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Gazing at the twilight of the soul: psychologists' perceptions of preparatory grief

Contemplando o crepúsculo da alma: a percepção de psicólogos acerca do luto preparatório

Contemplando el crepúsculo del alma: la percepción de los psicólogos sobre el duelo preparatório

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Abstract:
Objective: to investigate the perception of hospital psychologists about preparatory grief. **Methods:** qualitative research carried out in 2022, which used a questionnaire with some open-ended questions, applied to psychology professionals working in hospitals in the interior of the state of Minas Gerais, Brazil. The data were coded through Bardin's Content Analysis and analyzed through the theories of grief and Analytical Psychology of C. G. Jung. **Results:** the interviewees' responses composed three thematic categories: "*Symptomatology of preparatory grief*"; "*Psychologists' perception of preparatory grief*"; and "*Dealing with preparatory grief*", in which professionals visualize contrasting feelings in their patients, as well as their experience being ambiguous in the face of this phenomenon. They also point to spirituality/religiosity as an effective resource for the construction of meaning and coping. **Conclusion:** preparatory grief is a striking phenomenon in hospital practice. Specific training is important for working with grieving and terminally ill patients and reinforces the need for mental health care for psychologists who deal with this demand.
Descriptors: Bereavement; Psychology, Medical; Junguian Theory.

Resumo:
Objetivo: investigar qual a percepção de psicólogos hospitalares acerca do luto preparatório. **Método:** pesquisa qualitativa realizada em 2022, que utilizou questionário com algumas questões abertas, aplicado a profissionais de psicologia atuantes em hospitais no interior de Minas Gerais. Os dados foram codificados através da Análise de Conteúdo de Bardin e analisados através das teorias do luto e da Psicologia Analítica de C. G. Jung. **Resultados:** as respostas dos entrevistados compôs três categorias temáticas: "*Sintomatologia do luto preparatório*"; "*Percepção de psicólogos acerca do luto preparatório*"; e "*A lida com o luto preparatório*", nas quais os profissionais visualizam sentimentos contrastantes nos seus pacientes, bem como sua vivência se mostra ambígua frente a esse fenômeno. Também apontam a espiritualidade/religiosidade como um recurso eficaz para a construção de sentido e enfrentamento. **Conclusão:** o luto preparatório é um fenômeno marcante na prática hospitalar. A formação específica se mostra importante para a atuação com pacientes enlutados e em terminalidade e reforça a necessidade do cuidado com a saúde mental dos psicólogos que lidam com essa demanda.
Descritores: Luto; Psicologia Médica; Teoria Junguiana.

Resumen:
Objetivo: investigar cuál es la percepción de los psicólogos hospitalarios sobre el duelo preparatorio. **Método**: investigación cualitativa realizada en 2022, que utilizó un cuestionario con algunas preguntas abiertas, aplicado a profesionales de psicología que trabajan en hospitales del interior de Minas Gerais, Brasil. Los datos fueron codificados mediante el Análisis de Contenido de Bardin y analizados a través de las teorías del duelo y de la Psicología Analítica de C. G. Jung. **Resultados**: las respuestas de los entrevistados se agruparon en tres categorías temáticas: "*Sintomatología del duelo preparatorio*"; "*Percepción de los psicólogos sobre el duelo preparatorio*"; y "*El manejo del duelo preparatorio*", en las que los profesionales observan sentimientos contrastantes en sus pacientes, así como su experiencia se muestra ambigua frente a este fenómeno. También señalan la espiritualidad/religiosidad como un recurso eficaz para la construcción de sentido y afrontamiento. **Conclusión**: el duelo preparatorio es un fenómeno destacado en la práctica hospitalaria. La formación específica se muestra importante para la actuación con pacientes en duelo y en terminalidad, y refuerza la necesidad de cuidar la salud mental de los psicólogos que enfrentan esta demanda.
Descriptores: Aflicción; Psicología Médica; Teoría Junguiana.

