

# Brief Psychological Training for Health Care Professionals Dealing with Cancer Patients: A One-Year Assessment

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**Abstract:** *The usefulness of psychological training for health professionals dealing with terminally ill cancer patients is becoming more widely recognized, but little has been done to elaborate its content and form. Of special interest is the study of the effectiveness of brief psychological training groups and the quality of treatment to be achieved. The principal aim of the training group assessed here was to develop a better understanding of death and dying issues and ways to cope with them. The present study reports the attitudes of participants, assessed 1 year after the end of training in order to investigate the possible consolidation of the immediate posttraining effectiveness reported previously. Subjects (n = 78) who attended the training groups were compared to a control group (n = 42). Attitudes about oneself, illness and death, occupation, personal growth, and professional relationships were assessed with a semantic differential questionnaire before training, after training, and 1 year later. Results show a significant reduction of the positive effect assessed just after the training. While attitudes moved significantly to the positive pole immediately after the end of the training, 1 year later the reverse phenomenon is noted. These data suggest the necessity for improving the effectiveness of short psychological training proposed to help health care professionals dealing with terminally ill cancer patients.*

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## Introduction

The medical and nursing staff can, through their listening attitude and specific interventions, contribute to the psychosocial adaptation of the patient and assist in maintaining the quality of life in the terminal stage; general professional training, however, remains essentially centered upon technical aspects of medical care without fully investigating the psychological problems and issues of terminal cancer care. The responsibility for psychological aid to patients in the terminal stage of care, as well as to their families, rests with all involved staff and is not limited to mental health professionals. Psychiatrists and psychologists have important roles to play in training and sensitizing health care teams to the psychological aspects of their work [1].

The importance of psychological training is often recognized but rarely put into practice. Elaboration of its content and form (nature, program, length, techniques, and aims) varies with the experience and personal preference of the trainer. Interventions can be educational and/or psychodynamic [2-13]. Training effectiveness can be evaluated by cognitive, emotional, behavioral, or attitudinal measures of change [14-23].

Recently, we studied the immediate attitude changes in subjects participating in a brief psychological training program designed for health care professionals dealing with terminal cancer patients [24]. Subjects who reported negative attitudes at the beginning of the training benefitted most from the program. The aim of this study is to assess the 1-year posttraining effectiveness of a brief psycho-



logical training program designed for health care professionals. We know of no study at this point evaluating the long-term effectiveness of this kind of brief training program [25].

## Methodology

The participants of 14 training groups from a total of 18 reported in a previous paper were included in the study [24].

### Groups

All participating subjects were self-referred or invited to participate in the training by the institution's manager after an informational meeting, which described the objectives of the proposed training. In all cases, the training lasted 12 hours in duration, spread over 4 to 10 sessions. Each session lasted from 75 to 180 minutes; flexibility was required in the time available for training in each institution. The frequency of sessions varied with work schedules and holidays, so that the sessions were sometimes spread out over 3 months. The group trainer was, in most cases, a graduate psychologist, except in the case of one group trained by a psychiatrist and six groups trained by two graduate psychologists working together.

Aims, content, and techniques were similar across groups. The aim of the training was to develop understanding on death and dying in order to help professionals develop positive attitudes in their work. Training included role-playing, comparing experiences, and discussing cases and theoretical concepts. The first session was devoted to explaining the aims, techniques, and program of training, permitting participants to express their motivations for training. The content of the next meetings included case discussions, theoretical information, and exchange about terminal patient psychology, family coping reactions, and health care professionals' attitudes. Finally, information was given about terminal care in Belgium. The last meeting was devoted to an evaluation of the training by the participants and a discussion of their future expectations.

Varying types of health care workers participated in the training: nursing assistants, nurses, social workers, physicians, psychologists, physical therapists, and also nonprofessional volunteers. A majority of the participants were nurses. Training groups thus had multidisciplinary inputs. Small-

size (six to eight participants) groups were chosen in order to facilitate active participation.

