Author for correspondence: Sheng-Yu Fan, Institute of Gerontology, College of Medicine, National Cheng Kung University, No.1, University Road, Tainan City 701, Taiwan.
E-mail: shengyu@mail.ncku.edu.tw

Emotional and cognitive barriers of bereavement care among clinical staff in hospice palliative care

Wei-Chun Lin, M.SC., M.G.P.C.C.[1] and Sheng-Yu Fan, PH.D.[2]

[1]Department of Hematology and Oncology, Chi Mei Medical Center, Liouying, Tainan, Taiwan and [2]Institute of Gerontology, College of Medicine, National Cheng Kung University, Tainan, Taiwan

Abstract

Objective. Bereavement care is one of the major components of hospice palliative care. Previous studies revealed the barriers to the success of the system, including lack of time or support from mental health professionals. Few studies have explored the intrapersonal barriers to bereavement care by clinical staff. The aims of the study were to explore (1) the emotional and cognitive barriers of bereavement care by hospice palliative care staff and (2) the demographic and work characteristics related to these emotional and cognitive barriers.

Method. The participants were clinical staff ($n = 301$) who were working in hospice palliative care units, including hospice wards, home care, and hospital-based palliative care teams. Their professional backgrounds included physicians ($n = 12$), nurses ($n = 172$), social workers ($n = 59$), psychologists ($n = 34$), spiritual care specialists ($n = 15$), and others ($n = 9$). A cross-sectional design was used and a standardized questionnaire including emotional and cognitive barriers was developed. Information on demographic and work characteristics was also collected. Content validity index, an exploratory factor analysis, and multiple regression analysis were conducted.

Results. One emotional barrier, "negative emotional reactions" (13 items, Cronbach's $\alpha = 0.92$), and three cognitive barriers, "lack of ability" (7 items, Cronbach's $\alpha = 0.85$), "belief in avoidance" (5 items, Cronbach's $\alpha = 0.86$), and "outcome expectancy" (4 items, Cronbach's $\alpha = 0.85$) were identified. Clinical staff who had higher working stress, lower self-rated ability for bereavement care, and higher negative impact from major life loss tended to have higher emotional and cognitive barriers.

Significance of results. Clinical staff should be aware of intrapersonal barriers to bereavement care. Educational programs should be developed to improve the ability to engage in bereavement care.

Introduction

Hospice palliative care addresses not only physical symptoms but also psychosocial needs for patients with terminal illnesses and their family members. Bereavement care is one of the major components of hospice palliative care (Hudson et al., 2012). When patients and family members recognize the approach of death, they may have anticipatory grief; after a patient's death, family members might experience a grief reaction and need time to adjust to their new lives (Stroebe et al., 2008). Clinical staff provide bereavement care for patients who received hospice palliative care and extents the care to after a patient's death.

Bereavement care is a facet of psychosocial care and all clinical staff should take responsibility for bereavement care (NICE, 2013). Both physicians (Lemkau et al., 2000; Boyatzis et al., 2003) and nurses (Chan and Arthur, 2009) agreed about the importance of bereavement care in clinical service. In a large sample survey ($n = 2,583$) of pediatric oncologists, 96% of participants agreed that bereavement care is part of good clinical care, and 82% sometime engaged in some type of bereavement care (phone calls, condolence cards, memorial services, family meetings, or referrals for counseling). Being female, an attending physician, and having worked longer in clinical practice were significantly related to active participation in bereavement care (Jensen et al., 2017). In a survey about perceptions of bereavement care by physicians and nurses in an acute setting in Hong Kong, 60.0% of participants reported that they wanted to take an active role in managing grief for relatives of terminally ill patients (Tse et al., 2006).

However, caring for patients with a terminal illness and their family members caused stress (Vachon, 1995; McCloskey and Taggart, 2010), and clinical staff may experience emotional and behavioral reactions (Katz and Genevay, 2002), even leading to burnout and compassion fatigue (Keidel, 2002). Compared to those who did not provide psychosocial support, clinical staff who provided psychosocial support to patients and/or families had higher levels of compassion fatigue and burnout (Slocum-Gori et al., 2013).

