and the sentiment associated with them. Secondly, the analysis focused on the meanings associated with the death of patients and the emotions that such deaths provoked for professionals. The development of the analytical categories and the codification of the interviews were central to this stage. The last step of analysis was the interpretation and association of meanings with the circumstances and contexts in which they took place.

Extracts from the interviews illustrating the results are shown in table 2.

The main strategies of rigor and quality criteria associated with quali-

Table 1. Data sheet of the subjects interviewed,indicating profession and institution. Madrid. Spain 2021

Interview with professionals	Role	Institution
IP01	Medical Director	Private Hospital
IP02	Psychologist	Private Hospital
IP03	Priest	Improvised Morgue
IP04	Director and Owner	Senior Residence
IP05	Orderly	Senior Residence
IP06	Social Worker	Senior Residence
IP07	Psychologist	Senior Residence
IP08	Patient Experience Department Representative	Private Hospital
IP09	Nurse	Public Palliative Care Hospital
IP10	Chaplain	Cemetery
IP11	Communication Director	Chain of Senior Residences
IP12	Social Worker and Sales Manager	Chain of Senior Residences
IP13	Orderly Coordinator	Senior Residence
IP14	Orderly	Senior Residence
IP15	Chaplain	Palliative Care Hospital and Funeral Home
IP16	General Secretary and Secretary of the Board of Directors	Funeral Home
IP17	Quality Assurance Manager	Funeral Home
IP18	Chaplain	Religious Senior Residence
IP19	Sales	Funeral Home
IP20	Sales Director	Funeral Home
IP21	Hearse Driver and Mortician	Funeral Home
IP22	Head of Coordination and Control	Funeral Home
IP23	Customer Service Representative	Funeral Home
IP24	Public Relations Representative	Funeral Home
IP25	Human Resources Manager	Funeral Home
IP26	Communications Manager	Funeral Home
IP27	Assistant to the Business Director	Funeral Home
IP28	Firefighter	Fire Department of Madrid
IP29	Firefighter	Fire Department of Madrid
IP30	Doctor	Public Emergency Service
IP31	Nurse	Public Emergency Service
IP32	Director of Residence	Religious Senior Residence
IP33	Orderly	Religious Senior Residence
IP34	Public Relations Representative and Crematorium Technician	Funeral Home
IP35	Nurse	Public Hospital
IP36	Volunteer Social Worker	Official College of Social Work of Madrid: Emergency Team

IP37	Volunteer Social Worker	Official College of Social Work of Madrid: Emergency Team
IP38	Undertaker	Funeral Home
IP39	Public Relations Representative	Funeral Home
IP40	Doctor	Public Hospital
IP41	Doctor	Public Hospital
IP42	Social worker	Public Hospital
Interviews with relatives		
IF01	Granddaughter of deceased	
IF02	Daughter of deceased	
F03	Daughter of deceased	
IF04	Resident in a Senior Residence	
IF05	Daughter of deceased	
IF06	Wife of deceased	
IF07	Daughter of deceased	

tative research were applied. Reflexibility was used in the data collection process, as well as content saturation and key categories; to prevent biases in the first author's interpretations, the second author reviewed the results and analysis for dependability and confirmability.

FINDINGS

Between March and May of 2020, during the state of emergency decreed by Spain, healthcare professionals in Madrid confronted demands for their services and an accumulation of deaths at levels never previously experienced.

1. "I have worked in this profession for 25 years and the truth is I have never experienced anything similar."

During the interviews, the professional caregivers (healthcare professionals, psychologists, social workers, etc.) in recounting their experiences during this stage of the pandemic and in relation to deaths, expressed a notable degree of distress and showed significant emotional exhaustion both verbally and nonverbally (VP1).

The professionals whose work involved direct contact with bodies of the deceased (funeral services professionals and fire-fighters), but who did not have direct contact with living patients or their relatives, referred more often to the volume of work and the extraordinary nature of the situation, but showed a greater emotional distance from the deceased and less psychological exhaustion (VP2).

The funeral services personnel that directly served family members of the deceased, did express a greater psychological toll, at levels similar to caregiving professionals, as compared to other funeral services colleagues (drivers, technicians, and undertakers), who had no direct family interaction (VP3).

The workers that had had contact with patients or their families, could not suppress their emotions during the interviews, and said they had cried daily during the months of confinement (VP4). They often stated that this is the worst experience of their professional lives (VP5) and some compared the situation to what transpires in disasters, wars and third world countries (VP6).

2. "Patients must be touched when they are dying, you must be with them."

Despite the high number of deaths that occur in a typical nursing home or hospital, many healthcare and social services professionals indicated that they have never become accustomed to the phenomenon of death and were particularly impacted by the unique circumstances created by the pandemic, where patients died alone and without adequate care due to a lack of resources (VP7 and VP8). They recounted the dramatic way in which some of the deaths occurred, and the anxiety they still feel when reliving them (VP9).

The act of personalizing each patient and providing more humanizing care influenced professionals' emotional experience, causing greater psychological harm. Some professionals guarded against connecting personally with patients to protect themselves (VP10), as actions such as learning a patient's name or having to write it on the shroud after death could deliver an emotional shock (VP11).

While some professionals protected themselves by not personalizing patients and despite the tremendous workloads they had to manage, in some cases the professional-patient relationship became more intense than in periods prior to the pandemic, especially with the absence of family members. In these cases, the deaths could be even more painful for the professionals (VP12). This effect was magnified for senior home personnel given their close relationships with the residents, who could come to consider the professionals part of their family (VP13).

The professionals that historically worked with the deceased, but not with living patients or families, generally seemed more accustomed to the phenomenon of death, although they also recognized that the circumstances of the pandemic were anomalous, and they had more intense experiences in their work than before the pandemic (VP14).

For these professionals the difference from the pre-pandemic era resided not only in the volume of work, but also in the fact that they were managing a situation in which they themselves could become victims (VP15). Above all, the impact of the situation was especially notable in their concern for what might happen to their families (VP16), rather than the significant number of corpses seen in residences and hospitals, described as "Dantean" scenes (VP17). In verbalizing their thoughts, they used comparisons that allowed them to narrate the situation with an outsider perspective, even with a touch of levity (VP18).

3. "But nothing is more certain, nor more denied than death."

During the most intense months, healthcare and social services professionals were afraid of the virus and of death, and they were especially afraid for their families (VP19).

In many cases this fear, and the overexposure to dying forced them to reconsider their relationship with death and think about it in different ways. Some thought about the need to prepare for their own death (VP20), to address related issues with their family members (VP21), or to enjoy life more (VP22).

Several professionals commented that, after this experience, society as a whole and professionals themselves have become more conscious about the reality of death and have begun to see it as something that exists closer to home (VP23). They also highlighted how there is an increasing need to have more proactive conversations around related issues in senior residences and hospitals (VP24).

However, other workers, both in healthcare and funeral homes, signaled that they prefer not to think about death. For them this is a means of personally coping (VP25), avoiding having to confront the possibility of family members' deaths in the future (VP26), or as a method of self-protection to avoid suffering when their patients die (VP27).

4. "So, you attended to one and the other could die."

One of the major sources of stress, helplessness and frustration was the need to constantly choose who to prioritize for treatment (VP28) or which patients should be admitted to the ICU and which should not. These decisions made healthcare workers feel that they were letting people die who could have survived (VP29), which provoked serious concerns around ethics and crises of conscience (VP30). This frustration was especially intense in senior residences, where the professionals saw how residents were denied treatment (VP31), frustration that was compounded by a sense of being accused by the public of being personally responsible for residents' deaths (VP32).

5. "No, this will never be fully processed. It will stay with you forever."

When healthcare and social services professionals were asked about their current state of mind, many commented on their difficulty with processing what they had experienced (VP33), they described symptoms associated with possible post-traumatic stress (VP34), and they highlighted the need for psychological help to overcome the trauma that the situation is causing them (VP35). They emphasized that during the most difficult months of the pandemic, mutual support among colleagues had been fundamental to coping with the situation. (VP36). In the case of firefighters and funeral services professionals, conversations among peers were described as useful but they did not express a need for psychological support (VP37).

6. "The doctor began to cry, his tears were falling."

It is worth mentioning that relatives of the deceased commented that

even in the most dramatic moments, the social and health care professionals acted with sensitivity and humanity despite the demands for their services and the exceptional nature of the situation. (VF01). These family members were witnesses to the tears and helplessness of many healthcare providers and to their emotional state (VF02), and it is something that was valued positively. They acknowledged that at certain times it was difficult to understand the professionals' reactions, or the lack of information being provided, but afterwards family members exhibited empathy and gratitude for the professionals (VF03). (Table 2)

Table 2. Verbatin of the interviews illustrating the results obtained, classified into responses from professionals and responses from family members. Madrid. Spain 2021

	VERBATIM TRANSCRIPTIONS
	Professionals
VP1	*It was a brutal emotional load. And physically I don't know, there were many times I didn't know where we found the strength to continue on.* (IP06)
VP2	*There is always a case that hits you a little harder. Well, at least that is what I say. Then you shed two tears, you immediately start thinking about something else and it's over.* (IP34)
VP3	*Yes, it psychologically scars, scars, (...), and it especially scars psychologically because it is a family's pain that they are passing on to you and you empathize with them, even if from a distance.* (IP23)
VP4	*Look, the truth is that I used to leave shifts crying every day, in the car, I would get in the car, until I got to the car I was cheering people up, but when I got in the car I would start crying like a baby until I got home.* (IP30)
VP5	*For me this has been the worst thing I have ever experienced in my job. It has been terrible. When we had the first positive case and they started to raise the alarm, that was terrifying.* (IP06)
VP6	*We are not accustomed to this in Madrid, or at least I am not, to people dying without you being able to offer them everything you have. I have gone to other places in summer, I have been working in other places as a doctor, places where diabetics die because they don't have a fridge, and when you are there, you accept it for what it is, but you never think that it could happen in Spain.* (IP40)
VP7	*Look, what I have processed a lot is the agony of dying alone. The agony of not being able to say goodbye in the final moments you are alive...* (IP11)
VP8	*So, it was a feeling of seeing patients dying and not being able to help them, and well, it has been and was horrible, horrible, horrible.* (IP41)
VP9	*One especially odd thing that happened to me was when we were very calm, I went into a room one night and stumbled upon a cadaver on the ground, and this room was already occupied by another person and so, I entered into this room and I got angry, like a rage came over me for a few seconds, I mean, what do I do with anger in this context? It was, like, a very rare thing and very disjointed, and this is how the anxiety came and this has happened to many healthcare workers.* (IP09)

