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Including personal development in palliative care education to address death anxiety.

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Introduction

This research conducted in Portugal aimed to investigate whether an intervention combining personal development to address death anxiety and increase existential well-being, together with helping relationship skills would increase the HCW's inner congruence to face the suffering and death of their patients, reduce burnout and as a consequence, improve their self perceived capacity to engage in an effective helping relationship with the patient and family. This article expands on a previously published article presenting partial quantitative results of the research (Gouveia e Melo & Oliver, 2011). It presents more detailed quantitative results supported by qualitative data, within the context of a quasi-experimental design and focuses on the results related to death anxiety and self perceived helping relationship skills, although in the original study, instruments were also used to measure levels of burnout and personal well-being. The quantitative results show the levels of death anxiety and self perceived helping relationship skills in HCWs before and after the intervention and the qualitative results complement these results, showing the effects of death anxiety on HCWs' helping relationship skills and improvements after the intervention.

The intervention can be considered complementary to training in palliative care, because it approaches an important area of palliative care: giving the HCW the emotional tools and necessary preparation to capacitate them to put into practice the philosophy of palliative care with less risk of engaging in avoidance behaviours and suffering from burnout. To our knowledge, it is the only intervention of this type in Portugal, and although there have been many similar ones in other countries, none have been found that cover the combination of issues approached under the same kind of pedagogic format that gives individualized attention to each participant.

Death anxiety has been defined as a negative emotional reaction provoked by the anticipation of a state in which the self does not exist (Tomer & Eliason, 1996) or an experience of everyday life, rather than an immediate threat (Neimeyer, 1994) (Neimeyer, et al., 2003). This may include existential fears (as opposed to existential well-being) such as those related to pain, physical degradation and suffering, being alone and not having close and fulfilled relationships, living with uncertainty, not living a meaningful life, losing one's dignity and being judged by others, and what comes after death (Hennezel & Leloup, 1997). More recently, it has been defined as ''an unpleasant emotion of multidimensional concerns that is of existential origin, provoked on contemplation of death of self or others'' (Nyatanga & de Vocht, 2006).

However, evidence has been emerging indicating that nurses and doctors who care for patients with a terminal condition, both within formal palliative care arrangements and outside of these, may suffer from increased death anxiety, triggered by their daily routines with dying patients (Lowry, 1997) (Peters, et al., 2013) (Anderson, et al., 2015). This may affect HCWs' internal congruence (Rogers, 1951) and capacity to engage in an effective helping-relationship with the patient and family leading to the use of avoidance mechanisms, (Bernard & Creux, 2003) (Friedrichsen & Milberg, 2006) (Thiemann, et al., 2015). When patients perceive HCWs to be withdrawn, they tend to feel abandoned and without backup (Connelly, 2009) (Larsson, et al., 2011).

Research has suggested that to enable HCWs to help patients on an emotional and spiritual level, it is not sufficient to simply educate them about the patients; HCWs also need to learn how to get in touch with their deeper selves and to be aware of their own spiritual beliefs (Wasner, et al., 2005). Although education in palliative care addresses all issues related to patient care, they do not systematically provide modules of personal development to increase the HCW's existential well-being and reduce death anxiety.

Method

Design

Mixed methods approach, with a quasi-experimental pre-test, post test design (Robson, 2002). Quantitative questionnaires and open ended questions for the participants to answer in writing were used together with 26 semi-structured face to face interviews (Robson, 2002) to fully understand the benefits and weaknesses of the intervention.

Participants

208 HCWs who cared for the dying , both in and out of PCUs received the intervention, of which 150 HCWs (72%) completed both pre and post-test questionnaires. Of the 150 HCWs, 85 worked within palliative care units and 65 out of these. Four months after undertaking the above mentioned quantitative study, all 150 participants were provided with an open ended qualitative questionnaire and these were returned by 94 participants (64%). Answers were anonymous. Subsequently, the head nurse of each of the 10 units that had participated in the intervention group was approached with the aim to recruit some of the 150 participants for an interview. Purposive sampling (critical case sampling) (Marshall, 1996) was carried out and 26 of the 150 participants agreed to participate. This was considered sufficient to obtain data saturation (Green & Thorogood, 2004) (Charmaz, 2006).

