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Analysis of Psychotherapeutic Experiences based on the Systemic Model in Families with a Terminal Patient

Análisis de Experiencias Psicoterapéuticas desde el Modelo Sistémico en Familias con un Enfermo Terminal

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ABSTRACT

This article describes research with the families of terminal patients in the Municipal Hospital "Bajío del Oriente" in Santa Cruz de la Sierra, Bolivia. While interacting with terminal patients and their families, the need for systemic family therapy was recognized. Terminal illness interrupts the cycle of life of the individual as well as family dynamics. The objective of this study was to explore how systemic family therapy contributes to the emotional well-being and resilience of families facing the difficult situation of having a terminally ill loved one. Semi-structured interviews and participant observation techniques were used to collect qualitative data, which were analyzed using the thematic analysis approach. The Results revealed that systemic family therapy provided a safe space to express their emotions, engage in healthier relationships, and develop effective coping strategies. Additionally, the therapy was found to help strengthen family bonds and promote open and honest communication. These findings suggest that systemic family therapy can be a valuable tool in supporting families facing situations of terminal illness, providing them with a supportive space and promoting their emotional well-being.

Palabras clave:
Terapia sistémica familiar, enfermo terminal, resiliencia.

RESUMEN

El presente escrito describe una investigación hecha con las familias de enfermos terminales en el Hospital Municipal "Bajío del Oriente" de Santa Cruz de la Sierra, Bolivia. Al trabajar con los enfermos terminales se reconoció la necesidad del cuidado sistémico familiar. Una enfermedad terminal necesariamente es una fuente de estrés para todo el sistema familiar. La enfermedad terminal interrumpe el ciclo vital de la persona y la dinámica de la familia. El objetivo de este estudio fue explorar cómo la terapia sistémica contribuye al bienestar emocional y a la resiliencia de las familias que enfrentan la difícil situación de tener un ser querido en estado terminal. Se utilizaron entrevistas semiestructuradas y técnicas de observación participante para recopilar datos cualitativos, los cuales fueron analizados mediante el enfoque de análisis temático. Los

	resultados revelaron que la terapia sistémica proporcionó un espacio seguro para que las familias expresaran sus emociones, se relacionaran de manera más saludable y desarrollaran estrategias de afrontamiento efectivas. Además, se encontró que la terapia ayudó a fortalecer los vínculos familiares y promovió la comunicación abierta y honesta. Estos hallazgos sugieren que la terapia sistémica puede ser una herramienta valiosa en el apoyo a familias que enfrentan situaciones de enfermedad terminal, brindándoles un espacio de contención y promoviendo su bienestar emocional.

Introduction

The experience of having a terminally ill loved one can be extremely challenging. Uncertainty, emotional pain and changes in family dynamics can generate great stress. Psychotherapy based on the systemic model has been shown to be effective in understanding family dynamics in the grieving process, changes in family structure in the face of death, addressing emotional needs, and promoting resilience.

The family is a whole where each member is part of a system, necessarily interacting with each other. generate situations of conflict and anxiety. Therefore, it is necessary to intervene together with all those who make up the family system. When the different subsystems are affected, alterations are caused in the rest of the family environment.

The systemic model has the family as its unit of analysis. Traditional models centered on the individual are not enough to understand the family. A new conceptualization is required, a new way of thinking, in which the object of analysis is not the individual but the system. Thus, the systemic model is inspired first by general systems theory and then by complexity theories.

Lynn Hoffman (1987) traces the history of systemic family therapy. By the 1950s in the United States, researchers such as Ackerman, Bowen, Boszormenyi-Nagi, Framo, Watzlawick, Don Jackson and Bateson, began to work more systematically with families. The psychoanalytic therapeutic process produced results-but before long they relapsed. This caused the aforementioned authors (among others) to begin research within the families of these patients.

This first organized effort was followed by Salvador Minuchin and Whitaker in the 1960s. Bertalanffy's ideas are assimilated to Systemic Family Therapy, defining a system "as a set of elements that maintain a constant interrelation among themselves, and are differentiated from the external environment, considering that certain groupings of its elements form subsystems" (quoted by Villareal-Zegarra, and Paz-Jesús, 1987 p. 47).

