MLS PSYCHOLOGY RESEARCH
https://www.mlsjournals.com/Psychology-Research-Journal

ISSN: 2605-5295

How to cite this article:

Basalo, M., Rivera, F., González, J. and Cantero, M. (2022). Attitudes towards death in health personnel: intervention proposal. *MLS Psychology Research, 5* (2), 201-210. doi: 10.33000/mlspr.v5i2.1185.

Attitudes towards death in health personnel: intervention proposal

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Summary. This article reviews the attitudes towards death in health professionals. In order to deepen the practical implications of these attitudes, a literature review is carried out. Given the absence of interventions based on promoting resilience, coping strategies and other factors involved in the attitude towards death in this group, we present a program aimed at prevention and promotion of competencies to provide greater well-being and better management of these situations. Among the objectives are: to develop coping strategies to manage the adverse situations that arise when facing death on a daily basis, to facilitate good emotional management and to be able to recover from the impact caused by such situations through compassion, self-compassion, gratitude and guilt management. The program follows an experiential methodology; healthcare professionals are active agents in the process of change, and is accompanied by rigorous implementation and evaluation to analyze the changes that occur as the intervention progresses.

Keywords: Resilience; health care personnel; attitude toward death; coping; compassion; compassion

Actitudes hacia la muerte en el personal sanitario: propuesta de intervención

Resumen. En este artículo se realiza una revisión sobre las actitudes hacia la muerte en el profesional sanitario. Con el objetivo de profundizar en las implicaciones prácticas de dichas actitudes, se realiza un análisis de la literatura. Dada la ausencia de intervenciones basadas en promover la resiliencia, estrategias de afrontamiento y otros factores intervinientes en la actitud hacia la muerte en este colectivo, se presenta un programa destinado a la prevención y la promoción de competencias para proporcionar un mayor bienestar y un mejor manejo de estas situaciones. Entre los objetivos, se proponen: desarrollar estrategias de afrontamiento para gestionar las situaciones adversas que surgen al afrontar la muerte a diario, facilitar una buena gestión emocional y ser capaz de recuperarse del impacto que causan dichas situaciones a través de la compasión, autocompasión, gratitud y manejo de la culpa. El programa sigue una metodología experiencial; los profesionales sanitarios son agentes activos en el proceso de cambio, y se acompaña con una implementación y evaluación rigurosa que permiten analizar los cambios que se producen según se avanza en la intervención.

Palabras Clave: Resiliencia; personal sanitario; actitud hacia la muerte; afrontamiento; compasión

Introduction

The goal of the healthcare provider is to preserve life, care for and accompany the patient, especially those close to death (García-Avendaño et al., 2018) . Thus, death can be seen as a failure, even though it consists of a natural process (Vázquez-García et al., 2019). This highlights that negative attitudes have implications -also negative- in the health care setting(Cara Rodríguez, 2020; Puente-Fernández et al., 2020). These result in avoidance of the patient, delegation of responsibilities and emotional disconnection, and lead to worse care(Puente-Fernandez et al., 2020)this, together with the beliefs of failure, predispose the health worker to suffer compassion fatigue and burnout(Acevedo et al., 2013). Attitudes toward death of the healthcare worker are relevant because they impact their job performance, mental and emotional health (Kagan, 2020). These factors feed back, causing increased anxiety, following Zamora (2018), job dissatisfaction and low mood. However, there are healthcare workers who develop positive attitudes because of protective factors such as beliefs, experience or training (Bayat et al., 2018). These protective factors or coping strategies are related to resilience, this concept being understood as the capacity of human beings to recover from adverse situations and emerge stronger.

The aforementioned aspects motivated the authors to carry out a search on previous interventions on attitudes towards death in health personnel. However, in the literature we found that, although several articles point out the importance of staff training as a preventive factor(Cevik & Kav, 2013), there is a total absence of intervention programs that address the problem we have raised.

