Actitudes ante la muerte y factores relacionados de los estudiantes de enfermería en la comunidad autónoma de Catalunya

Montserrat Edo Gual

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Tesis Doctoral

Actitudes ante la muerte y factores relacionados de los estudiantes de enfermería en la comunidad autónoma de Catalunya

Facultad de Medicina y Ciencias de la Salud

Programa de Doctorado: Investigación en Salud

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DIRECTORES

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Dra. Cristina Monforte Royo

A mi familia, por todo lo que me han enseñado y por su apoyo incondicional durante estos años.

A Juan, por estar siempre ahí, por darme tiempo, espacio y comprensión, por creer en mí.

A los que ya no están, porque su ausencia no esconde su recuerdo.

Con todo mi cariño, gracias a TODOS por estar siempre a mi lado.

Cuando hayamos desaparecido no habrá nadie como nosotros, pero, por supuesto, nunca hay nadie igual a otros. Cuando una persona muere, es imposible reemplazarla. Deja un agujero que no se puede llenar, porque el destino de cada ser humano —el destino genético y neural— es ser un individuo único, trazar su propio camino, vivir su propia vida, morir su propia muerte.

No puedo fingir que no tengo miedo. Pero el sentimiento que predomina en mí es la gratitud. He amado y he sido amado; he recibido mucho y he dado algo a cambio; he leído, y viajado, y pensado, y escrito. He tenido relación con el mundo, la especial relación de los escritores y los lectores.

Y, sobre todo, he sido un ser sensible, un animal pensante en este hermoso planeta, y eso, por sí solo, ha sido un enorme privilegio y una aventura.

Oliver Sacks

De mi propia vida

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Me gustaría encontrar las palabras precisas que reflejaran lo que siento en estos momentos, para transmitirlas a todas las personas que me habéis acompañado a lo largo de la realización de esta tesis doctoral. Y probablemente la palabra es, GRATITUD. Sois muchos los que habéis compartido conmigo este proyecto, por lo que GRACIAS a TODOS.

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A modo de Prólogo

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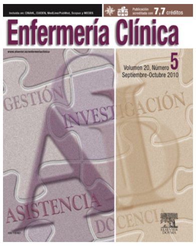

CARTA AL DIRECTOR

Afrontar el sufrimiento y la muerte: desafíos para el cuidado en el siglo XXI

Coping with suffering, dying and death: Challenges for care in the 21st century

Sra. Directora:

En la sociedad actual existe un progresivo envejecimiento de la población, lo que conlleva un incremento en la prevalencia de las enfermedades crónicas y su mortalidad asociada. En este contexto son necesarios profesionales de enfermería preparados en el ámbito de los cuidados paliativos, que puedan proporcionar la asistencia y bienestar adecuados. Las situaciones de muerte causan gran sufrimiento al paciente y a su entorno más cercano, sin olvidar el impacto emocional que producen en los profesionales de enfermería que los atienden. El contacto con el sufrimiento y la muerte es una de las experiencias relatadas como más estresantes por las enfermeras[1], ya que la muerte del otro les evidencia la certeza, irreversibilidad y universalidad de la muerte. Acompañar al paciente y a su familia al final de la vida puede actuar como un espejo que nos confronta con nuestra vulnerabilidad y nuestras pérdidas, tanto las de personas queridas como nuestra propia muerte, siendo frecuentes reacciones de miedo y ansiedad. Un reciente estudio con estudiantes de enfermería de nuestro contexto[2] muestra el importante impacto que produce la primera experiencia con la muerte durante las prácticas clínicas. Estos estudiantes también relatan la importancia de la formación en competencias socioemocionales para minimizar este impacto y poder proporcionar unos cuidados de calidad al paciente al final de la vida y a su familia. Son muchas las enfermeras que aún recuerdan la primera muerte que vivieron siendo estudiantes de enfermería o enfermeras recién tituladas, y a pesar de los años transcurridos, muchas podrían describir con detalle la cara de ese paciente, el aspecto del cadáver y los cuidados post mórtem, y es que, parece ser, que ese primer fallecido, «*nunca se olvida*»[2]. Aunque el recuerdo persista, la mayoría de las enfermeras logran gestionar sus emociones, sin embargo, algunas expresan tener miedo a «*sufrir demasiado*», a identificarse con el sufrimiento del otro, en definitiva, temen el contagio emocional, lo que puede favorecer la aparición de conductas frías y defensivas. En este sentido, un estudio[3] muestra reacciones defensivas y de autoprotección emocional en enfermeras de unidades de cuidados intensivos, ante la paradoja de seguir cuidando a pacientes, ya cadáveres, posibles donantes de órganos.

Por otra parte, el afrontamiento de situaciones difíciles como son la muerte y el sufrimiento, puede ser vivido como un estímulo para el crecimiento personal, al integrarlas, dotarlas de sentido e incorporarlas al propio sistema de valores. Mount et al.[4] lo denominan *healing connections*, explicando que son el resultado de encontrar sentido a situaciones de sufrimiento; son respuestas saludables, que permiten ser conscientes de la importancia de vivir el momento presente, la aceptación de que no lo controlamos todo o la necesidad de confiar en el proceso vital. En esta misma línea, Frankl[5] expone que la búsqueda fundamental del ser humano es encontrar sentido a lo que nos ocurre y dar significado a los eventos que nos rodean por difíciles que sean. Sin embargo, la sociedad actual tiende a huir del sufrimiento y la muerte, y evita afrontar las necesidades existenciales y espirituales, que si bien están presentes a lo largo de toda la vida, emergen si cabe, con mayor fuerza, en las situaciones de final de vida. Este es el gran reto para la enfermería en la sociedad actual: dar respuesta a estas necesidades existenciales, facilitar la búsqueda de sentido y encontrar sentido a todo lo que hacemos. Como expresa Torralba[6], hay enfermos y enfermedades incurables pero no incuidables, y es en este ámbito donde enfermería adquiere su rol esencial que es cuidar al otro en su totalidad. Además, la enfermera también puede encontrar sentido en los cuidados al final de la vida, ámbito en el que el sentido adquiere un valor especial y donde el éxito no reside en la curación, sino en la esencia de cuidar al otro de una manera excelente, dignificando su vida hasta el final. En este contexto el sentido puede estar en la relación dinámica y sanadora que se puede establecer entre el paciente y la enfermera, relación que puede facilitar una mejor integración de las pérdidas, con mayor control emocional, e incluso aceptando la muerte del otro como una experiencia de crecimiento.

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Y ahora…

Cuando pienso en mis años de trabajo como enfermera asistencial, los mejores recuerdos se remiten siempre a aquella época en que cuidaba de pacientes, adultos y niños, con patologías oncológicas. Con ellos compartí situaciones muy difíciles, de gran sufrimiento para ellos y también para su familia, a las que los profesionales intentábamos dar respuesta, en ocasiones con fármacos, y a veces, las más, humanamente. Pero también, paradójicamente, recuerdo haber vivido muchos momentos de gran serenidad y plenitud. Fue a lo largo de estos años en los que más aprendí a cuidar, no sólo a nivel profesional, sino, y sobre todo, a nivel personal. Cuidar a personas con enfermedades graves, especialmente cuando éstas evolucionan a fases terminales, ha sido para mí un privilegio. No quisiera mostrar una idea romántica del acompañamiento en el proceso de morir, ya que, en general, amamos la vida y, sin duda, nos cuesta dejarla, por lo que estas situaciones también se nos hacen duras y nos cuesta afrontarlas. Sin embargo, aprendí más en esta etapa profesional, que en todos los años de formación previa. Las palabras más sabias las he oído en boca de pacientes que estaban en situación de final de vida, tal vez porque en aquellos momentos emerge lo mejor de cada uno, porque quizás en estas situaciones solo hay tiempo para las cosas verdaderas, y uno no se entretiene en banalidades.

Frecuentemente, muchas personas de mi alrededor me han expresado no entender cómo podía realizar aquel trabajo, refiriéndose a la dureza de manejarse en estas situaciones, y tenía que explicarles que para mí no era un esfuerzo, que yo sentía que recibía mucho más de lo que daba. Puede resultar paradójico, pero recuerdo que cuando salía del trabajo, la mayoría de las veces, me sentía muy realizada, y en cierto modo muy llena de vida. Será porque la muerte tiene mucho que ver con la vida, porque forma parte de ella, y porque como enfermeras podemos hacer que el proceso de morir sea, a pesar del dolor que suscita, un camino más humanizado, y eso indudablemente, proporciona satisfacción y da sentido a nuestro trabajo.

Con el paso de los años, y a lo largo de mi experiencia docente con cuidadores y auxiliares, el ámbito de los cuidados paliativos siempre fue el tema con el que más me identificaba y disfrutaba, tanto durante su preparación como en su exposición en clase. Desde hace unos años he tenido la suerte de compartir con la Dra. Amor Aradilla la asignatura de Cuidados Paliativos de la titulación de Grado en Enfermería, además de impartir conjuntamente formación en este ámbito a profesionales de la salud en diferentes centros asistenciales. También en este contexto he vivido muchas satisfacciones, además de aprender de los alumnos, que con sus dudas y preguntas, me han retado continuamente a seguir formándome.

Y llegó el momento de plantearme el tema de estudio de esta tesis doctoral. Finalmente, he aquí el resultado: conocer las actitudes ante la muerte y factores relacionados de los estudiantes de enfermería catalanes. Este estudio me ha confirmado la necesidad y el reto que supone formar a los futuros profesionales de enfermería en este ámbito. Espero, con estos resultados empíricos, aportar una pequeña pieza al gran puzle del conocimiento en el ámbito de los cuidados enfermeros al final de la vida.

En la sociedad actual, valores como la juventud, la belleza, la productividad y el éxito, parecen ser los más valorados; sin embargo, la muerte, la vejez y la vulnerabilidad, también forman parte del mundo real, y son aspectos de los que no suele hablarse. Quizá el primer paso sería apostar por una pedagogía de la vulnerabilidad, que permitiera aceptarla como característica intrínseca del ser humano, aspecto que nos ayudaría a aceptar también nuestra condición de mortales. Es difícil acompañar al otro en procesos que uno previamente no ha reflexionado e integrado. Por ello, es fundamental la formación a las futuras enfermeras, capacitándolas mediante competencias socioemocionales que les faciliten cuidar de manera compasiva a personas en situaciones de alta vulnerabilidad. No es tarea fácil, por supuesto, ya que no se nos ha educado emocionalmente, pero, si todos entendemos que es necesario estudiar conocimientos teóricos y hacer prácticas de simulación para aprender a realizar técnicas y procedimientos, ¿por qué no hacemos lo mismo con el estudio y práctica de este tipo de competencias? Bimbela habla de practicar gimnasia emocional, nosotros hablamos, primero de conocer la evidencia científica, segundo, ponerla en práctica y aprender mediante metodologías experienciales y, finalmente, aplicar estas habilidades en el entorno asistencial.

Toda tesis supone mucho trabajo y esfuerzo, pero para mí es importante compartir que este trabajo lo he vivido y disfrutado más que sufrido, quizás porque he encontrado mucho sentido en poder aportar algunos conocimientos y ayudar, aunque sea muy humildemente, a los futuros profesionales de enfermería en el acompañamiento a personas en situación de final de vida y sus familias, ante el desafío que supone afrontar el sufrimiento y la muerte en este siglo XXI.

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ÍNDICE GENERAL

ÍNDICE

I. RESUMEN / ABSTRACT

RESUMEN

Las actitudes de los profesionales de la salud ante las situaciones de muerte y sufrimiento de los pacientes pueden influir en la calidad de los cuidados asistenciales. Las primeras experiencias relacionadas con la muerte durante las prácticas clínicas son uno de los eventos relatados como más estresantes por los estudiantes de enfermería. Desde el ámbito docente es necesario formar a estos futuros profesionales en estrategias de afrontamiento que les permitan gestionar de manera eficaz estas situaciones. Asimismo es importante utilizar instrumentos de medida que permitan evaluar las actitudes ante los cuidados al paciente en situación de final de vida y su familia.

Esta tesis doctoral pretende aportar datos empíricos sobre las actitudes ante la muerte y factores relacionados de los estudiantes de enfermería catalanes, mediante tres estudios. El objetivo del primer estudio fure profundizar en el conocimiento de la primera experiencia con la muerte de los estudiantes de enfermería. Los objetivos del segundo estudio fueron analizar las relaciones del miedo y ansiedad ante la muerte de los estudiantes de enfermería con la inteligencia emocional, la autoestima y la resiliencia, además de conocer el papel modulador de variables sociodemográficas, experiencias previas con la muerte y la formación en cuidados paliativos, en las actitudes ante la muerte. Los objetivos del tercer estudio fueron traducir, validar y analizar las propiedades psicométricas de la Frommmelt Attitudes Toward Car Of Dying (FATCOD), en estudiantes de enfermería españoles, y explorar las relaciones entre las actitudes ante el cuidado del paciente al final de la vida y su familia con las tres dimensiones de la inteligencia emocional (atención, claridad y reparación) y con el miedo y la ansiedad ante la muerte.

En los diferentes estudios participaron 772 estudiantes de enfermería de la comunidad autónoma de Catalunya. Una muestra de conveniencia de 12 estudiantes participó en un estudio cualitativo mediante entrevistas en profundidad. Por otra parte, 760 estudiantes en un segundo estudio, y de ellos 669 en el tercero, respondieron voluntariamente a un cuestionario anónimo que contenía variables sociodemográficas y escalas de medida de factores relacionados con los objetivos de los diferentes estudios. Las variables y instrumentos, en su versión española, utilizados en esta tesis fueron: miedo a la muerte (Collet-Lester Fear of Death Scale-CLFDS), ansiedad ante la muerte (Death Anxiety Inventory- Revised-DAI-R), resiliencia (Brief Resilience Coping Scale-BRCS), inteligencia emocional (Trait Meta-Mood Scale-TMMS_24), autoestima (Rosenberg Self-Esteem Scale-RSES) y actitudes ante los cuidados al paciente en situación de final y familia (Frommelt Attitudes Toward Care Of Dying- FATCOD-S).

Los principales resultados muestran que el primer contacto con la muerte de los pacientes durante las prácticas clínicas de los estudiantes, les produce un gran impacto emocional, destacando la necesidad de formación específica en competencias socioemocionales y comunicativas. Por otra parte, los resultados destacan que la atención emocional, la resiliencia y la autoestima son factores predictores de la ansiedad ante la muerte. Por último, los resultados sugieren que la FATCOD-S, en su versión española, presenta unas propiedades psicométricas adecuadas para su uso en estudiantes de enfermería españoles.

En conclusión, el contacto de los estudiantes de enfermería con situaciones de muerte y sufrimiento es una experiencia que les produce un gran impacto emocional, por lo que es importante conocer que estrategias de afrontamiento son las más eficaces, para favorecer unos cuidados asistenciales de calidad a la vez que minimizar su desgaste emocional. A su vez, cabe destacar que el uso de la FATCOD-S en el contexto de los estudiantes de enfermería españoles, puede proporcionarnos información importante sobre cómo estos futuros profesionales se relacionan con los enfermos y familias en situación de final de vida.

ABSTRACT

The attitudes of health professionals in situations of patient death and suffering can influence the quality of care provision. In this context, nursing students describe their first death-related experiences during clinical practices as one of the most stressful events. From the teaching environment, it is necessary to train these future professionals using coping strategies that enable them to effectively manage situations of suffering and death during their care practice. It is equally important to use measuring instruments to evaluate attitudes towards caring for a patient in an end of life situation and their family members to gain more knowledge about which situations produce the greatest discomfort.

This doctoral thesis intends to increase knowledge about the attitudes towards death and related factors held by Catalan nursing students by producing empirical data from three different studies.

The aim of first study was deepen insight into nursing students' first experience with death. The aims of second study were analyse how nursing students relate fear and anxiety towards death with resilient coping strategies such as emotional intelligence, self-esteem and resilience, further understand the modulating role of sociodemographic variables, prior experience with death and training in palliative care in attitudes towards death and dying. The aims of third study were: translate, validate and analyse the psychometric properties of the FATCOD scale and evaluate its reliability and validity in a sample of Spanish nursing students and explore the relationship between attitudes towards caring for dying patients and their family and the three dimensions of emotional intelligence (attention, clarity and repair) and the fear and anxiety towards death.

A total of 772 nursing students of the autonomous community of Catalonia participated in the different studies. A convenience sample of 12 students participated in the qualitative study through in-depth interviews. Furthermore, 760 students in the second study, of which 669 in the third, voluntarily answered an anonymous questionnaire containing sociodemographic variables and measurement scales of factors related to the objectives of

the different studies. The variables and instruments, in their Spanish version, used in this thesis were: fear of death (Collett-Lester Fear of Death Scale-CLFDS), death anxiety (Death Anxiety Inventory-Revised-DAI-R), resilience (Brief Resilience Coping Scale-BRCS), emotional intelligence (Trait Meta-Mood Scale-TMMS_24), self-esteem (Rosenberg Self-Esteem Scale-RSES) and attitudes towards patients in an end of life situation and their family (Frommelt Attitude Toward Care of the Dying-FATCOD-S).

The main results of the studies show that students' first exposure to death of a patient during clinical practice has a significant emotional impact and point to the need for specific training in the scope of palliative care, especially in terms of communication and socioemotional skills. Results of the second test highlight that emotional attention, resilience and self-esteem are predicting factors of death anxiety. Furthermore, students who had prior experiences with death and who have received training in palliative care display less fear and death anxiety. Finally, the results suggest that the Spanish version FATCOD-S contains suitable psychometric properties for use in Spanish nursing students.

In conclusion, exposure to situations of death and suffering is an experience that has a significant emotional impact on nursing students. It is therefore necessary to know what coping strategies are the most effective in order to provide them with the tools that enable them to give quality care and, at the same time, minimise their emotional stress. In turn, it should be noted that the use of the FATCOD-S in the context of Spanish nursing students can provide us with useful information on how these future professionals will interact with patients and their family in end of life situations.

II. ABREVIATURAS

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- BRCS	Brief Resilient Coping Scale
- CFA	Confirmatory Factor Analysis
- CLFDS	Collet-Lester Fear of Dying Scale
- DAI-R	Death Anxiety Inventory-Revised
- EOL	End of Life
- FATCOD	Frommelt Attitudes Toward Care Of Dying
- RSES	Rosenberg Self-Esteem Scale
- TMMS_24	Trait Meta-Mood Scale

1. INTRODUCCIÓN

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1.1. La vivencia de la muerte en la sociedad del siglo XXI

Aunque la muerte es un fenómeno natural e inevitable que forma parte del ciclo vital (Neimeyer, Wittkowski & Moser, 2004), en la mayoría de las personas suscita reacciones de miedo y ansiedad (Neimeyer & Van Brunt, 1995; Tomás-Sábado & Gómez-Benito, 2003; Gómez-Sancho, 2005), constituyendo la ansiedad ante la muerte, una de las causas fundamentales de toda ansiedad humana (Aries, 1999; Limonero Garcia, 1996). A lo largo de la historia, la muerte ha sido considerada una de las mayores amenazas para el hombre, aunque en la segunda mitad del siglo XX, esta amenaza parece haber sido reemplazada por la de la enfermedad. Los grandes avances científicos han contribuido a alimentar la idea de que la medicina tiene la potestad de librarnos de la muerte, en vez de aceptarla como el final natural de la vida y no como un enemigo a derrotar (Braun, Gordon & Uziely, 2010). Además, la convivencia con la muerte también ha evolucionado y ha pasado de ser un acto íntimo, vivido con la familia, hasta la actualidad, donde la mayoría de las defunciones tienen lugar en el medio hospitalario; así, en el último tramo de la vida, las relaciones personales del moribundo y la familia están fuertemente mediatizadas por las normas y reglas de las instituciones hospitalarias (Singer & Wolfson, 2003). Por ello, la muerte ha pasado de ser un acto de reconocimiento público (Gómez-Sancho, 2005), hasta una muerte ocultada, con *"un aceptable estilo a la hora de morir"* (Glasser & Strauss, 1968), donde el paciente no parezca que vaya a morir y así evitar el malestar al profesional que lo cuida (Benach & Pueyo, 2013). Probablemente, todos estos cambios han contribuido al alejamiento de la muerte de la cotidianidad en la que históricamente se ha desarrollado, favoreciéndose así su tabuización (Torralba, 1999; Lehto & Stein, 2009).

Por otra parte, en las últimas décadas, la esperanza de vida y el envejecimiento de la población han experimentado un considerable aumento en los países desarrollados, dando lugar a un incremento en la prevalencia de enfermedades crónicas y su mortalidad asociada (Gomez-Batiste, Espinosa, Porta-Sales & Benito, 2010; Gomez-Batiste *et al.*, 2012). Este contexto requiere un sistema de salud que proporcione cuidados paliativos dirigidos a mejorar la calidad de vida de los pacientes y familias que se enfrentan a problemas asociados a enfermedades que amenazan su vida, para aliviar y detectar precozmente el sufrimiento, así como tratar tanto el dolor, como los problemas físicos, psíquicos y espirituales, asociados a estas situaciones (Sepúlveda, Marlin, Yoshida & Ullrich, 2002). Para dar respuesta a esta necesidad, es necesario contar con profesionales específicamente formados en este ámbito, que aseguren el confort y cuidados de calidad a estas personas y familias en situaciones de gran vulnerabilidad (Cummings & Bennet, 2012). El afrontamiento del sufrimiento del paciente en situación de enfermedad avanzada, es uno de los objetivos y retos de enfermería, que entre otros, tiene el compromiso profesional de ayudar a la persona enferma a afrontar la enfermedad, otorgando una adecuada respuesta humana y aliviar el sufrimiento, siendo éste el núcleo del trabajo enfermero (Ferrell & Coyle, 2008).

En la actualidad, también debe considerarse el cambio de perfil en el nuevo usuario del sistema sanitario, con mayor educación sanitaria, y con un acceso fácil y rápido a información sobre salud mediante internet, además de una mayor implicación en la toma de decisiones y la demanda de una atención más personalizada (Centeno Cortazar & Nuñez Olarte, 1998; Nuñez Olarte & Guillen, 2001; Jovell, 2006). Todo ello supone un gran reto para la enfermería en la sociedad actual: dar respuesta a las necesidades del paciente y familia en situación de final de vida en una sociedad postmoderna, multicultural y tecnificada, donde la vivencia de la enfermedad y de la muerte tienden a ser evitadas (Goberna Tricas, 2004).

1.2. Actitudes ante la muerte: ansiedad y miedo a la muerte

En las últimas décadas, diferentes autores (Depaola, Griffin, Young & Neimeyer, 2003; Neimeyer *et al.,* 2004; Lehto & Stein, 2009) han estudiado las relaciones entre la ansiedad ante la muerte y diferentes variables, como el género, la edad, la profesión, la cultura o las creencias religiosas.

La *ansiedad ante la muerte* es un término utilizado para conceptualizar la aprensión generada por la conciencia de la propia muerte (Abdel-Khalek & Tomás-Sábado, 2005). El pensamiento y la conciencia de la propia muerte, que son características exclusivamente humanas, producen en todas las personas importantes reacciones de miedo y ansiedad (Limonero Garcia, 1996; Byock, 2002; Aradilla-Herrero, Tomás-Sábado & Limonero, 2007). Lehto y Stein (2009) exponen que la *ansiedad ante la muerte* es un constructo multidimensional relacionado con el miedo y la ansiedad derivados de la anticipación y conciencia de la realidad de la muerte y el morir, que incluye componentes emocionales, cognitivos y motivacionales, que varían según el desarrollo personal y las vivencias socioculturales.

Diferentes estudios (Neimeyer *et al*., 2004; Dunn, Otten & Stephens, 2005; Gama, Barbosa & Vieira, 2012) identifican la edad como una variable relacionada con la ansiedad ante la muerte, mostrando que las personas más jóvenes presentan unos niveles más altos de ansiedad y miedo a la muerte, probablemente relacionados con la falta de experiencia de pérdidas o fallecimientos próximos, y la falta de desarrollo de estrategias de afrontamiento eficaces. Análogamente, Fortner y Neimeyer (1999) observan que la ansiedad ante la muerte es más alta en las personas jóvenes, disminuye en la edad adulta, y se estabiliza en las personas mayores. No obstante, Kastenbaum (2000) expone que debemos ser cautos con estas interpretaciones, ya que la edad, *per se*, no es una variable predictiva para las actitudes ante la muerte.

En referencia al sexo, la mayoría de estudios (Depaola *et al.*, 2003; Neimeyer *et al*., 2004) coinciden en destacar que las mujeres presentan niveles más altos de miedo y ansiedad ante la muerte. Missler *et al.* (2011-2012), en un trabajo sobre la ansiedad ante la muerte en personas mayores, destacan que las mujeres presentan puntuaciones significativamente más altas que los hombres en relación al miedo a la muerte de los seres cercanos, y el miedo al dolor que pueda provocar su propia muerte a sus familiares más cercanos. Parece ser que el mayor miedo y ansiedad ante la muerte que expresan las mujeres es un fenómeno universal, y la hipótesis más aceptada desde una perspectiva expresivo emocional (Stillol, 1985), es que las mayores puntuaciones observadas, reflejan una mayor facilidad en las mujeres a admitir y expresar los sentimientos de preocupación, miedo y ansiedad que les puede generar la muerte.

Por lo que respecta a la relación de la ansiedad ante la muerte y la ocupación profesional, diferentes trabajos (DePaola, Neimeyer, Lupfer & Fiedler, 1992; Tomás-Sábado & Gómez-Benito, 2003) exponen que los profesionales de la salud no presentan mayor ansiedad ante la muerte que otros grupos poblacionales. Un estudio (Thorson & Powell, 1996) realizado con empleados de empresas funerarias y trabajadores de otros ámbitos, concluye que los primeros presentaban puntuaciones mucho más altas, interpretándose como que la continuada exposición y visualización de la muerte de aquellos empleados dificultaba la capacidad de disminuir sus miedos ante la muerte. Sin embargo, estudios más recientes (Harrawood, White & Benshoff, 2008; Harrawood, 2009) realizados en este mismo ámbito laboral, ponen de manifiesto que las puntuaciones de ansiedad ante la muerte de estos profesionales están más relacionadas con la presencia o no de espiritualidad y religiosidad, y no tanto con la propia profesión. Depaola *et al.* (1992), en un estudio realizado con profesionales de la salud, expone que el grupo control presentaba puntuaciones más altas en dos dimensiones de miedo a la muerte: miedo a la muerte y miedo a la muerte de los seres cercanos. En este sentido, Neimeyer *et al.* (2004) destaca que quizás no son tan importantes los niveles de ansiedad ante la muerte de los profesionales de la salud, sino cómo puede afectar esta ansiedad en sus actitudes ante situaciones de sufrimiento y muerte.

