Palliative care professionals, such as social workers, often work with death and bereavement. They need to cope with the challenges on “self” in working with death, such as coping with their own emotions and existential queries. In this study, the authors explore the impact of death work on the self of palliative care professionals and how they perceive and cope with the challenges of self in death work by conducting a qualitative study. Participants were recruited from the palliative care units of hospitals in Hong Kong. In-depth interviews were conducted with 22 palliative care professionals: five physicians, 11 nurses, and six social workers. Interviews were transcribed to text for analysis. Emotional challenges (for example, aroused emotional distress from work) and existential challenges (for example, shattered basic assumptions on life and death) were identified as key themes. Similarly, emotional coping (for example, accepting and managing personal emotions) and existential coping (for example, rebuilding and actualizing life-and-death assumptions) strategies were identified. This study enhances the understanding of how palliative care professionals perceive and cope with the challenges of death work on the self. Findings may provide insights into how training can be conducted to enhance professionals’ self-competence in facing these challenges.

KEY WORDS: competence; coping; death; palliative care; self
Thematic analysis was used to underpin this study and explore how helping professionals may develop the specific competence that helps them cope with the challenges of the work on their personal self. W.C.H. Chan and Tin (2012) referred to this kind of competence as self-competence in death work, which includes helping professionals’ possession of essential personal resources (for example, optimism) and their ability to cope with emotions and existential issues aroused by death work (emotional coping and existential coping). *Death work* is defined as “any supportive, therapeutic or remedial work in response to death or matters related to death” (W.C.H. Chan & Tin, 2012, p. 900). Previous studies also suggest that it is crucial for palliative care professionals to find ways of coping with the emotions aroused by their work, for example, handling their own grief following the death of patients (Keene, Hutton, Hall, & Rushton, 2010) and developing emotional intelligence to help in facing the suffering of patients and bereaved families (Bailey, Murphy, & Porock, 2011). They may also need to cope with various existential challenges in their work, for example, addressing concerns such as spirituality (Clark et al., 2007), meaning in life (Sinclair, 2011), death attitudes, and values on death-related issues (Gwyther et al., 2005; Prochnau, Liu, & Boman, 2003).

To further understand the self-competence of palliative care professionals in facing death, dying, and bereavement, we aimed in this study to explore the impact of death work on the self of these professionals and how they perceive and cope with the challenges of self in death work. “Self” is a term often used in social work (Chinnery & Beddoe, 2011; Edwards & Bess, 1998). Self may be defined as helping professionals’ personality traits, belief systems, and life experience (Dewane, 2006, p. 544). In this study, with reference to our earlier work on self-competence (W.C.H. Chan & Tin, 2012), we define self broadly as helping professionals’ emotions, thoughts, beliefs, and behaviors.

**METHOD**

**Research Design**

Thematic analysis was used to underpin this study (Braun & Clarke, 2006). We used this qualitative approach to identify the key themes that may illustrate how palliative care professionals perceive and cope with the challenges of death work on self. We sought ethical approval from the research ethics committees of participating hospitals in this study. The consolidated criteria for reporting qualitative research guidelines (better known as the COREQ guidelines) were applied (Tong, Sainsbury, & Craig, 2007).

**Interviewers**

A research assistant with a master’s degree conducted the interviews. She was trained by Wallace Chi Ho Chan and Agnes Fong (both are experienced social workers and thanatologists) before the interviews and conducted the first three interviews with their on-site guidance.

**Participants**

Participants, who were physicians, nurses, and social workers who had worked in palliative care for at least six months, were purposively recruited from three palliative care units of public hospitals in Hong Kong. Doris Man Wah Tse, Kam Shing Lau, and Lai Ngor Chan were the senior physicians or nurses working in these units. They helped to identify appropriate colleagues to join this study. Participants with different profiles were recruited to obtain variety in age, gender, and working experience specifically in palliative care. Written consent was obtained from all participants.

**Data Collection**

In-depth interviews were conducted with each participant in a semistructured format in their workplace. Two pilot interviews were conducted by Wallace Chi Ho Chan, Agnes Fong, and a research assistant. The initial interview guidelines were modified after the pilot interviews. Participants were invited to describe their daily work and illustrate how it might be different from their previous duties in other units, which was a conversation that might open a discussion on the effect of death work on the self. Follow-up questions were then asked, for example, “Apart from knowledge and skills, what are the challenges in your work? Do these challenges have any impact on you personally?” Participants were invited to give examples to illustrate what these challenges are, how they were influenced by these challenges, and how they coped with them. Each interview lasted from 60 to 90 minutes.
Analysis
All interviews were audio recorded, then transcribed to text for analysis. Field notes were also recorded during the interviews. The transcripts were sent to participants and verified by them. All participants acknowledged that the transcripts accurately reflected what they had shared.

