1-1-1990

The effects of an eight-hour continuing education course on the death anxiety levels of registered nurses

Susanne Fife Wilkey
University of Nevada, Las Vegas

Order Number 1340601

The effects of an eight-hour continuing education course on the death anxiety levels of registered nurses

Wilkey, Susanne Fife, M.S.N.

University of Nevada, Las Vegas, 1990

U·M·I
300 N. Zeeb Rd.
Ann Arbor, MI 48106

THE EFFECTS OF AN EIGHT-HOUR CONTINUING EDUCATION COURSE ON THE DEATH ANXIETY LEVELS OF REGISTERED NURSES

by

Susanne Fife Wilkey

A thesis submitted in partial fulfillment
of the requirements for the degree of

Master of Science

in

Nursing

Department of Nursing
University of Nevada, Las Vegas
May 1990

Approval Page

The thesis of Susanne Fife Wilkey for the degree of Master of Science in Nursing is approved.

Vicky Carwein
Chairperson, Vicky Carwein, R.N., D.N.S.

Cheryl L. Bowles
Examining Committee Member, Cheryl Bowles, R.N., Ed.D.

Susan Michael
Examining Committee Member, Susan Michael, R.N., M.S.

Warren J McNab
Graduate Faculty Representative, Warren McNab, Ph.D.

Cheryl L. Bowles
Graduate Dean, Ronald Smith, Ph.D.

University of Nevada, Las Vegas
May 1990

TABLE OF CONTENTS

ABSTRACT

The purpose of this quasi-experimental study was to determine the effects of a death and dying course on the death anxiety levels of registered nurses. It was hypothesized that registered nurses who participated in a death education course would show significant reductions in death anxiety levels at the completion of the course and continue to show these reductions on a second post-test six weeks later. A volunteer sample of 23 registered nurses employed in a rural acute care hospital participated in an eight-hour continuing education course on death and dying. This course was conducted in three consecutive two-hour weekly sessions. Two one-hour home modules were completed between sessions one and two and sessions two and three. A group of 27 registered nurses employed in an acute care hospital in an adjacent community comprised the nonequivalent control group.

The primary prevention mode of intervention of the Neuman Systems Model and Bandura's belief-oriented approach of the social learning theory provided the framework for this study. Templer's Death Anxiety Scale (DAS) was administered prior to the program

(pre-test), immediately following the program (post-test I), and six weeks after the completion of the program (post-test II).

Non-significant reductions in levels of death anxiety were reported between pre-test and post-test I ($t = = .78$, $p = .445$). Non-significant reductions in levels of death anxiety were reported between post-test I and post-test II on the six week follow-up ($t = .48$, $p = .633$). The decrease in mean scores from pre-test to post-test II was also not statistically significant ($t = 1.21$, $p = .238$).

Reliability testing of the DAS resulted in a Chronbach's alpha of .6103. This low reliability coefficient raised concern of the reliability and validity of the DAS in this sample. Recommendations for further study include: replication with a larger sample group and random sampling, development of a tool which accurately measures death anxiety in registered nurses, assessment of educational interventions of death and dying curricula, use of Neuman's theory in continuing education programs, evaluation of timing of post-test administration of death anxiety tools, and the effects of religion and cultural values on death anxiety.

LIST OF TABLES

ACKNOWLEDGMENTS

I wish to express sincere appreciation to my committee chair, Dr. Vicky Carwein. Her valuable input, competent direction, and continued support combined to make this thesis a reality. Additionally, I extend thanks to the other committee members, Dr. Warren McNabb, Dr. Cheryl Bowles, and Susan Michael for their scholarly contributions.

I wish also to extend deep gratitude and love to my family. Unwavering support, encouragement, and love from my husband, Rex, gave me the courage and conviction to succeed. Pure and unconditional love from my children provided great comfort and delight.

I express sincere love and thanks to my parents, Reed and Dorothy Fife. Their concern for my welfare is evident in all that they do for my behalf. I am indebted to them for instilling in me the desire to learn, the persistence to complete goals, and the determination to adhere to chosen values and priorities. Their support has given me confidence to pursue personal, academic, and professional aspirations.

Chapter 1

INTRODUCTION

As the numbers of individuals with chronic and terminal illnesses increase, the opportunity and responsibility for nursing professionals to assist clients in anticipating and coping with their losses intensifies. The abundance of losses experienced by the terminally ill as well as the extended length of illness and disability before death occurs demands sound nursing strategies that support the client prior to, during, and following his/her loss or losses (Rando, 1986; Osterweis, Solomon, & Green, 1984). The expectation of losses, especially the loss of life, creates much anticipation and anxiety in the individual, his or her loved ones, and in the professionals involved in health care (Shanfield, 1981; Rando, 1986).

The process of dying touches individuals on a penetrating and vital level. The death of someone significant affects one personally and often deeply. The loss of a close acquaintance, friend, or family member constitutes the death of some part of one's own self because of the influence and impact that

the individual had in one's life (Gonda & Ruark, 1984). The health care professional involved in caring for dying clients experiences the interpersonal aspects of death in a very relevant manner. The relationship and attachment of the care provider to the client often is deep and rich. Anxieties concerning the caregiver's own death often surface during times of high contact and involvement with a dying client.

Health care professionals who are frequently confronted with death often have as much difficulty accepting the actuality of dying and finality of death as other individuals (Lockard, 1989). These professionals must face their own mortality each time they interact with a dying client and/or family. This constant focus on death may lead to increased anxiety levels (Lockard, 1989; Worden & Proctor, 1976; Harper, 1977; Kubler-Ross, 1969). The professional who maintains a facade of dealing with death as an impersonal matter may be defending against his/her own difficult and unresolved emotional reactions and fears (Gonda & Ruark, 1984). In many instances physicians and nurses reflect the attitudes of our death-avoiding society by denying medical limitations,

projecting poor communication skills to the dying, refusing to identify needs and attitudes pertaining to death, lacking a systematic approach to interventions for the grieved and grieving, and failing to incorporate holistic approaches to the death experience (Blues, 1984; Parkes, 1972; Stephenson, 1985). These barriers lead to a lower quality of service and care to the dying client and grieving family as well as to a lower satisfaction level and experience for the health professional. The withdrawal of intimate and personal involvement with dying clients may function as a protective mechanism for the professional who is not prepared to deal with the realities of death, dying, and grieving (Fleming & Brown, 1983).

Denial of one's own death is a way to decrease death anxiety to a manageable and functional level (Laube, 1977). Deep, emotional anxieties that are evoked while working with the dying are often difficult and overwhelming for the health professional. During the helping process, the professional needs to 1) understand the dynamics of behavior of the clients who will not recover; 2) relate to the actions and

reactions of relatives; 3) give counseling, support, and strength to the clients and relatives; and 4) understand and deal with his/her own feelings and anxieties regarding death and dying (Harper, 1977).

The nurse, as health professional, can be a supportive influence to the client and the family during the time surrounding impending death. The nurse is capable of facilitating the achievement of tasks necessary for the dying individual and for the family (Humphrey, 1986). The nature of the relationship between a nurse and the client because of the time spent together, the nature of care giving, the communication and assessment of needs, and the sharing of information, places the nurse in a key position to provide interventions that promote positive grief experiences for the client and the family. This interaction can be effectively accomplished only with a situation of open communication through the elimination of communicative, attitudinal, and societal barriers that limit expressive interaction and interpersonal relations between the nurse and the client. The attitudes and behavior of nurses toward dying clients reflect their struggle to handle their

own fears and anxieties toward death (Murray, 1973).

Purpose of the Study

The purpose of this study was to focus on the death anxieties of registered nurses and attempt to reduce these death anxiety levels through a continuing education program. By understanding and dealing with nurses' feelings and anxieties regarding death and dying attention can be focused on assessments, interactions, and interventions with the dying client and his/her family. The specific purposes of the researcher were to plan, organize, and administer a continuing education program on death and dying for registered nurses, and to determine if such a program had an effect in reducing the death anxiety levels of the nurse participants.

Theoretical Framework

The review of literature on death anxiety and death education did not identify a dominant theory or conceptual framework for the reduction of death anxiety. Few studies reported the use of any theoretical guide in reported research. The lack of a dominant theory created an opportunity for the

implementation of related conceptual frameworks for evaluation and testing. Theory-linked research is important as it allows for information contribution to an overall knowledge base and is strongly recommended for research construction (Chinn & Jacobs, 1983). The progression of a nursing knowledge base through the development and testing of nursing theory is recognized as a vital element for the development of nursing as a distinctive profession (Louis & Kertvelyessy, 1989).

For this study a combination of two theories were utilized to create the framework. The primary prevention mode of intervention of the Neuman Systems Model (1989) for nursing identified the purpose, hypotheses, significance, and interventions of the research. The belief-oriented approach as identified in the social learning theory by Bandura (1969) provided a framework for the implementation and expectation of the educational intervention. Each theory is discussed as follows with relationship statements identified.

The Neuman Systems Model for nursing is an open systems model that promotes the holistic concept

of nursing practice. This model advocates the definition of appropriate nursing actions in stress-related situations of client reactions. The overall goal for nursing care is to reduce stressor impact, whether actual or potential, and to increase client resistance (Neuman, 1982 & 1989). These interventions attempt to improve client capability and performance, adjust behavior patterns, and increase task performance (Neuman, 1989).

Neuman identifies current or potentially disruptive forces as stressors. Stressors may produce either positive or negative effects upon the system. The identification of stressors as to type, time of encounter, and nature of reaction is critical to the analysis of the system (Neuman, 1982 & 1989).

Numerous environmental stressors exist. These stressors differ in potential for disturbing a client's normal line of defense, or usual wellness/stability level. The client variables--physiological, psychological, sociocultural, developmental, and spiritual--as they interrelate can affect the degree to which a client is protected by the flexible line of defense against possible reaction to a single

stressor or a combination of stressors (Walker & Avant, 1983; Neuman, 1989). The flexible line of defense is a dynamic, protective mechanism which acts as a buffer system for the client's normal line of defense. This line of defense ideally prevents stressor invasion of the client system, keeping the system free from stressor reaction or symptomatology (Neuman, 1989).

Stressors are classified as intrapersonal, interpersonal and extrapersonal in nature. Intrapersonal stressors are interactions that occur within the internal boundary of the client. Interpersonal stressors are external environmental interactions that occur outside the client boundary at proximal range. Extrapersonal stressors are external environmental interaction forces that occur outside the client boundary but at distal range (Neuman, 1982 & 1989).

Neuman postulates that potential reactions to intrapersonal, interpersonal, and extrapersonal stressors may be mitigated through appropriate intervention or prevention strategies. Through early intervention the flexible line of defense can be strengthened, thereby reducing the magnitude of

potential reaction. Early intervention, or prevention, consists of three levels or treatment modalities in the Neuman model. Primary prevention relates to general knowledge that is applied in client assessment and identification and reduction of risk factors associated with environmental stressors to prevent possible reaction. Secondary prevention relates to symptomatology following a reaction to stressors, ranking of intervention priorities, and treatment to reduce possible negative effects. Tertiary prevention relates to adjustments that occur as the client begins to stabilize following the treatment of stressor reactions or symptoms (Neuman, 1989).

With the current focus on primary prevention there is an increasing need to identify and clarify the relationship of variables affecting the health responses of individuals (Neuman, 1989). Primary prevention as a treatment modality focuses on need determination, objective and goal identification, and education and other supportive interventions that augment existing strengths related to the flexible line of defense. Potential reactions from stressors can be prevented through appropriate and timely primary

intervention strategies (Neuman, 1989).

The process of dying and the event of death are considered major stress-producing forces either intrapersonally, interpersonally, or extrapersonally (Worden & Proctor, 1976; Kastenbaum, 1986; Lonetto & Templer, 1986; Rando, 1986; Humphrey, 1986; Benoliel, 1988; Gonda & Ruark, 1984). As environmental stressors, dying and death can create significant anxieties and fears as each threatens the stability and equilibrium of an individual, a family, or a community. There is a certain attitude of abhorrence and shame surrounding the dying process and the event of death (Aries, 1984). This social attitude contributes to the formation of personal and interpersonal expectations, experiences, opportunities, and responses to dying.

Intrapersonal stressors may be partly manifest due to primordial anxieties of non-existence, fears regarding "afterlife," lack of experience in confronting death as an inevitable life occurrence, and lack of knowledge of the dying and death process (Aries, 1984; Kubler-Ross, 1969; Eddy & Alles, 1983). The various reactions to intrapersonal stressors are

affected by the levels of internal anxieties and fears regarding dying. Reactions to minor losses throughout the lifespan may provide insight into possible reactions to more major losses such as death (Gonda & Ruark, 1984; LaGrand, 1988).