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INTRODUCTION

Through Law No. 4,119 of 1962, the practice of Psychology was regulated in Brazil, which was not contested regarding its inclusion in school and business environments. However, many doctors were opposed to psychological practice in hospital environments, claiming that, in their terminology, “clinical” means bed, and psychologists did not perform consultations in hospital beds[1,2].

In the early 1950s, Hospital Psychology began to gain momentum in Brazil as a branch of Health Psychology, when pioneering professionals tried to understand the psychological dimensions of the illness process during hospitalization[3].

Hospital Psychology is the field in which knowledge about psychological aspects is focused on the context of illness and hospitalization, in which the subjectivity of an individual is affected by a pathology and significant emotional repercussions arise as a consequence[4].

This practice focuses on the emotional consequences of the health-disease process and not on the psychological causes themselves, thus expanding the scope of action not only for individuals who were hospitalized due to a mental illness, but also for biophysiological ones[5].

Psychological practice in hospital settings was and continues to be seen as a way for patients to express their emotions and feelings when trying to adapt to the limitations that illness and hospitalization can bring, both during the hospitalization process and afterwards, recognizing the individual's social, cultural and family contexts[3].

Given that illness in all phases of life requires a process of adaptation to the new reality, which generates emotional manifestations, the role of a psychology professional is essential, since they are the ones who directly act on the psychological implications generated by the illness process[6].

Hospital psychology seeks to understand the range of emotional manifestations of patients, family members and the healthcare team, which is aimed at attempts to improve the quality of life of hospitalized patients, which can generate emotional conflicts when facing situations of pain, finitude, loss in life and death[6]. A study indicates that:

The psychologist helps in dealing with internal conflicts, in dealing with losses, in the fragility of the being and in constant stress, working with the identification and relief of these subjects, favoring a better quality of life for them.[7:509]

Quality of life is understood as a multidimensional and interrelated concept involving physical health, psychological state, level of independence, living conditions, and social relationships. And since every illness process has the potential to become a hospitalization, losses are present and constant: of autonomy and freedom, individuality, personality, mobility

and functionality, the possibility of losing one's own life, generating a process of mourning in the patient[8].

The subjectivity of an individual in the hospitalization process is also weakened, since the possibility of carrying out daily practices that reinforce to the individual that they are truly lost, thus complementing and complicating the mourning process that occurs during hospitalization[6].

Grief, considered a complex process, involves psychological and cultural aspects that affect not only the bereaved individual, but a microsociety and, possibly, a macrosociety as well. It is a movement understood as unique, subjective and individual in the way in which the individual breaks a bond with something or someone and goes through a process of processing this loss[9].

Ill people may manifest depressed emotions not only with the hospitalization process, but also due to the loss of autonomy, losses caused by the illness, the possibility of no future with their loved ones, frustration at not living their dreams, and loss of control and the notion of invulnerability[10], even if this hospitalization is short.

When the individual is faced with a life-threatening diagnosis, the phenomenon of mourning becomes present, so that, at some point, they will have to face their terminal illness, thus characterizing preparatory mourning, which is nothing more than the cognitive, behavioral and emotional manifestations of the mourning process in the ill individual from the moment the diagnosis is made present to the patient[11].

A grieving process begins before the actual loss, and is called anticipatory grief, but this is intended for people who experience the process of death and loss of something or someone to whom they are attached; therefore, preparatory grief is the process that the terminally ill patient needs to undergo to prepare for their separation from this world, which is unique and specific to that individual who is dying[12].

As the phenomenon of grief is present daily in the reality of the Hospital Psychology professional, this study aims to investigate the perception of hospital psychologists regarding preparatory grief.

METHODS

This study consists of a descriptive, cross-sectional, and qualitative study. Psychologists working in hospitals in a city in the interior of the state of Minas Gerais, Brazil, participated in the study. Data collection was carried out between April and August 2022. Professionals with a

degree in psychology who had worked in the area of hospital care for at least six months were included.

For this study, a structured instrument was developed containing eight sociodemographic characterization questions, five open-ended questions about dealing with preparatory grief, and two other open-ended questions about the process of professional practice. The instrument was administered through a form generated by the Google Forms™ platform, which participants could access with greater reliability, while safeguarding ethical issues involving research confidentiality.