The second line that converges in the theoretical bases of systemics is Winer and Maruyama's cybernetics linked to the processes of homeostasis (maintenance of the status quo of a system) based on negative feedback and morphogenesis (process of change) related to positive feedback (Hoffman, 1987; Villarreal-Zegarra and Paz-Jesús, 2015).

Positive feedback has usually been considered from the point of view of its destructive effects on a system. There is an optimal feedback point. After that point the system will start to overcorrect causing the system to break down (Hoffman, 1987). The tendency to form personal interests, like social power, is, in essence, positive feedback beyond the sweet spot.

Something that characterizes families is their complex dynamics, in which emotional ties, projects in different phases, undertakings and confrontation with the problems that society poses on a daily basis have an impact on both their cohesion and their vulnerability. Therein lies the importance of research on therapeutic accompaniment from the systemic model, in order to understand and explain the different factors that can weaken the bond, increase conflicts or, on the contrary, be an opportunity to strengthen individual and group resilience. The framework for action will be the family system conceived by some authors as a group that is in a continuous process of change within itself as well as in its social context. In this way, it develops complex internment patterns in which each member fulfills different functions (Villarreal-Zegarra and Paz-Jesus, 2015).

The development of a terminal illness in a family member generates a series of maladjustments in the way the family functions and questions the ability of its members to cope with a difficult situation and can provoke complex situations that affect the functionality of the family system. The changes that occur do not follow a specific pattern, but will depend on certain family characteristics, such as family history, socioeconomic level, and the strength of their relationships, which determine the adequate adaptation to the new situation, not only the family system but also the patient (Ramirez, et. al., 2019).

Faced with the crisis of terminal illness, families find it difficult to make their habits more flexible and perpetuate previous patterns of functioning that may be ineffective in adapting to the new situation. These patterns (based on family history, values and rules) may hinder intrafamily communication, task distribution or role conflict, among others. The intervention of professionals in this situation should be aimed at making family functioning more flexible, for which it is necessary to know what the family is like, its rules and its capacity to adapt to new situations according to previous experiences (Cuesta, 2020). A circular epistemology is required, which Lynn Hoffman (1981) describes as a: "inextricable element of what he is trying to change" (p. 15). She explains that the therapist, family and other elements act and react on each other in unpredictable ways. Each action and reaction change the original situation-making circular epistemology necessary.

The family faces two stages during the patient's illness: the medical eviction stage that includes the announcement to the patient and family members of the end of possible treatments; and, the second stage is the patient's dying-a transition period in which some vital signs are still present and are gradually lost until the patient's life is ended. It is then that it becomes relevant to adequately face the inevitable fact in the family system. For them, systemic support is offered in order to achieve an understanding of the issue they are experiencing and the importance of the behavioral inheritance they leave to the next generations.

Authors such as David Kissane and An Hooghe (2022) argue for systemic family therapy as an effective approach to dealing with bereaved families. Generally, sharing the distress helps your recovery. Family therapy builds bridges between generations, utilizes an existing source of support, and allows for the cultivation of relational meaning as a key resource for recovery. The resilience of most families serves the needs of the grieving process admirably. Healthy families comfort each other, recognize and respond to needs, and encourage healthy adaptation among their members. For therapists, the challenge arises between families that are divided, or have damaged relationships, competition or lack of mutual support.

Likewise, Worden (2018) cites the literature (Gajdos, 2002; Roose and Blanford, 2011) in stating that an important reason for examining family systems is that unresolved grief not only serves as a factor in family pathology, but also contributes to multigenerational pathological relationships.

On the other hand, Kissane and Hooghe (2022) present several goals in systemic family therapy: (a) to recognize that illness, loss, and change entail human emotions of grief that are normal along with a transition point that is an opportunity to review, reconnect, and reconfigure, which flow from their relational and coping life; (b) to note areas of family relational strengths and cohesion that help balance differences in interests, temperaments, and disagreements that produce tension and vulnerability in the family; c) strengthen their acceptance of who they are as a family and what they can become by clarifying paths of mutual respect and caring, recognizing similarities and differences, embracing compromise, tolerance, and forgiveness; d) support each other through a period of reconciliation and reconfiguration as they grieve and choose future family life.

In their work, *Intervención desde el modelo sistémico*, Feixas, Muñoz, et al., (2016) state that systemic schools have the characteristic of finding the way to deepen in the basic systemic notions to develop their own style that allows them to work with families by placing their emphasis on this. On the other hand, they seek to exchange ideas with other schools they already know and thus enrich the possibility of intervention. In fact, almost all training programs in systemic family therapy teach content derived from various schools.