There were barriers for clinical staff providing bereavement care. Lack of time (Tse et al., 2006; Jensen et al., 2017), lack of knowledge and skills (Tse et al., 2006; McAdam and Erikson, 2016; Fan et al., 2017; Jensen et al., 2017), and lack of resources and professional support (Lemkau et al., 2000; Boyatzis et al., 2003; Jensen et al., 2017) were the most common barriers in surveys. Lack of adequate educational training was also an important barrier (McAdam and Erikson, 2016). However, the barriers came from not only the systems but also from intrapersonal factors.

Weiner and Cole (2004b) provided a conceptual framework for cognitive, emotional, and skill barriers to communicating about advance care planning. Emotional barriers were adverse emotional experiences in clinical communication, such as anxiety, sadness, anger, frustration, helplessness, shame, and guilty (Weiner and Cole, 2004b). Cognitive barriers were maladaptive beliefs. For example, patients generally do not want to discuss end-of-life issues, discussing relevant issues might reduce patients' hope, and the physicians must always have something to say when facing patients and family members (Weiner and Cole, 2004a).

Regarding emotional responses, 46.3% of pediatric oncologists were emotionally drained from working with dying patients and their families; 21.4% had a feeling of failure when a patient died; and 20.0% felt anxious when speaking with family members after the patient's death (Jensen et al., 2017). Compared with medical and radiological oncologists, palliative care physicians were significantly more likely to engage in active bereavement practices and had less sense of failure or anxiety speaking to family members after a patient's death (Chau et al., 2009). Qualitative studies also revealed that clinical staff had emotional responses to bereavement care (Wenzel et al., 2011; Walker and Deacon, 2016). Staff also thought about the appropriateness of management that whether they provided the right care. They were bereaved by the death of familiar patients and needed to grieve and express emotion (Saunderson et al., 1999).

Many studies surveyed the system barriers, such as lack of time and resources, or lack of professional support, but few studies explored intrapersonal factors related to cognitive and emotional barriers among physicians and nurses. For those providing bereavement care, such as physicians and nurse, it is necessary to explore attitudinal or other barriers — including general discomfort in discussing death and loss — and to develop educational training courses based on these results (Ghesquiere et al., 2014). Therefore, the aims of the study were (1) to explore the emotional and cognitive barriers when hospice palliative care staff provided bereavement care to patients with a terminal illness and their family members and (2) to identify the demographic characteristics and work variables related to these emotional and cognitive barriers.

Method

Study design

First, the potential items were developed from the literature review (Weiner and Cole, 2004a, 2004b) and the clinical experiences of the research team. Second, expert validity was tested. Six experts were invited, including one physician, two nurses, two social workers, and one psychologist. One expert had a bachelor's degree, and all the others had a master's degree or above. All of them had been working in hospice palliative care units for more than 15 years. These experts rated the appropriateness of the items. Third, the questionnaire was administrated to collect data from hospice palliative care staff from April 2015 to December 2015. Before beginning the study, ethical approval was obtained from the institutional review board at Chi Mei Medical Center (IRB number: 10302-L01).

Participants

The participants were clinical staff working in hospice palliative care units, including hospice wards, home care, and hospital-based palliative care teams. The staff included physicians, nurses, social workers, psychologists, and chaplains. The participants were recruited from hospice training courses about psychosocial care, bereavement care, and family dynamic facing death, held by a National Hospice Organization. The researchers explained the aims of the study and the clinical staff who were willing to participate completed the questionnaire.