The following questions about preparatory grief were addressed to psychology professionals throughout the form: A) Data on training and practice (time since graduation, degree, specific training for working with people in mourning, time working in the hospital area, and specific place of work – eight questions); and, B) questions about mourning: 1) "*Do you perceive the preparatory mourning process in hospitalized patients?*"; 2) "*What emotional manifestations/symptoms do you perceive in preparatory mourning?*"; 3) "*How do you perceive preparatory mourning in hospitalized patients?*"; 4) "*How often do you deal with this phenomenon?*"; 5) "*How do you feel about dealing with the demands of the preparatory mourning process?*".

Regarding the training process, professionals were asked: 1) "*What theoretical bases support your work with mourning?*"; 2) "*In general, how do you feel about dealing with the demands of mourning?*".

The data generated were organized and interpreted using Bardin's Thematic Content Analysis method[13], which consists of discovering the cores of meaning that make up a communication, whose presence or frequency mean something to the study proposal. With this analysis, it is then possible to elaborate cores of meaning that make up a communication.

The following phases were followed: pre-analysis; exploration of the material; processing and interpretation of the results obtained. In the pre-analysis phase, the responses contained in the form were read to understand these aspects. Afterwards, the material was explored in light of the theories of mourning[12,14] and the Analytical Psychology formulated by Carl G. Jung[15-17].

The project related to this study was submitted to the Research Ethics Committee and approved through CAAE 63449722.8.0000.5145. The participants signed the Free and Informed Consent Form (FICF) and received the letter P followed by a number to protect the identity of the participants.

RESULTS

Ten psychologists participated, most of which were women. The average age was 34 years; regarding self-declared race, 1 person identified as black and the others as white.

Of the respondents, eight had completed a *lato sensu* postgraduate degree, while one had a master's degree and one had a doctorate. Regarding specific training for working with mourning, one participant reported advanced training in Palliative Care and Thanatology, one had training in Palliative Care and another reported training in mourning. The other seven respondents did not have specific training for working with mourning.

Regarding professional experience, one interviewee reported having worked for more than 10 years, four of them between 5 and 10 years in the hospital area, two with between 2 and 5 years and another three between 6 months and 2 years. The hospital's areas of operation were: Hemodialysis, ICU, Adult ICU, Neonatal ICU, Infirmary Wards, Outpatient Clinics, Emergency Care and Infectious and Parasitic Diseases Unit.

Based on the questions asked and to better understand the subjective phenomenon that was expressed, three categories were created: "*Symptomatology of preparatory grief*"; "*Psychologists' perception of preparatory grief*" and "*Dealing with preparatory grief*".

DISCUSSION

Symptomatology of preparatory grief

All participants reported experiencing feelings such as acceptance, faith and hope, which are also counterbalanced by the presence of anguish, apathy, fear, grief, anger and sadness.

In 1999, the Dual Process Model[14] was created, which considers the experience of mourning to be organized through two phases: *loss* and *restoration*. The person who endures the mourning process needs to be able to oscillate between these two phases in order to experience a healthy experience. Thus, mourning is shown to be something dynamic, complex and subjective.

The phases are ways in which individuals face the stress generated by the experience of grief, taking into account that the phases of *loss* takes over the subject's perception and can barely be worked on, and with the experimentation of life, the oscillation towards *restoration* appears, which is knowing how to identify the stressors and act on them.[18].

Re-reading this theory, we can associate the content brought by the interviewees, because in a difficult diagnosis, psychologists perceive manifestations of the *loss* phase as mood swings, rumination of feelings such as anguish, fear, anger and grief. When the individual finds themselves needing to adapt to this new reality, sadness and even symptoms of anxiety may

appear, as stressors are identified as loss of autonomy, the inability to fulfill their previously outlined responsibilities (whether it be cooking, going to the bank, providing for the family, among others)[18].

