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Research Report

Hospital Psychologists' Experiences in Supporting Children's Grief at the End of Life

Experiência de Psicólogas Hospitalares no Suporte ao Luto da Criança em Finitude

Experiencia de Psicólogas Hospitalarias en el Apoyo al Duelo del Niño en Situación de Finitud

Expérience des Psychologues Hospitaliers dans le Support au Deuil de l'Enfant en Fin de Vie

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Abstract

This study examines the practices and challenges faced by hospital psychologists in supporting children's grief during the end-of-life process, with particular attention to the self-care strategies adopted by these professionals. Using a multiple case study design, data were collected through semi-structured interviews and analyzed using content analysis. The sample comprised seven hospital psychologists working in different pediatric care settings and providing follow-up to children with diverse diagnoses. The focus on female psychologists reflects the predominance of women in this field and the specific emotional impacts they experience, shaped both by the demands of the hospital environment and by sociocultural expectations associated with caregiving. The findings indicate that playful activities, such as games and drawing, are frequently used to help children express their emotions and understand finitude in an age-appropriate manner. However, the study identifies significant barriers, including family resistance and the predominance of a biomedical approach in hospital settings, which limit the provision of more comprehensive emotional support. Psychologists' self-care strategies include support networks, clinical supervision, and farewell rituals, which help manage the emotional impact of their work. The study concludes that institutional policies promoting an interdisciplinary and humanized approach are essential to enhance support for childhood grief and to safeguard the well-being of professionals working in this context.

Keywords: grief, hospital psychology, pediatrics, end-of-life care, self-care.

Resumo

Este estudo investiga as práticas e os desafios enfrentados por psicólogas hospitalares no suporte ao luto de crianças em processo de finitude, explorando as estratégias de autocuidado empregadas por essas profissionais. Com um delineamento de estudo de casos múltiplos, utilizando-se de entrevistas semiestruturadas e de análise de conteúdo, a pesquisa reuniu dados de sete psicólogas hospitalares atuantes em diferentes contextos pediátricos e que acompanham crianças com diagnósticos diversos. O enfoque nas psicólogas reflete a predominância feminina na área e os impactos emocionais particulares que essas profissionais enfrentam, influenciados tanto pelas exigências do ambiente hospitalar quanto pelas expectativas socioculturais associadas ao cuidado. Os resultados indicam que atividades lúdicas, como jogos e desenhos, são frequentemente utilizadas para ajudar a criança a expressar suas emoções e a compreender a finitude de maneira apropriada à sua idade. No entanto, o estudo identifica barreiras significativas, incluindo a resistência de familiares e a predominância de uma abordagem biomédica nos hospitais, que limitam a oferta de um suporte emocional mais abrangente. As

estratégias de autocuidado das psicólogas incluem redes de apoio, supervisão clínica e rituais de despedida, práticas que auxiliam na gestão do impacto emocional do trabalho. Conclui-se que políticas institucionais que promovam uma abordagem interdisciplinar e humanizada são essenciais para ampliar o suporte ao luto infantil e para o bem-estar dos profissionais que atuam nesse contexto.

Palavras-chave: *luto, psicologia hospitalar, pediatria, cuidados de fim de vida, autocuidado.*

Resumen

Este estudio investiga las prácticas y los desafíos enfrentados por psicólogas hospitalarias en el acompañamiento del duelo de niños en proceso de finitud, explorando las estrategias de autocuidado empleadas por dichas profesionales. Con un diseño de estudio de casos múltiples, mediante entrevistas semiestructuradas y análisis de contenido, la investigación recopiló datos de siete psicólogas hospitalarias que actúan en diferentes contextos pediátricos y acompañan a niños con diversos diagnósticos. El enfoque en las psicólogas refleja la predominancia femenina en el área y los impactos emocionales particulares que estas profesionales enfrentan, influenciados tanto por las exigencias del entorno hospitalario como por las expectativas socioculturales asociadas al cuidado. Los resultados indican que las actividades lúdicas, como juegos y dibujos, son frecuentemente utilizadas para ayudar al niño a expresar sus emociones y comprender la finitud de manera adecuada a su edad. Sin embargo, el estudio identifica barreras significativas, entre ellas la resistencia de los familiares y la predominancia de un enfoque biomédico en los hospitales, que limita la oferta de un apoyo emocional más integral. Las estrategias de autocuidado de las psicólogas incluyen redes de apoyo, supervisión clínica y rituales de despedida, prácticas que contribuyen a la gestión del impacto emocional del trabajo. Se concluye que las políticas institucionales que promuevan un enfoque interdisciplinario y humanizado son esenciales para ampliar el apoyo al duelo infantil y favorecer el bienestar de los profesionales que actúan en este contexto.

Palabras clave: *duelo, psicología hospitalaria, pediatría, cuidados al final de la vida, autocuidado.*

Résumé

Cette étude examine les pratiques et les défis auxquels sont confrontés les psychologues hospitalières dans l'accompagnement du deuil chez les enfants en processus de fin de vie, en explorant les stratégies d'auto-soins mises en œuvre par ces professionnelles. Avec une conception d'étude de cas multiples, s'appuyant sur des entretiens semi-structurés et une analyse de contenu, la recherche a rassemblé des données provenant de sept psychologues hospitalières exerçant dans différents contextes pédiatriques, accompagnant des enfants présentant divers diagnostics. L'accent mis sur les psychologues reflète la prédominance féminine dans le domaine ainsi que l'impact émotionnel spécifique auquel ces professionnelles sont confrontées, sous l'influence à la fois des exigences du milieu hospitalier et des attentes socioculturelles liées à la prise en charge. Les résultats indiquent que des activités ludiques, telles que les jeux et le dessin, sont fréquemment utilisées pour aider l'enfant à exprimer ses émotions et à comprendre la finitude d'une manière adaptée à son âge. Cependant, l'étude met en évidence des obstacles importants, notamment la résistance des proches et la prédominance d'une approche biomédicale dans les hôpitaux, qui limitent la possibilité d'offrir un soutien émotionnel plus global. Les stratégies d'auto-soins adoptées par les psychologues incluent des réseaux de soutien, la supervision clinique et des rituels d'adieu, des pratiques qui contribuent à la gestion de l'impact émotionnel du travail. Il en ressort que des politiques institutionnelles favorisant une approche interdisciplinaire et humanisée sont essentielles pour renforcer l'accompagnement du deuil chez l'enfant et pour le bien-être des professionnels intervenant dans ce contexte.