Table 1. Participants of quantitative and qualitative questions

Profession	Quantitative y/n	Nº	%	Qualitative y/n	Nº	%
Nursing Aide	Yes	30 (21 in PCU; 9 other)	100	Yes	20	66.7
				No	10	33.3
Nurse	Yes	87 (50 in PCU; 37 other)	100	Yes	53	60.9
				No	34	39.1
Doctor	Yes	8 (4 PCU; 4 other)	100	Yes	3	37.5
				No	5	62.5
Psychologist	Yes	12 (4 PCU; 8 other	100	Yes	9	75
				No	3	25
Social Worker	Yes	6 (3 PCU; 3 other)	100	Yes	4	66.7
				No	2	33
Physiotherapist	Yes	3 (1PCU; 2 other)	100	Yes	3	100
Priest PCU	Yes	1 (PCU)	100	Yes	1	100
Occupational therapist	Yes	1 (other)		Yes	1	100
Secretary	Yes	1 (other)	100	Yes	1	100
Nutritionist	Yes	1 (PCU)	100	yes	1	100

Table 2. Participants of face to face interviews

Profession	Nº	Place of work	Nº
Nurses	15	In palliative care unit	16
Nursing aides	6	In other units	10
Doctors	3	Total	26
Chaplain	1		
Unit secretary	1		
Total	26		

Procedure and Instruments

Recruitment of participants by invitation through the head nurses of each department, the interventions, data collection and analysis took place between July 2005 and May 2009.

The Intervention

The intervention "Life and Death, the Same Preparation" (Aitken, 2011) consisted of personal development within a setting of group therapy and experiential activities, with the aim to reduce death anxiety, and theoretical and practical training in psycho-existential care for patients with a terminal condition. The duration of the course was 36 hours over 6 days, divided into two modules of 3 days each, with a week interval between each module. The intervention was given to 29 groups with an average of 7 participants per group. The first module of the intervention was given by the first author, a psychologist with a post-graduate qualification in Person Centred Counselling, and the second by a Holistic Health Counsellor. The contents of the course can be found in a previously published article. (Gouveia e Melo & Oliver, 2011). Both the contents of the course and the two facilitators were consistent throughout the research, thereby ensuring the same quality level over time.

Instruments

Pre and post-intervention quantitative questionnaires: Three questionnaires and a demographic data sheet were given to the participants one week before the intervention. The participants returned the completed questionnaires at the start of the first day of the intervention, and they returned the next set four months after the course ended. It took three months to collect all the post-training questionnaires; 150 complete sets of questionnaires were received.

The questionnaires consisted of validated scales to measure levels of burnout, self perceived helping relationship skills and personal sense of well-being (Gouveia e Melo & Oliver, 2011), although results of burnout are not mentioned in this article. The sum scores ranged from 1 to 6. Construct validation for this population was performed (principal components analysis) and internal consistency (Cronbach's alpha) was assessed (Streiner & Norman, 2008), revealing the factors shown in table 6. (Gouveia e Melo & Oliver, 2011). Death anxiety was assessed in this study by the negative factors 'avoidance mechanisms', 'fear of dependence and physical degradation', and 'no time for family and meaningful activities' and the positive factors 'self-confidence in the face of adversity and illness', 'close personal relationships, and meaning in life' (Hennezel & Leloup, 1997).

Post-intervention Open Ended Questions. These questions were designed by the author to understand the main impact of the training on the participants (questions 1 and 2), to evaluate the structure and teaching methods (question 3), how it affected their relationship with the patient and family and also how it affected their own well-being (questions 4a-g), and finally, how it could be improved (question 5). Questions 6 and 7 were asked because there was the possibility at the time to provide further training for these participants after the end of the research. Question 8 was to give them the liberty to raise any other subject they thought relevant. The questions were as follows:

Table 3. Structured written questions

1	What was the most important thing you learnt in the training?
2	What was the main help you received from this training?
3	What did you appreciate (or not) in this training, in terms of content, structure, teaching methods, liberty to express feelings etc...) ?
4	In what way did the training improve, or not, the following (please specify):
4a	Your relationship with the patient?

