

Being “Mindful” of Dignity in Dying: Developing Awareness, Fostering a Psychological Understanding, and Supporting Dignified Endings-To-Life

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Abstract

Experiencing a sense of dignity when nearing end-of-life has been shown to be very important. There are many things that hospice and palliative nurses can do to support dignified endings-to-life. This paper explores the different aspects of this process from both the perspective of the person dying and in particular the individual in the caring role. Consideration is given to the different components of experiencing dignity in dying, especially those aspects that nursing staff can influence most. The importance of a sense of dignity to people who are dying is explored using two psychological models that provide an intrapersonal and transpersonal perspective. These include the Abandonment of Self Model and the Surface-Depth Model respectively. The types of obstacles to nursing staff providing this type of care and support are reflected upon, with particular emphasis placed on the practitioner’s own personal fears and anxieties and how these may manifest within the patient-nurse relationship. The final section explores the use of mindfulness practises as a way of interacting more fully with people diagnosed with terminal illnesses to support their experience of a dignified ending-to-life. This process is termed “mindful engagement”.

Keywords: death, dying, dignity, awareness, mindfulness, mindful engagement

Introduction

The challenges faced by any individual nearing death can be numerous. Those supporting people at this phase of life can make a significant impact on the way in which someone negotiates these challenges. Hospice and palliative care nurses hold a special position within healthcare systems. Their work brings them to the borders of existence on a daily basis. As a result, it is important that these professionals are supported as best they can be in caring for the patients they work with. This paper focuses on the role of nursing staff in supporting people who have a terminal illness to experience a dignified ending-to-life. The effect of doing so is considered using two different psychological models—one from an intrapersonal perspective and one from a transpersonal perspective. The obstacles nurses may face in providing this type of care are also discussed. Finally, “mindful engagement”, and a number of practises that facilitate it, is explored as a vehicle through which practitioners can support patients to experience a dignified ending-to-life.

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Dignity in Dying

A dignified ending-to-life is most likely experienced when the whole “self” is taken care of (Chochinov & Cann, 2005; Kristjanson, Chochinov, Hack, McClement, & Harlos, 2002; Chochinov & McKeen, 2011). This includes management of physical and psychological symptoms, preservation of independence, maintenance of self-respect and worth, preservation of meaning in life, and a sense of interpersonal and spiritual connectedness. By contrast, a diluted sense of dignity has been linked to shame, embarrassment, hopelessness, depression, and a wish for death (Chochinov, Hack, Hassard, McClement, Kristjanson, & Harlos, 2002).

Dignity is influenced by an individual’s internal and external world. In terms of the latter, people who are dying experience a sense of dignity when they feel respected by and worthy of others’ respect (Chochinov & McKeen, 2011). In this way, a sense of dignity is, in part, constructed through interactions with other people and how those interactions are appraised (McClement & Chochinov, 2006). It could be viewed as an extension of the attachment process that begins in the first days of life and continues to evolve throughout life (Ainsworth, 1968; Bowlby, 1988). The care that is received at the beginning of life is as important at the end of life.

This has particular relevance for nurses caring for people with terminal illnesses. In addition to people’s families, they are those whom patients are most likely to be surrounded by. This is strongly reflected in Chochinov and colleagues’ empirical dignity model (Kristjanson et al., 2002). One factor that has a very influential effect on a person’s sense of dignity is what has been called the “care tenor”. This reflects the degree to which dignity is dependent on the positive attitude, active listening, empathy, and compassion of healthcare practitioners and on the extent to which practitioners respect, value, and appreciate patients as whole individuals (Chochinov & McKeen, 2011). Reflections by hospice nurses have also highlighted the importance they place on these kinds of factors (Strang, Henoeh, Danielson, Browall & Melin-Johansson, 2014).

The Importance of Dignity in Dying

What occurs between patient and nurse at an interpersonal level can have a significant influence on the patient experiencing a dignified ending-to-life. The knock-on effect of this at an intrapersonal and transpersonal level can be very significant.

The Intrapersonal Level

“Intrapersonal” refers to that which relates to or takes place within the mind or self. William Shaver’s (2002) Abandonment of Self Model (Figure 1) is used to further explicate the influence that supporting a dignified ending-to-life can have on a patient at this level (see Figure 2 for Case Example). This model posits that, when a child is born, they have the potential to grow into a unique person, with an original sense of self. However, the child’s environment, those in their environment, and particularly their primary caregivers influence this process significantly. Certain aspects of a child’s emerging self—be it physical, intellectual, or emotional—may be reinforced and encouraged to develop (e.g., politeness, competitiveness, studiousness) while others are not (e.g., sensitivity, expressing anger). These will differ for every child dependent on their environment (e.g., parenting, schooling, culture). A child identifies with the former and rejects or abandons the latter. Eventually, the child loses access to, and consciousness of, those rejected facets. These become the “abandoned self”. What remains is an “illusory self”.