This highlights that, although it is known that attitudes towards death can be changed with educational programs, and that such attitudes can translate into better care for patients near death (Chua & Shorey, 2021) greater resilience, self-esteem and lower burnout (Edo-Gual et al., 2015; Guo & Zheng, 2019), no assistance is provided to healthcare personnel to provide them with tools in this direction. Thus, this team considered it important to make up for the absence of current formations. Having reviewed the causes that provoke an unfavorable attitude towards death and towards the last stage in the patient's life, the intervention program would provide a better service

by acting directly with the health personnel and indirectly on the patient. In addition, this program would prevent future difficulties for healthcare personnel in dealing with their palliative patients.

Thus, although the aim of this study was to review the attitudes towards death of health care personnel, as well as their personal and professional implications, and to study the existing interventions in this area, due to the lack of this type of program, it was decided to design an intervention proposal to address them.

Intervention Program on Attitudes Towards Death in Health Care Personnel

This absence, together with the repeated expression of the need for training of healthcare workers, led us to design a model intervention program, called "Intervention Program on Attitudes Towards Death in Healthcare Personnel". In this one, we decided to focus on coping strategies, resilience, compassion and self-compassion, guilt and gratitude, as well as behaviors towards death more explicitly. This is based on the protective factors highlighted in the literature. The program is formulated as a resource that can be accessed both in healthcare and telematically to be able to offer its application in hospitals, health centers, nursing homes or any other center where healthcare tasks are carried out.

Target population

The program is aimed at healthcare professionals who have day-to-day contact with patients in near-death situations and want to improve the way they relate to them, among whom we find prominently physicians from various specialties, such as: palliative care, oncology, geriatrics, internal medicine or primary care, nurses from primary care centers as well as from hospitals and specialty centers, psychologists, etc. These specialties are the target specialties for participation in the intervention program.

Inclusion criteria

1) willing to voluntarily participate in the intervention program,

2) sign consent to participate and perform the pre- and post-intervention evaluation,

3) to work actively in a public or private health center in contact with palliative or chronic patients who are in the last stage of life.

As exclusion criteria, it is established that

1) the participant must be working with completed formal training, excluding those persons who, while undergoing university or vocational training, are in an internship, rotation or performing any academic function in the health center

2) having a score higher than 20 in the items corresponding to the Beck Depression Inventory-II (BDI-II) when considering that the person presents symptoms of moderate or severe depression, and therefore, should be referred to another type of program more suitable to his or her situation.

In this way, it is intended that professionals improve their well-being, self-care and acquire coping tools with which they can relate to death in a healthier way. Ultimately, the aim is to benefit both them directly and the patients they serve indirectly.

Objectives and competencies

During the development of the program, it is intended that the participating health professionals acquire tools to be able to manage stress situations in an adaptive way and work on resilience. Participants will also delve into the concepts of compassion and self-compassion to increase their self-care, as well as manage possible feelings of guilt and coping behaviors towards death in a healthy way. The program will end by working on gratitude both to oneself and to others. In this way, the program not only aims to work on the management of stressful and anxiogenic situations, but also delves into the self-care of the healthcare professional, which influences a better perception of psychological well-being and a better service to the patient.

General objectives

The general objectives of the intervention program are:

- To reduce stress and anxiety in order to increase the well-being of healthcare personnel.
- Increase resilience to adaptively cope with stressful situations.
- Develop compassion and self-compassion for the participant's self-care.
- Manage feelings of guilt in an adaptive way.
- Developing gratitude to foster positive experiences
- Healthy coping with death-related situations.