VP10	*I know that it sounds very hard and very cold, and perhaps what I am going to say is appalling. But you were protecting yourself, saying: "This is not a person. It does not concern me, I do not care, I attend to them, I save their life if I can, I treat them, I do everything I can, but if they die, I don't want to know."* (IP35)
VP11	*That wasn't the worst for me, the worst that I experienced personally was when a patient died you activated the protocol (...) then we had to write the name with permanent (marker) on the sheet ... that was the worst part for me because I did not learn the name of my patients. I am very ... in normal conditions I didn't take bed 1 and 2, I took patient so-and-so by name, but no, in this case I couldn't. Today it was Francisco María, and tomorrow it was Pascual. Well...for what? (silence)* (IP35)
VP12	*And then one of the other things that happened is that everyone, doctors included, well, of course, you have a much closer bond with the patient who tells you their stories, and, so you knew much more about the patients than you might in the usual pace of life in the hospital when, perhaps, they are there for less time, or a family member is there with them. The people speak to you about their grandchildren, they tell you about such and such, (...) So every death that occurs...well, of course, they did not discharge number 103, Leandro has died, Leandro whose wife was admitted first, whose wife got out but not him. So, he has a story. Maybe the right thing would be not that you get used to it, but that it leaves less of an impression than at the beginning because there have been so many, but no.* (IP01)
VP13	*And saying goodbye to them and telling them that you are here, that you have been here, because at the end, they, I am not going to say that they love you more than they love their family, (...) but if we are with them all day long, taking care of them all day long, showering them, bathing them, helping them eat, helping them walk...well, ultimately they end up loving you as if you are a member of their family.* (IP05)
VP14	*We are used to putting on our armor and being up and running every day, and this has really made us take off the armor...to say, "Shit. This isn't normal."* (IP20)
VP15	*We are used to responding to what happens to someone else, but in this case, it is happening to someone else, but at the same time it could happen to you, it therefore causes a mix of emotions.* (IP17)
VP16	*You know, I was more worried about what was going on at home, than the impact picking up the bodies would have on me. Because as far as it is a job, you do it and that's it. And for that reason, it has had practically no impact on me. What impacted me was concern for my father, that the next day I could very well see him under one of the shrouds.* (IP29)
VP17	*And then, well, Dantean scenes. (...) A colleague said, "They have them (the bodies) on top of the tables." It is like, where else are they going to put them? There is no other way to do it. Often, they were on the floor...* (IP28)
VP18	*It was like, 'Shit, this seems like 'The Walking Dead' or I don't know,' it was like a very weird movie, you would arrive to pick them up...but of course, we went, it was like we were delivery drivers for, I don't know, Amazon, you know?... we went to a place, we did the pick-up and later we took them to the centers where we were supposed to take them.* (IP28)
VP19	*Well, any one of the people there could have been my father (...) It was dreadful, because at the time I was living with my father, and my father turned 62 yesterday. It made me terrified. I would arrive, grab the plate, and go into my bedroom.* (IP35)

VP20	*It has made us think and begin to prepare our affairs in case you die. So, I'm telling you things like that, or regarding leaving things arranged in your life, this, and that, and so on, ehhh... The fear of infecting your family, the fear of infecting your father, the fear of infecting everyone around you.* (IP30)
VP21	*As soon as they let me travel the first thing I did was go see my parents. And it is very clear where the things are for when my parents die, the green folder as my Mother says, the dead people's telephone, as my Mother says. (Laughing)* (IP09)
VP22	*Well, yes, it has changed, my concept of death, of living life, it is like that, people think that death is the end of life, and it is not, but it is part of life.* (IP09)
VP23	*In other words, we live totally oblivious to it, as if it will never happen. This has been a reality check in that sense because there has indeed been a 180% excess mortality rate in the community of Madrid. It is astounding. It has made us much more aware of the fact that we do indeed die.* (IP02)
VP24	*What I have learned about the topic of death is that there is a taboo about death, it is not talked about, especially in our industry, it is always hidden. So, from the (ethics) committee, yes, we have spoken about it, and I believe that we should improve the implementation in our service offerings as well, this issue of advanced directives. So, I think this should help us to begin to deal with all these issues more naturally.* (IP12)
VP25	*One must change the chip, because if not, we couldn't work here. How can you begin to empathize with all of the families, or allow yourself to start thinking that you work with death, with the pain, with the crying, at the end I believe you couldn't handle it, you would end up depressed.* (IP34)
VP26	*I have a very close relationship with my parents, and just thinking that something could happen to them, that at some point something is going to happen to them because they are already 80 years old, well, I don't handle it very well...it is that losing.... seeing that death is horrible, but, well, I don't know, I try not to think about death.* (IP41)
VP27	*A patient dies and you are left depleted, then comes a moment of pain, but you ignore it. (...) You try not to learn their name, hope that the family does not call you, and ...* (IP35)
VP28	*The medical part, in terms of attending to the people, was terrible, terrible because knowing that the hospitals were overflowing, sometimes we had to make decisions which are hmmm, it is not politically correct to say it, but we have had to let people die at home who in other circumstances could have, they might have been able to continue on.* (IP31)
VP29	*Because it was people that were still very alive, because the feeling is that you can't do everything that you should have been able to do. Because the people that are admitted now have the right to a ventilator (...), but the people in March and April didn't have that.* (IP40)
VP30	*In other words, many people were dying that ethically, should not have died...* (IP41)
VP31	*It is terrible because these people need healthcare attention just as you and I might need it. What happens? Because they are elderly you deny it to them? No, there is no right to do that, because they are equal people (cries). So, why were these people denied that?* (IP06)
VP32	*And that we are the murderers. I, in a chat of school mothers, the theme came up and I had to speak up. I stayed silent. "It is a shame that there are murderers who didn't take them (dying patients in senior residences) to the hospitals."* (IP12)

VP33	*No, this is never going to be processed. It will stay here forever, no matter how much it is discussed, whether you speak to a professional, it is not going to matter, what we have experienced, is experienced, I believe. No...it is something that will stay with us...* (IP14)
VP34	*And it is that you go out for a run and all of a sudden you feel like crying, and it lasts 5 minutes. And you return home like, what just happened? Or suddenly you can't sleep again at night.* (IP09)
VP35	*This has an impact. I already had a time when I went to a psychologist, a psychologist who was a friend of the family and she had told me "You seem to be a strong person...but it affects you..."* (IP33)
VP36	*We spoke about what we had experienced, how it seemed like so much more time had passed, (...), that we didn't really know how to act with the family or what to say to them, that we were not prepared for that, what we were experiencing with our own families and such.* (IP09)
VP37	*I believe that they (members of the department) have managed through it very well, uh, at a personal level. The Red Cross also came, two psychologists came here, to do a little therapy with us for the emotional effects that we might have, perhaps, negative (effects) from this and the truth is that, not that there has been resistance, but rather that we have listened and so on, and the feeling for me, because it coincided with three or four of my shifts is that...it is not that they haven't done their job it is that it wasn't very necessary. There was no need. (...) They (members of the department) have managed well, those who had problems with taking it home with them were more afraid but well, quite well, yes...* (IP28)
	Family Members
VF01	*And after a little while SAMUR (emergency services) came and I tried to tell them to do this, with the defibrillator and such, and the man looked at me and said, "My queen" - I will not forget these words - "My queen, he has left you." This man was a real sweetheart, really. He was huge, big, with glasses, (...) and he told me, "He has left you; he has left you."* (IF06)
VF02	*I started to really cry. The doctor began to cry, his tears were falling.* (IF07)
VF03	*What I understand about the toll the work takes, (...) and that they told me "Okay, okay, we understand you, but we can't keep up." I got angry and I told them "I don't care, it is your job," I told them, and later I regretted it a ton. They did what they could, but it made me so angry...but hey, it is what it is...* (IF01)

DISCUSSION

The number of deaths that healthcare and social services professionals, as well as funeral services professionals, have had to deal with during the state of emergency has been inordinate and unexpected. It might be presumed that healthcare and social services professionals, who routinely witness deaths in their work, may be accustomed to deaths and are therefore more sensitized,[15] and that these professionals' continuous contact with death allows them to create strategies to facilitate future contact with death.[16] However, the results of this study indicate that, when faced with the COVID-19 crisis, professionals were not able to get used to the unique circumstances, and the emotional impact caused by the deaths

was elevated, including in those professionals who work in high-mortality environments like ICUs, emergency rooms, palliative care, and senior residences.

As this study has shown and according to Chocarro,[17] depersonalizing the patient, avoiding conversations, or avoiding learning patients' names are coping strategies used by some professionals. However, it has been found that this has not always been possible or effective, since, as indicated by Ferrán and Barrientos-Trigo,[5] during the pandemic, professionals had to supplement, to the extent possible, the emotional support required by a dying patient that would otherwise fall to family members, or that might be alleviated by the support of other patients, especially in senior residences. In a situation of scarce resources, with very difficult working conditions similar to those in developing countries, or generated by disasters or wars, healthcare professionals have had to use their imagination to accompany and care for the sick as described by Torre.[18] This assumption of emotional care for patients has contributed to later separation anxiety among personnel[19] and difficulty in coping with death. On the other hand, the pressure to provide care was so high and the deaths that resulted occurred in such a dramatic way that any coping strategy could prove to be insufficient. It follows that many professionals are now in psychological treatment or say that they need it. Studies show that health professionals, who have worked during the first months of the epidemic, have experienced psychological symptoms such as stress, anxiety and depression, compassion fatigue and post-traumatic stress. [20]

Following the reviews carried out by Sakuma et al.[9] and Brooks et al.,[8] the psychological and emotional effects that are noted in this study can be similar to those described in disaster situations and with humanitarian relief, such as emotional distress or compassion fatigue, among others.

