Revista Bioética
Print version ISSN 1983-8042 | On-line version ISSN 1983-8034

Rev. Bioét. vol.34 Brasília 2026

Grief during the pandemic and in the post-pandemic period in Brazil: a bioethical analysis

Luciana Soares Rosas [1], *Mary Rute G. Esperandio* [1], *Juan José Camou Viacava* [1]

1. Pontifícia Universidade Católica do Paraná, Curitiba/PR, Brazil.

Abstract

With the outbreak of the COVID-19 pandemic, researchers have sought to understand the repercussions of this experience on complications in the grieving process. This study aimed to gather evidence regarding expectations of a higher prevalence of prolonged grief indicators among bereaved individuals during the COVID-19 pandemic in Brazil, as well as to verify whether specific variables related to the pandemic exacerbated levels of grief-related suffering, impacting well-being after the pandemic. A quantitative, exploratory, descriptive, and cross-sectional study was conducted with 426 bereaved individuals during (n=302) and after the pandemic (n=124). The results showed that 26.2% of bereaved individuals during the pandemic and 21.8% in the post-pandemic period presented indicators of prolonged grief. Variables related to the pandemic had a significant effect on higher levels of grief-related suffering, with impacts on lower well-being in the post-pandemic period. It is expected that this research will contribute to supporting public policies and mental health interventions.

Keywords: Bereavement. COVID-19. Mental health. Disaster vulnerability. Bioethics.

Resumo

Luto em contexto de pandemia e pós-pandemia no Brasil: análise bioética

Com o advento da pandemia de covid-19, estudiosos têm se debruçado para compreender possíveis repercussões dessa experiência em complicações no processo do luto. O objetivo do estudo foi levantar evidências sobre as expectativas de maior prevalência de indicativo de luto prolongado entre enlutados durante a pandemia de covid-19 no Brasil, bem como verificar se variáveis específicas do contexto pandêmico exacerbaram os níveis de sofrimento do luto, com impactos no bem-estar no pós-pandemia. Foi realizada pesquisa de abordagem quantitativa, exploratória, descritiva, de corte transversal com 426 enlutados durante (n=302) e pós-pandemia (n=124). Os resultados demonstraram que 26,2% dos enlutados durante a pandemia e 21,8% no pós-pandemia apresentaram indicativo de luto prolongado. Variáveis do contexto pandêmico apresentaram efeito significativo em maiores níveis de sofrimento do luto, com impacto em menor bem-estar no pós-pandemia. Espera-se que a pesquisa contribua para subsidiar políticas públicas e intervenções em saúde mental.

Palavras-chave: Luto. Covid-19. Saúde mental. Vulnerabilidade a desastres. Bioética.

Resumen

Duelo en contexto de pandemia y postpandemia en Brasil: análisis bioético

Con el advenimiento de la pandemia de covid-19, investigadores se han dedicado a comprender las posibles repercusiones de esta experiencia en las complicaciones del proceso de duelo. El objetivo del estudio fue recopilar evidencias sobre las expectativas de una mayor prevalencia de indicios de duelo prolongado entre personas en duelo durante la pandemia de covid-19 en Brasil, así como verificar si variables específicas del contexto pandémico exacerbaron los niveles de sufrimiento del duelo, con impactos en el bienestar en el período pospandemia. Se realizó una investigación cuantitativa, exploratoria, descriptiva y transversal con 426 personas en duelo durante (n=302) y después de la pandemia (n=124). Los resultados demostraron que el 26,2% de las personas en duelo durante la pandemia y el 21,8% en el período pospandemia presentaron indicios de duelo prolongado. Variables del contexto pandémico mostraron un efecto significativo en mayores niveles de sufrimiento del duelo, con impacto en un menor bienestar en el período pospandemia. Se espera que la investigación contribuya al desarrollo de políticas públicas e intervenciones en salud mental.

Palabras clave: Luto. COVID-19. Salud mental. Vulnerabilidad ante desastres. Bioética.

The authors declare no conflict of interest.
Approval CEP/PUC-PR 6.495.514 during the pandemic; Approval CEP/PUC-PR 6.908.210 for the post-pandemic period

Research

After the COVID-19 pandemic was declared in 2020 [1], several grief scholars have attempted to understand the impacts of the pandemic on the grief experience and the possible complications in its process over time.

The grief experience in a pandemic that affected the entire world can reach even more overwhelming contours and impacts due to the political and social context in which the COVID-19 pandemic was experienced in Brazil, during the denialist administration of former president Jair Messias Bolsonaro. Vulnerabilities that had historically beset the Brazilian population intensified during the pandemic, requiring the consideration and active initiative of bioethics [2].

Thus, the attempt to understand the extent, depth, and possible impacts of pandemic grief in the Brazilian context cannot be dissociated from the so-called persistent issues that plague the Brazilian population and that were exacerbated during the pandemic. In Brazil, the COVID-19 pandemic was marked by necropolitical issues implemented during this period, characterized by the power to dictate who can live and who must die [3]. Thus, asseverating a deliberate practice called programmatic vulnerability, which *synthesizes the explanatory category of ethical issues that are phenomenally expressed as management, longitudinality, team practice, primary health care profile, or confidentiality and privacy issues* [4], has become even more pressing.

This practice affected both those seeking access to healthcare and professionals who found themselves unable to access the necessary means to meet the needs of those seeking the healthcare system. Thus, the bereaved who lost significant persons to death during this period, victims of the negligence and deliberate action of the Brazilian federal administration, also became programmatically vulnerable.

Bereaved individuals who experience the death of a family member due to unnatural causes, such as accidents, homicide, and suicide, have a higher risk of developing prolonged grief disorder, post-traumatic stress disorder, and depression [5]. These deaths invade life unexpectedly, creating situations of vulnerability, which hinder the processing and integration of grief [6]. Studies conducted in the context of the COVID-19 pandemic corroborates these findings, as the new conjuncture changed the perception of death and grief [7], making the process of making sense of the event of death more difficult, increasing feelings of loneliness, anguish, and guilt among the bereaved [8], and posing a greater risk of suicidal ideation and depression [9]. These feelings can remain over time, hindering the process of accepting death [10] and integrating grief into life. Thus, the circumstances of death can expose the bereaved person to a greater risk of mental suffering [11].

The unique grief experience during the COVID-19 pandemic in Brazil underscores a situation that should be addressed in terms of public health: the suffering of those bereaved by the pandemic in Brazil, more than three years after the pandemic peak in the country, which may result in reduced overall well-being of the bereaved population in the post-pandemic era.

More temporally distanced studies can provide better insights into the impacts of grief during the COVID-19 pandemic in Brazil and, with that, consider the possibility of more complicated grief processes in the coming years [12]. Thus, the study objective was to survey evidence on the expectations of a higher prevalence of prolonged grief disorder indicators among individuals bereaved during the COVID-19 pandemic in Brazil, and to verify if specific variables of the Brazilian pandemic exacerbated grief suffering, with impacts on post-pandemic well-being.

