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ORIGINAL ARTICLE

Possibility of alleviating difficulties of health and social care professionals engaged in end-of-life care through Clinical Art program

Minako Kamimoto MD[1] | Daisuke Son MD, MHPE, PhD[2] | Kazuoki Inoue MD, PhD[3] | Shin-ichi Taniguchi MD, PhD[2]

[1]Tottori Medical Career Support Center, Tottori University Hospital, Yonago, Japan

[2]Department of Community-Based Family Medicine, Faculty of Medicine, Tottori University, Yonago, Japan

[3]National Health Insurance Daisen Clinic, Tottori, Japan

Correspondence
Daisuke Son, Department of Community-Based Family Medicine, Faculty of Medicine, Tottori University, Yonago 683-8503, Japan.
Email: sondtky@gmail.com

Abstract

Background: Health and social care professionals experience high-stress levels during end-of-life care. Various intervention programs have been proposed to reduce stress and prevent burnout among physicians and nurses, including arts-based activities that have shown potential. However, it is unclear how art programs can alleviate stress among healthcare professionals providing end-of-life care. This study aimed to explore the potential of Clinical Art programs to alleviate distress in professionals providing end-of-life care.

Methods: Two Clinical Art workshops, held in October and November 2020, were attended by local health and social care professionals. Focus groups were conducted with those who attended and consented to participate in the study. Verbatim transcripts were made, and a qualitative analysis of the text was conducted.

Results: Thirteen health and social work professionals participated in the study. Perceived difficulties in end-of-life care included the complexity and uncertainty of end-of-life care services, the approaches to patients and families, and the difficulties due to human aspects of healthcare providers. The positive effects of Clinical Art included pure enjoyment of art, empathic communication with patients and families and the application of an ontological view of human beings, which were identified as reasons for Clinical Art's effectiveness and applicability to care.

Conclusions: The results suggest that the Clinical Art program has a psychosocial moderating effect on health and social work professionals and can be used for empathic communication with patients and families in end-of-life care and for applying an ontological view of human beings in caring for patients.

KEYWORDS
art program, Clinical Art, end-of-life care, ontological view of human beings, qualitative research

1 | INTRODUCTION

Health and social work professionals providing end-of-life care experience a range of distressing factors and stressors, including suicidal ideation, increased alcohol and drug use, anxiety, depression, and difficulty coping with the issue of death.[1] Hospice work is considered particularly stressful due to the inherent complexity of providing end-of-life care.[2] Patients requiring end-of-life and palliative care may experience extreme difficulties such as depression, anger, anxiety, severe physical pain, or discomfort, social isolation, financial strain, and family conflicts.[3–5] Health and social care professionals must be prepared to respond to the demands of patients and families undergoing such distress. These pressures also become an additional source of stress. Furthermore, health and social work professionals involved in the provision of end-of-life care may experience moral distress due to poor communication among healthcare professionals and ethical dilemmas.[6–8] Various studies have been conducted on the attitudes of health and social care professionals toward care of the dying. Positive attitudes of nurses engaged in end-of-life cancer care were associated with age and clinical experience and were negatively associated with fear of death.[9,10] It has also been reported that burnout is associated with anxiety about death among healthcare professionals.[2] Different types of ongoing support are needed to prevent such burnout and emotional difficulties among healthcare professionals.

A systematic review of interventions to reduce burnout among physicians and nurses indicates that individual-focused, structural, or organizational, as well as combined, interventions are used, with bundled strategies being particularly important. Individual-focused interventions include self-care workshops, yoga, mindfulness, and stress management skills.[11] The potential for art therapy or art-based intervention programs has also been suggested as a type of individual-focused program.[12,13] A qualitative study of the effects of arts-based recreational activities on healthcare professionals found that the arts activities helped reduce individual stress over time, helped transform workplace relationships, and humanized the work climate in the healthcare setting.[14] However, there have been no studies that have examined the positive effects of art-based activities on healthcare professionals, especially in relation to distress related to end-of-life care, and it is unclear how these activities alleviate difficulties in end-of-life care.