A theme very close to that of death that is accompanied by others such as grief, bereavement, is the concept of resilience-a term that has been adapted to the social sciences to characterize those people who, despite being born and living in high-risk situations, develop psychologically healthy and successful. These are subjects who, with their attitude and

mentality, have been able to positively overcome the limits that medical science predicted for them. R. Spitz in the sixties and J. Bowlby with the first attachment theory, were the first scientists of resilience (Arciniega, 2005).

The family nucleus faces this process and it is when the human being's capacity to emotionally restructure in the face of an adverse situation arises in order to adapt to its new needs in order to manage or maintain an appropriate mental health that allows it to continue with its daily functions, which is called resilience. The role of resilience in the face of high vulnerability, such as facing the news and process of a terminal illness and the possibility of losing a family member, is very important.

Javier Cabanyes Truffino (2010) defines resilience as: "the ability to recover from extreme traumatic situations is called resilience" (p. 145). It also identifies family characteristics that result in resilience, highlighting positive outlook, spiritual sense, communication and agreement among its members, flexibility, family time and fun sharing, and the existence of rules and routines.

Palliative medicine treats the patient and family as a unit to be treated. The illness of the family member produces discomfort in the group, communication problems, relationship problems, anguish, role changes and they tend to create strategies to face health and economic problems. Astudillo also states that both the family and the patient need to be heard in their distress, frustration, anxiety and feelings of guilt. As well as guidance for proper care of the sick person that becomes a sign of affection towards him, which in some way will help the family with their subsequent grief (Astudillo and Mendinueta, 2018).

A patient is considered terminally ill when he or she has an advanced, progressive disease with a severe prognosis and numerous symptoms that are closely related to the possibility of death. It is the sum of events prior to death, which must be faced by the patient and the family. It is important that the family understands what to do and what to expect in this terminal stage in which their sick family member is, providing the necessary support to avoid the physical and psychological suffering of the patient and the family (Allende-Pérez and Verástegui-Avilés, 2016).

There is a consensus among health personnel on important aspects that are appropriate for the patient's well-being, such as providing the patient with physical well-being, providing food, hygiene, rest, medical care, visiting, touching, and physical accompaniment. The affective relationship with the patient is also of vital importance; we must try to satisfy the patient's need to feel contained in his or her emotions. The patient needs to be surrounded by their loved ones in a sense of familiarity, of a transparent relationship where the truth is told regarding their diagnosis and prognosis, they need to know the symptoms that are normal to their disease and it is their right to know the truth regarding their health status. Family therapy aims to induce an adequate family organization that maximizes its potential for the growth of its members. The capacity they have to affect the structure of the system, a therapeutic strategy that focuses on not substituting the roles that the disease has imposed, the recovery of the roles that have ceased to be exercised can help to contain the family and the patient, and above all to prevent the family nucleus from developing a chronic crisis (Parra-Fabara, 2021).

Faced with a diagnosis of terminal illness, there are many issues that the family must face, such as death, which, of course, generates a crisis within the family, but the family will also be responsible for the remaining time of life of the sick family member. There is a confrontation of situations from the news of the diagnosis, possible treatments, prognosis of the clinical picture, the emotional, social, economic effects, etc., will provoke an intervention in the patient from all possible areas.

Steinhauser, et al., (2000) studied the factors considered important at the end of life by patients, family, physicians, and other caregivers. Their study involved three hundred and forty terminally ill patients; three hundred and thirty-two family caregivers; three hundred

physicians; and four hundred and twenty-nine others (nurses, social workers, chaplains, and etc.). The survey results suggest that for patients and their families, physical care is crucial, but it is only one aspect of total care. While physicians tend to focus on physical aspects, patients and their families view the end of life with a broader psychosocial and spiritual meaning shaped by a lifetime of experiences. There is no single definition of a good death. Care of the terminally ill patient is highly individualized and should be achieved through a process of shared decision making and clear communication that recognizes the values and preferences of patients and their families. Patients, families, caregivers, and physicians all play a critical role in shaping the end-of-life experience.

