Unrecognized Grieving: Challenges and Contributions of the Psychologist in the Process of Coping with Death

Luto Não Reconhecido: Desafios e Contribuições do Psicólogo no Processo de Enfrentamento da Morte

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ABSTRACT
With the progress of medicine and technologies in the health area, finitude started to occur in hospital complexes, thereby, making the grieving institutionalized. The psychologist who has in his work routine the counseling of critically ill patients and their relatives needs to have academic preparation and psychic resources in his training. Understand the role of the psychologist in coping with patients who experience the grieving processes and characterize the sociodemographic profile of these professionals were the goals of the present. Qualitative, descriptive, cross-sectional research. Data were collected through interviews and a sociodemographic questionnaire. Descriptive and phenomenological modality analysis. Six psychologists, average age of 32.6 years, 50% of spiritual religion, 83.3% single, satisfied with their work and 66.7% were not currently undergoing psychological counseling. Among the categories of meaning, we highlight the aspect of the importance of working with families and also the professional's emotional issues, the unrecognized grieving. The main limitations of psychological performance go beyond the recognition of professionals by the teams, and training deficiency, seen the curricula do not include specific material for coping with death.

Keywords: Grief; Health care professionals; Attitude of health personnel; Attitude to death; Hospitalar psychology

RESUMO
Com o avanço da medicina e das tecnologias na área da saúde, a finitude passou a ocorrer nos complexos hospitalares, tornando o luto institucionalizado. O psicólogo que tem em sua rotina de trabalho o aconselhamento de pacientes críticos e seus familiares precisa ter preparo acadêmico e recursos psíquicos em sua formação. Compreender o papel do psicólogo no enfrentamento de pacientes que vivenciam processos de luto e caracterizar o perfil sociodemográfico desses profissionais foram os objetivos do presente. Pesquisa qualitativa, descritiva, transversal. Os dados foram coletados por meio de entrevistas e questionário sociodemográfico. Análise de modalidade descritiva e fenomenológica. Seis psicólogos, média de idade de 32,6 anos, 50% de religião espírita, 83,3% solteiros, satisfeitos com o trabalho e 66,7% que não faziam acompanhamento psicológico no momento. Dentre as categorias de significado, destacamos o aspecto da importância do trabalho com as famílias e também as questões emocionais do profissional, o luto não reconhecido. As principais limitações da atuação psicológica vão além do reconhecimento dos profissionais pelas equipes, e deficiência de capacitação, visto que os currículos não contemplam material específico para o enfrentamento da morte.

Palavras-chave: Luto; Profissionais do cuidado em saúde; Atitude de profissional em saúde; Atitude para a morte; Psicologia hospitalar
INTRODUCTION

Death symbolizes the end of life from the beginning to the present and has aroused curiosity and anguish in human beings, due to the fact that it is unknown to the living being, being interpreted according to a culture and transmitted by their peers over the years. To understand death and its complexity, it is necessary to make a historical-cultural analysis, about the progress and evolution of the centuries, the understanding and the ways of being experienced (Silva & Leão-Machado, 2017).

The arrival of the 20th century is marked by technological progresses in medicine, according to studies by Ortiz, Abilio and Sobreira (2016), has provided increased life expectancy and the possibility of healing for the diseases, ways to prolong life and delay aging. In all the functions of these progresses, the death location is no longer at home but in hospital complexes.

Despite the changes over the years and the historical-cultural construction, death is understood, almost always, with pain and suffering and this moment is called the grieving process. Such experience is indispensable in the elaboration of the loss, and it can be classified as normal or complicated grieving, based on the coping resources the bereaved possesses to overcome his/her pain (Rodrigues, 2016).

With the institutionalization of death in hospitals, the professionals specialized in healing and coping with diseases sometimes were not prepared for death and loss of patients. In this sense, working with the process of finitude and grieving makes teams feel frustrated in the performance of their tasks. The constant exposure of the other person's death, in the long run, can arise anxieties in relation to his own finitude process (Magalhães & Melo, 2015).