### Subjects

Of the 122 subjects participating originally in the study which assessed immediate effectiveness of a brief training group, only 92 subjects were eligible for the 1-year posttraining attitudes assessment. Thirty subjects of the original sample were not eligible because of the time lapse of more than 1 year after the end of their training. All of the 43 subjects who participated in the original control group were eligible for this study.

### Evaluation

The present study incorporates the semantic differential questionnaire designed by P.M. Silberfarb and P.M. Levine on the psychosocial aspects of cancer, and applied in the context of supportive groups designed for oncology nurses [26]. The questionnaire was translated into French and adapted for the psychosocial aspects of terminal illness (see Table 1).

Participants completed the questionnaire during the first and last meetings of the training and 1 year after the second evaluation. In the comparison group, the second and the third questionnaires were submitted 2 months and 14 months, respectively, following completion of the first questionnaire. The evaluation also included a subjective assessment made by both participants and trainers.

### Statistical Analysis

The chi-squared test was used to compare control and training subjects for sex, marital status, education, experience, and professional status. Student's *t*-test was carried out in order to compare age means in control and training groups. A statistical analysis was carried out to test different questions: immediate attitude changes after training, attitude changes after 1 year, and the predictive value of positive and negative attitudes on the training effectiveness [27,28]. Analysis was performed in the Brussels Free University Computer Center with the SPSS (Statistical Package for Social Sciences).

For each group (training and comparison) of subjects, a set of 20 indices was obtained, corresponding to attitude changes for the 20 questions.



Table 1. Attitudes and concepts investigated

Attitudes investigated	
A1	Providing care for dying patient.
A2	Quality of the care.
A3	Emotional growth as a result of working experience.
A4	Professional relationship with the physicians.
A5	Attitude toward myself as a health care professional.
A6	Professional role with dying patient.
A7	Providing care for young dying patient.
A8	Professional relationship with staff.
A9	Attitude toward illness.
A10	Attitude toward myself.
A11	Attitude toward death.
A12	Providing care for a dying patient of the same age.
A13	Professional relationship with the psychiatric team.
A14	Providing care for seriously ill patients.
A15	Personal relationship with the staff.
A16	Providing care for a middle-aged dying patient.
A17	Personal growth as a result of working experience.
A18	Attitude toward fatal illness.
A19	Providing care for elderly dying patients.
A20	Educational growth as a result of working experience.
Concepts investigated	
C1	Attitude about oneself (attitudes 2, 5, 6, 10).
C2	Attitude toward illness and death (attitudes 9, 11, 18).
C3	Personal growth (attitudes 3, 17, 20).
C4	Professional relationship (attitudes 4, 8, 13, 15).
C5	Occupational attitudes (attitudes 1, 7, 12, 14, 16, 19).

The 20 indices were grouped in five categories, reflecting attitudes about oneself (attitudes 2, 5, 6, 10); toward terminal illness and death (attitudes 9, 11, 18); personal growth (attitudes 3, 17, 20); professional relationships (attitudes 4, 8, 13, 15); and occupational attitudes (attitudes 1, 7, 12, 14, 19). For each of these five categories or concepts, an average index was obtained by averaging the indices of attitude changes for that category's constituent attitudes. The amount of attitude change immediately after training and 1 year later was measured by the following formula:  $d_i = d_1 - d_2$ ,  $d_2 - d_3$ ,  $d_1 - d_3$  ( $d_1$  = score before training,  $d_2$  = score after training,  $d_3$  = score 1 year after training). A negative  $d_i$  ( $d_1 < d_2$  or  $d_2 < d_3$ ) means a negative attitude change, as the highest values on

the differential semantic scale of the questionnaire represent a negative attitude.