This qualitative study aimed to explore the nature of the difficulties experienced by health and social care professionals who provide end-of-life care and the cognitive and emotional challenges that arts-based activities may alleviate.

2 | METHODS

2.1 | Arts-based activities: Clinical Art workshop

In this study, we used the "Clinical Art" method developed in Japan as an arts-based activity.[15] The clinical application of art therapy is practiced worldwide,[16] but "Clinical Art (Rinsho Bijutsu)" used in this study was developed in 1996 by a team of Japanese physicians, artists, and family care advisors. Clinical Art is a form of art therapy that activates the brain through the enjoyment of creating artworks such as pictures and objects. This type of art therapy is expected to be effective in preventing the need for nursing care for the elderly, preventing and improving symptoms of dementia, reducing stress among workers, and educating children about sensibility.[15] Clinical artists (Rinsho-Bijutsushi) who facilitate the practice of Clinical Art are professionals who have taken the Clinical Artist Training Course offered by the Japan Clinical Art Association, systematically learned the knowledge and skills necessary for Clinical Art, such as artistic techniques, communication skills, and a mindset that enjoys diversity, and are qualified to implement the programs. When participants create works of art, they move their hands while touching, smelling, tasting, and listening to music. In this way, participants stimulate all of their senses. In the art program, it does not matter how good or bad one is at creating artwork. In face-to-face communication with the facilitator (Clinical Artist) who supports the creation of artwork, participants are naturally encouraged to be positive, and they feel the joy of "praise" and "empathy." One of the core values of Clinical Art emphasizes an "ontological view of human beings," which considers that "people basically already have something to be pleased with based on the fact that they are alive, and that they are happy and grateful to be there."

The researchers held two Clinical Art workshops in October and November 2020. Each workshop was conducted once as a beginners' program. Health and social care professionals engaged in end-of-life care in Hino County, Tottori Prefecture (Hino Town, Kofu Town, and Nichinan Town) were invited to participate in the workshops. As of 2022, Hino County has a population of approximately 9300 people, 51.5% of whom are aged 65 or older, making end-of-life care a major issue. The Clinical Art workshop consisted of four processes. (1) General introduction: All participants were welcomed and made to relax. (2) Production introduction: Participants were encouraged to use all five senses to feel objects such as seasonal fruits and vegetables, feel their weight and smell, and taste them to stimulate their sense of taste. (3) Production: The Clinical Artist demonstrated the work in two or three stages, and the participants repeated the process of practicing the work. If a participant's behavior deviated from the curriculum, the Clinical Artist respected the participant's wishes and did not force the participant to change course. (4) Viewing: The Clinical Artist took each participant's work individually and provided positive feedback. At this point, the Clinical Artists did not evaluate the quality of the work or analyze the work in any way rather expressed their own subjective impression.

This time, the workshop featured the "Drawing Persimmons" program, an art program for beginners. Participants actually picked up a persimmon in front of them, felt its color, gloss, aroma, weight, etc. using all five senses, and then freely drew it on paper. The Clinical Artist demonstrated the process to the participants, and then each participant completed his or her own work.

2.2 | Participants and data collection

This study is based on the constructivist paradigm that human knowledge is socially constructed, not discovered. Sampling was conducted through purposive sampling: health and social care professionals working in Hino County, Tottori Prefecture, who attended the two workshops and agreed to participate in the study, were included in the data collection. Immediately after each workshop, focus groups were conducted, in which the first author (MK) asked the subjects to discuss the following questions in the interview guide: (1) What difficulties do you experience with end-of-life care in your daily clinical practice? (2) What did you feel after experiencing the Clinical Art workshop? and (3) What, if anything, could you apply to your daily practice that you learned in the Clinical Art workshop? The focus group discussion was recorded using digital recording equipment, and a verbatim transcript was prepared. We chose focus groups because we believe that the solidarity and interaction among participants in the Clinical Art workshops can elicit deeper thoughts and insights.

