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## Who thinks about death? A psychoanalytically informed interpretive study of communication about death among nursing home staff

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### ABSTRACT

The purpose of the present study was to gain insight into how death is a theme of communication and reflection among staff at a multicultural nursing home. Sixteen interviews with healthcare providers from five nursing homes in Norway were conducted and interpreted through a depth-hermeneutic approach. Our analysis across the dataset yielded an emergent finding related to a prominent lack of communication about death between the healthcare personnel and the patients, as well as among the staff community. We present a psychoanalytically informed interpretation of the absence of talk about death in the nursing homes. Our results indicate the operation of a social defence that helps health care providers maintain distance from anxiety associated with death. Reflection that foregrounds healthcare personnel's own experiences, feelings and thoughts related to death is needed to encourage staff to open up to, and digest, the various impressions death can generate.

### KEYWORDS

Death and dying; death anxiety; existential suffering; nursing home staff; social defence; death communication

## Introduction

Nursing homes have increasingly become the final residence for a large segment of the elderly population in Norway. As a result of this development, care for the dying has largely become not only an institutionalised but also a professionalised task. To ensure quality in institutional and professional end of life care, health policy documents highlight the importance of holistic care (White Paper 24, 2019–2020, p. 31). ‘What is important to you?’ is promoted by the health authorities as a key question professionals should pose to patients, in order to assess their physical, mental, social, spiritual and existential needs in end of life care – reflecting a new emphasis on establishing a culture of open communication (The Norwegian Directorate of Health, 2019, p. 18). Professionals’ communication with dying patients should, among other issues, address emotional aspects of the patient’s situation, including existential issues that may arise at the end of life. However, guidelines for practice acknowledge that such issues are not currently well enough catered for in Norwegian health care services (The Norwegian Directorate of Health, 2019, pp. 34–35, 37–42).

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How death is understood in the nursing home in Norway is informed by parallel developments in the neighbouring Nordic societies (Høeg & Pajari, 2013). For example, the Danish sociologist Michael Hviid Jacobsen has expanded on Ariès (1974) cultural-historical analysis of death with reference to the contemporary emergence of what he calls 'the spectacular death'. Here death is '[...] something that we witness at a safe distance with equal amounts of fascination and abhorrence, we wallow in it and want to know about it without getting too close to it' (Hviid Jacobsen, 2016, p. 10). Furthering Hviid Jacobsen's situated analysis, Ramvi & Gripsrud, (2017), discuss a new cultural 'de-tabooisation' of death. There seems to be a discrepancy between the imperative from the Norwegian health authorities and the Nordic culture Hviid Jacobsen is referring to.

Over the past two decades, end-of-life-patients' existential and spiritual concerns have received increasing attention within research. To illustrate, a recent analysis of the concept and phenomenon of existential loneliness deepens understanding of what such existential suffering might entail, including feelings of disconnection from the world and other people, isolation, alienation, emptiness and abandonment (Bolmsjö et al., 2019). For the very old there may be sparse social recognition, rather, they are susceptible to becoming recipients of denigrating projections of the terror of ageing and death. The loss of identity resulting from this psychosocial predicament can be difficult to mourn for the elderly (Frost & Hoggett, 2008). A literature review on existential suffering specifically in palliative care confirms that deep personal anguish at the end of life is one of the most debilitating conditions that can occur in patients who are dying, and yet it is not well understood whether or how such suffering can be alleviated in people's final days (Boston et al., 2011). This is not a new line of inquiry; in 1958, psychoanalyst Hanna Segal presented her case study of an old man, in which she concluded that the unconscious fear of death, which had increased with old age, had, in effect, led to a psychotic breakdown. Segal wrote, 'I believe that the same problem underlies many breakdowns in old age' (Segal, 1958, p. 178). This reflection was substantiated well over 45 years later by Depaola et al.'s study (2003) of older persons that identified participants anxieties about ageing and death, and, more specifically, a fear of the unknown.