Mots-clés : *deuil, psychologie hospitalière, pédiatrie, soins de fin de vie, auto-soin.*

Regulated as a specialty in Brazil in 2000, hospital psychology plays a fundamental role in promoting mental health at the secondary and tertiary levels of care, adapting its practices to the specificities of each clinical setting (Conselho Federal de Psicologia, 2019). It is dedicated to understanding and addressing the psychological dimensions that accompany illness, with the aim of supporting patients as they cope with and adapt to the emotional and physical demands of the disease process (Simonetti, 2004).

In pediatric settings, psychologists must develop specific skills to work effectively with children. As noted by Winnicott (1978), children require alternative means, such as play, to express their thoughts and anxieties. Because emotional understanding is still developing in childhood (Franco & Santos, 2015), children may find it challenging not only to cope with the limitations imposed by illness but also to manage disruptions such as changes in routine, invasive procedures, and separation from home (Cardoso, 2007). According to Winnicott (1978, p. 163), children play in order to master anxieties, to control ideas or impulses that would otherwise lead to anxiety if left unmanaged. Play is therefore a

central element in a child's life and a primary means through which experiences are acquired. Through play, children can attempt to communicate what is occurring within them.

Sarmento and Pinto (1997) emphasize that childhood is not merely a biological stage but a complex social category marked by specific vulnerabilities and challenges. Consequently, hospital psychological practice with children must recognize their diverse lived experiences and social contexts, promoting care that extends beyond mental health to encompass the particularities of their life trajectories and realities. Although childhood is often idealized and protected, children frequently experience a contradiction between the symbolic value attributed to them and the limitations imposed on their autonomy and voice. Within hospital environments, where discipline and control shape many interactions, children are especially exposed to institutional pressures that reinforce their dependence on adults.

As Torres et al. (1990) point out, the hospital is not only a place of healing but also a space of separation, in which individuals are removed from their family environments and placed within an institutional context governed by distinct rules. In addition to illness, hospitalized children face challenges such as routine disruption, loss of freedom, impacts on development, reduced social interaction, and separation from family life (Cardoso, 2007). The grief generated by the deprivation of fundamental elements such as routine and family contact requires particular attention, as it may manifest in intense and complex ways throughout hospitalization (Alencar et al., 2022). These everyday losses can result in an ongoing grieving process that, if not adequately recognized and supported, may lead to negative emotional outcomes (Cemin & Einsfeld, 2021).

Within this context, children may also experience an erosion of identity, as they are often perceived not as individuals but as embodiments of their illness, and are expected to adopt passive behaviors to avoid rejection. Such dynamics hinder children's ability to externalize emotions, potentially compromising their adaptation to treatment and to the hospital routine. Confronted with the multiple losses associated with illness and hospitalization, children may experience a wide range of difficult emotions and reactions characteristic of grief, which, if not adequately elaborated, can result in traumatic experiences (Mazorra & Tinoco, 2005).

These challenges intensify when curative treatment is no longer possible and a palliative approach is adopted. In such cases, the child's finitude collides with an adult world that often underestimates children's capacity for understanding and fears engaging with the reality of death. Neis et al. (2023) note that as disease progresses and the likelihood of cure diminishes, expectations are gradually dismantled and replaced by fear surrounding the child's finitude, leading to a predominance of hopelessness. In chronic illness, the body frequently becomes the site where the contours of finitude are most evident, as it is experienced as inherently fragile. Because death is perceived as aversive and distressing, some health professionals and family members choose to withhold truthful information from children regarding their clinical condition, excluding them from end-of-life decision-making processes (Queiroz, 2023).

Nevertheless, individuals with severe illness are already engaged in a grieving process due to significant losses, including the loss of health. Through cycles of improvement and deterioration, they often become aware that recovery will not occur, giving rise to anticipatory grief for what is already being lost: the future. Given their perceptiveness, children may recognize the imminence of death and often value open communication about their illness and prognosis. Truthful information can bring relief and support the elaboration of grief (Mazorra & Tinoco, 2005). Respecting children's lived experiences contributes to a more integrated experience of anticipatory grief and may reduce feelings of abandonment that arise in environments marked by silence or concealment.

As illness progresses, this process is further intensified, as children not only endure daily losses but also gradually perceive the worsening of their condition, which may elicit fear, insecurity, and anguish (Mazorra & Tinoco, 2005). Despite this, resistance persists among healthcare teams to address childhood finitude, with death often avoided through defensive mechanisms such as denial (Monteiro et al., 2022; Mello et al., 2021).

Engaging with death in hospital settings entails substantial emotional challenges, particularly in cases of unexpected loss, which frequently evoke feelings of frustration, helplessness, and sadness among health professionals (Kentor & Kaplow, 2020). For many, childhood death confronts their own finitude and is sometimes interpreted as a failure of treatment within the prevailing biomedical logic (Monteiro et al., 2022).

Beyond professional challenges, the manner in which loss is socially recognized also shapes the grieving process. Alencar (2011) conceptualizes grief as both a psychic and social process influenced by the circumstances of death and the social conditions in which it occurs. When loss is socially or institutionally denied, grieving may be inhibited or even prevented. Grief thus extends beyond the private sphere, encompassing social and political dimensions and reflecting an unequal distribution of the right to grieve and of the dignity attributed to each life lost. In this sense, grief becomes particularly complex when the bereaved individual is a pediatric patient, who may face even greater difficulty expressing and elaborating pain in environments that do not consistently provide adequate support.