Measures

Demographic and work characteristics

Demographic characteristics included age, sex, educational level, and material status. Working experience including years in medical care and hospice palliative care, self-rated working stress in hospice palliative care (5-points: 5 = extreme stress, 1 = no stress), self-rated confidence in ability to provide bereavement care (5-points: 5 = very confident, 1 = not confident at all), self-rated inner growth from hospice palliative care work (5-points: 5 = a great deal, 1 = not at all), experienced with major loss in life (yes or no), and the negative impact of major losses and the positive impact of major losses (5-points: 5 = a great deal, 1 = not at all).

Emotional barriers for bereavement care

Thirteen items were developed based on a literature review and experts' suggestions. The items started with: "When providing bereavement care for patients and family members, I would feel …." A five-point Likert scale was used to rate the level of impact of a certain emotional response on bereavement care (5 = very great and serious influence/impact and 1 = not at all).

Cognitive barriers for bereavement care

There were nineteen items related to cognitive belief. The participants rated the impact of certain cognitive beliefs on bereavement care using a five-point Likert scale (5 = very great and serious influence/impact and 1 = not at all).

Statistical analysis

Content validity index was calculated (Polit and Beck, 2006), and the items were modified based on the experts' suggestions. Exploratory factor analysis (Fabrigar et al., 1999) using principal axis factoring with oblique rotation was used to explore the core factors of the emotional and cognitive barriers. The items with low factor loading (<0.3) or cross-loading between two factors were deleted. The naming of the barriers was based on the meaning of the items. Cronbach's α was used to examine the internal reliability of the dimensions.

Multiple regression was used to explore the significant variables related to emotional and cognitive barriers. The predictors included age, gender, educational level, years working in medical care and hospice palliative care, working stress and inner growth, self-rated ability for bereavement care, and negative impact and positive impact of major life losses. Regarding professional

categories, because there were few cases of physicians, chaplains, and others, two categories were used: medical professionals, including physicians, nurses, and other professionals; and psycho-social professionals, including social workers, psychologists, and chaplains. Kruskal Wallis test was used to test the differences in the barriers between physicians, nurses, social workers, psychologists, chaplains, and others; and t-test was used to test the differences between medical and professionals.

All statistical analyses were performed with SPSS for Windows version 21.0 (IBM Corp., Armonk, NY, USA). A 2-tailed p-value of equal to or below 0.05 was considered statistically significant.

Results

Content validity index

The CVIs of emotional and cognitive barriers were 0.92 and 0.90, respectively. Based on the experts' suggestions, some minor revisions related to rhetoric were made.

Demographic characteristics of participants

A total of 343 potential participants were recruited. Of these, 42 who did not have any working experience in hospice palliative care were excluded. Therefore, 301 participants were included in this study. The mean age of the participants was 35.63 (SD = 7.13), 279 (92.69%) were female, 143 (47.51%) were single, and 148 (49.17%) were married. More than 60% had an undergraduate degree. Regarding professional categories, 57.14% was nurses, 19.60% was social workers, and 11.30% was psychologists. The mean length of experience was 10.66 years working in medical care (SD = 6.56) and 6.16 years in hospice palliative care (SD = 4.82) (see Table 1).

Factor analysis

Regarding emotional barriers, Bartlett's test of sphericity showed that there were correlations between variables ($\chi^2 = 2{,}077.45$, $p < 0.001$), and KMO was 0.930. Therefore, the data were suitable for factor analysis. Only one factor was extracted, and this factor was named "negative emotional reaction," and the extraction sum of squared loadings was 48.77% and the Cronbach's α was 0.92. The five most impactful emotional barriers were helplessness, frustration, anxiety and nervousness, sadness, and loss (see Table 2).

Regarding cognitive barriers, three items were deleted due to the cross-loading between different factors. Bartlett's test of sphericity showed that there were correlations between variables ($\chi^2 = 2{,}427.04$, $p < 0.001$), and KMO was 0.930. Therefore, the data were suitable for factor analysis. Three factors were extracted. The first factor included seven items related to bereavement care ability and was named "lack of ability." The second factor included five items related to the assumption of patients avoidance of bereavement issues and was named "belief in avoidance." The third factor included four items related to expectations for care outcome and was named "outcome expectancy." The extraction sum of squared loadings was 54.20% and the Cronbach's α of the three factors and total scale were 0.85, 0.86, 0.85, and 0.92, respectively. The six most impactful cognitive barriers were work loading, personal limitations, working alone, the feeling that skills can do nothing, lack of ability, and the responsibility to improve (see Table 3).