4b	Your relationship with the family?
4c	Your relationship with work colleagues?
4d	Your efficiency at work?
4e	Your self-knowledge?
4f	Your internal congruence?
4g	Your daily life and feelings of well-being?
5	In your opinion, how could this training be improved?
6	In your opinion, would follow-up workshops be beneficial? If so, what kind of workshops would you like?
6a	Difficulties in communicating with patient and family?
6b	Difficulties in communicating with the team?
6c	Spiritual care?
6d	Health care worker's emotional relationship with the "body" of the patient (smells, different types of touch, looks, "symbolic contamination" etc?
6e	The meaning of my life?
6f	Open theme group encounters?
7	Any other theme you would like to mention?
8	Any additional comment you would like to add (optional)?

Interview. The interviews were carried out at the HCWs' workplace in a room with privacy and only the interviewer and interviewee were present. Although these questions were similar to the qualitative written questions it was considered necessary to explore further the potential impacts through deeper exploratory methods. Filling in questionnaires can be cumbersome, and there is a risk that participants may not give complete feedback. This risk is minimised in a live interview, which also gives the attentive interviewer the possibility to pick up on issues that may otherwise have been missed.

Questions were similar to the written questions, but were less structured allowing for more freedom of expression:

Table 4. Interview schedule for live interviews

A few months ago, you did the AMARA training course. I would like to know what impact the course had on you. Did you notice any change, positive, or negative, after the course?	
1	In terms of you as a person and your private life
2	In terms of your professional life:
2a	With work colleagues
2b	With the patients and family
3	Is there anything you would like to say about the course itself
3a	In what way was the course useful
3b	Was there anything you were unhappy about
3c	Do you have any suggestions
4	Any comments you would like to add

These were carried out by the 1st author and another independent female Person Centred trained counsellor. They were audio-recorded, transcribed verbatim and rechecked against recordings.

Sounds, pauses and other audible behaviours were not transcribed, unless considered relevant. The interviews lasted approximately 20 - 30 minutes.

The intervention, open-ended questionnaires and interview questions were all pilot tested prior to the research.

Data Analysis

Statistical analysis for all the quantitative data was performed using SPSS 16 (Pallant, 2007). Assumptions of parametric tests were met. Paired samples t-tests were used to compare the summed scores of participants before (T1) and after the course (T2). All tests were two-tailed and alpha value was 0.05. Interpretation of effect size (η2) is as follows: .01= small effect; .06= moderate effect; .14 = large effect

Cut-off point was calculated as follows: the mean of the 11 factors of the 3 questionnaires, separating positive and negative factors, i.e. the mean of the negative factors and the mean of the positive factors. These two figures were summed up and divided by two:

Table 5: calculation of cut-off point

Positive factors	Mean	Negative Factors	Mean
Empathy and congruence	4.27	Avoidance mechanisms	2.93
Unconditional acceptance	5	Distance and impatience towards patient	1.87
Self-confidence, dignity and meaning in spite of adversity and	4.46	Fear of dependence, physical degradation and loss of control	3.8
Close relationships and personal well-being	4.74	Self criticism regarding no time for family, friends and meaningful activities	3.21
Professional fulfilment	4.44	Emotional exhaustion	3.1
		Depersonalization	1.81
Total	22.91		16.72
Mean	4.58		2.79
Cut-off point = mean of positive and negative factors:		(4.48+2.79)/2	3.69

The answers to written questions and interview transcripts were imported and stored into the NVivo 8 application (QSR International, 2007) which was used to perform content analysis in the form of thematic analysis (Pope & Mays, 2006). The main categories were pre-defined following the qualitative questions and the interview grid, and their sub categories were created by the author as the text was being analysed. Each relevant sentence was highlighted and dragged to an already existing category or to a new one created at the time. Categories were then re-grouped into themes. Once all the text had been analysed and categories created, all the data was reanalysed to check that no relevant quotations were overlooked. Underlying research materials can be obtained from the author.

Ethical Issues

Ethical consent was received from the Research and Ethics Committee of the Kent Institute for Health and Medical Sciences / Centre for Professional Practice at the University of Kent.

Results

Quantitative:

General analysis of means

The overall results of all participants, both in and out of PCUs showed a significant improvement in all factors assessed except for the factor "self criticism regarding no time for family and meaningful activities". Separate analysis of each group showed a significant improvement in all factors for HCWs working in other units with the exception of "close relationships and personal well being". In PCUs, with regard to "self criticism regarding no time for family and meaningful activities", the % of HCWs above the cut-off point increased from 18.17% to 20.39% after the intervention. Results also showed that most negative factors already were below the cut-off point, especially distance and impatience towards patients, and all the positive factors were above the cut-off point. Fear of dependence and physical degradation was the only negative factor that was above the cut-off point before the intervention and after the intervention this was reduced to just below the cut-off point.