Caring for children in vulnerable situations requires more than meeting basic needs; it demands that adults create a supportive environment that fosters emotional development (Santos & Soares, 2022). Such caregiving relationships are essential for helping children navigate critical moments, including those experienced in hospital settings during end-of-

life processes, enabling the establishment of affective bonds and emotional support tailored to their specific needs (Stone & Farias, 2024; Sena & Melo, 2023).

Childhood grief is a singular experience that must be understood in light of children's cognitive, personal, social, and emotional development (Worden, 2013; Campos et al., 2023). Valle (2001) observes that during grief, children may experience profound anguish that may be expressed openly or masked through symptoms and challenging behaviors. When children's concerns regarding their own death are not acknowledged, their pain and suffering may be significantly intensified (Trois & Wendt, 2022).

In such a distressing environment as the hospital, psychologists facilitate emotional expression and support children in assuming an active role in the illness process, with the aim of enabling the most adaptive possible elaboration of this experience (Cardoso, 2007). Accompanying children throughout their finitude exposes psychologists to intense emotional demands, as they engage with patients' emotions during hospitalization and confront the termination of this relationship with the child's death.

Within this process, psychologists must also address their own experiences of grief. Liberato (2015) emphasizes the importance of recognizing and respecting both personal limitations and those of others, ensuring that individual characteristics are acknowledged and cared for appropriately. In hospital psychology, social constructions frequently associate care and empathy with femininity. In Brazil, data from the Federal Council of Psychology indicate that the majority of psychology professionals are women, reflecting socially constructed notions that emotional care is intrinsically linked to the feminine role (Sandall et al., 2022). In hospital settings, female psychologists face additional challenges, including emotional overload and expectations of constant availability, reinforced by gender stereotypes that associate caregiving with women (Oliveira & Abrantes, 2020).

This study seeks to contribute to the advancement of scientific knowledge on childhood grief within pediatric hospital contexts. It also aims to advance the field of hospital psychology, particularly in pediatrics, where children face unique challenges related to illness, hospitalization, and grief. The findings may inform improvements in hospital psychological practice and health policies, with the goal of enhancing emotional well-being and quality of life for these individuals.

The primary objective of this study is to analyze hospital psychologists' understandings of support for grief among pediatric patients undergoing end-of-life processes. Although children's experiences of grief constitute a central dimension of the research, the approach prioritizes the intersection between the challenges faced by psychologists and the quality of support provided to children. To do so, seven hospital psychologists working in diverse pediatric contexts, including intensive care units, palliative care services, and pediatric wards in both public and private hospitals, were interviewed. The children followed by these professionals had diverse diagnoses and were not experiencing finitude due to the same condition. In addition to examining psychologists' practices and challenges in supporting childhood grief, the study also investigates the self-care strategies adopted by these professionals in light of the emotional impact of their work.

The decision to focus on female psychologists reflects the predominance of women in hospital psychology and the emotional and sociocultural particularities associated with caregiving work, which may influence professional experiences and coping strategies. Accordingly, this study aims to understand both the psychological approaches offered to children and the resources used by psychologists to manage the emotional demands of hospital contexts, contributing to reflections on the need for institutional support and policies that promote more humanized and sustainable caregiving practices.

The specific objectives are i) to analyze the practices employed by hospital psychologists in addressing grief with children undergoing end-of-life processes; ii) to examine the challenges faced by hospital psychologists in supporting childhood grief; and iii) to investigate the self-care strategies adopted by hospital psychologists.

Method

Study Design

This study adopted a multiple case study design (Lima et al., 2023), characterized as a qualitative approach involving in-depth investigation of several individual cases within a single study. This design is particularly suitable when the objective is to understand a phenomenon across different contexts or from multiple perspectives, allowing for comparative analysis among cases. Analyzing data from multiple cases can be challenging, especially when attempting to preserve the integrity of each individual case while identifying shared patterns.

To ensure analytic rigor and preserve case integrity, each interview was transcribed verbatim and initially analyzed independently, maintaining the specific features of each narrative prior to the identification of thematic patterns. An initial floating reading enabled immersion in the individual accounts, followed by a coding process that prioritized the uniqueness of each experience before grouping findings into broader categories. This approach sought to balance the identification of common elements across cases with careful attention to individual specificities, ensuring an analysis faithful to participants' reported experiences.

Participants

Participants were recruited using a snowball sampling technique (e.g., Siqueira & Freitas, 2022), whereby initially contacted psychologists referred other professionals who met the study criteria. The sample comprised seven hospital psychologists, all women, aged 27-36 years, with experience providing care to children in end-of-life contexts. Six participants had completed multiprofessional residency programs, and most had further supplemented their training with internships and specialized courses in hospital settings, thereby expanding their competencies in pediatric and hospital psychology.

Participants' professional backgrounds were diverse, encompassing work in intensive care units, palliative care services, and pediatric wards in both general hospitals and pediatric specialty institutions, across public and private healthcare systems.

The sample of seven hospital psychologists was selected by convenience, based on professional availability and accessibility within the study context. The qualitative approach enabled an in-depth exploration of the reported experiences, facilitating the identification of both shared patterns and unique elements relevant to understanding the phenomenon under investigation.

The study focused on hospital psychologists with experience in pediatric units in Fortaleza, Ceará, Brazil. Inclusion criteria were i) practicing in Fortaleza; ii) holding a degree in psychology; iii) currently working or having previously worked in pediatric hospital units; iv) having accompanied pediatric patients during end-of-life processes; and v) providing voluntary informed consent to participate in the study. Exclusion criteria were i) psychologists working exclusively outside hospital settings; ii) those with experience limited to adult patients; or iii) those unavailable to participate. Table 1 presents the sample characteristics.