One's intrapersonal attitudes and anxieties regarding death may affect one's reactions and responses when confronted with others experiencing dying. Highly death anxious individuals tend to shy away from those moving toward death causing a decrease in communication, avoidance of contact, reduction of interactions, and denial of vital experiences (Gonda & Ruark, 1984). Thus, one's intrapersonal anxieties surrounding death influence interpersonal reactions. The highly death anxious nurse may be less prepared to deal appropriately and effectively with a dying client. The nurse's flexible line of defense may not be equipped to withstand the environmental stressors created by frequent interpersonal contact with dying clients. Even more difficult may be energy draining intrapersonal and interpersonal stressors created in the event of a personal terminal illness or the illness or death of a significant other.

Extrapersonal stressors of dying and death, such as cultural and social attitudes and expectations, also affect one's internal and interpersonal responses.

By using the Neuman Systems Model it was postulated that a focus on primary prevention aimed at increasing the strength of a nurse's flexible line of defense as it relates to death anxiety would better prepare the nurse for effectively confronting situations with dying and death. By expanding the nurse's knowledge and awareness of death and dying, providing a supportive environment, and promoting self-reflection of the inevitability of one's own death, the nurse's flexible line of defense could be augmented and strengthened. The greater the expansiveness of this line from the normal line of defense, the greater the protectiveness (Neuman, 1989). Therefore, an education course on death and dying was implemented to identify the effects of primary prevention interventions on the death anxiety levels of registered nurses.

The theory which provided the framework for the educational intervention on death and dying was a portion of the social learning theory outlined by

Bandura (1969). This portion, identified as the belief-oriented approach, utilizes the exposure to information and various persuasive communications in an attempt to effect modifications in one's attitudes by altering one's beliefs about the attitude object. This approach assumes that one can be induced to change his/her evaluations of an object by receiving new or expanded information about its characteristics.

With the increasing emphasis by the nursing profession on the provision of holistic, quality care to clients, high level nursing skills when working with the terminally ill and dying client present much peer reward. Nurses as a group tend to be committed to self-improvement in order to provide exceptional care to their clients. Thus, through involvement in an educational course on death and dying, it is hoped that a nurse will expand his/her knowledge of the dying process, alter (to a greater or lesser extent) negative attitudes toward dying and death, and reduce personal anxieties regarding dying and death.

Hypotheses

1. Nurses who complete a death education program

will demonstrate a significant decrease in levels of death anxiety as measured by pre-test and post-test I scores on the Templer Death Anxiety Scale.

2. Nurses who complete a death education program will demonstrate a significant decrease in levels of death anxiety as measured by post-test I and post-test II scores on the Templer Death Anxiety Scale.

3. Nurses in the control group will demonstrate no significant difference in death anxiety scores as measured by pre-test and post-test scores on the Templer Death Anxiety Scale.

Definition of Terms

Death. Death refers to the cessation of human life as experienced physically, mentally, and emotionally (Combs, 1978).

Dying. Dying refers to the process of the cessation of life and the awareness of this process (Combs, 1978).

Death Anxiety. Death anxiety refers to the fear of one's own death (McCarthy, 1980). Death anxiety in this study will be operationally measured by the Templer Death Anxiety Scale (1970).

Death Education. Death education refers to the

process of teaching, lecturing, counseling, and/or discussing death and dying in an effort to improve nurse participants' knowledge about the death and dying processes (Combs, 1978). Death education in this study is designed to assist registered nurses to come to an awareness and understanding of the reality of death and personal death anxieties. An eight-hour course on death and dying will be presented. The course will be divided into three, two-hour weekly sessions with two, one-hour home modules between sessions one and two and sessions two and three.

Nurse. Nurse refers to registered nurses who voluntarily participate in this study as either control group or experimental group subjects. These registered nurses are currently licensed to practice nursing in the state of Utah, are presently engaged in direct client care, and work in the St. George-Cedar City area.

Primary Prevention. Primary prevention is an intervention typology for nursing action that is utilized before a reaction to environmental stressors occurs (Neuman, 1989). Primary prevention in this study will be operationally defined as an eight-hour

continuing education course on death and dying. The content of this course is outlined in Appendix A.

Flexible Line of Defense. The flexible line of defense is a protective, accordion-like mechanism that surrounds and protects the normal line of defense from invasion by stressors (Neuman, 1989). The flexible line of defense is a combination of cultural, spiritual, psychological, physical, and social variables. One indication of the strength or weakness of one's flexible line of defense is measured by one's death anxiety level. For this study the strength of one's flexible line of defense will be measured by death anxiety scores.

Intrapersonal Stressors. Intrapersonal stressors in this study will be defined as one's internal fear of non-existence, belief in an "afterlife," knowledge of death and dying, and other factors that influence one's attitudes and anxieties regarding death and dying.

Interpersonal Stressors. Interpersonal stressors in this study will be defined as the exposure to the death or dying of clients or significant others.

Significance of the Study

Many nurses have not had the opportunity in their undergraduate nursing education to confront death as a significant part of life. As a result many have not developed effective methods of caring for dying patients or their families (Murray, 1973). Younger nurses may not have had experiences with the death of a close friend or family member. The lack of a broad and continuing program of death education contributes to a deficiency of skills and abilities to appropriately interact with dying patients. This deficiency may be manifest by professional guilt, anger, frustration, dissatisfaction, and possibly resentment toward the dying experience. These feelings may be dealt with by withdrawal, avoidance, inappropriate persistence in efforts to cure, closed communication, and burnout in the professional nursing staff (Gonda & Ruark, 1984). This study is significant for the nursing profession as it will provide registered nurses through a death education program assistance in dealing with the problems they encounter when working with dying clients. The death education program will focus on personal death anxieties,

awareness of death, communication needs, relaxation methods, and peer support systems.

Limitations of the Study

This study is focused on the administration of a continuing education program of death and dying for registered nurses and on the determination of the effect of the program on nurses' levels of death anxiety. The study limits itself to a population of 23 experimental subjects and 26 control subjects from two small, adjacent communities in rural Utah. The subjects were volunteers from Dixie Medical Center in St. George, Utah and Valley View Medical Center in Cedar City, Utah. The study population includes a preponderance of nurses from the Latter-Day Saints (Mormon) religion and culture. Because of the emphasis on an afterlife and socio-cultural expectations regarding loss, mourning, and grieving processes in the Latter-Day Saints religion the results of this study may not generalize to diverse, multi-cultural populations. The small sample size also limits generalization of the results to larger populations.

Chapter 2

REVIEW OF RELATED LITERATURE

Death and Dying in American Society

Social attitudes and community approaches to death and dying have changed and transformed over history. Yet, with the alterations and evolutions of rituals and ceremonies related to dying, death, burial, and mourning, man continues to remain fearful and frightened of death processes (Kubler-Ross, 1969; Aries, 1984). As a society, we have not mastered our attitudes, fears, and anxieties toward death. Individual and community confrontation of death as an inevitable life event continues to be a major concern.

Aries (1984), in his historical account of death and dying over the past one-thousand years, states that a community of old feared death because it was weakened by the loss of one of its members. Such a community also feared death because the death of one or many opened a breach in the defense system. In current times, Aries (1984) argues, the community feels less and less involved in the death of one of its members. This lack of involvement has resulted

because the community no longer thinks it necessary to defend itself against nature. Also the community no longer has a sufficient sense of solidarity. Our current culture has abandoned responsibility for the organization of collective life (Aries, 1984). Community in the traditional sense of the word no longer exists. Death of the individual has become isolated, medicalized, institutionalized. Dying and mourning have become issues to deny and pity. The intimacy of death and dying has been removed (Aries, 1984).

At the turn of the century, infectious and communicable diseases of childhood were the leading causes of death. These "acute" diseases appeared quickly and the afflicted individual either recuperated or succumbed to the illness within a relatively short period of time. Because of the rapid onset of significant symptoms, and due to the lack of medical technology that would make a difference in morbidity and mortality rates, many deaths occurred at home rather than in institutions (Eddy & Alles, 1983).

Advances in medical technology have largely redirected health care to focus on "chronic" illness.

The discovery of antibiotics and immunizations has led to the movement from many acute problems to the more chronic problems of cardiovascular disease, cancer, diabetes, etc. (Fries, 1986). Chronic illness and trauma cases are now the leading causes of hospitalization.

The extent of time from diagnosis to death has also lengthened (Eddy & Alles, 1983). This change in dying from a quick, home death to a longer, hospital death has contributed to fears and anxieties surrounding the dying process. One is no longer supported by the family and community in a comfortable surrounding such as home. Many individuals now experience dying and death in an unknown institutional environment, with unknown care providers, accompanied by unknown routines and consequences. These social and environmental factors combine to intensify the fears and anxieties of the dying experience.

Death Anxiety

Death anxiety is the fear of one's own death or the fear of the death of another (Combs, 1978). Death is probably the most fundamental source of primordial anxiety for the vast majority of mankind.

The thought of one's own death, on a very primitive level, can come to equal the end of the world (Gonda & Ruark, 1984). This anxiety over one's own death may be manifested by feelings of tension, distress, and apprehension (Kastenbaum, 1986).

Dimensions of Death Anxiety

Death anxiety does not behave or respond to personal, environmental, or social factors in the same way as do better-documented forms of anxiety (Lonetto & Templer, 1986). Death anxiety is not bound by unidimensional definitions but is a composite of multiple components. According to Lonetto & Templer (1986) four of these components include: 1) concern about intellectual and personal emotional reactions to death, 2) concern about physical change, 3) awareness of and concern about the passage of time, and 4) concern about the pain and stress that can accompany illness and dying.

Kastenbaum and Aisenberg (1972) state that the fear of extinction, annihilation, obliteration, or ceasing to be constitutes the core of death anxiety. This definition reflects the ideas of Jacques Choron (in Gonda & Ruark, 1984) who identified fears

surrounding death as 1) the process of dying, 2) extinction or nonexistence, and 3) what comes after death. Nelson and Nelson (1975) in a factor analytic inquiry into the dimensionality of death anxiety, identified four dimensions of death anxiety as death avoidance, death fear, death denial, and reluctance to interact with the dying. These diverse factors lead to some difficulties in identifying specific variables that influence individual reactions regarding death anxiety. These factors also complicate the implementation of appropriate and proven tools or scales that may identify dimensions of importance.

Correlates of Death Anxiety

Multiple research studies have been implemented in an attempt to identify variables, correlations, and norms of death anxiety. Although clear-cut inferences regarding death anxiety have been difficult to identify, some generalizations and meaningful information have been described in literature (Lonetto & Templer, 1986).

A study conducted by Templer, Ruff, and Franks (1971) evaluated the degree of death anxiety as a function of age and sex in diverse populations, and

determined the extent to which the death anxiety of adolescents resembled that of their parents. A total of 2559 subjects from diverse backgrounds and of varying ages were surveyed for their death anxiety levels using the Templer Death Anxiety Scale (DAS). The survey included apartment house residents (n = 263), psychiatric aides (n = 115), psychiatric patients (n = 137), adolescents (n = 743), and parents of adolescents (n = 1271).

In this study there was no significant correlation between the DAS score and age for any group. Mean DAS scores of parents and their children of the same sex were very similar (father = 5.67, son = 5.83; mother = 6.52, daughter = 6.79). For all groups, females exhibited higher DAS scores than males. These differences were statistically significant ($p < .001$) for the apartment house residents, adolescents, and parents of adolescents.

Templer, Lester, and Ruff (1974) also demonstrated a positive, though weak, association between femininity and fear of death. Seventy-two female and 29 male undergraduates completed the DAS, the Femininity Scale, and the Costello and Comrey Anxiety Scale.

Death Anxiety-Femininity correlations were .22 ($p < .05$) for the females and .23 for males. Death Anxiety-Anxiety correlations were .25 ($p < .025$) for the females and .42 ($p < .025$) for the males. Anxiety-Femininity correlations were .58 ($p < .005$) for the females and .04 for the males. For the females, the partial correlation between the Death Anxiety Scale and the Femininity Scale with the effect of the Costello and Comrey measure of general anxiety removed was .09. The authors suggested that most of the death anxiety-femininity correlation was a function of general anxiety. For the males that partial correlation was .24, essentially unchanged from the unadjusted correlation.

In a study conducted by Cole (1978-1979) it was found that married females had a death anxiety higher that that of married males though not at a significant level. More specifically, married females with children had the highest death anxiety, followed by married females without children, and lastly single females.

Aday (1984-1985) also identified higher death anxiety levels in the female participants in his study

of 90 male and 91 female undergraduate students. Each respondent completed Templer's Death Anxiety Scale. A mean death anxiety score of 7.68 was found for the 181 respondents (SD = 3.18). Sixty-four percent of females reported high death anxiety scores compared to 43% of males. No mean scores were listed for the death anxiety for females.

The reasons for the higher DAS scores of females are not clear. Lonetto and Templer (1986) stated that females score higher on most self-report measures of anxiety, distress, and maladjustment. They also suggested that the greater degree of expressed death anxiety in females may be a product of the cultural tendency for women to express more emotions and fear than males.