Por otra parte, parece evidente que las actitudes ante la muerte varían en las diferentes culturas. Diversos autores (Neimeyer, 1994; Mazanec 2003; Lehto & Stein, 2009) explican que las sociedades occidentales muestran, respecto a la cultura oriental, una mayor tendencia a protegerse ante la conciencia de la muerte, considerándola como un fenómeno excepcional, separado del natural orden de la vida (Schumaker, Barraclough & Vagg, 1988). También hay que considerar que los factores culturales influyen en la comunicación y la toma de decisiones entre el profesional, paciente y familia (Kagawa-Singer & Blackhall, 2001), factores que a su vez están muy relacionados con las actitudes ante la muerte, ya que pueden modificar la vivencia de estas situaciones. Un estudio realizado con estudiantes de medicina ingleses y sudafricanos (Lloyd-Williams, Dogra & Morake, 2003) muestra que estos últimos muestran actitudes menos positivas hacia el cuidado de los pacientes moribundos, y que se muestran menos partidarios de informar con veracidad al paciente sobre su pronóstico. Shrank *et al*. (2005) en un estudio cualitativo realizado mediante entrevistas semiestructuradas, obtienen diferencias en las preferencias sobre la información en situaciones de final de vida entre pacientes americanos no hispanos y blancos, y pacientes afroamericanos. Estos últimos, prefieren compartir y discutir más la información con la familia, amigos o líderes espirituales. Por otra parte, los no hispanos y blancos solicitan mayor información sobre las opciones de tratamiento y valoran en gran medida la calidad de vida, mientras que el otro grupo prefiere mayor apoyo espiritual y valora más las intervenciones para prolongar la vida, que la propia calidad de vida. Otros estudios (Neimeyer, 1994; Rooda, Clements & Jordan, 1999; Depaola *et al*., 2003) destacan la importancia de la etnia y la cultura en las actitudes ante la muerte, así como la influencia de las vivencias personales y sistemas propios de valores. Este aspecto es de suma importancia, ya que la vivencia de la enfermedad, el sufrimiento y la muerte, adquiere distintos significados según el entorno cultural (Kagawa-Singer & Blackhall, 2001). Así, los estudios en nuestro entorno (Nuñez Olarte & Guillen, 2001; Die Trill, 2003), evidencian que, en España, el modelo relacional *profesional-salud-paciente* predominante hasta la actualidad, ha sido el modelo paternalista. Siguiendo la teoría de los modelos relacionales de Emanuel y Emanuel (1992), en la actualidad, este modelo está evolucionando hacia un modelo informativo y/o deliberativo, donde el paciente adquiere cada vez mayor protagonismo y autonomía, tanto en la demanda de información como en la toma de decisiones. Todo ello supone un reto para los profesionales de la salud, que han de dar una respuesta adecuada a esta situación, debiendo desarrollar más competencias en el ámbito comunicativo y, de manera específica, en situaciones altamente complejas, como es el acompañamiento al paciente y a su familia, en situación de final de la vida.

Respecto a la relación entre la religión y la ansiedad ante la muerte, aunque parece asumido que la religiosidad tiene un papel importante como moderador de la ansiedad ante la muerte, las investigaciones hasta la fecha no muestra resultados consistentes. Dezutter *et al*. (2009), explican que las personas religiosas que creen en la vida después de la muerte, muestran actitudes de mayor aceptación, sin embargo, las personas que expresan la religión como creencia dogmática presentan mayor ansiedad ante la muerte. Otros estudios (Tomás-Sábado & Limonero, 2006; Edo-Gual, Tomás-Sábado & Aradilla-Herrero, 2011) realizados con estudiantes de enfermería, muestran que los estudiantes que se manifiestan creyentes, practicantes y con mayor grado de religiosidad, expresan menos miedo a la propia muerte, aunque, según parece, la religiosidad no parece disminuir el miedo al propio proceso de morir, más relacionado con aspectos como el sufrimiento físico y emocional. Asimismo, estos resultados muestran que la creencia y práctica religiosa no son factores protectores ante el miedo a la muerte de otros, lo que puede sugerir que la religiosidad es útil únicamente para el afrontamiento de la idea de la propia muerte. Braun *et al.* (2010), en un estudio realizado con enfermeras de unidades de oncología israelíes, relaciona sus actitudes ante la muerte y ante los cuidados del paciente al final de la vida con la religión, concluyendo que el miedo a la muerte puede variar, no sólo por la práctica de la religiosidad, sino también según el tipo de religión. No obstante, otros estudios (Abdel-Khalek & Lester, 2009; Beshai & Lester, 2013) exponen que no existe correlación entre la ansiedad y miedo a la muerte y la religiosidad, por lo que serían necesarios más estudios en este ámbito.

1.3. Actitudes ante la muerte y enfermería

Las enfermeras desempeñan su actividad profesional en contacto permanente con el sufrimiento y la muerte ajena, de manera que, si el fenómeno de la muerte es importante para todas las personas, en el caso de enfermería lo es mucho más, ya que puede influir en la calidad del cuidado al paciente y familia al final de la vida (de Araújo, da Silva & Francisco, 2004; Zomorodi & Lynn, 2010). Asimismo, el contacto continuado de las enfermeras con personas en situaciones de sufrimiento emocional, aumenta el riesgo de desarrollar fatiga por compasión (Wright, 2004; Abendroth & Flannery, 2006; Sabo, 2006), como consecuencia del intenso esfuerzo emocional que comporta el cuidado prolongado de personas que sufren (McHolm, 2006). Diferentes estudios (Peterson *et al.*, 2010; Grafton & Coyne, 2012) muestran que el contacto continuado con el sufrimiento aumenta la prevalencia de estrés y burnout, provocando serias consecuencias, tanto en la salud física y psíquica del profesional, como en el cuidado al paciente, relacionadas sobre todo con una comunicación ineficaz y un distanciamiento en el trato.

Por otra parte, las enfermeras manifiestan dificultades en la interrelación con el paciente en situación de final de vida y con su familia (Schwarz, 2004; Deffner & Bell, 2005), expresando emociones de impotencia, ansiedad y tristeza (Cevik & Kav, 2012). Consecuentemente, con frecuencia desarrollan actitudes de afrontamiento y de aceptación desadaptativas ante la muerte de estos enfermos. En este sentido, Rooda *et al.* (1999), expresan que parece evidente que las actitudes hacia el cuidado de los enfermos en estado terminal son más negativas cuanto mayor es el miedo a la muerte que tienen las propias enfermeras. Braun *et al.* (2010), por su parte, en una muestra de enfermeras de oncología, confirman que las enfermeras que presentan mayor miedo a la muerte y conductas de evitación, muestran actitudes más negativas hacia el cuidado de enfermos al final de la vida. McVicar (2003) destaca que el afrontamiento de las necesidades emocionales del paciente en proceso de morir y de su familia, es una de las experiencias relatadas como más estresantes. No obstante, de acuerdo con Ferrell and Coyle (2008), este afrontamiento es una competencia necesaria del futuro profesional de enfermería, que debe contemplarse en los programas de formación (Skilbeck & Payne, 2003; de Araújo et al., 2004; Aradilla-Herrero, Tomás-Sábado & Gómez-Benito, 2012-2013).

1.4. Actitudes ante la muerte y estudiantes de enfermería

Los estudiantes de enfermería entran en contacto en sus prácticas clínicas con el sufrimiento y la muerte, debiendo desarrollar estrategias que le permitan afrontar, no solo los miedos del paciente y familia, sino también los suyos propios, ya que la muerte del otro confronta con la propia mortalidad (Walsh & Hogan, 2003; Costello, 2006). Diferentes estudios (Thyer & Bazeley, 1993; Timmins & Kaliszer, 2002; Burnard *et al.*, 2008), destacan que los estudiantes identifican como principales estresores, la muerte del paciente, el sufrimiento ajeno y la comunicación con la persona cercana a la muerte, además de explicar sentimientos de tristeza, frustración, culpa y miedo (Vargas, 2010). En esta línea, Benbunan-Bentata B, Cruz-Quintana, Roa-Venegas, Villaverde-Gutierrez y Benbunan Betata B.R (2007) destacan que la convivencia del estudiante de enfermería con la experiencia de la muerte y el proceso de morir es una de las vivencias relatadas como más impactantes y estresantes. Loftus (1998) detalla que en los diarios de prácticas que realizan los alumnos, los temas más recurrentes son la vulnerabilidad ante la muerte y la muerte súbita de los pacientes. Análogamente, los estudiantes expresan impacto ante la visión del cadáver y los cuidados postmortem, así como la necesidad de más formación en este ámbito (Terry & Carroll, 2008; Parry, 2011). Por otra parte, las actitudes de los estudiantes de enfermería ante la muerte también varían según el entorno sociocultural. Kao y Lusk (1997), explican la diferencia en los niveles de miedo a la muerte entre estudiantes americanos y asiáticos, destacando que estos últimos presentan más miedo al proceso de morir propio y mayor dificultad para comunicarse y relacionarse con el paciente en proceso de morir. En la misma línea, Abdel-Khalek y Tomás-Sábado (2005), en un estudio realizado con estudiantes españoles y árabes, exponen que los estudiantes árabes obtienen puntuaciones más altas de ansiedad ante la muerte. De manera similar, estudios realizados con estudiantes de enfermería en el ámbito anglosajón muestran estados de shock y malestar ante la inevitabilidad de la muerte, así como gran impacto ante la visión del cadáver (Kiger, 1994; Parry, 2011). Beck (1997), destaca que los estudiantes manifiestan miedo, tristeza, frustración y dificultad en la toma de decisiones en situaciones de acompañamiento a moribundos. Lillyman, Gutteridge y Berridge (2011), por su parte, en un estudio cualitativo, destacan las experiencias negativas relacionadas con la comunicación de malas noticias, las dificultades para interrelacionarse con el paciente y familia y el impacto que supone el rápido deterioro del paciente. Otros estudios (Vargas, 2010; De Oliveira, Da Silva Bretas & Yamaguti, 2007) realizados con muestras latinoamericanas identifican que los estudiantes de enfermería expresan sensaciones de pérdida, miedo y derrota ante la idea de la muerte, así como la importancia de escuchar, informar sin mentir y acompañar al paciente moribundo. También destacan sentimientos de tristeza, impotencia y culpa, así como miedo a hacer daño al tener que comunicar la muerte de un paciente (Da Silva Brêtas, De Oliveira & Yamaguti, 2006).

En el entorno cultural asiático, Huang, Chang, Sun y Ma (2010), exponen que los estudiantes de enfermería muestran un importante impacto ante la muerte del paciente, manifestando sentimientos de culpabilidad e incompetencia, así como el hecho de quedarse emocionalmente atrapados. No obstante, en este mismo estudio también explican sentimientos de autoafirmación, y que a pesar de las dificultades expresadas en el manejo de estas situaciones, los estudiantes percibían un aumento de su aprendizaje competencial. Análogamente, otros estudios (Shih, Gau, Lin, Pong, & Lin, 2006; Liu *et al.*, 2011) constatan que los estudiantes manifiestan sentimientos de sorpresa y resistencia ante la muerte, aunque acompañados por el compromiso profesional ante los cuidados del paciente en situación de final de vida.

En nuestro país, las actitudes ante la muerte de los estudiantes de enfermería han sido estudiadas por diversos autores. Algunos de ellos (Aradilla-Herrero *et al.*, 2012-13, Edo-Gual *et al*. 2011), destacan que el miedo a la muerte disminuye a medida que los estudiantes van avanzando en sus estudios, sobre todo en referencia al miedo a la muerte del otro (Aradilla-Herrero *et al.*, 2012-2013; Aradilla-Herrero, Tomás-Sábado, Gómez-Benito & Limonero, 2009; Edo-Gual *et al.*, 2011), justificando la necesidad de una formación específica en EOL care al inicio de los estudios de enfermería.

1.5. Estrategias de afrontamiento ante la muerte

En los últimos años se ha producido un creciente interés por parte de los investigadores hacia la llamada psicología positiva, que incluye diferentes conceptos relacionados con cualidades y actitudes psicológicas positivas. Diferentes autores (Seligman, Steen, Park & Peterson, 2005; Kobau *et al*., 2011), explican que este enfoque permite un afrontamiento más constructivo y saludable de las situaciones estresantes, entendiendo el afrontamiento como una acción proactiva, orientada al futuro y en la que el individuo adopta actitudes preparatorias antes de actuar reactivamente al estrés (Aspinwall & Taylor, 1997). En este contexto, conceptos como la inteligencia emocional, la resiliencia y la autoestima, están cada vez más presentes en la literatura sobre el acompañamiento al paciente y familia al final de la vida y son considerados como moduladores de las actitudes ante la muerte y el impacto que esta produce (Akerjordet & Severinsson, 2007; McAllister & McKinnon, 2009; Grafton & Coyne, 2012).

Salovey y Mayer (1990), definen la inteligencia emocional como un conjunto de habilidades que capacitan para percibir, comprender y regular las emociones propias y ajenas. Estos mismos autores diseñaron la Trait Meta Mood Scale (Salovey, Mayer, Goldman, Turvey & Palfai, 1995), una escala de rasgo de metaconocimiento emocional que contiene tres dimensiones: atención, claridad y reparación emocional. La atención emocional se refiere a cómo el individuo percibe las emociones y estados de ánimo, para poder responder a ellos adecuadamente. La claridad emocional se define como la habilidad para identificar y diferenciar las emociones y sus significados. Finalmente, la reparación emocional permite al individuo regular los estados de ánimo, modular las emociones negativas y mantener las positivas. Desde esta perspectiva, un estudio realizado con estudiantes de enfermería (Augusto Landa, Lopez-Zafra, Aguilar-Luzon & Salguero de Ugarte, 2009), muestra que la atención emocional se relaciona de manera positiva con el neuroticismo, y negativamente con la autoestima. Asimismo, Ramos et al. (Ramos, Fernández-Berrocal & Extremera, 2007) exponen que la claridad y la reparación emocional se relacionan positivamente con la autoestima y con la satisfacción de vida, y negativamente con los pensamientos rumiativos. Aradilla-Herrero *et al.* (2012-2013), por su parte, encuentran también que una mayor atención emocional se relaciona con más ansiedad ante la muerte de los estudiantes de enfermería.

En este contexto, la inteligencia emocional es considerada por diferentes autores (Bulmer- Smith, Profetto-McGrath & Cummings, 2009; de Araújo *et al.*, 2004) como un aspecto fundamental en la práctica enfermera, ya que la labor emocional es intrínseca a la relación humana que se establece en el acto de cuidar. Las enfermeras con una alta inteligencia emocional afrontan de manera más positiva las situaciones de muerte y sufrimiento (Hopkinson, Hallett & Luker, 2003; Augusto Landa, Lopez-Zafra, Berrios Martos & Aguilar-Luzán, 2008). Bailey, Murphy y Porock (2011), en un estudio cualitativo con enfermeras del servicio de urgencias, destacan que, a pesar del impacto que supone la muerte súbita de un paciente, las enfermeras con un correcto manejo emocional son capaces de prestar unos cuidados efectivos para intervenir positivamente en el cuidado al paciente y familia en situación de final de vida. Además, diferentes estudios (Aradilla-Herrero *et al.*, 2012-2013; Jack & Wibberley, 2013), sugieren la necesidad de formar adecuadamente en competencias emocionales a las futuras enfermeras, para afrontar más eficazmente y con un menor coste emocional, las situaciones de sufrimiento y pérdidas.

La resiliencia constituye otro constructo de considerable interés en el marco del estudio de estrategias de afrontamiento ante la muerte. Stephens, (2013) define la resiliencia como la capacidad de recuperarse y adaptarse después de haberse enfrentado a un evento psicosocial muy adverso, saliendo fortalecido y habiendo aprendido de la experiencia. Según Gillespie, Chaboyer y Wallis (2007), la resiliencia es un proceso dinámico de adaptación positiva, que puede potenciarse y modularse, constituyendo una capacidad útil para el profesional de enfermería, que debe afrontar, en su práctica diaria, múltiples situaciones adversas relacionadas con el sufrimiento y la muerte, a las que debe dar una respuesta constructiva a la vez que mantener su equilibrio emocional. Jackson, Firtko y Edenborough (2007), exponen que las enfermeras son testigos cotidianos de tragedias, sufrimientos y pérdidas por lo que las estrategias resilientes pueden serles muy útiles. Otros autores (Jackson *et al.*, 2007; Grafton, Gillespie & Henderson, 2010), concluyen que la resiliencia modula el impacto que producen las situaciones laborales adversas, disminuyendo la vulnerabilidad emocional de las enfermeras y mejorando los resultados de salud. Pines *et al.* (2014), en un estudio realizado con estudiantes de enfermería, muestran que la formación en estrategias resilientes ayuda a los futuros enfermeros en la resolución de conflictos interpersonales en su entorno laboral. Análogamente, un estudio cualitativo con una muestra de enfermeras noveles (Hodges, Keeley & Troyan, 2008) identifica como temas emergentes la necesidad de fomentar estrategias resilientes que protejan del estrés y la ansiedad generados por los acontecimientos imprevisibles e inesperados de la práctica asistencial. Hodges, Troyan y Keeley (2010), explican que la resiliencia es un factor protector frente al abandono profesional, ya que prepara para el afrontamiento de la realidad laboral, facilitando la respuesta positiva a los cambios y, favoreciendo la adaptabilidad al entorno.

Finalmente, en el marco de estudio de estrategias de afrontamiento ante la muerte, la literatura destaca también el concepto de autoestima. Diferentes autores (Taylor, Lerner, Sherman, Sage & McDowell, 2003; Lee-Flynn, Pomaki, Delongis, Biesanz, & Puterman, 2011), consideran la autoestima cómo un factor protector ante amenazas psicológicas y situaciones estresantes. Para Rosenberg (1965), la autoestima incluye el respeto hacia uno mismo, el sentirse digno y reconocer las propias limitaciones, así como la capacidad de crecer y mejorar. La autoestima también se relaciona con el mantenimiento de una buena salud mental y se considera un factor que contribuye a dar valor e identidad profesional al colectivo enfermero (Ohlen & Segesten, 1998; Lo, 2002;). Iacobucci, Daly, Lindell y Griffin (2013), en un estudio realizado con estudiantes de enfermería, destacan la relación entre la autoestima y la toma de decisiones éticas, subrayando el rol de la enfermera como abogado del paciente en situaciones de alta vulnerabilidad y en las que concurren conflictos éticos. De manera similar, Lee, Joo y Choi (2013), destacan que una adecuada autoestima favorece la comunicación asertiva y empática mejorando las interrelaciones con el paciente y familia, mientras que niveles bajos de autoestima se relacionan con menos recursos de afrontamiento y con la percepción de menor control ante situaciones de alta demanda emocional. Otros estudios (Olthuis, Leget & Dekkers, 2007; Edwards, Burnard, Bennett & Hebden, 2010), destacan el papel relevante de la autoestima durante las prácticas clínicas de los estudiantes de enfermería, ya que fortalece la relación terapéutica con el paciente. También desde la Terror Management Theory (Pyszczynski, Greenberg, Solomon, Arndt & Schimel, 2004), se postula que la autoestima actúa como un factor protector ante la ansiedad que produce la conciencia de la propia muerte (Schmeichel *et al.*, 2009).

1.6. Evaluación de las actitudes ante el cuidado del paciente al final de la vida y su familia. *The Frommelt Attitudes Toward Care of the Dying (FATCOD)*

Uno de los instrumentos más utilizados para evaluar las actitudes ante el cuidado del paciente moribundo y su familia es la Frommelt Attitudes Toward Care Of Dying (FATCOD, Form A) desarrollada por Frommelt (1991). Este instrumento está constituido por 30 ítems, con respuestas tipo Likert, con puntuaciones que van de 0 a 5 (ver anexo 5). Los ítems 1, 2, 4, 10, 12, 16, 18, 20, 21, 22, 23, 24, 25, 27, y 30 son ítems que puntúan positivamente. El resto de ítems son negativos. El rango de puntuación va de 30 a 150, y las puntuaciones más altas indican actitudes más positivas. Dos tercios de los ítems están relacionados con las actitudes ante el cuidado de las personas en situación de final de vida, y el tercio restante se refiere a los cuidados centrados en la familia del paciente moribundo. El instrumento original se diseñó para evaluar las actitudes de las enfermeras; posteriormente Frommelt (2003), modificó el instrumento diseñando la Forma B, para ser usada con personas cuidadoras de diferentes disciplinas. La escala ha sido traducida, adaptada y validada a diferentes idiomas, al japonés (Nakai *et al*., 2006) al sueco (Henoch *et al*., 2014) y al italiano (Leombruni *et al.*, 2014).

Nakai *et al.* (2006), validaron la FATCOD al japonés (FATCOD-Form B-J), identificando dos dimensiones después de realizar un análisis de componentes principales. Un factor que denomina FATCOD I (actitudes positivas ante el cuidado de paciente en situación de final de vida), con una consistencia interna (alfa de Cronbach) de 0.73, y el factor FATCOD II (percepciones ante el cuidado centrado en el paciente y familia) con un índice alfa de Cronbach de 0.65. La consistencia interna total de la escala FATCOD fue de 0.85.

Posteriormente, Henoch *et al*. (2014) adaptaron la FATCOD (Form A) al sueco, coincidiendo con Nakai (2006), en la identificación de dos dimensiones, con la excepción del ítem 24 que cambia de dimensión. El alfa de Cronbach de la versión sueca de la FATCOD I fue de 0.70 y de 0.57 para la FATCOD II. El coeficiente total de la escala FATCOD fue de 0.60. Los valores de alfa de Cronbach son inferiores a los de las subescalas y el total de la versión japonesa, por lo que Henoch *et al.* (2014) concluyen que la versión sueca de la escala debe usarse con reservas, ya que deben revisarse las propiedades psicométricas del instrumento en futuras investigaciones.

Más recientemente, Leombruni *et al*. (2014), han realizado un análisis de componentes principales para analizar la estructura factorial de la versión italiana de la FATCOD. Estos autores extraen cuatro factores, que, en su conjunto, explican el 37.2% del total de la varianza y son etiquetados como: compromiso emocional, percepciones sobre los cuidados al final de la vida, percepciones sobre los límites de los profesionales en los cuidados al final de la vida, y creencias y emociones sobre el proceso de morir. No obstante, la consistencia interna de la versión italiana de la FATCOD (Form B) es cuestionable, ya que los coeficientes de consistencia interna de las cuatro dimensiones propuestas, oscilan entre 0.72 y 0.11, con 0.68 para el total de la escala.

Aunque la escala FATCOD, ha sido utilizada en numerosos estudios en el ámbito de enfermería (Braun *et al.,* 2010; Dunn *et al.*, 2005; Iranmanesh, Dargahi & Abbaszadeh, 2008a; Lange, Thom & Kline, 2008; Mallory, 2003; Matsui & Braun, 2010), y en diversos entornos culturales, hasta el momento no ha sido aplicada en el contexto hispanohablante. Considerando la importancia de conocer las actitudes de los estudiantes de enfermería españoles ante los cuidados del paciente al final de la vida y su familia, parece conveniente adaptar y validar la FATCOD al contexto español y calcular sus propiedades psicométricas preliminares.

2. HIPÓTESIS Y OBJETIVOS

HIPÓTESIS Y OBJETIVOS

2.1. Hipótesis de los estudios cuantitativos

2.1.1. La edad, y el curso académico modulan las actitudes ante la muerte de los estudiantes de enfermería durante sus prácticas clínicas.

2.1.2. Las experiencias previas con la muerte y la formación en el ámbito de los cuidados paliativos, modifican las actitudes de los estudiantes de enfermería ante los cuidados del paciente en situación de final de vida y su familia.

2.1.3. Diversos aspectos de la psicología positiva influyen en un afrontamiento más eficaz de las situaciones relacionadas con la muerte y el morir en estudiantes de enfermería.

2.1.4. La versión española de la Frommelt AttitudesToward Care of the Dying (FATCOD), es un instrumento válido y fiable para evaluar las actitudes ante los cuidados del paciente al final de la vida y su familia en el ámbito de enfermería en poblaciones de habla hispana.

2.2 Pregunta de investigación del estudio cualitativo

¿Cómo es la vivencia del estudiante de enfermería respecto a la experiencia del primer contacto con la muerte durante las prácticas clínicas y desde su propio punto de vista?

2.3. Objetivo general

El objetivo de este trabajo es profundizar en el conocimiento de las actitudes, vivencias y estrategias de afrontamiento ante la muerte de los pacientes de los estudiantes de enfermería de la comunidad autónoma de Catalunya, durante sus prácticas clínicas.

2.4. Objetivos específicos

1. Explorar desde una perspectiva cualitativa, la experiencia de los estudiantes ante la muerte y el proceso de morir de los pacientes en el contexto de sus prácticas clínicas.
2. Analizar las relaciones del miedo y ansiedad ante la muerte con la inteligencia emocional, la autoestima y la resiliencia en estudiantes de enfermería.

3. Realizar la adaptación y validación de la Frommelt Attitudes Toward Care of the Dying (FATCOD), y evaluar su fiabilidad y validez en una muestra de estudiantes de enfermería españoles.
4. Confirmar la dimensionalidad de la FATCOD mediante el análisis factorial confirmatorio.
5. Explorar el papel modulador de ciertas variables sociodemográficas, las experiencias previas con la muerte y la formación previa en cuidados paliativos, en las actitudes ante los cuidados al paciente en situación de final de vida en estudiantes de enfermería.
6. Determinar las relaciones entre las actitudes ante el cuidado del paciente al final de la vida y su familia con las tres dimensiones de la inteligencia emocional (atención, claridad y reparación) y con el miedo y la ansiedad ante la muerte.

3. METODOLOGÍA

METODOLOGIA

Esta tesis se presenta en la modalidad de compendio de publicaciones. Los artículos que forman parte de la tesis son tres, dos de ellos publicados y uno en revisión. Adicionalmente, se presenta la publicación de una carta al Director.

El primer artículo, con título "*The impact of death and dying on nursing students: an explanatory model",* es un estudio cualitativo que profundiza en el conocimiento de la experiencia y vivencia de la muerte de los pacientes durante las prácticas clínicas de los estudiantes de enfermería.

El segundo artículo, bajo el nombre de *"Death attitudes and positive coping in Spanish nursing undergraduates. A cross sectional and correlational study"*, es un estudio cuantitativo en el que se analizaron las relaciones entre las actitudes ante la muerte, la inteligencia emocional, la resiliencia y la autoestima en una muestra representativa de estudiantes de enfermería de la comunidad autónoma de Catalunya.