Method

This is an empirical study, with a quantitative, exploratory, descriptive, and cross-sectional approach. The quantitative research method seeks to test objective theories by analyzing the relation between variables, which are generally measured by instruments that provide numerical data, enabling their analysis through statistical methodology [13].

Participation in the study was voluntary. Data collection employed links created for this purpose, which were made available on the Qualtrics platform. For the pandemic, collections were carried out between November 2023 and March 2024; for the post-pandemic period, between July and October 2024. The online survey mode

has been widely used for data collection, mainly because it expands researcher access to different publics, provides cost reduction for in-person stages (such as travel and personnel), and offers participants privacy and flexibility as to when to answer questionnaires [14].

The selection of participants for this study included specific inclusion and exclusion criteria. The pandemic sample included participants who lost a significant person (family member, friend, work colleague, etc.) to death, from any cause of death, between March 2020 and December 2022. March 11, 2020. the date of the declaration of pandemic status, was considered the start of the time frame. The post-pandemic sample included individuals who lost a significant person to death from May 2023, as on May 5, 2023, the World Health Organization (WHO) declared the end of the public health emergency of international concern. This marks a shift from an emergency situation to a management context, alongside other contagious diseases, a period that can be characterized as post-pandemic [15].

Study participants were recruited both virtually (by sending the link for the online survey) and in person (direct contact with potential participants). Virtually, the survey links were sent to target groups of bereaved people, distributed through the researcher's contact networks, and published on social media (such as Instagram, Facebook, and discussion groups and forums on the issue). Snowball sampling was employed, which refers to a non-probabilistic sample, using reference chains [16].

The minimum age for participation was 18 years, and the respondent had to reside in Brazilian territory. Answers were collected only if respondents agreed to the informed consent form (ICF) and accepted participation in the study, stating having read and understood all information provided, been able to make an uninfluenced decision, agreed to not receive any monetary compensation for participating in the study, and declared to be 18 years of age or older; if the ICF was not accepted through the online data collection link, the initiated questionnaire was automatically finalized.

The collection of data from bereaved individuals considered the risk of increased suffering during and after participation. Thus, participants were informed about the risks of emotional discomfort, with psychological support provided in case of perceived experience of emotional difficulties resulting from the study. It was also guaranteed that they could opt out of participation at any time (in case they decide to do so), without any penalty.

All data collected during the study was processed with strict confidentiality and anonymity. This means that all information provided during the study will not be linked to any specific person in the future. All confidentiality and data protection concerns were fully respected.

Two questionnaires were applied to two different samples: the first composed of people who lost a significant person to death during the COVID-19 pandemic, and the second consisting of people who lost a significant person to death in the post-pandemic.

The sociodemographic data collection aimed to survey the characteristics of the bereaved participants (gender, age, skin color, education, monthly income, among others) and information about the deceased person, such as the relationship with them (categorized as "family member" or "friend and acquaintance" for the analyses), the closeness of the relationship and age, the cause of death (categorized as "death by COVID-19 or complications," "unnatural death," or "natural death"), and date of death. The survey also collected information about the possibility of having said goodbye to the deceased person and having participated in the funeral (categorized as "participated" or "did not participate"), and about the perception of the care provided by the healthcare team.

The grief-related suffering assessment used the 13-item scale Prolonged Grief Disorder - 13 - Revised (PG-13-R), as this instrument can be used for a dual purpose: to continuously assess the intensity of this suffering and to assist in the differential diagnosis of prolonged grief disorder (PGD) according to criteria established by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR) [17]. The well-being survey used the 5-item scale WHO-5 Well-Being Index, as this instrument is proposed by the WHO for self-assessment of the psychological well-being dimension [18].

The PG-13-R is a unidimensional instrument composed of ten items measured on a Likert scale, where: not at all=1, slightly=2, a little=3, quite a bit=4, and overwhelmingly=5. The calculated score corresponds to the sum of all answers, with 10 being the minimum and 50 being the maximum points on the scale. The instrument also includes three questions considered gatekeepers: whether the person experienced loss by death of someone significant; how many months ago the loss occurred; and whether they feel there are impacts from grief suffering on important areas of life, such as social and labor/occupational life. Cronbach's alpha for the sample was 0.920.

The WHO-5 is a five-item scale, developed by the WHO based on the Psychological General Well-Being Index and the Scales for Anxiety and Depression, which range from 0=never, 1=sometimes, 2=less than half the time, 3=more than half the time, 4=most of the time, and 5=all of the time. The score is calculated by summing all the scale answers, with a minimum of 0 and a maximum of 25 points. Cronbach's alpha for the sample was 0.899.

The data analysis procedures followed the principles of descriptive analysis, in order to verify the existence of patterns or trends to be surveyed. The samples were compared using the chi-square test between groups for categorical variables and the independent samples t-test for interval variables. We also applied Kruskall-Wallis and Mann-Whitney tests (for disproportionate groups), two-factor Anova (to verify the interaction of qualitative factors on the dependent variable), and the Process Macro module for SPSS for analysis of the moderation model for the quantitative moderator variable [19]. Moderator variable is one that can affect the direction and/or strength between an independent variable (IV) and a dependent variable (DV) [20].

The data statistical analysis used the software IBM SPSS v.20 for Windows (Statistical Package for the Social Science). The adopted significance level was 5% (α=0.05) [21]. The tested hypotheses were: 1) there is a higher prevalence of prolonged grief disorder indicators among bereaved individuals who lost significant persons to death during the COVID-19 pandemic; and 2) specific variables of the grief experience during the COVID-19 pandemic period exacerbated grief suffering, with impacts on post-pandemic well-being.

Results

We obtained 695 responses from the links of the questionnaires hosted on the Qualtrics platform, of which 426 (61.30%) were qualified as valid for the analysis of the results. Responses that passed through the filters/gatekeepers and answered PG-13-R, WHO-5, and all other questions were considered valid. The sociodemographic data of the two samples were compared to verify if the groups are homogeneous (Table 1).

Only the demographic variable "Education" showed a difference between the two samples, but without statistically significant differences for the grief responses (Kruskall-Wallis x^2=8.889, p=0.114). Thus, despite a higher prevalence of people with a higher level of education in the post-pandemic sample, there are no significant sociodemographic differences between the two collected samples.

We also compared contextual data of the pandemic and post-pandemic grief experience for the two samples, to verify the differences between the groups (Table 2).

Table 1. Sociodemographic Data

	Pandemic (n=302)	Post-pandemic (n=124)
Gender		
Female	79.47%	76.61%
Male	19.87%	23.39%
Other	0.66%	0.00%
x^2=1.434; p=0.628		

continues...