Immediate and long-term attitude changes between training and control groups were tested with an analysis of covariance (ANCOVA). Two-tailed dependent *t*-tests were carried out for each attitude and concept in each group of subjects, in order to evaluate the level of significance of the difference observed when comparing the mean scores before and just after the training, the mean scores after the training and 1 year later, and the mean scores before the training and 14 months later. Further, subjects were divided in order to obtain a subgroup with negative attitudes and one with positive attitudes. The cutoff point chosen here was 3.06 (median of the whole sample). Subjects with negative attitudes thus had a mean global score before training 3.06 and those with a positive attitude had a mean global score  $< 3.06$ . Analyses of covariance and two-tailed *t*-tests for immediate and long-term posttraining differences of these "positive" and "negative" subgroups were also performed.

## Results

On the 92 subjects who participated in the study, only 78 subjects completed all the questionnaires (before the training, just after, and 1 year later). One control subject did not complete the third questionnaire. The 14 training participants and the control subjects who did not complete the questionnaires were excluded from the data analysis. There were no significant differences (chi-squared test and Student's *t*-test) between control ( $n = 42$ ) and trained ( $n = 78$ ) subjects when compared for age, sex, marital status, education, experience with dying patients, and professional status (see Table 2).

The results of the immediate posttraining changes summarized in Table 3 are similar to those reported in a previous paper [24]. For the trained subjects, 11 out of 20 attitudes moved significantly to the negative pole, while for the control subjects group, only two attitudes moved this way (Table 3). Attitude changes were significantly more important in subjects reporting more negative attitudes at the beginning of the training (see Tables 4 and 5).

The results of the long-term posttraining changes are summarized in Table 3. The assessment of attitudes realized 1 year later shows only small changes when scores are compared to those obtained just after the training. ANCOVA shows



**Table 2.** Demographic data

	Training group ( <i>n</i> = 78)		Control group ( <i>n</i> = 42)	
Age (years)				
Mean	34		32	
Standard deviation	9.5		9	
Sex				
Male	9	(11.5%)	3	(7%)
Female	69	(88.5%)	39	(93%)
Marital status				
Single	29	(37.2%)	22	(52.4%)
Not single	49	(62.8%)	19	(45.2%)
No information	0	(0%)	1	(2.4%)
Education				
College	34	(43.6%)	24	(57.1%)
High school	33	(42.3%)	14	(33.3%)
University	11	(14.1%)	3	(7.1%)
No information	0	(0%)	1	(2.4%)
Experience (last 2 years)				
No experience	9	(11.5%)	3	(7.1%)
1–10 patients	33	(42.3%)	10	(23.8%)
>10 patients	36	(46.1%)	29	(69.1%)
Professional status				
Employed	63	(80.8%)	38	(90.4%)
Manager	8	(10.2%)	1	(2.4%)
Other	7	(9%)	2	(4.8%)
No information	0	(0%)	1	(2.4%)

No significant differences by student's *t*-test or chi-squared test.

significant attitude change between training and control groups for 2 out of 20 attitudes. Attitude 17 and concept 3, both related to personal growth, move to the negative pole (Student's *t*-test;  $p < 0.05$ ) (Table 3).

When comparing trained and control subjects who reported pretraining negative attitudes 1 year after the training, no significant change is found. However, attitudes 4, 6, and 17 (Student's *t*-test;  $p < 0.05$ ) move significantly toward the positive pole in the control subgroup of subjects with pretraining negative attitudes (Table 4).

When trained and control groups with pretraining positive attitudes are compared 1 year after the end of the training, significant changes are found for attitudes 5 ( $p = 0.050$ ), 9 ( $p = 0.046$ ), and 17 ( $p = 0.001$ ) and concept 3 ( $p = 0.025$ ) (ANCOVA). The attitude changes occurring between the end of the training and 1 year after (two-tailed dependent *t*-test) for the trained subjects with pretraining positive attitudes is significant for attitudes 3 and 4 ( $p < 0.05$ ), attitude 17 ( $p < 0.01$ ), and concept 3 ( $p < 0.01$ ). These attitudes and concepts move to the negative pole. No significant attitude change is

found for the control subgroup with pretraining negative attitudes (see Table 5).