Table 1. Demographic and work characteristics of the participants

Variables	n (%)
Age	$M = 35.63$ (SD = 7.13)
Sex	
Male	22 (7.31)
Female	279 (92.69)
Marital status	
Single	143 (47.51)
Married	148 (49.17)
Separated and others	10 (3.32)
Professional categories	
Physicians	12 (3.99)
Nurses	172 (57.14)
Social workers	59 (19.60)
Psychologists	34 (11.30)
Chaplains/Spiritual care specialists	15 (4.98)
Others	9 (2.99)
Educational level	
Junior college	19 (6.31)
Undergraduate	193 (64.12)
Postgraduate	89 (29.57)
Work experience in medical care	$M = 10.66$ (SD = 6.56)
Work experience in hospice palliative care	$M = 6.16$ (SD = 4.82)

Demographic and work characteristics related to barriers

The results of Kruskal Wallis test showed that there was no difference between all clinical professionals in "negative emotional reactions" ($\chi^2 = 3.36$, $p = 0.645$), "lack of ability" ($\chi^2 = 11.08$, $p = 0.053$), "belief in avoidance" ($\chi^2 = 10.50$, $p = 0.062$), and "outcome expectancy" ($\chi^2 = 3.44$, $p = 0.633$). Then, the results of t-test showed that medical professionals had a higher score in "belief in avoidance" ($t = 7.18$, $p = 0.008$) than psychosocial care professionals. Therefore, two categories (medical vs. psychosocial professionals) were entered in the regressions.

For "negative emotional reactions," the significant predictors included work-related stress in hospice palliative care ($t = 3.42$, $p = 0.001$), self-rated ability for bereavement care ($t = -3.13$, $p = 0.002$), and negative impact ($t = 5.94$, $p < 0.001$) and positive impact from major life loss ($t = -2.54$, $p = 0.012$). For "lack of ability," the significant predictors included age ($t = -3.12$, $p = 0.002$), work-related stress in hospice palliative care ($t = 3.01$, $p = 0.003$), self-rated ability for bereavement care ($t = -2.24$, $p = 0.026$), and negative impact from major life loss ($t = 4.00$, $p < 0.001$). For "belief in avoidance," the significant predictors included having an undergraduate degree ($t = -2.40$, $p = 0.017$), inner growth from hospice palliative care ($t = -3.06$, $p = 0.003$), self-rated ability for bereavement care ($t = -2.20$, $p = 0.029$), and negative impact from major life loss ($t = 2.44$, $p = 0.012$). For "outcome expectancy," the significant predictors included age ($t = -2.75$, $p = 0.006$), work-related stress in hospice palliative care ($t = 3.24$, $p = 0.001$), and negative impact from major life loss ($t = 1.98$, $p = 0.049$) (see Table 4).