Similarities of death anxiety scores have been reported for husbands and wives. Templer, Ruff, and Franks (1971) described considerable death anxiety resemblance among family members, with the highest correlation being between husband and wife ($r = .59$, $p < .001$). This finding was supported by a study by Lucas (1974). Lucas included the wives of 20 male patients who were receiving hemodialysis at home, 20

who were receiving hemodialysis in a hospital, and 20 who were recovering from surgery. All 60 wives participated in the study. Lucas found significant husband-wife death anxiety resemblance in each of the three groups of patients. It is interesting to note that this study supported the work of Templer, Ruff and Franks (1971) in that the wives had higher mean DAS scores in both groups of hemodialysis couples. Only the surgical patients had higher DAS scores than their wives.

Lucas (1974) also noted that all of the T-scores for the patients and their wives were close to the mean of Templer's normal subjects that were used for comparison. It was suggested that serious physical illness does not necessarily lead to heightened death anxiety. This supported Templer's (1971) research which studied the relationship between the extent of physical disorders in elderly persons and their death anxiety. In this study, Templer found no significant relationship between death anxiety and symptoms of physical deterioration. The author concluded that physical decline was not necessarily a determinant of death anxiety level.

Lonetto and Templer (1986) concluded that death anxiety seems not so much a fixed entity as a state that is sensitive to environmental events and to the impact of intimate interpersonal relationships. The high correspondence between husband and wife and parent and child may be a function of the proximity of these relationships and of the shared life experiences in a family. Lonetto and Templer (1986) suggested that interpersonal relationships with friends, teachers, colleagues, and other significant individuals may influence one's degree of death anxiety more than has been identified and recognized.

Research has also indicated that death anxiety is inversely related to income and educational level (Aday, 1984-1985; Cole, 1978-1979). Some studies have found blacks to have higher death anxiety than whites, while other studies have reported no difference (in Lonetto & Templer, 1986). Marital status, parenthood, and number of children were reported by Cole (1978-1979) not to be associated with death anxiety. Templer and Lonetto (1986) summarized that being white, male, highly educated, from an intact family, with a good income and a higher IQ tended

to be associated with lower death anxiety.

Another important factor of interest in death anxiety is that of religion and religious commitment. Templer (in Lonetto & Templer, 1986) surveyed 390 deeply religiously involved persons for death anxiety. The subjects had participated in one of two previously held interdenominational, predominantly Protestant evangelical retreats. The DAS and a religion inventory were completed by 267 respondents. The more religious persons in the traditional sense, had lower DAS scores. Those persons who had a strong attachment to their religious belief system, attended religious functions more frequently, were certain of a life after death, believed that the Bible should be interpreted literally, and judged the strength of their convictions to be strong compared to those of others had lower death anxiety.

A study by Leming (1975) reported the relationship between religiosity and the fear of death. In this study of 403 predominately Latter-Day Saints individuals it was concluded that individuals with low religiosity had higher death fear than those with a high degree of religiosity. The very highly

committed religionist had the least anxiety concerning death while the moderately committed individual had a higher degree of death anxiety than either the low religious or very highly religious person. Leming suggested that religion along with a host of other socialization agents contributes to anxiety concerning death.

Aday (1984-1985) supported the curvelinear findings of Leming (1975) in a study of 181 undergraduate students. Students were surveyed for demographic information and completed the Templer Death Anxiety Scale and a Belief in Afterlife Scale. Those respondents reporting frequent church attendance (at least once a week) were more likely to report low death anxiety. Respondents attending church on a monthly basis were more likely to express a high level of death anxiety than infrequent (seldom or never) church attendance ($X^2 = 7.05$, $p < .05$). No significant relationship was demonstrated between belief in an afterlife and death anxiety.

Death Anxiety and Health Professionals

A patient's contact with health care providers may create, for the patient, an intense emotional

experience and dependence (Eddy & Alles, 1983). This contact may also create in the health care provider an intense emotional and anxiety-provoking experience. A therapeutic relationship between the two may be disrupted because of the insecurities, fears, attitudes, and anxieties that each has concerning the dying, death, and mourning process (Eddy & Alles, 1983; Kubler-Ross, 1969; Gonda & Ruark, 1984; Weisman, 1984). A non-therapeutic relationship between the dying individual and the health care professional will promote unfavorable experiences for all participants and will uphold existing negative attitudes and anxieties.

Because of the importance of the relationship between the health professional and the dying client, the death anxiety levels of the health professional are of interest to the researcher. As a result, physicians and nurses are increasingly targeted for study of their attitudes, fears, and anxieties regarding death and dying.

Physicians' behavioral outcomes resulting from high or low levels of death anxiety were examined by Schulz and Aderman (1978-1979). This interesting

retrospective analysis of hospital records of 24 participating physicians linked the length of hospital stay of a patient before death and the amount of death anxiety of the attending physician. The study was based on the hypothesis that physicians high in death anxiety would be less willing to accept their patients' terminality and, therefore, would be more likely to use heroic measures to keep them alive. It was hypothesized that terminally ill patients of high death anxiety physicians would survive longer during their final hospital stay than terminally ill patients of physicians with low death anxiety. Patients who died under the care of physicians with moderate to low death anxiety died on the average of five days sooner after admission than comparable patients of physicians with high death anxiety ($F(1,21) = 6.6$, $p < .05$). A strong positive correlation was shown between physicians' death anxiety and the average length of final stay for patients who died ($r = .49$, $p < .05$). The authors concluded that the level of death anxiety of physicians influenced specific behavioral outcomes in patient interaction.

In research conducted by Kane and Hogan

(1985-1986) a significant relationship was found between age, experience, and death anxiety in physicians. The younger and less experienced physician (less than thirteen years) displayed the greatest death anxiety ($\overline{X}$ = 7.05). The more experienced physicians had a DAS mean score of 5.53. This was found to be significant ($F(1,75) = 5.73$, $p < .01$). Interestingly, the younger physicians also were more frequently confronted with death.

Nurses as the health professionals who most closely work with the dying clients have been studied for their death anxiety levels, attitudes toward death, and fear of death. Lester, Getty and Kneisl (1974) examined the attitudes of 128 undergraduates, 66 graduate nursing students, and 62 nursing faculty toward death and dying. The Collett-Lester Scale of attitudes toward death and dying was administered to each participant. The subscale scores of fear of death of self, fear of death of others, fear of dying of self, fear of dying of others, general fear of death, and the consistency of attitudes toward death were compared according to levels of education and areas of clinical specialization. The results

indicated that fears of death and dying decreased with increased education, but differences based on area of clinical specialization were not statistically significant.

Denton and Wisenbaker (1977) studied death experience and death anxiety of 76 nurses and nursing students. The study was designed to test the assumption that experience with death and dying is inversely related to death anxiety. Death anxiety levels were measured by the Templer Death Anxiety Scale. Experience with death and dying was measured by a death experience inventory. No significant relationship between death of a family member or close friend and death anxiety score was identified. The hypothesis that death experience and death anxiety were inversely related was not supported (Yule's Q = -.14). However, examination of the relationship between death experience as measured by witnessing the death of someone and death anxiety indicated support for the hypothesis that death experience and death anxiety were inversely related (Yule's Q = -.39, $p < .05$). Further support was found for this inverse relationship when examining the findings for death

experience as measured by personal near-death experiences (Yule's Q = -.42, $p < .05$). When work experience and age were controlled, the correlation coefficients added further support to the findings that death experience as measured by witnessing a death and personal near-death was inversely related to death anxiety and that recent experience with loss was not correlated with death anxiety.

Effects of Death Education on Nurses

The effects of death education (implemented as courses, seminars, workshops, or continuing education/staff development programs) on nurses or nursing students have been examined during recent years. Nurse educators are faced with the challenge of preparing nurses to give high quality care to dying clients. Institutions which employ nurses are faced with the challenge of enhancing the skills of the nurse as he/she continues to require upgraded information, skills, and techniques for working with the dying client. Nurses carry the major responsibility for client care and are confronted with the stresses created by close physical and emotional proximity with the dying (Murray, 1974).

Murray continued that nurses need to be prepared to face the problems involving the rights of dying clients and be competent to make appropriate decisions regarding these rights.

The amount of death education content offered by schools of nursing has increased during the last decade. However, much of the education is inadequate and/or inconsistent (Lockard, 1989). Experimental programs and seminars in death education have recently been conducted in several hospitals and colleges. Evaluations of these programs have attempted to determine the effects of various death education interventions on the death anxiety levels of nurses.

Murray (1974) conducted an important study to evaluate the effects of a six-week continuing education course on death and dying for registered nurses. The subjects were 30 randomly selected nurses who participated in an intensive six-week program of ninety-minute long weekly sessions. The sessions included both didactic and experiential methods of learning. Educational intervention included audio-visual presentations, selected readings, sensitivity exercises, group dynamics,

lecture-discussion, role-playing, and interaction with a dying client. Participants were administered Templer's Death Anxiety Scale as a pre-test, post-test I at the completion of the course, and post-test II four weeks after course completion.

The nurses obtained DAS means of 6.70 (SD = 2.34) on pre-test, 6.36 (SD = 2.04) on post-test I, and 5.63 (SD = 1.97) on post-test II. The pre-test to post-test I decrease of .34 was not significant ($t = .91$); the pre-test to post-test II decrease was 1.07 ($t = 2.61$, $p < .025$); the post-test I to post-test II decrease was .73 ($t = 2.10$, $p < .05$).

Murray responded to the significant decrease of .73 from post-test I to post-test II by concluding that the four-week time period between completion of the course and post-test II may have provided the nurses with time for reflection upon their feelings and attitudes toward death. Murray continued that during this same period the nurses may have had an opportunity to utilize the information received during the course.

In a similar study, Laube (1977) examined the effects of a two-day workshop on death and dying on

the death anxiety of registered nurses. This program was presented through lectures, films, and small group discussion and experiential work. Forty-four nurses voluntarily participated in the workshop and were informed of the nature of the study. The Templer Death Anxiety Scale was administered as a pre-test, post-test I at the conclusion of the course, post-test II four weeks later, and post-test III three months following the workshop.

Twenty-four subjects returned post-test III. The t-test analyses of these 24 subjects reported a pre-test DAS mean of 6.21. No significant difference was reported in the nurses' level of death anxiety immediately following the workshop ($\overline{X}$ = 5.88, t = 1.09), but a significant decrease from the pre-test mean score was demonstrated one month following the workshop on post-test II ($\overline{X}$ = 5.38, t = 2.39, $p < .05$). When the subjects were tested three months following the workshop (post-test III) the mean death anxiety level remained below pretest and post-test I levels but had risen somewhat above their post-test II levels ($\overline{X}$ = 5.58, t = 1.57). The results of this study supported Murray's (1974) study and added the

dimension of continued effects of death education at a three month follow-up.

Another recent study (Chodil and Dulaney, 1984) attempted to evaluate the effect of a one-day continuing education offering on the death anxiety levels of registered nurses employed in critical care settings. The course included a strong emphasis on values clarification in an informal and relaxed interactive setting. The Templer Death Anxiety Scale was administered to the participants prior to the workshop and again two to three months following the workshop. Eleven critical care nurses participated in the study, however, only eight returned the follow-up DAS and were included in the sample. Of the eight who responded to the follow-up DAS four scored higher on the DAS, three scored lower, and one score remained the same. While Murray (1974) and Laube (1977) were able to demonstrate that participation in a workshop on dying and death decreased nurse's death anxiety, this study did not.

In a study involving a much larger sample, Murphy (1986) evaluated the effects of a sixteen-hour, two-day workshop on death and dying on the death anxiety levels

of 150 registered nurses. Nurses from a variety of work settings volunteered to participate in the course which included high levels of interaction and emotionally impactful stimuli, films, simulation discussion groups, an interview with a terminally ill client, lectures and panels. A group of 150 nurses from the surrounding area who did not participate in the course were included as the control. The Templer Death Anxiety Scale was administered as pre-test prior to the workshop, as post-test I at the completion of the workshop, and as post-test II one month later.

The nurses who attended the workshop showed a significant decrease in measured death anxiety between pre-test and post-test I ($n = 142$, pre-test $\overline{X} = 8.0$, post-test $\overline{X} = 7.5$, $t = 1.87$, $p < .05$). The mean difference for the control group was not significant.

One month after the workshop, 101 nurses returned post-test II. When compared with the pre-test scores the t-test of mean change was significant ($t = 2.87$, $p < .002$). A significant relationship was also reported between DAS and age of the respondent and length of nursing experience. The largest decrease

in DAS was for nurses between the ages of 31 and 40 and in nurses who had worked 7 to 12 years in nursing. No significant relationships were reported between DAS scores and marital status, type of nursing education, loss of a significant other, religious preference, and area of nursing responsibility.

Both short-term and long-term effects of a death education instructional unit on the death anxiety level of undergraduate nursing students were evaluated by Lockard (1989). An assessment was made of the effect of a seven-hour death education unit on death anxiety levels of the students. The relationship of reported death anxiety score to age, personal death experience, and nursing experience was also evaluated. Templer's Death Anxiety Scale was administered to two intact classes of nursing students who were randomly assigned to either the experimental or control group. The subjects completed the DAS prior to the course as pre-test and immediately following the course as post-test I. Post-test II was completed by 74 subjects one month following the course while 50 subjects completed the final post-test one year later.