Table 1. Continuation

	Pandemic (n=302)	Post-pandemic (n=124)
Relationship with the deceased		
Father or mother	29.14%	25.00%
Child	0.99%	1.61%
Sibling or Spouse	8.28%	13.71%
Friend, acquaintance, or other	61.59%	59.68%
x^2=3.510; p=0.167		
Closeness to the deceased		
Very distant	2.32%	1.61%
Distant	5.96%	7.26%
Neither distant nor near	12.25%	16.94%
Close	31.79%	24.19%
Very close	47.68%	50.00%
x^2=3,669; p=0.453		
Skin color		
White	68.54%	67.74%
Black	6.29%	2.42%
Brown	22.85%	20.16%
Yellow	1.32%	6.45%
Indigenous	0.99%	0.81%
Other	0.00%	2.42%
x^2=18,390; p=0.117		
Education		
Incomplete elementary education	0.00%	0.00%
Complete elementary education	0.66%	0.00%
Incomplete secondary education	0.33%	1.61%
Complete secondary education	7.62%	4.03%
Incomplete higher education	21.85%	8.87%
Complete higher education	24.83%	21.77%
Postgraduate education	44.70%	63.71%
x^2=19.454; p=0.001		

continues...

Table 1. Continuation

	Pandemic (n=302)	Post-pandemic (n=124)
Monthly income		
Up to 1 minimum wage	9.60%	1.61%
From 1 to 3 minimum wages	29.14%	18.55%
From 4 to 6 minimum wages	16.23%	29.03%
From 6 to 8 minimum wages	9.93%	12.10%
More than 8 minimum wages	15.89%	27.42%
No income	9.60%	3.23%
I prefer not to say	9.60%	8.06%
x^2=30.019; p=0.160		
Religiosity and spirituality		
Religious	20.20%	10.48%
Spiritual, but not religious	35.43%	50.81%
Religious and spiritual	32.78%	31.45%
Neither religious nor spiritual	11.59%	7.26%
x^2=11.629; p=0.977		
Belief in God		
Yes	85.10%	84.68%
No	7.28%	7.26%
I don't know	7.62%	8.06%
x^2=0.025; p=0.887		
Religious affiliation		
I don't believe in God and I don't have a religion	6.29%	4.84%
I believe in God, but I don't have a religion	23.84%	29.03%
Catholic	42.05%	33.87%
Evangelical	15.23%	10.48%
Spiritism	5.96%	8.87%
Afro-Brazilian religions	2.65%	6.45%
Other	3.97%	6.45%
x^2=9.793; p=0.177		
Age of the bereaved (in years)	**37.74±14.18**	**40.27±14.25**
t=−1.651; p=0.100		
Age of the deceased (in years)	**63.20±19.15**	**63.48±18.69**
t=−0.034; p=0.973		

Table 2. Contextual data of the grief experience

	Pandemic (n=302)	Post-pandemic (n=124)
Cause of death		
COVID-19 or complications	53.64%	4.84%
Natural causes	24.17%	53.23%
Unnatural causes	6.95%	10.48%
Others	15.23%	31.45%
x^2=88.796; p<0.001		
Able to say goodbye in some way before death		
Yes	30.46%	52.42%
No	69.54%	47.58%
x^2=18.209; p<0.001		
The deceased had access to adequate healthcare and resources		
Yes	55.82%	68.55%
A little	28.08%	20.97%
No	16.10%	10.48%
x^2=5.962; p=0.020		
The deceased received good treatment from the team		
Yes	66.10%	73.39%
A little	20.21%	16.13%
No	13.70%	10.48%
x^2=2.145; p=0.167		
Did you feel well served by the team		
Yes	36.99%	40.32%
A little	10.96%	16.13%
No	8.22%	4.84%
No contact with the team	43.84%	38.71%
x^2=4.036; p=0.246		
Participation in funerals		
Participated	68.54%	81.45%
Did not participate	31.46%	18.55%
x^2=8.033; p=0.005		
Medical/psychotherapeutic follow-up directly related to the loss		
Yes, currently	20.20%	21.77%
Yes, right after the loss, currently not	17.88%	14.52%
No	61.92%	63.71%
x^2=0.740; p=0.691		
Grieving period (in months)	**31.22±8.51**	**8.62±4.83**
t=34.52; p<0.001		

Excepting the variables "Perception of the treatment offered by the care team" (for the deceased and for the bereaved) and "Medical/psychotherapeutic follow-up," all others showed a significant difference in the composition between the samples. The "Grieving Period" had no impact on grief responses (p=0.692). For the others, there were statistically significant differences: "Cause of death" (Kruskall-Wallis x^2=11.021, p=0.012), "Adequate access to healthcare by the deceased" (Kruskall-Wallis x^2=16.632, p<0.001), "Able to say goodbye" (Mann-Whitney U=17957.000. p<0.001) and "Participation in funerals" (Mann-Whitney U=12793.500. p<0.001). This demonstrates that specific factors of the pandemic impacted the grief experience.

Direct effect of the pandemic context

The mean PG-13-R score for the pandemic was 23.02 (SD=9.051, minimum=10. maximum=49, median=21.00. skewness=0.714, kurtosis=−0.407, Shapiro-Wilk p<0.001, Kolmogorov-Smirnov p<0.001), and 26.2% of respondents scored 30 or higher, signaling intense grief-related suffering, indicative of prolonged grief.

For the post-pandemic, the mean PG-13-R score was 23.11 (SD=8.991, minimum=10. maximum=48, median=21.50. skewness=0.733, kurtosis=−0.186, Shapiro-Wilk p<0.001, Kolmogorov-Smirnov p<0.001), and 21.8% of participants showed indications of prolonged grief.

Hypothesis tests (1) indicated that there was no impact of the context (pandemic/post-pandemic) on grief responses (Mann-Whitney U=18630.000. p=0.935). Nor was a statistically significant difference found between the prevalences of prolonged grief indicator (x^2=0.904, p=0.342). Thus, hypothesis (1) was refuted.