A result of this partial sacrifice of aspects of the original self is the absence of a true sense of safety in the world. To overcome the discomfort that this creates, the illusory self looks to develop compensatory behaviours, called “alternate zones of safety” that enable it to cope. These behaviours develop in childhood and mature in adulthood. These may include acquiring wealth, becoming powerful or influential, becoming idolised or adored, or developing very close dependent relationships. Each of these enable the illusory self to feel safe and mask the absence of the abandoned self.

When someone is faced with their own death it triggers “death anxiety” (Yalom, 1980). This comes with the realisation that each individual dies alone without wealth, position, power, or relationships. These alternate zones of safety are rendered no longer effective; the illusory self becomes exposed, and this often results in significant loneliness and anxiety. This existential loneliness is compounded by the realisation, at whatever level of consciousness, that the unassimilated parts of the abandoned self are missing. Sometimes, distressing behaviour observed amongst people facing death is in part due to the painful realisation that the sense of self is incomplete. This might include significant pain that does not respond to medication, an inability to feel emotion, a sense of embarrassment over one’s illness, or increased levels of depression or isolation. Given that every human being is likely to have abandoned some aspects of self, this is likely to happen to most people in some way.

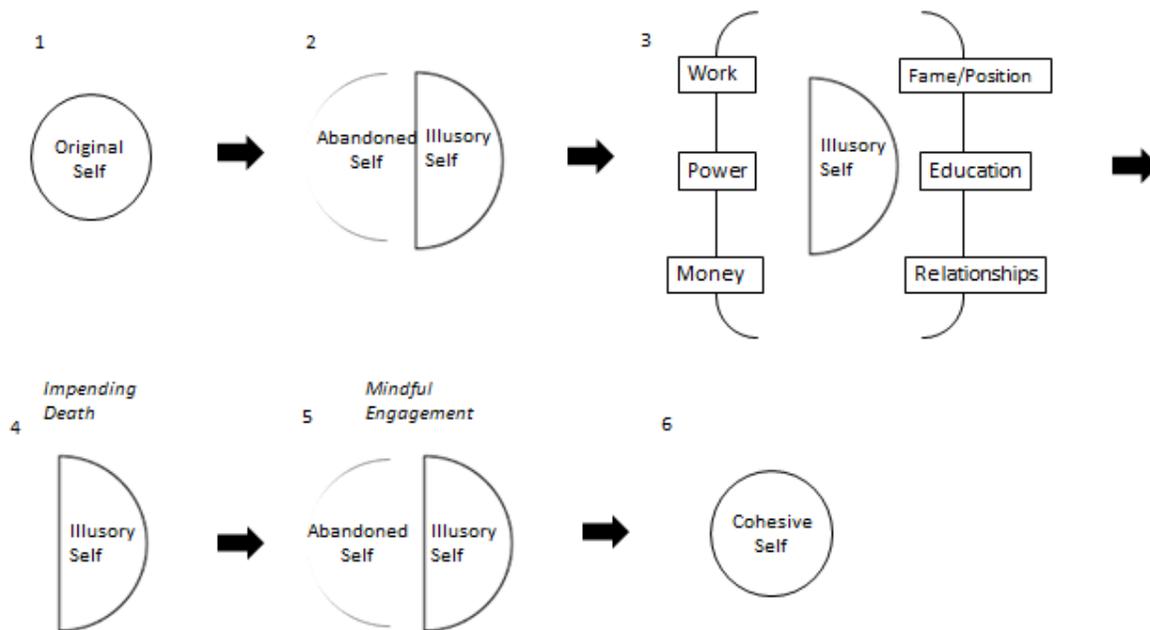


Figure 1. The “abandonment of self” and reintegration of “abandoned self”³.

³ Figure 1 adapted from Shaver (2002)

Case Example: Alice

This story about Alice is not unlike that of many people who are diagnosed with a terminal illness. As a baby, Alice was born with a sensitive temperament from which she started to grow into a little toddler. As she aged, her *Original Self* was influenced significantly by her parents. They were of the opinion that “children should be seen and not heard”, were very strict, and did not allow her to play freely or engage with other children out in the street. She was heavily encouraged to play quietly in her room and spend lots of time reading. As a result, Alice came to marginalise her capacity for being emotionally expressive, spontaneous and socially engaging (*Abandoned Self*). With time, she grew into someone who came to value being hardworking, independent, introspective, and who spent a lot of time on her own (*Illusory Self*)—this is what she came to view herself as. Alice was sent to boarding school, which was very academically-oriented. Her teachers were very strict, and she had to study a lot. Her parents only inquired after her grades. When it came to leaving school, Alice’s parents thought it would be a good idea that she get a job in a bank. By this stage, Alice agreed with them. She thought it was very important to be successful. Alice worked in finance, became a top banker and eventually CEO of a large Multi-National Company, earning a huge salary. Alice had few friends outside of work and never had a romantic relationship. She worked hard at her job and found it satisfying. *Alice’s education, professional status, and financial security were “Alternative Zones of Safety” in which her “Illusory Self” felt safe and supported.* At age 47, Alice developed terminal lung cancer. She realised that her job, her prestige, her position, and her money now meant very little. She found herself feeling lonely, isolated, and afraid of death. *This is the exposure of the “illusory self” when the “alternative zones of safety” are no longer able to maintain a sense of feeling safe, due to becoming ineffective in the wake of impending death.* Alice felt very vulnerable from this position. However, with time she came to trust one of the physiotherapists, Mary, and developed a very positive relationship with her. Alice experienced Mary as being very present, caring, and interested in her as a person (*Mindful Engagement*). *This helped Alice in reintegrating parts of her abandoned self.* That is, she became more emotionally expressive, more spontaneous, and socially engaging in the final months of her life. She began attending support groups within the hospital and some support groups in her local community. She spent more time with her nieces and nephews. With time, she was able to express to Mary how important her care had been; and before she died, she had two very meaningful conversations with her then-aging parents that she had not managed to have throughout the rest of her life. *As a result, Alice developed a more “Cohesive Sense of Self” as she neared death.*