Por último, en el tercer artículo titulado ***"****Spanish adaptation of the Frommelt Attitudes Toward Care of Dying Scale (FATCOD-S) in nursing undergraduates",* se ha realizado una adaptación transcultural, validación al español y estudio de la dimensionalidad mediante un análisis factorial confirmatorio, de la Escala de Evaluación de Actitudes ante los Cuidados del paciente al final de la vida (FATCOD) de Frommelt (Frommelt, 1991).

3.1. 1er Artículo: *The impact of death and dying on nursing students: an explanatory model.*

Este estudio publicado en Journal of Clinical Nursing [***Factor de impacto:*** 1.316 (2012); ***ISI Journal Citation Reports*®:** Nursing, posición 25 de 106 (1er cuartil)], fue realizado mediante metodología cualitativa, y explora la experiencia de los estudiantes de enfermería ante la muerte de los pacientes en el contexto de sus prácticas clínicas, desde su punto de vista y en su entorno social y cultural. Para ello se optó por un enfoque fenomenológico interpretativo sobre la experiencia de los estudiantes, utilizando el relato de esta vivencia para llegar a la comprensión e interpretación del fenómeno. Se realizó un muestreo de conveniencia, cuyos criterios de inclusión fueron que los estudiantes de enfermería hubieran vivido la experiencia de la muerte en su entorno de prácticas clínicas, y que no hubieran cursado la asignatura de *Cuidados Paliativos* o similar. Finalmente la muestra estuvo constituida por 12 estudiantes. Los datos se recogieron mediante entrevistas en profundidad.

En una primera fase se realizaron y analizaron nueve entrevistas, con las que se alcanzó la saturación de los datos, sin embargo, se realizaron tres entrevistas más para corroborar los datos y verificar que no surgieran nuevos temas. Para el análisis de los datos se siguió el procedimiento de siete pasos de Colaizzi's (1978) para obtener los temas y subtemas emergentes. Durante el proceso de análisis se mantuvo una continua reflexividad, volviendo una y otra vez a los datos para evaluar su interpretación y la construcción del significado (Pyett, 2003). El análisis de los datos se realizó con la ayuda del software Atlas-Ti v7.

Para asegurar el rigor en la interpretación de los datos se realizó triangulación mediante varios procedimientos; durante la fase inicial de codificación en el análisis del contenido, los datos fueron confirmados de manera independiente por otro investigador. Los resultados finales con los temas y subtemas identificados fueron redactados a modo de resumen, y retornados a los participantes para su validación. Paralelamente, estos resultados también fueron evaluados por otro investigador ajeno al estudio. Por último, se realizaron tres entrevistas a estudiantes con los mismos criterios de inclusión que los de la muestra inicial, que nuevamente confirmaron los resultados.

La última fase de interpretación de los resultados, permitió identificar relaciones entre los temas emergentes que configuraron un modelo relacional explicativo del fenómeno del impacto que produce la muerte en estudiantes de enfermería.

Este artículo responde al primer objetivo específico de este compendio.

3.2. 2º Artículo: *“Death attitudes and positive coping in Spanish nursing undergraduates. A cross sectional and correlational study”*.

Este segundo estudio, publicado en Journal of Clinical Nursing [***Factor de impacto***: 1.233 (2013); ***ISI Journal Citation Reports***®: Nursing, posición 32 de 107 (2º cuartil)], estudia la relación entre las actitudes ante la muerte, la inteligencia emocional, la resiliencia y la autoestima en una muestra de estudiantes de enfermería. Asimismo, se analiza la relación entre las actitudes ante la muerte y la edad y curso académico. El estudio se ajusta a un diseño transversal y correlacional en el que la población de estudio fue una muestra representativa de los estudiantes de enfermería de la comunidad autónoma de Cataluña. Finalmente, la muestra estuvo constituida por un total de 760 estudiantes que accedieron a participar en el estudio. El criterio de inclusión fue que todos los estudiantes estuvieran matriculados en uno de los cuatro cursos de la titulación de Grado en Enfermería. Los estudiantes respondieron a un cuestionario autoadministrado que además de variables sociodemográficas (sexo, edad y curso académico), incluía instrumentos de medida para evaluar el miedo y ansiedad ante la muerte, la resiliencia, la inteligencia emocional percibida y la autoestima. Para ello se utilizaron las formas españolas de los siguientes instrumentos: Collet-Lester Fear of DeathScale [(CLFDS), Collet-Lester, 1969], Death Anxiety Inventory-Revised [(DAI_R),Tomás Sábado & Gómez Benito, 2005], Brief-Resilient Coping Scale [(BRCS), Sinclair & Wallston, 2004],Trait Meta-Mood Scale [(TMMS-24), Salovey *et al.*, 1995]) , Rosenberg Self-Esteem Scale [(RSES), Rosenberg, 1965].

Los datos fueron tabulados y analizados con el SPPS 21.0v para Windows. Además del análisis descriptivo de los datos se calcularon los índices de correlación de Pearson *r,* la *t* de Student y el análisis de la varianza (ANOVA). Por último, para determinar las variables que podían considerarse predictoras de las actitudes ante la muerte, se utilizó el análisis de regresión lineal múltiple, método *stepwise,* considerando la ansiedad ante la muerte como variable dependiente, ya que presentaba correlaciones altamente significativas con el resto de variables. Como variables independientes se eligieron aquellas que presentaban un coeficiente de correlación significativo (la resiliencia, las tres dimensiones de la inteligencia emocional y la autoestima). Los resultados de la regresión múltiple incluyen como variables predictivas la Atención emocional, la resiliencia y la autoestima.

Este artículo permite responder al segundo objetivo específico de este trabajo.

3.3. 3er Artículo: "Spanish adaptation of the Frommelt Attitudes Toward Care of Dying Scale (FATCOD-S) in nursing undergraduates"

Finalmente, en este último trabajo empírico se realizó la adaptación, validación y estudio de la dimensionalidad de la escala Frommelt Attitudes Toward Care Of Dying (FATCOD, Frommelt, 1991), en el ámbito de estudiantes de enfermería españoles. Además, se analizaron las relaciones entre las actitudes ante los cuidados del paciente en situación de final de vida y su familia, con variables sociodemográficas, experiencias previas con la muerte, formación en cuidados paliativos, actitudes ante la muerte y inteligencia emocional. El estudio se ajusta a un diseño transversal en el que la muestra final fue de 669 estudiantes de enfermería de 4 centros universitarios de Cataluña, seleccionados aleatoriamente mediante muestreo por conglomerados. Todos los participantes respondieron a un cuestionario autoadministrado que contenía datos sociodemográficos y la Frommelt AttitudesToward Care Of Dying (FATCOD). Asimismo, para analizar las relaciones de las actitudes ante los cuidados al final de la vida con las actitudes ante la muerte y la inteligencia emocional, también cumplimentaron las siguientes escalas en sus versiones validadas al español: la Escala de Miedo a la Muerte de Collet-Lester (CLFDS, Collet-Lester, 1969), el Inventario Revisado de Ansiedad ante la Muerte (DAI-R,Tomás Sábado & Gómez Benito, 2005), y la Escala de Inteligencia Emocional Percibida (TMMS-24, Salovey *et al.*, 1995). El criterio de inclusión fue que todos los estudiantes estuvieran matriculados en uno de los cuatro cursos de la titulación de Grado en Enfermería.

En una primera fase se realizó la traducción al español. Para ello, se realizó una traducción y una retrotraducción siguiendo las recomendaciones de las guías internacionales [International Test Comission (ITC), 2005]. En primer lugar se obtuvo la autorización de Frommelt (1991), la autora de la versión original de la escala. La FATCOD fue traducida de manera independiente del Inglés al Español por cuatro investigadores bilingües que estaban especializados en formación en EOL care, y uno de ellos era también experto en el ámbito de la psicometría. A continuación se analizó y comparó la traducción de cada ítem hasta lograr un consenso entre todos los investigadores. Por último, la versión preliminar fue enviada a una persona bilingüe para la retrotraducción. La retrotraducción se comparó con la versión original en inglés y los investigadores discutieron sobre los ítems finales para asegurar que la traducción era comprensible, hasta que se obtuvo la versión final española FATCOD-S. La escala se puso a prueba con una pequeña muestra de estudiantes españoles para garantizar su claridad y comprensión.

Seguidamente se analizaron los distintos modelos de la escala FATCOD (Frommelt, 1991; Henoch *et al.,* 2014; Leombruni *et al.,* 2014; Nakai *et al.,* 2006), y se realizó un análisis factorial confirmatorio del instrumento, utilizando el programa LISREL 8.8 (Jöreskog & Sörbom, 2006a) y el programa Prelis 2.8 (Jöreskog & Sörbom, 2006b). Finalmente se analizaron las correlaciones entre las variables sociodemográficas, experienciales y formativas con las actitudes ante el cuidado de pacientes moribundos, el miedo y ansiedad ante la muerte y la inteligencia emocional percibida. Los datos fueron tabulados y analizados con el SPPS 21.0v para Windows. Se realizó un análisis descriptivo de los datos y se calcularon los índices de correlación de Pearson *r,* la *t* de Student y el análisis de la varianza (ANOVA).

Este artículo responde al tercer, cuarto, quinto y sexto objetivos específicos.

4. ARTÍCULOS PUBLICADOS

4.1 Artículo 1: “The impact of death and dying in nursing students: An explanatory model”

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ORIGINAL ARTICLE

The impact of death and dying on nursing students: an explanatory model

Montserrat Edo-Gual, Joaquín Tomás-Sábado, Dolores Bardallo-Porras and Cristina Monforte-Royo

Aims and objectives. To explore nursing students' experiences of death and dying in clinical practice.

Background. The encounter with death constitutes one of the most stressful experiences reported by nursing students during their clinical training. In particular, it can be difficult for student nurses to cope with the patient's suffering, to provide postmortem care and to communicate with the patient and his/her family as death approaches. Although some research has been carried out in relation to this phenomenon, there remains a need to identify and understand the situations and experiences that are of most concern to students, those which may affect their ability to cope and, therefore, interfere with the care they are able to offer to the dying patient and his/her family.

Design. Qualitative descriptive and hermeneutic study.

Methods. Semi-structured interviews ($n = 12$) were conducted with nursing students. Data were collected in 2012–2013. Transcripts were analysed using Colaizzi's seven-step procedure.

Findings. The analysis identified five themes: impact, training in end-of-life care, ethical issues, coping and learning/growth/healing connections. The central theme was the enormous impact the encounter with death had, while the other themes were a response to and/or modulators of this impact. An explanatory model was derived on the basis of the relationship between all these emergent themes.

Conclusions. It is essential to understand nursing students' experience of death so as to minimise its impact. The explanatory model described here could be a useful tool for the design of training programmes on end-of-life care.

Relevance to clinical practice. Adequate training of this kind would help to ensure that future nurses offer high-quality care to patients and their families, minimising the impact of death and preventing emotional fatigue.

What does this paper contribute to the wider global clinical community?

- Specific training in end-of-life care should be offered at the start of nurse education through a combination of experiential and participatory methods.
- Adequate training of this kind would help to ensure that future nurses offer high-quality care to patients and their families, minimising the impact of death and preventing emotional fatigue.
- Further research is needed to assess the effectiveness of training programmes.

Key words: clinical training, coping, impact of death, nursing students, qualitative research

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Introduction

Although death is a natural and inevitable part of the life cycle (Neimeyer *et al.* 2004), people often respond to it with fear and anxiety. Indeed, a fear of death is one of the foundations of all human anxiety (Tomás-Sábado & Gómez-Benito 2003).

Several authors have highlighted how culture and beliefs may shape not only attitudes towards death in general (Neimeyer 1994, Rooda *et al.* 1999, Depaola *et al.* 2003) but also attitudes towards end-of-life (EOL) care, the breaking of bad news, decision-making and advance directives (Kagawa-Singer & Blackhall 2001, Die Trill 2003, Searight & Gafford 2005, Ngo-Metzquer *et al.* 2008). This is clearly relevant to the professional lives of nurses, as they constantly come into contact with death and the suffering of others (Bayés *et al.* 1999, Gray 2009) and this may influence their attitudes. A recent study on obstetric nurses' experience of perinatal death (Puia *et al.* 2013) found that this was an unforgettable event capable of producing anxiety when nurses themselves became pregnant. Research has also shown that nurses' continuous contact with the emotional suffering of others can increase their risk of developing compassion fatigue (Wright 2004, Abendroth & Flannery 2006, Sabo 2006) as a result of the intense emotional effort that is required to provide prolonged care in such cases (McHolm 2006).

Nursing students (NS) will encounter death and suffering during their clinical placements, and the death of a patient, the suffering of others and communicating with a person who is close to death are the main stressors they identify (Thyer & Bazeley 1993, Timmins & Kaliszer 2002, Burnard *et al.* 2008). However, as Ferrell and Coyle (2008) pointed out, being able to cope with the suffering of a dying patient and his/her family is a necessary competence for all nurses to acquire, and it is an aspect that needs to be addressed as part of nurse education programmes (Skilbeck & Payne 2003, De Araújo *et al.* 2004, Aradilla-Herrero *et al.* 2012-2013).

Background

Qualitative research conducted in the UK and USA has found that nurses experience shock and distress when faced with the inevitability of death and also that their first encounter with a dead body has a major impact (Kiger 1994, Parry 2011). Kent *et al.* (2012) noted that among NS this experience could produce ruminative thoughts and vivid memories for a long time afterwards. Another reported cause of anxiety among NS is having to provide postmortem care, especially as regards seeing and handling the body (Cooper & Barnett 2005, Parry 2011), tasks for which they lack preparation (Terry & Carroll 2008). Lillyman *et al.* (2011) found that breaking bad news, interacting with the dying patient and his/her family and the impact of seeing the patient deteriorate rapidly were all examples of emerging themes linked to negative experiences among NS. Another factor to consider is that the impact of death on NS may be heightened by the fact that many of them are in the final stages of adolescence, with its associated emotional burden (Jenkinson 1997).

Studies carried out with Latin American samples have found that NS report feelings of loss, fear and defeat when faced with death, but also that they regard listening, truth-telling and supporting the dying patient as important aspects (Vargas 2010). Research in this cultural context has also highlighted how NS may feel sadness, impotence and guilt, as well as a fear of doing harm when informing relatives of the patient's death (Da Silva Brêtas *et al.* 2006, De Oliveira *et al.* 2007). In a study of Argentinian NS, Mutto *et al.* (2010) found that they preferred to minimise their contact with dying patients so as to protect themselves from the emotional impact.

In the Asian context, Huang *et al.* (2010) found that the death of a patient had a considerable impact on NS, who reported feeling guilty, incompetent and trapped emotionally. However, the nurses sampled in this study also experienced self-affirmation, and despite the difficulties encountered in managing these situations, they felt their skills had increased as a result. In line with this, other studies (Shih *et al.* 2006, Liu *et al.* 2011) have found that while NS may experience surprise and a reluctance to let go in the face of death, this can be accompanied by a commitment to their profession and to caring for the dying patient.

This brief review of the literature highlights the importance of studying nursing students' encounters with death and dying in relation to their own social and cultural context, as only then will it be possible to identify and understand the situations and experiences that are of most concern to them and which may affect their ability to cope.

Methods

Aim

The aim of this study was to explore nursing students' experience of death and dying during their clinical training.

Design

An interpretative phenomenological approach was used to explore nursing students' experiences regarding the death of a patient. Based on their accounts of their experience, a reflexive hermeneutic process was followed to arrive at an understanding and interpretation of the phenomenon.

Sample

Participants were recruited through convenience sampling (Table 1) by three university lecturers who were not part of the research team. The main researcher then contacted the proposed students to arrange an interview. The inclusion criteria were that they had already experienced the death of a patient during their clinical placements but had not yet received any academic training on palliative care or similar topics and also that they were capable of speaking about their experience without this proving overly distressing (Hewitt 2007). The final sample comprised 12 students (mean age 23·5 years, ±5·2). Nine interviews were conducted and analysed during the first half of 2012 until data saturation was reached. A further three interviews were carried out during the first quarter of 2013 to corroborate the data.

Data collection

Interviews were carried out by the main researcher (ME), who was trained in data collection. Audio recordings were made of the semi-structured interviews, each of which was conducted in a normal university classroom. Steps were taken to ensure a quiet setting without interruptions, and each interview lasted between 60–90 minutes. The interviews were conversational, with the interviewer maintaining an attitude of openness and attentive listening so as to encourage spontaneity on the part of the interviewee (Hermanowicz 2002). A field diary was also used. At the end of the interview, the meaning of the data was clarified with the interviewee. The interview guide was drawn up on the basis of a prior literature review, but any additional themes that emerged during the interviews were also incorporated (Table 2). Data collection ceased when the saturation point was reached.

Data analysis

Data were analysed according to Colaizzi's seven-step procedure (Colaizzi 1978; Table 3). The entire process of obtaining results was based on hermeneutic circles, interpreting the whole in relation to its parts and the parts in relation to the whole, incorporating the contributions of deconstruction and reconstruction so as to arrive at an understanding of the narrative (McConnell-Henry *et al.* 2009). Data analysis was performed with the help of ATLAS.TI, version 7.

Ethical considerations

The study was approved by a university research ethics committee. All participants were informed that their responses were anonymous and that participation was voluntary. They all signed informed consent.

Rigour

The principal investigator took into account her own experience as a nurse educator, and during the study, she kept a diary record of the emotions and personal opinions that studying the phenomenon aroused in her (Malterud 2001). The relationship between the investigator and the students was considered to be exclusively research based, rather than a student–teacher type relationship.

Reflexivity was maintained throughout the process of analysis, returning time and again to the data. To verify

Table 1 Sample data

Code	No. of interview	Age	Year	Gender	University	Date of interview
P1	1	20	1	Female	1	1st half of 2012
P2	2	37	2	Female	2	1st half of 2012
P3	3	28	2	Female	2	1st half of 2012
P4	4	28	2	Female	2	1st half of 2012
P5	5	20	2	Female	1	1st half of 2012
P6	6	21	2	Female	1	1st half of 2012
P7	7	23	2	Female	1	1st half of 2012
P8	8	25	2	Male	2	1st half of 2012
P9	9	22	2	Female	3	1st half of 2012
P10	10	20	3	Female	1	1st quarter of 2013
P11	11	19	2	Female	1	1st quarter of 2013
P12	12	20	2	Female	1	1st quarter of 2013

Table 2 Interview guide, showing the questions put to participants

Do you remember what and how you felt when you first experienced the death of a patient? What do you think it was about the experience that made you feel that way?
What do you remember about the first time you had to provide postmortem care?
What do you think would have helped you during those first few moments after the patient died? And a few hours later?
Was there anything, or did anything happen, that you think made it more difficult for you to cope with the situation?
When people talk about 'a good death', does this make sense to you? How would you describe it? What is good about it?
When people talk about 'a bad death', does this make sense to you? How would you describe it? What is bad about it?
What do you think it would be useful for you to learn so as to be able to support and care for a dying patient and his or her family?

Table 3 Analysis: application of Colaizzi's seven-step procedure

1. Listen to the interview recordings several times, transcribe them, and then read and re-read the transcriptions, taking into account the information regarding non-verbal communication that accompanies the discourse.
2. Extract from each transcript significant statements related to the experience of death and dying.
3. Formulate meanings from these significant statements and apply a code to them (units of meaning). These codes should be verified by another researcher.
4. Sort the formulated meanings into categories or clusters.
5. Compare the different transcriptions and categories several times in order to identify any discrepancies and validate the results.
6. Identify and describe the fundamental structure of the phenomenon, its essence, the themes.
7. Present the transcripts and the results to the participants so that they can validate the findings.

that the data were accurate, the interview transcripts were sent to participants, all of whom expressed their agreement with the content.

The data were triangulated through various procedures. During the initial coding stage of the content analysis, the data were independently confirmed by a second researcher. The final results containing the themes and subthemes were summarised and given to participants for validation purposes. This was done by means of nine interviews, in which all the participants corroborated the results. Complementarily, these results were also assessed by another researcher who was not part of the study team. Finally, a further three interviews were conducted with NS who were recruited through the same inclusion criteria used for the original sample. These students also confirmed the results, and no new themes emerged from these interviews.

Findings

The data were first condensed into 31 categories that corresponded to statements of content in the transcripts. Through a process of abstraction and interpretation, these categories yielded 20 subthemes and, finally, five themes (Table 4).

Impact

The main theme that emerged in all the interviews concerned the enormous *impact* that the first experience of a patient's death had on the NS. This was described as an experience that *you never forget, it really sticks in your mind (P2) (00:04)*. This theme includes three subthemes (see Table 4).

Impact of what death implies. This impact was associated with feelings of impotence, frustration and anger, related to the irreversibility, universality, uncertainty and fear of the unknown that is produced by death:

> …But what I find really hard is the sense of impotence, that after death… and now what? The body is here, but it's not breathing, not speaking… what should I do? Is the person gone? We don't know why… that's it, it's all over, we've done everything we could… and that's how it ends? I don't know, it's… phew! (P4) (0:27)

Impact of seeing the dead body. Seeing the dead body and the associated physical changes is a reminder of human vulnerability and was described as making an enormous impact. Indeed, most of the students said that they still remembered the first time they saw the face of a dead body:

> It made a real impact on me when they put the body in a special bag… they closed it up and… phew, treating it as if it were just a body… but closing that bag, good grief, I think that's what really affected me, apart from seeing the person dead. (P1) (00:08)

Fear of emotional contagion. With respect to the patient's family, all the students said that the impact of the experience was even greater when witnessing the suffering of relatives, and they expressed a fear of emotional contagion:

> I felt really bad… the patient's daughters were more or less my age and… I don't know, you empathize, you put yourself in their shoes and then the experience becomes even more intense…. (P3) (00:14)

The students also said that the impact of death was modulated by the patient's age, it being greater the younger the person was. Similarly, a sudden death had a bigger impact

Table 4 Categories, subthemes and themes of qualitative content analysis

Categories	Freq.	%	Subthemes	Themes
Feeling uncertain	6	50·0	Impact of seeing the dead body	Impact
Feeling impotent	8	66·6	Impact of what death implies: fragility, irreversibility, finitude, certainty, etc.	
Feeling frustrated	7	58·3		
Being affected	12	100·0	Impact of not being able to talk about death	
Feeling sad	7	58·3		
Silence	3	25·0	Fear of emotional contagion	
Awareness of mortality	7	58·3		
Fear of suffering	9	75·0		
Not knowing what to say	12	100·0	Training in how to break bad news	Training in end-of-life care
Not knowing what to do	11	91·6	Training in managing your emotions	
Fear of doing harm	8	66·6	Training in postmortem care	
Confusion regarding knowledge about end-of-life treatments	5	41·6	Training in relation to palliative sedation and the concepts of euthanasia and withholding/withdrawal of life support	
Lack of awareness about physical changes to the dead body	8	66·6		
Attitudes of health professionals toward death	5	41·6	Ethical care Ethical dilemmas	Ethical issues
Unfinished business	11	91·6	Beliefs	
Emotional suffering	7	58·3	'Good' and 'bad' death: Being allowed to die	
Spiritual suffering	6	50·0		
Pain	11	91·6		
Being alone	6	50·0		
Doubts about what is needed	4	33·3		
Talking	12	100·0	Accepting death as part of life	Coping
Crying	4	33·3	Talking about death	
Sharing	9	75·0	Support from qualified staff	
Doing things for the patient and family	8	66·6	Being involved in patient care Beliefs	
Spirituality	6	50·0		
Enriching experience	10	41·6	Professional learning	Learning, growth and healing connections
Special experience	9	91·6	Personal learning: growth	
Privilege	6	58·3	Healing connections	
Acquiring knowledge	10	50·0		
Gaining experience	11	41·6		

than did a death resulting from a progressive illness. The impact was also greater when the relationship with the deceased had been more well established.

Training in EOL Care

This theme consists of four subthemes (see Table 4).

Training in managing your emotions. All the students said that they often did not know how to deal with the emotional reactions that emerged when providing care and support to the patient and his/her family, and they expressed a need to acquire competences that would facilitate the expression of emotion:

> What do you say to this person? How should I start the conversation so that they cry, shout… so that they get it all off their chest? Because I'm sure they feel angry… what do I do? What do I say to them? (P2) (2:1/1:86)

Training in how to break bad news. The students commented that intense emotions of this kind are particularly present when having to break bad news:

> When you have to break bad news … How to you go about it? Where do you find the words? … Seeing somebody breakdown in front of you and knowing that you have to cope with it … I think training is very important… (P2) (2:1/2:74)

Training in relation to palliative sedation and the concepts of euthanasia and withholding/withdrawal of life support. It also emerged that students did not really understand what was meant by palliative sedation, or the difference between euthanasia and the withholding or withdrawal of life support:

> There's a lot of confusion about these topics… I think more training is needed as that would also help with the dying process. (P4) (10:3)

Training in postmortem care. Most of the students commented that seeing how the dead body changed physically both surprised and affected them, and they highlighted the need for specific training that would enable them to talk more about death and to develop the skills required by EOL care:

> I didn't know that a dead person turns yellow so quickly, and that the body temperature … it drops really quickly… and of course, touching it… you realize that the body is heavy, that it's yellow and cold, but in fact very little time has gone by… (P9) (9:9 7 9:13)

> The theoretical training in this area didn't help me… what I found most helpful was a talk we had from a woman with cancer, how she feels about it all… (P9/2) (47′)

Ethical issues

This theme has four subthemes (see Table 4).

Ethical care. The students highlighted the importance of providing humane care and of treating the patient with respect and dignity, even after he or she has died:

> I tried to say my goodbyes to the patient… when he died, I tried to be there for the family… to be respectful, to say goodbye in my own way… removing the line, closing his mouth, and making him as presentable as possible for the relatives to see. (P5) (5:5/5:58)

Ethical dilemmas. In terms of ethical dilemmas, doubts emerged in relation to the practice of palliative sedation:

> Patients and relatives aren't given all the information they need… I think that if the family had had more knowledge they wouldn't have administered the sedation, and I also think it's important to listen to the patient, because maybe he wanted to be 'with it' right to the very end, rather than being so drugged up… (P11) (47′)

Beliefs. Beliefs and values was another subtheme that emerged. The students felt it was important to respond to spiritual needs and to respect the beliefs of the patient and family.

'Good' and 'bad' death: being allowed to die. A good death was characterised by the absence of pain, not feeling alone, being at peace, having dealt with any unfinished business and having said one's goodbyes:

> Leave the slate clean… if you have to ask somebody to forgive you, then do so, if you have to say something, then say it…sort out your differences, don't leave unfinished business… I think it's really important to bring things to a proper close, as it will help you to die in peace, it's like saying to yourself: 'now I've done all there was to do' … (P1) (1:58)

The students also said that 'being allowed' to die contributed to a good death, by which they meant that if both the patient and the family accept the process of dying, such that the patient is 'allowed to let go', then the passage is somewhat easier:

> Up to a point the person chooses who will be there when he dies… when he's allowed to die and to let himself do so, when both he and his relatives accept death … (P10) (45:5)

> I've seen patients who died once the relatives had left… they didn't want the family to see them suffer and die, and to a certain point they chose to die alone… and the family allowed that and took it well. (P9/2) (53′)

As regards a bad death, the students associated this with pain, distress, being alone and leaving unfinished business, not being able to 'close the book'.