Subjects who participated in the death education unit had a significantly lower DAS score than those who did not participate in the unit for post-test I ($F > 8.41$ (1,71 df), $p < .001$), post-test II ($F > 8.41$ (1,71 df), $p < .001$), and the one year follow-up post-test ($F > 8.66$ (1,47 df), $p < .001$). There was no significant relationship between pre-test DAS scores and age, death experience, or nursing experience. There was a low negative relationship between change in DAS scores and nursing experience from post-test I to one-year follow-up and post-test II to one-year follow-up.

The results of this study did support previous studies which demonstrated that death anxiety could be reduced as a result of a planned educational experience with death and dying. The attitude changes reported seemed to be stable over time. The author recommended further study of death education instruction and its long-term effects. Lockard also recommended that nursing educators emphasize the importance of basic education for nurses in the area of death and dying.

Continuing research into the area of the effects

of various educational programs of death and dying education for registered nurses is indicated. This study attempted to evaluate the effects of a continuing education program on death and dying on the death anxiety levels of registered nurses employed in the hospital setting.

Chapter 3

METHODOLOGY

The purpose of this study was to determine the effects of a death and dying course on the death anxiety levels of registered nurses. It was hypothesized that registered nurses who participated in a death education course would show a significant reduction in death anxiety levels at the completion of the course. It was also expected that the participants would continue to show a reduction in death anxiety at the time of the second post-test six weeks later.

Population

St. George and Cedar City are small communities located in rural, southern Utah. These cities are situated approximately fifty miles apart. Each city is the largest community in its respective county. St. George has approximately 23,000 citizens and is located in Washington County which has a population of 45,000. Cedar City has approximately 14,000 citizens and is located in Iron County which has a population of 19,200. These communities were chosen

for study because of the similarities of the residents and the close proximity for data collection.

The hospital used for the experimental sample is located in St. George and is a 106-bed acute care hospital. It employs approximately 140 full or part-time registered nurses. Nearly 30 of these registered nurses hold a Bachelor's Degree in Nursing and 15 others are presently enrolled in a Bachelor's Degree program.

The hospital used for the control sample is located in Cedar City and is a 30-bed acute care hospital. It employs 35 registered nurses, 15 of whom hold a Bachelor's Degree in Nursing. Ten others are currently enrolled in a Bachelor's Degree program.

Both hospitals are owned and operated by a health care corporation and have a preponderance of Caucasian, female, Latter-Day Saints nurses in their employ. Both hospitals provide similar services and treat similar types of clients.

Sample

The subjects of this research study were registered nurses from the St. George and Cedar City, Utah areas. The 23 nurses who composed the

experimental group were employed by the hospital in St. George. The 27 subjects who composed the control group were registered nurses employed by the hospital in Cedar City.

Design

To determine the effects of death education on the death anxiety level of registered nurses, a quasi-experimental nonequivalent control group time-series design was chosen. This design was utilized due to the fact that the nurses volunteered to participate and were not randomly selected nor assigned. In order to keep the control group as free from influence as possible these subjects were selected from a similar population in a nearby community (Cedar City, Utah). The groups were, therefore, considered intact groups and were not randomly assigned to an experimental or control group. However, due to the close proximity of the two areas, the expected similarities of subject demographics, and the similar employment and educational experience of the subjects, a close equivalence in groups was predicted.

The time-series (pre-test/post-test) was utilized to provide information about death anxiety and

biographical data between and within groups. A pre-test/post-test design allowed for identification of change within groups over time. By comparing pre-test to post-test scores it was possible to determine the effects of the experimental variable. Comparison of the pre-test scores between the control and experimental groups identified characteristics of each group prior to the intervention and identified similarities of nonequivalent groups (Shelly, 1984). Comparison of post-test scores between the control and experimental groups identified changes incurred for both groups.

Educational Intervention

The death education course was conducted in three consecutive weekly sessions. Each session was two hours in length. In addition a one-hour home module was completed by the subjects between sessions one and two and a second one-hour home module between sessions two and three. In total there were eight hours of death education. Seven point two (7.2) units of continuing education were available from the Utah Nurses' Association for the participants of the workshop.

The course objectives and content were developed from an outline of a death education instructional unit published by Lockard (1989). For the purpose of this research the objectives of the course focused on the process of grief and mourning, coming to terms with one's own death, communicating with the dying or grieving person, coping with the death of a friend or relative, and improving nursing care of dying clients and their families.

Information and selected readings, audio-visual materials, and structured learning experiences were obtained through an extensive review of death education literature and through consultation with a nationally certified death education specialist. Objectives of the course were also reviewed by unit managers and the nurse education coordinator of Dixie Medical Center. Unit managers were consulted to elicit support and to arrange scheduling changes for those nurses who wished to participate. Flyers were distributed throughout the hospital to announce the course and to generate interest.

The method of presentation of course content varied depending on the objectives of the session.

The methods included: lecture-discussion, audio-visual presentations, group dynamics, structured learning experiences, and outside readings. The sessions combined both didactic and experiential learning methods as the combination of these methods was identified through literature review as being effective (Eddy & Alles, 1983).

The three two-hour sessions were spaced one week apart to allow time for absorption and assimilation of the previous week's experience. This spacing also permitted time for the completion of assigned readings and exercises. The sessions were scheduled in the hospital education classroom during the early evening. A course manual was provided which included course objectives, selected readings, various structured exercises, and correspondent handouts. A complete outline of the course is described in Appendix A.

Data Collection

All subjects were invited to participate in the study on a voluntary basis. Each volunteer received information and explanation from the investigator regarding the nature of the study. Each subject signed a letter of consent prior to data collection. A cover

letter which accompanied each consent form described the nature of the study, confidentiality measures, and ability of the participant to withdraw. Subjects in the experimental group were also advised of the availability of continuing education units (CEU's). See Appendices B and C.

Immediately prior to beginning the first session of death education, the subjects in the experimental group completed two instruments to; 1) identify death anxiety levels, and 2) describe demographic information. Templer's (1970) Death Anxiety Scale (DAS), a 15-item scale, was utilized to measure death anxiety (see Appendix D). A 14-item Biographical Information tool was utilized to describe demographic information (see Appendix D). Data on demographic and independent variables of age, educational level, sex, race, marital status, years of experience in nursing, religious affiliation and commitment, previous death education, and experience with terminally ill clients were collected and analyzed to compare groups, identify possible variables affecting death anxiety, and identify future research needs in the fields of nursing and death education. Ten minutes were allowed

for completion. The investigator distributed and collected the instruments.

The DAS was administered a second time immediately following the final session of the course (post-test I). The subjects completed the DAS in about five minutes. The DAS was administered by the investigator. Code numbers were used to identify the subjects in order to match demographic, pre- and post-test information.

At the conclusion of the final educational session, a course evaluation, as required by the Utah Nurses' Association for CEU's, was distributed. The participants were requested to respond to the program regarding content, presentation, handouts, and relevance to practice.

The final administration of the DAS occurred six weeks following post-test I. The DAS was administered to the subjects by the investigator during their regular shifts at the respective hospitals. The subjects completed the DAS with the investigator present to assure that each scale was completed by the correct person, that the code numbers for the subjects matched, and that the subject did not elicit

help from others. This approach also assured the maximum number of subjects followed through with the post-testing.

The control group completed the DAS pre-test and the Biographical Information tool during the same week that the experimental group completed pre-testing. The investigator administered the pre-tests to the control group subjects during their work shifts. Assistance in locating the participants was given by an administrative secretary.

The control group was given the second post-test eight weeks following the pre-test. This post-test was administered during the week the experimental group completed post-test II. No post-test was given to the control group at the time which corresponded to post-test I for the experimental group. It was felt that testing at that time would not yield significant data. The post-test was administered by the investigator.

Tools

The instrument utilized to measure death anxiety was the Templer (1970) Death Anxiety Scale (DAS). This scale was used to determine the pre-test and

post-test scores for death anxiety levels. See Appendix D. Permission to use the DAS was granted by Donald Templer prior to this investigation. See Appendix E.

The DAS is a 15-item questionnaire. The subject responds true or false as to whether or not a particular item describes personal feelings about death. Scores for this questionnaire may range from 0 to 15. Higher scores indicate greater anxiety regarding death. The items reflect a range of personal perceptions and experiences surrounding the subject of the fear of death and dying.

The Templer DAS is a frequently used and much researched tool for the identification of personal death anxiety. Kastenbaum (1986) states that the DAS has been subjected to the most extensive development and evaluation and has also become one of the most popular instruments for research on death anxiety.

The DAS items reflect a wider range of life experiences than other death scales (Templer, 1970). Forty items were originally devised and after item analysis 15 items remained to compose the present-day

form of the DAS. Of these 15 items, 9 are keyed "true" and 6 are keyed "false." Internal consistency was determined through point biserial correlation coefficients for three independent groups of subjects. The independent groups of subjects consisted of undergraduate college students throughout the states of Kentucky and Tennessee (Templer, 1970).

Reliability for the DAS was established in test-retest scores of thirty-one undergraduate college students. A product-moment correlation coefficient of .83 between the two sets of scores demonstrated acceptable test-retest reliability. A coefficient of .76 demonstrated internal consistency with the thirty-one students (Templer, 1970).

Construct validity of the DAS was established in two separate studies. In the first study psychiatric patients in a state mental hospital were utilized as subjects. DAS scores of 21 presumably high death anxiety psychiatric patients were compared with those of control patients. The psychiatric patients had a DAS mean score of 11.62. The control group obtained a mean of 6.77. A t of 5.79 was significant at the .01 level. It was concluded that

psychiatric patients who spontaneously verbalize death anxiety concern have higher DAS scores than other psychiatric patients.

In the second study the DAS, Boyar's (1964) Fear of Death Scale (FODS), a sequential word association task, and the MMPI were administered to 77 advanced undergraduate college students. The FODS was employed as one means of determining the validity of the DAS as it was probably the most adequate death anxiety tool developed at the time (Templer, 1970). The word association task was utilized as another validation procedure. The MMPI was employed as it contains three well-known measures of anxiety, the Manifest Anxiety Scale, the Welsh Anxiety Scale, and the Welsh Anxiety Index. Modest positive correlations with these scales were predicted.

The DAS correlated significantly with the FODS (.74), the sequential work association task (.25), and the Welsh Anxiety (.39) and Manifest Anxiety Scales (.36) of the MMPI. Templer purported that the DAS, because of the low positive correlations with general anxiety, measured something beyond general anxiety. The DAS correlation with the Welsh Anxiety Index of

the MMPI was not significant (.18) (Templer, 1970). A study to determine whether embedding of DAS items had an effect on responses showed little or no effect on such scores (Templer & Ruff, 1971).

Norms have not been established for the DAS. Scores may range from 0 to 15. The means of normal subjects tend to range from 4.5 to 7.0 with a standard deviation of just over 3.0. Mean and standard deviation data were compiled from subjects in 23 categories involved in seven different studies involving over 3600 adults and adolescents (Templer, Ruff & Franks, 1971). Psychiatric patients obtained higher scores than normals (Templer, 1970). Females consistently had higher DAS scores than males (Cole, 1978-79; Templer, Ruff, & Franks, 1971). In a study involving over 2500 subjects from 19 to 85 years of age, no significant relationship was found between age and DAS scores (Templer, Ruff & Franks, 1971).

The DAS is scored by tabulating the number of answers which agree with the key. The higher the score, the greater the level of death anxiety. The items in the DAS that are keyed "true" include: 1, 4, 8, 9, 10, 11, 12, 13, 14. The items keyed "false"

include: 2, 3, 5, 6, 7, 15. The test has no time limit.

A biographical data sheet (see Appendix D) was utilized to collect demographic information and data regarding selected independent variables, i.e., age, educational level, sex, race, marital status, years of experience in nursing, religious affiliation and commitment, experience with terminally ill clients, and previous death education courses. These variables were identified as important correlates to death anxiety through the review of literature. This data sheet was developed by the investigator to assess details on a variety of vital statistics and general information. The data provided information on the relationships and similarities between the experimental and control groups as well as determined similarities of these groups to other studied populations.

Statistical Analyses

To determine the effects of death education on the death anxiety level of nurses, a nonequivalent control group design was implemented. Subjects in both the experimental and control groups completed biographical information as well as pre-tests and

post-tests for death anxiety. The Statistical Package for Social Sciences (SPSSX) program was used for analysis (SPSSX, 1983).

Descriptive statistics were utilized to analyze the demographic data to identify characteristics of the sample. The experimental and control groups were compared on selected biographic and demographic variables using frequency distributions.

A dependent t-test was used to compare the mean pre-test scores with each of the mean post-test scores within each group. The t-test demonstrated changes in death anxiety by comparing pre- and post-test I and II scores in the experimental group and pre- and post-test scores in the control group.

The t-test was also used to compare the mean death anxiety levels of the experimental and control groups. These data provided information about the similarities of groups on death anxiety and allowed comparison of the groups to other similar populations.