Table 1

Sociodemographic characteristics of the participants

Participant	Age (years)	Gender	Training	Practice setting
P1	27	Female	Specialization through Multiprofessional Residency in Pediatrics	Public pediatric hospital
P2	30	Female	Specialization through Multiprofessional Residency in Pediatrics	Public and private pediatric hospitals
P3	27	Female	Specialization through Multiprofessional Residency in Pediatrics	Public pediatric hospital
P4	31	Female	Specialization through Multiprofessional Residency in Pediatrics	Public pediatric hospital
P5	35	Female	Specialization through Multiprofessional Residency in Pediatrics	Public and private pediatric hospitals
P6	28	Female	Postgraduate Degree in Hospital Psychology	Private pediatric hospital
P7	36	Female	Specialization through Multiprofessional Residency in Pediatrics	Public pediatric hospital

Instruments

Data were collected using semi-structured interviews comprising three core questions that explored professional practices, perceived challenges, and self-care strategies among hospital psychologists working with pediatric patients undergoing end-of-life processes in hospital settings. These questions enabled an in-depth understanding of how professionals approach childhood grief, the difficulties encountered in providing support to these children, and the ways in which they manage the emotional impact of their work.

Data Analysis

Data analysis followed a descriptive qualitative approach aimed at illustrating the concepts and experiences reported by participants. Descriptive data analysis constitutes a fundamental stage in qualitative research, as it allows researchers to organize, summarize, and present collected data in a coherent and meaningful manner (Cardoso et al., 2021). This approach involves an in-depth analytical process and may include the construction of thematic categories to support systematic description. Beyond describing content, the analysis also sought to contextualize participants' narratives, offering insights into their meanings and their relationship to the contexts in which they were produced.

The analytical process began with full transcription of the interviews, followed by a floating reading to achieve familiarity with the material. Subsequently, participants' accounts were coded, and meaning units were identified and grouped into

thematic categories. Interpretation of the findings was informed by the existing literature, with the aim of understanding the experiences described by the participants. All analyses were conducted by one researcher and subsequently reviewed by a second researcher, who assessed the coherence of the defined categories, thereby enhancing the methodological rigor of the study.

Ethical Considerations

This study was conducted in accordance with Resolution No. 466/2012 and Resolution No. 510/2016 of the Brazilian National Health Council (CNS for short, in Portuguese). The research project was submitted to the Research Ethics Committee of Universidade Christus (Unichristus) and approved under protocol number 6,925,385. Data collection commenced only after formal approval by the research committee.

Participants were informed about the objectives and procedures of the study and were asked to sign two copies of the Free and Informed Consent Form (TCLE for short, in Portuguese). Voluntary participation was ensured, as was the right to withdraw from the study at any time without penalty. All participants received clear explanations regarding the content and purpose of the interview questions. The study involved minimal risk; nevertheless, the interviewer remained attentive to any signs of significant discomfort during the interviews and was prepared to provide appropriate support if needed.

To ensure data confidentiality, interview recordings and transcripts were transferred to an external hard drive and stored offline in a secure location with restricted access limited to authorized researchers. Regular backups were performed to ensure data integrity and availability. Both the external storage device and the computers used were protected with up-to-date antivirus software and additional digital security measures. Study data will be stored for a minimum period of 5 years in order to ensure the confidentiality and security of participants' information. Consent forms will be stored securely at the university for the same duration.

Results

Interviews revealed specific practices and challenges experienced by hospital psychologists when providing support for grief among pediatric patients undergoing end-of-life processes. Although the participants followed distinct professional trajectories, all demonstrated a strong commitment to hospital psychology and to working with children facing finitude.

Participant 1 developed her professional training with a focus on childhood and hospital settings and currently works in a public pediatric hospital, following experience in primary care, outpatient clinical practice, and a pediatric residency program. Participant 2 began her career at a support center for children living with HIV, later specializing in hospital psychology and expanding her practice to intensive care and palliative care, including pediatrics. Participant 3 completed training in pediatrics with experience in pediatric hospital psychology and subsequently broadened her practice to adult intensive care units, while maintaining significant work with children and adolescents in end-of-life contexts.

Participant 4 specialized in pediatrics through a residency program, with a professional trajectory centered on providing care to children and their families. Participant 5 has worked for 8 years in a private pediatric hospital, focusing on health psychology and emotional support for children. Participant 6 specialized in hospital psychology, complemented her training with clinical placements, and currently works in a private pediatric hospital. Participant 7 has extensive experience supporting children with chronic conditions and providing emotional support to their families.

Results were organized into three main sections: i) practices and interventions in the approach to childhood grief; ii) challenges within the hospital context; and iii) self-care strategies adopted by professionals. These findings are presented below.

Practices and Interventions in the Approach to Childhood Grief

All psychologists emphasized the use of play-based resources as a fundamental strategy to facilitate communication and enable children to express their emotions. Tools such as children's books, games, and drawing activities were frequently employed to address finitude indirectly, creating a space in which children could externalize their feelings and gradually make sense of their situation. One professional noted that play provides children with a "symbolic language" (Participant 2) through which they can engage with complex issues, supporting the acceptance and elaboration of grief. Another participant explained that "the resource is only a mediator; it is the way we use it to establish contact with that child" (Participant 3).

An important aspect of the reported practices was respect for children's autonomy. The psychologists highlighted the importance of recognizing and valuing children's capacity to make decisions about their final moments whenever possible. Respect for autonomy was reflected in allowing children to choose how they wished to spend their time and which activities they wanted to engage in, including meaningful actions such as farewells or special moments with family members, thereby acknowledging them as protagonists of their own stories. As one participant stated, "I always made it very clear to them: 'Here, we only do what you want and what makes sense to you.' Sometimes, that psychotherapy session was the only space of autonomy they still had" (Participant 2).