To enhance the credibility of the findings, we used methods triangulation and analyst triangulation (Patton, 1999, p. 1193). Two levels of data analysis, with different methods of data analysis and different analysts, were conducted. At the first level, the research assistant analyzed the qualitative data using NVivo (Version 9) (Richards, 2015). She did the open coding by reading the transcripts line by line. Initial codes were given to different segments of text before major themes were identified. At the second level, Wallace Chi Ho Chan and Agnes Fong analyzed the data again with reference to the framework of W. C. H. Chan and Tin (2012). Coding was then conducted independently, and themes were identified. Themes identified at the first and second levels were compared. All themes identified at the first level were compatible with those at the second level; that is, most themes identified at these two levels were similar in meaning and could be reconceptualized into common themes, and differences could be resolved by reconceptualization into broader themes. After thorough comparison between the analyses at levels 1 and 2, themes were finalized.

RESULTS
Twenty-two palliative care professionals participated in this study: five physicians, 11 nurses, and six social workers. The majority of them were women (17 participants). Details are shown in Table 1.

Two key themes, challenges and coping, which interact with each other, were identified. Participants reported the challenges as situations in which they felt affected personally by death in their work, and they referred to coping as how they tried to cope with these challenges. Under the main theme of challenges, existential challenges and emotional challenges were identified as subthemes. Similarly, under the main theme of coping, existential coping and emotional coping were identified. The term “existential” was used to describe how participants perceived the challenges and adopted the coping in relation to their queries on existence, including assumptions on life and death and meaning in life and suffering. The term “emotional” was used to describe the challenges that aroused their emotions (for example, helplessness and grief) and the coping that was used to manage these emotions. Figure 1 shows all of the key themes and subthemes identified in this study. All of the subthemes under the two main themes, challenges and coping, were identified and reported as follows.

Existential Challenges: Shattered Basic Life and Death Assumptions
Participants perceived the shattering of basic life and death assumptions to be the main existential challenge in death work. For example, they found it hard to see a young patient die, because this violates their assumption that elderly people should die first. Participants also found it difficult to understand why bad things happen to good people when they witnessed a kindhearted patient experience great pain and suffering. Findings revealed that the shattering included three subtle processes: awareness or confrontation of the nature of life and death, discrepancy from old self-beliefs, and reactions of distress and confusion. For example, one participant shared the observation, “I sometimes feel sorry for my patients why they are unable to achieve a life without regret despite trying very hard. . . . This makes me feel upset” (Participant 6). Another participant stated, “I was unhappy. This was related to my patient. I was
angry. . . . Why did a hardworking family man receive such punishment?” (Participant 22).

**Emotional Challenges: Emotional Distress Related to Personal Life and Professional Work**

Two types of emotional challenge, personal emotional arousal and work-related emotional arousal, were identified. Personal emotions were aroused when death work forced the participants to confront death-related concerns in their personal lives, such as participants’ own death anxiety, past grief, regrets, and unfinished business. For example, one participant shared her worries of enduring cancer: “Thoughts just come to my mind. ‘Do I have cancer like my patients?’” (Participant 18). Another participant stated, “The suffering of my patients reminds me of my deceased relatives” (Participant 17). One participant observed, “[My] inability to cope with negative emotions aroused at work may be related to [my] past unsolved bereavement experiences” (Participant 1).

Emotions participants reported experiencing in their work were a sense of helplessness and powerlessness, worry about the time constraints of death work, guilt, a sense of heaviness, being overwhelmed, and anger. For example, a participant shared his sense of helplessness and powerlessness:

I sometimes feel powerless. I just can’t do much. . . . I tried to give my patient [a] high dose of morphine, but my patient’s pain was not relieved. I didn’t know what to do. I felt very helpless. My patient suffered because the morphine was too heavy for my patient. . . . Not only me but also my whole palliative care team was nervous. This was stressful. I suffered as the physician. I felt helpless, just like my other colleagues in the team. (Participant 22)

Another participant also described her guilty feelings stemming from an incident at work:
It was a Friday and was getting to the end of the day. There was something I promised a patient to help with. I was thinking to leave the hospital and come back to help the coming weekend or the coming Monday. When I came back to the hospital during the weekend, my patient had already passed away. I felt sad and kept thinking that I should have helped my patient before I left on Friday and that it was my fault to leave the hospital on Friday. (Participant 1)

**Existential Coping**
Participants found rebuilding life and death assumptions to be a major existential coping strategy. Participants expressed their need to identify their life priorities and goals, reflect on their life, and search for the meaning of suffering and death. For example, a participant indicated her renewed life priorities and goals:

I will have a deeper thought. I will think about, to me, what my life priorities are. I keep searching my life priorities. . . . I keep thinking what things or who are the most valuable or most important to me. My meaning of life would be to do things which are most important to me and spend time with people who are most important or treasured to me. (Participant 9)

Another existential coping strategy is more action oriented: actualizing the life and death assumptions. It can be further categorized into three areas: (1) acceptance of the nature of life and death, (2) better preparation for death, and (3) living a meaningful life. The first area, acceptance of the nature of life and death, is characterized by participants’ development of a revised understanding of life and death, such as suffering and regrets are inevitable in life and death cannot be controlled. For example, one participant shared, “My personal insight to life is that life and death are natural processes. Everyone has to face them. Illnesses and death are full of uncertainties. We just can’t control them” (Participant 13).