Emotional burdens, personal and social resistance, occupational stress, absence from work and or deviations from function can be the consequences of professionals who have death as a work partner. Because it generates excessive feelings of suffering, since curriculum training is geared towards healing and not the loss of a patient, death can be characterized as a professional failure (Rocha, Nascimento, Raimundo et al., 2017).

The term “Fatigue due to Compassion” is used to express the epidemic that mainly affects health professionals, due to the constant exposure to suffering, fear and pain of others, triggering a series of emotional disorders that directly affect the professional's life. Feeling about the patient's condition, in addition to other factors such as family, double shift and other routine activities that require physical and mental effort, characterize the predisposition to illness (Rodrigues, Santana, Pereira, 2017).

To deal with the anguish of feeling exposed to daily suffering, the individual uses defense mechanisms, coldness and distance, and may fail to notice the patient's limitations and afflictions. Prioritizing saving the patient at any cost, from the imminence of death or an incurable disease, can cause the team's work to be perceived as frustrating, demotivating and meaningless. In view
of the fact, he/she will not be able to avoid, postpone or alleviate the suffering of his/her patients for many times, and may bring to the professional the experience of its limits, impotence, finitude and psychological suffering (Kovács, 2003).

Regarding the challenges faced by these professionals, unpreparedness and personal difficulties in the face of death and the process of dying, limit the right of the patient and his family to express thoughts, feelings, preferences, pending issues, which, in turn, are directly related with the grieving process, whether anticipatory or post-death of the patient (Silva, Almeida, Brito et al., 2017).

It is known that education for death directed to health professionals occurs sparingly. In this sense, a critical look in relation to the training of these professionals is relevant, through training in continuing education, so that they can be better prepared to experience and deal with the natural and inherent demands of the context of illness, death and grieving (Braz & Franco, 2017).

Studies indicate the need for continuous training with teachers, and should be implemented in teaching hospitals, aiming at preparing students and providing continuing education for professionals to deal with life and death in work contexts. Therefore, there is a need for constant preparation in relation to the theme for the professional performance, acquired through study and in-depth knowledge (Oliveira-Cardoso & Santos, 2017).

Regarding education for death, Kovács (2008) proposes a continuous development of man based on education. This is not a standardized formula, but a way of evoking reflections that provoke debates about death and its consequences. This proposal is based “on the importance of discussing the theme in a society in which interdicted death coexists, the search for the rehumanization of death and death faced in people's daily lives” (p.194).

The psychology professional has a greater contact with natural issues throughout the life of human beings, the processes of illness and death. In this sense, he/she can contribute to the health team through education for death and consequently the elaboration of grieving. Many professionals have fallen ill due to an excessive burden of suffering without the possibility of it being elaborated. It is not a question of hiding the subject, but of bringing the theme of death/grieving in a humanized way (Kovács, 2007).

Among the tools that the psychologist can use to elaborate his pains and emotions resulting from work, are the discussion groups, supervision and psychotherapy. For being the health team professional who has the best instruments to deal with this issue, the psychologist will be able to carry out activities that help the rest of the health team, expanding perceptions of disease and terminality, enabling them to deal better with patients as well as the suffering patients and their families (Silva, Almeida, Brito et al., 2017).

In this context, the hospital psychologist can help containing the feelings of the team that deals with death, promoting meetings/groups, where there is space for the expression of emotions
and exchange of experiences. Encouraging the team to perceive and talk about their difficulties, can facilitate a better elaboration of their fears and anxieties, allowing professionals to be free to expose their feelings (Ortiz, Abilio, Sobreira, 2016).

In addition to assisting the team, psychological intervention for patients who approach the terminal phase has the potential to improve their quality of life, especially in the moments that precede terminality, from diagnosis to the moment of death. The main goal of the psychologist’s action is to mitigate the suffering caused by emotional changes. One of its main functions is to support patients and their families: assessment, goal setting, performance plans, psychological intervention and articulation with other professionals in the health team (Martinho, Stack, Sapeta, 2015).

Finally, this study sought to understand the role of the psychologist in coping with patients who experience the grieving processes, aiming to present the contributions and challenges of practice in such situations and to characterize the sociodemographic profile of these professionals.