One should not forget that the healthcare and social services professionals have been socialized through the same processes as the population they serve, and therefore dismiss the idea of death in the same way that the rest of the population does.[17] Studies conducted before the pandemic[21] indicate that some healthcare workers demonstrate negative attitudes towards the concept of death and that this is one of the situations that regularly generates the most stress, among nursing staff for example.[17] This research exposes the existence of these negative attitudes, which have been exacerbated by the impact of the deaths during the crisis. The professionals have narrated their difficulty in coming to terms with these deaths, even more so in an environment in which they considered that the deaths could have been avoided. For many healthcare professionals, death is not only something that isn't accepted, but also something that they prefer to avoid in their everyday thinking[22] in and during this crisis they have had to confront it daily. During the hardest months of the pandemic, death anxiety increases markedly among professionals[23].

The psychological distress for these workers is also caused by their perception of the risk of infection to themselves and their families, as previously indicated by Simione and Gnagnerella.[24] So not only do they suffer with the deaths of their patients, but many of them, as this study indicates, connect the deaths of their patients with a fear of losing their loved ones.

Most of the research about psychological distress for healthcare and social services workers during the COVID-19 crisis does not refer explicitly to the relationship the healthcare professionals have with death, as evidenced by Bohlken el al.[25] and Spoorthy et al.[26] in their review of the literature. However, the present study considers that the professionals' prior experience with death is a determining factor for understanding their fears, emotions, and their need for psychological support.

With respect to social workers, we find few studies that speak of their relationship with death. Some, like that of Quinn-Lee et al.[27] carried out with palliative care social workers, affirm that exposure to death at work decreases the anxiety it generates. As has been suggested with respect to health care workers, this study indicates that such standardization is not applicable in times of pandemic crisis. On the other hand Martínez-López et al.[28] point out that social workers in Spain have suffered high levels of anxiety about death during the pandemic, especially in relation to fearing the death of others and the process of death.

In the case of funeral services workers Van Overmeire and Bilsen[29] indicate that the COVID-19 crisis also generates a risk to their mental health, due to the number of funerals, the high demands of their job, and overexposure to death in the course of their work. This risk was not evident in the present study. Although the data indicate that the demands and workload were frequently mentioned factors for funeral services professionals, there was not similar evidence in the data for an overexposure to death. The same author indicated in a later study that compassion fatigue and burnout among funeral home personnel is lower than among healthcare professionals.[30] Rodríguez-Rey et al.[31] also state that the psychological impact on protective services professionals has been lower than on health professionals. Previous studies also indicated that there is no relationship between exposure to death and mental health in these groups.[32]

Limitations

This study faced notable limitations due to the circumstances of the pandemic: a) access to a wide range of healthcare professionals was difficult due to their ongoing workload as well as their state of mind; b) the interviews were designed to be conducted in person, however some had to be conducted virtually making nonverbal communication and observations of nonverbal expressions difficult and c) some professionals, especially social workers, were very reluctant to participate for fear of revealing

particular professional situations experienced in their workplaces.

Implications

This study reveals the need to establish mental health surveillance measures for all frontline professionals who have worked with patients who have died during the most difficult months of the pandemic.

Supportive resources such as support groups and spaces for emotional healing should be strengthened.

It is necessary to expand the curricula of healthcare and social services professional training to include subjects that support development of coping skills for dealing with death, both in periods of crisis and in normal care provision, as well as expanding the bioethical view of death. It is furthermore advisable to promote initiatives whereby professionals and patients can talk about death to further normalize it.

This study opens the way for other research in the mental health field to consider the experience of death as an indicator of mental health and to study the real impact of this crisis, in the medium and long term, on healthcare and social services professionals as well as other professionals, such as emergency and funeral services personnel.

Conclussions

Overexposure to death, the circumstances of death and decision-making related to dying patients, has had a significant emotional impact on healthcare and social services professionals, many of whom express the need for psychological help. Having previously worked in environments or residences where there is a high mortality rate was not a protective factor. The level of emotional involvement and suffering was lower in professionals dedicated to the collection of the deceased and their burial or cremation.

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7.3. Carta de la revista

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8. CAPÍTULO IV: NOBODY SHOULD DIE ALONE. LONELINESS AND A DIGNIFIED DEATH DURING THE COVID-19 PANDEMIC.

8.1. Justificación introductoria

Realizados los estudios sobre los efectos que producían los fallecimientos durante la pandemia de la COVID-19 en los familiares y dolientes, y también en los profesionales, me quedaba por resolver una pregunta importante, ¿Qué habrá significado para las personas fallecidas haber muerto solas y haber sido enterradas en soledad? (Imagen 24)

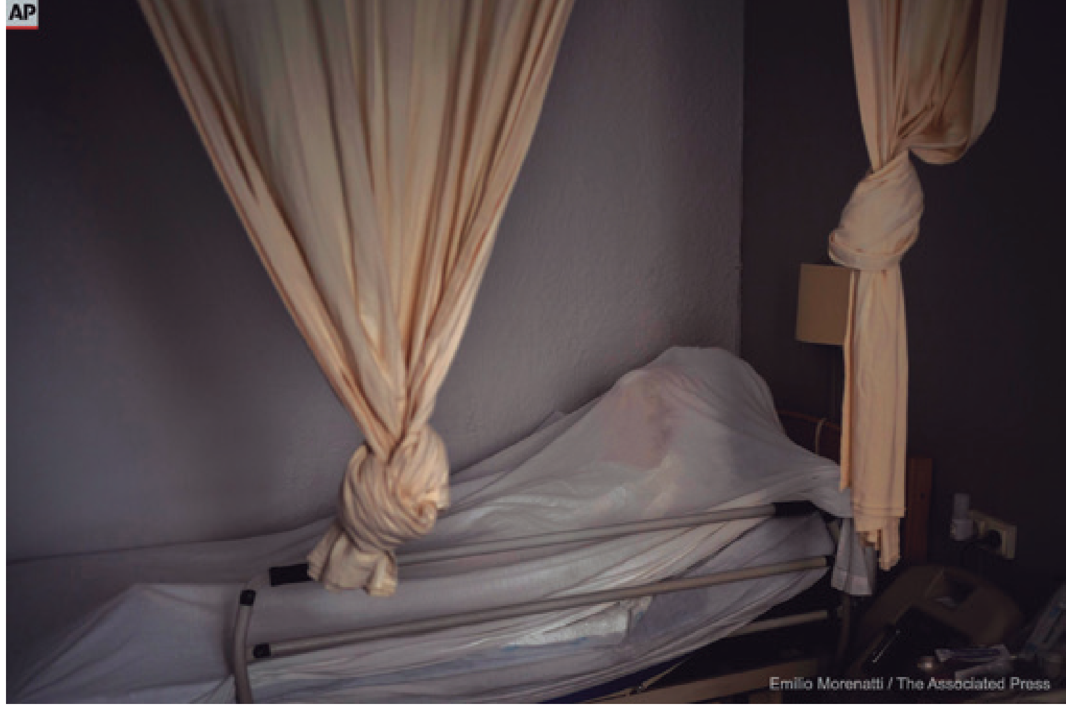

Imagen 24: Un cadáver espera a ser recogido en una residencia de ancianos. Emilio Morenatti

Obviamente la pregunta no se podía realizar al que ha sufrido esta experiencia, porque el mero hecho de experimentarla le hace trascender a un no ser, a un no estar. De entre los ritos de paso (Gennep, 1969/2008; Turner, 1967/1980) hay que señalar que la muerte es el único en el que el sujeto protagonista no puede participar de él porque no está, no existe como ser vivo, aunque todo rito gire en torno a su persona.

Habría que preguntar entonces a los vivos qué creen que significa para el que fallece morir en soledad, e incluso cuestionarse, también, qué creen que significaría para ellos el tener que morir en estas condiciones. Muy posiblemente entendiendo la proyección del pensamiento sobre la idea de la propia muerte podríamos entender el significado que ha tenido para miles de personas estar solas en sus últimos días de vida.

En el imaginario popular español, existe la idea de que no se debe morir solo, hay expresiones al respecto que nos hablan de ello, como cito en el artículo, e incluso coplillas humorísticas como la de Luis Sánchez Polack, Tip, que escribía: “El día que me muera/ quiero estar vivo/ para ver si a mi entierro/ van mis amigos” (Polack, 1980)

Pero la pregunta, o, mejor dicho, la respuesta, requería un análisis más profundo, requería estudiar si morir solo se puede considerar como un tipo de mala muerte, e incluso avanzando un paso más, había que estudiar si el mero hecho de morir en solitario era una señal de muerte no digna.

Los primeros problemas me los encontré por la falta de un acuerdo en la comunidad científica respecto a lo que se considera una buena muerte como nos indica Steinhauser et al. (2000) o las revisiones de Meier et al. (2016)English-language, peer-reviewed reports of qualitative and quantitative studies that provided a definition of a good death. Stakeholders in these articles included patients, prebereaved and bereaved family members, and healthcare providers (HCPs, si bien todo parecía indicar que la muerte en soledad no deseada no era una forma de fallecer considerada buena para la población en general.

En las entrevistas, al formular las preguntas sobre cómo pensaban las personas entrevistadas que se había muerto durante la primera ola de la COVID-19 muchas de estas personas proyectaban directa o indirectamente cuales eran sus deseos a la hora de morir. En este sentido este artículo nos habla también de la trascendencia del individuo pues nos hace reflexionar sobre nuestra propia vida y sobre la muerte que queremos.

Por otro lado, estaba la segunda parte de la pregunta que he formulado previamente. Una vez que el individuo ha fallecido ¿tiene algún significado el hecho de que sea enterrado o incinerado en soledad? Había que estudiar si este hecho era o no significativo porque estas respuestas nos ayudarían además a entender el verdadero significado del ritual fúnebre. Con este artículo se cerraba el círculo

de una tesis doctoral que empieza hablando del rito y concluye hablando del rito, o mejor dicho, de los efectos de su ausencia.