The process of *restoration* in mourning also requires the transformation of one's own identity, from someone healthy to someone who is in the process of becoming ill, hospitalized and dependent, giving rise to feelings such as fear and a certain anxiety about not being able to handle this entire reality on one's own. When these stressors are identified and emotionally worked through, the oscillation between the phases occurs, allowing the individual to express a certain acceptance of the reality of the loss, developing feelings of hope, strengthening faith and creating mechanisms to deal with the experience.

In the manifestations of the process of acceptance of the clinical condition of the hospitalized patient, observations were made: regrets, need to say goodbye, preparation of family members for the final moment, as well as resolutions of pending issues and existential reflections. This is in line with an oncology study[19] that mentioned that individuals who are in advanced stages of the disease, in an attempt to adjust to reality, manifest behaviors of preparation for this experience, this being a movement resulting from the preparatory mourning process.

Hope, also raised as an aspect of the experience perceived by psychologists, plays an important role during the process of illness. This feeling brings a certain comfort in the possibility of the existence of something that can save them and, even if there is no such salvation, the presence of this feeling in the patient, family members and health team establishes trust, in addition to the "*feeling that everything must have some meaning, that it can be worth it, if they can hold on for a little longer*"[12:144].

The feeling of hope is present in the health team when faced with a human being in a process of severe illness and with no possibility of cure. The professional's attitude is to understand that such an individual deserves even more care, considering that "*giving up on a patient can make them give up*"[12:145]. And this attitude does not mean giving them false beliefs that the process of death is not happening or that lies are the way to keep hope alive, but rather establishing a serious and open dialogue about the process of death and dying as something intrinsic to life, consequently, having hope and the meaning of life as something valuable.[12].

Furthermore, the interviewees reported the existence of symptoms that resemble psychopathologies such as anxiety (exaggerated expectation about a certain news item or event) and depression (constant crying, depressed mood, mood swings, discouragement, hopelessness and social isolation). It is necessary that, during the process of death and

manifestation of preparatory mourning, the symptoms of anxiety and depression be identified because "*depression is not inevitable and should not be considered a normal part of the dying process*"[20:884].

The symptoms present as: changes in self-image and self-esteem, hopelessness, active desire to die and ruminating thoughts about death and suicide as being indicative of a process with low quality of life and great suffering, issues that can be avoided when palliative care work is carried out aimed at minimizing discomfort and strengthening the patient's dignity[20].

Psychologists' perception of preparatory grief

When asked about how they perceive the preparatory grieving process in hospitalized patients, the interviewees mentioned manifestations of spirituality/religiosity as being one of the fundamental factors of understanding and action for psychology professionals:

Depressed mood upon diagnosis. Patient goes through a period of redefining life. (P2)

It is very unique, I observe that the patient's beliefs greatly interfere in the way he or she will experience the moment. (P6)

Each patient experiences it differently depending on age, cultural level, religious/spiritual experience. (P10)

Generally, with existential reflections, mood swings and emotional changes, guilt, regrets and desires. Content of faith, religiosity. (P4)

Spirituality is a concept associated with the individual search for understanding about issues related to the meaning of life, the relationship that the individual has with the transcendental or sacred and that can lead (or not) to the development of rituals and the formation of communities linked by the religious aspect[20]. While religiosity deals with religious practice itself, with actions aimed at going to a religious field and practicing rituals that are part of a certain religion[21].

Human beings are free to choose the religious-spiritual path to be followed in life, regardless of their place of insertion and the human concepts linked to religion[22]. This involvement in itself has been shown to be a factor of great impact on health, being considered one of the fields of prevention of disease.

However, the most common manifestations in the interviewees' statements are questions about the meaning of life as a strategy for coping with the process of illness and terminal illness.

It is believed that the dimension of spirituality is part of human nature and is incorporated into the dimension of the Collective Unconscious, which also seeks meaning and purpose in life. This dimension is one of those responsible for achieving psychic homeostasis

and emotional balance to the extent that it is incorporated into the way of life of each human being[15,16].