The effects of selected independent variables upon death anxiety were also investigated for both groups. These variables included age, race, sex, years of nursing experience, marital status, level

of education, religious affiliation, religious commitment, religious attendance, belief in life after death, frequency of care for the dying, history of family death, history of self near-death experience, and previous death education.

One-way analysis of variance (ANOVA) was utilized to determine the effect of the independent variables on post-test I and II scores for the experimental group and on pre-test and post-test scores for the control group. Several analyses of variance were done for selected variables where there appeared to be differences in the variable subgroups for scores on the DAS. These selected variables included religious attendance, age, and near-death experience for the experimental group and age and care for the dying for the control group. The .05 probability level was set to determine significance.

Human Subjects' Rights Committee Approval

A description of the study which included the purpose, theoretical framework, hypotheses, significance, design, proposed sample, data collection methods, instruments, course outline, and letters of approval was submitted to the Human Subjects' Rights

Committee, Department of Nursing, University of Nevada, Las Vegas in December, 1989. Committee approval was obtained and data collection was completed in February and April 1990. See Appendix F. The study was also approved by the Institutional Review Board at the hospital in St. George, Utah in December 1989. Administrators at the hospital in Cedar City, Utah gave permission for the investigator to solicit volunteers for the control group from its registered nurse employees during their work hours.

Chapter 4

FINDINGS AND DISCUSSION

Description of the Sample

The sample population consisted of 23 subjects in the experimental group and 27 subjects in the control group. The data collection occurred during February and April, 1990. Subjects for the experimental group were registered nurses employed by the hospital in St. George, Utah. Subjects for the control group were registered nurses employed by the hospital in Cedar City, Utah. All subjects volunteered to participate in the study and 100% were retained through the final post-testing.

The frequency distributions for demographic variables of age, marital status, nursing experience, education, and religion for the sample are presented in Table 1. The experimental group ranged in age from 19 years to over 60 years with 47.8% of the group between 40 and 49 years. The control group was slightly younger with 48.1% between 30 and 39 years. The experimental group also had 17.3% of subjects over the age of 50 while the control group reported no one age 50 or above. The majority of the subjects

were married, 16 (69.6%) in the experimental group and 25 (92.6%) in the control group. Six (26%) subjects in the experimental group were divorced. Both the experimental and control groups had one male participant and all subjects were Caucasian.

Years of nursing experience ranged from less than one year to over 21 years. In the experimental group 13 (56.5%) subjects reported 5 to 10 years of experience and five (21.7%) reported over 21 years of experience. In the control group nine (33.3%) subjects reported 5 to 10 years of experience and nine (33.3%) reported 11 to 15 years. Only two (7.4%) subjects in the control group reported over 21 years of experience.

With regard to education, 16 (69.6%) subjects in the experimental group reported an Associate Degree in Nursing as the highest level of education, and four (17.4%) subjects held a Bachelor's Degree in Nursing. In contrast, 13 (48.1%) subjects in the control group held the Associate Degree in Nursing and 12 (44.1%) held the Bachelor's Degree in Nursing.

The subjects in both the experimental and control groups were predominantly from the Latter Day Saints

Table 1

Frequency Distributions for Experimental and Control Groups by Age, Marital Status, Years of Nursing Experience, Education, and Religion (Experimental Group n = 23, Control Group n = 27)

	Experimental		Control	
Age in Years	Frequency	Percent	Frequency	Percent
19 to 29	4	17.4	7	25.9
30 to 39	4	17.4	13	48.1
40 to 49	11	47.8	7	25.9
50 to 59	3	13.0	0	0
60+	1	4.3	0	0
Total	23	100.0	27	100.0

(table continues)

(Table 1 continued)

Marital Status	Experimental		Control	
	Frequency	Percent	Frequency	Percent
Single	1	4.3	1	3.7
Married	16	69.6	25	92.6
Divorced	6	26.1	1	3.7
Total	23	100.0	27	100.0

Nursing Experience in Years	Experimental		Control	
	Frequency	Percent	Frequency	Percent
0 to 4	2	8.7	6	22.2
5 to 10	13	56.5	9	33.3
11 to 15	1	4.3	9	33.3
16 to 20	2	8.7	1	3.7
21+	5	21.7	2	7.4
Total	23	100.0	27	100.0

(table continues)

(Table 1 continued)

	Experimental		Control	
Education	Frequency	Percent	Frequency	Percent
AD	16	69.6	13	48.1
Diploma	2	8.7	1	3.7
BSN	4	17.4	12	44.1
BS	1	4.3	1	3.7
Total	23	100.0	27	100.0

	Experimental		Control	
Religion	Frequency	Percent	Frequency	Percent
LDS	19	82.6	24	88.9
Catholic	0	0	1	3.7
Protestant	0	0	1	3.7
Other	3	13.0	1	3.7
None	1	4.3	0	0
Total	23	100.0	27	100.0

(LDS) religion. Nineteen (82.6%) subjects in the experimental group were reportedly LDS, three (13%) reported themselves as non-denominational Christian in the "other" religion category and one (4.3%) reported no religious affiliation. Latter Day Saints accounted for 24 (89%) subjects in the control group with one (3.7%) Catholic, one (3.7%) Protestant, and one (3.7%) Episcopalian as reported in the "other" religion category.

The frequency distributions for variables of religious attendance, religious commitment, belief in an afterlife, care for the dying, death of a significant other, near-death experience, and previous death education are presented in Table 2. With regards to religious attendance, 11 (47.8%) subjects in the experimental group reported church related attendance at once per week, three (13%) reported monthly attendance, four (17.4%) reported attendance several times per year, and five (21.7%) reported they rarely attended church. Of the control group 18 (66.7%) subjects attended once per week, six (22.2%) attended once per month, and four (11.1%) attended rarely.

Table 2 also presents data regarding religious

commitment and belief in an afterlife. The majority of subjects in both the experimental and control group reported very strong to strong religious commitment, 61% of the experimental group and 74% of the control group. Nearly all subjects reported a belief in an afterlife with 21 (91.3%) subjects in the experimental group and 25 (92.6%) subjects in the control group reporting an affirmative belief.

The frequency of caring for the dying was also assessed for both groups. Of the experimental group, 69.6% cared for the dying either very often or often. The control group reported slightly less frequent contact with the dying with 44.4% of subjects in contact either very often or often. Each group had 22% of subjects who worked with the dying on a rare basis.

The death of a family member, close friend, or other significant other was reported by 13 (56.5%) subjects in the experimental subjects within the past year. This contrasts with five (18.5%) subjects in the control group reporting a recent death experience. Five (22%) subjects in the experimental group and nine (33%) subjects in the control group reported the death

Table 2

Frequency Distributions for Experimental and Control Groups by Religious Attendance, Religious Commitment, Belief in Afterlife, Care for the Dying, Death of Significant Other, Near-death Experience, and Previous Death Education

(Experimental Group n = 23, Control Group n = 27)

Religious Attendance	Experimental		Control	
	Frequency	Percent	Frequency	Percent
Once per week	11	47.8	18	66.7
Once per month	3	13.0	6	22.2
Several per year	4	17.4	0	0
Rarely	5	21.7	4	11.1
Total	23	100.0	27	100.0

(table continues)

(Table 2 continued)

Religious Commitment	Experimental Frequency	Experimental Percent	Control Frequency	Control Percent
Very Strong	10	43.5	14	51.9
Strong	4	17.4	6	22.2
Moderate	5	21.7	6	22.2
None	3	13.0	1	3.7
Total	23	100.0	27	100.0

Life After Death	Experimental Frequency	Experimental Percent	Control Frequency	Control Percent
Yes	21	91.3	25	92.6
No	0	0	1	3.7
Uncertain	2	8.7	1	3.7
Total	23	100.0	27	100.0

(table continues)

(Table 2 continued)

Care for Dying Client	Experimental Frequency	Experimental Percent	Control Frequency	Control Percent
Very Often	10	43.5	8	29.6
Often	6	26.1	4	14.8
Occasionally	2	8.7	9	33.3
Rarely	5	21.7	6	22.2
Total	23	100.0	27	100.0

Death of Other	Experimental Frequency	Experimental Percent	Control Frequency	Control Percent
< 1 year	13	56.5	5	18.5
2 years	3	13.0	8	29.6
3 to 5 years	2	8.7	5	18.5
5+ years	5	21.7	9	33.3
Total	23	100.0	27	100.0

(table continues)

(Table 2 continued)

Near-death Experience	Experimental		Control	
	Frequency	Percent	Frequency	Percent
Never	9	39.1	17	63.0
Once	8	34.8	8	29.6
Twice	3	13.0	2	7.4
More than twice	3	13.0	0	0
Total	23	100.0	27	100.0

Previous Death Education	Experimental		Control	
	Frequency	Percent	Frequency	Percent
No	16	69.6	14	51.9
Yes	7	30.4	13	48.1
Total	23	100.0	27	100.0

of a significant other as happening five years ago or longer.

With regards to a personal near-death experience nine (39.1%) of the experimental group subjects reported never having had such an experience compared to 17 (63%) of the control group. Eight (35%) subjects in the experimental group and eight (30%) in the control group reported one near-death experience.

In the experimental group, 16 (69.6%) subjects had never participated in a death education course or seminar, and 14 (51.9%) of the control group had had no such prior education.

Death Anxiety Scale Scores

Pre-test scores on the Death Anxiety Scale ranged from 2.00 to 12.00 for the experimental group and 1.00 to 11.00 for the control group. Scores on the Death Anxiety Scale may range from 0 to 15 with low scores indicating low death anxiety and high scores indicating high death anxiety.

The means and standard deviations for the pre-test and post-test scores on the Death Anxiety Scale for the experimental group and the control group are displayed in Table 3. For the experimental group

the pre-test mean was 7.39, post-test I was 7.04, and post-test II was 6.87. For the control group the pre-test mean of 6.70 and the post-test mean of 6.48 were slightly lower than scores for the experimental group. However, as shown in Table 4, there was no significant difference between the groups on the pre-test scores ($t = 1.17$, $p = .708$) nor on the final post-test scores ($t = 1.09$, $p = .829$).

Hypothesis 1

1. Nurses who complete a death education program will demonstrate a significant decrease in levels of death anxiety as measured by pre-test and post-test I scores on the Templer Death Anxiety Scale.

Although the trend of the DAS scores for the experimental group was in the downward direction (Table 3) no statistically significant decrease in scores was identified for pre-test to post-test I ($t = .78$, $p = .445$). See Table 5. Therefore, Hypothesis 1 was not supported. Nurses who completed the death education course did not demonstrate a significant decrease in levels of death anxiety as measured by pre-test and post-test I scores on the Templer Death Anxiety Scale.

Table 3

Means and Standard Deviations for Pre and Post Test Scores on Death Anxiety Scale for Experimental and Control Groups

Experimental Group	n	$\bar{X}$	SD
Pre-test	23	7.39	2.43
Post-test I	23	7.04	2.21
Post-test II	23	6.87	2.74
Control Group	**n**	**$\bar{X}$**	**SD**
Pre-test	27	6.70	2.63
Post-test	27	6.48	2.62

Table 4

T-Tests Comparing Experimental Group (n = 23) and Control Group (n = 27) Scores on Death Anxiety Scale for the Pre-test and Final Post-test

Experimental Pre-test		Control Pre-test		t-value	2-tailed probability
$\bar{X}$	SD	$\bar{X}$	SD		
7.39	2.43	6.70	2.63	1.17	.708

Experimental Final Post-test		Control Post-test		t-value	2-tailed probability
$\bar{X}$	SD	$\bar{X}$	SD		
6.87	2.74	6.48	2.62	1.09	.829

Hypothesis 2

2. Nurses who complete a death education program will demonstrate a significant decrease in levels of death anxiety as measured by post-test I and post-test II scores on the Templer Death Anxiety Scale.

Hypothesis 2 was also not supported. Nurses who completed the death education program did not demonstrate a significant decrease in levels of death anxiety as measured by post-test I and post-test II scores on the Templer Death Anxiety Scale ($t = .48$, $p = .633$). See Table 5. The decrease in mean scores from pre-test ($\overline{X} = 7.39$) to post-test II ($\overline{X} = 6.87$) was also not statistically significant ($t = 1.21$, $p = .238$). Therefore, although a downward movement in DAS scores was identified, no significant decrease in death anxiety as measured by the DAS was reported pre-test to final post-test one month following the course.

Hypothesis 3

3. Nurses in the control group will demonstrate no significant difference in death anxiety scores as measured by pre-test and post-test scores on the Templer Death Anxiety Scale.