Si, siguiendo a Ariès (1977/2011), muchos autores afirman que existe una individualización de la muerte, el hecho haber llegado por imperativo de la pandemia a la máxima expresión de dicha individualización: la despedida del cadáver, en solitario, sin presencia de la comunidad, nos debería hacer preguntarnos de nuevo por esos significados rituales y por la necesidad de resignificarlos. Esto interpela si, como sociedad, realmente queremos una muerte en la que los ritos carezcan de importancia, o en unas circunstancias en las que se nos ha negado la celebración de estos, somos conscientes de que los necesitamos. (Imagen 25)

Por último, quería comprobar también la importancia que el tratamiento del cadáver, a las pocas horas del fallecimiento, tiene para la familia. El cadáver del fallecido representa al fallecido mismo, y cómo tal, se pretende que sea tratado. En ese paso ritual, en esa transición de un estado a otro, quería constatar si para los que estamos vivos el fallecido también está, en cierto modo, aún vivo. (Imagen 26)

Este artículo pretende ahondar en estos términos y contar con el testimonio, no solo de los familiares, sino también de los que yo he llamado testigos de excepción, aquellos que han visto morir a miles de personas en pocas semanas o que han tenido que tratar con el cadáver de miles de fallecidos en unas condiciones no deseadas.

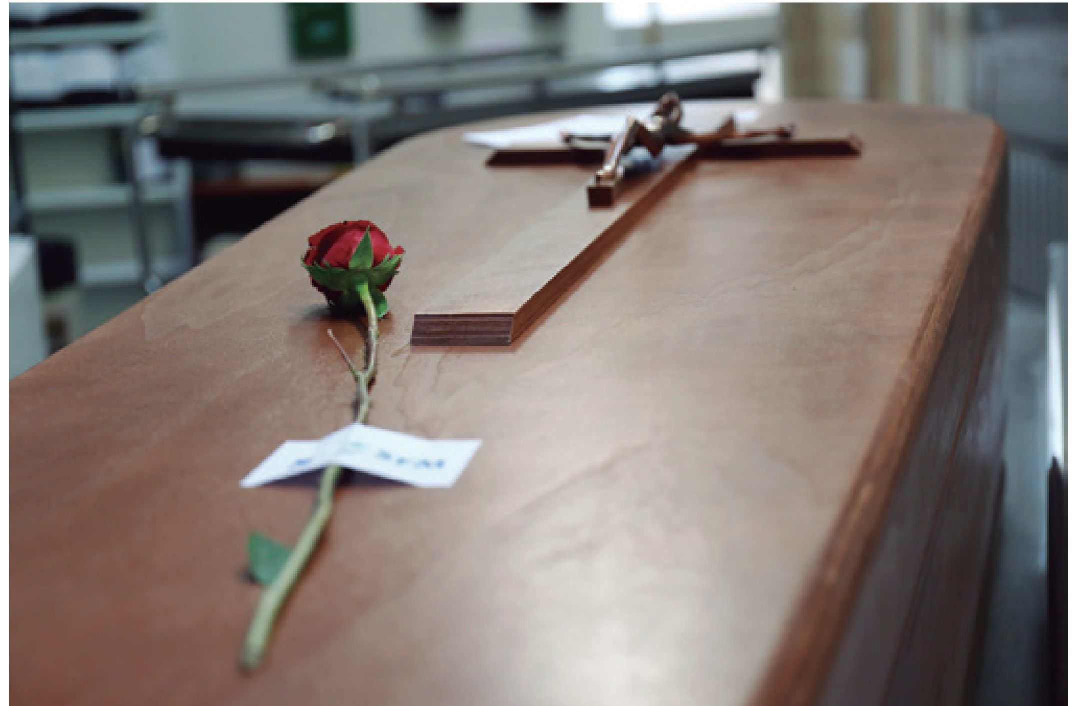

Imagen 25: Los profesionales de algunas funerarias pusieron flores en los féretros de los fallecidos. Oscar Barroso. Cedida por SFM

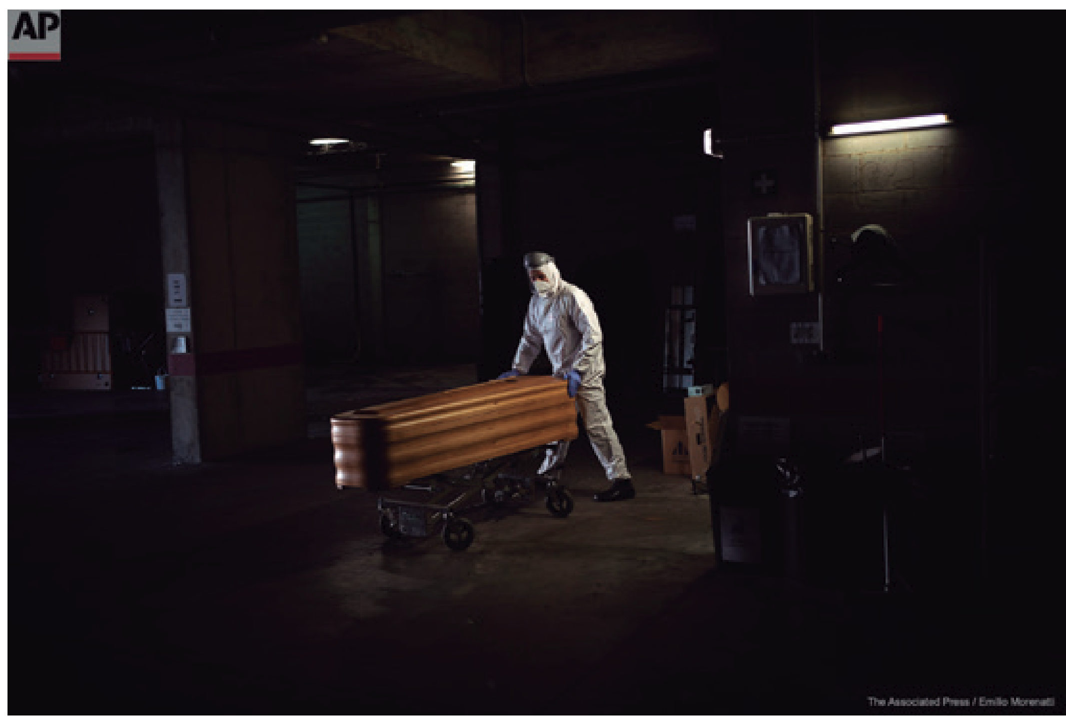

Imagen 26: Un empleado de una funeraria traslada un féretro durante la pandemia. Emilio Morenatti

Al igual que en los dos artículos anteriores, se ha contado con la misma muestra, y aunque cada uno ha aportado su visión desde el rol que le ha tocado desempeñar, la reflexión sobre lo que es una buena muerte o una muerte digna no puede evitar hacerse desde la propia individualidad, desde los propios valores y creencias de cada persona independientemente del rol que a cada uno le toque representar.

Es, quizá, de los cuatro, el artículo más reflexivo, y en el que la bioética cobra una importancia especial. Es un artículo que, más allá de sus resultados académicos, nos debe invitar a reflexionar sobre nuestra propia muerte.

8.2. Artículo: Hernández-Fernández, C & Meneses-Falcón, C “Nobody should die alone”. Loneliness and a dignified death during the COVID-19 pandemic.

Resumen

Durante los meses más críticos de la pandemia de la COVID-19 miles de personas murieron en soledad. Este estudio analiza si estas muertes, sin la compañía de los seres queridos, pueden considerarse o no muertes dignas o good death. Se ha realizado una investigación con enfoque cualitativo, fenomenológico e interpretativo mediante 49 entrevistas en profundidad a profesionales y familiares, realizando posteriormente un análisis cualitativo, interpretativo y categórico. Entre los resultados principales destacan que durante estos meses críticos los fallecimientos carecieron de la dignidad deseada, a pesar de que los profesionales hicieron lo posible por acompañar y dignificar los fallecimientos.

Palabras clave

Muerte, COVID-19, Buena muerte, soledad, muerte digna

Nobody should die alone. Loneliness and a dignified death during the COVID-19 pandemic.

Keywords: death; COVID-19; good death; loneliness; dignified death.

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Ethical approval: This research project was approved by the Ethical Committee of the Universidad Pontificia Comillas of Madrid on 15th June 2020.

Nobody should die alone. Loneliness and a dignified death during the COVID-19 pandemic.

During the direst months of the COVID-19 pandemic, thousands of people died alone. This study analyzes these deaths, which occurred without the presence of loved ones, and seeks to a) examine the significance for relatives, as well as professionals, of dying alone, b) determine if these solitary deaths can be considered dignified, or good deaths, and c) evaluate if the treatment of the cadavers and the funeral rites transpired with the desired dignity and sensitivity. The study was carried out in the autonomous community of Madrid using a qualitative, phenomenological, and interpretative approach through in-depth interviews of 49 informants, professionals and relatives. Interviews were conducted between July and November of 2020, followed by an interpretive, categorical, qualitative analysis. Among the key findings are that during the most critical months, deaths lacked the desired dignity, even though the involved professionals did their best to accompany and dignify the deaths.

Keywords: death; COVID-19; good death; loneliness; dignified death.

Introduction

Through the end of July 2021, 4.2 million deaths were recorded worldwide as a result of COVID-19, with 80,000 of these deaths recorded in Spain (Statista, 2021). The number of infected and number of deaths between the months of January and May 2020, in what was considered the first wave, were especially high in the country. During this time 152,230 deaths from illnesses occurred in Spain, of which 45,684 were caused by the COVID-19 virus (Instituto Nacional de Estadística, 2020), a 44.8% increase in deaths compared to 2019.

During the first wave in Spain, protocols were activated for hospitals and senior residences that prohibited visitors and prevented family members from accompanying their loved ones. Most people who died during this time spent the last days of their lives without company and passed alone or with just the accompaniment of healthcare workers, who found themselves overwhelmed by the situation.