Table 2. Factor loading and internal reliability of emotional barriers

	Mean (SD)	Factor loading: negative emotional reactions	Cronbach's α
Total of scale	25.22 (6.60)		0.92
1. When providing bereavement care for patients and family members, I feel helpless.	2.31 (0.77)	0.78	
2. When providing bereavement care for patients and family members, I feel shame.	1.70 (0.72)	0.75	
3. When providing bereavement care for patients and family members, I feel lost.	2.08 (0.70)	0.74	
4. After providing bereavement care for patients and family members, I feel sorry.	1.96 (0.73)	0.74	
5. When providing bereavement care for patients and family members, I feel nervous or anxious.	2.16 (0.59)	0.71	
6. When providing bereavement care for patients and family members, I feel depressed.	1.85 (0.65)	0.71	
7. After providing bereavement care for patients and family members, I feel regret.	1.65 (0.69)	0.71	
8. When providing bereavement care for patients and family members, I feel guilty.	1.50 (0.64)	0.70	
9. When providing bereavement care for patients and family members, I have a desire to escape.	2.02 (0.83)	0.70	
10. When providing bereavement care for patients and family members, I feel frustrated.	2.26 (0.66)	0.65	
11. When providing bereavement care for patients and family members, I feel impatient or irritable.	1.77 (0.45)	0.65	
12. When providing bereavement care for patients and family members, I feel alone.	1.86 (0.81)	0.63	
13. When providing bereavement care for patients and family members, I feel sad.	2.11 (0.56)	0.60	

Discussion

This study explored the emotional and cognitive barriers for bereavement care among clinical staff in hospice palliative care. One emotional barrier, negative emotional reactions, and three cognitive barriers, lack of ability, belief in avoidance, and outcome expectancy were identified. In addition, the significant demographic and work characteristics related to those barriers were identified, including work-related stress in hospice palliative care, self-rated ability for bereavement care, and negative impact from major life loss.

Negative feelings in the bereaved included grief response. Providing bereavement care was a type of "emotional work" that they had to deal with not only in regard to the relatives of the deceased but also their own emotional wellbeing (Walker and Deacon, 2016). They had to be aware of patients' and family members' negative emotional responses and help them through the grief journey. Some staff anticipated negative impacts from addressing bereavement-related issues, such as the fear of inducing grief reactions among patients and family members and the fear of harming the doctor-patient relationship (De Vleminck et al., 2013).

Previous studies revealed that clinical staff were concerned about their ability to engage in bereavement care (McAdam and Erikson, 2016; Jensen et al., 2017). Bereavement care is one type of psychosocial care, which are not like medical care or treatments that have standardized procedures. Not knowing how to do this is one of difficulties in providing psychosocial care (Fan et al., 2017). Staff acknowledged a lack of experience and confidence and addressed self-imposed limits on their contributions to care (Walker and Deacon, 2016). The ability to engage in bereavement care includes knowledge, skill, and attitude. They needed to understand grief reactions, manage negative emotional responses, accept the grief reactions of patients and family members, and provide support. Furthermore, they needed educational training and support from psychosocial care professionals (Chan and Arthur, 2009).

Belief in avoidance involved assumptions about patients' and family members' reactions. Clinical staff assumed patients and family members did not want to discuss the issue (Weiner and Cole, 2004a). On the other hand, they worried that discussions related to bereavement would make patients and family members feel worse or cry. This unverified belief would be an excuse to avoid the relevant discussion or neglect relevant information and needs. Thus, staff did not provide appropriate care or follow-ups. Clinical staff thought that other healthcare professionals were better positioned to provide care, that patients or family member did not want to talk, or that it was the personal business of the patients or family members (De Vleminck et al., 2013).

A survey revealed that 33.5% of physicians and nurses did not have confidence in their ability to manage relatives' grief, and that their reasons for not taking action included the desire to leave the bereaved alone (25.0%) and the fear of hurting relatives (14.1%) (Tse et al., 2006). Personal discomfort about death and dying, reluctance to deliver bad and painful information, and perceptions of personal failures about end-of-life discussions made physicians avoid relevant issues (Granek et al., 2013). These cognitive beliefs would stop clinical staff from taking action or approaching patients and family members.

The outcome expectancy was that participants expected they could make the patients and family members feel better or reduce their grief responses. Clinical staff believed that it was their responsibility to help family members progress through grief because not expressing empathy after the patient's death might make family members feel abandoned (Jensen et al., 2017). This expectation would increase psychological burden when approaching patients and family members.