Table 6. Results using paired sampled t-tests relating to death anxiety and self perceived helping relationship skills of all participants (n= 150):

Factors derived from factor analysis using PCA	T1 (pre-intervention) Score 1-6	SD	T2 (post-intervention) Score 1-6	SD	T1 and T2		
					t (149)	p < (2-tailed)	η2
Empathy and Congruence	4.27	0.68308	4.48	0.66514	-4.4	0.001	0.11
Unconditional Acceptance	5	0.56051	5.14	0.5295	-3	0.003	0.06
Distance and impatience towards patient	1.87	0.53892	1.72	0.5616	3.2	0.002	0.06
Avoidance mechanisms	2.93	0.67678	2.69	0.6901	4.68	0.001	0.06
Self-Confidence, dignity and meaning in spite of adversity and illness	4.46	0.64593	4.73	0.57904	-5.9	0.001	0.19
Close relationships and personal well-being	4.74	0.6634	4.86	0.61892	-2.3	0.022	0.03
Fear of dependence, physical degradation and loss of control	3.8	0.88017	3.49	0.88384	5.58	0.001	0.17
Self criticism regarding no time for family, friends and meaningful activities	3.21	0.72773	3.16	0.6753		Ns	

Analysis of Death Anxiety and self perceived helping relationship skills in PCUs and other units

Table 7 shows that self perception of helping relationship skills showed most significant results in other units, with the exception of empathy and congruence, where results were significant in both groups. Death anxiety showed significant improvements in both groups with regard to avoidance mechanisms and fears related to death and dying and this comparison is further explored in table 8. However, whereas in the general results (table 6) paired samples T-tests showed no significant changes for self criticism regarding lack of time for family, friends and meaningful activities, comparison of both groups showed the lack of improvement was only the case in PCUs. Other units showed a significant improvement (p < .007).

Table 7. Results using paired sampled t-tests relating to death anxiety and self perceived helping relationship skills of participants in PCUs and in other units

Factors derived from factor analysis using PCA	Mean PCU	Mean other	N PCU	N other	SD PCU	SD other	T1 and T2 PCU			T1 and T2	
							t (84)	p < (2-tailed)	η2	t (64)	p < (taile
T1 Empathy and congruence	4.19	4.37	85	65	.67	.70	-2.652	0.01	0.08	-3.801	.00
T2 Empathy and congruence	4.38	4.62	85	65	.71	.58					
T1 Unconditional acceptance and positive regard	5.01	5.14	85	65	.54	.57		Ns		-2.962	.004
T2 Unconditional acceptance and positive regard	5.14	5.15	85	65	.54	.47					
T1 Distance and impatience towards patient	1.79	1.96	85	65	.54	.53		Ns		3.028	.004
T2 Distance and impatience towards patient	1.70	1.75	85	65	.59	.52					
T1 Avoidance mechanisms	2.90	2.97	85	65	.64	.73	2.899	0.005	0.09	3.729	.00
T2 Avoidance mechanisms	2.71	2.66	85	65	.68	.71					
T1 Self confidence, dignity and meaning when faced with adversity and illness	4.52	4.37	85	65	.59	.70	-3.178	0.002	.11	-5.280	.00
T2 Self confidence, dignity and meaning when faced with adversity and illness	4.71	4.75	85	65	.57	.59					
T1 Close relationships and personal well being	4.78	4.69	85	65	.65	.68		Ns			ns
T2 Close relationships and personal well being	4.89	4.83	85	65	.58	.67					

Table 8, shows a comparison of means above the cut-off point, of items related to the fear of death and dying in HCWs in and out of PCUs at T1. Results are similar between the two groups, but in HCWs within PCUs, the number one fear is related to personal relationships (table 7 shows that lack of time for family and meaningful activities continued to be an issue of concern after the intervention), whereas in HCWs working in other units, the number one fear is related to the process of death: “If I have to die, may it be quick”. HCWs in other units showed two fears above the cut-off point that HCWs within PCUs did not show: “I often do not show my appreciation to friends and family and then regret it” and “The time of dying has no value. It is best to die quickly to end the suffering”.