Figure 2. The “abandonment of self” and reintegration of “abandoned self” — Case Example.

The Transpersonal Level

The “transpersonal” refers to states of consciousness that are considered beyond (trans) traditional concepts of “self” (Walsh & Vaughan, 1993). Michael Kearney’s (1996) Surface-Depth Model (Figure 3) provides further understanding for some of the transpersonal processes that may unfold as someone approaches death. Within this model, the “surface mind” represents the rational, literal, and logical aspects of the mind. It is concerned with understanding and

analysis, and communicates through words. The “ego” or the “I” is the organising part of the surface mind. The ego is what is aware of everything else. The ego feels safe in the surface mind where things are orderly, familiar, and predictable. As a result, it feels more in control and derives a sense of power from this. This could be likened to Shaver’s (2002) illusory self and its alternate zones of safety. The ego views the deep mind with fear and mistrust. Given that it cannot get away from it, it chooses to banish it from consciousness and pretend that it does not exist.

The “deep mind” represents the more intuitive and unconscious aspects of the psyche with a stronger connection to the emotions and physical body. It communicates through symbol, image, and myth and is activated through the processes of dreaming, imagination, creativity, and meditation. It is a reservoir of inner resources and childhood spontaneity, often holding the intuitive answer to life’s most challenging predicaments that seem to evade the order and logic of the surface mind. The deep mind is also where fears, hurtful memories, and old psychological wounds are kept, to avoid disrupting life on a daily basis. The transpersonal component to Kearney’s model is represented by the “deep center”. It is considered to be the essence of what humans truly are. It is something within each person that defies definition. It is without limit; its dimension is depth and it contends with the subjective experience of meaning. Similar to Shaver’s (2002) abandoned self, it holds both great promise and great hurt. If people can learn to—or be supported in—tolerating the latter, the former can enrich life greatly, especially when approaching death.

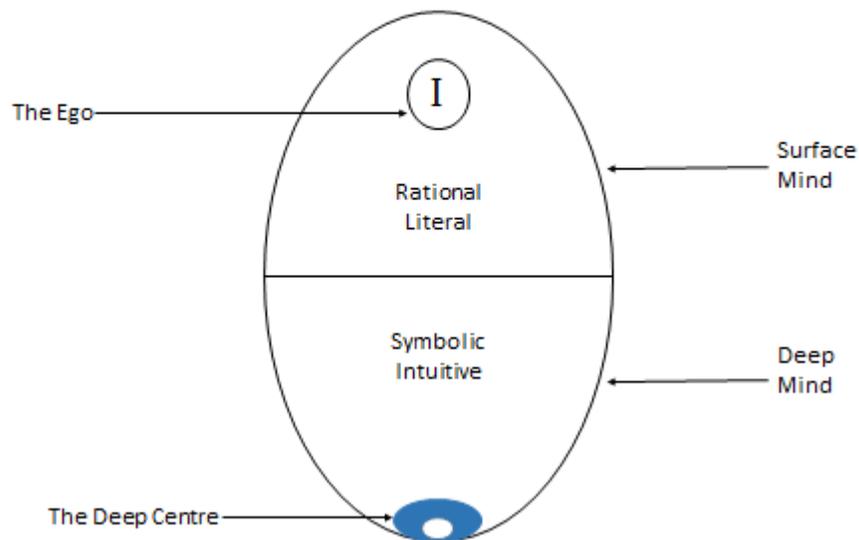


Figure 3. The Surface-Depth Model⁴.

⁴ This figure originally appeared in *Mortally Wounded: Stories of Soul Pain, Death and Healing* by Michael Kearney, published by Spring Journal Books in 2007. Reprinted with permission from Spring Journal Books. www.springjournalandbooks.com

Reconnection and Reintegration

Both models suggest that death triggers a process in which people seek to regain access to “lost” or forgotten parts of their intrapersonal or transpersonal experiences. This may involve redressing old hurts or fears, reintegrating abandoned parts of self, and reconnecting with deeper and more unconscious parts of the psyche. This happens for many people nearing death in a natural manner, which can allow them to find a richness and peace in the remainder of their living.