A confounding factor when it comes to addressing such suffering and accommodating emotional and existential needs at the end of life is that it may be difficult for dying patients to talk to their relatives about anxiety and fear in relation to death (Gustafsson & Malmlöef, 2012). This situation highlights the need for professional care providers to develop the necessary skills and become more involved in communication about emotional and existential issues at the end of life. The literature emphasises the key skills necessary for providing good quality whole-person care, which include the ability of professionals to invite and establish an intimate dialogue that may help alleviate patients' existential and spiritual suffering (Boston & Balfour, 2006; Gjerberg et al., 2010).

However, there is reason to believe that death is a difficult topic, not only for the elderly who are approaching death and their relatives, but also for health care professionals (Ramvi & Gripsrud, 2017; Gjerberg & Bjørndal, 2007). There appears to be an elusive aspect of death and dying, notably the affective experiences and existential fears that surround the topic, which are hard to express for most of us, including for both the dying and their care providers (Gjerberg & Bjørndal, 2007). The same goes for 'existential pain' (Strang et al., 2004), which can be experienced by both patients and care providers. The experience of being confronted by another's death inevitably makes the individual

conscious of their own mortality and can give rise to considerable anxiety and unease. According to psychoanalytic theory, the objective of anxiety is to conceal from us its unconscious meaning. For this reason, death anxiety is typically not a part of our conscious experience. We may be aware of anxiety in the sense of an embodied feeling of discomfort, but we may not be able to connect this feeling with conscious thought, let alone with words (Lehto & Stein, 2009).

Because death anxiety – as part of the human condition – is something we often do not have conscious contact with, acquiring knowledge about it is also difficult. The same goes for researching the presence of death anxiety in end-of-life care: due to its largely unconscious nature, it cannot be studied directly, and instead must be interpreted as a latent phenomenon within the manifest actions, words and attitudes of health personnel. Often, it is only the psychological defence against anxiety that we can see and hear; rarely do we witness the face or voice of ‘death anxiety’ itself. Denial and repression of death allow us to live in a fantasy world where there is an illusion of immortality (Freud, 1915/2010). Although this denial of death may help a person avoid being in touch with painful experiences, it may subsequently prevent the development of more healthy coping mechanisms (Mercês et al., 2019).

Many studies have approached the topic of death anxiety through surveys, relying primarily on self-report instruments. However, a self-report approach is not capable of capturing a death anxiety that is not consciously experienced or that is denied or avoided (Nia et al., 2016). Instead, we need a greater understanding of how care providers think and talk about death in end-of-life care (Mitchel et al., 2006).

Thus, the purpose of the present study is to gain more insight into how death is a theme of communication and reflection in nursing homes. We build on an underlying assumption that there is a connection between health care providers’ abilities to communicate with patients about death and their own defence against death anxiety as part of the human condition.

Before we present our interview study involving health care personnel in nursing homes, we will briefly turn to the theory that constitutes the onto-epistemological foundation of our research questions. We approach this theory with an illustrative vignette.

### ***Being confronted with death ‘does something to you’***

One of our participants in this study is Jasmine. She is now 50 years old, and she migrated from Eritrea to Norway as a young woman. Today she works as a nurse in a nursing home. When we asked her if she had ever thought of her own death she replied:

Especially the day when you are there when it happens [that one of the patients dies], then you think of your own death. Yes . . . I think one day that will happen to me too. And then, what should I say – it’s so hard – yes, it’s very difficult – what should I say – you’re just staring into the air . . . It’s not that you forget it when you go out from that room. It goes on in the head all the time. All the time. Especially when you’ve been there all the way, to the last moment, been there and helped with the care and stuff – it’s heavy. Yes, it is heavy . . . (. . .) It does something to you, with your feelings.

The meeting with death is 'heavy', and 'does something' with Jasmine, something with her feelings. As the pauses and ruptures in the above quote illustrates, she is struggling to find words. The experience is spinning in her head; although she is unable to find explicit verbal expression, she cannot forget it. We will now follow up this vignette by adding to it a psychoanalytic theoretical understanding of thinking about emotionally difficult experiences.