Several interviewees also emphasized the importance of tailoring their practices to the specific needs and characteristics of each child undergoing end-of-life care, ensuring that professional interventions were welcoming and respectful of individual differences. One participant remarked, "What I can say is that, in psychology, it depends a lot. There are children we are able to work with, and others we are not. Often, we need to return to the present moment, to what makes sense today, focusing on comfort and daily life" (Participant 3). Another added, "I really like to understand what the child knows. Does she understand why she is going through all of this? Sometimes we think we are protecting them, but they notice everything, from the weaker body to the different dynamics around them" (Participant 4). Adaptation therefore involves flexibility in both approach and intervention, allowing psychologists to adjust their practices according to the child's understanding, developmental stage, and emotional responses.

Most participants emphasized the need to adapt communication to each child's age and cognitive condition. This adjustment involved the use of simple language, avoidance of technical terms or expressions that might generate confusion or fear, and the incorporation of playful strategies to make information more accessible. As one psychologist explained, "Depending on the age, sometimes we use metaphors through books or even games, but the important thing is that the message is clear so the child can understand what is happening without being abruptly exposed" (Participant 2). Another participant noted, "I like to start from the principle of what the child is understanding. Does she know that she is going to die? Because it is her right to know" (Participant 4). A third added, "Children understand when their body is failing, you know? And this needs to be communicated clearly, without excluding the patient from the truth" (Participant 1). Communication strategies were thus carefully adjusted to ensure that children could comprehend their condition in a gradual and sensitive manner.

Challenges in Supporting Childhood Grief in Hospital Settings

Resistance from family members, and, in some cases, from health care teams, was identified as one of the main challenges faced by psychologists. Motivated by a desire to protect the child, adults in the child's environment often avoid sharing information about the terminal condition, which may intensify the child's suffering and hinder the creation of a transparent communicative space around grief. As one participant explained, "Whenever we have this contact, we obviously need to welcome the family's denial, but at the same time show them the impacts of this, of not telling, of not explaining, of leaving the child confused at such a moment in life" (Participant 1). Medical discourse, with its hegemonic focus on cure, frequently frames death as a failure rather than as a natural part of the life cycle, thereby limiting openness for grief to be experienced authentically. As another participant noted, "The hospital is an extremely biomedical environment, oriented toward cure, which can make it difficult to provide the necessary support at moments of loss" (Participant 2).

Interviewees emphasized that this resistance, often rooted in cultural conceptions that seek to distance death from the child's imaginary world, can generate distress and confusion. Children perceive changes in adult behavior and in hospital dynamics, even when they do not fully understand their condition. One participant illustrated this by stating, "The child notices that their little body is no longer the same as when they entered the hospital. They feel, 'I'm taking more medications, I'm getting weaker, I'm feeling more fragile and sensitive'" (Participant 4). Another participant's assertion that "the greatest challenge is not the child, but the adults around them" (Participant 2) highlights the tension between recognizing children's capacity to understand their reality and adult ideologies aimed at preserving childhood innocence. This conflict challenges psychologists to create spaces of trust and communication despite resistance from families and health care teams.

Another significant challenge reported by the professionals concerned hospital infrastructure and institutional regulations, which often restrict the emotional support available to children and their families. Several participants noted that infection control policies and bed management rules can limit family presence during the child's final moments and constrain the implementation of more humanized care practices. As one participant emphasized, "The hospital institution is like a factory that forces us to be very rigid, very restrictive of actions that could be more humanizing and more sensitive" (Participant 1). Another added, "Many areas in the hospital are inhospitable to welcoming. Everything is black on black, white on white. So, the most we can do is try to make that small bedside space reflect the patient, to the extent possible" (Participant 5). Such restrictive contexts often prevent psychologists from providing more comprehensive emotional support and limit families' opportunities for meaningful farewells.

Participants also highlighted difficulties within health care teams in addressing childhood grief, which directly affect psychologists' work. Many health professionals were described as focusing primarily on technical treatment, leaving little room for empathic engagement with death and loss. As one psychologist observed, "Health professionals are not prepared to provide this kind of support, especially when it comes to dealing with patients' grief, the loss of the patient" (Participant 6). In addition, the psychologists pointed to divergent perspectives across hospital disciplines regarding how to approach grief, which can hinder the coordination of interventions aimed at offering continuous support to the child. As one participant stated, "For me, the biggest challenge is being able to coordinate strategies together, because everything has to be done as a team. There's no point in me working on one issue if another area of health care comes in and does the opposite" (Participant 7).

Professionals' Self-care Strategies

Participants reported adopting a range of self-care strategies to cope with the emotional impact of working with children undergoing end-of-life processes in hospital settings. These strategies were closely related to the challenges identified in their professional practice and were described as essential means of managing the emotional demands inherent to this work. Personal and professional support networks were highlighted as particularly important resources, offering safe spaces for sharing experiences and receiving emotional support. As one participant noted, "For me, one of the main strategies, one of the main coping resources, is my family and community support network, building secure affective bonds and well-established, safe relationships with my family and friends" (Participant 2).

Clinical supervision and personal therapy were also identified as key components in promoting psychologists' mental health, enabling reflection on professional experiences and personal emotional responses. As one interviewee explained, "Nowadays, I don't think I can separate supervision from my personal therapy anymore. I take things from supervision and work through them in therapy" (Participant 1). In addition, many participants emphasized the incorporation of physical and/or spiritual activities into their routines, viewing these practices as essential for emotional balance and stress reduction. One participant stated, "I always try to look inward, especially after particularly moving sessions, and to notice as much as possible what affects me. We need to find moments outside of work that help separate these issues" (Participant 3). Another added, "Having spaces that allow us to reflect on the emotional impact of the work is fundamental, because the hospital environment demands a great deal from us emotionally" (Participant 6).