Some patients, however, become distressed as they become aware, whether at a cognitive or more emotional level, of disintegrated parts of self and the original hurts that gave rise to these. For others, the surface mind finds it too distressing to let go of the control it is used to and there is much resistance to the descent into the deep mind. This resistance results in what Kearney (1996) calls “soul pain”. While this distress might at one level be looked on as upsetting and something to be eliminated, at another level it can be viewed as the start of someone engaging in an important process as they near end-of-life. If patients can be helped with that process, it may enhance the quality of their living, and dying, greatly. Some people struggling with this process may require specialist assistance, but for many it is friends, family, and nurses who support them on this journey. The more awareness that is brought to the unfolding of these processes, the more that can be done—or “not done”—to help.

The role of hospice and palliative nurses is associated, by many, with endings, death, and dying. This paper supports the idea that, in another way, their role is also closely connected to a process of reintegration. Often, practitioners in palliative settings are those who facilitate patients to reconnect with parts of their intrapersonal and transpersonal experiences that they have had less access to for much of their lives. It is for this reason that providing the conditions that support a dignified ending to life is so important. The often-unspecified skills of the nurse provide these very conditions (positive attitude, active and reflective listening, compassion, empathy, validation), ensuring that patients can face dying with more wholeness on an intrapersonal and transpersonal level. This also allows them to engage more fully, at an interpersonal level, with those they leave behind.

It is important to note however that nursing staff may face a range of obstacles in trying to engage in this way with their patients.

Obstacles to Supporting Dignified Endings-to-Life

Actively listening to someone with real empathy, congruence, and unconditional acceptance (Rogers, 1957) requires significant awareness from the practitioner. There are many factors that may hinder this process. These include systemic factors (e.g., busy schedules, waiting lists, meetings, administrative duties, staff shortages) and the impact of this work on practitioners which may leave them “burnt out” or “compassion fatigued” (Pessin, Fenn, Hendriksen, DeRosa, & Applebaum, 2015). Practitioners’ biggest obstacles, however, and those which can more easily evade awareness, may come from within themselves.

The same way the surface mind (Kearney, 1996) affects many patients nearing end-of-life, it also dominates many practitioners working with them. Many nurses spend much of their day problem-solving, fixing, rationalising, analysing, and maintaining control. While these values may be integral to the survival of many hospital settings, they are often not what is required to be fully present to someone who is nearing end-of-life. It is important for nurses to

become aware of how often they engage with patients from a surface mind position and to consider the impact this may be having on those interactions.

In modern societies, achievement, success, beauty, and youth are prized. The corollary of this is that death and dying are very much feared. Irvin Yalom (1980) suggests that this fear of dying is a typical aspect of human development and why people construct “normal” defences to deal with it. These include developing a sense of “specialness” and believing in there being an “ultimate rescuer”, not unlike Shaver’s (2002) zones of alternative safety. As someone comes closer to death, it becomes more difficult to hold on to these defences, and so they are faced with death anxiety. Yalom posits that this is normal and that difficulties emerge when people try to repress this anxiety. Kearney (1996) interprets this process as the surface mind resisting the journey into the deep mind. There is much evidence from many different fields that shows how the emotional expression of one human influences another (Casement, 1992; Marlock, Weiss, Young, & Soth, 2015; Mindell, 2014; Yalom & Leszcz, 2005), and so no healthcare practitioner works independently of those they care for. Nurses face the obstacle of remaining open to the person who is dying while also not becoming overwhelmed by their and their family’s death anxiety and the associated distress.

This work also brings nursing staff closer to the deaths and losses they have experienced themselves and their own sadness and grief connected to these. Moreover, they have to negotiate their own death anxiety, which they are brought closer to through working with people who are dying (Yalom, 1980). While this anxiety is quite typical, it is invariably uncomfortable at times. It is therefore important to develop an awareness of it. Where nurses are not aware of this process, they run the risk of allowing this anxiety to close them down or shut them off from the suffering of those they hope to help. While palliative nurses cannot allow themselves to become overwhelmed with sadness or anxiety on a regular basis, should they find themselves becoming completely unaffected by their work, it is important for this to be considered and reflected upon. A nurse’s own death anxiety is more likely to have a significant effect on their practise when the patient, or something about the patient’s life, is close to their own (e.g., nurse and patient are similarly aged, married in the past three years, have a newborn baby). In such situations, the nurse is more likely to be faced with thoughts around, “That could be me... What if I was faced with death?” This may occur consciously or further from consciousness.

A further relevant contribution from the field of existentialism is what has been called “existential isolation” (Yalom, 1980). “Interpersonal isolation” arises when a person feels lonely in the absence of other people. “Intrapersonal isolation” arises where someone becomes disconnected from parts of the self. “Existential isolation” represents the separation between the individual and all the other individuals in the world. It denotes the extent to which humans come into this world alone and leave it alone. It refers to the inevitable gap between an individual and any other human being. As with death anxiety, this fear is banished for much of life. People try to evade it through many different means as they go through life (e.g., appending themselves to another in the name of love). A confrontation with death brings this into consciousness. The anxiety that this generates may be observed in people nearing-end-of-life, and consequently in nurses working with these people. As with death anxiety, where practitioners try to keep this out of awareness, it is more likely to have a negative impact on their interactions with patients.