### ***Thinking from experience***

According to psychoanalytic thinking, when emotionally difficult experiences do not find expression, they cannot be 'digested', and therefore, they cannot be conceived of, thought about or learned from (Bion, 1962/1991). In what follows, we shall explain this more closely. The British psychoanalyst Wilfred Bion used the mother-child dyad as a prototype for the process he calls *containment*. The caregiver (mother) takes in the raw unarticulated feelings that the child cannot accommodate on their own. The caregiver 'ponders' over and 'detoxifies' what she has received so that the child can receive her feelings, now in a digested form. This process of containment is necessary for the child to be able to endure, and to learn to think about, frustrating feelings – a kind of learning that engages with emotional experience. Digestion of emotional experience is thus central to our ability to symbolise, which in turn provides the basis for thinking and for actions based on thinking. The child gradually develops an ability to digest their own emotional experiences. In other words, they develop the ability for self-containment. However, the need for containment in interpersonal relationships or through cultural norms or procedures does not completely cease in childhood. Bion extends his account of intersubjective processing of experience into adulthood. In this sense, in addition to the individual's capacity for reflective self-containment, in order to be able to think and act on thinking, we also continue to need others and a sociocultural context to make sense of ourselves and our experiences (Bion, 1962/1991).

Psychoanalytic thinking may be extended to organisations such as nursing homes, in the sense that they represent social systems with both conscious and unconscious activities (Gould et al., 2001). Working with vulnerable patients can have a profound impact on those who work there, as we have seen in Jasmine's vignette. Such overpowering experiences may generate a response in the organisation that primarily aims to defend against anxiety (Gould et al., 2001). Psychoanalyst Isabel Menzies Lyth conceptualised such an organisational response as a 'social defence'. She described how an organisation wants to manage anxiety to the greatest possible extent, and for this purpose institutional norms and practices can develop into a social defence system. Anxiety and tensions experienced by staff as unbearable are projected onto the social structure and culture of the workplace (Lyth, 1959/1988).

Jasmine expressed, albeit hesitantly, the need she has for an opportunity to open up about the experiences, feelings and thoughts she encounters with death, in order to be better able to manage what the experience 'does to' her. Bion's theory on learning from experience provides a link between the ability of health care professionals to accommodate their own feelings and their ability to communicate with patients about death.

## Method

### *Study context, recruitment and participants*

For Norwegian municipalities, it is an ongoing challenge to get sufficient and competent nursing home staff. Recruitment of employees with a migrant background has offered a solution to this problem (Tingvold & Fagertun, 2020). Migrants are reported to represent 17% of the work force (Claus, 2018). A multicultural staff community has thus become a norm in Norwegian nursing homes.

This study is part of a major research project that examines the multicultural staff community in Norwegian nursing homes (MULTICARE, project number 256617). In this article we focus on staff's personal, emotional, and existential experiences of death to gain insight into how death is a theme of communication and reflection in multicultural nursing homes. Hence, our focus is not on the particular challenges facing immigrant workers in Norwegian nursing homes. However, these have been described in previous studies (see for example, Lavik et al., 2020; Egede-Nissen et al., 2017; Tingvold & Fagertun, 2020).

In this part-study, five nursing homes were recruited by the municipality based on their proportions of multiculturalism. A total of 16 health care providers were recruited from the five nursing homes by the head of the nursing homes. The enrolment criteria were: healthcare providers (nurses, health care workers) who were born and raised in countries outside the Nordic and western European countries, who have come to Norway as labour migrants, refugees, marital migrants or other. Participant enrolment was based on both written and verbal requests. The interviews took place in a suitable room at the nursing home during the participant's working day, with the permission of the nursing home's management team.

Six registered nurses and 10 healthcare workers were enrolled, of which three were men and 13 were women. Participants were between the ages of 26 and 55 (with a majority younger than 40). They had migrated to Norway from East Africa, South East Asia and Eastern Europe. Most of our participants had no previous experience of working in healthcare from their country of birth, and most of them had received their healthcare education in Norway. The majority of our participants had lived in Norway for less than 10 years.