Coping

This theme includes five subthemes (see Table 4).

Accepting death as part of life. One of the thoughts that students described as being most helpful concerned accepting death as part of the life cycle and keeping this in mind, as by doing so, it was possible to live a fuller life with greater awareness:

> Being at peace, content… satisfied with what you've done… this helps, and we all need to remember that just as we were born into this world, one day we will die… (P5) (01:02:12-8)

Support from qualified staff. They also said that the support of qualified staff was helpful, especially when this involved advice about what to do or reassurance:

> Being with a qualified member of staff… that they explain it to you with an air of calm…. that they help you and say to you, 'don't worry, it's not your fault, nor anybody's'… (P4) (00:14:17-1)

Talking about death. One of the things that most helped modulate the impact of death was being able to talk about it, as this facilitated the expression of feelings. Some of the students talked about it with a relative, while others shared their experiences with a placement tutor or with friends:

> ... I'd already spoken to my Mum on the phone, and by the time I got home I needed to explain everything, I needed to get it off my chest with somebody who would understand me. (P10) (37:00)

Being involved in patient care. The students also said that being able to provide care to the patient and family and/or being present at the time of death helped them to cope, as they then felt they had been useful:

> Spending longer with death, having been able to care for the patient, bathing him, being at his side... going through that experience helps, you can understand it more ... (P9/2) (45′)

Learning, growth and healing connections
This theme has three subthemes (see Table 4).

Personal learning: growth. All the students agreed that the encounter with death had been a learning experience that had made them more aware of their own vulnerability and of the importance of living life to the full:

> Having seen that it's such a thin line between life and death... I want to live my life more intensely... seek out what I like...fight for it... enjoy my friends, my family, my quality time... get the most out of the days and years, live intensely and enjoy life... because little separates life and death. (P1) (1:55-1:6)

Healing connections. Most of the students described their experience of the dying process as something that led to personal growth, as an enriching experience that brought them feelings of peace and/or well-being:

> Even though it's hard, I'm helping... and that comforts me... I think that I'm helping someone to have 'a lovely death'... whenever I think about the first time a patient died, I smile... it's not just a feeling of pity, there's also a smile, which seems like a contradiction, but that's how it is... I was moved, it was hard but at the same time it brought me peace... yes, it brought me peace. (P3) (00:55:22-7)

Professional learning. The students also said that they had learnt things from a professional point of view, in that they had acquired greater knowledge about the process of dying and the needs of patients and families. This kind of learning was highly valued by the students, as they recognised that the experience had not only increased their competences in this area, but had also helped them to modulate their own response to death.

Explanatory model

Having gathered these findings, the initial interviews were then analysed again so as to compare the results as a whole. This enabled us to identify relationships between the different themes and to derive an explanatory model (Fig. 1). The model is built around a central theme, namely the enormous *impact* that the first experience of patient death has, while the remaining themes appear as a response to, as needs of or as modulators of the impact. One of the outcomes of this series of events is learning and personal growth on the part of NS, and this can also modulate the impact that the death of a patient has.

Discussion

The results of this study show that the first experience of the death of a patient has a considerable impact on NS. Indeed, this is an event of enormous emotional significance that is never forgotten and which may have lasting effects, both personally and professionally (Rhodes-Kropf *et al.* 2005, Chen *et al.* 2006, Kent *et al.* 2012). The strength of the impact is likely related to the fact that the death of another person confronts us with our own fragility and mortality, as well as that of our loved ones, and it also serves as a reminder of the certainty and universality of death (Costello 2006, Lehto & Stein 2009, Peters *et al.* 2013). These results are important, because the way in which NS experience this first encounter with death will determine the kind of protective mechanisms they adopt, which in turn may influence their subsequent responses to grief (Gerow *et al.* 2010). It is also worth noting that our findings are consistent with those of studies conducted in non-Western cultures (Huang *et al.* 2005, Shih *et al.* 2006, Liu *et al.* 2011), suggesting that the death of a patient has a universal impact that bridges different cultural contexts and belief systems. Our results are also in line with previous research as regards the impact of seeing the dead body and helping with postmortem care (Johnson 1994, Cooper & Barnett 2005, Rhodes-Kropf *et al.* 2005, Parry 2011).

In line with previous research (Burnard *et al.* 2008, Warnock *et al.* 2010), one of the situations that our students reported as being particularly stressful was having to break bad news, an aspect that may be influenced by the difficulties health professionals have in sharing information and the decision-making process with patients. The interviews with students also highlighted a clear need for specific

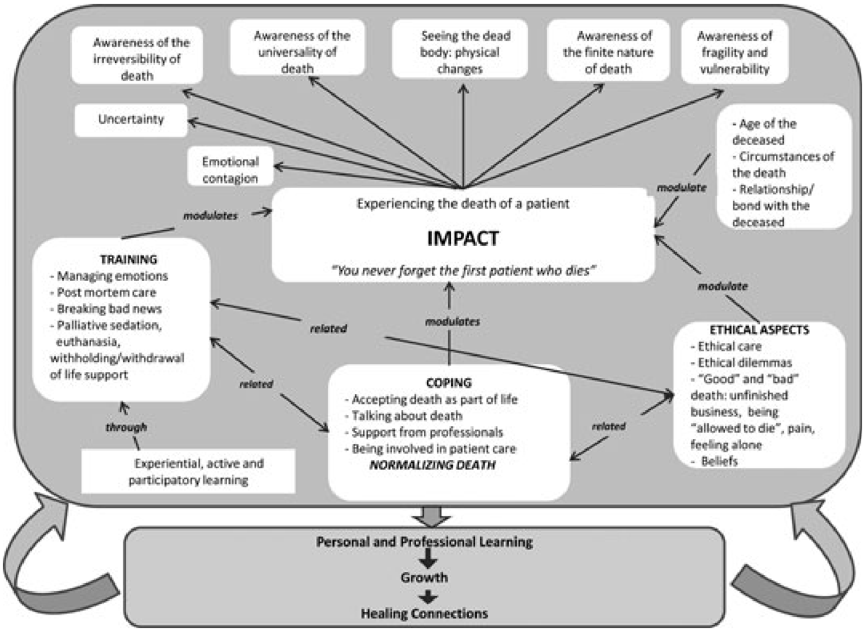

Figure 1 Explanatory model of nursing students' experience of death and dying during their clinical training.

training on communication skills and on managing emotions so as to foster a more therapeutic nurse–patient relationship (Tizón García 2007). Such training would help in terms of enabling more personalised care and avoiding emotional contagion, thereby reducing the likelihood of nurses suffering compassion fatigue (Najjar *et al.* 2009, Sabo 2011). Consequently, training in social and emotional competences could help them to develop the empathy and respect that are required in order to provide compassionate care (Adam & Taylor 2013).

In a recent literature review, Peters *et al.* (2013) highlight the need to establish EOL care programmes so as to reduce levels of death anxiety and compassion fatigue among nurses, and to provide future professionals with the skills they need to reduce the emotional toll of their work. In the present study, being able to talk about and share one's experiences was one of the things that NS felt most helped them to 'normalise' the death of a patient. In this context, Wong and Tomer (2011) refer to the need for a greater acceptance of death, which would include a deeper understanding of the meaning of life. According to these authors, talking about death facilitates learning and favours a more respectful and compassionate treatment of others. Although theories of coping have traditionally focused on the management of distress and negative emotions, Folkman (1997) suggested that it is also important to consider the role played by positive psychological states in coping with highly stressful situations. Example discussed by this author is the ability to find positive meaning in the stressful event. The results of our study support this idea, as the NS were better able to deal with the dying process when they saw it as a learning opportunity, one in which the care they gave was of help to the patient. They also stated that spiritual beliefs and practices could help both the nurse and the patient in the process of meaning reconstruction when facing the pain of a life that is ending (Depaola *et al.* 2003, Mount *et al.* 2007, Giske 2012). A further point of note is that, in their view, training on all the above issues should be based on experiential and active learning that is integrated around realistic scenarios.

With regard to ethical issues, our findings are in line with the literature suggesting that ethical dilemmas are common in the context of EOL care (Oberle & Hughes 2001, Ferrell 2006). As Oberle and Hughes (2001) pointed out, nurses must live with decisions made by doctors, patients and families, as well as with the uncertainty surrounding what is the best thing to do, and all this can create moral and emotional distress (Rietjens *et al.* 2007, Broeckaert 2011). Two of the issues that raised doubts among our NS concerned how much the patient should be told and the clinical justifications for the use of palliative sedation and how it differs from euthanasia. Also, within the ethical domain, all the students defined a 'good' death in terms that were consistent with the literature on this topic (Saunders *et al.* 2003, Shea *et al.* 2010). However, an aspect that has not previously been reported but which they felt contributed to a good death was ‘being allowed to die’, in the sense of both the patient and the family accepting that the former is going to die. In this context, they also mentioned the importance of dealing with any unfinished business, something which they felt was a key aspect of a good death.

Despite the impact that the first experience of death can have, all the students also spoke about a process of learning and growth. Various studies (Byock 2002, Huang *et al.* 2005, Wong *et al.* 2009) have suggested that having to face the reality of death can act as a stimulus to personal growth, as it enables the person to take on board difficult experiences, giving them meaning and incorporating them into a system of values. The learning and personal growth described by our students may be understood in terms of what Mount *et al.* (2007) called ‘healing connections’, which result from being able to find meaning or significance in suffering. Making healing connections means that the person discovers healthy responses to suffering, for example recognising the importance of the present moment, being able to let go and accepting that some things are beyond our control, such that we may be required to make a leap of faith or trust to fate. Of relevance here is the work of Viktor Frankl (1996), who argued that the fundamental task in human life involves the search for meaning, the ability to make sense of what happens to us. In the context of caring for a patient who has reached the end of life, meaning may lie in the dynamic and healing relationship that can be established between patient and caregiver (Mount *et al.* 2007).

Finally, mention should be made of the explanatory model derived from the results of this study. The model relates the impact of death to an awareness of the universality, irreversibility and uncertain nature of this event. Previous research has noted how the contact with death reminds us of our own mortality and may heighten death anxiety (Byock 2002, Neimeyer *et al.* 2004). The major impact of the first experience of death has also been described by other authors who highlight the need for training on this issue (Huang *et al.* 2010, Kent *et al.* 2012, Whyte *et al.* 2013), especially the need for EOL training to address ethical matters and to teach coping strategies and ways of managing emotions (Ferrell *et al.* 2005, Whittaker *et al.* 2006, Aradilla-Herrero *et al.* 2012-2013). We believe that our explanatory model provides a useful basis for the design of such training programmes, which need to ensure not only that student nurses develop the competences required to provide EOL care to patients and their families, but also that they are equipped to cope with the impact that their clinical responsibilities can have and that they become capable, therefore, of facilitating a patient-centred death (Clark 2003). Indeed, only if professionals are able to manage the impact of these situations will they be able to offer the high-quality care that patients deserve (Aradilla-Herrero *et al.* 2014).

Limitations

This study does have a number of limitations. The first of these relates to the use of a convenience sample, as this meant that all the students came from the same geographical area and also shared the same ethnic background and culture. The sample is also relatively small, although the final number of participants was determined by the data saturation point, which in this case was reached after nine interviews.

Conclusions and relevance to clinical practice

The impact that the first experience of death can have on student nurses justifies continued research in this area. One way of complementing the present results would be to consider other variables such as attitudes towards death and the effects these can have on the care provided by nursing professionals and students. It would also be necessary to evaluate the outcomes of training interventions.

Students require training in how to manage their emotions so as to facilitate their contact with patients and families, and also to prevent emotional fatigue. They would also benefit from the development of coping strategies that enable them to acknowledge death as an inevitable part of life. Specific training on ethical issues and dilemmas arising in the context of EOL care could also help to reduce their emotional distress. All such training should begin before student nurses start their clinical placements, thereby giving them some initial preparation for their first encounter with death.

In conclusion, the fact that the proposed explanatory model is based on the needs expressed by student nurses themselves makes it a useful tool with which to design training programmes on EOL care, and as such, it may help to optimise the care that is offered to both patients and their families.

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The authors have confirmed that all authors meet the ICMJE criteria for authorship credit (www.icmje.org/ethical_1author.html), as follows: (1) substantial contributions to conception and design of, or acquisition of data or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content, and (3) final approval of the version to be published.

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Conflict of interest

No conflict of interest is declared by any of the authors.

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4.2 Artículo 2: “Death attitudes and positive coping in Spanish nursing undergraduates. A cross sectional and correlational study”

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ORIGINAL ARTICLE

Death attitudes and positive coping in Spanish nursing undergraduates: a cross-sectional and correlational study

Montserrat Edo-Gual, Cristina Monforte-Royo, Amor Aradilla-Herrero and Joaquín Tomás-Sábado

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Aims and objectives. To analyse the relationship between death attitudes, emotional intelligence, resilience and self-esteem in a sample of nursing undergraduates.

Background. The death attitudes held by nursing students may influence the care they offer to end-of-life patients and their families. Emotional intelligence, resilience and self-esteem are important social and emotional competencies for coping positively with death and dying.

Design. Cross-sectional and correlational study.

Methods. Participants were 760 nursing undergraduates from four nursing schools in Spain. Data were collected in 2013–2014. The students responded anonymously to a self-report questionnaire that gathered socio-demographic data and which assessed the following aspects: fear of death (Collett-Lester Fear of Death Scale), death anxiety (Death Anxiety Inventory-Revised), perceived emotional intelligence (Trait Meta-Mood Scale, with its three dimensions: attention, clarity and repair), resilience (Brief Resilient Coping Scale) and self-esteem (Rosenberg Self-Esteem Scale). In addition to descriptive statistics, analyses of variance, mean differences, correlations and regression analyses were computed.

Results. Linear regression analysis indicated that attention to feelings, resilience and self-esteem are the significant predictors of death anxiety.

Conclusions. The results show that death anxiety and fear of death are modulated by social and emotional competencies associated with positive coping.

Relevance to clinical practice. The training offered to future nurses should include not only scientific knowledge and technical skills but also strategies for developing social and emotional competencies. In this way, they will be better equipped to cope positively and constructively with the suffering and death they encounter at work, thus helping them to offer compassionate patient-centred care and minimising the distress they experience in the process.

What does this paper contribute to the wider global clinical community?

- Attention to feelings, resilience and self-esteem are predictors of death anxiety among nursing undergraduates.
- The nursing curriculum should include training in specific positive coping strategies so as to reduce the emotional burden experienced by professionals and to help them offer high-quality care to end-of-life patients and their families.

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Introduction

Death is a natural, universal phenomenon and an inevitable part of the life cycle. However, attitudes towards death vary considerably across cultures and different ethnic groups, and they are influenced by religious beliefs, personal experiences and individual value systems (Neimeyer *et al.* 2004). Similarities and differences can also be observed in the context of end-of-life (EOL) care. For instance, Meñaca *et al.* (2012) reported that in Spain in 2009, around 50% of the population expressed a preference to die in hospital, while 45% preferred to die at home, as compared with the situation in Portugal, where around a third of people died at home. In the qualitative study by Reyniers *et al.* (2014) of 23 nurses and 39 family physicians in Belgium, one of the main emergent themes was that the acute hospital setting was seen as an inadequate place to die, although health professionals did at times regard it as a 'safe haven' in relation to the fear of death. A further aspect to consider here is the complexity of caring for EOL patients and their families in a multicultural and increasingly technologized society characterised by a tendency to shy away from the experience of illness and death (Byock 2002).

Background

Attitudes towards death in the nursing context

Health professionals may encounter death and dying on a daily basis, and their attitudes towards death can influence the quality of care they offer to EOL patients and their families (de Araújo *et al.* 2004). Deffner and Bell (2005) conducted with North American nurses have found that they can find it difficult to relate to the dying patient, and they may experience feelings of impotence, anxiety and sadness when having to deal with such patients and their families. A recent study (Cevick & Kav 2012) examining attitudes towards EOL care among 300 Turkish nurses found that negative attitudes were significantly associated with a greater fear of death and avoidance of such situations. Braun *et al.* (2010), in a study of 147 oncology nurses in Israel, likewise found that the most negative attitudes towards EOL care were held by those who reported a greater fear of death and who presented more avoidance behaviours. Research has also shown that the continuous contact with suffering increases the prevalence of stress, burnout and compassion fatigue (Melvin 2012), all of which can have serious repercussions not only for the physical and mental health of professionals but also for the quality of care they are able to provide, a common consequence being poor communication and a detached relationship with the patient. Attitudes towards death among nurses in our country, Spain, have been examined in a number of studies. One report, involving 126 Spanish nursing students and 132 Egyptian nursing students (Abdel-Khalek & Tomás-Sábado 2005), found that the former scored higher on the Death Anxiety Scale. Aradilla-Herrero *et al.* (2012–2013), involving Spanish nursing students, have reported that the fear of death, especially the death of others, decreases significantly as students progress with their training.

Nursing students will inevitably come into contact with death and dying during their clinical placements and must confront not only the fears of patients and families but also their own anxieties, as the death of a patient will serve to remind them of their own mortality (Costello 2006). In the phenomenological study of Spanish nursing students by Edo-Gual *et al.* (2014), the main theme to emerge was the enormous emotional impact that the death of a patient during their clinical placements had on them, it being an experience that they said they never forgot. In a similar vein, the study by Burnard *et al.* (2008) of nursing students from five different countries found that the suffering experienced by patients and families, the relationships required by the EOL context and the eventual death of the patient were the most stressful events they experienced. Studies carried out with Spanish and English nursing students (Parry 2011, Edo-Gual *et al.* 2014) have likewise reported the impact that seeing the dead body and the provision of post mortem care can have on nursing students, who themselves highlight the need for more training in this area.

Social and emotional competencies and positive psychology

Recent years have witnessed a growing interest among researchers in what is referred to as positive psychology, a term that covers a range of concepts related to positive qualities and attitudes that enable individuals to cope in a more healthy and constructive way with stressful situations (Seligman *et al.* 2005, Kobau *et al.* 2011); in this context, coping refers to proactive and future-oriented action in which the individual adopts an anticipatory attitude before reacting to stress (Aspinwall & MacNamara 2005). Reflecting this interest, concepts such as emotional intelligence, resilience and self-esteem increasingly feature in the literature on caring for EOL patients and their families and they are regarded as modulators of attitudes towards death and of the impact it can have (Grafton & Coyne 2012).

One current debate in the literature concerns whether emotional intelligence and other social and emotional competencies can be learnt and taught (Humphrey *et al.* 2007). Recent research suggests that such skills can indeed be promoted through training (Dugan *et al.* 2014). In an experimental study involving Belgian psychology students, Nelis *et al.* (2009) found a significant increase in emotion identification and emotion-management abilities in the training group, and also observed that these changes remained significant six months after intervention. The rest of this section looks briefly at the three concepts of emotional intelligence, resilience and self-esteem.

Salovey *et al.* (1995) define emotional intelligence as a set of skills that enable individuals to perceive, understand and regulate their own emotions and those of others. De Araujo *et al.* (2004) consider emotional intelligence to be a fundamental aspect of nursing practice, as emotional labour is an intrinsic part of the human relationship that is established in the act of caring. Research in this area suggests that nurses with high emotional intelligence cope more positively with death and dying (Hopkinson *et al.* 2003). In one study involving 180 Spanish nurses, Augusto Landa *et al.* (2008) found that nurses who scored high on clarity and mood repair, two aspects of perceived emotional intelligence, reported lower levels of stress. Another study of Spanish nurses by Arantzamendi *et al.* (2012) found that while 62·6% of them felt competent to provide physical care to the EOL patient, only 35% reported preparedness in relation to patients' emotional needs. In accordance with this, a number of recent studies (Aradilla-Herrero *et al.* 2012–2013, Jack & Wibberley 2013) have highlighted the need for future nurses to be offered training in emotional competencies so that they are better able to cope – at less emotional cost – with situations involving death and loss. The study by Aradilla-Herrero *et al.* (2014) involving 1417 Spanish nurses and nursing students found that greater attention to feelings was significantly associated with higher levels of death anxiety among students, whereas scores on clarity and mood repair showed a significant negative correlation with such anxiety (i.e. higher scores, less death anxiety).

Resilience is defined by Stephens (2013) as the capacity to recover and adapt in the face of significant adversity, with the person emerging stronger as a result and having learnt from the experience. Jackson *et al.* (2007) note that nurses are witnesses on a daily basis to tragedy, suffering and loss, and strategies for building resilience could therefore be very useful to them.

In a quasi-experimental study of 60 nursing students in the USA, Pines *et al.* (2014) found that postintervention scores for resilience strategies were significantly higher than predicted, and also that nurses showed an increased capacity to resolve interpersonal conflicts in the workplace.

The third concept, self-esteem, has been considered to act as a buffer against psychological threats or stress (Lee-Flynn *et al.* 2011), and it is also related to the maintenance of good mental health. Lee *et al.* (2013), in a sample of 287 Korean nurses, observed a significant negative correlation between self-esteem and perceived stress, suggesting that low self-esteem may be associated with fewer coping resources and with a sense of less control over situations involving high emotional demands. In a longitudinal study of nursing students in the UK, Edwards *et al.* (2010) likewise found a significant negative relationship between self-esteem and stress. These findings suggest that self-esteem plays an important role during student nurses' clinical placements, as it underpins the therapeutic relationship with the patient. From the perspective of terror management theory it has also been argued that self-esteem acts as a buffer against the anxiety generated by an awareness of one's own mortality (Pyszczynski *et al.* 2004).

Aims

The aim of this study was to analyse the relationship between the death attitudes held by nursing students and the three capacities discussed above, namely emotional intelligence, resilience and self-esteem.

Methods

Design and setting

The study design was cross-sectional and correlational. The target population was nursing students in Spain.

Subjects

The sample size required was calculated on the basis of enrolment data gathered by the Catalan Association of Heads of Nursing Schools, which gave a figure of 6000 students for the academic year 2011–2012. Assuming a confidence level of 95% and precision of ±0·5, a representative sample would therefore need to comprise a minimum of 750 subjects. Four of the 15 university schools of nursing in Catalonia (Spain) were selected by means of random cluster sampling. The questionnaire was administered to a total of 854 nursing students, 32 of whom returned it blank. A further 62 questionnaires were excluded due to incomplete data. The final sample therefore comprised 760 students (89% of the initial pool).

Data collection

All the nursing students were informed about the study objectives and procedures prior to administration of the questionnaire. The questionnaire was administered to students by the main author during their regular class timetable between December 2012–January 2014. The inclusion criterion was being enroled in a nursing degree programme. However, any student who was absent on the day of questionnaire administration was excluded.

It was made clear to all the students that the questionnaire included reference to death-related issues that might cause some emotional distress. More specifically, any students who were going through a grieving process due to a recent bereavement and/or severe illness involving someone they knew were advised not to complete the questionnaire. Students were also given the name of someone they could contact for support or advice in the event that they experienced distress subsequent to completing the questionnaire.

Self-administered instruments

Students responded voluntarily and anonymously to a self-administered questionnaire that gathered the following socio-demographic data: gender, age, marital status, course year, place of birth, religious belief and practices, degree of religiosity, and previous experience of death and dying (i.e. experiencing the death of a close friend or relative, coming into contact with death during their clinical placements, and having seen someone die). This section of the questionnaire also gathered information about any training they had received in palliative care.

In addition to collecting socio-demographic data the questionnaire also contained the validated Spanish version of the following measurement instruments:

Collett-Lester Fear of Death Scale (CLFDS)

The CLFDS (Lester & Abdel-Khalek 2003, Spanish adaptation by Tomás-Sábado *et al.* 2007) is a self-report instrument comprising 28 items that assess four dimensions of the fear of death: fear of death of self, of dying of self, of death of others and of dying of others. Each subscale contains seven items that are rated on a five-point Likert scale from 1 (not) to 5 (very), such that higher scores indicate a greater fear of death. Reported indices of internal consistency (Cronbach's alpha) for each of the four subscales are 0·83 for death of self, 0·89 for dying of self, 0·79 for death of others and 0·86 for dying of others (Lester & Abdel-Khalek 2003). The corresponding alpha values in the present study were 0·79, 0·82, 0·80 and 0·82 respectively.

Death Anxiety Inventory-Revised (DAI-R)

The DAI-R (Tomás-Sábado *et al.* 2005) is a 17-item scale for measuring death anxiety. Items are rated on a five-point Likert scale from 1 (totally disagree) to 5 (totally agree), such that the higher the score the greater the degree of death anxiety. The Cronbach's alpha coefficient in the present sample was 0·89, the same as that reported in the original validation study.

Brief Resilient Coping Scale (BRCS)

The BRCS is designed to measure tendencies to cope with stress in a highly adaptive manner (Sinclair & Wallston 2004), and a Spanish adaptation has been developed by Limonero *et al.* (2010). The BRCS contains four items that are rated on a five-point scale from 1 (doesn't describe me at all) to 5 (describes me well). A total score of 13 or less indicates low resilience, whereas scores of 17 or higher correspond to high resilience. The original scale has internal consistency of 0·68, with Cronbach's alpha for the present sample being 0·65.

Trait Meta-Mood Scale (TMMS-24)

The TMMS-24 assesses people's beliefs or perceptions about their emotional skills, and its three subscales (eight items each) address the following dimensions of emotional intelligence: attention to feelings, clarity of feelings and mood repair. Higher scores indicate a higher level of emotional intelligence on each of these three dimensions. The TMMS, originally devised by Salovey *et al.* (1995), was modified and adapted to Spanish by Fernández-Berrocal *et al.* (2004). More recently, the factor structure of the latter instrument was confirmed in a sample of nursing students (Aradilla-Herrero *et al.* 2014). The Spanish adaptation of the scale, the TMMS-24 contains 24 items that are rated on a five-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). The internal consistency of the TMMS-24 subscales was reported to be 0·90 for attention, 0·90 for clarity and 0·86 for repair. The corresponding Cronbach's alpha values in the present sample were 0·83, 0·88 and 0·83 respectively.

Rosenberg Self-Esteem Scale (RSES)

The RSES, developed by Rosenberg (1965) and adapted to Spanish by Martin-Albo *et al.* (2007), assesses perceived self-esteem and comprises 10 items that are rated on a four-point scale ranging from strongly agree to strongly disagree. There are five positively worded items (items 1, 3, 4, 7 and 10) that are scored 1 for strongly disagree and 4 for strongly agree, and five negatively worded items (items 2, 5, 6, 8 and 9) that are reverse scored. The total score therefore ranges from 10–40, with 10 representing the lowest level of self-esteem and 40 the highest. The Spanish version of the RSES has shown adequate temporal stability and internal consistency (Cronbach's $\alpha = 0{\cdot}85$) (Martin-Albo *et al.* 2007). The same alpha value, namely 0·85, was obtained in the present sample.