In sum, one of the factors that is most likely to create an obstacle to nurses facilitating patients in having a dignified ending-to-life is their own fear or anxiety. When people are afraid, they react in accordance with an evolutionary survival response—the fight, flight, or freeze response (Kolb & Wishaw, 2015). In reaction to a dangerous predator or situation, this allowed

early homo sapiens to brace the body for combat (fight), automatically run away (flight), or become completely still so as to be unnoticed (freeze). It is unlikely that such a response will be expressed in its complete manifestation by nursing staff while engaging with someone who is dying. However, it may present itself in more subtle ways through communication signals. A fight response might manifest itself in terms of there being a mildly abrasive quality to a nurse's energy and interaction style. This might be expressed in the way they say, "Good morning. How are you?" without looking at the patient; their tone is sharp and they are focused intently on writing on the patient's chart. A flight response might be observed in the form of a quickness, or activeness in how nurses move or speak, and the degree to which they fill in gaps in communication and avoid leaving silences to materialise. A freeze response might be communicated through a closed body posture and a "coolness" in the quality of their engagement style. In reality, any combination of these bodily reactions and their resultant communication signals may cooccur simultaneously.

These signals, particularly those that are further from consciousness (e.g., tone of voice, body posture, eye gaze, facial expression) will be registered by the patient, either consciously or more likely at a more intuitive or emotional level. This will occur via the amygdala and other components of the limbic system or "old brain"—that part of the human system responsible for feeling and sensing (Kalat, 2017). It is this response that leaves the person nearing end-of-life on their own—to contend with death anxiety, existential isolation, their abandoned self, and their struggles with the surface mind. Unless practitioners develop an awareness of it and cultivate ways of overcoming it, this fear response can create one of the biggest obstacles to engaging fully with someone who is dying.

Supporting Dignified Endings-to-Life Through "Mindful Engagement"

The first stage of being more open and present to people nearing end-of-life is developing awareness at an intellectual level. This alone, however, is unlikely to result in significant changes to behaviour. There is a key difference between understanding the obstacles outlined above and having the presence of mind to act differently in each situation. The latter requires a mindful moment-to-moment awareness. This is the focus of this final section. Much of that which is mentioned hereafter is uncomplicated. However, it is the implementation of these practises that requires continued effort and integration of this way of being.

"Mindfulness" has made a significant impact on healthcare provision over the past 20 years. It can be described as focusing attention in a definite, purposeful manner in the present moment, without judgement (Kabat-Zinn, 1990). It advocates for living in the "Now" as opposed to ruminating over the past and worrying about the future. It is about letting go of the thinking, doing, active mind—when we do not need it—and coming into the present moment. Being present with someone who is nearing end-of-life in a mindful way is a simple but effective psychosocial intervention that all staff can provide, and such practises have been shown to reduce distress and enhance self-care within palliative care teams (Orellana-Rios, Radbruch, Kern, 2017). "Mindful Engagement" of this nature can help practitioners in supporting patients with the process of accepting death and making meaning within the process of dying, which have been shown to be very important (Tomer, Eliason, & Wong, 2007; Wong, 2007, 2009, 2010, 2012; Wong & Tomer, 2011). It begins with being present to the self.

There are two key features to developing a mindful approach. The first is a formal mindfulness meditation practise that enables people to focus their attention in a meditative way on the present moment (Kabat-Zinn, 2018; Segal, Williams, & Teasdale, 2018). The second

involves living each moment, or as much as is possible, in a mindful manner. In practise, the latter involves noticing worrying or daydreaming and refocusing on whatever is being done “now”, even if that is doing nothing. Both are important features of engaging in life in a more mindful way, and both would benefit those working with people nearing end-of-life. Some practises and considerations that may help practitioners with this process are discussed below. These may consequently enable nurses to be more present to those nearing end-of-life.

This final section proposes that these simple mindfulness practises can serve as an important first stage to engaging in a more complete way with people who are nearing end-of-life. This mindful engagement gives the foundation for providing patients with what Rogers (1957) called the core conditions for growth: (1) congruence (realness or genuineness); (2) unconditional positive regard (caring and acceptance); and (3) accurate empathic understanding (capturing and understanding the subjective world of another individual). We propose that the former helps the practitioner to provide the latter, and both together support patients in reintegrating abandoned parts of self and making the necessary shift to the deep mind, both of which make the process of dying more whole.

Punctuate the Day with Mindful Pausing

Often, practitioners are not fully present to patients because they are thinking about things they have done or things that they have to do. The more that this constant stream of thinking can be broken, and practitioners come into the moment, the more that patients will experience them as being more present. In service of this, one intervention is to break up the day as regularly as possible with a mindful pause. This can be easily done by taking a number (e.g., 1-3) of slow deep breaths. The key point is remembering to do it. It is helpful to develop a means of remembering initially and to routinely bring mindful pausing into each day. Nursing staff might do it before starting ward rounds, between different patient rooms, or between meeting each patient. Ideally, the practitioner would pause between each activity. Through doing so, each activity is started from a place of awareness and stillness and can be done with more presence in the “Now”. It can be helpful to start with a set number of times a day and build it up accordingly.