Direct effect of the relationship with the deceased person

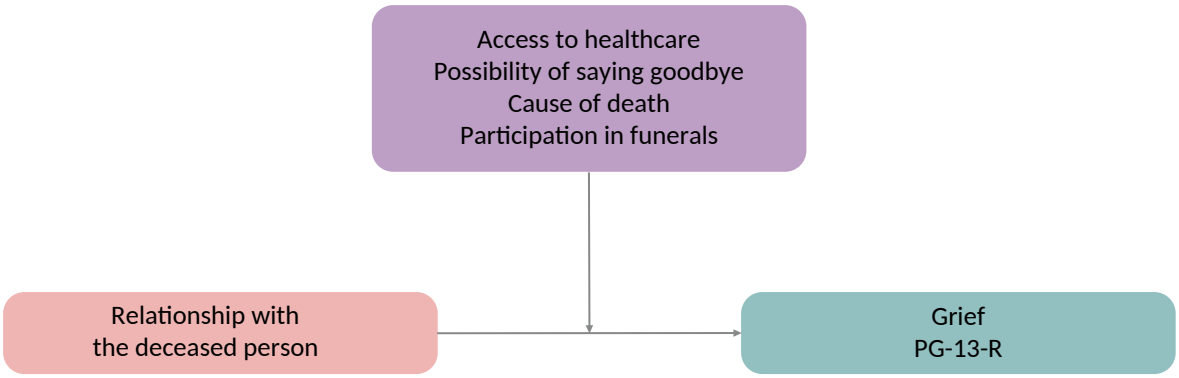
The relationship of the bereaved person's with the deceased person is expected to have a significant effect on grief responses. Therefore, the Kruskal-Wallis test was performed, which confirmed the predicted effect (x^2=31.114, p<0.001). The test was performed excluding the "Child" category, given the low number of samples: n=5. For the other categories: "Parent" (n=119), M=25.65, SD=9.936; "Sibling/spouse" (n=42), M=27.55, SD=9.077; "Friend/acquaintance/other" (n=260), M=20.90. SD=7.735, with differences between "Friend/acquaintance/other" and the other groups (p<0.001), but not between "Parent" and "Sibling/spouse" (p=0.216).

When considering "Parent" and "Sibling/Spouse" familial relationships as a single category, labeled "Family members," and classifying relationships involving "Friend/acquaintance/other" under the label "Friends and acquaintances," it was found that 39.76% of "Family members" showed indicators of prolonged grief, while for "Friends and acquaintances" the percentage was 15.38%, with a statistically significant difference (x^2=32.204, p<0.001).

Effects of interaction of contextual variables

Based on the contextual data of the grief experience (presented in Table 2), it was verified whether the variables impacted by the context (pandemic/post-pandemic) interacted with the variable "relationship with the deceased person" (0=family members and 1=friend/acquaintance). Thus, a moderation model was tested considering the impact of the contextual variables and the relationship with the deceased person. For the analyses, we used two-factor Anova tests (Figure 1).

Figure 1. Model of the relationship with the deceased person and interaction of the contextual variables



Access to adequate healthcare and resources

The two-factor ANOVA (Levene $p<0.001$) showed a significant effect of the independent variable "Access to healthcare" on the dependent variable "PG-13-R Score" ($F(2.410)=8.175$, $p<0.001$, $\eta p^2=0.038$, with $M_{yes}=21.67$ and SD=8.650. $M_{a_little}=24.18$ and SD=8.083, and $M_{no}=26.63$ and SD=10.849) and of the independent variable "Relationship with the deceased person" on the dependent variable "PG-13-R Score" ($F(1.410)=31.590$. $p<0.001$, $\eta p^2=0.072$, with $M_{family_members}=26.24$ and SD=9.790 and $M_{friends}=20.95$ and SD=7.831). This means that both the relationship with the deceased person and the perception of access to healthcare impact grief suffering responses. No significant interaction was found between the independent variables "Access to healthcare" and "Relationship with the deceased person" ($p=0.258$).

The *post hoc* test with Bonferroni correction indicated significant differences for the "Access to healthcare" group ("Yes": $p<0.001$; "A little": $p=0.027$; "No": $p<0.001$). For the "Relationship with the deceased person" group, the *post hoc* test indicated significant differences in the "Family members" subgroup between "Yes" and "No" ($p=0.002$) and "A little" and "No" ($p=0.045$). This means that, for family members who perceive that the deceased person did not have adequate access to healthcare, the levels of grief suffering are significantly more intense. For the "Friends and acquaintances" subgroup, there was no significant difference ($p>0.117$).

Able to say goodbye

The two-factor ANOVA (Levene $p<0.001$) showed a significant effect of the independent variable "Able to say goodbye" on the dependent variable "PG-13-R score" ($F(1.422)=10.371$, $p=0.001$, $\eta p^2=0.024$; $M_{said\ goodbye}=21.80$. SD=9.087; $M_{did\ not\ say\ goodbye}=23.77$, SD=8.922) and of the independent variable "Relationship with the deceased person" on the dependent variable "PG-13-R score" ($F(1.422)=42.800$. $p<0.001$, $\eta p^2=0.0.92$; with $M_{family\ members}=26.41$, SD=9.855; and $M_{friends}=20.90$. SD=7.735). That is, those who responded as being a family member and not having had the opportunity to say goodbye presented more intense grief suffering responses. No significant interaction was found between the independent variables "Possibility of saying goodbye" and "Relationship with the deceased person" ($p=0.493$).

Cause of death

The two-factor ANOVA (Levene $p=0.024$) showed a significant effect of the independent variable "Cause of death" on the dependent variable "PG-13-R Score" ($F(3.418)=4.451$, $p=0.004$, $\eta p^2=0.031$, with $M_{covid}=24.18$ and SD=9.469, $M_{unnatural}=24.85$ and SD=8.907, $M_{natural}=22.58$ and SD=8.459, and $M_{others}=19.54$ and SD=7.751) and of the independent variable "Relationship with the deceased person" on the dependent variable "PG-13-R Score" ($F(1.418)=32.194$, $p<0.001$, $\eta p^2=0.072$, with $M_{family\ members}=26.41$ and SD=9.855 and $M_{friends}=20.90$ and SD=7.735). It is worth noting that both the relationship with the deceased person and the cause of death impact grief

suffering responses. No significant interaction was found between the independent variables "Cause of death" and "Relationship with the deceased person" (p=0.218).

The *post hoc* test with Bonferroni correction indicated significant differences for the "Cause of death" group ("COVID-19 or complications": p<0.001; "Unnatural causes": p=0.007; "Natural causes": p=0.008; "Other causes": p=0.045). For the "Relationship with the deceased person" group, the *post hoc* test indicated significant differences in the "Family members" subgroup between "COVID-19" and "Natural causes" (p=0.039) and "COVID-19" and "Other causes" (p=0.038), but not between "COVID-19" and "Unnatural causes" (p=1.000). That is, for family members who lost a significant person to death by COVID-19, grief suffering levels are equivalent to those of unnatural deaths, such as homicide, suicide, and accident. For the "Friends and acquaintances" subgroup, there was no significant difference (p>0.946).

Participation in funerals

The two-factor ANOVA (Levene p<0.001) showed a significant effect of the independent variable "Participation in funerals" on the dependent variable "PG-13-R score" (F(1.422)=8.753, p=0.003, ηp^2=0.020. with $M_{participated}$=24.33 and SD=9.295, and $M_{did_not_participate}$=19.69 and SD=7.305) and of the independent variable "Relationship with the deceased person" on the dependent variable "PG-13-R score" (F(1.422)=24.717, p<0.001, ηp^2=0.055, with $M_{family\ members}$=26.41 and SD=9.855, and $M_{friends}$=20.90 and SD=7.735). It is worth noting that those who responded as being a family member and having been able to attend the funeral presented significantly more intense grief responses. No significant interaction was found between the independent variables "Participation in funerals" and "Relationship with the deceased person" (p=0.460).