Dying alone during the pandemic was mostly a result of prevention measures and patient isolation protocols enacted by authorities (Consuegra-Fernández, 2020). Healthcare professionals tried to replace the physical accompaniment of family members with creative solutions, using the telephone or video calls, but neither the professionals nor the family members were able to find a solution that was considered adequate (Wakam et al., 2020).

Dying alone, in another context, might be a choice, but when dying alone is not wanted it can be considered a failure of emotional support (Caswell & O'Connor, 2019). Dying alone is not considered a good death (Seale, 2004) and no one wants to die alone, isolated, in the middle of chaos and with few resources providing care (Khoo & Lantos, 2020), as was the case with many

deaths during the direst months of the pandemic.

Even if death might be described as an act of solitude, accompaniment and human contact are necessary (Strang et al., 2020). For patients, healthcare professionals and relatives, saying goodbye to those who are important is one of the factors that defines a good death (Steinhauser et al., 2000) and that, in these circumstances, was not possible.

For anthropology, death is more than an individual experience (Barley, 2012) and is considered a collective phenomenon that belongs to the community.

Death in Spain, before and after the pandemic

The experience of death as a collective phenomenon (Lisón, 2008) is a constant in Spanish culture where, guided by catholic tradition, the presence of community in funeral rituals is fundamental, and visiting the sick is considered a labor of mercy for believers, according to their catechism (Iglesia Católica, 2012).

In popular Spanish tradition there are expressions such as "die like a dog" referring to dying alone and abandoned, or sayings like "burials, baptisms and weddings summarize all of life," indicating the community character of death and funeral rites (Rodriguez, n.d.).

There is not a single death culture in Spain as differences are seen depending on the region in which a death occurs, whether it occurs in a rural or urban environment, and whether a specific ethnic group is involved. There is hardly any literature on contemporary death in urban Spanish settings (Vazci, 2019). In the rural environment, such as Galicia, death is still a central theme in people's lives (Lison, 2008).

Nevertheless, as in other westernized countries, secularization, medicalization and individualization (Vaczi, 2019) have brought about notable changes in the way Spanish citizens perceive death.

Medicalization has led many people to prefer to die in hospitals, rather than at home as in the past. After death, the corpse is taken to a morgue where family and friends accompany it until the subsequent burial or cremation. This ritual process removes death completely from the home, and therefore from the everyday environment, and in Spain all formalities related to the corpse are typically complete in less than 36 hours, allowing some level of normality to quickly return.

Funeral rituals are still performed in the context of Catholicism, even for lesser believers, and most of the acts performed are religious. However, secularization and the culture of denial of suffering, paradoxically so alien to the Catholic tradition, have recently put the concern for dignified death and euthanasia on the social and political agenda of the country (Bernal-Carcelén, 2020), opening new debates about death.

Death during the pandemic

During the pandemic the dying only had contact with their caregivers, con-

tact that was limited due to the use of personal protection equipment as well as safety and isolation measures, which prevented the dying from having physical contact with and from even recognizing the faces of the people who were caring for them. Under these conditions the dignity of their last days is called into question (Thompson et al., 2019).

Given the circumstances, it is likely that patients experienced a fear of dying without anyone by their side (Wakam et al., 2020) as well as some symptoms of depression, anxiety, anger and loss of self-esteem (Abad et al., 2010), which can increase distress in the days and hours before death.

In this context, certain questions arise that this study intends to address. How did people die during the COVID-19 pandemic? Is it acceptable for society to have people die alone in hospitals and nursing homes? Could the performance of funeral rituals have dignified the deaths?

This study seeks to a) examine the significance for relatives and mourners, as well as healthcare and social services professionals, of dying alone during the most dire months of the pandemic, b) determine if these solitary deaths can be considered, from the point of view of ethics and community, as dignified, or good deaths, c) analyze if the treatment of the cadavers and the funeral rites that transpired during the most significant months were carried out with the desired dignity and sensitivity, and were socially acceptable.

Material and methods

Design

This work is based on a qualitative, phenomenological, and interpretative approach through in-depth interviews. The experience of the participants who had, in one way or another, a relationship with the deaths during the state of alarm is studied in depth, gathering their feelings, perceptions and thoughts, and observing how they gave meaning to what they observed and experienced. The interview offers a contextualized view of the experience, allowing one to historically and socially frame personal experiences and thus understand the social processes that may underlie subjective evaluations or interpretations (Finkel et al., 2008).

Recruitment and sampling

The study was carried out in Madrid, a city with one of the highest number of deaths from COVID-19 between March and May 2020. To ensure a diverse set of perspectives was acquired, 49 informants of different types (general informants and key informants) (Table 1) were interviewed incorporating: a) nine hospital employees including doctors, nurses, social workers, psychologists and chaplains b) eleven senior residence employees including management, psychologists, social workers, chaplains and orderlies; c) two emergency services professionals, one a doctor and the other a nurse; d) sixteen funeral service professionals across all functions including management, office administration, sales, customer service, drivers, chaplains, crematorium technicians, and undertakers;

e) two firefighters; f) two social workers from the Official College of Social Work of Madrid: Emergency Team g) six family members of the deceased and h) one resident of a senior home. All participants were contacted by telephone, the project was explained, and their collaboration was requested. The interviews were carried out progressively, following the theoretical sampling model of Glaser and Strauss (1967), utilizing the constant comparison between each type of informant (general and key), and seeking distinctive aspects in newly selected informants, or to augment central analysis categories that required greater depth; finally, the research questions and objectives guided the inquiry process and the search for new observations and interviewees. When information received was repeated over and over, the information required to fulfill the objectives was considered to have reached a saturation point. Interviews were conducted between July and November 2020. One of them was conducted in writing and seven by videoconference due to pandemic restrictions. The rest were conducted in person, and all were recorded. The interviews were approached as a conversation, following Kvale (2006), around three dimensions: a) the significance of dying alone, b) beliefs about a good death and a dignified death, and c) how the dignity of the deceased is taken into consideration.

Table 1. Data sheet of the subjects interviewed

Interview with professionals	Role	Institution
IP01	Medical Director	Private Hospital
IP02	Psychologist	Private Hospital
IP03	Priest	Improvised Morgue
IP04	Director and Owner	Senior Residence
IP05	Orderly	Senior Residence
IP06	Social Worker	Senior Residence
IP07	Psychologist	Senior Residence
IP08	Patient Experience Department Representative	Private Hospital
IP09	Nurse	Public Palliative Care Hospital
IP10	Chaplain	Cemetery
IP11	Communication Director	Chain of Senior Residences
IP12	Social Worker and Sales Manager	Chain of Senior Residences
IP13	Orderly Coordinator	Senior Residence
IP14	Orderly	Senior Residence
IP15	Chaplain	Palliative Care Hospital and Funeral Home
IP16	General Secretary and Secretary of the Board of Directors	Funeral Home
IP17	Quality Assurance Manager	Funeral Home

IP18	Chaplain	Religious Senior Residence
IP19	Sales	Funeral Home
IP20	Sales Director	Funeral Home
IP21	Hearse Driver and Mortician	Funeral Home
IP22	Head of Coordination and Control	Funeral Home
IP23	Customer Service Representative	Funeral Home
IP24	Public Relations Representative	Funeral Home
IP25	Human Resources Manager	Funeral Home
IP26	Communications Manager	Funeral Home
IP27	Assistant to the Business Director	Funeral Home
IP28	Firefighter	Fire Department of Madrid
IP29	Firefighter	Fire Department of Madrid
IP30	Doctor	Public Emergency Service
IP31	Nurse	Public Emergency Service
IP32	Director of Residence	Religious Senior Residence
IP33	Orderly	Religious Senior Residence
IP34	Public Relations Representative and Crematorium Technician	Funeral Home
IP35	Nurse	Public Hospital
IP36	Volunteer Social Worker	Official College of Social Work of Madrid: Emergency Team
IP37	Volunteer Social Worker	Official College of Social Work of Madrid: Emergency Team
IP38	Undertaker	Funeral Home
IP39	Public Relations Representative	Funeral Home
IP40	Doctor	Public Hospital
IP41	Doctor	Public Hospital
IP42	Social worker	Public Hospital
Interviews with relatives		
IF01	Granddaughter of deceased	
IF02	Daughter of deceased	
IF03	Daughter of deceased	
IF04	Resident in a Senior Residence	
IF05	Daughter of deceased	
IF06	Wife of deceased	
IF07	Daughter of deceased	

Ethical considerations

Considering the sensitivity of topics involved in this research, compliance with the appropriate ethical requirements was maintained, under the supervision of the university Ethics Committee, who issued a report of approval. All participants were informed of the objectives of the research study, the sources of financing and the planned use of the results. Informed consent was solicited, and informants were notified that their

participation was voluntary. Permission for audio recording was also requested. Anonymity was guaranteed through a confidentiality agreement.

Data Analysis

After the verbatim transcription of all the interviews, the analysis began with the support of the Nvivo 12 plus program, which facilitated categorization and codification. The participants' discourses were examined via a categorical analysis that considered both content and discourse analysis. First, the language used was explored, taking into account the words and phrases spoken and the sentiment associated with them. Secondly, the analysis focused on the meanings associated with the death of patients and the emotions that such deaths provoked for professionals. The development of the analytical categories and the codification of the interviews were central to this stage. The last step of analysis was the interpretation and association of meanings with the circumstances and contexts in which they took place.

The main strategies of rigor and quality criteria associated with qualitative research were applied. Reflexibility was used in the data collection process, as well as content saturation and key categories; to prevent biases in the first author's interpretations, the second author reviewed the results and analysis for dependability and confirmability.

The results are illustrated by extracts from the interviews reflected in table 2.

Table 2. Extract Interview Transcripts – Verbatin Professionals (VP) and Verbatin Family Members (VF).