## Discussion and Conclusion

After 1 year, the attitude changes due to the training are limited to a positive change in professional relationship with physicians. Such limited training effects could be explained by the short duration of the training assessed here or by problems related to the assessment tool used. Results show that the significant attitude changes observed just after the end of the program were no longer evident. The fact that attitudes move to the negative pole after the end of the training—a trend that seems more related to subjects with positive pretraining attitudes—is difficult to interpret at this point.

Hypotheses that could be raised are numerous. First, the training program could be too short to teach participants—perhaps especially those with positive pretraining attitudes—psychological skills related to their everyday work. The training program probably gives the participants an awareness of the problems met in terminal care, and/or facilitates their relationships with patients. Presumably, there is recognition that there is much to learn with a simultaneous sense of not knowing how to practically apply any new knowledge. This could have led to the development of feelings of frustration.

Second, the absence of consolidation of effectiveness reported just after the end of the training could be explained by the loss of the "peer support group effect" generated by the training program.

Third, it can be hypothesized that the trained participants did not find support and/or time in their institutions to give them the opportunity to allow a practical development of their skills.

Therefore, the question of whether or not the training program should be longer and/or consolidated by several follow-up sessions should be investigated. Different questions are still raised concerning the optimal number of sessions, the duration and the content of the training. Possible predictors (personality, experience, and type of responsibilities) of effectiveness are also important issues to be considered.

A better differentiation of a training and/or support program designed for students on the one hand and for health care professionals on the other should be included in future research. Such training and/or support programs should also be distinguished from interventions designed for health



care professionals showing significant adjustment problems specifically to cancer and terminal care.

One should, as mentioned in an earlier paper [24], not exclude the possibility that significant findings may result from the well-known rating errors (halo, leniency or severity, central tendency, and restriction of range effects) and/or from the influence of expectancies [29,30]. One should also not exclude the possibility that significant findings may result from bias related to repeated measures (regression toward the mean).

This study was designed in order to minimize bias related to possible rating errors and/or repeated measures by a controlled design and a

covariance statistical analysis. Observer rating errors were also minimized by the use of a self-assessment questionnaire. Rating errors related to a halo effect should still be considered in order to avoid a too-rapid interpretation about a significant change in an isolated attitude and/or concept.

The effect of expectations (and related effects) for trainers and trainees should be taken into account for both explanation of possible bias and interpretation of the significant change observed in this study in subjects with negative attitudes. Other instruments seem necessary to assess changes consequent to the training of health care professionals. Actually, only a small number of val-

**Table 3.** One-year assessment of the effectiveness of brief psychological training for health care professionals

	Before-after differences (di)				tg/cg comparison (ANCOVA <i>p</i> value)	
	Training group (tg) ( <i>n</i> = 78)		Control group (cg) ( <i>n</i> = 42)		1-2	2-3
	di 1-2	di 2-3	di 1-2	di 2-3		
A1	0.113	-0.078	-0.142	0.221	0.121	0.184
A2	0.400*	-0.075	0.000	-0.091	0.566	0.697
A3	0.317*	-0.106	0.069	0.108	0.238	0.306
A4	0.406*	-0.087	0.059	0.122	0.003	0.512
A5	0.148	-0.027	0.118	0.184	0.943	0.104
A6	0.306*	-0.062	-0.189	0.258	0.078	0.040
A7	0.301*	-0.010	0.250	0.064	0.876	0.438
A8	0.089	-0.024	-0.229	0.109	0.224	0.540
A9	0.304*	-0.171	0.053	0.033	0.785	0.058
A10	0.144	-0.011	0.052	0.035	0.955	0.455
A11	0.324*	0.104	0.327*	-0.104	0.643	0.396
A12	0.161	0.223	0.144	0.039	0.970	0.351
A13	0.180*	0.071	0.222	0.001	0.926	0.400
A14	0.149	-0.020	0.050	0.016	0.789	0.496
A15	0.287*	-0.093	-0.145	0.119	0.101	0.344
A16	0.127	0.031	0.045	0.077	0.956	0.603
A17	0.031	-0.181*	-0.180	0.265*	0.122	0.002
A18	0.272*	-0.011	0.083	0.205	0.689	0.145
A19	0.228	-0.111	0.309*	0.034	0.518	0.304
A20	0.214*	-0.166	0.119	-0.021	0.328	0.498
C1	0.249*	-0.043	-0.005	0.097	0.163	0.126
C2	0.300*	-0.026	0.154	0.045	0.828	0.378
C3	0.187*	-0.151*	0.003	0.117	0.098	0.053
C4	0.240*	-0.032	-0.023	0.087	0.012	0.932
C5	0.180*	0.006	0.109	0.075	0.827	0.484
Total	0.225*	-0.040	0.050	0.084	0.157	0.221