Data analysis

Data were tabulated and analysed using SPSS v21.0 (IBM, New York, USA) for Windows. In addition to a descriptive analysis, Pearson *r* correlation coefficients and Student's *t* values were calculated, and multiple linear regression analysis was performed.

Ethical considerations

The study was approved by a university research ethics committee. All participants were informed about the nature and objectives of the study, and it was made clear to them that their responses were anonymous and that participation was voluntary.

Results

The final sample comprised 760 nursing students (89% of the initial pool) with a mean age of 22·44 years (SD 5·24, range 17–49). There were 602 women (79·2%) and 141 men (18·6%); the remaining 17 students did not specify their gender.

Table 1 shows socio-demographic and experiential data for the participants. It can be seen that 80% had experienced the death of a loved one, 47·2% had had some contact with death during a clinical placement and 47·1% had been present when someone died. Also noteworthy is the fact that 60·8% of students had not received any training in palliative care.

Table 1 Socio-demographic and experiential data for participants ($N = 760$)

	n	%	*M* (SD)
Age, years	760	100	22·44 (5·24)
Gender			
Male	141	18·6	
Female	602	79·2	
Year of training			
1st	402	52·9	
2nd	221	29·1	
3rd	91	12	
4th	46	6·1	
Country of birth			
Spain	700	92·2	
Other	60	7·9	
Marital status			
Single	580	76·3	
Married	32	4·2	
Living with partner	67	8·8	
Separated/divorced	7	0·9	
Other	73	9·6	
Religiosity			
Beliefs only	248	32·6	
Practising	86	11·3	
Religion			
Catholic	209	31·1	
Other	51	6·7	
None	500	65·7	
Previous experience of death			
Death of a loved one	608	80	
Contact with death during clinical placement	359	47·2	
Present when someone died	358	47·1	
Previous training in palliative care			
Yes	286	37·6	
No	462	60·8	

Table 2 shows the means and standard deviations, along with the corresponding values of the contrast test (ANOVA) and their significance (*p*), for the study variables in relation to year of training. It can be seen that scores on similar (with nonsignificant differences) on almost all the variables, the exception being clarity, one of the dimensions of emotional intelligence ($p < 0{\cdot}01$).

Table 3 shows the Pearson correlation coefficients between death attitudes (CLFDS and DAI-R) and age, resilience (BRCS), the three dimensions of the TMMS-24 and self-esteem (RSES).

The results show that age was negatively and significantly correlated with death anxiety ($p < 0{\cdot}01$), fear of death of

Table 2 Means, standard deviations (SD), and values of the contrast test (ANOVA) and their significance (*p*) for the study variables in relation to year of training

	Year 1 (n = 402)		Year 2 (n = 221)		Year 3 (n = 91)		Year 4 (n = 46)			
Variables	Mean	SD	Mean	SD	Mean	SD	Mean	SD	*F*	*p*
DAI-R	42·41	13·2	41·04	12·4	40·89	12·68	41·52	14·24	0·70	n.s
Resilience	14·87	2·43	15·19	2·17	14·89	2·2	14·59	2·43	1·38	n.s
Attention (TMMS-24)	28·46	6·02	29·32	5·33	28·11	5·47	28·54	5·7	1·41	n.s
Clarity (TMMS-24)	28·00	5·46	29·64	4·84	30·23	5·22	28·96	4·14	7·4	<0·01
Repair (TMMS-24)	29·14	6·06	29·84	5·61	29·97	5·09	29·35	5·27	0·97	n.s
Self-esteem (RSES)	30·96	4·57	31·58	4·96	32·32	4·68	31·54	4·99	2·38	n.s

DAIR, Death Anxiety Inventory-Revised; TMMS, Trait Meta-Mood Scale; RSES, Rosenberg Self-Esteem Scale.

Table 3 Pearson correlation coefficients between death attitudes [scores on the DAI-R and the four dimensions of fear of death (CLFDS): fear of death of self, fear of dying of self, fear of death of others and fear of dying of others]and age, resilience (BRCS), the three dimensions of emotional intelligence (attention, clarity and repair; TMMS-24) and self-esteem (RSES)

	Age	1	2	3	4	5	6	7	8	9
Death anxiety (DAI-R)	−0·122**									
Fear of death of self (CLFDS)	−0·107**	0·653**								
Fear of dying of self (CLFDS)	−0·013	0·400**	0·584**							
Fear of death of others (CLFDS)	−0·212**	0·485**	0·545**	0·529**						
Fear of dying of others (CLFDS)	−0·107**	0·471**	0·476**	0·551**	0·649**					
Resilience (BRCS)	0·121**	−0·224**	−0·164**	−0·113**	−0·188**	−0·151**				
Attention (TMMS-24)	−0·054	0·291**	0·196**	0·161**	0·268**	0·188**	−0·014			
Clarity (TMMS-24)	0·244**	−0·140**	−0·108**	−0·122**	−0·113**	−0·089*	0·345**	0·099**		
Repair (TMMS-24)	0·094**	−0·099**	0·006	0·005	−0·089*	−0·026	.0·536**	0·032	0·384**	
Self-esteem (RSES)	0·189**	−0·232**	−0·143**	−0·171**	−0·254**	−0·169**	0·361**	−0·123**	0·414**	0·397**

DAIR, Death Anxiety Inventory-Revised; TMMS, Trait Meta-Mood Scale; BRCS, Brief Resilient Coping Scale; CLFDS, Collett-Lester Fear of Death Scale; RSES, Rosenberg Self-Esteem Scale.
*$p < 0·05$; **$p < 0·01$.

self ($p < 0·01$), fear of death of others ($p < 0·01$) and fear of dying of others ($p < 0·01$). Death anxiety was positively and significantly correlated with the four dimensions of fear of death and also with attention to feelings (all $p < 0·01$), whereas it showed a negative and significant correlation with resilience, self-esteem, clarity and mood repair (all $p < 0·01$). All four dimensions of fear of death were negatively and significantly correlated with clarity. Mood repair showed a negative and significant correlation with fear of death of others ($p < 0·05$) and with death anxiety ($p < 0·01$). Finally, self-esteem was negatively and significantly correlated ($p < 0·01$) with the four dimensions of fear of death and with death anxiety.

The final part of the analysis sought to determine which variables could be considered predictors of death attitudes. This was done by conducting a stepwise multiple linear regression with death anxiety as the dependent variable; this choice was based on the fact that death anxiety showed highly significant correlations with all the other variables. The independent variables chosen were those presenting a significant correlation coefficient (resilience, the three dimensions of emotional intelligence and self-esteem). It can be seen in Table 4 that the model which explained the highest proportion of the total variance ($R^2_{\text{adj}} = 0·15$) included three predictive variables: attention to feelings, resilience and self-esteem.

Discussion

The aim of this study was to analyse the relationship between death attitudes, emotional intelligence, resilience and self-esteem in a sample of nursing undergraduates. The

Table 4 Multiple linear regression analysis

Death anxiety (DV)	*B*	β	*t*	*p*	Confidence interval (95%)
Step 1					
Constant	22·96		10·01	<0·01	18·46–27·47
Attention	0·66	0·29	8·36	<0·01	0·5–0·81
Step 2					
Constant	41·6		11·45	<0·01	34·48–48·74
Attention	0·65	0·29	8·5	<0·01	0·5–0·8
Resilience	−1·23	−0·22	−6·5	<0·01	0·6–0·86
Step 3					
Constant	50·26		11·76	<0·01	41·88–58·65
Attention	0·61	0·27	8·02	<0·01	0·46–0·76
Resilience	−0·96	−0·17	−4·75	<0·01	−1·35 to −0·56
Self-esteem	−0·37	0·14	−3·77	<0·01	−0·57 to −0·18

For step 1: $R = 0{\cdot}29$; $R^2_{\mathrm{adj}} = 0{\cdot}08$; $F_{1,758} = 69{\cdot}94$; $p < 0{\cdot}01$.
For step 2: $R = 0{\cdot}36$; $R^2_{\mathrm{adj}} = 0{\cdot}13$; $F_{2,757} = 58{\cdot}06$; $p < 0{\cdot}01$.
For step 3: $R = 0{\cdot}39$; $R^2_{\mathrm{adj}} = 0{\cdot}15$; $F_{3,756} = 44{\cdot}11$; $p < 0{\cdot}01$.

main finding is that attention to feelings, resilience and self-esteem are all predictors of death anxiety.

Death attitudes and emotional intelligence

In terms of the relationship between emotional intelligence and death attitudes the results confirm the findings of other authors (Aradilla-Herrero *et al.* 2012–2013) who have likewise observed that those nursing students who score higher on clarity and mood repair report less fear and anxiety in relation to death. However, the positive correlation observed between attention and death anxiety suggests, as Fernández-Berrocal and Extremera (2008) argue, that excessive attention to one's own feelings can favour ruminative thoughts and personal distress. Consequently, those individuals who pay close attention to their feelings also report higher levels of death anxiety.

In the context of these findings, several authors have highlighted the potential value of promoting emotional intelligence among future nurses, especially as regards helping them to manage and regulate the emotions that are produced through regular contact with death and dying (Bailey *et al.* 2011). In their qualitative study of Brazilian hospital nurses, de Araújo *et al.* (2004) found that the emergent themes were related to the need for specific training in emotional competencies; the idea was that such training could help nurses to manage their own feelings and conflicts regarding EOL care and, therefore, prevent these feelings from interfering with the provision of adequate care. In this context, a study of Spanish nurses concluded that attention to feelings, clarity of feelings and mood repair are essential competencies for nurses, who are required to engage in active listening and to communicate with empathy and in a patient-centred way (Augusto-Landa *et al.* 2009). A recent study of qualified and student nurses in Spain by Aradilla-Herrero *et al.* (2014) likewise found that clarity and mood repair were factors related to a reduction in death anxiety.

Death attitudes and resilience

Our analysis showed that those students who scored higher on resilience reported lower levels of death anxiety. In this regard, Sinclair and Wallston (2004) found that people who could draw upon strategies of resilience were better able to deal with adversity, and experienced less anxiety in the process. Similarly, Mealer *et al.* (2012), in a study of 744 nurses in the USA, reported that the most resilient nurses presented fewer symptoms of anxiety and depression and were less prone to burnout. These findings suggest that it is important to provide training that can enhance nurses' resilience so that they are able to cope with change and adversity in a more constructive and healthier way. Based on their study of Australian nurses and midwives, McDonald *et al.* (2013) concluded that training in personal resilience should include a range of components such as ways of promoting an internal locus of control, the opportunity to share experiences following exposure to a situation involving death or dying, and strategies for developing one's assertiveness and self-care skills. In the cyclic model of resilience building described by Grafton and Coyne (2012), self-care is seen as essential if one is to be able to care for another person, as it promotes overall well-being, positive adaptation and cognitive transformation, all of which are factors that also heighten resilience, which, in turn, improves the individual's ability to deal with stress.

Thus, in the context of EOL care, building resilience among nurses can help them to integrate better their experiences of loss, fostering greater emotional control and, potentially, enabling them to regard the contact with death and dying as an opportunity to grow as individuals. In this regard, Ablett and Jones (2007), in a qualitative study based on in-depth interviews with 10 palliative care nurses in the UK, found that the emergent themes included commitment, finding meaning and purpose in one's work, and compassion satisfaction, it being suggested that all these aspects could be regarded as the result of resilient behaviour.

Death attitudes and self-esteem

With regard to self-esteem and death anxiety our results are again similar to those of other authors (Aradilla-Herrero *et al.* 2014), who likewise found that individuals with greater self-esteem hold more favourable attitudes towards death. More specifically, our findings are consistent with those reported by Aradilla-Herrero *et al.* (2014) in their study of qualified and student nurses in Spain, among whom self-esteem was positively and significantly correlated with clarity and mood repair, and negatively correlated with attention to feelings. Pyszczynski *et al.* (2004) point out that self-esteem not only conveys positive affect and psychological well-being, but also heightens the person's ability to deal with conflict and serves as a buffer against anxiety and existential threats. Therefore, one would expect individuals with high self-esteem to have greater confidence in their own abilities and to respond more adequately in the face of stress, such as would be encountered in the EOL context. Chang *et al.* (2010), in a descriptive study of 314 Taiwanese nurses, identified self-esteem as being a predictor of job satisfaction, which in turn may be considered as a protector against the stress associated with providing EOL care. Given that high self-esteem has also been linked to increased self-efficacy and a reduction in anxiety and stress levels (Trzesniewski *et al.* 2003) it would seem reasonable to recommend that training in the EOL context should include specific components focused on helping future nurses develop their self-esteem and improve their attitudes towards death.

This study has a number of limitations, the most important being the fact that the cross-sectional design prevents any causal relationships from being inferred among the study variables. The use of a sample comprised solely of nursing undergraduates also limits the extent to which the findings are generalizable. Future studies should aim to gather longitudinal data from different cohorts of students and/or professionals, as this would enable more robust conclusions to be drawn regarding the possible causal relationship between the different variables studied here.

Conclusions and relevance to clinical practice

The results obtained in this sample of nursing undergraduates illustrate how death attitudes are modulated not only by existential and training-related variables but also by the social and emotional competencies associated with positive coping. More specifically, the analysis revealed that attention to feelings, resilience and self-esteem are predictor variables of death anxiety.

Death and dying are commonly encountered in the healthcare setting, and nurses need to be equipped to provide adequate care in these complex situations. Consequently, nurse training should focus not only on scientific knowledge and technical skills, but also on social and emotional competencies. In this regard, further research is required to identify the key components of training programmes that would enable student nurses to acquire the skills they need to cope positively and constructively with the vulnerability and uncertainty that is experienced by patients who are suffering or facing the end of life. By equipping them with these skills, nurses would be better placed to offer compassionate and patient-centred care, while also establishing limits and managing their own emotional well-being.

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Conflict of interest

The authors declare that they have no conflicts of interests.

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4.2 Artículo 3: “Spanish adaptation of the Frommelt Attitudes Toward Care of Dying Scale (FATCOD-S) in nursing undergraduates”

SPANISH ADAPTATION OF THE FROMMELT ATTITUDES TOWARD CARE OF DYING SCALE (FATCOD-S) IN NURSING UNDERGRADUATES

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ABSTRACT

Background

The attitudes of health professionals towards situations involving the death or suffering of patients may influence the quality of the care provided. The Frommelt Attitude Toward Care of the Dying Scale (FATCOD) is designed to assess the attitudes of professionals and trainees towards caring for the dying patient and his or her family members. The FATCOD has been used in several countries, although it has yet to be adapted for the Spanish-speaking population.

Objectives

To adapt the FATCOD to a Spanish context (FATCOD-S), to test its dimensionality by means of confirmatory factor analysis (CFA) and to estimate the reliability of the resulting scale dimensions. A further aim was to examine the relationship between FATCOD-S scores and a series of sociodemographic and training-related variables, as well as with respect to emotional intelligence and death attitudes.

Design

This was a cross-sectional study.

Settings and Participants

A convenience sample of 685 nursing undergraduates was recruited from four Spanish universities. Of these, 669 students correctly completed a self-administered questionnaire. They ranged in age from 17 to 49 years (M = 22.57; SD = 5.32).

Methods

The validation process followed internationally recognized guidelines regarding the psychometric properties of instruments, translation and back translation, content validity, internal consistency and construct validity, as well the relationship between these and other relevant variables. Participants responded to a questionnaire that gathered sociodemographic data and which also included the FATCOD-S and the Spanish version of the following instruments: Collett-Lester Fear of Death Scale (CLFDS), Death Anxiety Inventory-Revised (DAI-R) and Trait Meta-Mood Scale (TMMS-24).

Findings

The CFA supported a two-factor model. The first factor (labelled ‘Positive attitude toward caring for the dying patient’) had an internal consistency of 0.74, while the second (‘Perception of patient and family-centred care’) had an α of 0.65. The α coefficient for the total FATCOD-S was 0.76. Students with past experience of death and those who had received training in palliative care scored significantly higher on both factors of the FATCOD-S (p<0.01).

Conclusions

The FATCOD-S is an effective and valid tool for measuring the attitudes of Spanish nurses toward caring for patients at the end of life. It is important that student nurses receive training in end-of-life care, especially as regards strategies for building their emotional intelligence so that they are able to manage the emotions generated through their work with patients and families in the end-of-life context.

Key words: confirmatory factor analysis, death attitudes, emotional intelligence, end-of-life attitudes, FATCOD, nursing students, validation scale.

Contribution of the Paper

What is already known about the topic?

- The Frommelt Attitude Toward Care of the Dying Scale (FATCOD) was designed to assess attitudes toward caring for the dying patient and his or her family members, and it has been used in several different cultural contexts.
- The attitudes of health professionals towards care of the dying may influence the quality of the care provided and impact on how both patients and family members are treated.
- Training in palliative care promotes positive attitudes towards caring for patients at the end of life.

What this paper adds

- The Spanish version of the FATCOD (FATCOD-S) is a valid and reliable instrument for assessing attitudes toward end-of-life care in the Spanish-speaking context.
- A positive attitude toward care of the dying is associated with less fear of death and greater emotional intelligence.
- Nursing students who have received training in palliative care have more positive attitudes toward caring for terminally ill patients and their families.

INTRODUCTION

The professional role of nurses brings them into close contact with patients and families facing an end-of-life situation, and they must therefore be able to manage and respond adequately to the suffering this entails (Ferrell & Coyle, 2008). However, the encounter with death and suffering is one of the experiences that nurses report finding most stressful (Costello, 2006; Peterson *et al.*, 2010), and it is known that continuous contact with the suffering of others can exert an emotional toll that requires considerable effort to manage (Wright, 2004), thus heightening the risk of compassion fatigue (Showalter, 2010; Slocum-Gori *et al.,* 2013). Consequently, there is a need for professionals with specific training in end-of-life (EOL) nursing who are able to provide the high-quality care that these vulnerable patients and families require (Cummings & Bennett, 2012), while simultaneously maintaining their own emotional equilibrium. In this context, a number of studies (Barrere *et al.*, 2008; Mallory, 2003; Wessell & Garon, 2005) have shown that attitudes and coping strategies regarding EOL care can be modulated and enhanced through education, and that such training reinforces more positive attitudes toward death and dying.

One of the most widely used instruments for assessing attitudes towards caring for the dying patient and his or her family is the Frommelt Attitude Toward Care of the Dying Scale (FATCOD; Frommelt, 1991). Although several studies have used this scale in the nursing context (Braun *et al.*, 2010, Henoch *et al*., 2014; Dunn *et al.*, 2005), it has not, to the best of our knowledge, been adapted for use in the Spanish-speaking population.

The Frommelt Attitude Toward Care of the Dying Scale (FATCOD)

Frommelt (1991) developed the FATCOD (Form A) to assess nurses’ attitudes toward caring for terminally ill persons and members of their families. The instrument consists of 30 Likert-type items that are scored on a 5-point scale (see Appendix 1). Items 1, 2, 4, 10, 12, 16, 18, 20, 21, 22, 23, 24, 25, 27 and 30 are all positively worded, while the remainder are framed negatively. Possible scores range from 30 to 150, and higher scores reflect more positive attitudes. Two-thirds of the items relate directly to a person's attitudes toward the patient, while the remaining third relate directly to attitudes toward family members of the terminally ill person. Although the original tool was designed to assess nurses' attitudes, Frommelt subsequently made some slight modifications and developed the FATCOD Form B to be used by persons from any discipline (Frommelt, 2003). The scale has been adapted and validated in several different languages, including Japanese (Nakai *et al*., 2006), Swedish (Henoch *et al*., 2014) and Italian (Leombruni *et al.*, 2014).

Nakai *et al.* (2006) translated the FATCOD into Japanese (FATCOD-Form B-J) and, using principal component analysis (PCA), found evidence of two scale domains. The first factor, which they labelled FATCOD I (positive attitudes toward caring for dying patients), had an internal consistency (Cronbach's alpha) of 0.73, while the second factor, FATCOD II (perceptions of patient and family-centred care), had an alpha of 0.65. Internal consistency for the total FATCOD-Form B-J was 0.85.

Henoch *et al*. (2014) recently translated and adapted the FATCOD (Form A) into Swedish. In order to compare their results with those of studies carried out using the Japanese FATCOD (Matsui & Braun, 2010; Miyashita *et al*., 2007; Nakai *et al.*, 2006), they applied PCA to examine a two-component solution. The two-factor solution obtained in the Swedish sample was similar to that reported for the Japanese version. The only item that loaded on a different factor was item 24. Internal consistency for the Swedish adaptation was 0.70 for FATCOD I, 0.57 for FATCOD II and 0.60 for the total scale. As Cronbach alpha coefficients were fairly low for the total FATCOD and the two subscales, Henoch *et al.* (2014) recommend that the Swedish version of the scale should be used with caution, and highlight that its psychometric properties need to be examined further.

The factor structure of the Italian version of the FATCOD was examined using PCA in a study by Leombruni *et al*. (2014). Four factors accounting for 37.2% of the total variance were extracted: emotional engagement, beliefs about end-of-life care, beliefs about professional boundaries, and beliefs and feelings about dying. The authors state that the results cannot be generalized because the internal consistency of the Italian version of the FATCOD (Form B) was questionable. Specifically, alpha coefficients for the dimensions ranged between 0.72 and 0.11, with a value of 0.68 for the total FATCOD.

Use of the FATCOD in the nursing context

The FATCOD scale has been used in numerous studies in the nursing context (Braun *et al.,* 2010; Dunn *et al.*, 2005; Iranmanesh *et al.*, 2008a; Lange *et al.*, 2008; Mallory, 2003; Matsui & Braun, 2010). Mallory (2003) applied the FATCOD to a sample of 104 North American nursing undergraduates in order to assess changes in their attitude toward care of the dying following a specific training programme. The results indicated that training in EOL care and early practical experience of palliative care could lead to more positive attitudes towards caring for these patients. In another study conducted in the USA, Dunn *et al*. (2005) examined attitudes among 58 nurses working in oncology or medical/surgical units. They found that attitudes toward caring for dying patients and their families became more positive with greater professional experience. Based on their results they suggest that undergraduate nurse training should include the teaching of strategies for coping with death and dying. Other studies have obtained similar results (Abudari *et al.*, 2014; Braun *et al.*, 2010; Lange *et al.*, 2008), although it has also been highlighted that culture and religiosity can influence attitudes towards care of the dying. For instance, Matsui and Braun (2010), in their Japanese study involving 190 nurses and 177 caregivers, obtained mean FATCOD scores that were considerably lower than those reported by Dunn *et al.* (2005) in the USA and by Braun *et al.* (2010) with nurses in Israel, thus suggesting that Japanese nurses had less favourable attitudes toward care of the dying. Similarly, the mean FATCOD scores obtained by Iranmanesh *et al.*, (2008a) in their study of Iranian nursing students were also lower than those reported in other cultural contexts.

Numerous studies have found that training in EOL care leads to more positive attitudes when working with the dying patient and his or her family members (Iranmanesh *et al*., 2008b; Kassa *et al.*, 2014; Matsui & Braun, 2010; Miyashita *et al.*, 2007). In a mixed-methods study of 21 North American nursing students who attended an educational workshop addressing critical moments in EOL care, Bailey and Hewison (2014) observed a significant improvement in attitudes towards caring for the dying. The qualitative data revealed that nurses felt the workshop to have been a valuable learning opportunity that had enabled them to share experiences with peers, as well as being a good way of linking theory and practice. Another factor that has been shown by research to favour more positive attitudes toward EOL care is previous contact with death and dying (Leombruni *et al.*, 2014), whereas according to Iranmanesh *et al*. (2008a) the fear of death can lead to less positive attitudes toward the dying patient.

In addition to the need for adequate training in EOL care, other authors (Aradilla-Herrero *et al.*, 2012-2013; Edo-Gual *et al.*, 2014; Jack & Wibberley, 2013) stress the importance of including complementary training in social and emotional skills as part of undergraduate nurse education. The idea here is that such training can help student nurses not only to develop more positive attitudes toward care of the dying patient, but also to cope more effectively with suffering and loss, at less emotional cost to themselves and with less anxiety about death.

In light of the above, and based on the available literature, the aim of the present study was to analyse the attitudes of Spanish nursing students toward care of the dying patient and his or her family. This was done after first producing a validated Spanish adaptation of the FATCOD. A further objective was to examine the relationship between these attitudes and both emotional intelligence and attitudes toward death in general.

AIMS

The specific aims of the study were to adapt the FATCOD to a Spanish context (FATCOD-S), to test the dimensionality of the scale by means of CFA and to estimate the reliability of the resulting scale dimensions. A further aim was to examine the relationship between FATCOD-S scores and a series of sociodemographic and training-related variables, as well as with respect to emotional intelligence and death attitudes.

METHODS

Study design and participants

This was a cross-sectional study carried out among Spanish nursing students. A convenience sample of 685 nursing undergraduates was recruited from four universities. Of these, 669 students completed the questionnaire correctly.

Data collection and ethical considerations

All the nursing students were informed about the study objectives and procedures prior to administration of the questionnaire. The questionnaire was administered to students during their regular class timetable between March and December 2013. All students were informed of the voluntary nature of the study, and it was made clear that all data would remain anonymous and confidential. The study was approved by the research ethics committee of the Universitat Internacional de Catalunya.

Instruments

The students completed a self-administered questionnaire that gathered the following sociodemographic data: gender, age, academic year, past experience of death and dying (experiencing the death of a close friend or relative, coming into contact with death during their clinical placements, and having seen someone die) and previous training in palliative care. In addition to the FATCOD-S, the questionnaire also included the following validated scales:

Collett-Lester Fear of Death Scale (CLFDS)

The Collett-Lester Fear of Death Scale (Lester & Abdel-Khalek, 2003; Spanish adaptation by Tomás-Sábado *et al.*, 2007) is a self-report instrument with 28 items that assess four dimensions of the fear of death: fear of death of self, fear of dying of self, fear of death of others and fear of dying of others. Each subscale contains 7 items that are rated on a 5-point Likert scale. Higher scores indicate a greater fear of death. Reported indices of internal consistency (Cronbach's alpha) for each of the four subscales are 0.83 for death of self, 0.89 for dying of self, 0.79 for death of others and 0.86 for dying of others (Lester & Abdel-Khalek, 2003). The corresponding alpha values in the present study were 0.79, 0.82, 0.80 and 0.80, respectively.