Table 8. Items above cut-off point related to fear of death and dying within PCUs (n=85) and in other units (n= 65).

Fears related to death and dying and avoidance mechanisms (in PCU)	Mean T1 (score 1-6)	Fears related to death and dying and avoidance mechanisms (in other units)	Mean T1 (score 1-6)
If I were to die tomorrow, I would need to talk to some people close to me, to feel up to date with them	4,69	If I have to die, may it be quick	4,64
I feel the need to be informed of everything that surrounds me	4,41	I feel the need to be informed of everything that surrounds me	4,43
I am not at ease until I have everything "under control"	4,35	If I were to die tomorrow, I would need to talk to some people close to me, to feel up to date with them	4,32
I am afraid of being a burden to others	4,34	I am afraid of being a burden to others	4,23
If I have to die, may it be quick	4,31	I am not at ease until I have everything "under control"	4,20
I do everything I can to avoid any difficulties or instabilities in my life	4,20	There are times when my outward response to them is quite different from the way I feel underneath	4,02
If I become ill, I would rather die than become dependent on others	3,95	If I cannot be an active and independent person, my life would lose all meaning	3,98
There are times when my outward response to them is quite different from the way I feel underneath	3,94	I often do not show my appreciation to friends and family and then regret it	3,94
If I cannot be an active and independent person, my life would lose all meaning	3,87	I do everything I can to avoid any difficulties or instabilities in my life	3,85
		If I become ill, I would rather die than become dependent on others	3,82
		The time of dying has no value. It is best to die quickly to end the suffering	3,71

Qualitative

Thematic analysis revealed four main themes, indicated below.

Table 9. Main themes

Improvements to feelings of incongruence leading to avoidance mechanisms
Addressing separation with loved ones
Feeling less helpless
Negative feelings still present at work after the intervention

The results will elaborate on each of the themes using referenced quotes extracted from the data to justify analysis.

Improvements to feelings of incongruence leading to avoidance mechanisms

Fears relating to keeping to trivial conversations or avoiding eye contact were appeased when HCWs had had the opportunity to work on their own personal existential fears during the course. In the following examples, the HCWs realised that their reluctance to allow patients to talk freely could contribute towards the conspiracy of silence. As a consequence, the quality of the helping relationship improved both in and out of palliative care units:

> *"The relationship with the patient improved, because the course helped me to accept that suffering is part of life, and this allowed me to stop running away or avoid talking about these things with the patient" (Nurse in other units: Appendix 17-4:11);*
>
> *"I found ways to deal with questions asked by the patient and family related to the progression of the disease, or to death" (Nurse in PCU (Palliative Care Unit): Appendix 17-1:6).*

Being part of a group showing empathy, authenticity and unconditional acceptance towards each other seemed to be effective in creating a better understanding of what the patients are going through and in providing the same caring atmosphere for them, both in and out of PCUs:

> *"It gave me more confidence and motivation in my relationship with the patient. More confidence, because I began to understand the experiences they go through with their illness and losses. More motivated, because I understood how much we can do with simple gestures, with love and with 5 minutes of attention." (Nurse in other units: Appendix 17-2:19);*

> *"I am more tolerant when the family talks to us aggressively, as a result of their anger" (Appendix 20 - Nurse in PCU: 7:9).*

Internal congruence did seem to improve, with a positive effect on the relationship with the patient:

> *"The main help that the training brought me was the fact that it gave me the possibility to think about myself, and thereby be able to establish a more genuine relationship with my patients" (Appendix 17-Nurse in PCU: 1:1);*

> *"Not being afraid of showing my emotional and spiritual side, with the aim of helping patients, especially those in a terminal phase" (Doctor in other units: Appendix 19-4:7).*

HCWs also mentioned they felt more confident exercising what Kearney et al (2009) refers to as 'exquisite empathy'. This can be manifested through an awareness to be present and respectful:

> *"Professionally, I think I am better in terms of humanity and relationships because I have changed my time management at work and started to give more value to moments of sharing and listening to the patient." (Appendix 17-Nurse in PCU: 1:27);*
>
> *"With the patient, what changed was my capacity to listen and accept the silences...." (Appendix 17-Nurse in PCU: 6:35).*