Being Present to the Self: The BBET Check

The BBET (Behaviour, Body, Emotions, Thoughts; Figure 4) check is something that can help nurses to become more self-aware. It can help them to determine how they are feeling so that they can notice how their state of being may impact the patients they work with. Figure 4 presents questions and considerations that nurses can put to themselves to facilitate this. While practitioners may need to bring this to mind very consciously at the outset, once used to doing it, it is possible to scan through the four areas with more ease. It can be useful to do this when travelling to work and at regular intervals throughout the day, especially when moving from administrative activities to working with patients. Once the practitioner is aware of their own process, it is less likely that they will give mixed signals to the patient or that their anxiety will stifle the interaction in some way. Being more present to the self gives rise to being more present to the patient.

Behaviour	First, notice how you are acting. Is your walk quick and pressured or balanced and paced? Are you fidgety and restless or more relaxed? Are you trying to do a number of things at once or are you more focused and tempered?
Body	Second, fall still and do a quick scan of your body, particularly around the temples, chest, and stomach. Observe any sensations. Is there any tightness around the temples? Is there any strong feeling in your chest? Or do you notice anything about your stomach?
Emotions	Third, pay attention to how you are feeling. The sensations you've picked up on will give you lots of information about whether you may have any anxieties, fears, or worries; whether you are feeling a bit low or drained; or if your being is relatively calm.
Thoughts	Lastly, allow your attention to observe your thoughts and what it is that may be preoccupying you. You may find that you are still worrying about something that happened earlier in the day. It can be useful to leave the thoughts until last as often we pay less attention to the other components.

Figure 4. Becoming more mindful of the self: The BBET Check.

A Going Towards

The previous section considered how a fear of death can result in a fight, flight, or freeze response within the practitioner. This may lead to greater distance between, or a “moving away” from someone nearing ending-of-life. This moving away may not be in an obvious physical sense, but the internal response may result in communication signals from nursing staff that are registered by the patient, who may end up feeling isolated as opposed to connected and supported. It is important for practitioners to become aware of this fear response within themselves and use it as a source of information so as to limit the effect it may have on patients. Once aware of it, it is less likely to have a negative impact on the patient.

Once this anxiety is noticed, it may be useful for nurses to ask themselves the types of questions listed in Figure 5. Sometimes, even though much of the practitioner is present, some part may wish to leave (e.g., that part that is reminded of the brother they lost to cancer, whom the patient reminds them of). It is important for nurses to actively bring awareness to the part of them that wants to leave so that they can remain present when they are with the patient. It can be helpful to revisit this at a later point (e.g., with a colleague at coffee break, or in supervision). Promoting reflective self-care of this nature and making it okay for nurses to be open and honest about this part of their experience is important. As described below, clinical supervision can be very helpful in this regard as it helps practitioners to become their own internal supervisor whereby they regularly reflect on these issues.

Once the practitioner notices that sense of retreat that is being driven by fear, it is important to overcome it and engender a sense of “going towards” (the patient). Being mindful of the present moment can help in this regard. Through doing so, the practitioner becomes aware of their own thoughts and feelings without getting drawn into them or acting unconsciously as a result of them. Focusing attention on the breath as it moves in and out of the nostrils helps in building this awareness. The breath also serves as a point of anchoring—whatever else should arise, the breathing is constant. Lastly, giving focused attention to the patient facilitates the practitioner in discerning what is required in each moment.

One caveat of note concerns the fact that there will always be occasions whereby the message being communicated to the practitioner by their fear response is to avoid “going towards” with good reason. An example might be where they have had a recent bereavement and are not yet ready to return to the frontline. It is for this reason that it is important for palliative nurses to be aware of themselves within their work so they can establish what any “urges to leave” (the patient) may be about. The more mindful practitioners are and the greater awareness of themselves they develop, the more able that they become at doing this.

How am I today about meeting this patient?
Am I anxious in any way?
Does any part of me want to leave?
What is it about this patient’s situation that is a little different for me?

Figure 5. Questions to the self to aid “going towards” with awareness.

Adding a Being-Ness to the Doing-Ness

In becoming more present to the self and to the patient, the practitioner is endeavouring to connect with greater awareness. It is one of the least intellectually demanding or procedurally complex therapeutic interventions, and yet is often missed because it requires access to the deep mind—something many people are unaccustomed to doing. It requires surrendering control, slowing down, being okay with uncertainty or not understanding, being comfortable with not being able to “fix” or “cure”, and being less solution-focused. In this way, the authors have viewed this type of intervention “as being both everything and nothing”. From such a place, the practitioner can better meet someone nearing end-of-life.

In doing this, it is necessary to “meet the person for the first time every time”. Practises of this nature have been highlighted by the most experienced of mindfulness practitioners, including Mullhall (2010). While it is important to hold all of the information that is known about a particular patient, it is equally important that this information does not cloud an interaction with them. This approach encourages nurses to let go of what they know about the patient in each moment and meet them afresh every time. This helps in being fully present. It is about holding both perspectives and using each at the right time.