Table 5

T-Tests for the Experimental Group (n = 23) Comparing Scores on the Death Anxiety Scale for the Pre-test and First and Second Post-test

Pre-test $\bar{X}$	Pre-test SD	Post-test I $\bar{X}$	Post-test I SD	t-value	2-tailed probability
7.39	2.43	7.04	2.21	.78	.445

Pre-test $\bar{X}$	Pre-test SD	Post-test II $\bar{X}$	Post-test II SD	t-value	2-tailed probability
7.39	2.43	6.87	2.74	1.21	.238

Post-test I $\bar{X}$	Post-test I SD	Post-test II $\bar{X}$	Post-test II SD	t-value	2-tailed probability
7.04	2.21	6.87	2.74	.48	.633

Table 6

T-Tests for the Control Group (n = 27) Comparing Scores on the Death Anxiety Scale for the Pre-test and Post-test

Pre-test		Post-test		t-value	2-tailed
$\bar{X}$	SD	$\bar{X}$	SD		probability
6.70	2.63	6.48	2.62	.67	.507

The control group subjects demonstrated no significant difference in death anxiety scores as measured by pre-test and post-test scores on the Templer Death Anxiety Scale ($t = .67$, $p = .507$). Therefore, Hypothesis 3 was supported. Pre-test and post-test means and standard deviations are presented in Table 6.

Analysis of Variance

Several one-way analyses of variance were done for selected variables where there appeared to be differences in the variable subgroups for scores on the DAS. The variables of age, religious attendance, and near-death experience were selected for the experimental group. The variables of age and frequency of care for the dying were selected for the control group. No significant differences in DAS scores were found for any of the variables examined in either the experimental or control group.

Reliability

The Cronbach's alpha estimate of internal consistency was employed to evaluate the reliability of the Death Anxiety Scale. The results revealed an alpha reliability of .6103. This reliability

coefficient is not consistent with the coefficient of .76 reported by Templer (1970) raising some concerns about the reliability and validity of this tool for this sample population. Further discussion of this concern will be presented in the following chapter.

The following chapter will summarize the conclusions, discussion and recommendations of the findings of this study.

Chapter 5

SUMMARY, CONCLUSIONS, RECOMMENDATIONS

The purpose of this study was to investigate the death anxiety level of a group of registered nurses and to determine if these death anxiety levels would change as the result of the presentation of a continuing education program on death and dying. To determine the effects of the death education program on the death anxiety levels of registered nurses, a quasi-experimental non-equivalent control group time-series design was chosen. The experimental group was composed of 23 registered nurses employed in an acute care hospital. The control group was composed of 27 registered nurses employed in an acute care hospital in a near-by community. The subjects who participated in this study were Caucasian, predominantly Latter Day Saints (LDS), and female (one male in each group). All subjects volunteered to participate in the study. The primary prevention mode of intervention of the Neuman Systems Model (1989) was utilized as the theoretical framework for the study. The belief-oriented approach of the social learning theory as proposed by Bandura (1969) provided

a framework for the implementation and expectation of the educational intervention.

The experimental group participated in an eight-hour course on death and dying. The course was divided into three, two-hour weekly sessions with two one-hour home modules between sessions one and two and sessions two and three. The experimental group completed a pre-test measure of death anxiety, the Death Anxiety Scale (DAS), and a biographical information tool. Post-test I of the DAS was administered immediately following the course. Post-test II was administered six weeks following the course. The control group completed the DAS pre-test and biographical information tool during the same week as the experimental group and completed the post-test DAS during the same week as the final post-test for the experimental group. No significant difference was found between the experimental and control group pre-test scores on the DAS.

No significant decreases in DAS scores were identified between pre-test and post-test I, post-test I and post-test II, or pre-test and post-test II for the experimental group. In addition, no

significant change occurred between pre-test and post-test scores for the control group. Hypotheses 1 and 2, therefore, were not supported. These hypotheses will be summarized together. Hypothesis 3 was supported and will be discussed separately. A discussion of the validity and reliability of the Templer Death Anxiety Scale will also be presented. Conclusions and recommendations will be discussed.

Death Anxiety Scale

The reliability and validity of the Templer Death Anxiety Scale (DAS) were questioned with this sample. The relatively high DAS pre-test scores for the experimental group and inconsistent results on the post-test scores led to an evaluation of the reliability and validity of the DAS as an effective measure of death anxiety. A Cronbach's alpha of .6103 was identified for the sample population. This reliability coefficient is considerably lower than the .76 reported by Templer (1970). This difference raised the concern that the tool was not a reliable measure of death anxiety levels, at least in this sample. The tool was not stable and internally consistent in its measure of death anxiety levels.

Re-examination of the literature revealed another report of a Chronbach alpha lower than that reported by Templer (1970). Warren and Chopra (1978-1979) studied the applicability of the DAS cross-culturally. In this study of 244 undergraduate students and 64 helping professionals, a Cronbach's alpha coefficient of .65 was identified.

If the reliability of the tool is in question then the validity of the tool is also obscure. The results raise the concern that the DAS may not have measured death anxiety exclusively, but may have included general anxiety, death attitudes, and/or environmental influences.

During the testing periods, the investigator observed that many of the respondents asked whether the items on the DAS were to be answered as if the respondent were thinking of himself/herself alone or in relationship to a dying client in the hospital. Items such as "The thought of death seldom enters my mind," and "The thought of death never bothers me" were challenged since a nurse may often think of death while at work but may seldom think of death while at home. Also "I dread to think about having

to have an operation," caused hesitation as some respondents dreaded particular operations and did not dread others. Many respondents also indicated that they would answer the questions differently if they were excessively tired or depressed, i.e., "I am often distressed by the way time flies so very rapidly."

Two items which concerned some of the respondents were "I am very much afraid to die," and "I am not at all afraid to die." A few respondents stated that they were "somewhat" or "sometimes" afraid to die and did not know how to reply to the true/false item.

An interesting observation in the responses of this sample of nurses is dramatically demonstrated by Items 6 and 11 on the pre-test administration of the DAS. Item 6 states "I am not particularly afraid of getting cancer." Of the 50 total respondents, 7 answered 'true' while 43 answered 'false' to Item 6. This indicated that 86% of the sample was concerned about contracting cancer. On the other hand, Item 11, "I am really scared of having a heart attack," had exactly the opposite outcome. On this item, 86% of the sample answered 'false' indicating that the

respondents were not scared of having a heart attack. Thus, it may be inferred that the registered nurses in this combined experimental and control sample may be more concerned about the diagnosis that influences the "dying" process (amount of pain, longevity of illness, feelings of powerlessness, and other health care aspects) rather than over the 'death.'

The concerns and comments shared by this sample along with the low alpha coefficient may lend caution about using this scale to measure death anxiety in similar sample groups. Other factors which may have contributed to the test responses of these nurses may be the characteristics of the nurses themselves. These characteristics may include the respondents' ability to take tests, the effect of fatigue and stress of a 12-hour shift on testing response, the need to respond in an acceptable manner, the attitude toward death and dying of the nursing staff and hospital staff in general, and increased knowledge of improved detection methods and treatment of serious illness.

One of the difficulties with the procedures of this study may have been the timing of death anxiety assessment. It has been summarized by Lonetto and

Templer (1986) that research has not identified a critical time for administration of post-tests on the DAS. Post-workshop assessments on the DAS have ranged from four weeks to one year. Post-test administrations in similar groups have occurred at four, eight, and twelve weeks post-workshop (Murray, 1974; Laube, 1977; Chodil & Dulaney, 1984; Murphy, 1986; Lockard, 1989). Lonetto and Templer (1986) have stated that the identification of the crucial post-test timing is an urgent area of research regarding the impact of death education on death anxiety levels. The results of Murray (1974), Laube (1977), and Lockard (1989) suggest that post-testing may be reasonable for periods exceeding one month post-workshop. It has been postulated by these investigators that it may take time for attitudes, anxieties, and behavioral changes to take place after a death education program. It has also been suggested that opportunity over time for the nurse to utilize new knowledge and skills relating to death and dying may affect internalization and incorporation of changes (Murray, 1974; Laube, 1977; Chodil & Dulaney, 1984; Murphy, 1986; Benoliel, 1987-1988; Lockard, 1989).

Comparison of Death Anxiety Scale Scores

The experimental group's pre-test death anxiety mean score was higher than death anxiety levels in two similar groups (Murray, 1974 & Laube, 1977). This higher death anxiety mean score may be due to the predominance of females, possibly the influence of religion, the stress of testing after or on a 12-hour shift, or possibly the personality factors of the self-selected group. However, it must be kept in mind that the control group, whose mean score was slightly lower, was similar to the experimental group in regards to predominance of females, religion, and stress of testing during a 12-hour shift.

Hypotheses 1 and 2

1. Nurses who complete a death education program will demonstrate a significant decrease in levels of death anxiety as measured by pre-test and post-test I scores on the Templer Death Anxiety Scale.

Hypothesis 1 was not supported. Nurses who completed the death education course did not demonstrate a significant decrease in levels of death anxiety as measured by pre-test and post-test scores on the Templer Death Anxiety Scale. The downward

movement in the mean DAS from pre-test (7.39) to post-test (7.04) indicated some change in response although this decrease was not statistically significant.

2. Nurses who complete a death education program will demonstrate a significant decrease in levels of death anxiety as measured by post-test I and post-test II scores on the Templer Death Anxiety Scale.

Hypothesis 2 was not supported. Nurses who completed the death education program did not demonstrate a significant decrease in levels of death anxiety as measured by post-test I and post-test II scores on the Templer Death Anxiety Scale. The decrease in mean DAS scores from post-test I (7.04) to post-test II (6.87) indicate a change in the expected direction though not at a significant level. The mean DAS scores from pre-test (7.39) to post-test II (6.87), though notable, are not significant.

There are several areas for consideration regarding the minimal decrease in mean DAS scores. One area of concern is the small number of subjects in the experimental group. Having only 23 subjects in the experimental group created difficulty with

meaningful statistical interpretations of the influence of selected variables. Generalization of the results is difficult because of the small sample.

Another area of consideration relates to the tool. The Death Anxiety Scale was administered as a pre-test, two weeks later, and again six weeks following the the first post-test. The frequency of the administration of the test during such a short period of time may have contributed to a "test-retest" problem by confounding the results with a "test-wiseness" factor. Since the DAS has few items, is in a simple "yes/no" format, and was administered several times over a short period, it is conceivable that the subjects may have remembered previous responses and were affected accordingly.

The factors of religion, belief in an afterlife, and religious commitment may also have influenced the DAS and may help explain the higher pre-test scores. The preponderance of subjects with L.D.S. religious and cultural background raises the question of the impact of these factors on death anxiety levels. The L.D.S. religion places great emphasis on the "afterlife." A member's actions and faithfulness

in this life affect his or her opportunities throughout the eternities. A church member who is faithful, active, and committed to the religion and to the Lord, is assured of a rewarding eternal experience. A less active or uncommitted member is in jeopardy of not associating family and friends throughout eternity. High expectations of moral action and Christian service, the impact of these actions on eternal progression, and pressure to reunite with family and friends through eternity may lead to higher death anxiety due to one's concern with his or her final judgment.

Another factor which may influence the death anxiety level of L.D.S. members is the tendency of the members to deny the trauma and impact of death. Members of this religion may tend to deny the impact of the actual death since they focus on the afterlife so effectively. Members of the family are encouraged to care for the dying and aid in the transition of the dying individual from this life to the life after death. There is also strong support within the church community for caring for the dying. The belief in an afterlife is so strongly advocated by church members

that some members are actively discouraged from mourning, as the deceased person is not regarded as truly lost (Gonda & Ruark, 1984). In this religion, the separation of death is temporary in the eternal spectrum. Clients and clinicians belonging to the L.D.S. religion may deny the need to express fears and anxieties regarding death since the individual may perceive that such expression may indicate a lack of understanding and faith.

A multidimensional factor intertwined with the belief system of L.D.S. church members is that of high performance expectations for women. The women of this church are encouraged to remain in the home with the prime responsibility to raise their children. However, many women of the church (subjects in this sample as examples) either choose to work outside the home or are economically obligated to do so. This situation places a great stress on these women as many try to compensate for their time away from family by becoming "superwomen" and attempting to become all things to all people at all times. It is the opinion of the investigator that many of these women place unreasonable demands upon their time and

energy levels in order to retain their self-image as a mother and wife and faithful church member. These demands often lead to high levels of stress and anxiety which may be manifest on a death anxiety scale.

These multiple factors may have combined to contribute to the higher death anxiety levels of this sample on the pre-test. The higher death anxiety levels may be a product of deeply embedded, unique values which may not respond to brief interventions such as a mini-course or seminar on death and dying. However, a long-term or extended educational program may provide effective and significant reductions in death anxiety. A program which emphasizes anxiety reduction and lifestyle alteration to effectively control stress reactions may be suitable in populations with deeply embedded religious and cultural anxieties.

Hypothesis 3

3. Nurses in the control group will demonstrate no significant difference in death anxiety scores as measured by pre-test and post-test scores on the Templer Death Anxiety Scale.

Hypothesis 3 was supported. Control group subjects demonstrated no significant difference in

death anxiety scores as measured by pre-test and post-test scores on the Templer Death Anxiety Scale.

Discussion of Death Education Course

Another consideration involves the continuing education course curriculum, length, presentation, and setting. This course was offered over a three week period during which eight hours of death and dying information were presented. The results suggest that the death education program was somewhat effective in reducing death anxiety levels immediately after the course and six weeks after the course, however, this effect is limited. In view of the minimal decreases noted and the questionable reliability and validity of the DAS inferences are restricted.