1 = First assessment (baseline).

2 = Second assessment (2 months).

3 = Third assessment (14 months).

\**p* < 0.01 (two-tailed) Student's dependent *t*-test.

\**p* < 0.05 (two-tailed) Student's dependent *t*-test.

**Table 4.** One-year posttraining attitude changes in subjects with pretraining negative attitudes

	Before-after differences (di)				tg/cg comparison (ANCOVA <i>p</i> value)	
	Training group (tg) ( <i>n</i> = 45)		Control group (cg) ( <i>n</i> = 15)			
	di 1-2	di 2-3	di 1-2	di 2-3	1-2	2-3
A1	0.247	-0.043	-0.262	0.305	0.006	0.788
A2	0.602*	-0.087	-0.200	0.065	0.105	0.960
A3	0.404*	0.038	-0.011	0.132	0.181	0.798
A4	0.447*	0.083	-0.281	0.562*	0.001	0.365
A5	0.250 <sup>b</sup>	0.011	0.077	0.169	0.118	0.975
A6	0.463*	-0.036	-0.287	0.403 <sup>b</sup>	0.022	0.351
A7	0.319	0.173	0.083	0.101	0.539	0.597
A8	0.140	0.041	-0.488*	0.195	0.020	0.483
A9	0.351 <sup>b</sup>	-0.112	0.139	0.091	0.761	0.564
A10	0.258*	0.071	-0.153	0.122	0.019	0.845
A11	0.479*	0.087	0.089	0.044	0.169	0.523
A12	0.119	0.291	-0.142	0.111	0.277	0.276
A13	0.183 <sup>b</sup>	0.118	0.092	0.250	0.471	0.916
A14	0.324 <sup>b</sup>	-0.050	0.026	0.292	0.353	0.340
A15	0.443*	-0.126	-0.471	0.197	0.003	0.931
A16	0.329 <sup>b</sup>	0.117	-0.102	0.193	0.124	0.728
A17	0.166	-0.094	0.077	0.423 <sup>b</sup>	0.137	0.380
A18	0.408*	0.068	0.367	0.336	0.752	0.476
A19	0.507 <sup>b</sup>	-0.197	0.024	0.220	0.042	0.304
A20	0.326 <sup>b</sup>	-0.183	0.253	-0.083	0.013	0.855
C1	0.393*	-0.010	-0.141	0.190	0.002	0.677
C2	0.412*	0.015	0.198	0.157	0.393	0.667
C3	0.298*	-0.079	0.106	0.158	0.065	0.755
C4	0.303*	0.029	-0.287*	0.301	0.001	0.452
C5	0.307 <sup>b</sup>	0.049	-0.062	0.204	0.049	0.765
Total	0.338*	0.009	-0.059	0.206	0.003	0.592

1 = First assessment (baseline).

2 = Second assessment (2 months).

3 = Third assessment (14 months).