The area of better preparation for death illustrates participants’ willingness to face death proactively, such as enhancing their deeper understanding of death, making practical preparations for their own death, dealing with unfinished business, and discussing death openly with family members. For example, a participant shared her preparation for death:

Death is inevitable. So why don’t we prepare for our death? Everyone knows that death is inevitable, ever since they are born. I rarely thought about preparing for my death before, but after I have been working in the field of palliative care, I tell myself that I have to prepare for my death. (Participant 5)

Living a meaningful life is the aspiration of the participants to live each day to the fullest by minimizing regrets, enhancing life’s meaningfulness, being mindful of the present moment, fulfilling responsibilities, and being grateful for what they have. For example, a participant shared,

You have to live in the present moment. This gives you energy to face tomorrow’s challenges. . . . I keep reflecting on this as you never know what will happen tomorrow. This supports me to survive and work in palliative care for six years. . . . This gives me huge encouragement. (Participant 12)

**Emotional Coping**
Emotional coping is categorized at both personal and professional levels. At the personal level, the coping strategies of acceptance of own emotions and management of own emotions were identified. By accepting their own emotions, participants perceived emotional arousal at death work as normal. Management of own emotions refers to measures to mitigate the impact of emotional arousal, such as sharing with others, relaxing, finding joy in life, rationalizing, distracting oneself by work, and dealing with losses and relationship issues. For example, one participant shared about her acceptance and management of emotions:

I have to accept that when I heard about the difficult situations of my patients or their family, I will get emotional like ordinary people do, even though I am a social work professional. . . . Because life is uncertain and unpredictable, we have to enjoy life in the present moment. (Participant 20)

At the professional level, four emotional coping methods were identified: (1) adjustment of expectations in death work, (2) searching for meaning in work, (3) differentiation between work and self, and (4) adjustment of expectations in professional identity.
Adjustment of expectations in death work may include developing suitable goals, accepting the reality of patients and families, and achieving a good death for the patient. For example, a participant stated,

In palliative care, I aim at good death. . . . In acute care, I aim at avoiding death. . . . I have to be clear with my objective what I have to do in palliative care first. This helps regulate my negative emotions at work and reduce my emotional suffering. In palliative care, I hope to achieve a good death, or at least appropriate death. . . . This helps me adjust my emotional pathway. . . . I believe that if you as a physician aim for avoiding death in palliative care, everyone will suffer, no matter the patient or you. So I have to clarify to myself that death is unavoidable. What I have to do is to enhance the quality of the dying process. (Participant 22)

The strategy of searching for meaning in work involves participants achieving a sense of reassurance through finding meaning, satisfaction, and passion in work and experiencing love among people. A participant echoed this point: “To me, this is [the] meaning of work: The patient is touched by or changed positively because you have tried hard to help.” (Participant 4).

The strategy of differentiation between work and self encompasses the participants’ ability to separate work from personal life so that distress from work does not interfere with personal life and vice versa. It includes differentiating one’s own needs or emotions from patients’ needs and emotions and maintaining an optimal distance from patients.

The final strategy, adjustment of expectations in professional identity, requires participants to contemplate their professional roles and limitations. Participants revealed that it is important to acknowledge that they are not different from patients in facing death and dying, that they cannot control the fate of patients but can only be their companion, that they have to accept their own limitations as helping professionals and not take over responsibilities in patients’ lives. One participant shared, “You have to strike a balance. You can’t keep yourself too distanted from the patient, but you can’t be too involved in your work. That means you have to separate work and personal life” (Participant 19). Another participant also acknowledged her emotions: “When a family member of my patient talked about her difficult situation, I could not help but cry. It was understandable to cry for this family member even though I am a social work professional” (Participant 20).

**DISCUSSION**

This study deepened the understanding of palliative care professionals’ perception of the effects of death work on the self, which includes the confrontation of challenges and the development of coping skills. Echoing the previous work of W.C.H. Chan and Tin (2012) on self-competence, participants elaborated on existential and emotional concerns in relation to the self. Participants perceived their challenges of the self as both existential and emotional, and hence corresponding existential and emotional coping were developed. This study provides a more thorough elaboration of the concepts of existential and emotional challenges inherent in death work and palliative care professionals’ corresponding coping strategies.