2.3 | Data analysis

Textual data were analyzed by Steps for Coding and Theorization (SCAT).[17] The method of analysis comprised a four-step coding process: (1) focusing on words within the interview text; (2) coding for words outside the text that could be substituted for words in the first step; (3) coding for words describing words coded in steps 1 and 2; and (4) coding of themes and constructs, including storylines and theoretical descriptions. For each of the two focus groups, storylines were described, and the emerging themes were organized. The textual data and coded themes were read and reread to refine the theme categories. Multiple themes were grouped according to semantic similarities and inductively organized into categories. The above analysis was conducted in consultation with the first and second authors (MK and DS), and the content was refined through discussions with other authors for triangulation.

2.4 | Ethical considerations

Before conducting the focus groups, the study participants were informed of the purpose and methods of the research, were assured that their participation was voluntary, and were guaranteed anonymity in the publication of the results. Written informed consent was obtained from all the participants. This study was conducted under the approval of the Hino Hospital Ethics Committee (Approval No. 2020-9).

3 | RESULTS

There were 13 study participants, including four hospital nurses, two clinic nurses, two home care nurses, one physiotherapist, two care managers, one medical social worker, and one certified caregiver. They ranged in age from 20s to 60s, with two males and 11 females.

The themes and categories analyzed and generated by SCAT are presented in Tables 1 and 2. Nine themes and three categories of the difficulties perceived by health and social care professionals in end-of-life care were obtained (Table 1), and 10 themes and three categories for the effectiveness of Clinical Art and its applicability to care were obtained.

3.1 | Difficulties in end-of-life care

3.1.1 | Complexity and uncertainty in end-of-life care

Health and social care professionals felt the oscillation between different options in end-of-life care and the difficulty that there is no one right answer. They also felt difficulties in protecting the dignity of patients who are unable to make decisions and in dealing with the

TABLE 1 Difficulties in end-of-life care.

Categories	Themes
Complexity and uncertainty in end-of-life care	Oscillation between options in end-of-life care
	Difficulty in finding one right answer
	Dignity of patients unable to make decisions
	Diversity and complexity of the patient's home environment
Approaches to patients and families	Emotional care for caring families
	Empowerment of both patients and families
	Lack of responsiveness to grief care for bereaved family members
Human aspects of healthcare providers	Differences in coping methods based on healthcare providers' experiences
	Grief care for the healthcare providers themselves

TABLE 2 Effectiveness of Clinical Art and its applicability to care.

Categories	Themes
Pure enjoyment of art	Comfort of working without thinking
	Sense of accomplishment in creating artwork
	Breaking down stereotypes
	Unconditional affirmation
	Increased motivation
Empathic communication with patients and their families	Application to dialogical communication
	Compassion and empathy for others
	Fostering a sense of psychological security
Application of the ontological view of the human beings	Recognizing and approving the other person
	Acknowledging the individuality of the person

diversity and complexity of patients' home environments. The complexity and uncertainty associated with end-of-life care were cited as factors that contributed to their stress levels.

> The other question was how should I let the patient finish the end-of-life? And how I will do it, even though I have many choices, I don't think the answer will be easy to find at that time. I really experienced it firsthand.
>
> (Clinic nurse, theme "Oscillation between options in end-of-life care")

> I think there are many different families, and everyone is under a lot of stress. Some are doing their best to care for only one person at the end-of-life, while others are dealing with a variety of issues as they care for the patient at the end-of-life.
>
> (Care manager, theme "Diversity and complexity of the patient's home environment")

3.1.2 | Approaches to patients and families

In their approach to patients and families during end-of-life care, health, and social work professionals felt, it was difficult to provide sufficient psychological assistance to the caregiving family and empower both the patient and the family. They also felt that grief care for bereaved families was insufficient.