### *Data collection*

In-depth interviews were conducted with the participants from September to November 2017. The interviews were guided by a semi structured interview guide in three parts, where we asked for (i) experiences with death from country of birth, (ii) experience of working with death in a Norwegian nursing home and (iii) how they feel working with death affects them – personally and professionally. In all three parts, there was a focus on how they experienced communication of death, which is the issue in this article. Where it was appropriate, we always asked the participants to give concrete examples and stories to illustrate their statements. The interviews were recorded and transcribed verbatim. Each interview lasted approximately 1.5 hours.

## **Data analysis and interpretation**

Data analysis started during data collection and was an ongoing process. The transcripts were read and reread, and the audio recordings were listened to. Through a depth-hermeneutic approach, these data were analysed and interpreted in terms of their manifest content (what was presented); performative qualities (how it was presented) and unstated, partly unconscious and sociocultural, latent significance (why it was presented in the way that it was) (Gripsrud et al., 2018; Hollway & Volmerg, 2010). The strength of the depth-hermeneutic approach is that it engages a group in critically analysing data extracts, including unconscious aspects, with the aim of generating not just a deeper but a wider understanding of latent meanings. Through group data interpretation, we sought to go beyond the immediate level of meaning in the data by looking for gaps, silences or contradictions indicative of unconscious material in participants' accounts, as well as in our own reactions to and reflections on the material in question. In other words, as researchers, we are not just relying on the emergence of different feelings about the data, we are using those feelings to think against the grain of the data extracts and thereby delve deeper into content that may be 'under the surface' of the transcribed text. Another pathway into unconscious material may be found in searching for and analysing what are called *particular incident narratives* (Wengraf, 2001), in that the particular stories and incidents that are recalled and told by interview participants always have an emotional timbre – otherwise they would not be significant enough to be recalled in the first place.

## **Ethical considerations**

Participants were informed about the study in writing and orally, and they signed a consent form before the interview took place. They were duly informed about their right to withdraw from the study at any time.

In conducting an interview study on health personnel with minority backgrounds, we were wary of creating an othering distinction between 'immigrants' and 'Norwegians'. On the one hand, we were careful to avoid the temptation of stereotyping by presenting our participants as single representatives of a 'native' or 'exotic' culture, rather than as citizens in a multicultural society characterised by the intermingling of different cultural backgrounds and influences. Significantly, the interviews included the production of shared representations that reflect the universality of death and dying in all cultures.

On the other hand, we have no wish to underestimate the potential impact of cultural differences on practices in the workplace when it comes to challenges associated with speaking a language different from your mother tongue. However, communication of compassion and grief is not just about finding the 'right' words, but also about the ability to 'digest' one's experiences, as Bion, 1962/1991 helps us understand.

## **Results**

In this section, we will present the results of our analyses. The theme headlines are descriptive, and we elaborate each theme with both descriptive analyses (the 'what was presented' level) and interpretations of the interview data (the how and the why levels of what was presented).



### ***'I think old people want to avoid the theme'***

The main holistic impression of these data is that there is silence when it comes to talking to patients and their relatives about death. For example, Mono says, 'We don't talk about death and such things [with the patients]. I have never experienced that.' Dora has never spoken to patients about death, and neither do other nursing home staff, as far as she knows. She says, 'It's too sensitive to talk about to the patients. I think we must be careful talking about it. We do not know well enough what the patients have inside here [pointing to her chest].' Charlotte has also avoided speaking with patients about death; however, she does seem to acknowledge the presence of patients' fear. She says: 'but those who are going to die are afraid. I can see that they are afraid. You see it in their eyes. They are afraid. But I never heard anyone say that.'

In the event that patients themselves should initiate conversations about death, our participants said that as professionals, they would attempt to divert them, to make them think about something else. For example, some said they might change the topic by talking about the weather or practical things instead of engaging in a conversation about the end of life. Some of the patients in the nursing home suffer from dementia and may be scared and anxious, forgetting that they expressed a fear about something only minutes ago. In such situations, the professionals may try to make patients feel more comfortable and safer by deliberately using a diversion tactic to prevent recurrent distress. However, other than in such particular instances, which may well merit diversion at times, how can we understand the fact that healthcare providers do not talk to the patients about death and that they think it is best to divert patients' attention from the topic? You may recall that we, in our theoretical point of departure, noted how all relationships are regulated by both conscious and unconscious emotions, and that we all defend ourselves unconsciously against anxiety and emotions that we cannot accommodate. Let us take a closer look at some of the statements participants made in the interviews, considering this starting point.