Death Anxiety Inventory-Revised (DAI-R)

The Death Anxiety Inventory-Revised (Tomás-Sábado *et al.*, 2005) is a 17-item scale for measuring death anxiety. Items are rated on a 5-point Likert scale from 1 (totally disagree) to 5 (totally agree). Possible scores range from 17 to 85, with higher scores corresponding to a greater degree of death anxiety. The Cronbach alpha coefficient in the original validation study was 0.89, compared with 0.88 in the present sample.

Trait Meta-Mood Scale (TMMS-24)

The Trait Meta-Mood Scale (TMMS-24) was devised by Salovey *et al.*, (1995), and subsequently modified and adapted to Spanish by Fernández-Berrocal *et al.*, (2004). The TMMS-24 is a 24-item scale that uses a 5-point Likert format (anchored by 1 = strongly disagree and 5 = strongly agree). The scale assesses people's beliefs or perceptions about their emotional skills, and its subscales (eight items each) address three dimensions of emotional intelligence: attention to feelings, clarity of feelings and mood repair. In the Spanish version of the scale validated in the nursing context (Aradilla-Herrero *et al.*, 2014), the internal consistency of the subscales was 0.87 for attention, 0.87 for clarity and 0.84 for repair. In the present sample we obtained Cronbach alpha values for each of the TMMS dimensions of 0.81 for attention, 0.88 for clarity and 0.83 for repair.

Translation Procedure

The Spanish version of the FATCOD (FATCOD-S) was created following a forward-backward translation design based on international guidelines (International Test Commission, 2005). We began by obtaining permission from Frommelt, the author of the original version, for the translation and validation of the instrument. The

FATCOD was then independently translated from English into Spanish by four bilingual researchers who were specialized in EOL education; one of them was also an expert in the field of psychometrics. The translation of each item was then compared and discussed until consensus was achieved among all the researchers. Finally, the preliminary version was sent to a bilingual professional for back translation. The back translation was then compared with the original English version and discussed by the initial group of researchers in order to ensure that the translation was comprehensible. The final Spanish version of the FATCOD was then tested in a small sample of Spanish students to ensure that all its items were clear and easy to understand. Appendix 2 shows the Spanish version of the FATCOD (FATCOD-S).

Data analysis

With the exception of the CFA, all data were analysed using SPSS for Windows v21.0 (SPSS Inc., Chicago, IL, USA). Descriptive statistics were obtained for age, gender and other sociodemographic variables, while Pearson r correlation coefficients were calculated between FATCOD-S scores and other measures (DAI-R, CLFDS and TMMS-24). An analysis of variance (ANOVA) was performed across academic years.

The dimensional structure of the FATCOD-S was tested by CFA using the LISREL 8.8 program (Jöreskog & Sörbom, 2006a). Due to the ordinal nature of the data, the maximum likelihood robust method was used for estimation, with the polychoric correlations and their corresponding asymptotic covariance matrices being previously generated by means of the Prelis 2.8 program (Jöreskog & Sörbom, 2006b. Model fit was evaluated with the following indices: the Satorra–Bentler scaled chi-square (S-Bχ^2), the root mean square error of approximation (RMSEA) and its relative confidence interval, the non-normed fit index (NNFI), the comparative fit index (CFI) and the Akaike information criterion (AIC). Following Kaplan (2000), indicators of a good fit are that S-B χ^2 is not significant, that NNFI and CFI have values above 0.90 (acceptable) or 0.95 (good), and that the RMSEA has a value between 0.05 and 0.08

(acceptable) or below 0.05 (good) (Kaplan, 2000). The AIC index has a comparative purpose and the model with the lower value shows the best fit.

Cronbach α coefficients were calculated to examine the internal consistency of the total scale and of the dimensions resulting from the CFA.

RESULTS

Sample characteristics

Of the 669 students who completed the questionnaire correctly, 539 (80.5%) were female and 130 (19.4%) male. They ranged in age from 17 to 49 years (*M = 22.57; SD = 5.32*), and were drawn from across four academic years (323 students from year one, 212 from year two, 90 from year three and 44 from year four).

Confirmatory factor analysis (CFA)

To test the dimensional structure of the FATCOD-S, four competing models were compared:

1) The model proposed by Frommelt (1991), which formulates the FATCOD-Form A as a unidimensional scale.

2) The model of Nakai *et al.* (2006), which found evidence for two factors (factor I: positive attitudes toward caring for dying patients, which includes items 1, 2, 3, 5, 6, 7, 8, 9, 11, 13, 14, 15, 17, 26, 29 and 30; and factor II: perceptions of patient and family-centred care, which includes items 4, 12, 16, 18, 19, 20, 21, 22, 23, 24, 25, 27 and 28). Item 10 was eliminated.

3) The model described by Henoch *et al.* (2014), which proposes a two-factor scale that is consistent with the Japanese version (Nakai *et al*., 2006), except for item 24 loading on Factor I. Item 10 was eliminated.

4) The model of Leombruni *et al.* (2014) based on four factors: factor I: emotional engagement (items 3 ,5 ,7, 11, 13 ,14 ,15, 17, 21), factor II: beliefs about end-of-life care (items 4, 6, 16, 18, 19, 22, 28), factor III: beliefs about professional boundaries (items: 10,18,20,24) and factor IV: beliefs and feelings about dying (items 1, 2, 8, 25, 26, 29). Items 9, 12, 23 and 30 were eliminated.

Table 1 shows the fit indexes achieved by the four models tested. The S-B χ^2 test showed a statistically significant result for all the models ($p<0.01$). However, given that this index is affected by sample size, by the degrees of freedom in the model and by discrepancies in the normality of the data, Kaplan (2000) recommends that the assessment of fit be based on the alternative criteria that were listed in the data analysis section. According to the goodness of fit of these alternative indices, the two-factor model described by Nakai *et al.* (2006) was the most plausible of all the models tested: this model had the lowest AIC of the four models, and its RMSEA, NNFI and CFI values were within the range corresponding to an acceptable fit. The first factor in this model (Positive attitude toward caring for the dying patient) had an internal consistency of 0.74, while the second (Perception of patient and family-centred care) had an α of 0.65. The α coefficient for the total FATCOD-S was 0.76.

FATCOD-S scores in relation to sociodemographic and training-related variables

Table 2 shows the mean scores and standard deviations for the two FATCOD-S factors in relation to the following independent variables: gender, academic year, past experience of death and dying, and training in palliative care. The table also shows the results of the Student's *t* test and the analysis of variance (ANOVA), and indicates their significance (*p*).

Male and female nursing students did not differ significantly on either of the two factors. Mean scores on both FATCOD-S factors increased in line with the academic year, although the differences were only significant between year one and the remainder ($p<0.01$).

Students who had come into contact with death and dying during their clinical placements, those who had seen someone die and those who had received training in palliative care scored significantly higher on both FATCOD-S factors than did their peers without these experiences ($p<0.01$).

Correlation with other variables

Age was positively and significantly (*p*<0.01) correlated with both FATCOD-S factors. Table 3 shows Pearson correlation coefficients between the two FATCOD-S dimensions and the DAI-R, the CLFDS and the TMMS-24. The first FATCOD-S factor was negatively and significantly (*p*<0.01) correlated with all the variables related to attitudes toward death. For factor II, however, all the correlations were close to zero.

Regarding the relationship between the FATCOD-S and the three dimensions of emotional intelligence, the results showed that clarity and repair were positively and significantly (*p*<0.01) associated with both scale factors.

DISCUSSION

No previous study of the FATCOD in the nursing context has conducted a psychometric analysis that includes CFA of the scale's dimensions. In developing the Spanish version of the FATCOD (FATCOD-S) we tested the four models proposed in the literature: a unidimensional structure based on the construct '*attitudes toward care of the dying*', as formulated by the author of the original scale (Frommelt, 1991, 2003); the two-factor models proposed by Nakai *et al.* (2006) and Henoch *et al.* (2014) following exploratory factor analysis; and the four-factor model proposed by Leombruni *et al.* (2014). The two-factor model described by Nakai *et al.* (2006) showed the best fit to the data obtained in the Spanish validation, and it should be noted that this model is also one of the most widely used in research with the FATCOD (Mahiro *et al.*, 2014; Matsui *et al.*, 2013; Yoshioka *et al.*, 2013). The fit indices obtained indicate that the two two-factor models are more appropriate than the unidimensional or the four-factor model, and of the two the model of Nakai *et al.* (2006) shows the best fit to the data obtained in the Spanish context.

As already noted, the scale comprises two factors, one referring to attitudes toward care of the dying patient, and the other to perceptions of patient and family-centred care. In terms of the content of the two factors, we consider that the nomenclature used by Nakai et al. (2006) to label the dimensions is appropriate for the Spanish version of the FATCOD.

Our results regarding age are similar to those reported by other authors (Dunn *et al.,* 2005; Lange *et al.*, 2008), since younger nurses had less positive attitudes toward end-of-life care. This is probably due to their more limited experience of loss or death, and to the fact that they are likely to have not yet developed effective strategies for coping with such situations. As Kastenbaum (2000) notes, however, these findings should be interpreted with caution since age per se is not a predictor of attitudes toward death.

With respect to academic year the results show that attitudes toward care of the dying patient become more positive as nursing students progress through their training. This finding is consistent with previous reports (Aradilla-Herrero *et al.*, 2012-13; Edo-Gual *et al.*, 2011). When students begin their training they will have yet to experience the reality of the healthcare setting, one in which they are likely to encounter terminally-ill patients and where they will come into contact with the pain and suffering of others. This contact, together with their inexperience and lack of control, can become a source of stress for nursing students and lead them to have more negative attitudes toward caring for such patients. The fact that their attitudes subsequently become more positive suggests that their increasing experience and training in this context helps to minimize the impact of these stressful situations.

Regarding past experience of death, our results show that attitudes were more positive among those students who have previously come into contact with death. In a study of oncology nurses, Lange *et al.* (2008) likewise found that those with previous experience of caring for terminally-ill patients reported more positive attitudes towards this role, a finding that led them to suggest that more training in EOL care could improve attitudes toward the care of these patients. Other authors (Dunn *et al*., 2005, Henoch *et al.*, 2014) have similarly concluded that professional experience of palliative care is associated with more positive attitudes toward work of this kind. However, it should be noted that Barrere *et al.* (2008), in a study of North American nurses, found that previous experience of death was a predictive factor in the negative sense, since more positive attitudes were reported by nurses without such experience. These results suggest that a lack of contact with the reality of death and dying may mean that nurses have unrealistic attitudes towards EOL care, and that they underestimate the impact it can have. Given these discrepant findings, further research is needed on this topic.

With respect to previous training in palliative care, our analysis showed that this modulated attitudes toward care of the dying patient and his or her family, since attitudes were more positive among those nursing students who had received such training. This is consistent with the findings of Mallory (2003), who, in a study that included both an experimental and a control group of student nurses, found that those who underwent specific EOL training had more positive attitudes toward the care of these patients. Other studies in different cultural contexts (Hirakawa *et al.*, 2013; Nagamatsu *et al.*, 2014; Yoshioka *et al.,* 2013) have similarly found that training in EOL care is a key factor in terms of improving attitudes toward working with dying patients and their families, and that it improves the quality of the care offered.

Regarding fear of death and death anxiety, our results show that the nursing students with more positive attitudes toward care of the dying patient were those who reported less fear of death on all four of the dimensions measured: fear of death of self, fear of dying of self, fear of death of others and fear of dying of others. Positive attitudes toward care of the dying patient were also negatively correlated with death anxiety. These results are consistent with previous studies (Braun *et al*., 2010; Lange *et al*., 2008) showing that nurses who report a greater fear of death have less favourable attitudes toward care of the dying patient and his or her family.

A further objective of our study was to analyse the relationship between attitudes toward care of the dying patient and the three dimensions of emotional intelligence. The results show that students who scored higher on emotional clarity (i.e. the ability to understand the feelings aroused by coming into contact with death and suffering) and repair (i.e. the ability to manage their emotional states) held more favourable attitudes toward caring for the dying patient and his or her family. These findings are consistent with previous studies (Aradilla-Herrero *et al*., 2012-13; Aradilla-Herrero *et al.*, 2014; Edo-Gual et al., 2015) showing that qualified and student nurses with higher levels of emotional intelligence report less death anxiety and fear of death. In this regard, Bailey and Hewison (2014) argue that the development of emotional intelligence should be one of the objectives of nurse training in relation to EOL care, and also that it should be based on experiential learning. This is because emotional work is a key component of the nursing role in this context, and adequate training can help to reduce the risk of occupational stress and burnout. Other authors (Aradilla-Herrero *et al.*, 2014; Edo-Gual *et al.*, 2014; Huang *et al*, 2010; Strang *et al*., 2014) have similarly highlighted the importance of providing nurses with training in social and emotional skills, since caring for the dying patient is a complex task that requires an adequate emotional response in order to ensure high-quality care and to avoid an excessive emotional toll on the professional involved.

LIMITATIONS

This study has two main limitations. First, the use of a sample comprised solely of nursing undergraduates limits the extent to which the findings are generalizable. It is therefore important to conduct further studies of this kind in samples of qualified nurses in order to confirm the validity of the FATCOD-S. Second, the cross-sectional design prevents any causal relationships from being inferred among the study variables. Thus, future research should aim to gather longitudinal data from different cohorts of students and/or qualified professionals, as this would enable more robust conclusions to be drawn regarding the possible causal relationship between the different variables studied here.

CONCLUSIONS

The results of this study indicate that the FATCOD-S is a valid instrument for assessing attitudes toward end-of-life care in the Spanish context. Fear of death and death anxiety can make it difficult for nurses to work with dying patients, and this may affect the quality of the care they provide. By contrast, emotional intelligence can help nurses to manage the feelings evoked through their close contact with patients and families in the end-of-life setting.

The use of the FATCOD-S with nursing students could provide important information about how these future professionals relate to dying patients and their family members. In this context, the training they receive should include strategies for developing their own social and emotional skills, thereby equipping them with the resources they need to care effectively not only for others but also for themselves.

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Table 1. CFA goodness-of-fit statistics

Model	χ^2	RMSEA	90% CI	NNFI	CFI	AIC
One factor (Frommelt, 1991)	2108.98	0.078	0.075-0.082	0.81	0.82	2228.98
Two factors (Nakai et al., 2006)	246.27	0.055	0.052-0.059	0.90	0.91	1368.27
Two factors (Henoch et al., 2014)	1421.31	0.061	0.057-0.064	0.88	0.89	1543.59
Four factors (Leombruni et al., 2014)	2242.06	0.081	0.078-0.085	0.79	0.81	2362.06

Table 2. Comparisons of FATCOD-S scores according to gender, academic year, past experience of death and dying, and previous training in palliative care

		FATCOD-S I. Positive Attitude Toward Caring for the Dying Patient		FATCOD-S II. Perception of Patient and Family-Centred Care	
Gender	n	Mean *(SD)*	*t/F*	Mean *(SD)*	*t/F*
Female	539	60.92 (7.35)	0.59	58.34 (5.47)	1.10
Male	130	60.50 (6.72)		57.76 (4.98)	
Academic year					
1st	323	59.38 (7.17)	10.89***	57.15 (4.96)	10.98***
2nd	212	61.65 (7.25)		58.84 (5.75)	
3rd	90	63.27 (6.74)		59.80 (5.09)	
4th	44	63.36 (7.08)		60.45 (5.40)	
Experiencing the death of a close friend or relative					
Yes	550	61.10 (7.30)	1.71	58.49 (5.24)	2.74**
No	119	59.84 (7.17)		57.02 (5.82)	
Coming into contact with death during clinical placements					
Yes	329	62.69 (7.12)	6.58***	59.31 (5.36)	5.28***
No	340	59.09 (7.03)		57.16 (5.19)	
Having seen someone die					
Yes	330	62.19 (7.38)	4.67***	58.80 (5.47)	2.70**
No	339	59.60 (7.30)		57.68 (5.23)	
Previous training in palliative care					
Yes	264	62.82 (6.90)	5.73***	59.38 (5.26)	4.55***

**p*<0.05 ***p*<0.01 ****p*<0.001

Table 3. Pearson's correlation coefficients between the two FATCOD-S dimensions and scores on death anxiety (DAI-R), the four dimensions of fear of death (CLFDS) and the three dimensions of emotional intelligence (TMMS-24)

	FATCOD-S I. Positive Attitude Toward Caring for the Dying Patient	FATCOD-S II. Perception of Patient and Family-Centred Care
Fear of Death of Self (CLFDS)	- 0.22**	- 0.05
Fear of Dying of Self (CLFDS)	- 0.14**	0.00
Fear of Death of Others (CLFDS)	- 0.28**	- 0.09*
Fear of Dying of Others (CLFDS)	- 0.33**	- 0.06
Death anxiety (DAI-R)	- 0.42**	- 0.08*
Attention (TMMS-24)	- 0.02	0.09*
Clarity (TMMS-24)	0.24**	0.14**
Repair (TMMS-24)	0.13**	0.12**

*p<0.05 **p<0.01

Appendix 1: Original version of the FATCOD scale

Frommelt Attitude Toward Care of the Dying Scale

Original Form A

In these items the purpose is to learn how nurses feel about certain situations in which they are involved with patients. All statements concern the giving of care to the dying person and/or, his/her family. Where there is reference to a dying patient, assume it to refer to a person who is considered to be terminally ill and to have six months or less to live.

Please circle the letter following each statement which corresponds to your own personal feelings about the attitude or situation presented. Please respond to all 30 statements on the scale. The meaning of the letters is:

SD = Strongly Disagree
D = Disagree
U = Uncertain
A = Agree
SA = Strongly Agree

1. Giving nursing care to the dying person is a worthwhile learning experience.
SD D U A SA
2. Death is not the worst thing that can happen to a person.
SD D U A SA
3. I would be uncomfortable talking about impending death with the dying person.
SD D U A SA
2. Nursing care for the patient's family should continue throughout the period of grief and bereavement.
SD D U A SA
5. I would not want to be assigned to care for a dying person.
SD D U A SA
6. The nurse should not be the one to talk about death with the dying person.
SD D U A SA
7. The length of time required to give nursing care to a dying person would frustrate me.
SD D U A SA
8. I would be upset when the dying person I was caring for gave up hope of getting better.
SD D U A SA
9. It is difficult to form a close relationship with the family of the dying person.
SD D U A SA
10. There are times when death is welcomed by the dying person.
SD D U A SA
11. When a patient asks, "Nurse am I dying?," I think it is best to change the subject to something cheerful.
SD D U A SA
12. The family should be involved in the physical care of the dying person.
SD D U A SA
13. I would hope the person I'm caring for dies when I am not present.
SD D U A SA
14. I am afraid to become friends with a dying person.
SD D U A SA

15. I would feel like running away when the person actually died.

SD D U A SA

16.Families need emotional support to accept the behavior changes of the dying person.

SD D U A SA

17.As a patient nears death, the nurse should withdraw from his/her involvement with the patient.

SD D U A SA

18.Families should be concerned about helping their dying member make the best of his/her remaining life.

SD D U A SA

19.The dying person should not be allowed to make decisions about his/her physical care.

SD D U A SA

20.Families should maintain as normal an environment as possible for their dying member.

SD D U A SA

21.It is beneficial for the dying person to verbalize his/her feelings.

SD D U A SA

22.Nursing Care should extend to the family of the dying person.

SD D U A SA

23.Nurses should permit dying persons to have flexible visiting schedules.

SD D U A SA

24.The dying person and his/her family should be the in-charge decision makers.

SD D U A SA

25.Addiction to pain relieving medication should not be a concern when dealing with a dying person.

SD D U A SA

26.I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying.

SD D U A SA

27.Dying persons should be given honest answers about their condition.

SD D U A SA

28.Educating families about death and dying is not a nursing responsibility.

SD D U A SA

29. Family members who stay close to a dying person often interfere with the professionals job with the patient.

SD D U A SA

30.It is possible for nurses to help patients prepare for death.

SD D U A SA

Last 4 digits of your Social Security №.

Completion and Return of This Questionnaire Will Be
Construed as Your Consent to be a Research
Subject in This Study. Your Anonymity is Guaranteed.

DEMOGRAPHIC DATA SHEET

Please check the appropriate spaces:

1. Age 2. Sex ___ Male
___ Female

___ 18-22 years
___ 23-27 years
___ 28-35 years
___ 36-45 years
___ 46-55 years
___ 56-65 years
___ 66 years and over

3. Highest degree held: ___ High School Equivalency (GED)
___ High School Diploma
___ Associate Degree
___ Bachelors Degree
___ Masters Degree
___ Education Beyond Masters
___ Other (Please Specify)

4. Previous education on death and dying

___ I took a course in death and dying previously.
___ I did not take a specific course on death and dying, but material on the subject was included in other courses.
___ No information dealing with death and dying was previously presented to me.

5. Previous experience in dealing with terminally ill persons

___ I have cared for terminally ill persons and their family members previously.
___ I have had NO experience caring for terminally ill persons and their family members previously.

Appendix 2: Spanish version of the FATCOD scale (FATCOD-S)

FATCOD

Instrucciones. En cada una de las siguientes frases, marque con una X la opción de respuesta elegida, según el grado de acuerdo o desacuerdo con el que se identifique.

Escala de Frommelt sobre Actitudes ante los cuidados del paciente moribundo	**Totalmente en desacuerdo**	**En desacuerdo**	**Neutro**	**De acuerdo**	**Totalmente de acuerdo**
1. Proporcionar cuidados de enfermería a una persona que se está muriendo es una experiencia muy valiosa	1	2	3	4	5
2. La muerte no es lo peor que le puede suceder a una persona	1	2	3	4	5
3. Me resultaría incómodo hablar con una persona que se está muriendo de su propia muerte	1	2	3	4	5
4. Los cuidados de enfermería a la familia deben continuar durante todo el proceso de duelo	1	2	3	4	5
5. No me gustaría tener que cuidar a una persona que se esté muriendo	1	2	3	4	5
6. La enfermera no es la persona adecuada para hablar de la muerte con una persona que se esté muriendo	1	2	3	4	5
7. Me provoca frustración el tiempo que requiere proporcionar cuidados de enfermería a una persona que se esté muriendo.	1	2	3	4	5
8. Me molestaría que una persona moribunda a la que estuviera cuidando perdiera la esperanza de mejorar	1	2	3	4	5
9. Es difícil establecer una relación estrecha con la familia de una persona que se está muriendo	1	2	3	4	5
10. A veces la muerte es aceptada por la persona que se está muriendo	1	2	3	4	5
11. Cuando un paciente pregunta a la enfermera, “¿me estoy muriendo?”, pienso que es mejor cambiar de tema	1	2	3	4	5
12. La familia debería implicarse en los cuidados físicos de la persona que se está muriendo	1	2	3	4	5
13. Preferiría que la persona a la que estoy cuidando muriese cuando yo no esté	1	2	3	4	5
14. Me da miedo establecer amistad con una persona que se está muriendo	1	2	3	4	5
15. Cuando una persona se muere, me dan ganas de salir corriendo	1	2	3	4	5
16. La familia necesita soporte emocional para aceptar los cambios en la conducta de la persona que se está muriendo	1	2	3	4	5
17. Cuando un paciente está cercano a la muerte, la enfermera debería dejar de implicarse en su cuidado	1	2	3	4	5
18. La familia debe preocuparse de que el enfermo viva lo mejor posible lo que le queda de vida	1	2	3	4	5
19. La persona que se está muriendo no debería tomar decisiones sobre sus cuidados físicos	1	2	3	4	5
20. La familia debería mantener un entorno tan normal como sea posible por el bien del enfermo	1	2	3	4	5
21. Es bueno que la persona que se está muriendo verbalice sus sentimientos	1	2	3	4	5
22. Los cuidados de enfermería deben hacerse extensivos a la familia de la persona que se está muriendo	1	2	3	4	5
23. Las enfermeras deben permitir un horario flexible de visitas para las personas que se están muriendo	1	2	3	4	5
24. La persona que se está muriendo y su familia deberían ser los responsables de la toma de decisiones	1	2	3	4	5
25. La adicción a los analgésicos no debería ser una preocupación para las enfermeras de un paciente moribundo	1	2	3	4	5

	Totalmente en desacuerdo	**En desacuerdo**	**Neutro**	**De acuerdo**	**Totalmente de acuerdo**
26. Me sentiría incómodo/a si al entrar en la habitación de un paciente con una enfermedad terminal, me lo encontrase llorando	1	2	3	4	5
27. Las personas moribundas deberían recibir respuestas honestas sobre su estado	1	2	3	4	5
28. Educar a las familias sobre la muerte y el proceso de morir no es una responsabilidad de enfermería	1	2	3	4	5
29. Los familiares que permanecen junto al paciente moribundo, a menudo interfieren en el trabajo del profesional con el paciente	1	2	3	4	5
30. Las enfermeras pueden ayudar a los pacientes a prepararse para la muerte	1	2	3	4	5

1. DISCUSIÓN

DISCUSIÓN

Aunque los resultados de cada estudio han sido discutidos en sus correspondientes artículos, en este apartado se discuten a modo de resumen los resultados a la luz de los objetivos e hipótesis previamente planteadas, así como sus implicaciones para la práctica clínica.

OBJETIVO 1

Explorar la experiencia de los estudiantes de enfermería ante la muerte y el proceso de morir de los pacientes en el contexto de sus prácticas clínicas.

La primera experiencia de los estudiantes de enfermería con la muerte de un paciente, es relatada en la literatura como un evento de gran impacto emocional, que queda grabada y que puede influir en términos de memoria y tener efectos duraderos, tanto personal como profesionalmente (Chen, Del Ben, Fortson & Lewis, 2006; Kent, Anderson & Owens, 2012). Nuestro estudio cualitativo (Edo-Gual, Tomás-Sabado, Bardallo Porras & Monforte-Royo, 2014) confirma el importante impacto que producen estas primeras experiencias. Cabe destacar la relevancia de estos resultados, ya que, según cómo vivan esta primera experiencia, los estudiantes crearán diferentes estrategias de protección que pueden influir en sus futuras respuestas al duelo (Gerow *et al.* 2010).

Coincidiendo con otros estudios (Burnard *et al.* 2008; Warnock, Tod, Foster & Soreny, 2010), los estudiantes relatan como una de las situaciones más estresantes, la comunicación de malas noticias, expresada sobre todo por la dificultad para compartir la información y la toma de decisiones con el paciente en situación de final de vida. En este sentido destaca que los estudiantes manifiestan una clara necesidad de formación específica en habilidades comunicativas y en gestión emocional, que facilite una atención personalizada y evite el contagio emocional. Además, los estudiantes expresan que la formación en este ámbito debe ser impartida mediante metodologías experienciales y activas que utilicen situaciones en entornos simulados lo más parecidos a la realidad.