METHODS

Study participants

Qualitative, descriptive, cross-sectional research conducted with psychologists from different institutions, selected participants by convenience, in which ten (10) hospital psychologists were eligible, however four (4) were excluded, as they did not meet the criteria, totaling six (6) participants. The professionals recruited by convenience were invited to participate in the study through email contact, presenting the goals of the study as well as the relevant ethical aspects. In order to access the professionals’ electronic mail, a search was carried out on the websites of associations, foundations and other representative bodies, such as the Brazilian Association of Health Psychology, where professionals living in municipalities close to the research site were selected.

The interviews were carried out according to the convenience and availability of the professionals, however the confidentiality and ethics of the information was guaranteed; the Free and Informed Consent Term (Model in accordance with Resolution No. 466/12 - National Health Council) had been presented and read, containing researcher and participant identification data, research goals and procedures.

Data Collection Instruments

For the data collection process, participants responded to the following instruments:

✓ Questionnaire on socio-demographic data: authored by the researchers, built with the goal of characterizing the participants regarding the demographic and training aspects of the participants;
Qualitative interview: comprehensive interview from a phenomenological perspective, which consists of a dialogue initiated by a guiding question, in the case of this research: How do you understand your role in facing people who experience the grieving processes?

Compliance with Ethical Standards
This research was evaluated and approved by the Research Ethics Committee of the Faculty of Medicine of São José do Rio Preto - SP (FAMERP) with the opinion: 2.868.810.

Data Analysis
The information obtained by the sociodemographic questionnaire was distributed in tables in numbers and frequency, using descriptive analysis.

The interviews were recorded and transcribed in full by the researcher, with the consent of the psychologists, and later a descriptive analysis was carried out. With the psychologists' reports in mind, we submitted the data analysis step, based on the phenomenological modality of Amatuzzi (2009).

RESULTS
The study sample consisted of six psychologists, whose sociodemographic characteristics are shown in Table 1.

Table 1. Description in frequency (n) and percentage (%) of the sociodemographic characteristics of the sample's psychologists.

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritist</td>
<td>03</td>
<td>50</td>
</tr>
<tr>
<td>Catholic</td>
<td>02</td>
<td>33.3</td>
</tr>
<tr>
<td>Agnostic</td>
<td>01</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>05</td>
<td>83.3</td>
</tr>
<tr>
<td>Married</td>
<td>01</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>01</td>
<td>16.7</td>
</tr>
<tr>
<td>No</td>
<td>05</td>
<td>83.3</td>
</tr>
<tr>
<td><strong>Time working with grieving</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;1 year &lt;5 years</td>
<td>03</td>
<td>50</td>
</tr>
<tr>
<td>≥5 years &lt;10 years</td>
<td>02</td>
<td>33.3</td>
</tr>
<tr>
<td>≥10 years</td>
<td>01</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Currently Psychological Counseling</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>02</td>
<td>33.3</td>
</tr>
</tbody>
</table>

[^1]: Source of data.
Following to the goal of the study, from the phenomenological analysis of the qualitative data obtained through the comprehensive interview, five categories of meaning emerged: 1- The cultural issue of the concept of death; The grieving for the losses due to disease; 3- The role of the psychologist; 4- The work with family and 5- The emotional issues of the professional.

**Category 1: The cultural issue of the concept of death**

In this category, participants report on how the concept of death is linked to the cultural context in which we live. Highlighting the importance for professionals to understand the patient's cultural issue in order to understand the way in which they deal with death. Table 2 shows the units of meaning present in the category.

<table>
<thead>
<tr>
<th>Psychologist</th>
<th>Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P1</strong></td>
<td>We see that there has been a change in the way people deal with death. So when it comes to losing people, loved ones, we see that as medical technology progress, industrialization progress, death begins to be transferred to the hospital and this makes people to become detached of this contact, which, in the past, was a death shared with society, with loved ones, with family members at home.</td>
</tr>
<tr>
<td><strong>P5</strong></td>
<td>When the patient doesn’t accept it... we see it a lot too, the patient doesn’t accept it, the family doesn’t accept it either, because we often don’t think about death, we here inside who experience this reality, who see that death is possible, who see that death happens, who see that disease happens to people who were leading the same life as us, they are okay and suddenly a bad diagnosis or a person we like gets very sick , an accident, anyway... we stop to think a little more, right... but not many people do that, many people revolt against God, many people do not accept the diagnosis, the condition does not accept death, they really die without accepting it.</td>
</tr>
<tr>
<td><strong>P6</strong></td>
<td>Culture also imposes a very strong barrier, both the culture of the taboo of death and the culture of the obligation of happiness... in this culture that we live in, you are always happy, productive and grieving is not that, grieving is the moment for you to recluse (..) rebuild your plans for the future.</td>
</tr>
</tbody>
</table>