Sometimes, it is difficult to know what to say to someone who is dying. This paper argues that the manner in which something is said is as important as what is said. It is okay to say the “wrong” thing. Saying the “wrong” thing while being fully present may be better than saying nothing or little. The patient is likely to feel more isolated and alone in the case of the latter, whereas there is plenty space for connection and engagement with the former. It is also the case that filling the space with mindless chatter, because it is too difficult to tolerate the silence, may have a similar effect. Finally, it is important to remember that the manner in which a nurse listens to the patient may be far more important than what they say.

Use of Clinical Supervision

In addition to moment-to-moment mindfulness, clinical supervision can further support the development of this awareness. In Frankl’s (1959) terms, the supervisor helps the supervisee to

extend their field of perception so that a deeper range of meaning and values is brought into awareness. Addressing this issue, Henoeh, Strang, Browall, Danielson, and Melin-Johansson (2015) explored healthcare professionals' existential issues when caring for patients with cancer. The authors reported a gap in knowledge regarding how oncology staff support patients' existential wellbeing, as well as how they deal with their own feelings of powerlessness and identification with patients. Professionals were found to better understand patients' emotional and existential reactions, such as sorrow and thoughts of death, following discussion and reflection in clinical supervision. Staff recognised that they did not have to provide answers to patients' existential questions. Clinical supervision is a vehicle for hospice nurses to grapple with their own existential issues, and subsequently support patients through theirs. It offers staff a time to accommodate all aspects of their experiences, and an opportunity to understand the complexities of working with serious illness and dying. Self-care and awareness of this nature have been found to support professionals in coping with death and protect against compassion fatigue and burnout (Sanzo et al., 2015).

Conclusion

In reading this article, some practitioners may experience a sense of resistance. An initial thought may be something like, "I don't have time for all this pausing and slowing down. The demands are just too high, and there's just too much to do." This is a very valid point. In this modern era of health economics, meeting targets and continuous pressure to increase efficiency places excessive demands on many healthcare practitioners. However, it is also the case that this resistance may be coming from the surface mind—that part that doesn't want to slow down, because slowing down may lead to inhabiting a way of being that may initially feel uncomfortable, strange, or unfamiliar. This paper asks practitioners to consider this resistance—and try overcoming it—for a reasonable period and observe the effects of doing so on the self and on patients. Most interactions with people who are dying may not change very much from an external perspective. Nurses will continue doing all the things that they have always done (e.g., giving an injection, checking their temperature, chatting about the weather)—only with greater awareness. Being mindful of the self and the patient will help in making decisions about what is needed "Now" within providing that care. Through engaging with greater presence, there is an increased likelihood that a patient will share something or some part of themselves that is important for them to share. Someone nearing end-of-life will notice this presence, even if at a very unconscious level. This increases the likelihood that the practitioner will notice when someone wants to have such a moment, however brief, and they will be there to catch it. This is the period whereby within talking about the weather, a patient tells a brief story about the child that was lost at the beginning of their marriage, or the guilt they have over never accepting their eldest daughter's partner, or any other multitude of stories in this vein. In this way, change or healing occurs within the interaction as a result of a change within the practitioner. This is why some staff more than others regularly get told special stories or more intimate sharings—often, these nurses are those who are more naturally present to those they care for. For many practitioners, however, it is something that requires more mindful consideration.

References

- Ainsworth, M. D. S. (1968). Object relations, dependency, and attachment: A theoretical review of the infant mother relationship. *Child Development, 40*(4), 969-1025. <https://doi.org/10.2307/1127008>
- Bowlby, J. A. (1988). *Secure base: Parent-child attachment and healthy human development*. New York, NY: Basic Books.
- Casement, P. (1992). *Learning from the patient*. New York, NY: Guilford Press.
- Chochinov, H. M., & Cann, B. J. (2005). Interventions to enhance the spiritual aspects of dying. *Journal of Palliative Medicine, 8*(1), 103-115. <https://doi.org/10.1089/jpm.2005.8.s-103>
- Chochinov, H. M., Hack, T., Hassard, T., Kristjanson, L. J., McClement, S., & Harlos, M. (2002). Dignity in the terminally ill: A cross-sectional, cohort study. *Lancet, 360*(9350), 2026-2030. [https://doi.org/10.1016/S0140-6736\(02\)12022-8](https://doi.org/10.1016/S0140-6736(02)12022-8)
- Chochinov, H. M., & McKeen, N. A. (2011) Dignity therapy. In H. M. Chochinov, & N. A. McKeen (Eds.), *Handbook of psychotherapy in cancer care* (pp. 79-88). Chichester, England: Wiley.
- Frankl, V. E. (1959). *Man's search for meaning*. New York, NY: Washington Square Press.
- Henoch, I., Strang, S., Browall, M., Danielson, E., & Melin-Johansson, C. (2015). Development of an existential support training program for healthcare professionals. *Palliative and Supportive Care, 13*(6), 1701-1709. <https://doi.org/10.1017/s1478951515000632>
- Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain and illness*. New York, NY: Random House.
- Kabat-Zinn, J. (2018). *Falling awake: How to practice mindfulness in everyday life*. New York, NY: Hachette Books.
- Kalat, J. (2017). *Biological psychology* (13th ed.). Boston, MA: Cengage Learning.
- Kearney, M. (1996). *Mortally wounded: Stories of soul pain, death, and healing*. Dublin, Ireland: Mercier.
- Kolb, B., & Wishaw, I. Q. (2015). *Fundamentals of human neuropsychology* (7th ed.). New York, NY: Worth Publishers.
- Kristjanson, L., Chochinov, H. M., Hack, T., McClement, S., & Harlos, M. (2002). Dignity in the terminally ill: A developing empirical model. *Social Science and Medicine, 4*(3), 433-443. [https://doi.org/10.1016/S0277-9536\(01\)00084-3](https://doi.org/10.1016/S0277-9536(01)00084-3)
- Marlock, G., Weiss, H., Young, C., & Soth, M. (2015). *The handbook of body psychotherapy and somatic psychology*. Berkeley, CA: North Atlantic Books.
- McClement, S. E., & Chochinov, H. M. (2006). Dignity in palliative care. In E. Bruera, I. Higginson, C. von Gunten, & C. Ripamonti (Eds.), *Textbook of palliative medicine* (pp. 100-107). New York, NY: Arnold.
- Mindell, A. (2014). *The leader as martial artist: Deep democracy leadership in conflict resolution, community building and organisational transformation*. Portland, OR: Deep Democracy Exchange.
- Mullhall, S. (2010, April). *Philosophy and relationships: How to enjoy relationship with everyone*. Presentation at the School of Philosophy and Economic Science Spring Lecture Series, Cork, Ireland.
- Orellana-Rios, C. L., Radbruch, L., & Kern, M. (2017). Mindfulness and compassion-oriented practices at work reduce distress and enhance self-care of palliative care teams: A mixed-method evaluation of an “on the job” program. *BMC Palliative Care, 17*(1), 79-89. <https://doi.org/10.1186/s12904-017-0219-7>