Participants identified their existential challenges as the shattering of life and death assumptions. This is similar to what people experience when they face traumatic events (Janoff-Bulman, 1989, 1992). The discrepancy between what participants experience in death work and what they believe about life and death may lead to distress and confusion. Our findings suggest that coping with this existential challenge requires rebuilding the shattered life and death assumptions. However, it seems that this rebuilding involves not only cognitive restructuring, such as rethinking life priorities, but also an action component (for example, better preparation for death) in which participants need to actualize the rebuilt assumptions of life and death. This is consistent with existential perspectives that emphasize the importance of living one’s beliefs and values with courage (Camus, 1991; Frankl, 1984).

A previous study on death preparation in Hong Kong also echoes this point with its finding that those who thought about preparing for their own death but did not act on those thoughts experienced higher death anxiety than did those who prepared for their own death (T.H.Y. Chan, Chan, Tin, Chow, & Chan, 2006–2007).

Our findings on emotional challenges and coping suggest that death work seems to have dual effects on the emotions of participants. At the personal level, participants’ own death anxiety and grief over their losses may be aroused. At the professional level, participants’ sense of guilt and helplessness may be aroused. This perhaps reveals the unique essence of death work: professional yet personal (Katz, 2006). That is the
reason why coping with emotions aroused from death work should involve coping at the personal level (for example, dealing with own losses and grief) (Worden, 2002) and the professional level (for example, accepting losing control in professional practice) (Shapiro, Astin, Shapiro, Robitshk, & Shapiro, 2011).

External professional resources (for example, professional training, peer support, and supervision) are needed to support palliative care professionals (for example, social workers), especially those who are relatively inexperienced in the field of palliative and end-of-life care. We also propose that professional training focusing on the development of self-competence is an important means to effectively prepare helping professionals to cope with the existential and emotional challenges in death work.

The importance of the role of self has long been recognized in the field of social work, counseling, and psychotherapy. Freud (1917/1959), for example, believed that a successful therapist should handle his personal life to avoid becoming entangled in the patient’s personal life. Bowen (1972) and Bandler, Grinder, and Satir (1976) also proposed systematic training that resolved therapists’ personal conflicts from their own family of origin.

**Proposals**

Training models that highlight the role of self are rare in death work. To enhance the self-competence of helping professionals in death work, we propose two directions. First, helping professionals must better understand their level of competence in coping with the existential and emotional challenges in death work. Our findings on existential and emotional coping provide rich information on what is crucial when coping with these challenges. This could be a good basis for developing a scale to facilitate helping professionals’ self-rating of their level of self-competence. Such awareness and understanding may be helpful for those planning to enter the field of death work.

The second direction we propose is the development of a training model to enhance helping professionals’ coping skills for dealing with existential and emotional challenges in death work. On the basis of the findings of this study and our past training experience, we recommend that a training model on self-competence for death work involve the following elements.

**Experiential Learning.** Our findings show that the necessary coping in death work involves input coming from cognitive levels (for example, rebuilding life and death assumptions), emotional levels (for example, acceptance of own emotions), and behavioral actions (for example, actualizing the life and death assumptions). Experiential learning is therefore the most suitable means of developing helping professionals’ coping strategies in death work because it is particularly effective in arousing cognitive, emotional, and behavioral changes in the learning process (Kolb, 1984).

**Reflection on Own Existential and Emotional Coping in Personal Life.** Helping professionals are encouraged to review their own existential and emotional coping, explore and understand how they are developing, evaluate their suitability in death work, and make any necessary changes.

**Integration of Self-Competence in Professional Work.**

Aponte and Winter (2000) commented that existing educational models often offer an either-or model for trainees. Educational programs may focus on either professional technical skills or participants’ personal growth and learning. Few programs offer an in-depth focus on both the participants’ personal reflection and how such reflection relates to their professional work. We therefore propose that the training should be oriented toward not only developing the participant as a more intact person, but also supporting the participant in incorporating self-competence into technical interventions and professional work. In this way, we believe that palliative care professionals, such as social workers in palliative and end-of-life care, can then better apply “use of self” in their practice.

**Limitations and Future Directions**

We are aware that our participants of different disciplines may be different in their perception of challenges and adoption of coping in death work. Yet, in this study, we analyzed these data together to examine the impact of death work, the nature of work that different disciplines have in common, on the self. We plan to compare and discuss the similarities and differences between participants of different profiles (for example, different disciplines, working experience in palliative care) in future studies.

**CONCLUSION**

In this study, we explored how palliative care professionals perceive the impact of death work on self and how they cope with it. Existential and emotional challenges and the professionals’ corresponding coping methods were revealed by the findings. Appropriate training can be developed to enhance
coping with these challenges on self in death work and, in turn, enhance self-competence.

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