Source: Author data (2020)
Category 2: Grieving for losses due to disease

Table 3 presents the reports in which the psychologists describe what are the losses that the patients present during the disease process. All losses are experienced through a grieving process and, therefore, also need the psychologist's performance. In this category, participants report on how the concept of death is linked to the cultural context in which we live.

Table 3. Grieving for losses due to disease.

<table>
<thead>
<tr>
<th>Psychologist</th>
<th>Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>We realize that he will go through several losses which are significant... the loss of health, right, that he believed he had control over that, the difficulties of thinking what is happening to him. He will interrupt the plans he was making, the trip he was going to take or now that I retired... often they say I would enjoy life and now this disease came, now that I was trying to have children, what I'm going to do, the possibility of being infertile with treatment. We see that this patient will go through several losses during the treatment, even if the result of the treatment is positive and he gets control or remission of the disease, he has to deal with invasive procedures, the distance from friends to hospitalization. Sometimes the distance from family members, as many patients come from other states, stay away from the family, away from home, have financial difficulties because they had to stop working... so our role is very important in helping this patient to readapt, organize himself due to treatment.</td>
</tr>
<tr>
<td>P3</td>
<td>It is a grieving for the losses too, grieving for things that the children will have to lose... contact with the school, he will lose contact with family members, he will live much more inside the hospital... hair loss, he is very concerned about all this... will make them live this grieving process due to disease.</td>
</tr>
<tr>
<td>P6</td>
<td>Grieving whether due to loss of health, or some other change in the body, or death, it is a crisis situation... it generates a lot of disorganization, not only psychological, but a family, professional crisis, it generates an extensive crisis in people's lives.</td>
</tr>
</tbody>
</table>

Source: Author data (2020)

Category 3: Role of the psychologist

Given the understanding of the suffering that the grieving process can cause in patients, the participants highlight how the psychologist can act in this context. Such reports are presented in Table 4.

Table 4. Role of the psychologist.
And we as psychologists have a very important role... to be able to clarify people about grieving, to be able to guide what is expected, that the person will feel in this phase. We help him/her organize his/her life without the presence of that loved one.

The professional can help this person to reorganize and organize his/her thoughts and emotions, even organize his/her behaviors, as well as how to act in these situations, but initially the most important is this welcoming, listen to what no one else listens, the person lost his/her child two weeks ago and no one else wants to listen. So, we are one of the people who have the chance to understand these people being able to listen, to listen to this pain, to listen about the challenges of what they do, that has helped.

But we try to put together a waiting room group, especially when it happens... we do it every week, but when it happens, we do it even if it is not the group day. They can express everything they are feeling... expressing this anguish, for not knowing if the treatment will work or not, because we are not sure.

So, my role is actually to make people experience, to make this family or this patient really experience the grieving.

So, I'm going to work on what the family or what the patient brings to me, right, first of all, the first contact with the family or the patient is listening... empathetic listening. So it's a moment, that moment that the patient is with me, that the person is with me to really talk about everything he/she is feeling, to cry, to unburden and... to talk about his/her fears, his/her anguish, their his/her, right,... this is the moment, very, very welcoming, very respectful, very loving.

So for me, one of the important contributions of psychology, of the psychologist for the work of grieving, is at first to perceive, consider and help people to understand grieving as a natural aspect of life, an experience and a task of human development... complementing this... the other contribution is precisely knowing how to identify when this state of natural grieving starts to become a health problem that needs to be taken care of. So, I think that psychology has these contributions: to understand if it is natural, but also to alert when it stops being natural as these two aspects are dangerous.