The participants who rated themselves as experiencing higher work-related stress in hospice palliative care, less ability for bereavement care, and having negative impacts from major life loss, tended to have higher emotional and cognitive barriers. Previous studies showed that nurses who held religious beliefs,

Table 3. Factor loading and internal reliability of cognitive barriers

	Mean (SD)	Factor loading			Cronbach's α
		Factor 1	Factor 2	Factor 3	
Total of scale	32.50 (8.57)				0.92
Factor 1: Lack of Ability	15.18 (4.30)				0.85
1. I cannot help patients and family members deal with grief properly because the workload was too heavy.	2.48 (0.99)	0.79	−0.11	−0.21	
2. Facing death makes me recognize my own personal limitations.	2.32 (0.84)	0.76	−0.08	0.03	
3. I think I am unable to help patients and family members deal with grief.	2.12 (0.78)	0.65	−0.02	0.17	
4. In my clinical work, I often need to deal with patients' and family members' grief alone.	2.29 (0.91)	0.59	0.09	0.03	
5. In bereavement care, the only things I can do are be caring company, and interview skills are useless.	2.16 (0.85)	0.55	0.13	0.12	
6. Sometimes, I think I "wish the patient pass away quickly."	1.99 (0.79)	0.48	0.14	0.06	
7. I think I cannot bear/handle too much discussion related to death.	1.80 (0.74)	0.47	0.08	0.13	
Factor 2: Belief in Avoidance	9.46 (2.82)				0.86
8. I think patients and family members do not want to discuss their grief and loss with medical staff.	1.85 (0.69)	−0.06	0.96	−0.14	
9. I think that it makes patients and family members sadder if medical staff take the initiative in discussing grief or loss with them.	1.91 (0.70)	−0.12	0.90	0.03	
10. I should not express grief in front of patients and family members.	1.83 (0.65)	−0.01	0.56	0.11	
11. I can provide no help to patients and family members who are experiencing grief.	1.97 (0.73)	0.37	0.49	−0.04	
12. I do not know how to deal with patients' and family members' crying in interviews.	1.89 (0.72)	0.17	0.43	0.23	
Factor 3: Outcome Expectancy	7.86 (2.51)				0.85
13. It is a failure if I cannot make patients and family members feel better.	1.79 (0.77)	−0.19	−0.03	1.01	
14. I have to reduce patients' and family members' fear, grief, and anger.	2.10 (0.79)	0.04	−0.07	0.79	
15. I must say something to relieve patients' and family members' grief.	1.94 (0.74)	0.06	0.05	0.70	
16. I should be able to provide clear answers to patients and family member when delivering bereavement care.	2.02 (0.72)	0.12	0.27	0.37	

positive attitudes toward the policy of bereavement care, and specialized training tended to have more positive attitudes toward bereavement care (Chan and Arthur, 2009). However, the results of this study also showed the importance of stress management, work ability, and recovery from personal loss.

Clinical staff members' stress may come from the responsibility of hospice palliative care, the workload in clinical care, or the lack of sufficient professional support from colleagues. Similar to previous studies (Tse et al., 2006; McAdam and Erikson, 2016; Fan et al., 2017; Jensen et al., 2017), perceptions of lack of ability made clinical staff avoid the relevant care. In addition, caring for dying patients and bereaved family members while witnessing their suffering may induce various emotional reactions (Walker and Deacon, 2016). Past major life loss caused negative impacts on clinical staff, and unsolved grief or loss experiences became barriers for approaching patients or discussing similar issues.

Professional category was not a significant predictor of the barriers; however, medical and psychosocial professionals have different training backgrounds and tasks in the medical team. Medical professionals may encounter a bereavement reaction when providing physical care. For psychosocial professionals, it is their main task to deal with patients' and family members' grief reaction and provide bereavement care. They may have different barriers and need different training programs.

Clinical staff should learn the relevant skills and prepare themselves to interact with terminally ill patients and their family members, as well as to provide bereavement care (Raymond et al., 2017). The foundation of an educational training program should be to foster expectations for external resources from mental healthcare professionals, reduce their workload, and understanding intrapersonal barriers. Clinical staff can engage in self-introspection to explore the barriers of providing bereavement care and try to overcome those barriers.