PG-13-R scores are higher for those who participated in funerals than for those who did not participate. Among the bereaved who participated in funerals, 45.45% declared themselves family members. Among those who responded they did not participate in the funeral rituals, only 22.03% stated they were family members.

Moderating role of context in well-being

Based on the study data, it was also verified whether the grief experience context (0=pandemic and 1=post-pandemic) plays a moderating role in the well-being of the bereaved participants. We used Model 1 of the PROCESS module – Bootstrap samples 5000.

The PG-13-R and WHO-5 variables showed a significant, moderate negative correlation (r=−0.500. p<0.001), that is, the higher the grief suffering levels, the lower the well-being; when considering WHO-5 as dependent variable and PG-13-R as independent variable, the results were R^2 = 0.250. F(1.425)=141.594, constant = 20.422, B = −0.303, and r=−0.500.

The results of the model (F(3,422)=49.2160. p<0.0001, R^2=0.2592) indicated that when levels of grief suffering are higher, there is a significant reduction in well-being (Coef=−0.2691, p<0.0001, LLCI=−0.3281, ULCI=−0.2101); that, for the pandemic, well-being is significantly lower (Coef=3.1126, p=0.0253, LLCI=0.3870. ULCI=5.8382). Furthermore, we found a significant interaction of context and grief on well-being (Coef=−0.1168, p=0.0376, LLCI=−0.2268, ULCI=−0.0067, with an R^2 increment=0.0076 in the model); and that, for the pandemic, grief suffering levels have a greater negative impact on well-being (Coef=−0.3858, p<0.0001, LLCI=−0.4787, ULCI=−0.2929) than in the post-pandemic (Coef=−0.2691, p<0.0001, LLCI=−0.3281, ULCI=−0.2101).

Discussion

To the best of our knowledge, this is the first Brazilian study to compare the grieving experience between bereaved individuals during and after the COVID-19 pandemic, in addition to considering various causes of death and different relationships with the deceased.

Even though hypothesis (1) was not corroborated, the results point to and confirm the initial research expectations: the pandemic exacerbated levels of grief suffering, impacting post-pandemic well-being.

It is important to note that the grieving period was not found as a variable of impact on the grief

responses, which raises the hypothesis that the recent grief experience of the post-pandemic sample may have contributed to the result not being statistically significant. Still, the fact that 26.2% of the individuals bereaved during the pandemic showed indicators of prolonged grief having passed, on average, more than two and a half years after the death signals a higher prevalence than that indicated by the literature, of approximately 10% among the bereaved [22-25].

Hypothesis (2) was corroborated; however, it is noted the result for the variable "Participation in funerals." The literature presents inconclusive results on the effect of participation in funeral rites on grief responses in the context of a pandemic: sometimes with significant results [26-30.] sometimes without significant differences [31-35].

The results of the present study indicated a significant impact of participation in funerals on grief responses, but with a contrary outcome to that initially hypothesized, with greater grief suffering responses among those who participated than among those who did not participate in funeral rites. In the case of the studied sample, this may be a result of the higher composition of family members who participated in the funerals, since, even during sanitary restrictions, family members were those who could attend the rituals.

Given that close family members were the people who had the most contact with the suffering of the deceased person and who, in general, were closely involved in the possible negligence suffered by the deceased person in the context of the Brazilian pandemic, it is justified that they are the ones who present more intense grief responses, even having participated in funeral rites. Still, there should be emphasis on the importance of considering funeral rites and their significance beyond grief symptom levels [35], as they are a means of honoring the deceased person, assisting in the recognition of the change in social identity by the bereaved, and reaffirming the sense of community [36].

The perception of lack of access to adequate healthcare and resources by the deceased person as a significant risk factor for greater intensity of grief suffering may indicate the consequence of the occurrence, in the Brazilian pandemic, of misthanasia, that is, grief suffering from a death understood as premature and avoidable [37]. Misthanasia results from the State's failure to fulfill its social *duties towards its citizens*, *opting for inadequate practices and/or measures*, *which lead to the unnecessary death of citizens* [38].

Accordingly, the results on the relation between COVID-19 as the cause of death and higher levels of suffering directly related to grief and equivalent to other unnatural deaths (such as accidents, homicides, and suicides) underscore the importance of understanding the impact of the Brazilian pandemic on grief. This same result was corroborated by other studies [39,40]; however, several studies did not find significant differences between deaths from COVID-19 and other causes [28,32,34,41-44].

Differences previously found in grief responses when comparing COVID-19 with other causes of death could be explained by the timing of data collection and that, over time, they decreased in intensity [41]. COVID-19, as a cause of death, comes to be understood as a natural death, due to the perception that, from time to time, pandemics affect humanity and due to a common sense of humanity, as pandemic restrictions affected the whole world [45]. Contrary to this trend, the results of this study demonstrate that, for the Brazilian context, this may not have occurred.

The impossibility of saying goodbye also appears as a contextual variable that impacts more intense grief responses, potentially being associated with how the death occurred, as well as with the fact that the death was sudden, as in the case of COVID-19. Unexpected death and the impossibility of having been present and said goodbye to the deceased person can suggest the presence of feelings of regret, sadness, guilt, and rumination [34,36].

Finally, it is noted the results for well-being when comparing bereaved individuals during and after the pandemic. Lower levels of well-being for the bereaved of the pandemic and a greater negative impact of grief suffering on well-being for those bereaved during the COVID-19 pandemic underscore the ongoing suffering of the bereaved.

The passage of time does not determine whether a bereaved person will experience intense suffering related to grief, or thereof associated with symptoms of depression [46]. There are few longitudinal studies on grief in populations that

suffered disasters and, although the level of suffering decreases over time, grief appears to have a significant long-term impact on psychological distress and to decelerate the recovery process of the grieving person [11].

From the perspective of understanding the impact of the pandemic as a factor that exacerbated grief suffering in Brazil, intervention bioethics upholds a commitment toward the vulnerable and matters of public interest through the cultivation of *responsibility*, *care*, *critical solidarity*, *otherness*, *commitment*, *transformation*, *tolerance* [47]. It also calls upon the Brazilian State for social responsibility, since, in situations where people are victims of specific social vulnerabilities, its duty is to intervene and protect through public policies [4]. Thus, the vulnerabilities and harms to which the population was subjected during the COVID-19 pandemic in our country must be recognized, and efforts must be made to promote specialized care for the suffering that remains.