\**p* < 0.01 (two-tailed) Student's dependent *t*-test.<sup>b</sup>*p* < 0.05 (two-tailed) Student's dependent *t*-test.

idated instruments measuring the effectiveness of training are available. Semantic differential questionnaires are one of these few instruments and are easy to use.

In this study it has been hypothesized that the learning of new skills is often associated with a change of attitudes. Despite this, it could also be that a change in attitudes does not always mean a change in skills. Attitude change could be associated, for example, with the initial phase of learning. It is also difficult to believe that a training module could be effective without being associated with attitude change. With this perspective, the Semantic Differential Questionnaire will remain

easy to implement in studies attempting to assess training modules for health care professionals, along with other techniques of assessment, such as the videotaped interview.

Considering the major involvement of health care professionals in terminal care and their direct responsibilities for the quality of care achieved, it is urgent to generalize the implementation of an optimal psychological education program in all health care settings. A second generation of studies should aim at assessing effectiveness of training programs not only by change in attitudes but also by measures of the quality of life reported by patients and families.



Table 5. One-year posttraining attitude changes in subjects with pretraining positive attitudes

	Before-after differences (di)				tg/cg comparison (ANCOVA <i>p</i> value)	
	Training group (tg) ( <i>n</i> = 33)		Control group (cg) ( <i>n</i> = 27)			
	di 1-2	di 2-3	di 1-2	di 2-3	1-2	2-3
A1	-0.071	-0.127	-0.076	0.175	0.676	0.335
A2	0.124	-0.057	0.111	-0.178	0.583	0.674
A3	0.198	-0.303 <sup>b</sup>	0.114	0.095	0.356	0.086
A4	0.351 <sup>b</sup>	-0.318 <sup>b</sup>	0.249	-0.123	0.099	0.931
A5	0.009	-0.078	0.140	0.193	0.641	0.050
A6	0.091	-0.097	-0.136	0.178	0.388	0.285
A7	0.275	-0.257	0.342	0.044	0.983	0.207
A8	0.018	-0.111	-0.085	0.062	0.914	0.293
A9	0.241	-0.252	0.005	0.002	0.745	0.046
A10	-0.012	-0.122	0.166	-0.013	0.261	0.247
A11	0.113	0.127	0.459 <sup>b</sup>	-0.187	0.193	0.284
A12	0.218	0.130	0.302	-0.001	0.994	0.426
A13	0.175	0.008	0.294	-0.138	0.941	0.296
A14	-0.088	0.021	0.064	-0.138	0.723	0.588
A15	0.075	-0.047	0.036	0.075	0.893	0.404
A16	-0.148	-0.085	0.127	0.012	0.312	0.567
A17	-0.152	-0.299 <sup>a</sup>	-0.323 <sup>b</sup>	0.178	0.452	0.001
A18	0.086	-0.119	-0.074	0.132	0.585	0.243
A19	-0.153	0.007	0.468 <sup>b</sup>	-0.070	0.012	0.700
A20	0.060	-0.143	0.044	0.012	0.989	0.408
C1	0.053	-0.088	0.071	0.045	0.691	0.224
C2	0.146	-0.081	0.130	-0.018	0.885	0.472
C3	0.035	-0.248 <sup>a</sup>	-0.055	0.095	0.492	0.025
C4	0.155	-0.117	0.123	-0.031	0.595	0.953
C5	0.006	-0.052	0.204 <sup>b</sup>	0.004	0.347	0.721
Total	0.007	-0.106	0.111	0.127	0.853	0.358

1 = First assessment (baseline).

2 = Second assessment (2 months).

3 = Third assessment (14 months).

<sup>a</sup>*p* < 0.05 (two-tailed) Student's dependent *t*-test.<sup>b</sup>*p* < 0.01 (two-tailed) Student's dependent *t*-test.