Source: Author data (2020)

Category 4: Work with the family
In addition to working with the patients, the participants highlight how the performance extends to the patient's family, since they understand that they are also experiencing suffering with the sick family member. The reports in table 5 clarify the issue.

Table 5. Work with the family.

<table>
<thead>
<tr>
<th>Psychologist</th>
<th>Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P1</strong></td>
<td>Helping this family to also understand what is happening, as very often the patient will present mood changes, will be sadder, more worried... angry sometimes, with no desire to do the treatment with fear... and often familiar will demand that the patient be strong, that he does not have these emotional reactions because he does not know how to deal with it, so we have a fundamental role with this family, also during, explaining about the grieving... explaining how they can help family members, validating these feelings, listening to them.</td>
</tr>
<tr>
<td><strong>P4</strong></td>
<td>With the family members you should work with after... I was in cardio, right,... welcome the anguish to do the preparation, elaborate with them some ideas related to the bureaucratic part, mainly related to how much they will miss the person and which their representation of that person was, in death and family configuration, how it would be.</td>
</tr>
<tr>
<td><strong>P5</strong></td>
<td>The welcoming of this family, the welcoming of this pain and then go on working on what they bring to me, right,... if I realize that their confrontation is religion, this is the path I will follow, what if I can’t stand to see his suffering anymore or I can’t stand to suffer anymore, it’s more or less thereon I’m going to try to work. I am often the professional in here, right,... and sometimes we take a patient or a family who... has no one to talk to, right,... especially if you are the caregiver, right, then normally that son, that daughter, that wife who tries to say that everything is fine, knows that she only hears bad news, but that she wants to preserve the patient or vice versa too.</td>
</tr>
<tr>
<td><strong>P6</strong></td>
<td>We can offer and give psychological support right after the notification of the loss, this has proved to be very important... it will not prevent the person from being sad, disorganized in the emotional aspects... psychological, affective care right after the notification of the loss, it is a protective factor so that the person can position himself in the face of this loss, in a more active way, already trying to deal with it or even guaranteeing professional support for this.</td>
</tr>
</tbody>
</table>

Source: Author data (2020)

Category 4: Emotional issues of the professional
In this category, the participants report the difficulties in grieving that are not limited to the patient and his family, but to themselves, since they are subject to face situations that affect their individual emotional aspects. In Table 6, the reports clarify this category.

Table 6. Emotional issues of the professional.

<table>
<thead>
<tr>
<th>Psychologist</th>
<th>Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P2</strong></td>
<td>Sometimes, in some moments, it is more difficult for us to work with some situations, sometimes some situations that affect more than others, I know that we should be a little more comfortable with these things, but when they kind of affect us, how we are going to deal with all this and have this notion of our limit, as far as we can know that some issues will be more difficulty than others. For example, I have a huge difficulty working with children, this is a limitation... if I were to attend to child deaths or some things like that, I would have a huge difficulty. So, I think that is the situation where there are personal limitations.</td>
</tr>
<tr>
<td><strong>P5</strong></td>
<td>So it was my first contact with grieving, right... a child, that I think is one of the most difficult things, right, because it is a child dying, a sick child, so I say that my first contact was very, very difficult, right, but for me it was enriching as it is a more difficult process, and then we see it like that, I heard many situations like this because he is a child, because seeing a sick child is sad, because seeing a child dying is sad, because a child has his whole life ahead, it really is all of that.</td>
</tr>
<tr>
<td><strong>P6</strong></td>
<td>It is necessary to have a good knowledge about these theories of grieving, that he (the psychologist) has a good position on this... due to the fact he has also suffered losses, he will also deal with losses, and he may be afraid of experiencing losses.</td>
</tr>
</tbody>
</table>

Source: Author data (2020)

**DISCUSSION**

The average age of the participants is 32.6 years (± 6.74), with a minimum age of 26 years and a maximum of 42 years. The sample is primarily composed of psychologists with a spiritist religion option (50%), single people (83.3%) and childless (83.3%) (Table 1).

Half of the participants had between one and five years of experience of working with grieving, however 66.7% were not currently undergoing psychological counseling. According to Vieira and Waischung (2018), psychological counseling is indispensable for the psychologist, due to the overload he faces in the exercise of his activities. It also points out the need to have characteristics such as knowledge, intuition, talent and empathy.