> To help a family member who is under a lot of stress to relax a bit, or to acknowledge or take some time to appreciate someone who is in a situation where they work very hard and repeat it day in and day out as a matter of course.
>
> (Care manager, theme "Emotional care for caring families")

> There are several people for whom I have provided end-of-life care at home, but I have not had the opportunity to visit them again. I am very concerned about the fact that the visit ends there, so I think it is an issue for the future that we are not able to follow up with the family members after the visit.
>
> (Home care nurse, theme "Lack of responsiveness to grief care for bereaved family members")

3.1.3 | Human aspects of healthcare providers

Difficulties attributable to healthcare providers in end-of-life care included the fact that each healthcare provider's coping methods differ based on their own experience and that there is a lack of care for the healthcare providers who themselves experience grief when parting with a patient.

> I think it's difficult to know how I should react when someone says they want to go home, or how I should talk to them. I have never been involved in such a situation, so I don't know how I can intervene.
>
> (Hospital nurse, theme "Differences in coping methods based on health care providers' experiences")

> So I'm wondering if sharing this time with the family after the death is an important time for both of us to take one step forward.
>
> (Home care nurse, theme "Grief care for the health care providers themselves")

3.2 | Effectiveness of clinical art and its applicability to care

3.2.1 | Pure enjoyment of art

Through the experience of Clinical Art, the health and social work professionals felt a sense of comfort in being able to work without thinking and a sense of accomplishment in creating artwork. They also felt that their stereotypes were broken down and that the unconditional affirmation of their artwork led to increased motivation.

> I thought it was pure fun. But I wondered if I could do it without thinking too much once I got used to it... I'm in the habit of thinking a lot about things on a daily basis, so I thought I'd like to express myself without thinking as much as possible.
>
> (Physiotherapist, theme "Comfort of working without thinking")

> I can receive evaluations, praise for my good points, and motivation. It's good to have that kind of thing that makes you feel more and more motivated, and I thought it was important to use the five senses.
>
> (Certified caregiver, theme "Increased motivation")

3.2.2 | Empathetic communication with patients and their families

Healthcare providers felt that what they had learned in Clinical Art could be applied to empathetic communication with patients and their families. They also felt that what they had learned could be applied to dialogical communication, to fostering compassion and empathy toward others, and to a sense of psychological security.

> I think it's really a way to catch the good things about a person in a medical situation, or whatever it is, and then proceed with a conversation, or a clue to an intervention.
>
> (Home care nurse, theme "Application to dialogical communication")

> When the first words of a speech are 'That's good,' or 'You're good at that,' I feel a little relieved that it's okay. I feel that the way you start a conversation is helpful.
>
> (Certified caregiver, theme "Fostering a sense of psychological security")

3.2.3 | Application of the ontological view of the human beings

The core value of Clinical Art is an ontological view of human beings, according to which the health and social work providers felt that it is crucial in the medical field to recognize and validate the other person and to acknowledge the individuality of the person involved.

> I think we need to learn more about how to praise, not only this picture, but also other things. We tend to focus on what is not done, without thinking about it. Instead, we should recognize what is being done, praise it and develop it.
>
> (Home care nurse, theme "Recognizing and approving the other person")

> I could see that each of you had your own sensibilities, and that you could draw in such a way. I could see that the colors are not one, and the scars are not the same in the same place, and I could see that it is good to see them in that way.
>
> (Certified caregiver, theme "Acknowledging the individuality of the person")

4 | DISCUSSION

This study revealed that the difficulties experienced by health and social work professionals who provide end-of-life care result from the complexity and uncertainty of end-of-life care itself, the difficulties in approaching patients and their families, and the difficulties due to the human aspects of healthcare providers. Furthermore, health and social work professionals felt that the experience of Clinical Art was one of pure enjoyment of art and that its use in empathic communication with patients and their families and the application of an ontological view of human beings to patients was useful in end-of-life care.

Previous studies have shown that uncertainty in end-of-life care leads to anxiety and stress among healthcare professionals,[18,19] which is consistent with the present study. With regard to the communication difficulties with patients and families when providing care at the end-of-life, studies have shown challenges in communicating about prognosis[20] and problems in dealing with diverse family opinions about patients' wishes,[21] which are generally consistent with the results of the present study.