Hannah does not believe that the patients have a desire to talk about or relate to death. She says:

I think old people wish to avoid the topic. For example, when there's [i.e. a notice] on the table in the hallway that a patient has died, I've noticed that they [patients] glance briefly at the information and then they look the other way.

Hannah has thus observed and concluded that the patients themselves wish to avoid the topic of death. This can, of course, be a perfectly valid observation; however, at the same time, we may ponder over whether it can also be a result of Hannah's own defence mechanisms. It could be interpreted as a projection of her own desire to avoid dealing with death. We learned in the interview that as a child, Hannah had lost her mother and that she has painful and difficult memories and experiences of loss and death from childhood in her country of birth, supporting our pursuit of a further interpretation of her need to avert her attention from death. We asked Hannah how she thinks these childhood experiences have influenced her. She answered that after all her experiences of loss, she did not want to go to funerals anymore. However, Hannah herself made no links between her childhood experiences and the way she deals with dying and death in the nursing home.



Neither did Hannah make a link to her childhood experiences when she said that she has tried to imagine what it is like to know you are going to die soon – she says: ‘And I think it’s terrible. I think that is why everyone will not think about it and will push away death’.

Despite this articulation of death’s terror, Hannah does not reflect on why she does not believe the patients want to relate to death, as she claims in the earlier quote. Boston and Balfour (2006) use the concept ‘wounded healer’. They say that for the care provider, the challenge is to become aware of the aspects of their own suffering that they are projecting onto the patient. The situation Hannah is talking about could be an example of this. However, Hannah has no reflexivity around it. Thus, it could be Hannah’s own undigested anxiety that fuels her interpretation of why patients turn away from the information about the death of another patient. One consequence of the fear of death held by the care provider can be that this fear can be unconsciously picked up on by the patient, thereby increasing their own fear of death. Emotions are thus projected between the patient and the care provider in the relationship, making it impossible to say who the originator of a feeling is. If the care provider is unable to accommodate her own feelings, but defends herself against them, the consequence may be that she unconsciously deflects the patient’s feelings.

In contrast to Hannah, Philippa appears more able to distinguish between her own feelings (of sadness) and a patient’s wish to die. In this quote, Philippa is talking about the patient who had died most recently:

She [the patient] said to me, ‘I have no health to live on, so I pray to God every day that He can let me die’. Sometimes I feel sad [when patients die], but for her . . . she wants to pass. I can get sad because I love that person.

Here, Philippa evokes an example of ethics of care, in the sense that her account shows how she is capable of holding them both (the patient and herself) in mind.

Like the other participants, Jasmine stated that she finds it difficult to talk to the patients and their relatives about death, articulating that it is difficult to ‘find words’. However, she seems able to approach this difficult topic in a more open way than most of the other participants we talked to. She expressed that if a patient introduces a fear of death to her, she will try to find out what makes the patient think like this:

You don’t find the words right away. How to comfort him or . . . yes, it’s just about death it’s a little hard! You do not know what to answer. You try to say that ‘everyone is going there – but why are you feeling this right now? Do you have any pain anywhere? Did you feel anything unusual?’, things like that. You just circle around the issue. But when it’s direct, it’s a little hard to find words. So, you just think that if they have such thoughts, it would be better if a priest came. They [the priests] have more words.

Jasmine goes around the difficulty, as she says, but still she wants to stick to the topic, to try to talk. She is able to approach the unthinkable in a way that can help the patient. Jasmine opens up the possibility that the patient can talk about whatever they want or need to talk about. But we also hear that Jasmine feels on shaky ground sometimes and would prefer it if a priest can have such conversations instead of her, as she feels they have more words to talk about death.

Some may argue that there is a time when silence or actions can be better than words. But even in such situations, the care provider who struggles with her own feelings will also struggle to be present and receptive to the patient’s needs related to difficult feelings about death.