Another self-care strategy described by the participants involved engaging in personal farewell rituals following the death of a patient. These rituals could include revisiting memories and meaningful moments shared with the child or allowing oneself to cry and experience the loss authentically. Such practices enabled psychologists to process the loss and work through their own grief in a healthy manner. As one participant shared, "Whenever I lose a patient, especially when there was a strong bond, I cry all day if necessary. But I go through my own farewell process, I remember the photos, the things we built together. That helps me cope better with the loss and move forward" (Participant 1). Another emphasized, "We have to live through the suffering, because it is part of the process, but it is essential to find ways to reorganize ourselves so we can continue" (Participant 5).

In addition, the interviewees highlighted the importance of maintaining a clear boundary between personal and professional life. Deliberately "disconnecting" from the hospital environment after working hours was described as a strategy to preserve the quality of personal relationships and minimize the emotional spillover of work into private life. As one participant stated, "I try not to take the hospital's suffering home with me. This distance is important so that we can preserve our mental health and continue working in the long term" (Participant 7). This practice was considered essential for sustaining mental health and ensuring long-term professional well-being and performance.

Discussion

This study aimed to understand the experiences of hospital psychologists in supporting grief among pediatric patients undergoing end-of-life processes. The practices and interventions described by the participants seek to create spaces for emotional expression and support, while taking into account children's cognitive development and capacity for understanding.

According to the psychologists interviewed, the use of play-based resources is fundamental for creating a therapeutic environment in which children can approach complex issues such as finitude without the rigidity of technical language. Winnicott (1978) emphasizes that play is a central activity in children's emotional development, enabling them to explore and make sense of their anxieties. In this process, play becomes a language through which children can symbolize difficult experiences and emotions. Thus, play serves as an essential medium for connecting children's internal and external worlds, while also fostering a therapeutic setting that supports coping and the elaboration of grief-related emotional issues (Valle, 2001; Farias et al., 2021).

Beyond play as a therapeutic resource, another key aspect highlighted by the psychologists was the need to adapt communication to each child's age and cognitive abilities. Kovács (1992) notes that children's understanding of death develops gradually, as they progressively assimilate the irreversibility of finitude and its emotional implications. With cognitive maturation, children begin to integrate both concrete and abstract aspects of death, recognizing its universality and inevitability. This process depends not only on emotional maturity but also on the supportive environment provided by adults, who must validate and welcome children's feelings in order to promote a healthier understanding of grief (Alencar et al., 2022; Worden, 2013).

According to Worden (2013), adapting communication involves recognizing the specific emotional needs associated with each stage of child development, allowing psychologists to employ individualized strategies that support grief processing while respecting each child's pace and characteristics. Furthermore, childhood grief in Brazilian hospital

settings is deeply intertwined with social issues, including economic inequalities, limited access to healthcare, and cultural factors that shape how death and suffering are perceived and addressed. The psychologists emphasized the importance of flexibility and the ability to tailor interventions to each child's needs. In hospital environments, the psychologist's capacity to adapt to individual circumstances is essential for providing effective psychological support (Cemin & Einsfeld, 2021; Franco & Santos, 2015).

Within this context, creating an atmosphere of trust that facilitates open communication was identified as a key intervention in helping children feel safe and supported in expressing their emotions. Mazorra and Tinoco (2005) argue that honest communication supports children in elaborating grief and enables a dignified and humanized dying process. Valle (2001) further emphasizes that children facing finitude need to have their questions addressed, as silence can intensify fear and feelings of abandonment. When psychologists position themselves as welcoming and available figures, they create a vital space for emotional support, fostering therapeutic relationships that enable children to express themselves and confront grief in a healthier manner (Neis et al., 2023).

The findings also underscore the importance that hospital psychologists place on respecting children's autonomy during end-of-life processes. Whenever possible, professionals seek to value children's preferences and decisions regarding how they wish to spend their time and which activities they want to engage in. This practice is guided by the understanding that allowing children to exercise some degree of control over their experiences contributes to a more positive and less traumatic elaboration of grief (Gonçalves & Bittar, 2016).

Respect for children's autonomy aligns with literature highlighting the importance of children's active participation in coping with death (Valle, 2001). Hospitalization already entails a significant loss of control for children, along with separation from their family environment and daily routines. Illness and medical treatment may further intensify perceptions of lost freedom, leading children to feel subjected to others' decisions, which can undermine emotional coping. The opportunity to make choices allows children to affirm their identity and feel respected in their preferences (Gonçalves & Bittar, 2016).

Despite these practices, the implementation of certain interventions is permeated by challenges within hospital contexts. Family members and some healthcare professionals may resist approaches that allow pediatric patients to understand and participate openly in discussions about their condition. Although often motivated by a desire to protect children from suffering, this stance can result in overprotective behaviors that limit children's expression and autonomy, intensifying distress by creating environments of silence (Torres et al., 1990). Such attitudes are frequently rooted in the belief that children should be shielded from painful information. However, this perspective often underestimates children's autonomy and compromises their ability to elaborate grief (Kovács, 1992; Valle, 2001).

This so-called "protective silence" can exacerbate distress among children facing finitude. Even without fully understanding their situation, children perceive changes in their surroundings and in adults' behavior. Mazorra and Tinoco (2005) argue that while many adults believe children should be spared from the realities of death, this approach may generate greater fear and confusion, leading children to feel isolated. Valle (2001) further notes that when confronted with environments of omission, children experience significant frustration, which intensifies emotional suffering, as they sense the gravity of the situation despite adults' avoidance of open discussion.

Such resistance largely stems from cultural beliefs that children must be protected from suffering, prompting adults to avoid discussing the severity of pediatric illness. Some health professionals and family members choose silence or vague explanations, assuming this will prevent further distress. However, the psychologists interviewed emphasized that silence may cause more suffering than honest communication about imminent death, as children often perceive behavioral changes in adults and, when feeling excluded, experience a confused and poorly elaborated grieving process (Torres et al., 1990).