As for job satisfaction, all of them said they were satisfied. Job satisfaction is influenced by causes, of personal nature and those related to the organization. Personal causes include the
individual differences of each subject and demographic factors; organizational causes cover the most diverse components related to work. If work activity represents a constant source of stress and emotional exhaustion for the professional, it can trigger indifference and disconnection from the organization (Silva, 2018).

Performance due to grieving can be challenging, as death is still an issue denied by society. It is often not treated as a natural evolutionary process, which can lead to feelings of fear, frustrations and suffering. The possibility of imminent death brings with it thoughts that can cause inconvenience to those who assist, since death is a difficult subject to be addressed (Vázquez-García, De-la-Rica-Escuín, Germán-Bes et al., 2019).

According to Soares, Santos, Amorim et al. (2015), despite the adverse feelings, the human being is capable of emotionally withstand death, even though for some the difficulty in dealing with the situation is greater than for others. In this context, the author points out that the psychologist contributes to coping with bereaved families, when he understands the means by which this phenomenon occurs, talks about the losses and works on the naturalization of death.

It is worth mentioning that the concept of grieving is not only linked to death. Throughout the reports, the professionals also highlight the various losses that the patient faces during the illness process.

A study by Alves, Viana and Souza (2018) points out that as a result of the diagnosis, changes in social and psychological contexts arise and these changes can influence the effectiveness of the treatment, as it depends a lot on the patient's emotional state. Among these factors is the loss of self-esteem, severe pain, anxiety, fear of death, stress, annoyance, interruption of life plans, changes in body image and social and financial styles.

Dealing with loss is not characterized by an easy situation, since in contemporary society the meaning of life is often attributed to the accumulation of things, jobs, specializations, material goods, among others. Thus, the idea of losing what was built and conquered, can lead to feelings of frustration and, consequently, of suffering (Soares & Castro, 2017).

From the suffering these patients experience, the psychologist's performance as an aid in coping with situations and in the elaboration and overcoming of difficulties stands out. Psychological counseling becomes important as it helps the patient to elaborate his current condition, giving the necessary support to the different moments of difficulties that may arise during the phases of the disease. From then on, Psychology will help the subject to look for ways to deal with this new reality, allowing the patient to find out ways to make the situation less painful, within the limits of his clinical condition (Silva & Boaventura, 2011).
The participants highlight the main actions: guidance and clarification about grieving, affirm death as a natural aspect of life; help the patient to reorganize due to his losses and after death, help the family to reorganize without the presence of the loved one; listen to and understand patients’ pain and suffering; offer continence and accept this pain. Vieira and Waischunng (2018) point out that the psychologist observes the need to unveil this issue, in order to help the patient, family members to deal with the feelings of loss and frustration arising from this difficult moment. It is common for these feelings to hinder communication between the patient and the family, and this is one of the reasons why the psychologist becomes an important mediator.

All of these actions can be offered not only in individual care, but also in group activities, as the report P3 highlights, which states that based on activities in waiting room groups, it offers a space for expression and welcoming suffering. Through the waiting room space, the development of educational actions is allowed, as it is in this environment that the professionals welcome by patients. With this, the psychologist has the opportunity to develop skills related to communication and interaction, in this way, the waiting room is not just another daily activity, but an instrument that also allows the exchange of knowledge between participants, recognition of sociocultural reality, as well as, beliefs and expression of feelings (Rodrigues, Dallanora, Rosa, et al., 2009).

In their study, Silva, Almeida, Brito et al. (2017), corroborate these issues when stating that the psychologist in his hospital performance has the main function of providing psychological support through the welcoming and understanding the patient. However, he emphasizes that psychological work aims to welcome and minimize the suffering not only of the patient, but also that of his family.

Regarding family counseling, the participants highlight the following actions: helping family members to understand the situation the patient faces, as it can often cause changes in the patient's behavior and mood. In addition to helping the family to play the role of caregivers and welcome the suffering that may be related to the physical and emotional overload caused by the demand for care. Thereupon, Espindola, Quintana, Farias et al. (2018) point out that the responsibility for care falls on someone close to them, and the decision on who will care for the patient is generally arbitrary. Therefore, patient care is not always permeated by feelings of love and affection, and can be understood as a moral obligation, which hinders the performance of this function and requires a new meaning in the relations between both parties.