Perhaps a tool which assessed death attitudes or death concerns may have generated results that demonstrated more influence and change due to the death education intervention. However, these factors were not included in the purpose of the study and therefore, were not evaluated. To lend support to the curriculum and presentation, and the appropriateness, applicability, and influence of the course upon the participants a few verbal and written

comments are shared.

The participants completed a written evaluation tool following the final session. This evaluation elicited responses regarding course objectives, relevance to practice, personal relevance, method of presentation, knowledge of instructors, and physical setting. Written comments were solicited for the best aspects of the course as well as for areas of suggested improvement. The participants responded that the course was timely, relevant to practice, and interesting. Most responded that the course was relevant to issues in personal and family communication regarding death and dying. The best-liked aspects of the course included the up-beat nature of the presentations, the sharing and interaction, and the speakers. The majority of participants requested more time for sharing and more courses on death and dying. The least-liked aspects included the physical setting (uncomfortable chairs, hospital setting), the fact that the sessions were held after a 12-hour shift, and that the sharing of personal feelings was limited due to the lack of time.

Extraneous Factors and Death Anxiety

Extraneous factors occurred during this nine-week testing period that may have influenced the death anxiety for some participants. The following information was volunteered by the subjects in the experimental group to the investigator prior to the final post-test. One participant underwent surgery to rule-out a possible ovarian tumor. Another had to be hospitalized for pain control. A participant was diagnosed with systemic lupus erythmatosis, and one endured a spontaneous abortion. One participant experienced the death of a close friend, while another experienced the loss of a close friend's mother. Several participants from one of the units in the hospital endured a particularly stressful experience with a dying client and family. Also during the study period, there was a stressful change of management structure in the hospital of the experimental group which affected nearly half of the participants. The impact of these known extraneous factors on death anxiety test responses remains unmeasured.

Findings Related to Framework

The primary prevention mode of intervention of

the Neuman Systems Model (1989) was utilized as the theoretical framework for the study. The belief-oriented approach of the social learning theory as proposed by Bandura (1969) provided a framework for the implementation and expectation of the educational intervention. These frameworks as they relate to the findings of this study will be presented.

By using the Neuman Systems Model (1983) it was postulated that a focus on primary prevention aimed at increasing the strength of a nurse's flexible line of defense as it relates to death anxiety would better prepare the nurse for effectively confronting situations of dying and death. By expanding the nurse's knowledge and awareness of death and dying, providing a supportive environment, and promoting self-reflection of the inevitability of one's own death, the nurse's flexible line of defense could be augmented and strengthened. The greater the expansiveness of this line from the normal line of defense, the greater the protectiveness (Neuman, 1989). Therefore, the education course on death and dying was implemented to identify the effects of primary prevention interventions on the death anxiety levels

of registered nurses.

The death anxiety levels of the subjects in the experimental group decreased slightly from pre-test to first and second post-tests. This decrease in death anxiety scores lends support to the framework that educational interventions can strengthen the participant's flexible line of defense as related to death anxiety as a stressor. The limitations of statistical interpretations have been previously discussed.

One of the unexpected issues that arose during the interventions was the utilization of the primary prevention mode. This primary prevention mode was intended to be the education intervention occurring before the participant was strongly or adversely affected by a recent death and dying experience. As has been previously discussed, many of the participants experienced a recent or current death or intensely anxiety-provoking experience which placed these participants into either the secondary or tertiary mode of prevention of Neuman's theory. The secondary mode of prevention could be classified as the acute phase of grief or mourning. The tertiary

mode of prevention could be classified as the resolution and rebuilding phase of grief or mourning. Those nurses who experienced a life-altering diagnosis, participated in the death of a client or loved one, were involved in a management transition, were hospitalized, or experienced the loss of a fetus would not be classified in the primary prevention mode but in one or both of the other prevention categories.

In order to precisely assess the effects of a course aimed toward a specific prevention modality, the subjects participating in such a course would need to be screened for appropriateness of placement in that specific mode of prevention. Thus, if a subject in a primary prevention course on death and dying had a death-related experience, then that subject would have to be assessed differently or dropped from the structure in order to maintain focus on the effects of the primary prevention curriculum on an appropriately placed subject.

The fluctuating presence or absence of death-related environmental stressors may have affected the usefulness and measurability of primary prevention strategies in this sample. Time restrictions with

this course probably placed the largest restraint on interventions that would have assisted a participant in the secondary or tertiary prevention. Many participants vocalized the desire for more time to share thoughts, feelings, and self-reflection which may indicate that they were more in need of actual grief resolution rather than information about how to resolve grief. A future study utilizing Neuman's framework may focus on a course on death and dying employing secondary or tertiary prevention strategies.

The belief-oriented approach (Bandura, 1969) utilized the exposure to information and various persuasive communications in an attempt to effect modifications in one's attitudes by altering one's beliefs about the attitude object. It was expected by the investigator that this modification through education would be measurable by the Death Anxiety Scale. The literature presents arguments that death anxiety is not the same as death fear or death attitude (Templer, 1970; Kastenbaum, 1986; Combs, 1978; Kalish, 1985; Lonetto & Templer, 1986). In retrospect, it may have been more appropriate to assess an alteration in beliefs and knowledge regarding

this framework by utilizing a death attitude or death knowledge tool. Support for the course as having affected a change for the participants may be measured by the verbal comments and written evaluations for the course.

The participant who was diagnosed with systemic lupus erythmatosis (SLE) during the treatment period stated to the investigator that the course was "invaluable" in assisting her to identify a course of action and to set priorities. A participant who recently experienced the loss of a sister stated that the course "encouraged and supported" her to improve communication with her mother and to resolve some family conflicts related to the death. Another participant stated that the course gave her "confidence" in discussing death and dying with her dying clients. This nurse reported a history of avoidance and withdrawal with dying clients.

These shared experiences may be interpreted as support for the effectiveness of the course according to Bandura's framework. Suggestions for future research utilizing this framework may include the use of a tool which measures the outcomes of teaching,

the effect of differing methods of presentation to similar groups, or the effect of a teaching intervention on subsequent behavior.

Implications for Nursing

The nursing profession needs to come to grips with the responsibility of better educating and preparing nurses for the role of working with the dying individual and the family of that individual. The low numbers of nurses who have received education about the dying process and other issues related to death suggest that both formal and informal methods of training and instruction have fallen short in supporting the nurse in properly fulfilling his/her role.

It has been stated that the majority of health care workers have not been adequately prepared for giving terminal care (Benoliel, 1988). Emphasis needs to be placed on teaching such skills as: 1) communication with dying patients and families under various sets of circumstances, 2) personal decision making in relation to conflicts in values, 3) shared decision making with other occupational groups, and 4) clinical knowledge and skills to facilitate the

client's opportunities to bring closure to life (Benoliel, 1988). The complexities of terminal care as they relate to intrapersonal and interpersonal stresses and reactions need to be processed and resolved. The health care professional needs opportunity for personal growth, reflection, and resolve.

This study certainly raised multiple issues that are important for the nursing profession to confront. The participants were enthused about a course on death and dying and especially wanted the opportunity to share some of their feelings and experiences regarding loss and grief. The high percent of nurse participants in this sample that had never received death education reflects the lack of death preparation during basic training as well and the meager continuing education programs in the workplace. Further study needs to focus on the preparation, implementation, and evaluation of both nursing program curricula and continuing education curricula regarding death, dying, grief, and loss. Reliable and valid tools which will measure death anxiety in registered nurses need to be developed. Grief and loss education presented

as primary, secondary, and tertiary prevention within the Neuman framework needs to be further utilized and researched.

The effects of religious and cultural values on death anxiety levels are of interest to the nursing profession. The impact of religious and spiritual factors upon the behavior of the client as well as the nurse needs further investigation. The influence of these factors upon nurse/client interaction is an important issue in terminal care. Further studies investigating various religious beliefs and values as they relate to the client and the nurse in terminal care are necessary.

Recommendations for Further Study

Based on the results of this study, the following recommendations for further study are suggested:

1. This study should be repeated using a larger sample population and random sampling.

2. A tool specifically for registered nurses needs to be developed which will measure the outcomes of continuing education on death anxiety. Registered nurses, possibly due to their unique knowledge of diagnosis, pain control, surgery, etc., may need a

death anxiety tool which measures personal death anxiety more precisely. Research into the relationship between death anxiety and nursing behavior is also recommended.

3. The length, presentation methods, and timing of educational interventions of death and dying information for nurses should be further investigated.

4. The effects of Neuman's (1989) primary, secondary, and tertiary prevention strategies utilized as educational intervention needs specific study.

5. Reliable and valid measures of death anxiety need to be developed and continuously refined.

6. The current study should be replicated with the time of post-test administration lengthened. It is important to identify the relationship of post-test timing to responses on death anxiety tools and to assess the long-term effects of death education programs.

7. The assessment of death attitudes and knowledge in conjunction with evaluation of death anxiety may provide information on the relationships of these factors.

APPENDICES

APPENDIX A

DEATH EDUCATION COURSE

Session One

Coming to Terms with Death

Following this session the participant will be able to:

1) List the stages of dying identified by Kubler-Ross and Weisman.
2) List the phases of grief as outlined by Parkes and the tasks of the griever as identified by Worden.
3) Identify general physiological and psychological responses of persons who are experiencing grief.
4) Identify common reactions to death and dying by health care professionals.
5) Explore personal feelings about grief, death, and dying.
6) Share experiences concerning the death of a friend or relative or other loss experience.

Agenda:

Pretest and biographical information

Welcome

Review and discussion of death and dying

Break

Video "Jocelyn"

Small group activity

Large group sharing

Assignments for Session II

Dismiss

Objective 1

1) List the stages of dying identified by Kubler-Ross and Weisman.

Definitions of death and dying. During this course death referred to the cessation of human life as experienced physically, mentally, and emotionally (Combs, 1978). Dying referred to the process of the cessation of life and the awareness of this process (Combs, 1978).

Stages of dying. Kubler-Ross (1969) outlined the stages of dying as:

a. Denial and isolation
b. Anger
c. Bargaining
d. Depression
e. Acceptance of death

Phases of dying. Weisman (in Gonda & Ruark, 1984) identified the phases of dying as:

a. Existential plight

b. Mitigation and accommodation

c. Decline and deterioration

d. Preterminality and terminality

Characteristics and behaviors of clients in each of these stages or phases were identified and reviewed. It was continually stressed that clients vary as to how they progress through or experience these stages. All clients will not experience all stages. The stages may repeat or the order of experience may alter.

Fears surrounding death. J. Choron (in Gonda & Ruark, 1984) identified fears surrounding death. The client's fears or perceptions of death influence to some extent how he/she may experience the phases or stages of dying. These fears were outlined as follows:

a. The process of dying.

b. Extinction of nonexistence.

c. What comes after death.

Teaching/learning strategies utilized to meet this objective included: transparencies for overhead presentation, lecture/discussion, handouts for participants.

Objective 2

2) List the phases of grief as outlined by Parkes and the tasks of the griever as identified by Worden.

Four phases of grief. Parkes (1972) identified four phases of grief as:

Phase I: This phase is a period of numbness that occurs close to the time of the loss. This numbness, which is experienced by most survivors, helps them to disregard the fact of the loss for at least a brief period of time.

Phase II: This phase of mourning is characterized by preoccupation with the deceased and a yearning to recover the lost person. Emotions can fluctuate wildly, from intense sadness, to anger, to guilt.

Phase III: Disorganization and despair characterize the third phase. The bereaved person finds it difficult to function in the environment. The survivor ceases attempts to recover the lost person.

Phase IV: The fourth phase involves resolution and reorganization of behavior. Normal activities resume, and the bereaved person regains interest in usual activities. Some new social contacts are made.

The result may not be a complete return to previous activities but a loss of the preoccupation with the deceased. Past events with the deceased person can be recalled with some pleasure.

Four tasks of mourning. Worden (1982) identified four tasks of mourning. Emphasis was made on the influence that these phases have on the client and family, as well as on the nurse who is also involved in the grieving process. These tasks were presented as follows:

First: The grieving person must accept the reality of the loss, that the death has in fact occurred.

Second: The grieving person must accept that grief is painful.

Third: The grieving person needs to adjust to an environment that no longer includes that person who has died.

Fourth: The grieving person needs, over time, to be able to withdraw much of the emotional energy once invested in the dead person and begin to reinvest it in other relationship. To withdraw emotional energy does not mean to forget the dead person but to become

able to develop healthy new relationships.

Teaching/learning strategies utilized to meet this objective included: transparencies for overhead presentation, lecture/discussion, handouts for participants.

Objective 3

3) Identify general physiological and psychological responses of persons who are experiencing grief.

General physiological and psychological responses of persons who are experiencing grief were reviewed. It was emphasized that the nurse must be aware of his/her own manifestations of these signs and symptoms as the behaviors of the nurse will influence the relationship with the client. Clients need to be aware of grief behaviors and the importance of working through the grief process as they begin to experience losses. Manifestations of atypical grief reactions were also introduced. This information was compiled from Gonda & Ruark (1984), Rando (1986), Worden (1982).