Many family members and healthcare professionals struggle to acknowledge that pediatric patients may have some understanding of their own finitude. According to Kovács (1992), adults often view children as incapable of grasping the irreversibility of death and, by "protecting" them from this reality, deprive them of the opportunity to process their own grief. However, both the literature and the psychologists' accounts indicate that silence surrounding death tends to intensify children's suffering, creating environments of emotional isolation (Alencar et al., 2022; Mazorra & Tinoco, 2005).

In contrast, the participants emphasized that honesty, when adapted to children's level of understanding, generally alleviates distress and facilitates the elaboration of anticipatory grief. Studies such as Valle (2001) support the notion that transparent, developmentally appropriate communication enables children to cope with grief in healthier ways. These practices aim to ensure that information is conveyed clearly and sensitively, without inducing fear or confusion, while allowing children to recognize and participate in their own reality (Cardoso, 2007). Consequently, the psychologists described ongoing efforts to identify alternative ways of engaging in dialogue with children while respecting cultural and family-related barriers. This dilemma, balancing respect for family beliefs with the need to provide children with space to understand their condition, demands considerable sensitivity and adaptability from hospital psychologists (Alencar et al., 2022; Mazorra & Tinoco, 2005).

In addition, because hospital environments are deeply embedded in a biomedical, cure-centered logic, they often foster a climate in which death is perceived as a "failure" of treatment. This perspective hinders the emotional support required to address grief adequately. According to Cardoso (2007), such a framework shapes the attitudes of hospital teams, who tend to avoid discussions about finitude and adopt a more distant stance toward the emotional needs of terminal patients. As a result, hospital psychologists frequently find themselves isolated in their efforts to provide grief support, encountering resistance when attempting to create spaces for transparent and empathic communication.

Another challenge identified by the psychologists concerns the hospital structure itself, which restricts emotional support for both children and their families. Infection control protocols, visitation restrictions, and bed management demands can limit children's contact with loved ones, particularly during final moments of life. Torres et al. (1990) describe the hospital as a setting in which children are removed from their familial environment and placed within a rigid institutional routine, intensifying feelings of separation and abandonment. These structural constraints not only affect children's well-being but also hinder psychologists' ability to implement more humanized and welcoming interventions (Alencar et al., 2022; Maciel et al., 2022).

In the Brazilian context, institutional, cultural, and social challenges significantly shape practices of care for pediatric patients. Hospitals across Brazil, particularly in the public sector, often operate with limited resources and are primarily oriented toward physical care, with insufficient attention to psychological and emotional support. These structural limitations directly affect hospital psychologists' work, requiring them to adapt interventions and develop alternative strategies to provide emotional support under adverse conditions (Cemin & Einsfeld, 2021; Pereira et al., 2021).

Although technical care is essential, its predominance tends to minimize the relevance of emotional and social dimensions in experiences of dying, thereby constraining psychologists' capacity to offer deeper and more individualized emotional support. As emphasized by one of the interviewed psychologists, the hospital context "makes it difficult to provide the necessary support at moments of loss," given that the prevailing biomedical logic prioritizes physical and organic aspects of care while often neglecting patients' emotional dimensions. Many participants reported that, in the face of these barriers, they must continuously adapt their interventions, balancing institutional rules with the emotional needs of children and their families (Monteiro et al., 2022; Queiroz, 2023).

Psychologists also identified limited integration among health care disciplines as a major challenge, as different professional groups often hold divergent perspectives on how to address pediatric death. This lack of alignment can generate conflict and undermine the implementation of cohesive and continuous grief support. Participants' experiences reinforce the need for an interdisciplinary approach that enables integrated and collaborative practice, ensuring that children and families receive adequate emotional support throughout the end-of-life process. As discussed by Gonçalves and Bittar (2016), team integration is essential for providing consistent emotional care.

Gender-related issues in hospital psychology practice also warrant attention. The predominance of women in the profession (Oliveira et al., 2021) contributes to a social imaginary that associates caregiving and empathy with femininity, reinforcing expectations that female psychologists should always be emotionally available. Such stereotypes can hinder the establishment of professional boundaries and lead to emotional overload, negatively affecting psychologists' well-being (Souza et al., 2024).

As reported by the participants, hospital psychologists actively seek to promote a more humanized approach within hospital settings. The emphasis on physical recovery can result in a "depersonalization" of pediatric patients, who are often viewed primarily through the lens of illness, with their emotions and psychological needs underestimated (Cardoso, 2007). By advocating for recognition of these emotional dimensions, psychologists help ensure that hospitalized children are valued as whole individuals, rather than merely as "patients."

In addition to humanizing care for children, psychologists also provide essential support to healthcare teams, who frequently struggle to cope with pediatric death. Emotional distancing, adopted by some professionals as a protective mechanism, may compromise care quality, particularly for children who are already vulnerable and sensitive to a lack of empathy (Torres et al., 1990). By creating spaces in which healthcare teams can express their own anxieties and difficulties related to finitude, psychologists contribute to a more balanced emotional care environment, benefiting both patients and professionals (Queiroz, 2023).

To sustain this humanized approach and manage the emotional demands of their work, hospital psychologists rely on a range of self-care strategies that are essential for preserving mental health and ensuring continuous, sensitive support for patients and families throughout the end-of-life process. In this sense, self-care becomes a foundational element of sustainable practice, enabling psychologists to meet patients' emotional needs without compromising their own well-being (Pereira et al., 2021).

Among these strategies, both professional and personal support networks were identified as fundamental to psychologists' well-being. Participants reported that sharing experiences and seeking emotional support from colleagues are indispensable practices for coping with the daily challenges of hospital environments. These support networks create safe spaces for emotional exchange and reflection, allowing psychologists to process their experiences constructively. Support from colleagues, friends, and family members who understand the nature of the work helps reduce isolation and fosters a sense of belonging, which is crucial for professional resilience (Franco, 2015).