***'Death is the worst issue. No one [among the staff] wants to talk about it'***

So, what did the healthcare professionals we interviewed say about their ability to express their experiences, thoughts, feelings and fantasies related to death among themselves in the staff community? How do they get help to 'digest' their experiences, as Bion, 1962/1991 claims is necessary to learn from experience? As it turns out, our participants told us they rarely or never shared their thoughts, feelings or experiences about death with other employees in the nursing home, irrespective of different institutional contexts or of the employees' different cultural backgrounds. It was acceptable for them to show emotions of mourning, such as beginning to cry, to their colleagues in connection with patients' deaths, but there were no routines for staff to sit down and reflect on what effect a patient's death had on the individual or on the nursing home community of staff. If a death was discussed among colleagues, it was almost coincidental; according to Grace, they would typically say: 'It is just like this: "What happened to her?" Only such informal conversations'. Isabella said that they (staff) once had addressed death as a topic at work: 'We had one day, just like a seminar. Then it was about procedures, how to provide care, and things like that'. A few participants said that they had been involved in an ethical reflection group at work where they had, among other things, talked about how they should accommodate patients who were dying. But the focus was not on what working so close to death did to themselves as human beings. A curious fact is that several participants told us that our interview was the first time they had experienced the opportunity to talk to someone else about their own feelings and thoughts about death in the context of their end-of-life work.

In other words, participants experienced that there was no 'room' in the workplace to help them accommodate or work through strong feelings and experiences related to death. As already indicated, the lack of such a containing space can be interpreted as an expression of a social defence system (Lyth, 1959/1988). The social defence system, which is unconscious but nevertheless intended, is about the strategies to which healthcare providers are subjugated and which ensure an emotional distancing. In our particular study context, the social defence system concerns distancing from emotions that arise in the face of death.

***'It should not be normal for me to see it [death] as normal'***

Their first professional encounter with death in nursing homes in Norway was daunting to most of our participants. Isabella had only been present at one death in the nursing home, and had the following to say about this first and only experience for her:

I think I got a shock the first time [...] I cold sweated and shivered. [...] Always after him [this patient] I pray [for other patients], 'God help me, you shall live today!' [Laughs]. I have not had deaths [since then] on my shift. So, I pray every day for all [the patients].

Nonetheless, most participants told us that, with experience, they no longer felt afraid. Several pointed out that it has become 'normal' for them to see people die and that it is natural when the patients die. However, let us go back to Jasmine, whose words contributed to the vignette earlier. She said that facing death at work in the nursing home was 'doing something' to her. She talked about the day she stayed with a patient who died and how the experience was spinning around in her head, and she

continues: ‘The next day you come [to work], and you are straight into the usual routine’. Jasmine had heard a colleague say it did something to her – when she learned that a patient’s death is seen by fellow staff as just a normal occurrence. Jasmine says:

And I got that aha experience. It’s true what she says! It is a human being who is dead! But as soon as you see this repeatedly it becomes normal, but it should not be so normal, you see? [addressed to researcher] You can’t do anything about it, but it does something with your feelings, that before if you hear someone who has died then it was like ‘AHHH!’ [sharp breath out as if she has got a shock] but now it is ‘mmm-ok’ [with a shrug].

Later in the interview, Jasmine continued: ‘It should not be normal for me to see it [death] as normal (. . .) maybe I have to stop [working] here [in the nursing home] to keep the old feeling’ [she is aiming for the feeling of ‘AHHH!’].

What happens when death becomes ‘normal’? What is it that Jasmine is afraid of losing if death should become normalised to her? Lifton (1974) studied the situation after the nuclear bomb in Hiroshima in 1945, believing that such extreme incidents can give us insight into how we encounter everyday deaths. He introduced the term *psychic numbing*, which refers to an inability to feel or to digest certain experiences and is linked to a blockage or absence of inner images that may be associated with such experiences. He explains inner numbness in this way: ‘if I feel nothing, then death does not exist; therefore I need not feel anxious about death either actually or symbolically; I am invulnerable’ (Lifton, 1974, p. 282).