As for that, the responsibility of mental health professionals in caring for these bereaved individuals is also cited. Grief is, at the same time, a universal experience, as we all experience it, and a deeply personal experience [48]. Therefore, therapeutic strategies must take into consideration the unique experiences of each bereaved person who experiences suffering, promoting the dignity of the human person, a pillar advocated by bioethics and ethical care [49].

Ethical care is a relational ethics [50.51] that values and ensures the autonomy and dignity of vulnerable people, using a relational and contextual approach [52] for this purpose and providing broadened moral horizons for discussing and promoting care [53]. Thus, care must address the uniqueness of the grieving person, understood as a manifestation of the universal, but always with the specific concern of understanding and providing support for suffering in its unique presentation [54].

Thus, care for the grieving person in suffering should be provided in the form of support, considering the needs of those requiring care, with active and attentive listening, and respect for vulnerabilities [50]. It also fosters action, because community is built through initiative, since aspects such as ethnicity, hierarchy, race, and social class influence the care provided [50]. Thus, mental health professionals should have a better understanding of potential complicating factors of grief, as this *removes from the person the sole responsibility for the problems. There are circumstances prior to the death, in the situation itself, and after the death that can make the grieving process difficult* [55].

The results demonstrated that there were significant impacts on the grieving process of those who lost a significant person during the COVID-19 pandemic in Brazil, which continue to reverberate in the post-pandemic period. Discussing the Brazilian pandemic grief and its post-pandemic implications from the perspective of the field of bioethics broadens the understanding of the phenomenon, as it provides *the integration of sociocultural and political-economic dynamics into the discussion*, since *its role is to foster critical thinking and reflection on the issues involved in life in its broadest sense* [56].

Thus, this study is expected to provide inputs for the (re)cognition, discussion, planning, and initiative on the issue in our country, both in the scope of public policies and in interventions by mental health professionals.

This study, as any study, has limitations. Data collection from bereaved individuals in the post-pandemic period presented a limitation as to the grieving time. It should also be noted that the survey data are based on self-report information, which may be subject to both memory biases and socially desirable responses from the study participants.

Quantitative research aims to serve as a survey on a given phenomenon. In the case of grief, the subject of this study, it is recommended that qualitative research with in-depth analysis be developed in the future, in order to provide better insights into the singularities, reverberations, and needs of people bereaved during the COVID-19 pandemic in the Brazilian context.

It is also important to note that the general sample is composed, for the most part, of white individuals, of the female gender, and with complete higher education or postgraduate education. These limitations show the importance of making efforts so that social intersectionality factors, such as race/skin color, gender, and class, are considered in scientific research, without being limited to them.

Final considerations

Due to the conjuncture of chaos and social helplessness experienced during the COVID-19 pandemic in Brazil, the processes of pain and suffering arising from grief experienced under these conditions often could not be processed and integrated into the lives of the bereaved.

The results demonstrated by the present study underscore the specificities of the grief experienced during the pandemic in the Brazilian context. The suffering remains and impacts the well-being of these bereaved individuals in the post-pandemic era.

Intervention bioethics, by assigning to bioethics the social duty of being committed to the vulnerable and to issues of public interest, contributes toward the understanding of the Brazilian State's responsibility in its omissions and deliberate actions of the necropolitical administration implemented during the pandemic in our country. Thus, it calls upon that same State to assume responsibility before the population that suffered (and continues to suffer) from their losses and their griefs.

From the perspective of mental health professional practice, care must be provided with respect for the vulnerabilities and harms experienced by the bereaved. Ethical care, by integrating empathy, collective responsibility, and sensitivity to human relations, promotes care practices that respect the dignity and context of each person.

The study aimed to fill a gap in the literature of quantitative studies on the impacts of the grief experience in the pandemic and post-pandemic in Brazil, considering a greater temporal distancing from the event that caused death, as well as a greater diversity of variables, for a more comprehensive understanding of the impacts of the phenomenon.

The results of this study are expected to contribute evidence to foster discussions on the issue, as well as to support the development and implementation of public policies in mental health and the intervention of mental health professionals for the promotion of ethical care based on the experience of Brazilian bereaved individuals. This commitment must be considered as a bioethical imperative given the magnitude of the losses and grief faced by the Brazilian population.

Funding: *This study was partially funded by the National Council for Scientific and Technological Development (311588/2020-4 and 311082/2023-8).*

References

1. OMS afirma que COVID-19 é agora caracterizada como pandemia. [Internet]. Washington: Opas/OMS; 2020 [acesso 31 out 2022]. Disponível: https://bit.ly/3Rq8vrJ
2. Matos PBL, Correa RS, Branco DC, Almeida GM, Silva ÉQ, Nascimento LS. Vulnerabilidades evidenciadas pela pandemia de covid-19 na perspectiva da bioética. Rev. bioét. (Impr.) [Internet]. 2022 [acesso 1° jul 2023];30(4):900-9. DOI: 10.1590/1983-80422022304580PT
3. Mbembe A. Necropolitics. Public Culture [Internet]. 2003 [acesso 2 set 2024];15(1):11-40. DOI: 10.1215/08992363-15-1-11
4. Junges JR, Barbiani R, Zoboli ELCP. Vulneração programática como categoria explicativa dos problemas éticos na atenção primária à saúde. Trab Educ Saúde [Internet]. 2018 [acesso 15 jul 2023];16(3):935-53. p. 951. DOI: 10.1590/1981-7746-sol00149
5. Kaltman S, Bonanno GA. Trauma and bereavement: examining the impact of sudden and violent deaths. J Anxiety Disord [Internet]. 2003 [acesso 6 abr 2024];17(2):131-47. DOI: 10.1016/s0887-6185(02)00184-6
6. Kovács MJ. A caminho da morte com dignidade no século XXI. Rev. bioét. (Impr.) [Internet]. 2014 [acesso 10 out 2024];22(1):94-104. Disponível: https://bit.ly/4u4Jpwb
7. Tang S, Xiang Z. Who suffered most after deaths due to COVID-19? Prevalence and correlates of prolonged grief disorder in COVID-19 related bereaved adults. Global Health [Internet]. 2021 [acesso 28 jun 2024];17(1):1-9. DOI: 10.1186/s12992-021-00669-5