En el ámbito de las estrategias de afrontamiento, los estudiantes de enfermería de nuestro estudio, expresan que el poder hablar y compartir su experiencia, constituyó uno de los elementos más útiles para poder "normalizar" la experiencia de la muerte ajena, coincidiendo con Wong y Tomer (2011), quienes exponen que hablar de la muerte ayuda a su aceptación como parte de la vida y favorece un trato respetuoso y compasivo hacia el otro.

Por otra parte, los estudiantes manifiestan la ayuda que suponen las creencias y prácticas espirituales, que contribuyen a dar sentido al proceso de reconstrucción que supone el dolor en el contexto de EOL care (Depaola *et al.* 2003; Giske, 2012; Mount, Boston & Cohen 2007).

Otro de los temas que surgen en nuestro estudio, es el relacionado con las cuestiones éticas, de manera similar a otros trabajos que exponen que los dilemas éticos son frecuentes en el ámbito de EOL care (Ferrell & Coyle, 2006; Oberle & Hughes 2001). Cabe destacar que, a diferencia de otros estudios, nuestros estudiantes manifiestan dudas sobre aspectos éticos en la información al enfermo y las justificaciones clínicas de la sedación paliativa y su diferencia con la eutanasia. Además, en la definición de lo que consideran una buena muerte identifican, como aspecto clave para una buena muerte, el "tener permiso" para morir, relacionándolo con la aceptación por parte del paciente y familia de su muerte y destacando la gran importancia de la resolución de asuntos pendientes.

Análogamente a otro autores (Byock 2002, Hwang *et al.* 2005), nuestro estudio muestra que a pesar del impacto que supone la experiencia de la primera muerte, también supone un proceso de aprendizaje y crecimiento personal, ya que permite incorporar experiencias difíciles, dotarles de sentido e incorporarlas a cada sistema de valores.

Estos resultados permiten dar respuesta al primer objetivo de explorar la experiencia de los estudiantes de enfermería ante la muerte y el proceso de morir de los pacientes en el contexto de sus prácticas clínicas. Además, al relacionar los temas que emergen del estudio se deriva un modelo explicativo de la vivencia del fenómeno. Este modelo parte de un tema central que es el gran impacto que producen las primeras experiencias con la muerte de los pacientes, y el resto de temas, como son la formación en competencias socioemocionales, las estrategias de afrontamiento y las cuestiones éticas se manifiestan como respuesta, necesidad o modulación al impacto; fruto de todo el proceso anterior es el último tema, un aprendizaje y crecimiento personal que a su vez pueden modular el impacto que supone la muerte del paciente. En este sentido, consideramos que este modelo resultante puede ser de gran utilidad para el diseño de los programas formativos en EOL care, ya que parte de las necesidades expresadas por los propios estudiantes en este ámbito.

Este estudio presenta algunas limitaciones. Podría considerarse que la muestra es relativamente pequeña, sin embargo el número de participantes estuvo condicionado por la saturación de los datos que ocurrió con las nueve primeras entrevistas. Otra limitación es que al seguir el criterio de mejor informante y ser la participación voluntaria, podría pensarse si las actitudes expresadas ante la muerte fueron más "positivas", respondiendo a la deseabilidad social, aunque el alto impacto que surge en los resultados parece no corroborar esta interpretación.

OBJETIVO 2

Analizar las relaciones de las actitudes ante la muerte de los estudiantes de enfermería con la inteligencia emocional, la autoestima y la resiliencia, con el fin de identificar las necesidades formativas en este ámbito.

En el estudio cuantitativo realizado con 760 estudiantes de enfermería españoles, se pretendía analizar las relaciones entre las actitudes ante la muerte y la inteligencia emocional, la resiliencia y la autoestima. Los resultados identifican la resiliencia, la autoestima y la atención emocional como variables predictoras de la ansiedad ante la muerte. Cabe también destacar que los estudiantes con mayor comprensión y regulación emocional presentan menos miedo y ansiedad ante la muerte, hallazgos que coinciden con llos obtenidos por Aradilla-Herrero *et al.* (2012-13) en un estudio realizado en el mismo contexto y que evidencia que los estudiantes con puntuaciones más altas en claridad y reparación emocional, presentan menos miedo y ansiedad ante la muerte.

Según nuestros resultados, la relación entre la inteligencia emocional y las actitudes ante la muerte justifica una formación específica en el ámbito de las competencias socioemocionales durante los estudios de Grado de Enfermería. En esa línea, coincidimos con diferentes autores (de Araújo *et al.*, 2004; Bailey *et al.*, 2011) que explican la conveniencia de desarrollar la inteligencia emocional en las futuras enfermeras, para facilitar el manejo y regulación de las emociones que se generan al afrontar situaciones de sufrimiento y muerte. Además, la atención, claridad y reparación del propio estado emocional son imprescindibles para poder desarrollar una escucha activa y llevar a cabo una comunicación empática y centrada en el paciente (Augusto Landa *et al.*, 2009).

Desde estos hallazgos, sugerimos que una de las estrategias formativas para facilitar el manejo emocional es la práctica de *mindfulness* (Epner & Baile, 2014). El *mindfulness* incluye la presencia y atención plena en el aquí y ahora, así como la aceptación sin juicio tanto de las emociones propias como las ajenas, facilitando su regulación y favoreciendo la empatía compasiva (Beckman *et al.*, 2012; Epstein, 1999). Además, la práctica del *mindfulness* disminuye la reactividad emocional que puede generarse en situaciones de gran distrés emocional como son las situaciones de final de vida (Arch & Craske, 2010; Hill & Updegraff, 2012), contribuyendo a disminuir el contagio emocional y el riesgo de sufrir fatiga por compasión.

Con respecto a la resiliencia, nuestro estudio muestra que los estudiantes con niveles más altos de resiliencia presentan menos ansiedad ante la muerte, lo que sugiere que las personas que utilizan estrategias resilientes afrontan las situaciones adversas con mayor confianza y menor ansiedad (Sinclair & Wallston, 2004). Además, las enfermeras más resilientes presentan menos síntomas de ansiedad, depresión y menor prevalencia de burnout (Mealer *et al.*, 2012). En consecuencia, apostamos por la formación en estrategias resilientes que faciliten un afrontamiento de los cambios y las situaciones adversas de una manera más constructiva y saludable. Así pues, apostamos por la formación en estrategias resilientes en el ámbito de EOL care, ya que pueden favorecer una mejor integración de las pérdidas, con mayor control emocional, e incluso aceptar la muerte como una experiencia de crecimiento.

Respecto a la autoestima y su relación con las actitudes ante la muerte, nuestros resultados coinciden con los de Aradilla-Herrero, Tomás-Sábado y Gómez-Benito (2014), destacando que los estudiantes que manifiestan niveles más altos de autoestima tienen menor miedo y ansiedad ante la muerte, además de presentar mayor comprensión y regulación emocional. Parece lógico suponer que una persona con alta autoestima tiene mayor confianza en sus propias capacidades, pudiendo dar respuestas más adecuadas a situaciones estresantes, como son las situaciones de final de vida. Además, según Baumeister, Campbell, Kreuger y Vohs (2003), los estudiantes con una alta autoestima presentan más resistencia al fracaso y menos sensación de incompetencia. Por todo ello, podemos considerar la autoestima como un protector en la adaptación al estrés, por lo que sugerimos formación específica para facilitar el desarrollo de la autoestima y mejorar las actitudes ante la muerte de los futuros enfermeros.

Cabe considerar que este estudio presenta ciertas limitaciones. La más importante de ellas viene determinada por la naturaleza transversal del estudio que no permite concluir la asociación causal entre las distintas variables estudiadas. Además existe la limitación de la muestra utilizada, formada exclusivamente por estudiantes de enfermería, lo que necesariamente restringe la capacidad de extrapolación de los resultados. Asimismo, la mayoría de los estudiantes son mujeres, lo que limita la significación de los resultados de la comparación por sexos; no obstante esta es una limitación de carácter general en los estudios que se llevan a cabo en profesionales y estudiantes de enfermería, donde el sexo femenino es más prevalente. En futuras investigaciones, cabría considerar la recogida longitudinal de datos en diferentes cohortes de estudiantes y/o profesionales que permitiese concluir de manera más sólida la posible asociación causal entre las diversas variables estudiadas.

OBJETIVOS 3 y 4

Realizar la adaptación y validación de la Frommelt Attitudes Toward Care of the Dying (FATCOD), y evaluar su confiabilidad y validez en una muestra de estudiantes de enfermería españoles. A su vez, confirmar la dimensionalidad de la escala FATCOD mediante un Análisis factorial confirmatorio.

En el contexto de este trabajo, otro de los objetivos específicos fue la adaptación, validación al español y estudio de las propiedades psicométricas del instrumento the Frommelt Attitudes Toward Care of the Dying (FATCOD), una escala desarrollada para evaluar las actitudes ante los cuidados de las personas al final de la vida y sus familias (Frommelt, 1991). Después de haber evaluado las cuatro configuraciones propuestas por la literatura (Frommelt, 1991; Nakai *et al.,* 2006; Henoch *et al.,* 2014; Leombruni *et al., 2*014), adoptamos el modelo bifactorial propuesto por Nakai *et al.* (2006), ya que es el que mejor se adapta a los datos de la muestra española.

En consecuencia, se propone que la escala FATCOD-S (ver anexo 6) contiene dos factores, un primer factor que se refiere a las actitudes ante el cuidado del paciente al final de la vida, con un coeficiente α de consistencia interna de 0.74, y un segundo factor, relacionado con la percepción del cuidado centrado en el paciente y familia, que tiene un α de Cronbach de 0.65. El α de Cronbach total de la escala es de 0.76.

En nuestro análisis del contenido de los dos factores, coincidimos con la nomenclatura de las dimensiones propuestas por Nakai *et al.* (2006).

En definitiva, nuestro estudio evidencia que la FATCOS-S es un instrumento bifactorial, con índices satisfactorios de fiabilidad y validez, que justifican su uso en el ámbito de enfermería en el contexto español.

Sin embargo, cabe considerar ciertas limitaciones. En primer lugar el uso de una muestra formada exclusivamente por estudiantes de enfermería limita la generalización de los resultados a otros profesionales de la salud, por lo que sería importante replicar este tipo de estudio en profesionales de enfermería que aportarán mayor consistencia a la consideración de la validez del instrumento.

OBJETIVO 5

Conocer el papel modulador que sobre las actitudes ante los cuidados al paciente en situación de final de vida presentan ciertas variables sociodemográficas, las experiencias previas con la muerte y la formación en cuidados paliativos.

Los resultados del estudio 3 confirman la influencia que las características demográficas, experienciales y formativas tienen sobre las actitudes ante la muerte. En relación a la edad, nuestros resultados son similares a los de otros autores (Dunn *et al.,* 2005; Lange *et al.*, 2008), que confirman que los sujetos más jóvenes presentan unas actitudes menos positivas ante el cuidado del paciente en situación de final de vida, que podría estar relacionado con que aún no han tenido contacto con situaciones de sufrimiento y muerte, por lo que no han desarrollado mecanismos para su afrontamiento.

Respecto al curso académico, los resultados muestran que las actitudes ante el cuidado del paciente moribundo son más positivas a medida que el estudiante va progresando en los cursos académicos. En este sentido, los resultados son similares a los obtenidos por otros autores (Aradilla-Herrero *et al.*, 2012-13; Edo-Gual *at al.*, 2011). Según parece, cuando el estudiante inicia sus estudios aún no han tenido contacto con la realidad asistencial, donde probablemente afrontará el cuidado al paciente en situación terminal, experimentando el contacto con el sufrimiento y dolor del otro. El contacto de estos estudiantes con situaciones nuevas, su inexperiencia y la falta de control pueden actuar como fuentes estresoras y disminuir las actitudes positivas hacia el cuidado de este tipo de pacientes. Por otra parte, el incremento positivo posterior en estas actitudes, puede sugerir que la experiencia y la formación en este ámbito minimizan su impacto.

En relación a las experiencias previas con las muerte y la formación en cuidados paliativos, el estudio muestra que los estudiantes que presentan actitudes más positivas hacia el cuidado del paciente en situación de final de vida, son aquellos que han tenido contactos previos con la muerte y han recibido formación en EOL care. En este sentido, diferentes autores (Lange *et al.;* 2008 Dunn *et al.*, 2005, Henoch *et al.*, 2014) muestran que la la experiencia previa en cuidados a pacientes en situación terminal, está relacionada con actitudes más positivas hacia este tipo de cuidados, además de sugerir aumentar la formación en EOL care para mejorar las actitudes ante los cuidados de estos pacientes. Por ello, desde la perspectiva docente, parece conveniente que el estudiante de enfermería, inicie de manera precoz su formación en las prácticas clínicas para desarrollar estrategias de afrontamiento de las situaciones de sufrimiento y muerte.

En relación a la formación previa en cuidados paliativos, los resultados indican que es una variable moduladora en las actitudes ante los cuidados a pacientes en situación de final de vida y familia, ya que los estudiantes con formación previa presentan actitudes más positivas. Diferentes estudios coinciden con estos resultados (Mallory, 2003; Hirakawa, Kimata & Uemura, 2013; Nagamatsu, Natori, Yanai & Horiuchi, 2014), al destacar que los estudiantes que habían recibido formación previa específica en el ámbito de EOL care mostraban actitudes más positivas hacia el cuidado de estos pacientes. Así pues, a la luz de estos resultados parece lógico proponer mayor formación en el ámbito de EOL care en los estudios de pregrado de enfermería.

OBJETIVO 6

Determinar las relaciones entre las actitudes ante el cuidado del paciente al final de la vida y su familia con las tres dimensiones de la inteligencia emocional (atención, claridad y reparación) y con el miedo y la ansiedad ante la muerte.

Este último objetivo se aborda en el artículo nº 3. Los resultados muestran que los estudiantes que presentan actitudes más positivas hacia los cuidados de los pacientes en situación de final de vida, tienen menos miedo a la muerte propia y ajena, asi como menor ansiedad ante la muerte. Estos resultados coinciden con otros estudios (Braun *et al*., 2010; Lange *et al*., 2008) que muestran que las enfermeras con más miedo a la muerte presentan actitudes menos favorables ante el cuidado del paciente en situación terminal y familia.

Otro aspecto del objetivo propuesto era analizar las relaciones de las actitudes ante el cuidado del paciente en situación de final de vida y familia, con las tres dimensiones de la inteligencia emocional. Nuestro estudio revela que los estudiantes con mayor comprensión hacia las emociones que les suscita el contacto con la muerte y el sufrimiento, y que además presentan una correcta gestión de estos estados emocionales, están más predispuestos a cuidar a personas moribundas y sus familiares. Estos resultados son coherentes con los de otros estudios (Aradilla-Herrero *et al*., 12-13; Aradilla-Herrero *et al.* 2014; Edo-Gual, Monforte-Royo, Aradilla-Herrero & Tomás-Sábado, 2015, in press) que ponen de manifiesto que los estudiantes y profesionales de enfermería con inteligencia emocional presentan menos miedo y ansiedad ante la muerte. En este sentido, diferentes autores (Bayley y Hewison, 2014; Aradilla-Herrero *et al.*, 2014; Edo-Gual *et al.*, 2014; Strang *et al*., 2014) proponen la necesidad de contemplar el desarrollo de la inteligencia emocional en los planes formativos enfermeros en EOL care, y realizarla mediante metodologías activas y experienciales, ya que la labor emocional de la enfermera en este ámbito es muy importante. Coincidimos plenamente con este aspecto, ya que es fundamental la formación en competencias socioemocionales, pues el cuidado a pacientes en situación de final de vida requiere afrontar situaciones muy complejas que precisan unas habilidades emocionales adecuadas para poder proporcionar una asistencia de calidad, además de minimizar el impacto emocional en el propio profesional.

2. CONCLUSIONES

CONCLUSIONES

- El primer contacto de los estudiantes de enfermería con la muerte durante sus prácticas clínicas es expresado como un fuerte impacto y como una experiencia que siempre se recuerda y que puede influir en conductas asistenciales futuras.
- Los estudiantes de enfermería manifiestan que la experiencia del contacto con la muerte constituye un aprendizaje vital que relacionan con el crecimiento personal.
- La formación específica en cuidados al final de la vida debe realizarse al inicio del plan formativo, antes de la realización de las prácticas clínicas, que, previsiblemente, van a constituir para los estudiantes de enfermería sus primeras experiencias con la muerte. Esta formación debe realizarse aplicando metodologías experienciales y participativas.
- El modelo explicativo propuesto sobre la vivencia de la primera muerte durante las prácticas clínicas, puede constituir una herramienta de utilidad para el diseño de programas formativos en EOL, ya que tiene su origen en las necesidades expresadas por los propios estudiantes de enfermería.
- La atención emocional, la resiliencia y la autoestima son factores predictores de la ansiedad ante la muerte en estudiantes de enfermería.
- Sería necesario incluir en los planes curriculares de los estudios de enfermería, la formación en competencias socioemocionales y comunicativas, así cómo estrategias de afrontamiento resilientes, que potenciaran la autoestima y el desarrollo de la inteligencia emocional, para facilitar un afrontamiento más constructivo y saludable, minimizando el desgaste emocional del futuro profesional y favoreciendo unos cuidados de alta calidad al paciente en situación de final de vida y familia.
- Son necesarios estudios adicionales que evalúen la eficacia de las acciones formativas.
- La Frommelt Attitudes Toward Care Of Dying (FATCOD-S) es un instrumento válido y fiable para su uso con estudiantes de enfermería españoles.

- El uso de la FATCOD-S en el contexto de los estudiantes de enfermería puede proporcionar información importante sobre cómo estos futuros profesionales se relacionan con los enfermos y familias en situación de final de vida.
- Es necesario replicar este tipo de estudio en profesionales de enfermería que consolidaran la validez del instrumento.
- Los estudiantes de enfermería que presentan más miedo y ansiedad ante la muerte, muestran actitudes menos positivas ante el cuidado del paciente moribundo y su familia.
- Los estudiantes que han tenido experiencias previas con la muerte y los que han recibido formación en cuidados al final de la vida presentan unas actitudes más positivas ante el cuidado del paciente en situación de final de vida y familia.
- Los estudiantes con una inteligencia emocional más desarrollada presentan mejor predisposición ante los cuidados del paciente moribundo y familia.
- La formación de los estudiantes en el ámbito de cuidados al final de la vida debería incluir estrategias que favorecieran el desarrollo de competencias socioemocionales que dotaran a los futuros estudiantes de recursos eficaces para poder cuidar y cuidarse de manera eficaz.

3. LÍNEAS DE INVESTIGACIÓN Y PROPUESTAS DE FUTURO

LÍNEAS DE INVESTIGACIÓN Y PROPUESTAS DE FUTURO

En la actualidad, desde nuestra labor docente seguimos trabajando a lo largo de los estudios de pregrado, en la formación en competencias sociemocionales y comunicativas, así como en estrategias de afrontamiento eficaces en el entorno de situaciones de final de vida. Sin embargo, son necesarios más acciones docentes y estudios en este ámbito, que a nivel general son:

- Implementar estrategias de afrontamiento positivo ante situaciones de sufrimiento y muerte a lo largo del currículum enfermero, integradas en situaciones de simulación y mediante técnicas experienciales, evaluando su eficacia con estudios longitudinales.
- Diseñar e implementar programas formativos de prácticas de simulación en el ámbito de EOL care que permitan un aprendizaje significativo en las competencias sociemocionales necesarias para una eficaz interrelación con el enfermo y familia en situación de final de vida.
- Evaluar la adquisición de competencias socioemocionales de los estudiantes de enfermería en el entorno de EOL care, mediante pruebas de Evaluación Clínica Objetiva Estructurada (ECOE).
- Analizar la eficacia de la formación en EOL care en la asignatura de Cuidados Paliativos y conocer la experiencia de aprendizaje de los estudiantes. Para ello hemos diseñado un estudio mixto experimental, con una fase cualitativa de diseño metodológico utizando la técnica de grupos focales y análisis de documentos, y una segunda fase cuantitativa con medidas de competencias socieoemocionales y actitudes ante la muerte, antes y después de la intervención educativa.
- Validar la escala FATCOD en profesionales de enfermería para consolidar la validez del instrumento.

- Propuestas de etiquetas diagnósticas enfermeras en el ámbito de situaciones de final de vida, referentes al miedo y ansiedad ante la muerte.

4. PRODUCCIÓN CIENTÍFICA

PRODUCCIÓN CIENTÍFICA

Artículos originales que constituyen la memoria de la Tesis Doctoral.

1. *The impact of death and dying on nursing students: an explanatory model.*

Edo-Gual M., Tomás-Sábado J., Bardallo-Porras D. y Monforte-Royo C. (2014). *Journal of Clinical Nursing*, 23(23-24): 3501-3512. DOI: 10.1111/jocn.12602.

Factor de impacto: 1.316 (2012).

ISI Journal Citation Reports®: Nursing, posición 25 de 106 (1er cuartil).

***2. Death attitudes and positive coping in Spanish nursing undergraduate*. A cross sectional and correlational study.** Edo-Gual M., Monforte-Royo C., Aradilla-Herrero A. y Tomás-Sábado J. (2015). *Journal of Clinical Nursing*. *en prensa.*

Factor de impacto: 1.233 (2013).

ISI Journal Citation Reports®: Nursing, posición 32 de 107 (2º cuartil).

3. Spanish adaptation of the Frommelt Attitudes Toward Care of Dying Scale (FATCOD-S) in nursing undergraduates. Edo-Gual M., Tomás-Sábado J., Gómez-Benito J., Monforte-Royo C. y Aradilla-Herrero A. (2015), *en revisión.*

Artículos y manuscritos complementarios publicados

1. *Afrontar el sufrimiento y la muerte: desafíos para el cuidado en el siglo XXI.*

Coping with suffering, dying and death: Challenges for care in the 21st century.

Edo-Gual M., Monforte-Royo C. y Tomás-Sábado J. (2015). *Enfermería Clínica,* 25(1): 42-43. DOI: 10.1016/j.enfcli.2014.10.002.

2. ***Relational Model of Nursing Students' Experiences of Death and Dying during their Clinical Training.*** Edo-Gual M., Aradilla-Herrero A., Bardallo-Porras D., Tomás-Sábado J. y Monforte-Royo C. (2014). Palliative Medicine, 28 (6): 602.

Factor de impacto: 2.845 (2013)

ISI journal citation reports®: Health Care Sciences & Services posición 19 de 86: Medicine, General & Internal, posición 26 de 156 ; Public, Environmental & Occupational Health, posición 31 de 162 (1er cuartil).

3. ***Preliminary Validation of the Spanish Version of the Frommelt Attitudes toward Care of the Dying Scale (FATCOD).*** Aradilla-Herrero A., Edo-Gual M., Monforte-Royo C. y Tomás-Sábado J. 2014. Palliative Medicine, 28 (6): 830-831.

Factor de impacto: 2.845 (2013).

ISI journal citation reports®: Health Care Sciences & Services posición 19 de 86; Medicine, General & Internal, posición 26 de 156; Public, Environmental & Occupational Health, posición 31 de 162 (1er cuartil).

4. ***Fear of dying: Conceptual Proposal for Improving Nursing Care at the End of Life. Preliminary Results.*** Fernandez-Donaire L., Monforte-Royo C., Aradilla-Herrero A., Edo-Gual M., Fernandez-Narvaez P., Mate-Mendez J. y Tomás-Sábado J. 2014. Palliative Medicine, 28 (6): 756-757.

Factor de impacto: 2.845 (2013)

ISI journal citation reports®: Health Care Sciences & Services posición 19 de 86; Medicine, General & Internal, posición 26 de 156; Public, Environmental & Occupational Health, posición 31 de 162 (1er cuartil).

5. ***Miedo a la muerte en estudiantes de enfermería.*** Edo-Gual M., Tomás-Sábado J. y Aradilla-Herrero A. 2011. *Enfermería Clínica* 21 (3): 129-135. DOI: 10.1016/j.enfcli.2011.01.007. PMID:21531603.

6. ***Modelos de competencias emocionales en Enfermería en el contexto del Espacio Europeo de Educación Superior.*** Aradilla-Herrero A., Edo-Gual M. y Tomás-Sábado J. (2011). *En*: Fernández-Berrocal y otros (Coords). *Inteligencia Emocional: 20 años de investigación y desarrollo* (525-529). *Santander: Fundación Marcelino Botín.*

7. ***Miedo a la muerte, inteligencia emocional y autoestima en estudiantes de enfermería.*** Aradilla-Herrero A., Tomás-Sábado J., Monforte-Royo C., Edo-Gual M. y Limonero J.T. (2010). Medicina Paliativa, 17 (supl I) 110.

Factor de impacto: 2.845 (2013)

ISI journal citation reports®: Health Care Sciences & Services posición 19 de 86; Medicine, General & Internal, posición 26 de 156; Public, Environmental & Occupational Health, posición 31 de 162 (1er cuartil).

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5. ANEXOS

ANEXO 1: Hoja de información al participante

HOJA DE INFORMACIÓN AL PARTICIPANTE (Entrevista en profundidad)

Código del protocolo de investigación:
Versión del protocolo: 1.0
Fecha de la versión del protocolo: 29 de marzo de 2012
Fecha de la presentación del protocolo: 3 de julio 2012
Título del estudio: Actitudes ante la muerte y factores relacionados de los estudiantes de enfermería en la comunidad autónoma de Catalunya.

Director/a de la Tesis: Dr. Joaquín Tomás-Sábado
Doctorando: Montserrat Edo Gual
Tutor/a / Monitor/a: No procede
Departamento: Facultad de Medicina y Ciencias de la Salud
Línea de investigación: Programa de doctorado en Investigación en Salud

Hemos solicitado su participación en un estudio de investigación. Antes de decidir si aceptan participar, es importante que comprenda los motivos por los cuales se lleva a cabo esta investigación: como se utilizará su información, en qué consistirá el estudio y los posibles beneficios, riesgos y molestias que pueda comportar.

Propósito: Conocer la percepción de diferentes estudiantes de enfermería sobre el fenómeno de la muerte de los pacientes y su vivencia como estudiantes en prácticas. Para poder llevar a cabo este trabajo se estudiarán las respuestas a las entrevistas de diversos estudiantes de enfermería. La investigadora responsable del proyecto forma parte del equipo de profesores de l'Escola d'Infermeria Gimbernat, adscrita a la Universitat Autònoma.

Procedimiento: Para la obtención de información se realizarán entrevistas en profundidad. La entrevista en profundidad es una técnica que, mediante una conversación profesional, permite obtener oralmente el relato de una vivencia, narrado por la misma persona que lo ha experimentado, y desde su punto de vista. Su participación en el estudio consiste en colaborar en una entrevista, permitiendo que el entrevistador pueda hacerle preguntas y usted pueda expresar su experiencia, sus significados e interpretaciones tal como los experimenta en su propio mundo. Esta información será grabada mediante una grabadora de audio. Posteriormente se transcribirá esta información para posteriormente poder ser analizada. Todos los datos serán guardados mediante archivos electrónicos que serán completamente destruidos al finalizar la investigación.