It seems that Jasmine is reluctant to lose the strong feelings that she feels should naturally accompany the witnessing of a person’s death. We interpret this as that Jasmine is afraid of becoming increasingly numb, afraid of losing herself as the person she wants to be – namely as a nurse who sees the patient who just died as a fellow human being and who lets death impact on her – in the sense that a death should mean something to her as an exceptional event and not be routine or normal. Vachon et al. (2011) claim that death confrontation could be an awakening experience for palliative nurses, helping them to shift from an everyday mode of existence to a higher, more authentic one. However, in order to let death have an impact on Jasmine and others, to allow death to awaken memories as well as one’s own existential questions, healthcare professionals must, according to a psychoanalytical understanding, feel contained. They must have a suitable environment and people around them who can withstand listening to them and help them put into words what is hard to think about. Instead, death, in all its emotional unruliness, is largely ‘tamed’ in the institution (Candrian, 2014). The normalisation and ‘taming’ of death as a detached or ‘routine’ event can be interpreted as an expression of a social defence system.

In their review of death anxiety among nurses and other healthcare professionals, Nia et al. (2016, p. 7) conclude with a request to ‘reduce the culture of death as a taboo topic for health care workers’, arguing for the need to increase quality of communication and thus enhance perceptions of care between healthcare professionals and their patients and family members. Boston and Balfour (2006) claim the need for a *healing environment* i.e. promoting therapeutic depth discussions, as well as self-awareness and staff support among caregivers in palliative care.

The professional culture of the institution and different departments socialise healthcare professionals. The implication is that managers, as conveyers and creators of a professional culture, have a responsibility to promote openness among care providers towards existential

and spiritual issues. Giske and Cone (2015) point out that within the professional culture in health care teams, there is a stronger focus on providing physical and medical care for patients, compared to the attention given to openness around and discussion of spiritual and existential issues. However, according to our psychoanalytical framework, we suggest that it is not just a matter of conscious intention whether the care provider is able to open up to emotional and existential issues. The only way out of this silence about death is for the caregiver to do the necessary psychological work (Ramvi & Gripsrud, 2017). It is only through recognising the reality of oneself as a ‘wounded healer’ that the caregiver can see the patient as they are and respond adequately and empathetically to their needs as caring professionals. Kearney (2000, as cited in Boston & Balfour, 2006, p. 25) states that “‘being there’ with another in his or her suffering promotes an ability to contain the primal emotions aroused in confronting the unknown. This containment by the care provider enables the patient to feel heard, as well as to feel held and secure’.

## Conclusions

In this article, we have investigated the emotional struggles that healthcare providers are confronted with when working with dying patients in nursing homes, and how this struggle affects their ability to communicate about death with both colleagues and patients. Because most nursing homes in Norway today rely on a multicultural workforce, we opted to give voice to, and represent, care providers who are culturally diverse due to minority backgrounds. In engaging with the interview material, our point of departure for the data analysis and further interpretation was the emergent finding that care providers from all cultural and faith backgrounds shared a common existential fear of death. It is our interpretation, based on psychoanalytic understanding, that to tackle such fear in an institution where death is a regular occurrence can lead to the development of a social defence system, which allows staff to keep strongly unpleasant emotions associated with death at bay. In our study, we see evidence of such a defence system through the striking lack of organised guidance and reflection, which would foreground care providers’ own experiences, feelings and thoughts related to death as matters of importance to care work in these institutions. One participant expressed her concern that death would become ‘normalised’ and would thus stop making an impression on her, indicating the risks of emotional numbing that may be associated with a ‘successful’ social defence.

In contrast to aversion of death or emotional numbing, conditions should be provided for healthcare professionals to open up to the impression of death – to allow their own experiences, thoughts and feelings related to death to emerge from embodied experience to a more fully articulated account. The crucial opportunity for healthcare providers to ‘digest’ their emotional experiences connected to death must be organised in, and secured by, the workplace. In this way, healthcare providers will be better able to mature as professionals and be more equipped to use their capacity both to feel for their patients and reflect upon their patients’ inevitable fear of death as it approaches. Of all the arenas in our society, we feel that the nursing home should be a place that accommodates thinking about death. Our study provides the basis for further discussion of the consequences of the silence around death in nursing homes, not only for patients, but for their relatives and, not least, for healthcare providers themselves.

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