Elizabeth Kübler-Ross (2009) notes that attention should be paid to the dying for three reasons: a) they are still alive and still have unfinished business that they want and need to share; b) we need to listen actively so that we can identify with them in relation to their needs for care; c) they have much to teach us about the final stages of life with their anxieties, fears, and hopes. The central message of Kübler-Ross's *On Death and Dying* is the importance of listening to what the dying have to say about their needs, and trying to put oneself in their shoes at each of the final stages of the patient's life.

Based on the above findings, it was necessary to create the Psychology Service with systemic family therapy intervention in the processes and protocols of the Municipal Hospital "Bajío del Oriente", following the medical protocols already established. The investigation was carried out from diagnosis of the terminal patient and notification of the family until death or discharge to die at home. It is hoped that the results of this study can contribute to the understanding of the effectiveness of systemic therapy in the context of terminal illness and provide relevant information to improve psychological care in this health situation affecting the patient and his or her family.

Method

Research design

A qualitative phenomenological study was carried out in which semi-structured interviews, field notes, and group discussion were conducted with families receiving systemic therapy at the “ajío del Oriente”Municipal Hospital. Paley's nterpretive phenomenological design was used (2018). The phenomenological method is “form of interview-based research that usually invites interviewees to talk about their experiences, and aims to elucidate the meaning of the phenomenon of interest” (Paley 2018, p. 2).

The main characteristic of qualitative studies is the importance of seeing social phenomena in the light of the context, the experiences, since a proper analysis could not be carried out separately. It uses observation and is oriented towards the process and develops a description of the phenomenon to be investigated, making use of different techniques that serve for the recovery of data and its explanation. All this set must be understood as natural, in order to comply with the characteristics of a research with a qualitative methodology (Balcázar Nava et al., 2013).

Participants

We worked with 10 families with a terminally ill patient hospitalized at the Bajío del Oriente Municipal Hospital. Given the culture and structure of the family system in Bolivia, extended family members who live in the home and are in some way related to the patient and his/her care also participated. The research period was between January 2022 and November 2023. Patients were referred from intensive care or internal medicine to the Psychology Service. Intervention began with each family at the time of diagnosis of terminal illness. The

hospital physicians referred the patient to the investigating psychologist to inform the patient and family of the diagnosis. This according to the protocol implemented by the presence of the Psychology Service implemented for the purpose of the doctoral research.

Procedure

Participant observation techniques were used to obtain a more complete picture of family interactions during therapy sessions. Participants were selected if they had a loved one who was terminally ill and willing to voluntarily participate in the study. The interviews were recorded and transcribed for later analysis. The thematic analysis approach was used to identify relevant patterns and themes in the data collected.

Techniques were applied to analyze the phenomena from the point of view of each of the family members from a collectively constructed perspective. The discourse and specific themes in the family in the face of the situation were analyzed, as well as the search for meaning. The family's experiences were contextualized in terms of temporality (time in which they occurred) and the relational context-the bonds generated during the experience-by focusing on both the patient and the family to obtain firsthand information. Recordings and field notes were used for data collection during the interviews. The individual data files contain: the consent agreement, the semi-structured interview notes, observations subsequent to each interview, additional data volunteered by the participant, and preliminary grouping of words and phrases into themes related to the research.

Systemic family therapy was used to examine family dynamics and worked on communication, limit setting and conflict resolution. In addition, emotional support strategies, such as individual and group support, were employed to help family members express and manage their emotions in a healthy way. Education about the terminal illness and the grieving process is also essential to provide the family with information and coping tools.

The development of resilient capacities in the family was identified based on systemic psychotherapy. Systemic psychotherapy has been shown to play an important role in the development of resilience in families coping with terminal illness. Through this perspective, we sought to strengthen the family's internal and external resources to face challenges and adapt to changes. In systemic therapy, we work on identifying and strengthening the family's support systems, whether at the interpersonal, community or spiritual level. Open communication and the establishment of healthy boundaries within the family were promoted to facilitate collaboration and mutual support.

In addition, patterns and family dynamics that may be hindering resilience were explored, and strategies and techniques to modify them are offered. Family members are encouraged to seek joint solutions, share responsibilities and work as a team to cope more effectively with the terminal illness and the grieving process. Systemic psychotherapy can also help identify and strengthen each family member's individual resources, such as personal resilience, coping skills, and ability to find meaning and hope in difficult times.