- Pessin, H., Fenn, N., Hendriksen, E., DeRosa, A. P., & Applebaum, A. (2015). Existential distress among caregivers or professionals taking care of dying patients. *Current Opinion in Supportive and Palliative Care*, 9(1), 77-86.
<https://doi.org/10.1097/SPC.0000000000000116>
- Rogers, C. R. (1957). *On becoming a person*. Boston, MA: Houghton Mifflin.
- Sanso, N., Galiana, L., Oliver, A., Pascual, A., Sinclair, S., & Benito, E. (2015). Palliative care professionals' inner life: Exploring the relationships among awareness, self-care, and compassion satisfaction and fatigue, burnout, and coping with death. *Journal of Pain Symptom Management*, 50(2), 200-207.
<https://doi.org/10.1016/j.jpainsymman.2015.02.013>
- Segal, Z. V., Williams, M., & Teasdale, J. (2018). *Mindfulness-based cognitive therapy for depression* (2nd ed.). New York, NY: Guilford.
- Shaver, W. A. (2002). Suffering and the role of abandonment of self. *Journal of Hospice and Palliative Nursing*, 4(1), 46-53. <https://doi.org/10.1097/00129191-200201000-00015>
- Strang, S., Henoeh, I., Danielson, E., Browall, M., & Melin-Johansson, C. (2014). Communication about existential issues with patients close to death-nurses' reflections on content, process and meaning. *Psycho-Oncology*, 23(5), 562-568.
<https://doi.org/10.1002/pon.3456>
- Tomer, A., Eliason, G. T., & Wong, P. T. P. (2007). *Existential and spiritual issues in death attitudes*. New York, NY: Erlbaum.
- Walsh, R., & Vaughan, F. (1993). On transpersonal definitions. *Journal of Transpersonal Psychology*, 25(2), 199-207. Retrieved from https://shenjiva.com/1036_69_Articles_On-transpersonal-definitions.pdf
- Wong, P. T. P. (2007). Meaning-management theory and death acceptance. In A. Tomer, G. T. Eliason, & P. T. P. Wong (Eds.), *Existential and spiritual issues in death attitudes* (pp. 65-87). New York, NY: Erlbaum.
- Wong, P. T. P. (2009). Existential positive psychology. In S. J. Lopez (Ed.), *Encyclopedia of positive psychology* (Vol. 1, pp. 361-368). Oxford, UK: Wiley Blackwell.
- Wong, P. T. P. (2010). Meaning therapy: An integrative and positive existential psychotherapy. *Journal of Contemporary Psychotherapy*, 40(2), 85-93. <https://doi.org/10.1007/s10879-009-9132-6>
- Wong, P. T. P. (2012). The meaning mindset: Measurement and implications. *International Journal of Existential Psychology and Psychotherapy*, 4(1), 1-3. Retrieved from <http://journal.existentialpsychology.org/index.php/ExPsy/article/view/181/143>
- Wong, P. T. P., & Tomer, A. (2011). Beyond terror and denial: The positive psychology of death acceptance. *Death Studies*, 35(2), 99-106. <https://doi.org/10.1080/07481187.2011.535377>
- Yalom, I. D. (1980). *Existential psychotherapy*. New York, NY: Basic Books.
- Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York, NY: Basic Books.