One novelty of the results of this study is that the experience of Clinical Art was found to break down stereotypes and increase motivation by health and social work professionals. Learning to transform one's stereotypes and beliefs is known from Mezirow's transformative learning theory.[22–24] Previous studies have shown that arts-based programs can lead to transformative learning through critical reflection, new perspectives, and a sense of empowerment.[25,26] It is possible that the participants in this study experienced sensations through Clinical Art that they had not previously experienced, which may have led to transformative learning.

The results of this study showed that healthcare providers were concerned and felt difficulty with the complexity and uncertainty of end-of-life care and that they may not be adequately responding to the grief of the family members. They also expressed the need for grief care for the healthcare providers themselves. The results of this study suggest that Clinical Art can not only alleviate the psychological stress and distress of these healthcare providers but also provide suggestions for a compassionate and empathetic approach to families. It also seems to have the effect of providing an ontological endorsement that no matter how one behaves in such "no right answer" situations, it is acknowledged to be who one is and to act in a way that recognizes one's individuality.

An ontological view of human beings is a core value in Clinical Art. It bears some similarity to Benner's conception of the "phenomenological view of human beings" in nursing.[27] Benner criticized the Cartesian view of the human being, which assumes a separation of the mind from the body and views the human being in mechanistic terms, suggesting that the body has inherent intelligence and that various aspects of "caring" for others can be expressed through this view of the human being.[28] Benner's phenomenological view of human beings is not that of a machine with functions but as a unique and inherent being. Like an ontological perspective of human beings, Benner's view recognizes the "individuality" of the other person and relates to the other person as an entity who has value simply by existing.

The majority of participants in this study were female. A previous study found that women are more likely than men to participate in art therapy, but it is unclear whether participating men benefit more, less, or differently from women.[29] In addition, no physicians participated in this study. The participants in this study participated voluntarily, so physicians may not have been able to participate due to their busy schedules. It is not clear how the effects of art-based activities differ between physicians and non-physicians or between men and women of different genders, and future research is warranted.

A practical implication of this study is the provision of art-based activities, such as Clinical Art programs, for a variety of health and social care providers involved in end-of-life care. For example, an art-based program for healthcare professionals' own self-care and grief care could be offered as an option in training series on end-of-life care and palliative care. Comprehensive palliative programs for health and social care professionals involved in end-of-life care are still insufficient in Japan, and future development in this area is needed.

There are several limitations to this study. First, because of the small sample size and the limited number of participating health and social work professionals, it is unclear whether the results of this study can be applied to various health and social care professions. Second, the gender balance was skewed, as the majority of participants were female. Third, because the Clinical Art workshop intervention was a one-time event, the effect on participants may have been limited. We believe that further research should be conducted to determine what effect Clinical Art may have on participants over time, such as through an ongoing intervention program.

5 | CONCLUSIONS

The challenges experienced by health and social care professionals in the provision of end-of-life care were due to the complexity and uncertainty of providing care at the end-of-life, difficulties in approaching patients and their families, and the difficulties due to the human aspects of healthcare providers. In addition to the pure enjoyment of the art experience, the health and social work professionals felt that the use of Clinical Art for empathic communication with patients and their families and the use of an ontological view of human beings with patients were useful in end-of-life care.

AUTHOR CONTRIBUTIONS

MK interviewed the participants and was the major contributor in analyzing the text data under the supervision of DS. The results of the analysis were discussed with KI and ST for triangulation. MK and DS wrote the first draft of the manuscript. All authors read and approved the final manuscript.

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CONFLICT OF INTEREST STATEMENT

The authors have stated explicitly that there are no conflicts of interest in connection with this article.

ETHICS STATEMENT

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PATIENT CONSENT STATEMENT

None.

CLINICAL TRIAL REGISTRATION

None.

ORCID

Daisuke Son https://orcid.org/0000-0002-7053-162X
Kazuoki Inoue https://orcid.org/0000-0001-6959-2751

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