In addition to support networks, clinical supervision and personal psychotherapy were frequently cited as important self-care practices, enabling psychologists to reflect on their emotional responses and address the challenges inherent in working with childhood grief. Liberato (2015) emphasizes that prolonged exposure to suffering and finitude requires psychologists to recognize and respect their own emotional limits as well as those of their patients. This mutual respect for suffering is essential to prevent emotional exhaustion and preserve empathic capacity. Clinical supervision not only supports technical development but also provides a safe space for psychologists to express and work through their own distress. Personal therapy complements this process by helping psychologists maintain emotional balance and distinguish their own experiences from those of their patients, as highlighted by one interviewee: "Personal therapy is essential for me to separate my patients' suffering from my own" (Souza et al., 2024).

Another self-care strategy described was the use of personal farewell rituals following patient deaths. These practices help psychologists process and elaborate grief in a healthy manner and may involve reflecting on the therapeutic relationship, recalling meaningful moments, or allowing space for sadness and mourning. Kovács (1992) notes that by acknowledging and welcoming their own emotional responses to patient loss, psychologists can cope with grief without compromising their ability to support other children and families. Franco (2015) similarly emphasizes that processing pain and emotions associated with working with terminal patients is essential for maintaining resilience and preventing burnout.

Maintaining clear boundaries between personal and professional life was also identified as a fundamental strategy for protecting personal relationships and emotional health. Although complete emotional neutrality is neither possible nor desirable, preserving individual boundaries within the therapeutic setting helps prevent the negative spillover of work-related suffering into personal life (Liberato, 2015). This deliberate "disconnection" from the hospital environment allows psychologists to restore emotional resources and sustain their professional roles over time. Establishing clear boundaries thus serves as a protective factor against long-term emotional exhaustion and illness (Monteiro et al., 2020).

Physical and spiritual practices were also mentioned by some participants as important forms of self-care and emotional regulation. Physical activity is widely recognized for its effectiveness in reducing stress and promoting psychological well-being. For some professionals, engagement in spiritual practices provides a sense of peace and acceptance in the face of death, offering emotional comfort and a broader perspective on finitude. Such practices may facilitate a more balanced engagement with patients' end-of-life processes and contribute to sustainable coping in emotionally demanding contexts (Mazorra & Tinoco, 2005).

Finally, it is important to highlight that the feminization of psychology reinforces associations between gender and caregiving roles, shaping female psychologists' experiences in managing finitude-related situations such as childhood grief. Stereotypes suggesting that women are inherently more capable of handling intense emotional demands can contribute to emotional overload and burnout, particularly when expectations of empathy and dedication are not accompanied by adequate institutional support (Souza et al., 2024). Recognizing the impact of gender dynamics on psychologists' work is therefore essential for informing public and institutional policies that promote self-care, emotional balance, and sustainable professional practice, ultimately ensuring more effective and humanized care for pediatric patients and their families.

Final Considerations

This study highlights the relevance of hospital psychologists' work in supporting grief among pediatric patients, underscoring the complexity and challenges inherent to this context. By adopting practices centered on emotional expression and respect for children's autonomy, hospital psychologists move beyond a solely physical model of care, integrating psychological and social support into their work with children. Play-based resources and communication adapted to patients' cognitive capacities enable children to understand and participate in their end-of-life processes in less traumatic ways. Within hospital environments predominantly guided by biomedical logic, such practices are essential for addressing grief in a sensitive and supportive manner.

Nevertheless, the challenges identified are substantial. Resistance from family members, and at times from other health professionals, to allowing children to consciously engage with their condition can hinder the elaboration of grief. Although such protective behaviors are often well intentioned, they may intensify children's suffering by fostering silence, limiting understanding, and restricting opportunities for emotional expression. In addition, institutional constraints may restrict contact between children and their families during final moments, exacerbating feelings of abandonment and loneliness.

To navigate these challenges, hospital psychologists rely on flexible approaches and essential self-care strategies to sustain their practice in emotionally demanding environments. Support networks, clinical supervision, and personal psychotherapy were identified as fundamental resources that help professionals process their own emotions and maintain the balance necessary to work with empathy and resilience. Moreover, many psychologists engage in personal farewell rituals to elaborate the grief associated with patient loss, allowing them to cope with bereavement in healthy ways and continue providing appropriate support to other patients.

The findings reinforce the need for institutional policies and healthcare practices that promote interdisciplinary and humanized approaches, enabling hospital teams, including psychologists, to offer comprehensive support to pediatric patients. The development of clear protocols and the promotion of humanized hospital environments can transform care settings into more welcoming spaces that recognize children as active subjects in their end-of-life processes. Institutional acknowledgment of emotional care is essential to ensure that children have the right to participate consciously in their condition, supported by open and sensitive communication.

In conclusion, the implications of this study point to the need for structured and sensitive approaches to childhood grief in hospital settings, supported by policies that address both patients' emotional needs and professionals' well-being. Greater flexibility in institutional norms and increased awareness of the psychologist's role in addressing childhood finitude may contribute to more empathic and effective interventions.

Despite its contributions, this study has some limitations. The small sample size of seven hospital psychologists from a single city limits the generalizability of the findings to other contexts and healthcare realities. In addition, the snowball recruitment technique may have resulted in a relatively homogeneous group of participants, reducing the diversity of perspectives. Although the qualitative approach enabled in-depth analysis, it limits direct comparison with other populations. Finally, the exclusive inclusion of women in the sample precluded examination of potential gender differences in professional practice. Future studies should therefore expand sample sizes, include diverse hospital contexts, and adopt mixed-methods designs to deepen understanding of psychologists' roles in supporting childhood grief and to strengthen policies and practices in this field.

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