Riesgos: La participación en la entrevista no supone en ningún momento ningún peligro o riesgo para la salud física ni psíquica.

Beneficios: La participación en la entrevista puede ser incluso beneficiosa para usted al aportar experiencias personales y profesionales respecto a la vivencia del fenómeno de la muerte y contribuir a aumentar el conocimiento enfermero.

Compromiso de confidencialidad: La investigadora se compromete a garantizar la confidencialidad respecto a la identidad de cada participante y a mantener los registros de la investigación a recaudo para asegurar el anonimato de los participantes en el estudio. Estos datos, no incluyen ni su nombre ni su dirección, sino que se le asignará un número de código. Únicamente el equipo investigador, tendrá acceso a la clave del código que permite asociar los datos del estudio con usted. Las copias de los documentos y grabaciones de este estudio serán conservados en los archivos del departamento de Enfermería de la Universidad Internacional de Catalunya, teniendo únicamente acceso a esta información los investigadores del proyecto. Estos procedimientos están sujetos a lo que dispone la Ley Orgánica 15/1999 del 13 de diciembre de protección de datos de carácter personal. Los hallazgos de este estudio sólo podrán ser publicados o presentados en reuniones científicas sin revelar la identidad de sus participantes.

Libertad para retirarse del estudio: Su participación es libre y voluntaria, por lo que si usted lo prefiere, puede retirarse del estudio en cualquier momento, incluso sin verse obligado a dar ninguna explicación. Su retirada del estudio no supondrá ninguna consecuencia ni para su salud ni para su persona.

Contactos adicionales: Puede ponerse en contacto con los investigadores para aclarar dudas sobre su participación en el estudio.
Por favor, si no lo ha hecho todavía, haga las preguntas que le parezcan oportunas e intentaremos responderle lo mejor que podamos.

Datos de contacto
Investigadora: Montserrat Edo Gual
Av. De la Generalitat, 202-206; 08174 Sant Cugat del Vallès (Barcelona)
Escola Universitària d'Infermeria Gimbernat. Adscrita a la Universitat Autònoma
Telf. 93 5893727
montserrat.edo@eug.es

ANEXO 2: Hoja de consentimiento informado

HOJA DE CONSENTIMIENTO INFORMADO

Nombre del proyecto: “Actitudes ante la muerte y factores relacionados de los estudiantes de enfermería en la comunidad autónoma de Catalunya”.

Investigadora: Montserrat Edo Gual
Av. De la Generalitat, 202-206; 08174 Sant Cugat del Vallès (Barcelona)
Escola Universitària d’Infermeria Gimbernat. Adscrita a la Universitat Autònoma.
Telf. 93 5893727
montserrat.edo@eug.es

El/la investigador/a _____Montserrat Edo Gual________________________________ con DNI __77288422G___________ informa al participante Sr/Sra. ____ con DNI __________________, sobre la participación en el proyecto titulado: “Actitudes ante la muerte y factores relacionados de los estudiantes de enfermería en la comunidad autónoma de Catalunya”.

Su participación en este estudio es completamente voluntaria y puede retirarse del estudio en cualquier momento que desee, sin ninguna consecuencia de ningún tipo.

Su firma a continuación confirma que ha leído el documento de información adicional o que alguien se lo ha leído. Se le ha dado y se le continuará dando la oportunidad de hacer preguntas y de concretar su participación en el proyecto

Firme solo este documento en el caso de haber leído la información adicional, haber aclarado sus dudas y si su participación es libre y voluntaria.

	Nombre y apellidos	Fecha	Firma
Participante			
Informante			

ANEXO 3: Documento de aprobación del comité de ética de la Universitat Internacional de Catalunya (CER)

CER Comitè d'Ètica de Recerca
Universitat Internacional de Catalunya

CARTA APROVACIÓ PROJECTE PEL CER

Codi de l'estudi: INF-2012-04
Versió del protocol: 1.1
Data de la versió: 24/07/12
Títol: "Actitudes ante la muerte y factores relacionados de los estudiantes de enfermería en la comunidad autónoma de Catalunya".

Sant Cugat del Vallès, 24 de juliol de 2012

Investigadora: Montserrat Edo Gual

Títol de l'estudi: "Actitudes ante la muerte y factores relacionados de los estudiantes de enfermería en la comunidad autónoma de Catalunya".

Benvolgut(da),

Valorat el projecte presentat, el CER de la Universitat Internacional de Catalunya, considera que, des del punt de vista ètic, reuneix els criteris exigits per aquesta institució i, per tant, ha

RESOLT FAVORABLEMENT

emetre aquest CERTIFICAT D'APROVACIÓ per part del Comitè d'Ètica de la Recerca, per que pugui ser presentat a les instàncies que així ho requereixin.

Em permeto recordar-li que si en el procés d'execució es produís algun canvi significatiu en els seus plantejaments, hauria de ser sotmès novament a la revisió i aprovació del CER.

Atentament,

Dr. Josep Argemí
President CER-UIC

ANEXO 4: Escala FATCOD versión inglesa original

Frommelt Attitude Toward Care of the Dying Scale

Original Form A

In these items the purpose is to learn how nurses feel about certain situations in which they are involved with patients. All statements concern the giving of care to the dying person and/or, his/her family. Where there is reference to a dying patient, assume it to refer to a person who is considered to be terminally ill and to have six months or less to live.

Please circle the letter following each statement which corresponds to your own personal feelings about the attitude or situation presented. Please respond to all 30 statements on the scale. The meaning of the letters is:

SD = Strongly Disagree
D = Disagree
U = Uncertain
A = Agree
SA = Strongly Agree

1. Giving nursing care to the dying person is a worthwhile learning experience.
SD D U A SA

2. Death is not the worst thing that can happen to a person.
SD D U A SA

3. I would be uncomfortable talking about impending death with the dying person.
SD D U A SA

3. Nursing care for the patient's family should continue throughout the period of grief and bereavement.
SD D U A SA

5. I would not want to be assigned to care for a dying person.
SD D U A SA

6. The nurse should not be the one to talk about death with the dying person.
SD D U A SA

7. The length of time required to give nursing care to a dying person would frustrate me.
SD D U A SA

8. I would be upset when the dying person I was caring for gave up hope of getting better.
SD D U A SA

9. It is difficult to form a close relationship with the family of the dying person.
SD D U A SA

10. There are times when death is welcomed by the dying person.
SD D U A SA

11.When a patient asks, "Nurse am I dying?," I think it is best to change the subject to something cheerful.
SD D U A SA

12. The family should be involved in the physical care of the dying person.
SD D U A SA

13. I would hope the person I'm caring for dies when I am not present.
SD D U A SA

14. I am afraid to become friends with a dying person.
SD D U A SA

15. I would feel like running away when the person actually died.

SD D U A SA

16.Families need emotional support to accept the behavior changes of the dying person.

SD D U A SA

17.As a patient nears death, the nurse should withdraw from his/her involvement with the patient.

SD D U A SA

18.Families should be concerned about helping their dying member make the best of his/her remaining life.

SD D U A SA

19.The dying person should not be allowed to make decisions about his/her physical care.

SD D U A SA

20.Families should maintain as normal an environment as possible for their dying member.

SD D U A SA

21.It is beneficial for the dying person to verbalize his/her feelings.

SD D U A SA

22.Nursing Care should extend to the family of the dying person.

SD D U A SA

23.Nurses should permit dying persons to have flexible visiting schedules.

SD D U A SA

24.The dying person and his/her family should be the in-charge decision makers.

SD D U A SA

25.Addiction to pain relieving medication should not be a concern when dealing with a dying person.

SD D U A SA

26.I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying.

SD D U A SA

27.Dying persons should be given honest answers about their condition.

SD D U A SA

28.Educating families about death and dying is not a nursing responsibility.

SD D U A SA

30. Family members who stay close to a dying person often interfere with the professionals job with the patient.

SD D U A SA

30.It is possible for nurses to help patients prepare for death.

SD D U A SA

Last 4 digits of your Social Security Nº.

Completion and Return of This Questionnaire Will Be
Construed as Your Consent to be a Research
Subject in This Study. Your Anonymity is Guaranteed.

DEMOGRAPHIC DATA SHEET

Please check the appropriate spaces:

1. Age 2. Sex ___ Male
___ 18-22 years ___ Female
___ 23-27 years
___ 28-35 years
___ 36-45 years
___ 46-55 years
___ 56-65 years
___ 66 years and over

3. Highest degree held: ___ High School Equivalency (GED)
___ High School Diploma
___ Associate Degree
___ Bachelors Degree
___ Masters Degree
___ Education Beyond Masters
___ Other (Please Specify)

4. Previous education on death and dying

___ I took a course in death and dying previously.
___ I did not take a specific course on death and dying, but material on the subject was included in other courses.
___ No information dealing with death and dying was previously presented to me.

5. Previous experience in dealing with terminally ill persons

___ I have cared for terminally ill persons and their family members previously.
___ I have had NO experience caring for terminally ill persons and their family members previously.

ANEXO 5: Escala FATCOD versión española

FATCOD

Instrucciones. En cada una de las siguientes frases, marque con una X la opción de respuesta elegida, según el grado de acuerdo o desacuerdo con el que se identifique.

Escala de Frommelt sobre Actitudes ante los cuidados del paciente moribundo	**Totalmente en desacuerdo**	**En desacuerdo**	**Neutro**	**De acuerdo**	**Totalmente de acuerdo**
31. Proporcionar cuidados de enfermería a una persona que se está muriendo es una experiencia muy valiosa	1	2	3	4	5
32. La muerte no es lo peor que le puede suceder a una persona	1	2	3	4	5
33. Me resultaría incómodo hablar con una persona que se está muriendo de su propia muerte	1	2	3	4	5
34. Los cuidados de enfermería a la familia deben continuar durante todo el proceso de duelo	1	2	3	4	5
35. No me gustaría tener que cuidar a una persona que se esté muriendo	1	2	3	4	5
36. La enfermera no es la persona adecuada para hablar de la muerte con una persona que se esté muriendo	1	2	3	4	5
37. Me provoca frustración el tiempo que requiere proporcionar cuidados de enfermería a una persona que se esté muriendo.	1	2	3	4	5
38. Me molestaría que una persona moribunda a la que estuviera cuidando perdiera la esperanza de mejorar	1	2	3	4	5
39. Es difícil establecer una relación estrecha con la familia de una persona que se está muriendo	1	2	3	4	5
40. A veces la muerte es aceptada por la persona que se está muriendo	1	2	3	4	5
41. Cuando un paciente pregunta a la enfermera, "¿me estoy muriendo?", pienso que es mejor cambiar de tema	1	2	3	4	5
42. La familia debería implicarse en los cuidados físicos de la persona que se está muriendo	1	2	3	4	5
43. Preferiría que la persona a la que estoy cuidando muriese cuando yo no esté	1	2	3	4	5
44. Me da miedo establecer amistad con una persona que se está muriendo	1	2	3	4	5
45. Cuando una persona se muere, me dan ganas de salir corriendo	1	2	3	4	5
46. La familia necesita soporte emocional para aceptar los cambios en la conducta de la persona que se está muriendo	1	2	3	4	5
47. Cuando un paciente está cercano a la muerte, la enfermera debería dejar de implicarse en su cuidado	1	2	3	4	5
48. La familia debe preocuparse de que el enfermo viva lo mejor posible lo que le queda de vida	1	2	3	4	5
49. La persona que se está muriendo no debería tomar decisiones sobre sus cuidados físicos	1	2	3	4	5
50. La familia debería mantener un entorno tan normal como sea posible por el bien del enfermo	1	2	3	4	5
51. Es bueno que la persona que se está muriendo verbalice sus sentimientos	1	2	3	4	5
52. Los cuidados de enfermería deben hacerse extensivos a la familia de la persona que se está muriendo	1	2	3	4	5
53. Las enfermeras deben permitir un horario flexible de visitas para las personas que se están muriendo	1	2	3	4	5
54. La persona que se está muriendo y su familia deberían ser los responsables de la toma de decisiones	1	2	3	4	5
55. La adicción a los analgésicos no debería ser una preocupación para las enfermeras de un paciente moribundo	1	2	3	4	5

	Totalmente en desacuerdo	En desacuerdo	Neutro	De acuerdo	Totalmente de acuerdo
56. Me sentiría incómodo/a si al entrar en la habitación de un paciente con una enfermedad terminal, me lo encontrase llorando	1	2	3	4	5
57. Las personas moribundas deberían recibir respuestas honestas sobre su estado	1	2	3	4	5
58. Educar a las familias sobre la muerte y el proceso de morir no es una responsabilidad de enfermería	1	2	3	4	5
59. Los familiares que permanecen junto al paciente moribundo, a menudo interfieren en el trabajo del profesional con el paciente	1	2	3	4	5
60. Las enfermeras pueden ayudar a los pacientes a prepararse para la muerte	1	2	3	4	5

ANEXO 6: Consentimiento Dra. Frommelt para validación escala FATCOD en lengua española

Zimbra: **amor.aradilla@eug.es**

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about FATCOD

De : AMOR ARADILLA HERRERO <amor.aradilla@eug.es> vie, 21 de sep de 2012 16:44
Asunto : about FATCOD
Para : kay frommelt <kay.frommelt@clarke.edu>

Dear Prof Frommelt,
First of all we want to congratulate you for your development of the "Frommelt Attitude Toward Care of the Dying Scale (FATCOD)". We think this instrument could be a very interesting tool for the assessment nurse's attitude toward caring for dying patients.

We are a relatively new research group interested in the study of "attitudes toward death in nursing" and the application of research results to improve the training of future nurses.

We would like to apply your scale to our country (Spain) in future studies. We are requesting permission to translate and to validate the spanish version of your scale for this purpose. Our group includes experts in this type of task.

We look forward to hearing from you.
Kind regards,

Amor Aradilla-Herrero, RN, MS
Escoles Universitaries d'Infermeria Ginbernat, Barcelona. Universitat Autónoma de Barcelona.

Montserrat Edo-Gual, RN, MS
Escoles Universitaries d'Infermeria Ginbernat, Barcelona. Universitat Autónoma de Barcelona.

Joaquin Tomas-Sábado, Psychologist, PhD
Escoles Universitaries d'Infermeria Ginbernat, Barcelona. Universitat Autónoma de Barcelona.

Cristina Monforte, MS,PhD
Universitat Internacional de Catalunya,

Amor Aradilla Herrero
Associate Professor
Escola Universitària d'Infermeria Gimbernat (Universitat Autónoma de Barcelona)
Avinguda Generalitat, 202-206
08174 Sant Cugat del Vallès (BARCELONA) - ESPAÑA

Zimbra: **amor.aradilla@eug.es**

RE: about FATCOD

De : Kay Frommelt <Kay.Frommelt@clarke.edu> vie, 21 de sep de 2012 18:14
Asunto : RE: about FATCOD 3 ficheros adjuntos
Para : AMOR ARADILLA HERRERO <amor.aradilla@eug.es>

Dear Amor

I need to know if you plan to use the original FATCOD, which was designed for use by nurses only or the revised FATCOD, Form B, which was revised so that it could be used by persons from any discipline, including nurses. Form B also has more demographic questions. I am attaching both forms and the scoring instructions to this e-mail. Please let me know which one you plan to use.

Kay Frommelt
Katherine H Murray Frommelt, PhD, RN, FT

From: AMOR ARADILLA HERRERO [amor.aradilla@eug.es]
Sent: Friday, September 21, 2012 9:44 AM
To: Kay Frommelt
Subject: about FATCOD

Dear Prof Frommelt,
First of all we want to congratulate you for your development of the "Frommelt Attitude Toward Care of the Dying Scale (FATCOD)". We think this instrument could be a very interesting tool for the assessment nurse's attitude toward caring for dying patients.

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Kind regards,

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Escoles Universitaries d'Infermeria Ginbernat, Barcelona. Universitat Autónoma de Barcelona.

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Amor Aradilla Herrero
Associate Professor
Escola Universitària d'Infermeria Gimbernat (Universitat Autónoma de Barcelona)
Avinguda Generalitat, 202-206
08174 Sant Cugat del Vallès (BARCELONA) - ESPAÑA

ANEXO 7: Hoja de datos sociodemográficos del cuestionario

Apreciado/a alumno/a,

Estamos realizando un proyecto de investigación sobre actitudes y habilidades personales, que pensamos aportará datos de interés para la docencia y el desarrollo profesional en enfermería. Solicitamos tu colaboración respondiendo a los cuestionarios adjuntos. Te garantizamos que todos los datos serán tratados con absoluta confidencialidad y anonimato, siendo utilizados únicamente a efectos estadísticos.

Fecha:

Sexo: Mujer ☐ Hombre ☐ Código: ……………………………………..

Escuela Universitaria o Universidad ………………………………………………

Edad: .... años

País de nacimiento: …………………..

Curso académico: ……….

Estado civil: Casado/a ☐ Soltero/a ☐ Viudo/a ☐ Separado/divorciado/a ☐

Vive en pareja ☐ Otro ☐

Estado de salud actual:

En una escala del 1 al 10, señala donde sitúas tu estado actual de salud física:

1 2 3 4 5 6 7 8 9 10

muy mala	muy buena

En una escala del 1 al 10, señala donde sitúas tu estado actual de salud psíquica:

1 2 3 4 5 6 7 8 9 10

muy mala

muy buena

¿Prácticas alguna religión?: ☐ Sí ☐ No

¿Crees alguna religión?: ☐ Sí ☐ No

En caso afirmativo, ¿cuál?: …………………………..

¿Cuál consideras que es tu nivel de religiosidad? (valóralo de 0 a 10): ……………..

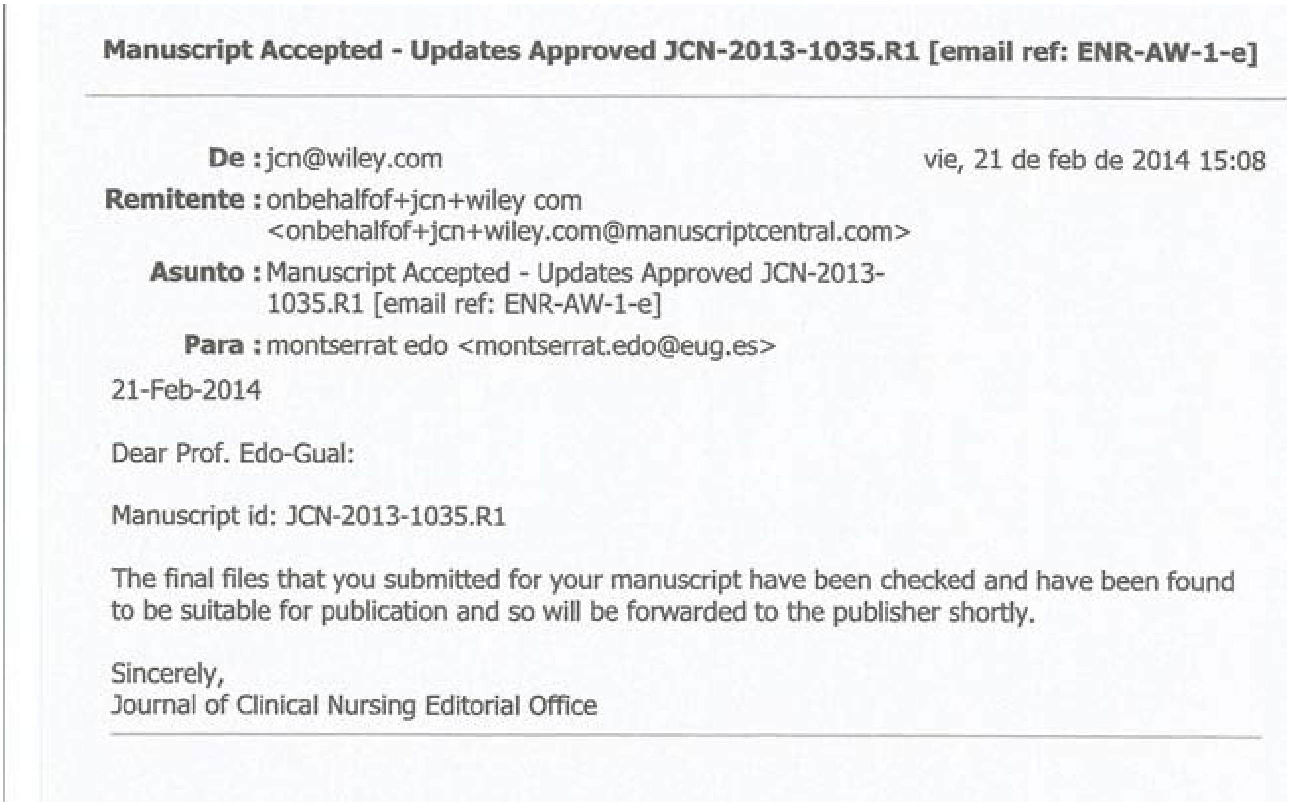
¿Has sufrido la muerte de alguna persona cercana?: ☐ Sí ☐ No

¿Has tenido contacto con la muerte a nivel profesional o durante tus prácticas clínicas?: ☐ Sí ☐ No

¿Has visto morir a alguien?: ☐ Sí ☐ No

¿Has recibido formación sobre cuidados paliativos? ☐ Sí ☐ No

ANEXO 8: Documento de aceptación del 1er artículo del Journal of Clinical Nursing



Manuscript Accepted - Updates Approved JCN-2013-1035.R1 [email ref: ENR-AW-1-e]

De : jcn@wiley.com vie, 21 de feb de 2014 15:08
Remitente : onbehalfof+jcn+wiley com <onbehalfof+jcn+wiley.com@manuscriptcentral.com>
Asunto : Manuscript Accepted - Updates Approved JCN-2013-1035.R1 [email ref: ENR-AW-1-e]
Para : montserrat edo <montserrat.edo@eug.es>

21-Feb-2014

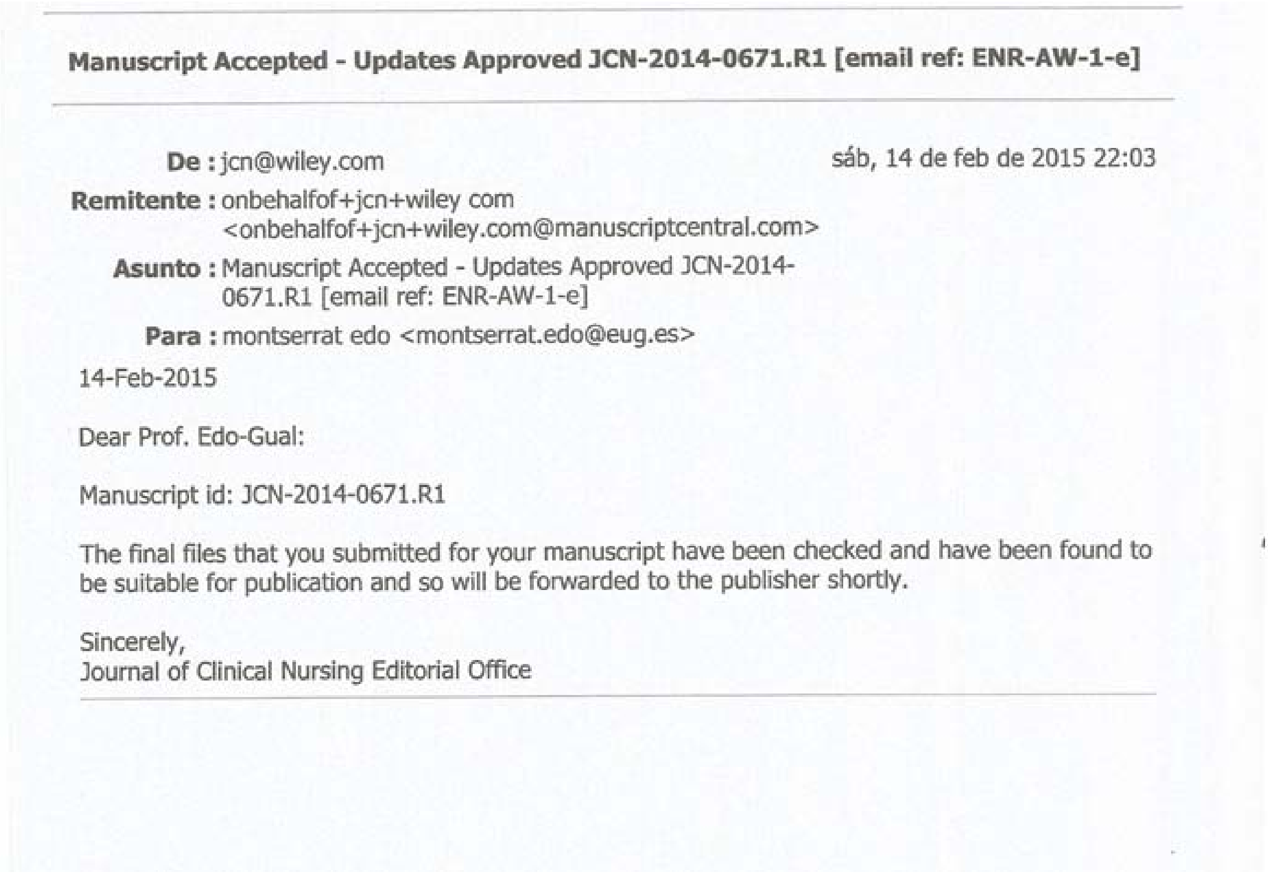
Dear Prof. Edo-Gual:

Manuscript id: JCN-2013-1035.R1

The final files that you submitted for your manuscript have been checked and have been found to be suitable for publication and so will be forwarded to the publisher shortly.

Sincerely,
Journal of Clinical Nursing Editorial Office

ANEXO 9: Documento de aceptación del 2º artículo del Journal of Clinical Nursing



Manuscript Accepted - Updates Approved JCN-2014-0671.R1 [email ref: ENR-AW-1-e]

De : jcn@wiley.com sáb, 14 de feb de 2015 22:03

Remitente : onbehalfof+jcn+wiley com <onbehalfof+jcn+wiley.com@manuscriptcentral.com>

Asunto : Manuscript Accepted - Updates Approved JCN-2014-0671.R1 [email ref: ENR-AW-1-e]

Para : montserrat edo <montserrat.edo@eug.es>

14-Feb-2015

Dear Prof. Edo-Gual:

Manuscript id: JCN-2014-0671.R1

The final files that you submitted for your manuscript have been checked and have been found to be suitable for publication and so will be forwarded to the publisher shortly.

Sincerely,
Journal of Clinical Nursing Editorial Office