8. Kaya E, Barlas Z, Barlas F, Wilson A, Dönmezler S. Bereavement during lockdown: the potential impact of COVID-19 restrictions on grief and post-traumatic stress disorder in a Turkish-Muslim population. Ment Health Relig Cult [Internet]. 2024 [acesso 1º maio 2024];1-14. DOI: 10.1080/13674676.2023.2244905
9. Drucker A, Levi-Belz Y, Hamdan S. Depression, complicated grief, and suicide ideation following bereavement during the covid-19 pandemic. Omega (Westport) [Internet]. 2023 [acesso 10 jun 2024];1-15. DOI: 10.1177/00302228231186361
10. Harrop E, Medeiros Mirra R, Goss S, Longo M, Byrne A, Farnell DJJ *et al*. Prolonged grief during and beyond the pandemic: factors associated with levels of grief in a four time-point longitudinal survey of people bereaved in the first year of the COVID-19 pandemic. Front Public Health [Internet]. 2023 [acesso 11 jun 2024];11:1-29. DOI: 10.3389/fpubh.2023.1215881
11. Kristensen P, Weisæth L, Heir T. Bereavement and mental health after sudden and violent losses: a review. Psychiatry [Internet]. 2012 [acesso 10 nov 2024];75(1):76-97. DOI: 10.1521/psyc.2012.75.1.76
12. Pereira DA. O canto que não cala: biossegurança e o direito à ritualização dos mortos [dissertação] [Internet]. Recife: Universidade Católica de Pernambuco; 2023 [acesso 3 maio 2024]. Disponível: https://bit.ly/49l1Vc8
13. Creswell JW, Creswell JD. Projeto de pesquisa: métodos qualitativos, quantitativo e misto. 5ª ed. Porto Alegre: Penso; 2021.
14. Salvador PTC de O, Alves KYA, Rodrigues CCFM, Oliveira LV. Estratégias de coleta de dados online nas pesquisas qualitativas da área da saúde: scoping review. Rev Gaucha Enferm [Internet]. 2020 [acesso 5 set 2023];41:e20190297. DOI: 10.1590/1983-1447.2020.20190297
15. OMS declara fim da Emergência de Saúde Pública de Importância Internacional referente à COVID-19 [Internet]. Washington: Opas/OMS; 5 maio 2023 [acesso 10 de set 2023]. Disponível: https://bit.ly/4dC2MI0
16. Vinuto J. A amostragem em bola de neve na pesquisa qualitativa: um debate em aberto. Temáticas [Internet]. 2014 [acesso 20 ago 2023];22(44):203-20. DOI: 10.20396/tematicas.v22i44.10977
17. Esperandio MRG, Rosas LS, Viacava JJC, Prigerson HG. Brazilian validation of the Prolonged Grief Disorder Scale – Revised (PG-13-R). Omega (Westport) [Internet]. 2025 [acesso 1º jun 2025]. DOI: 10.1177/00302228251348277
18. Souza CM, Hidalgo MPL. World Health Organization 5-item well-being index: validation of the Brazilian Portuguese version. Eur Arch Psychiatry Clin Neurosci [Internet]. 2012 [acesso 28 ago 2023];262(3):239-44. DOI: 10.1007/s00406-011-0255-x
19. Hayes AF. Introduction to mediation, moderation and conditional process analysis. New York: The Guilford Press; 2018.
20. Baron RM, Kenny DA. The moderator-mediator variable distinction in social psychological research: conceptual, strategic, and statistical considerations. J Pers Soc Psychol [Internet]. 1986 [acesso 3 out 2023];51(6):1173-82. DOI: 10.1037/0022-3514.51.6.1173
21. Field A. Descobrindo a estatística usando o SPSS. 2ª ed. Porto Alegre: Artmed; 2009.
22. O'Connor MF. O cérebro de luto: como a mente nos faz aprender com a dor da perda. Rio de Janeiro: Principium; 2023.
23. Lundorff M, Holmgren H, Zachariae R, Farver-Vestergaard I, O'Connor M. Prevalence of prolonged grief disorder in adult bereavement: a systematic review and meta-analysis. J Affect Disord [Internet]. 2017 [acesso 15 ago 2023];1:212:138-149. DOI: 10.1016/j.jad.2017.01.030
24. Prigerson HG, Vanderwerker LC, Maciejewski PK. A case for inclusion of prolonged grief disorder in DSM-V. In: Stroebe MS, Hansson RO, Schut H, Stroebe W, editores. Handbook of bereavement research and practice: advances in theory and intervention. Washington: American Psychological Association; 2008. p. 165-86.
25. Latham AE, Prigerson HG. Suicidality and bereavement: complicated grief as psychiatric disorder presenting greatest risk for suicidality. Suicide Life Threat Behav [Internet]. 2004 [acesso 12 jul 2023];34(4):350-62. DOI: 10.1521/suli.34.4.350.53737
26. Manquinho S, Albuquerque S, Delalibera M, Coelho A, Salvador Á. "I could not give him the funeral he deserved": the role of alternative mourning rituals during the pandemic. Curr Psychol [Internet]. 2024 [acesso 7 jul 2024];43(15):13668-78. DOI: 10.1007/s12144-023-05305-6

27. Vincenzo C, Biancalani G, Sani L, Bacqué MF, Novelletto L, Scussolin D, Testoni I. The impact of covid-19 on grief: a quantitative and qualitative analysis in Italy. Omega (Westport) [Internet]. 2024 [acesso 2 jun 2024];1-20. DOI: 10.1177/00302228241248534

28. Blanckenburg P von, Seifart C, Ramaswamy A, Berthold D, Volberg C. Prolonged grief in times of lockdown during the covid-19 pandemic. Omega (Westport) [Internet]. 2023 [acesso 27 jun 2024];1-19. DOI: 10.1177/00302228231182738

29. Bovero A, Pidinchedda A, Clovis F, Berchialla P, Carletto S. Psychosocial factors associated with complicated grief in caregivers during COVID-19: Results from a preliminary cross-sectional study. Death Stud [Internet]. 2022 [acesso 14 jun 2024];46(6):1433-42. DOI: 10.1080/07481187.2021.2019144

30. Selman LE, Farnell DJJ, Longo M, Goss S, Torrens-Burton A, Seddon K *et al*. Factors associated with higher levels of grief and support needs among people bereaved during the pandemic: results from a national online survey. Omega (Westport) [Internet]. 2022 [acesso 2 maio 2024];1-28. DOI: 10.1177/00302228221144925

31. Cunha M, Simões G, Soares J, Santos E. Coping e processo de luto em familiares e pessoas significativas de vítimas mortais de COVID-19. Referência [Internet]. 2023 [acesso 1° maio 2024];6(2). DOI: 10.12707/RVI22063

32. Arslan BS, Buldukoğlu K. Grief rituals and grief reactions of bereaved individuals during the covid-19 pandemic. Omega (Westport) [Internet]. 2023 [acesso 29 jun 2024];87(4):1293-307. DOI: 10.1177/00302228211037591

33. Zou X, Xu X, Tang R, Jiao K, Qian W, Shen X, Wang J. Potential risk factors for acute grief during the COVID-19 pandemic: the mediating role of avoidance processes. Clin Psychol Psychother [Internet]. 2023 [acesso 3 maio 2024];30(1):202-12. DOI: 10.1002/cpp.2794

34. Chen CYC. Grieving during the covid-19 pandemic: in-person and virtual "goodbye". Omega (Westport) [Internet]. 2022 [acesso 28 jun 2024];1-17. DOI: 10.1177/00302228221090754