To gather information about the psychotherapeutic experiences of the families, methods were used that led to a deep and meaningful understanding of their experiences. Through semi-structured interviews and questionnaires the perceived change and other relevant aspects of the therapy. Semi-structured interviews were used which provided the opportunity to explore in depth the experiences and perceptions of the families, allowing them to express their feelings, challenges and improvements throughout the therapeutic process. These interviews were recorded and later transcribed for further analysis.

Data Analysis

Data analysis involved identifying common experiences when interacting with families and the terminally ill, identifying words and phrases that related to the topic and might indicate

resilience. The researcher looked at the different ways in which families experienced grief and managed the family, patient, and medical staff relationship. The units of meaning relevant to the research questions were delimited and analyzed with psychological terms. Relevant meaning units were marked with different colors in order to code the text of the interviews. The citations were then extracted and classified according to the objectives of the study. The variables of interest in relation to the research objectives are: sociocultural context, risk factors, family typology, therapeutic techniques, resilient capacities. Key words (codes) were identified in relation to the variables. Although the objectives and variables of interest were established a priori in relation to the objectives, the emerging themes or codes were determined by the text.

The perspectives and meanings were grouped into an overall description of how families experience the eventual loss of a loved one. The end result is a description of the phenomenon through the eyes of people who have experienced it first hand.

Results

Analysis of the interviews identified several psychological risk factors in families with a terminally ill member. Some of the common factors mentioned by participants include high levels of stress, anxiety, distress, confusion, depression, feelings of guilt and loneliness. It was also noted that lack of social support and poor communication within the family can exacerbate interpersonal conflicts related to medical decision making and care of the terminally ill patient. Family members were observed who, when faced with the decision-making process, completely distanced themselves from the family nucleus. There were also other relatives who appeared even from other cities or regions, who for unimportant reasons had disappeared from the family picture and who appeared to contribute with their company and care for the sick person whom they had not seen for a long time.

Different typologies of families and the characteristics of their family dynamics emerged. There were families that showed a cohesive dynamic and mutual support, while others presented a conflictive dynamic and lack of communication. Families coped with terminal illness in different ways, including the degree of involvement of each member and the roles assigned. Through the observation of the families, it was possible to classify them into different typologies according to their characteristics and family dynamics. Cohesive families supported each other and showed greater emotional support. Families with more dysfunctional dynamics were also observed, with recurrent conflicts and difficulties in establishing clear limits and roles. These families had difficulty coping due to lack of emotional support and inability to make joint decisions. In addition, there are overprotective families, who may have difficulty accepting the reality of the terminal illness and may exaggerate in their care and protection, which can generate tensions and conflicts. It is important to note that these typologies are approximations and that each family has its own unique dynamics. However, recognizing these characteristics helped to tailor therapeutic interventions more effectively.

Positive changes were observed in the way families coped and adapted to terminal illness, such as increased problem-solving skills, greater flexibility in family roles, and improved communication and mutual support. The findings were compatible with Barnes and Figley (2005) with their five phases of family therapy.

A commitment was achieved to accompany the patient in the psychotherapeutic treatment and to the adherence to the medical treatment of all patients. The therapy helped patients to recall information, and to speak confidently in the family context without the need to defend their position.

For reasons of lack of time and others relevant to terminal patients and difficult or absent families, it was possible to reach a consensus and new meaning for the family to face the imminent death of the terminal relative in some families. Family restructuring as part of

therapy is noted in several of the patients in the study. In the case of absent and difficult families, more time is required than is available due to the hospitalization of the terminal patient.

The closing and preparation stage consists of a discussion on the need for intra and extra-familial social support and should be able to discuss to whom they would turn in the future in times of need. Being more prepared to accept the inevitable makes healthy grieving more likely. It was possible to involve patients in this stage of preparation for resilience.

These techniques focused on improving family communication, strengthening emotional support, and helping families develop effective coping skills. facilitating adaptation to the terminal illness situation.

When analyzing the development of resilient capacities in the family based on systemic psychotherapy, it was noted that it was efficient. During the interviews, systemic therapy was found to help families understand interaction patterns and identify internal and external resources for coping with terminal illness. In addition, systemic therapy was highlighted as fostering resilience by promoting adaptation and positive change in family dynamics.
Resilience rested in most families:

1. On the responsibilities designated to you by the deceased family member.
2. In the acceptance of the family that respects such a decision.
3. The family adheres in some way to support the fulfillment of the wishes of the departed.
4. Teamwork that defines the new roles and functions that correspond to this new family structure.