	Verbatim Transcripts
VF1	*If I had to imagine her dying, the truth is, although it sounds selfish, I would have preferred that she would die here with us and not abandoned in a hospital, where they have her alone for 6 or 7 hours in a hospital room, (...) There must have been some humane way for one to see their relatives. That should not, I don't believe that it should happen the way it happened.* (IF06, female, 62 years old)
VF2	*I was unable to speak with my father from Sunday until Tuesday. All Monday I was trying to talk to him, calling the phone in the room. They didn't pick it up, they didn't pick it up, and I, desperate, spoke with my brother.* (IF05 female, 47 years old)
VF3	*I know that he suffered because he didn't have us there, (...), this just kills me, because he didn't hear anything from us... It's just, he couldn't have known anything, besides, we called him and we couldn't speak with him, so the fact that he didn't suffer, I don't know, it doesn't make me feel much better honestly. I mean, he has died and he died alone, that is the worst part.* (IF01, female, 23 years old)
VF4	*And they called him back and I felt super guilty because I imagined him alone somewhere, waiting, not knowing, scared to death, I mean, I just know it.* (IF07 female, 26 years old)
VF5	*I don't cry a lot. But I have lots of panic attacks if I start to think about the fact that my Dad was alone.* (IF07 female, 26 years old)

VF6	*And well, the only thing I can be grateful for is that he passed away at home, that he didn't pass away in the hospital, that he had the chance to be...I mean that he was not alone. Fortunately, my brother and I were there to support him when he died.* (IF06 female, 62 years old)
VF6	*The funeral home tried to do everything possible so that we could, in some way, spend some time watching over him or, well, accompanying him.* (IF02 female, 35 years old)
VF7	*The funeral services workers did it with gentleness, honestly, things being as they are.* (IF06 female, 62 years old)
VP1	*And later the feeling of guilt for the relatives, "It's just that he is alone or she is alone" that was brutal, the feeling of guilt was tremendous, when in reality the relatives were not to blame, because evidently none of us were to blame for what happened.* (IP37, female, 36 years old)
VP2	*And one of the questions that you were asked a lot was, "Were you with him? Did he die with you?" They worried a lot about whether they had someone by their side.* (IP09, male 36 years old)
VP3	*To be alone when facing death or dying is the fear and it is the failure. "What have I done in this life that at the end I die alone? I may have achieved things, I may have done things but in the crucial moment, there where...I am alone."* (IP02, female, 38 years old)
VP4	*Look, what I have thought a lot about is the anguish of dying alone. The anguish of not being able to say goodbye in the last moments that you are alive.* (IP11. male, 38 years old)
VP5	*The great helplessness of not knowing what is happening. If they have abandoned me or the world has ended, if this has become widespread, if this is something personal, and from there you are led to think of anything and everything, the entire avalanche of feelings.* (IP15, male, 58 years old)
VP6	*It's just that it is very sad to die alone. To me this seems very sad.* (IP31, female, 55 years old)
VP7	*(They have died) in a bad way, obviously, dying without your family is a bad death, obviously, dying alone, alone is very bad, I believe they have had a terrible death, very bad.* (IP4150, female, years old)
VP8	*Yes, I believe it is fundamental (to die with others by your side), even if it is only having your hand held, you know, in the last moment, or two words of breath, of goodbye. For me it seems extremely important, I mean, dying alone, to me that seems very sad.* (IP30 female, 63 years old)
VP 9	*If you want to talk about a dignified death, dying alone in a room is not dignified and it is horrible. Horrible. Horrible. I wouldn't have wanted to be in the situation of any of those family members*. (IP01, male, 50 years old)
VP10	*During this entire difficult time, when I was not on duty, I was here alone at home, and I would be overcome by a super distressing feeling about dying alone, you know, it's like how awful, I mean, and I started to cry and I was saying "hey enough, enough, enough" (laughs). (...) And this thing about dying alone was one of the things that came into my head.* (IP31 female, 55 years old)
VP11	*The elderly that have died with us, I have felt much pain, but at least they were with us, they died with someone by their side, holding their hand, and at peace... "we are here with you" and it seemed like you said these words to them and they stayed, they stayed calm and died.* (IP06, female, 45 years old)

VP12	*Well, if dignified signifies having the people you love by your side, no, no. The have died alone. Have we tried to make it as dignified as possible? Well, yes.* (IP40 female, 50 years old)
VP13	*Those that have passed here, we were with them until the end, always. They were never left alone; they were never left alone.* (IP33 male, 28 years old)
VP14	*The most intense weeks were dreadful because you could go two hours without seeing those patients, two hours would pass -people, alone, eh- these two hours would go by and you would go back, and you would find them all dead, eh, dead without family or anything.* (IP09, male, 36 years old)
VP15	*They talked a lot about death in the senior residences and of the possibility of having died in the hospital, and I have mixed feelings about this, there are people who died in the residences that if they wouldn't have died in the residence, they would have died in the hospital, because the situation was what it was, and they were very sick and the survival rate was nil; And we would say "It is just that..." In fact, there was a thread on Twitter about this. Well, it isn't so bad, in the residence you have died with the professional that you know, in the company of people that you know, and with the people by your side who have taken care of you over the last months, years...and the alternative...in one tweet they said: "yes but at least to have the opportunity to go to the hospital." No...well if, but the possibility was very low, then they died within hours, and sometimes they went from the senior home to the hospital and they died, and they died alone.* (IP09 male 36 years old)
VP16	*Let's see, that is one of the excuses that the hospitals gave us when they wouldn't take the referrals, they stated it to me directly: "so that you know, in other words, do you want them to die alone in a hallway or to die in the senior residence with someone by their side."* (IP11, male, 38 years old)
VP17	*In view of what I've seen, I think the best thing that could have happened to them is to be here. I don't think the outcome would have changed much; I don't think so. And they were here, in the end we are with them every day and although they have died without their family, they had a familiar face, and not in the hospital; and in the hospital, well, the treatment is different because they are people who come and go, here in the end we have them every day and for many years.* (IP13 female, 42 years old)
VP18	*You can imagine the mess we had here, when we had to put the grandparents in the bags, and we had to do it ourselves because in the beginning it was said that they (the funeral homes) could not pass beyond a certain part of the residence and therefore could not do it.* (IP05 female, 41 years old)
VP19	*Later when they told us at first to put them in a garbage bag. And I: "I don't know, I don't know, until they come from the mortuary and pick them up, I am covering them with a sheet, and I will throw it away, but I am not covering them with a garbage bag," they had already told me what I was supposed to do, but no. What is this? This is inhumane.* (IP04 female, 65 years old)
VP20	*I believe it was Dantesque, it was like...well, I imagine like a concentration camp, I don't know, I mean...depersonalized, I don't know, I don't know where they took them down to, I imagine to the hospital morgue, I don't know our hospital's morgue capacity, my hospital isn't very big, 400 beds, but...apparently it was overflowing...and stacked I believe.* (IP41, female, 50 years old)

VP21	*After you have worked a ton of hours and many days, you are already carrying the weight of it, it is yet another burden. You have the respect that there are people in there, and above all you are careful with them because you don't, you don't just throw them around as if they were a sack of potatoes, but, of course, sometimes you do forget a bit that they are corpses.* (IP29 male, 39 years old)
VP22	*Many colleagues said that the families told them, "Hey, take care of yourself."* (IP26, female, 40 years old)
VP23	*Well, my father was going to go to a morgue or wherever, and he was going to be alone for another whole day until someone meets him, at the morgue or wherever.* (IF07, female, 26 years old)
VP24	*Then there had been many deceased who had died alone, and in some way, our presence, although small, was symbolic, we were there (in the morgue).* (IP03, male, 53 years, old*)*
VP25	*The funeral home thought to put a flower on each coffin and they were doing it. The idea came from the employees*. (IP38 man, 46 años)

Results

(1) *He has died and he died alone, that is the worst part* (IF01, female, 23 years old)

One of the factors that had the greatest emotional impact on the family members of those who died during the state of emergency in Spain between March and May 2020, was the fact that their loved ones died alone.

Healthcare professionals reported that when communicating the news of a death, one of the most frequent concerns of the relatives was whether their loved one died alone (VP1).

In their narratives, relatives who were interviewed expressed two key causes of anguish when facing the idea that their loved ones died alone.

On the one hand, the feelings of anger or sadness, that still lingered at the time of this study, were a result of not having been able to be with their loved one in their final moments (VF1), on top of the uncertainty and despair the relatives experienced during the days prior to the death of their family member because they were unable to communicate with them (VF2).

On the other hand, the anguish was caused by imagining how their loved one must have felt when facing dying alone (VF3). These thoughts and emotions were often derived from a family member's feelings of guilt as they processed a feeling that in some way, they had abandoned their loved one. This sensation of culpability has been referred to by both the actual family members, as well as the caregiving professionals who provided social and emotional support to the family members at the time (VF4 and VP2).

Some of the family members interviewed also stated that these thoughts continued to appear months after their family member's death, producing disproportionate reactions such as panic attacks or anger when recalling the aloneness of their loved one's last days (VF5).

On the other hand, the relatives who were able to accompany their loved ones, because they died at home,

highlighted the positive aspect of having been present at the moment of death and commented on the importance of their relative having been accompanied in their last moments and not having died alone (VF6).

(2) *Dying alone in a room is not dignified and is horrible* (IP01, male, 50 years old)

When asked what it might mean for someone to die alone, the answers were associated with feelings of failure and fear (VP3), of anguish (VP4), of abandonment, (VP5), or of sadness (VP6); and even professionals such as medical workers affirmed that the people who died alone during the most difficult months of the pandemic did not have a good death (VP7). They also emphasized the need for every human being to die accompanied in order to die well (VP8).

When faced with the question of whether the deaths that occurred in hospitals or senior residences during the pandemic were dignified deaths, the professionals stated emphatically that no they were not, and the isolation in which patients found themselves meant that many deaths occurred in an undignified manner (VP9).

Being present during the passing of many patients who were alone has awakened a discomfort in the professionals about the end of their own lives and has made them aware of the desire to die accompanied when their end-of-life moments arrive, as they believe it is not good to die without having loved ones close to you (VP10).