Moments of difficult diagnoses may involve reflections focused on personal achievements, interpersonal relationships and even whether such an experience refers to a sacred or transcendent calling, and such experiments involve the search for the meaning of life, which is only found through the actions and decisions that the individual takes when faced with a given risk situation[16].

The psychology professional, seeing such manifestations in the patient, must adopt a posture that is capable of translating these experiences that, for numerous reasons, may not be intelligible to those who experience them:

Deep sadness, anger, greater understanding of the situation in some cases, preparation of farewells. (P3)

I observe that older patients show greater acceptance and serenity when going through this process, as they have the feeling that their mission is accomplished, that they have already done everything they needed in life. Younger patients tend to present more anxious symptoms: desire to go home, anguish, insomnia, restlessness, anxiety attacks... (P10)

Experiences like these, which are common in hospital settings, are reflections of the stages of grief. For Kluber-Ross[12], there is a loss of meaning in suffering with technological advances: "*The belief that suffering here on earth will be rewarded in heaven has long since disappeared. Suffering has lost its reason for being*"[12:20].

This statement comes with the reflection that humanity, in losing the meaning of suffering, has also failed in the capacity to produce meaning in life, when it places itself in denial of mortality and, consequently, terminality:

While religious rejection, that is, the belief in the meaning of suffering here on earth and the reward in heaven after death, has offered hope and meaning, the rejection propagated by society offers none of this, only increasing our anxiety, contributing to accentuating our sense of destruction and aggression: killing to escape reality and the confrontation with our own death[12:20].

Dealing with preparatory grief

Regarding the handling of the demand for preparatory mourning, the statements present dualities, that, while they feel prepared and their interventions are effective, there is gratitude and relief, but there is also frustration and discomfort in dealing with this reality when the patient presents greater difficulties in this coping process:

When I look at the patient, it is better to observe, since we have to contribute to the patient's quality of life. (P1)

Feelings of relief, since I can work on and care for the patient and their family, contributing to their autonomy and preserving their dignity. (P3)

I believe it is challenging, because it deals with something that each patient and family member will feel. We deal with the subjectivity, the uniqueness of the individual. Thus, each person will have their own way of expressing themselves, expressing what they feel and think. (P4)

It requires a lot of technique, empathy and respect for the patient's 'moment'. At times it causes emotional discomfort. (P6)

Sometimes I feel helpless, but I try to provide as much information as possible to try to broaden the vision of possibilities for the patient and the family, to welcome, mediate and make room for this pain. (P5)

As with any and all mental illness within the hospital context, I feel I am facing a great challenge to be overcome. Because it is a common demand, I often try to seek theoretical support to support my practice. (P8)

It depends on the patient's emotional manifestation. When the patient experiences grief in a more natural, serene way, with better psychological organization, or when, even expressing their pain and suffering, they respond well to the proposed interventions, my experience as a professional is calm and rewarding. However, when the patient's suffering is so intense and/or they have more difficulty accepting the proposed interventions, I experience a feeling of helplessness, which makes me uncomfortable. (P10)

In their training process, psychology professionals seek theoretical contributions that support their perspective on the world and provide technical and scientific support to deal with all the situations they face in their daily practice. Thus, each professional builds their theoretical framework to deal with the demands that may arise. A study that surveyed publications between 2003 and 2021 indicates that the psychological approaches most used in the hospital context were Psychoanalysis (by Sigmund Freud) and Cognitive-Behavioral Therapy (by Aaron Beck)[23]. As for the techniques and instruments used, a variety can be seen that ranges from protocols for treating grief, structured interviews, inventories and even playful strategies[23].

The practice of psychology is permeated by particularities regarding the relationships that are established between the patient and the professional, regardless of the technique or approach chosen, which refers to the concept of countertransference.

Transference, in simple terms, is the mechanism used by the patient to project unconscious thoughts and desires onto someone (in this case, the psychology professional), while countertransference does the opposite, with the therapist's unconscious emotions, thoughts and desires being projected onto the patient[17]. Being aware of these concepts helps to understand the unconscious dynamics in the relationship between the individuals involved in the process and can influence the path to "healing", that is, adherence to intervention proposals and successes achieved in this relationship[24].