Specific objectives

The specific objectives covered by the program are:

- To prevent the occurrence of stress and anxiety responses in healthcare personnel exposed to risk factors.
- Identify risk factors and protective factors against stress and anxiety.
- Identify, understand and accept emotions.
- Work on emotional clarity and emotional repair.
- Adaptive coping in threatening and stressful situations, through the qualities of resilient people.
- To know the participant's strengths and areas of development.
- Obtain tools for positive coping, based on emotions and the problem.
- Develop social skills based on assertiveness and emotional social support.
- To increase the participant's self-knowledge in actions of compassion towards other people and self-compassion towards him/herself.
- Be able to identify situations of compassion and self-pity.
- Differentiate compassion and self-pity from other emotions.
- To develop tools that allow the participant to have compassionate and self-compassionate behaviors that optimize his or her perception of psychological well-being.
- Provide the participant with tools to avoid compassion fatigue.
- Differentiate adaptive from maladaptive feelings of guilt.

- Identify factors outside one's control that influence situations about which one feels guilt.
- Learning guilt repair behaviors.
- Identify fears and ideas associated with death and the dying process.
- Acquire adaptive skills to cope with death.
- Develop gratitude behaviors to foster positive experiences, both to the participant and to others on their behalf.

Program content

In order to meet the objectives and achieve the competencies described above, the program is structured in 9 sessions of 90 minutes, which will be carried out weekly, both face-to-face and telematically. In addition, a session zero or initial session will be developed with the objective of promoting the familiarization of the facilitator with the group of professionals, as well as establishing the first rules of the group (confidentiality, respect, etc.) and the initial evaluation. In this same session, the objectives/contents of the program are introduced to the participants, and a brief reflection is made on the importance of working on attitudes towards death. The following is a brief description of each of the sessions.

- *Session 0. Presentation and Evaluation*.
- *Session 1. The importance of emotions*. This session introduces the participant and the facilitator to the intervention program, as well as raising awareness of the emotional risk factors involved in health processions.
- *Session 2. Resilience and coping*. The objective of this session is to learn about the term "resilience", as well as the characteristics of the most resilient people, and to work on the self-knowledge of each of the participants, as well as to learn about coping strategies in stressful situations.
- *Session 3. The problem, assertiveness and social support*. Through this session we will continue to deepen in coping strategies in adverse situations, in addition to learning tools that facilitate assertiveness and social support in the participant.
- *Session 4. Compassion and self-pity*. The objective of this session will be to learn about the feelings of compassion and self-compassion, differentiating them from others, as well as to identify professional situations of compassion towards other people.
- *Session 5. We and our self-care: self-pity and compassion fatigue*. In this session we work on concepts of self-care, focusing on self-compassion and the provision of tools to avoid compassion fatigue.
- *Session 6.- Guilt and reparation.* The objective is to reflect on and work with guilt, in adaptive and maladaptive situations, as well as to identify factors beyond the participant's own control, and to develop reparative tools to deal with guilt.
- *Session 7. Coping behaviors in the face of death*. In this session, the effects of death anxiety are addressed, as well as how to confront the participant with these situations through the situation, with the objective of implementing the tools discussed in previous sessions.
- *Session 8. Gratitude*. This session aims to work on the concept of gratitude, both to others and to oneself.

- *Session 9. Post-intervention measurement.* The objective of this session is to conduct a post-intervention measurement of the program participants for evaluation, in addition to closing the program with the participants themselves.

Methodology

The program uses experiential methodology(Ariza, 2010). The true meaning of the experiential model implies following a process of reflection and analysis of educational practices, involving the participant directly in what is being taught. Thus, psychoeducation will be used -as minimally as possible, for the conceptualization of ideas and clarification of terms- and exercises that allow the participant to experience individually or collaboratively with other participants the topics addressed in the sessions. For this purpose, techniques such as role-playing, meditations, breathing techniques and various group exercises will be used. All the techniques and tools proposed are adapted to the topics covered in each session, the profile of the participants, and the modality of the session (face-to-face, virtual or mixed). Following this methodology, the facilitator's task is to help participants to build their own knowledge and experiences, guiding them and encouraging reflection, and being a support point for the realization of tasks outside the session (voluntary inter-session tasks, in which the participant, with the prior support of the facilitator, will carry out in order to internalize more effectively the contents covered in the different sessions). Likewise, it will also be the facilitator's role to create a motivating and challenging work environment for the participant, guiding him/her throughout the experiential exploration towards the proposed changes.