Participants shared their perceptions of the benefits of therapy, such as increased understanding of the disease, improved family communication, and relief of emotional stress. Some challenges were also highlighted, such as initial resistance to therapy and the need for continued commitment to maintain the changes achieved.

Overall, the results provided a comprehensive view of psychological risk factors, family typologies, therapeutic techniques, resilience development and psychotherapeutic experiences in families with a terminally ill member. These findings can be very useful for the design of more effective therapeutic interventions focused on the needs of these families. The study provided valuable information on the psychotherapeutic experiences of the families, which were subsequently analyzed. These experiences included family members' perceptions of the effectiveness of the therapeutic intervention, the changes observed in their family dynamics, and the impact on their psychological well-being

Systemic therapy provided a safe space for families to express their emotions and share their concerns. The therapy facilitated open and honest communication between family members, which allowed them to strengthen their bonds and support each other. In addition, therapy was observed to help families develop effective coping strategies and find a sense of hope and resilience in the midst of adversity. These findings suggest that systemic therapy may be a valuable intervention in supporting families coping with terminal illness.

Discussion and Conclusions

In order to carry out this research work, we worked with 10 families with a terminally ill patient hospitalized in the Bajío del Oriente Municipal Hospital. Given the culture and structure of the family system in Bolivia, extended family members who live in the home and are in some way related to the patient and his/her care also participated.

Following the analysis of the present research, it has been identified that families with a terminally ill member are exposed to a series of psychological risk factors. These factors include high levels of stress, anxiety and depression, feelings of loss and anticipatory grief, family

conflicts and communication difficulties. It is essential to be able to recognize these risk factors in order to be able to intervene effectively and provide adequate psychological support to these families.

The psychologist's job in this intervention was to make the family feel accompanied, providing information and a link between the family and the rest of the hospital team. It also provides the patient and his family with the necessary tools to face the situation by strengthening their emotional state, favoring adaptation to the disease process and its inevitable end.

Systemic therapy provided a safe space for families to express their emotions and share their concerns. The therapy facilitated open and honest communication between family members, which allowed them to strengthen their bonds and support each other. In addition, therapy was observed to help families develop effective coping strategies and find a sense of hope and resilience in the midst of adversity. These findings suggest that systemic therapy may be a valuable intervention in supporting families coping with terminal illness.

This study explored psychotherapeutic experiences from the systemic model in families with a terminally ill person. The results indicated that systemic therapy provides valuable support to these families in different aspects of the family nucleus:
a) promoted emotional well-being; b) strengthened emotional bonds; c) facilitated the expression of emotions; d) promoted open and honest communication; e) helped families develop effective coping strategies.

These findings highlight the importance of providing psychotherapy services based on the systemic model in the context of terminal illness, and underscore the need to continue researching and developing appropriate therapeutic interventions for these situations in which emotional support is of vital importance for the entire family and the patient.

Overall, the study provided a broad overview of the psychological risk factors present in terminally ill families, as well as the typologies and family dynamics observed. It also made it possible to analyze the impact of therapeutic interventions and the development of resilient capacities in the families, as well as to gather relevant information on the psychotherapeutic experiences of the families for subsequent analysis and improvement of the care provided.

The accompaniment of the family in times of terminal illness strengthens communication and affection among survivors. Developing coping mechanisms for dealing with conflict and adapting to change is more fluid with the intervention of a therapist using systemic family therapy guidelines. The presence of an intermediary helps reconciliation and the establishment of new roles to make up for the absence of the deceased family member. Family counseling strengthens parent-child relationships to achieve mutual understanding, settlement of differences, and effective coping with risk factors associated with confusion, doubt, anxiety, stress, and deterioration of interpersonal relationships in the family. By being in the process, the terminal patient has more peace of mind concerning issues that would not normally be addressed and even those that are no longer relevant to address at this time. Among the limitations in conducting this research is the short period of time between diagnosis and death or the removal of the patient and family from the hospital to end their days at home. In some cases, the family was absent when they learned of the diagnosis due to lack of funds to continue with treatment, which depending on the pathology, the cost can be high. Future studies based on the results can work with categories defined in a psychological service protocol to be followed during the intervention with terminally ill patients and their families.

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