Addressing separation with loved ones

Caring for the dying raised some existential anxieties about life and death and reminded HCWs of what it would be like to never see their own loved ones again. During the intervention, time was spent on reflecting on the meaning of their life and the importance of their relationships with loved ones:

> *"...it allowed me to give more value to the meaning of life in a way that I hadn't done before, which probably influenced my attitude towards life and other people" (Psychologist in PCU: Appendix 22-1:49);*
>
> *"I give a lot of value to my family. Today I find more time to listen to my children and husband, and I see life in a different way" (Nursing aide in other units: Appendix 22-2:21).*

Changes also seemed to have occurred through understanding that setting time aside for themselves is not being selfish, but responsible, because feeling rested and fulfilled at home may increase the quality of care to their patients:

> *"My daily life and sense of well-being really got better. Since then, I have organized my work to have more time for me and my family. I have even found time to go to the gym once a week…" (Doctor in PCU: Appendix 22-1:25).*

However, some HCWs acknowledged the need for continuous support to maintain their well-being:

> *"In the beginning, I felt a big difference in well-being, and I am sure that it was due to the calming effect of the training, but unfortunately, this effect didn't last for long, and now I worry even more about the death of my loved ones." (Nurse in other units: Appendix 22-1:47).*

Feeling less helpless

Feelings of helplessness towards death and patients' frailty and vulnerability were reduced. HCWs felt that a reduction in death anxiety and an increase in inner peace had had a positive effect on the relationship with the patient, and this may have consequently reduced their sense of helplessness:

> *"…if we accept death better, and that the patient is here to die, but with more quality of life and less suffering…maybe we will be capable of caring for them differently…not that before we cared for them badly, …we gave the best technically…but perhaps in terms of relationships, we can help the patient in a different way" (Nurse in PCU: Appendix 17-1:7).*

Equally important, was the ability HCWs gained to trust in the patient's resources to cope, and this improved their own serenity to cope with suffering. If carers do not have this belief, there may be a tendency to overprotect and this may not be beneficial in helping the patient grow (Rogers, 1951).

> *"The patient has more resources than I thought. The patient can go through many emotional stages and we must respect this. I am continuously trying to understand him" (Nursing aide in PCU: Appendix 17-1:21).*

Negative feelings still present at work after the intervention

However, despite many improvements, feedback showed that a one-off intervention was not sufficient. HCWs needed continuous emotional support to cope with the suffering:

> *"We do give, but it is almost a routine...talking to the patient…that's all fine, but there is something missing…everything is so mechanical…." (Doctor in PCU: Appendix 24-1:3);*

> *"For many of us, the intervention was like planting a seed in fertile land, but, as everything in life, it would have been important to water the seed and care for it….perhaps with regularly organized interventions" (nurse in other units: Appendix 23-2:4).*

Understaffing and work overload also seems to affect HCWs' well-being:

> *"...in terms of efficiency, things are the same. Some things can't be changed with the course, because they have to do with the need for more health care workers…" (Nurse in PCU: Appendix 24-1:3).*

> *"The volume of work to do fills our head up in such a way, that we have to just do what is most urgent, and you lose that sense of well-being that would lead us to do that bit extra…" (Doctor in PCU: Appendix 17 - 1:9).*

Discussion

This study showed how an intervention designed to help HCWs cope with their own anxieties towards death and dying and increase their personal existential well-being, combined with helping relationship skills, can increase the quality of psycho-existential care to dying patients and their families.

The study was performed with Portuguese HCWs in and out of PCUs and the quantitative results showed how death anxiety can be manifested with regard to the process of death, such as the fear of becoming a burden, of losing control, and issues related to personal relationships and meaning in life (Hennezel & Leloup, 1997). Analysis of the items related to death anxiety before the intervention shows that the main concern of HCWs in PCUs is related to their awareness of the importance of personal relationships in their private lives, whereas HCWs in other units were mainly concerned about issues related to dependence and physical degradation. This difference can be explained by the lack of education in palliative care of HCWs in other units. The post intervention quantitative results of this study seemed to show clear improvements with regard to self perceived helping relationship skills and death anxiety, with the exception of “self-criticism regarding no time for family, friends and meaningful activities” which showed a significant reduction in other units, but an increase after the intervention in HCWs working within PCUs. A possible explanation for this, is that HCWs within PCUs were already making efforts to spend more time with their family, and these results show that they were not able to as much as they felt they should, due to understaffing and work overload, and therefore their anxiety increased.