Program implementation

The implementation of the program is a key point to facilitate the effectiveness of the work with healthcare personnel, and it is for this reason that we have to ensure the principles and methodology of the program, in addition to adapting it to each of the groups of participants, as well as the physical or virtual presence of the participants, in order to optimize the results of the program.

The working group will present the program to the different centers that will be offered, and once the centers have been decided, a communication will be made through management, service/department heads and team leaders, in addition to the use of posters, leaflets or web resources, in order to create a pool of participants and have groups according to the objectives of the program. Once the groups have been formed, an inaugural event will be held at the level of the hospital, health center, or any other organization or institution where the program is carried out, with the objective of informing the entire center of the subject matter and intervention objectives.

At the end of the intervention program with as many groups as deemed appropriate, a communication will be made as a conclusion, addressing the topic again, and where general recommendations on self-care will be given, as a reminder for attendees, and as a way of education for non-attendees. Both the opening and closing speeches, whenever permitted by the center or institution, will be broadcast via streaming to ensure the attendance and participation of

all those attendees, whether or not they are participants in the program, who wish to participate online.

Program evaluation

In order to carry out a rigorous evaluation of the effectiveness of the program, the process will be carried out at different times: 1) initial evaluation, 2) evaluation at the end of the process and 3) post-process evaluation. Table 1 describes the instruments to be used in each of the evaluation phases. In this way, the end of the program does not mean its closure, but rather that four months after the end of the last session of the program, an evaluation will be carried out with the same measures as the initial and final evaluation to determine whether the effects are maintained over time.

Table 1

Program evaluation

Moment	Instrument	Dimensions evaluated	Informants
Session 0	Questionnaire	Sociodemographic data and physiological indicators	Participants
	Bugen's Coping with Death Scale and the Revised Profile of Attitudes Toward Death	Approach acceptance, death avoidance, escape acceptance, fear of death and neutral acceptance.	Participants
Initial / Final with immediate and deferred post-testing	Maslach Burnout Inventory	Frequency and intensity of burnout in three subscales: emotional exhaustion, depersonalization and personal fulfillment	Participants
	Brief Resiliency Scale (BRS)	Global resilience	Participants

	Compassion and Satisfaction Fatigue Test. PALIEX	Compassion fatigue	Participants
	Life Satisfaction Scale (SWLS)	Satisfaction with life	Participants
	State-Trait Anxiety Questionnaire (STAI)	State Anxiety (A/E) and Trait Anxiety (A/R)	Participants
	BDI-II	Evaluation of depressive symptomatology in adolescents and adults	Participants
	WOC-R. (Ways of Coping Inventory)	Assessment of coping modes	Participants
Session 9	Program evaluation questionnaire	Questionnaire for evaluation of the intervention program by the participants	Participants

Final conclusions

As we have seen, the taboo on death has repercussions on how healthcare personnel relate to death, leading to negative attitudes towards it and, subsequently, to poorer patient care and self-care. However, the way of relating to death can be modified through various techniques of intervention in prevention and promotion of competencies.

Based on this premise, and on all the scientific literature that insists on the importance of intervention programs and training for health professionals, we propose the program "Attitudes Towards Death in Health Personnel". This program is in line with what is proposed by relevant authors on the subject such as Cervik &Kav (2013). Thus, starting from the main objective of facilitating the development of more positive coping attitudes towards death on the part of healthcare personnel, we propose working on compassion and self-compassion to relate appropriately to this type of situation, feelings of guilt, resilience, stress and anxiety management, and gratitude. The program uses experiential methodology, putting the participants in an active role, involving them and making the sessions dynamic. In order to reach as many healthcare professionals as possible, the program can be carried out in person, blended learning or online.

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Date received: 21/03/2022
Revision date: 14/07/2022
Date of acceptance: 07/09/2022