According to Vieira and Waischunng (2018), the family can be helped by Psychology due to difficulties in the rehabilitation process or the imminence of loss, as falling ill causes, in most cases, several psychological changes and the psychologist in a hospital environment, either in the nursery ward, emergency room, surgical centers or Intensive Care Unit (ICU), must listen
and observe all aspects related to becoming ill, respecting the fears, beliefs and weaknesses of the patient and his family (Moreira, Martins & Castro, 2012).

Another study points out that if the psychology professional includes family members in their actions, through attention based on appropriate coping with death and acceptance of finitude, such actions may provide minimization of physical, psychological and spiritual suffering (Espindola, Quintana, Farias et al., 2018).

Thus, families should be included in care as they seek to adapt them to situations related to illness and terminality, so that they can also provide adequate support to their patients, to face the period of grieving. The psychologist's task proposes the development of adequate bonds with patients and their families, through honest, effective and affective communication (Fonceca & Rebelo, 2011).

Participants also report on family members counseling right after the patient's death notification. As highlighted by the P6 report, the welcoming and emotional support at that moment can be a protective factor for the family to organize themselves due to loss. Almeida (2015) points out that the psychologist will be able to provide support so that they are able to withstand frustrations and loss symptoms due to the imminent death of the patient, and also help family members preparing them with the appearance of risk factors that can generate complicated grieving after the loss of the loved one.

Report P4, on the other hand, points to the help of family members when dealing with bureaucratic issues required even in the hospital context. After the news of death, the family needs to organize itself in relation to the required documentation, contact with a funeral director, decision regarding the funeral. In this context, the psychologist can act as a reference professional to help them deal with these issues and direct them to specific professionals to provide such information. Therefore, Santos and Silva (2016) corroborate by citing that psychosocial care and joint care (psychologist and social worker) are forms of welcoming. It is noticeable that professionals should always be alert to any crucial situation so that in due time they can carry out their interventions.

It is necessary to point out that the psychologist is also the subject of the cultural context, initially discussed, who denies death as a natural process and values achievements throughout life, therefore, when faced with the described situations of illness, losses, grieving and deaths, can share the same feelings and anxieties as their clients (Lacerda & Los, 2016).

Despite the technical and academic preparation, the psychologist also has his concepts of death, his personal losses and his emotional limits. For an effective performance, there is a need for constant work in order to be attentive so that your personal issues do not interfere with your
professional practice. Hence the importance of the personal psychotherapy process in the training of the psychologist, as the way of relating to oneself has an inevitable impact on the relationship with the patient (Silva & Soares, 2014).

The professional must pay attention to self-care, looking for alternatives that help him deal with the emotional burden that he will encounter during his daily life (Silva, Almeida, Brito et al., 2017).

CONCLUSION

Working with grieving is challenging for all areas of knowledge, since death is culturally denied by society, permeated by fear, frustration and suffering.

In the hospital context, the psychologist plays an important role, with his work based on the mitigation of pain and suffering of patients, family members and the health team. When looking for ways to perform, the groups present great results, in view of the exchange of experiences and mutual growth.

Other contributions about the role of the psychologist are especially talk about losses, work with the concept of death and its naturalization, help the patient to reorganize due to his losses and after death, assist the bereaved family. In addition to help the teams coping with daily losses, work with these professionals, take the humanized and welcoming look into action.

However, the main limitations of psychological performance go beyond the recognition of the professional before the teams, being asked, very often, in conflict situations. Another aspect is the training deficiency, since the curriculum does not include specific material for coping with death.

Therefore, it is expected through the research to present the role of the psychology professional, presenting as consequences the relevance of self-care, by psychotherapies, supervisions, exchange groups, in the search for alternatives which help to deal with emotional burden related to performance, and thus, can elaborate his difficulties and recognize his limits.
It is concluded that the number of participants is a limiting factor of the research, in addition to being professionals from the same region, in which other research with professionals from other states may represent an expanded view of this theme.

REFERENCES


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