This study used a quantitative analysis method to explore the barriers of bereavement care. There are some limitations to this study. First, most of the participants were female and various kinds of professionals were recruited; however, medical professionals and mental health professionals may experience different barriers and need different training education. Second, the participants were interested in the course of psychosocial care and

Table 4. Summary of regression analyses: unstandardized coefficients (B) and 95% confidence interval

	Negative emotional reactions	Lack of ability	Belief in avoidance	Outcome expectancy
Age	−0.13 (−0.27, 0.02)	−0.16 (−0.24, −0.05)**	−0.05 (−0.12, 0.01)	−0.08 (−0.13, −0.02)**
Sex	−0.44 (−3.11, 2.22)	−0.35 (−2.13, 1.44)	−1.02 (−2.21, 0.18)	−0.49 (−1.58, 0.59)
Educational level				
Junior college	1.00 (ref.)	1.00 (ref.)	1.00 (ref.)	1.00 (ref.)
Undergraduate	−1.31 (−4.13, 1.51)	−0.46 (−2.36, 1.43)	−1.54 (−2.80, −0.28)*	−0.68 (−1.83, 0.46)
Postgraduate	−1.51 (−4.59, 1.57)	−0.77 (−2.84, 1.30)	−1.08 (−2.46, 0.30)	−0.61 (−1.87, 0.64)
Professionals categories				
Psychosocial professionals	1.00 (ref.)	1.00 (ref.)	1.00 (ref.)	1.00 (ref.)
Medical professionals	−1.32 (−3.22, 0.58)	−1.11 (−2.39, 0.17)	0.35 (−0.51, 1.22)	−0.26 (−1.03, 0.52)
Working years in medical care	−0.00 (−0.02, 0.01)	0.00 (−0.01, 0.01)	0.00 (−0.00, 0.01)	−0.00 (−0.01, 0.01)
Working years in hospice palliative care	0.01 (−0.00, 0.03)	0.01 (0.00, 0.02)	0.01 (−0.00, 0.01)	0.00 (−0.01, 0.01)
Working stress in hospice palliative care	1.77 (.75, 2.78)**	1.06 (0.37, 1.76)*	0.28 (−0.17, 0.74)	0.68 (0.27, 1.09)**
Inner growth from hospice palliative care	0.33 (−0.50, 1.16)	−0.40 (−0.96, 0.16)	−0.58 (−0.96, −0.21)**	−0.16 (−0.50, 0.18)
Self-rated ability for bereavement care	−1.86 (−3.03, −0.69)**	−0.89 (−1.68, −0.11)*	−0.59 (−1.11, −0.06)*	−0.10 (−0.57, 0.37)
Negative impact from major life loss	2.64 (1.77, 3.52)***	1.21 (0.61, 1.80)***	0.49 (0.09, 0.88)*	0.36 (0.00, 0.72)*
Positive impact from major life loss	−0.79 (−1.40, −0.18)*	−0.29 (−0.70, 0.11)	−0.12 (−0.39, 0.16)	−0.16 (−0.41, 0.08)

*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$.

might have high self-reflection or awareness of their psychosocial care work. Third, personal variables related to barriers needed comprehensive measurement, including the personal loss or work-related stress. Fourth, the initial items were reviewed by an expert panel for the concept of items and wording, but a pilot study was not conducted for demonstrating the acceptability of wording. Future studies can address the impact of barriers on clinical work, and the effects of educational training programs that aim to modify these barriers.

In conclusion, the barriers to bereavement care by clinical staff in hospice palliative care included not only negative emotions but also cognitive barriers. These cognitive barriers included lack of ability, belief in avoidance, and outcome expectations. In addition, the significant predictors were work-related stress, self-rated ability, and negative impact from major life loss.

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