(3) *We have done everything we could* (IP06, female, 25 years old)

Almost all the professionals agreed that they did their best to ensure that patients died accompanied (VP11), so that a bad death was avoided and to dignify, to the extent possible, the moment of death (VP12).

The professionals in the senior residences spoke often of how they were able to accompany the dying in their last moments of life (VP13), while in the hospitals due to the extreme amount of patient care required, healthcare workers had fewer possibilities for making accompaniment a reality and told how, often, they would enter rooms and find patients had already passed (VP14).

In some cases, hospital professionals believed it was better for the elderly not to be transferred to the hospital centers since this might help ensure that the patients would die accompanied by personnel in the residences, something that would not have occurred if they had ended up in the hospital, where, most likely, they would have still died but would have died alone (VP15). Professionals in the senior residences, however, expressed that at the very least they should have given these people the opportunity to obtain medical attention and that this failure to provide care was to the detriment of the patients' dignity (VP16). Nonetheless, these same professionals recognized that death in the senior residences almost always transpired in the company of others and was therefore a better death than those that occurred in the hospitals (VP17).

(4) *I had to put them in a bag and spray them* (IP14, female, 30 years old)

Healthcare professionals also did everything possible to dignify the moments after the deaths when they had to handle and prepare the cadavers, something that not all were accustomed to (VP18). Some professionals in senior residences commented on a lack of resources and extensive security measures around the treatment of the bodies, which placed them in a position where they felt they were treating the bodies in an inhumane or undignified manner (VP19). This feeling of undignified treatment was also generated by the number of bodies that accumulated in some residential and hospital centers as it was impossible for funeral homes to complete their work within normal and adequate timeframes (VP20). Some of the funeral service professionals responsible for collecting the bodies also told us that with such a large volume of deceased, they sometimes ran the risk of forgetting that they were dealing with the corpses of human beings, who deserved respect and dignified treatment (VP21).

(5) *"Hey, take care of yourself"*
(IP26, female, 40 years old)

Caring for the bodies of the dead, as if they were still alive, is something that concerned relatives (VP22), who in the interviews referred to their deceased loved ones with attributes of living people, such as the possibility they could be feeling cold or lonely (VP23). A worry existed that the body of the person who had passed alone was also alone after death, and both funeral homes and family members expressed that the ideal would have been for the body to be accompanied in the time between death and the burial or cremation (VF6). The use of the word accompany appears frequently in reference to the cadaver as if it was a living person who needed to be kept company.

In these cases, it was the funeral service professionals and morgue chaplains who tried to be with the deceased body providing accompaniment in a symbolic way and in doing so, to dignify these solitary deaths (VP24). The workers in one funeral home told us how they placed a rose on every casket at the time of burial to also dignify the funeral rite (VP25).

One interviewee who was able to be with their loved one in the final moments, as their family member had died at home, expressed satisfaction with the gentleness with which the undertakers collected and treated the body, emphasizing how important it was that the body was treated with tact and dignity (VF7).

Discussion

Given the exceptional circumstances in which millions of deaths have occurred during the COVID-19 crisis, it is necessary to ask whether, in this situation, the people who have died have done so well and in a dignified manner.

Steinhauser et al. (2000) claim that there is no empirical support that allows us to define what a good death is. Meier et al. (2016), in an exhaustive literature review, also indicate that there is a certain lack of agreement regarding this concept. Meier's study makes no reference to dying in the company

of others being an indicator of a good death (Meier et al., 2016), but implicit references to this criterion are found in some of the literature reviewed.

This indicator does appear in relation to dying alone or accompanied in studies related to death during COVID-19, such as that of Strang et al. (2020), in which, through an examination of the difference between existential loneliness and social loneliness, it is stated that dying alone is not a good way to die.

Richard Smith (2000) indicates that among others, elements that constitute a good death are having time to say goodbye and having access to adequate emotional and spiritual support, something that did not occur in the deaths studied here.

The testimonies collected in this study confirm that dying alone is not socially considered a good death, and that many of the deaths that occurred during the most critical months of the COVID-19 pandemic occurred without the company of family as would have been desired. To die alone can have the social significance of dying abandoned or to have failed as a human being in the social and family dimension, and this idea has worried family members and professionals during these months.

In the face of the traditional idea that death is understood as a collective act (Lisón, 2008) that transcends the individual (Barley, 2012), this study describes how, in Madrid during the indicated months, the moment of death and the subsequent rituals have been emptied of that important communal element that gives death meaning and that is also necessary for the elaboration of a healthy mourning process (Worden, 2009).

Weisman and Hackett (1961) refer to the concept of an appropriate death, indicating that an appropriate death, to be considered as such, should be supported by four pillars, one of which has to do with the continuity of social relationships. This study could not uncover evidence of whether the dying felt, or not, a rupture in relationships or if they felt emotionally abandoned in the hospitals and residences, but evidence did appear that relatives felt they had abandoned their loved ones and had let them die in an inappropriate way.

Leaving a family member to die alone can be a threat to both personal ontological security and moral reputation (Seale, 2004), hence, as it appears in the results of this study, the relatives of the deceased have strong feelings of guilt, which could complicate their elaboration of healthy grief (Worden, 2009).

With respect to healthcare professionals, there exists a generalized thought that no one should die alone (Caswell & O'Connor, 2019), a thought that, as this study has proven, often projects an individual's desires for their own death and renews one's desire to die in the company of others.

As a result of this thinking, and to compensate for the sensation of abandoning the dying while also trying to facilitate a good death, healthcare and social services professionals, as this study demonstrates, did their best to

accompany their patients and ensure they would not be alone at the moment of death. The professionals tried in this way to carry out the work of accompaniment as described by Torre (2020), focusing not only on the medical aspects, but also seeking to make the patient feel led, and not abandoned to their fate, while facilitating a good death as indicated by Küng (2016).

Strang et al. (2020) concur with the idea that arose in this study, that accompaniment of the dying by professionals could have compensated, to some extent, for the lack of a family presence.

Another aspect shared by the present study and the research of Strang et al. (2020), which was conducted in Sweden, is the fact that in the senior residences it was more feasible to provide professional accompaniment than in the hospitals.

Wang et al. (2020) indicated in May of 2020 how healthcare professionals should help to dignify the deaths that were occurring due to COVID-19 and several of these indications were directly related to this effort to compensate for the lack of family accompaniment.

This study also infers that deaths in solitude are not socially considered to be dignified deaths from an ethics point of view. Family accompaniment is a decisive category for the achievement of a dignified death according to Ibáñez-Masero et al. (2016) but during the pandemic this has not been possible to fulfill. Lack of companionship and support, as well as not feeling valued or respected, undermines the dying's sense of dignity (Chochinov et al., 2020). Chochinov et al. (2020) claim that during the COVID-19 pandemic, dignity has been under assault and Consuegra-Fernández (2020) signal that during the COVID-19 crisis, ethical standards of medical care have been breached and the rights of dying patients have been neglected.

On the other hand, the present study also indicates that for mourners, the dignity of the deceased does not end at the moment of death, but rather extends to the ongoing treatment of the cadaver, from the time of death until the moment of burial or cremation. For relatives, the corpse still has the attributes of the living person. The ethical and legal question of whether a corpse is a person or a thing, and at what point the transformation transpires, is raised by Stroud (2018) and Posel and Gupta (2009), who state that the living resist the idea that a corpse is simply flesh and indicate that this resistance is the reason for the existence of rituals that try to give human dignity to the bodies of the deceased. These community rituals have been diminished, and almost disappeared during the COVID-19 crisis and as can be seen in the above results, this fact has also provoked a certain sense of guilt or abandonment for the mourners.

The corpses deserve reverence, but the protocols and limitations governing rituals during the pandemic have sometimes broken this respect (Kumari, 2021). The concepts of dignity and respect are intimately linked to each other (Jones, 2015). This research shows how

relatives of the deceased want the cadavers to be treated with respect, and it causes them pain to imagine that this has not been the case. Although San Agustín (1995) indicates that funeral services and their solemnity constitute more a consolation for the living than a relief for the deceased; this consolation comes, in part, from considering that the ritual dignifies the deceased.

In a study of forensic pathologists, Schwarz et al. (2021) stated that the external conditions of the work interfered with the dignified handling of the bodies. This result is similar to that of the present study, which found that the volume of deaths and the accumulation of corpses in hospitals and residences created a barrier for the professionals and interfered with the dignified and respectful handling of the corpses. Even so, this study observes that professionals have tried to provide dignity to the handling and accompaniment of the bodies of the deceased, despite the circumstances and the over-saturation of the system (González-Fernández et al., 2020).

The results obtained in this study are well-understood within the theory of the historical evolution of death developed by Aries (2011). The solitary deaths that occurred during the COVID-19 pandemic are the maximum expression of the individualization and denial of death that Aries identifies in his studies. From this historical perspective of death, which incorporates the existence of the so-called inverted death, it is easier to appreciate that the solitary deaths mentioned in the current study have indeed come to occur.

Conclusions

Most of the deaths that occurred in Spain during the months of the state of emergency and the accompanying restrictions cannot be considered good or dignified deaths, since they occurred in seclusion without the patient being able to choose whether to be surrounded by his or her loved ones. Healthcare professionals did their best to accompany patients, but in most cases, it was impossible due to the pressures on the healthcare system and providers. However, the accompaniment of a family member will never be the same as that of a professional.

Likewise, professionals who dealt with corpses have tried to give respect and dignity to the bodies in the absence of the rituals of accompaniment desired by relatives. The volume of deceased and the overload of the system has not always made this possible. Relatives consider that a corpse deserves the same respect as a person who is still alive.

Limitations

The main limitations are derived from the exceptional circumstances in which the data was collected. The interviews were conducted immediately after the most intense months of the pandemic. Some professionals were still under great pressure to provide care, and still had an altered emotional state, therefore making it difficult to make contact with them. Likewise, contact with family members who were initiating the mourning process was complicated. Additionally, the interviews were designed to be conduc-

ted in person; however, some had to be conducted virtually, making the expression and observation of nonverbal emotions and meanings more difficult.

On another note, the lack of agreement in the scientific community on the meaning of a good death or death with dignity is another limiting factor for establishing the substance of this study.