35. Mitima-Verloop HB, Mooren TTM, Kritikou ME, Boelen PA. Restricted mourning: impact of the covid-19 pandemic on funeral services, grief rituals, and prolonged grief symptoms. Front Psychiatry [Internet]. 2022 [acesso 20 maio 2024];13:1-8. DOI: 10.3389/fpsyt.2022.878818

36. Neimeyer RA, Lee SA. Circumstances of the death and associated risk factors for severity and impairment of COVID-19 grief. Death Stud [Internet]. 2022 [acesso 9 jul 2023];46(1):34-42. DOI: 10.1080/07481187.2021.1896459

37. Ricci LAL. A morte social: mistanásia e bioética. São Paulo: Paulus; 2017.

38. Loureiro CROMS. Mistanásia social, Covid-19 e direitos humanos: um tratado internacional para o enfrentamento das pandemias. Revista de Direitos e Garantias Fundamentais [Internet]. 2022 [acesso 2 out 2024];22(3):135-57. p. 139. DOI: 10.18759/rdgf.v22i3.1896

39. Eisma MC, Tamminga A. COVID-19, natural, and unnatural bereavement: comprehensive comparisons of loss circumstances and grief severity. Eur J Psychotraumatol [Internet]. 2022 [acesso 15 jul 2023];13(1):2062998. DOI: 10.1080/20008198.2022.2062998

40. Gang J, Falzarano F, She WJ, Winoker H, Prigerson HG. Are deaths from COVID-19 associated with higher rates of prolonged grief disorder (PGD) than deaths from other causes? Death Stud [Internet]. 2022 [acesso 1° jul 2024];46(6):1287-96. DOI: 10.1080/07481187.2022.2039326

41. Lenferink LIM, Boelen PA. DSM-5-TR prolonged grief disorder levels after natural, COVID-19, and unnatural loss during the COVID-19 pandemic. J Affect Disord Rep [Internet]. 2023 [acesso 30 jun 2024];12:1-4. DOI: 10.1016/j.jadr.2023.100516

42. Yıldırım YE. Prevalence of prolonged grief disorder and related clinical factors among turkish psychiatric outpatients during the covid-19 pandemic. Omega (Westport) [Internet]. 2023 [acesso 4 maio 2024];1-17. DOI: 10.1177/00302228231187296

43. Salisbury MR, Harmsen CRW, Muller RT. Help-seeking buffers the impact of grief on quality of life: a study of loss during the covid-19 pandemic. Omega (Westport) [Internet]. 2022 [acesso 1° jun 2024];1-20. DOI: 10.1177/00302228221146337

44. Shahini N, Abbassani S, Ghasemzadeh M, Nikfar E, Heydari -Yazdi AS, Charkazi A, Derakhshanpour F. Grief experience after deaths: comparison of covid-19 and non-covid-19 causes. J Patient Exp [Internet]. 2022 [acesso 7 jul 2024];9:1-6. DOI: 10.1177/23743735221089697

45. Akmese I, Foreman T, Brooks G. Bereavement during and not during the pandemic in terms of complicated grief and social support. Omega (Westport) [Internet]. 2024 [acesso 29 jun 2024];1-18. DOI: 10.1177/00302228241240944

46. Boelen PA, Reijntjes A, Djelantik AAAM, Smid GE. Prolonged grief and depression after unnatural loss: latent class analyses and cognitive correlates. Psychiatry Res [Internet]. 2016 [acesso 6 dez 2024];240:358-63. DOI: 10.1016/j.psychres.2016.04.012

47. Garrafa V, Porto D. Bioética de intervención. In: Tealdi JC, organizador. Diccionario Latinoamericano de Bioetica. Cidade do México: Unesco; 2008. p. 161-164. p. 163.

48. Guldin MB, Leget C. The integrated process model of loss and grief – An interprofessional understanding. Death Stud [Internet]. 2024 [acesso 8 dez 2024];48(7):738-52. DOI: 10.1080/07481187.2023.2272960

49. Leget C. Analyzing dignity: a perspective from the ethics of care. Med Health Care Philos [Internet]. 2013 [acesso 8 dez 2024];16(4):945-52. DOI: 10.1007/s11019-012-9427-3

50. Tronto JC. Moral boundaries: a political argument for an ethic of care. London: Routledge; 2020.

51. Gilligan C. In a different voice. Cambridge: Harvard University Press; 2009.

52. Fernández-Truillo A, Vallverdú-Cartié H, Román-Maestre B. Care ethics. a new bioethical approach to humanize the ICU. Med Intensiva [Internet]. 2016 [acesso 7 dez 2024];40(8):511-3. DOI: 10.1016/j.medin.2016.07.001

53. Vries M, Leget CJW. Ethical dilemmas in elderly cancer patients: a perspective from the ethics of care. Clin Geriatr Med [Internet]. 2012 [acesso 11 nov 2022];28(1):93-104. DOI: 10.1016/j.cger.2011.10.004

54. Freitas J de L. Luto e fenomenologia: uma proposta compreensiva. Rev Abordagem Gestalt [Internet]. 2013 [aceso 24 fev 2025];19(1):97-105. Disponível: https://bit.ly/4tZ0F5E

55. Kovács MJ. Desenvolvimento da tanatologia: estudos sobre a morte e o morrer. Paidéia (Ribeirão Preto) [Internet]. 2008 [acesso 10 out 2024];18(41):457-68. p. 460. DOI: 10.1590/S0103-863X2008000300004

56. Trombert A. Rumo à consolidação de uma bioética latinoamericana: entrevista ao professor José Roque Junges. Revista Binacional Brasil Argentina [Internet]. 2018 [acesso 10 out 2024];7:167-74. p. 168. Disponível: https://bit.ly/4abEDWg

Luciana Soares Rosas – Master – lucianasoaresrosas@gmail.com
0000-0001-5404-5659

Mary Rute G. Esperandio – PhD – mary.esperandio@pucpr.br
0000-0001-8521-8794

Juan José Camou Viacava – PhD – juan.camou@pucpr.br
0000-0002-1945-0592

Correspondence

Luciana Soares Rosas – Rua Benedito Antunes de Oliveira, 53, Uberaba, CEP 81570-320. Curitiba/PR, Brasil.

Contribution of the authors

Luciana Soares Rosas: conceptualization; data curation; methodology; formal analysis; writing – original draft; writing – review & editing. Mary Rute G. Esperandio: conceptualization; supervision; writing – original draft; writing – review & editing. Juan José Camou Viacava: methodology; formal analysis; supervision; writing – original draft; writing – review & editing.

Data availability: All data used or generated in this study are described and presented in full in the body of the article.

Editor in charge: Dilza Teresinha Ambrós Ribeiro

Received: 12.8.2025
Revised: 3.6.2026
Approved: 3.27.2026