The personality of the professional, in terms of contact with the patient, is one of the most important factors during psychological care, considering that "*we naturally resist*

admitting that we can be affected, in the most intimate part of ourselves, by a 'random' patient"[17:59].

Based on Jungian precepts[25], the patient-therapist relationship requires a confident attitude between having "*one foot inside the situation and the other outside*"[25:102], in other words, the professional must use their empathy to feel as if they were in on the action experienced by the patient, but must look at it with a historical, theoretical, and practical context that relates to the patient's psychic development, or even "*empathy alone, despite its extreme importance, can be misleading, as the analyst's emotional experiences can easily be confused with those of the patient*"[25:102].

By promoting a safe and non-judgmental sphere of care, the psychologist can, along with the patient, develop what is called the *Analytical Encounter*, which is the idea of a therapeutic relationship that aims to overcome the obstacles that exist in the exploration of unconscious material, so that together they can find the safest path to self-knowledge[25]. However, each encounter produces different effects, and overcoming technicality in favor of a safe, affectionate and non-judgmental relationship leads to different and sometimes antagonistic responses in the relationship with each individual.

When the professional is faced with the subject of grief, the distressing feeling of one's own death tends to be more imminent, causing feelings such as frustration, regret, pain, injustice, relief when contact with grief is over, and even believing that when one acts in a more technical manner, and with emotional distance, there may be no obstacles to carrying out one's activities[26].

For this reason, it was for situations like this that Jung suggested *Training Analysis*, which reduces the danger of the therapist's projections, so that through it the professional becomes more aware of what is happening to them, either by expanding their perception of their own weaknesses or by finding important ways to confront their difficulties[25].

Therefore, it is necessary for psychology professionals to be up to date on how to care for their own mental health in order to come into contact with the contents of mourning, finitude and mortality of others, being able to exercise their role with empathy and technique, but without confusing the pain of others with their own suffering.

CONCLUSION

In hospitals, the routine of losses, whether subjective or material, forces professionals to deal with grief on a daily basis. Thus, the current research showed that professionals are able to visualize in their practices the grieving processes that occur with hospitalized patients.

Preparatory grief, with its specificities, is also contemplated by the interviewees' views, through manifestations of apathy, constant crying, hopelessness, depressed mood, fear, feelings of acceptance, faith and hope, and symptoms similar to psychopathologies such as anxiety and depression.

In situations in which patients perceive themselves facing finitude, the discourses return to the perception that psychology professionals gave to spirituality/religiosity and the meaning of life that each individual presents when faced with this situation. The study in question shows the importance of a facilitating and translating behavior of feelings that are unknown to patients, but that are still experienced.

It is argued that psychology professionals should take care of their own mental health, since coming into contact with realities involving finitude brings feelings of one's own mortality to the surface, because while caring for others, the confusion between the suffering of others and one's own suffering can be detrimental to the care provided.

Although mental health care requires special attention, the lack of theoretical support can become an obstacle in caring for others. Therefore, this study highlights the importance of specific training for working with people in mourning, to prepare psychologists for this phenomenon and to offer practical technical support for the necessary interventions, since losses are part of everyday hospital life.

It is important to emphasize the urgency of research like this being carried out with patients themselves in situations of hospitalization or even facing their own terminality, since this way, more consistent theoretical constructs will be available for carrying out effective, dignified and respectful practice.

The gap in scientific production related to preparatory mourning is notorious and proved to be a limitation of this study, since the publications are mostly from countries other than Brazil and not updated, in addition to the fact that Brazilian production is scarce and describes only theoretical and explanatory studies on this type of mourning, distancing itself from the professional practices experienced in reality.

Individuals in the process of terminal illness already experience their suffering, such as the loss of autonomy, mobility, identity, and subjectivity, but when they are subjected to care that is based on scientific construction, with ethics, empathy, and respect, they will be able to experience this unique and final moment with more dignity.

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