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## References

1. Stedeford A, Bloch S: The psychiatrist in the terminal care unit. *Br J Psychiatry* 35:1-6, 1979
2. Bloom S: On teaching an undergraduate course on death and dying. *Omega* 6:223-226, 1975
3. Leviton D, Frets B: Effects of death education on fear of death and attitudes towards death and life. *Omega* 9:267-277, 1978-79
4. Barton D, Crowder M: The use of role playing techniques as an instructional aid in teaching about dying, death, and bereavement. *Omega* 6:243-250, 1975
5. Anderson JL: Evaluation of practical approach to teaching about communication with terminal cancer patients. *Med Educ* 16:202-207, 1982
6. Kalish RA: *Death, Grief and Caring Relationships*. Monterey, Brooks, 1985
7. Moore K: Training social workers to work with the terminally ill. *Health Soc Work* 9:268-273, 1984

8. Shanfield SB: The mourning of health care professionals: an important element in education about death and loss. *Death Educ* 4:385-395, 1981
9. Shinn M, Rosario M, Morch H, et al: Coping with job stress and burnout in human services. *J Person Soc Psychol* 46:864-876, 1984
10. Ziegler JL, Kanas N, Strull WM, et al: A stress discussion group for medical interns. *J Med Educ* 59: 205-207, 1984
11. Bertman SL, Greene H, Wyatt CA: Humanistic health care education in a hospice/palliative care setting. *Death Educ* 5:391-408, 1982
12. Campbell TW: Death anxiety on a coronary heart unit. *Psychosomatics* 21:127-136, 1980
13. Barstow J: Stress variance in hospice nursing. *Nurs Outlook* December:751-754, 1980
14. Amaral P, Nehemkis AM, Fox L: Staff support on a cancer ward: a pilot project. *Death Educ* 5:267-274, 1981
15. Miles MS: The effects of a course on death and grief on nurses' attitudes toward dying patients and death. *Death Educ* 4:245-260, 1980
16. Craytor JK, Fass ML: Changing nurses' perceptions of cancer and cancer care. *Cancer Nurs* February: 43-49, 1982
17. Mullins LC, Merriam S: The effects of a short-term death training program on nursing home staff. *Death Educ* 7:353-368, 1983
18. Murray P: Death education and its effects on the death anxiety levels of nurses. *Psychol Rep* 35:1250, 1974
19. McClam T: Death anxiety before and after death education: negative results. *Psychol Rep* 46:513-514, 1980
20. Gray-Toft P: Effectiveness of a counseling support program for hospice nurses. *J Counsel Psychol* 27: 346-354, 1980
21. Liberman MB, Handal PJ, Napoli JG, et al: Development of a behavior rating scale for doctor-patient interactions and its implications for the study of death anxiety. *Omega* 14:231-239, 1983-84
22. Brown I: The effects of a death education program for nurses working in a long-term hospital. *Dissert Abstr Int* 42:54, 1981
23. Bensing J, Sluijs E: Leren luisteren, maar wat dan? evaluatie van een gespreksttraining voor huisartsen. *Ned Tijdschr Psychol* 39:265-280, 1984
24. Razavi D, Delvaux N, Farvacques C, et al: Immediate effectiveness of brief psychological training for health professionals dealing with terminally ill cancer patients: a controlled study. *Soc Sci Med* 27:369-375, 1988
25. Delvaux N, Razavi D, Farvacques C: Cancer care: a stress for health professionals. *Soc Sci Med* 27:159-166, 1988
26. Silberfarb PM, Levine PM: Psychosocial aspects of neoplastic disease. III. Group support for the oncology nurse. *Gen Hosp Psychiatry* 3:192-197, 1980
27. Dagnelie P: *Théorie et Méthodes Statistiques*. Gembloux, Duculot, 1969
28. D'Hainaut L: *Concepts et Méthodes de la Statistique*. Bruxelles, Labor, 1975
29. Jones EE: Interpreting interpersonal behavior: the effects of expectancies. *Science* 234:41-46, 1986
30. Saal FE, Downey RG, Lahey MA: Rating the ratings: assessing the psychometric quality of rating data. *Psychol Bull* 88:413-428, 1980