Implications

This study highlights the need to review and establish protocols for future crisis and emergency situations to ensure that victims can have a good death and a dignified death whenever and wherever possible.

End-of-life discussions in social intervention and primary care, as well as the use of advance directives, should be encouraged. But this would be insufficient if the public system cannot guarantee that patients' wishes can be carried out. Individuals cannot be forced to die alone or accompanied, but their will must be respected by applying the principle of autonomy.

Likewise, in the face of crises and catastrophes, protocols should be established for the care of the corpse to ensure the corresponding respect it deserves, since it represents the de facto living person.

Data availability statement

The authors confirm that the data supporting the findings of this study are available within the article.

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8.3. Carta de la revista

Carlos Hernández

De:	OMEGA - Journal of Death and Dying <onbehalfof@manuscriptcentral.com>
Enviado el:	lunes, 6 de septiembre de 2021 13:40
Para:	jhernandezf@comillas.edu
Asunto:	OMEGA - Journal of Death and Dying - Decision on Manuscript ID OMEGA-21-0190.R1

06-Sep-2021

Dear Dr. Hernández:

It is a pleasure to accept your manuscript entitled "Nobody should die alone. Loneliness and a dignified death during the COVID-19 pandemic." in its current form for publication in OMEGA - Journal of Death and Dying. The comments of the reviewer(s) who reviewed your manuscript are included at the foot of this letter.

Thank you for your fine contribution. On behalf of the Editors of OMEGA - Journal of Death and Dying, we look forward to your continued contributions to the Journal.

Sincerely,
Dr. Ken Doka
Editor in Chief, OMEGA - Journal of Death and Dying KnDok@aol.com

Reviewer(s)' Comments to Author:
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9. CONCLUSIONES GENERALES E IMPLICACIONES

9.1. Conclusiones generales

La muerte es un hecho irrefutable por el que todas las personas tienen que pasar, y esta constante en la propia esencia del ser humano está presente de forma holística en todos los ámbitos, en el cultural, el religioso, el emocional, el social, el biológico, el artístico, etc.

Siguiendo esta visión holística de las manifestaciones en torno a la muerte y el morir, se comprueba cómo las expresiones rituales en torno a la muerte, sean estrictamente fúnebres o no, son algo más que una expresión folclórica y cultural particular en cada una de las culturas en la que se realizan.

Los rituales que giran en torno a la muerte son un reflejo de las actitudes del ser humano ante este hecho irreversible y guardan, para las personas que en ellos participan, el significado de su relación con la muerte propia y ajena.

El miedo a la muerte o al sufrimiento que esta provoca, el deseo de huir de ella y de no afrontarla cara a cara, propio de la modernidad, hace que los rituales evolucionen de forma distinta.

Rituales como el de Santa Marta de Ribarteme guardan, en lo más profundo de su significado, la expresión del miedo del ser humano ante la muerte y su relación con el fenómeno religioso. Aun así, evolucionan hacia una visión más festiva que trascendente en el que los féretros se pueden convertir, con el paso de los años, en una mera anécdota dentro de la celebración, o incluso llegar a desaparecer.

El rito funerario posee tanto para la comunidad como para para el individuo una función clave en la elaboración del proceso de duelo que se ha evidenciado ante la llegada de la COVID-19 y la consecuente imposibilidad de realizar estos rituales.

Muchos de los duelos producidos por las muertes por COVID-19 en la llamada primera ola podrían evolucionar en duelos complicados debido a la dificultad de

despedirse de la persona en sus últimos días de vida. Así mismo, la ausencia del ritual fúnebre y la imposibilidad para ver al ser querido fallecido han provocado sensación de pérdida ambigua y dificultad para iniciar los procesos de duelo.

Las personas que han tenido que poner a la muerte en su agenda diaria durante la pandemia, como ha sido el personal sociosanitario, no siempre han tenido recursos emocionales para adaptarse a esta situación. La exposición continua y desproporcionada a la muerte durante las semanas que duró la primera ola de la COVID-19 puede provocar en estos profesionales problemas tales como ansiedad o trastorno por estrés postraumático. El hecho de trabajar previamente en servicios con alto volumen de personas fallecidas (unidad de paliativos o emergencias) no ha supuesto un factor de protección para estos profesionales.

El personal, cuyo trabajo consiste, o ha consistido durante la crisis de la COVID-19, en trabajar con cadáveres, pero que no ha presenciado los fallecimientos, acusa un menor agotamiento psicológico que los profesionales del ámbito sanitario, debido en gran parte a la despersonalización del difunto.

Tanto los profesionales como las personas que han perdido familiares durante los meses más críticos de la enfermedad han constatado que las muertes no se han producido de la forma deseada y aceptable para una sociedad como la nuestra. Morir en soledad se equipara a morir abandonado y, por tanto, de forma indigna.

Tampoco se consideran dignos ni adecuados los entierros o incineraciones realizados sin la presencia de seres queridos. Este hecho no solo se considera indigno para la persona difunta, que aún continúa viva en la mente de los dolientes, sino que además priva a los deudos de las muestras de cariño de sus seres queridos.

Morir en compañía de los seres queridos y ser incinerado o enterrado con el acompañamiento de estos, dota por tanto de dignidad al propio fenómeno de la muerte, tanto desde la perspectiva del moribundo como desde la de la comunidad.

El personal sanitario ha tratado de acompañar a los fallecidos en sus últimos momentos a pesar de la dificultad, si bien esto no siempre ha sido posible debido a la presión asistencial. En todo caso, el acompañamiento de un profesional no puede suplir el cariño de un ser querido ni la forma en que este se relaciona con su familiar moribundo en los últimos momentos de la vida.

Los rituales fúnebres en España están en continua evolución y sufren una resignificación continua. La presencia de la COVID-19 ha demostrado la importancia que aún poseen para ayudar a dar sentido a las muertes.

8.2. Implicaciones

Durante los meses más duros de la COVID-19 en España se ha hablado política y socialmente de dos crisis, la crisis sanitaria y la crisis económica. Esta tesis

evidencia que ha habido una tercera crisis que se ha silenciado: la crisis de los cuidados. No se ha cuidado la forma de morir, no se ha cuidado a las familias, no se ha cuidado el acompañamiento, no se han cuidado las despedidas, no se han cuidado los ritos, no se ha cuidado a los que nos cuidaban... Y aunque los profesionales han hecho todo lo posible por cuidar y acompañar, la falta de previsión, de respuesta política y las circunstancias propias de la pandemia han impedido la realización de estos cuidados dando lugar a esta crisis ignorada. Una crisis que posiblemente se vea reflejada a corto y medio plazo en la salud mental de miles de personas.

Esta tesis doctoral abre recorridos por tres caminos distintos, a) el camino de la investigación, b) el camino de la reflexión y c) el camino de la prevención.

a) El camino de la investigación.

Son varias las líneas de investigación que se abren tras esta tesis.

Sería interesante estudiar en profundidad los escasos rituales festivos y religiosos que existen en nuestro país en torno a la muerte o que usan los símbolos propios del mundo funerario. Es conveniente documentar estas celebraciones, darlas a conocer y mantener así el patrimonio cultural y popular español.

Es también necesario realizar estudios sobre los rituales funerarios existentes en España en la actualidad, su significado y su función, teniendo en cuenta la perspectiva de género, las diferencias culturales, la edad, la etnicidad y otras categorías que estructuran la sociedad y le aportan diversidad y riqueza.

Por otro lado, se deben realizar estudios de carácter longitudinal que midan los efectos de la sobrexposición a la muerte y sus consecuencias en la salud mental en el personal que ha trabajado en el entorno sociosanitario durante la pandemia de la COVID-19. Así mismo se debe realizar este tipo de estudios para observar el desarrollo de los duelos fruto de las pérdidas ocurridas durante los meses más duros de la pandemia.

b) El camino de la reflexión

Lo ocurrido durante la pandemia de la COVID-19, en relación con las muertes y su tratamiento, nos debe llevar a reflexionar sobré qué tipo de sociedad queremos ser y cómo queremos morir, y, sobre todo, cómo queremos acompañar y cuidar a los que fallecen.

Se hace necesario ofrecer una mirada bioética y humanizadora desde la intervención sanitaria, la intervención psicosocial y la asistencia funeraria que rehumanice la muerte y ofrezca un rostro más humano a los que han de afrontar sus consecuencias: pacientes, familiares y profesionales. El debate en torno a la muerte digna no debe mantenerse solo para debatir o legislar la eutanasia, sino que se debe abordar desde su máxima dimensión.

c) El camino de la intervención

Por último, esta investigación abre múltiples direcciones en el camino de la prevención y de la intervención psicosocial.

Es necesario introducir en los estudios de materias sanitarias y sociales asignaturas que desarrollen competencias que permitan a los y las profesionales del futuro afrontar la muerte con naturalidad y sobre todo saber acompañar a dolientes y moribundos con empatía, respeto y autenticidad. En este sentido hay que cuidar también la formación continua del personal sociosanitario.

Se precisa la realización de protocolos en residencias y hospitales que aseguren el correcto acompañamiento de los moribundos, incluso en circunstancias excepcionales. También se debe asegurar la posibilidad de participar en actos de despedida adecuados en situaciones de crisis y emergencias.

Las funerarias deben plantearse su función meramente higiénica y pasar a ser centros de referencia en dos ámbitos: el de los cuidados y el del rito. Por un lado, el ámbito de los cuidados y del acompañamiento a las personas que inician un proceso de duelo, integrando en sus plantillas personal capacitado para hacerlo. Y, por otro lado el ámbito del rito funerario, resignificando rituales de despedida que sirvan como protector emocional para los dolientes y que aseguren, a su vez, el mantenimiento de los valores culturales de la comunidad, sin ignorar los signos de los tiempos.

Esta tesis partía analizando un ritual en el que algunas personas miran cara a cara a la muerte para celebrar la vida y se cierra evidenciando la dificultad de celebrar una vida digna cuando las circunstancias nos arrancan rituales de despedida que tienen que ver con la muerte.

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