The qualitative results provided a deeper insight into how the use of avoidance mechanisms and feelings of helplessness were reduced through the intervention, and of the way HCWs became aware of the need to bring meaning into their own personal lives and relationships and also how this had a positive impact on the relationship with the patient and family.

A contributing factor to this outcome may have been the benefits of group therapy which have been well documented (Rogers, 1973) (Jones, 2006) and specifically with regard to death anxiety (Nienaber & Goedereis, 2015). HCWs were able to experience how it felt to express their difficulties without being afraid of being evaluated. This enabled them to find the inner resources to face patients' and their families' suffering without resorting to avoidance mechanisms. Furthermore, being part of a group where empathy and unconditional acceptance were present helped them to understand how this atmosphere can benefit patients even when no cure is available and this contributed towards reducing their feelings of helplessness. HCWs were also able to reflect on ways of improving their own personal relationships, and this seemed to increase their personal well-being and capacity to enter a quality relationship with their patients.

However, the same did not seem to occur with issues of fear towards dependence and physical degradation (Payne, 1998) (Mercadier, 2002) shown in the quantitative results. The absence of qualitative comments relating to this may imply that this difficulty remains at a subconscious level, requiring more attention. A possible reason for this is that although the subject was present in the intervention, it did not occupy a large part of the course curriculum and this aspect of the course has been revised.

Looking at the qualitative results from the point of view of different professions, there is a need to take into consideration that 76% of written answers and 80% of interviews were given by nurses and nursing aides. However, although comments from doctors were scarce, these showed that after the intervention, doctors working out of palliative care units felt more at ease to show their genuine feelings with their patients, increasing the quality of the relationship and some doctors within PCUs noted that fatigue and work overload resulted in more impersonal relationships with patients, a situation they were unhappy with.

These findings support the need to address these issues in the preparation of HCWs who care for the dying through personal development to improve their personal well-being and to help them cope better with death anxiety. By helping HCWs to accept that death is not a failure of medicine, and by helping them cope with their own existential issues, HCWs can learn to stay present with the patient, even when there is no cure. Personal development to address these issues may have the potential to allow them to shift to the concept that after doing all that needs and can to be done to ensure comfort, just being with the patient with a different quality of presence is extremely important to help the patient die ‘healed’, as discussed by Twycross, (2005).

However, comments also showed that despite the initial benefits of the intervention, teams need on-going support in order to maintain these positive results and other studies have shown how death anxiety can affect work engagement (Sliter, 2014). Furthermore, the absence of comments regarding feelings towards dependence and physical degradation shows that a one-off intervention can only go so far in reducing anxiety and other studies have shown that sources of support in the workplace would be considered valuable (Peters, et al., 2013).

Limitations

While efforts were made to gather responses from and involve different disciplines in the qualitative part of the study, as mentioned above, the main respondents were nurses which gave an ultimate bias to the results. Thus any intervention changes in response to the findings would need to be validated with other professionals. In addition, the author not only conducted the intervention but also the research. While the post-intervention qualitative questionnaires afforded some anonymity, the interviews did not and therefore there may have been the potential for respondents to reply in a more positive way (Robson, 2002). However, the author was aware of this and provided ample opportunity for any negative experiences to be expressed, which were forthcoming as highlighted in the results. No evidence about the long term effect of the intervention exists.

Conclusion

Complementing education in communication and psycho-existential support with personal development related to death anxiety may help HCWs within different settings and of different professions, including doctors, who care for patients with a terminal condition to reduce their need for avoidance mechanisms to protect themselves, resulting in a more meaningful helping relationship. However, an initial intervention should be followed by continuous support to maintain results.

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Conflict of Interest Statement

The author declares there is no conflict of interest

Supplementary Materials

- For access to statistical data, please contact carolgouveiamelo@gmail.com.
- For access to qualitative data, please contact carolgouveiamelo@gmail.com or the Calouste Gulbenkian Foundation in Lisbon: Processo nº 71773 – Concurso para Financiamento de Projectos na Área da Investigação em Cuidados Paliativos – “Formação vs Qualidade nos Cuidados Paliativos”

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