Physiological manifestations of loss and grief.

* anorexia and other GI disturbances
* loss of weight

* inability to sleep
* crying
* tendency to sigh
* lack of strength
* physical exhaustion
* feelings of emptiness and heaviness
* feelings of "something stuck in the throat"
* heart palpitations and other indications of anxiety
* nervousness and tension
* loss of sexual desire or hypersexuality
* lack of energy and psychomotor retardation
* restlessness and searching for something to do
* shortness of breath

Psychological manifestations of loss and grief.

* depression
* withdrawal
* avoidance
* anger, frustration, rage, sadness
* irritability and hostility
* disorganization
* inability to concentrate
* anxiety, restlessness
* fear

* despair
* ambivalence
* depersonalization
* guilt

Manifestations of atypical grief.

* prolonged grief--several years
* delayed grief reaction
* severe depression, bitter self-reproach
* continuing, serious thoughts of suicide
* hypochondriacal conditions
* overactivity without a sense of loss
* furious hostility
* lack of emotional expression, formal conduct
* alteration in relationships with friends and relatives
* appearance of stress-related disease--colitis, asthma, arthritis, etc.
* persistent lack of initiative or drive, immobilization
* dramatic change in lifestyle or social behaviors
* acquisition of symptoms belonging to the last illness of the deceased

Coping tasks of the chronically ill. The coping tasks of the chronically ill (Miller, 1983, p. 19) were presented to alert the participants to the many issues facing the client. The client experiences multiple losses throughout the dying process. These tasks were presented as follows:

a. maintain a sense of normalcy
b. modify daily routine, adjust lifestyle
c. obtain knowledge and skill for continuing self-care
d. maintain a positive self-concept
e. adjust to altered social relationships
f. grieve over losses concomitant with chronic illness
g. deal with role changes
h. handle physical discomfort
i. comply with prescribed regimens
j. confront the inevitability of one's own death
k. deal with social stigma of illness or disability
l. maintain a feeling of being in control
m. maintain hope despite uncertain or downward course of health.

Teaching/learning strategies utilized to meet this objective included: transparencies for overhead

presentation, lecture/discussion, handouts for participants.

Objective 4

4) Identify common reactions to death and dying by health care professionals.

A story was told to the group to stimulate discussion about common reactions to death and dying by health care professionals. "Death in the first person" (in Kubler-Ross, 1975, pp. 25-26) identified that the dying person can feel the fear and anxieties of the care giver. The author expressed the need for the care giver to be honest, admit fears, touch the client, and care.

Common untoward reactions during terminal care were discussed. Some of the reactions identified by Gonda & Ruark (1984) included:

1) Anger--manifest as the absence of warmth or caring gestures, or as derogatory humor in conversation with colleagues.

2) Helplessness--manifest as frustration with clients, system, medical limitations.

3) Guilt--provoked by failure to meet legitimate expectations, manifest by withdrawal, inappropriate

anger, irritation, professional distancing.

4) Avoidance--a reaction to unresolved emotional tension in terminal care settings. May be manifest by oversedating the patient or through withdrawal.

5) Inappropriate persistence in efforts to cure--may be due to improperly established goals or misunderstood goals plan of care.

6) Closed communication--result of high stress situations and fears and anxieties of persons involved in situation.

7) Burnout--common result of inadequate understanding of professional role, expectations, unresolved grief, previous loss experiences, avoidance of issues regarding death and dying.

Teaching/learning strategies utilized to meet this objective included lecture and discussion.

Objectives 5 and 6

5) Explore personal feelings about grief, death, and dying.

6) Share experiences concerning the death of a friend or relative or other loss experience.

The video Jocelyn" was viewed. The nurses were instructed to focus on the thoughts and feelings of

the young woman in the story. They were also instructed to identify the emotions that the film aroused in them.

This video presents the story of a 17-year-old young woman who is dying with leukemia. The video portrays how this young woman has chosen to cope with the inevitability of death by drawing her family together to celebrate each precious remaining moment. Candid discussions about the reality of her situation are presented with Jocelyn and her family. (Production of Canadian Broadcasting Corporation Television, Man Alive series.)

After a brief discussion of the video, the nurses were divided into groups of four. In these small groups, the nurses explored personal feelings about grief, death, and dying. They also shared an experience with death that was meaningful to them.

After the small group sharing experience, the group as a whole was asked the following questions:

1. What various coping methods were utilized at the time of the loss experience?
2. What influence has the passage of time had on loss resolution?

3. How can these personal experiences be related to the experiences of working with terminal or dying clients?

Teaching/learning strategies utilized to meet these objectives included: lecture/discussion, video presentation, handouts for participants, group process, and transparencies for overhead presentation.

Home Module I

Completion of this module will enable the participant to:

1) Reflect on personal associations to death and dying, life and living.
2) Confront the inevitability of his/her own death.
3) Increase awareness of the death of self and the death of others.

Activities and strategies to achieve objectives

1) Exercise "I'm Living/I'm Dying" (in Thanatopics, Knott, Ribar, Duscon, & Kling, 1982, p. 51).

This exercise encouraged the participant to reflect on his/her particular association to death and dying and life and living. The following instructions were given to each participant:

"Obtain the sheet of paper with "I'm Dying" written at the top. Take a few moments and reflect. Then draw a picture that shows what you would feel if you fully knew you were dying soon. The picture you draw does not have to highly artistic or realistic, only an expression of what you feel. Obtain the sheet of paper with "I'm Living" written at the top. Take time again and reflect. Then draw a picture that shows what you feel when you fully know you are living."

2) Exercise "Eulogy" (in Thanatopics, Knott, Ribar, Duscon, & Kling, 1982, p. 53).

This exercise invited the participant to confront the inevitability that his/her life will sometime end. The following instructions were given to each participant:

"Write the eulogy that you wish it were possible and realistic to have delivered about you at your funeral. An eulogy is to be distinguished from an obituary which appears in the newspaper as notification of your death. Don't write the eulogy that could be delivered if you died tomorrow, unless that represents all you want to be in the future. Give

yourself time, hope, and even allow yourself some fantasy and wishful thinking, in constructing your story. This exercise requires reflection, silence, being alone with yourself so take the time necessary to compose a eulogy to your life."

3) Selected readings:

The selected readings for this session included:

1. "Appropriate and appropriated death," (A. Weisman, in E. Shneidman, 1984).
2. "Doctors, too, must learn to cope with death," (Horn, 1985).
3. "Facing your own mortality," (Getto, 1984).

Session II

Communicating/ Caring/ Coping

Following this session the participant will be able to:

1) Share personal feelings and anxieties about death and dying.
2) Share personal feelings and anxieties about one's own death.
3) Discuss anxieties of one's own death which may create barriers in establishing a helping

relationship with a dying or grieving person.

4) Share difficulties encountered in communicating with a dying or grieving person.

5) Identify interventions and actions that could help the nurse cope with the challenges of working with the dying client.

Agenda:

Review and share home assignments

Communication issues in terminal care

Break

Interventions for improved coping

Assignments for Session III

Interventions for improved coping

Relaxation experience (Bonnie Woolf, R.N.)

Dismiss

Objectives 1 and 2

1) Share personal feelings and anxieties about death and dying.

2) Share personal feelings and anxieties about one's own death.

During this session the nurses were encouraged to share personal feelings and anxieties about death and dying and about their own death. Their experiences

with the assignments in Home Module I were used to stimulate sharing.

Teaching/learning strategies utilized to meet these objectives included: sharing of home assignments, open discussion, review of selected readings.

Objectives 3 and 4

3) Discuss anxieties of one's own death which may create barriers in establishing a helping relationship with a dying or grieving person.

4) Share difficulties encountered in communicating with a dying or grieving person.

Communication issues and barriers in terminal care. Communication issues and barriers in terminal care as identified in Session I (Objective 4) were discussed. Barriers and issues which interfere with communication include: anger, feelings of helplessness, guilt, avoidance, burnout, withdrawal, fear, unresolved grief, etc.

The group identified a current and troubling situation with a dying client and the client's family. Various ideas for positively approaching the situation were generated. Some suggested interventions were:

a. Be sensitive to losses incurred by client.

b. Attempt to empower the client and his family by including them in self-care, encouraging decision-making, keeping client and family informed, encouraging self-care, accepting the client and family for what and where they are and not placing personal values or judgments on them.

c. Do not avoid client and family.

d. Assist family in confronting issues of dying family member--provide time and environment for communication, promote reminiscing, encourage the client and family to set goals for care, identify expectations and fears.

Discussion of the impact of accumulated grief in the terminally ill client followed. Family issues of grieving were discussed. The family experiences the same losses as the client. The family also experiences the tasks of the chronically ill, the stages and phases of mourning, and anticipatory grief reactions.

Teaching/learning strategies utilized to meet these objectives included: lecture/discussion, sharing, situation problem-solving.

Objective 5

5) Identify interventions and actions that could help the nurse cope with the challenges of working with the dying client.

Interventions and actions that can improve the nurse's ability to cope were identified through discussion of Harper's (in Rando, 1986) Schematic Growth and Development Scale in Coping with Professional Anxieties in Terminal Illness. It was emphasized that growth occurs as the professional gains understanding, knowledge, strength, works through conflicts, and adds upon the caring dimension. The nurse matures professionally. This model helps nurses reflect on emotional progress. The stages outlined by Harper include:

Stage I: Intellectualization--Knowledge and Anxiety.

Stage II: Emotional Survival--Trauma.

Stage III: Depression--Pain, Mourning, Grieving

Stage IV: Emotional Arrival, Moderation, Mitigation, Accommodation

Stage V: Deep Compassion--Self-realization, Self-awareness, Self-actualization

Interventions and actions that improve the nurse's

coping abilities were identified by the group as: attending inservices or workshops on death and dying, update knowledge by reading current journal articles and publications, participate in support groups, set boundaries on work, confront stress with early interventions, become aware of personal energy level and limitations, allow time for relaxation.

Relaxation presentation. A relaxation experience was presented by Bonnie Woolf, R.N., B.S.N. Objective: To provide a relaxation experience with the group that would be particularly applicable for use with terminally ill clients.

Ms. Woolf discussed the importance of getting a good closure on one's life. She stressed that the attitude one carries into the nurse/client relationship makes a difference in the quality of that relationship. She related the experiences that she had with the recent death of her father. She learned of his past and used his memories to provide experiences of reminiscence and life closure.

Ms. Woolf related the importance of drawing out good memories for the dying client. If a client has few good memories to draw from then the nurse may

create a "special" place that the client can share with the nurse. This special experience can come about through the use of guided imagery sessions and the utilization of memories, daydreams, fantasies, to guide the experience.

Ms. Woolf stated that guided imagery is most successful if the following factors are utilized:

1. Use all five senses,
2. Choose a peaceful place,
3. Create a relaxing mood,
4. Assume a comfortable position,
5. Use progressive relaxation methods,
6. Use positive affirmations throughout the exercise, such as: "I am relaxed." "I feel at peace." "I am not tense." "The tension is flowing from my body." "I am in harmony with life." "I feel good." "I feel calm." "I am comfortable with myself." "This is my place. It is a safe place." "I can come here whenever I wish and stay as long as I like."

Guided imagery.

Theme: Mesa Verde Park and Palace of the Sun. This is the place of the Anasazi (The Ancient Ones). It

is a place of quiet solace and peaceful isolation, a place that one can be reassuring about one's own sense of mortality in order to bond better with a terminally ill client.

"Close your eyes. Begin progressive relaxation. Focus on the sun that is warm on your head and moving down through your body in a relaxing way. I am taking you to my special place. Drive up to the mesa and park at the parking lot. Get out of the car. Feel the sun on your face. Look up to the blue sky with cumulus clouds floating, floating softly across the sky. I feel a peaceful, calm feeling as I follow the path to the ruins. I look to the right and to the left and notice the blue and purple sage. I smile. I smell the pungent perfume in the air. I also smell the pinon pines and look about and see the pine cones and nuts on the ground. I feel the soft, sandy, loam under my feet. I feel an occasional breath of wind ruffle by hair. I feel safe here. I am at peace with all around me. I follow the path to the canyon edge to the steep steps in the sandstone. The steps are narrow so I put my hands out to guide me down the sandstone. I feels rough under my hands, but

it also feels solid and gives me a safe feeling. All the tension is leaving my body as I climb down the ladder into the ruins. I like the feel of the sandstone floor. It gives me a feeling of permanence. I look around in awe at these ruins built so many years ago, before my time. It gives me a sense of my own mortality, and I feel as one with these ancient inhabitants of Mesa Verde. Were they like me? Did they have the same feelings? I look at the stone kivas built so many years ago, stone by stone. I have a peaceful sense of belonging. I walk out to the edge and look down into the canyon where I see a small stream of water. When I close my eyes I can hear the sound of the water making ripples in the canyon bottom. I can see the beautiful yellow leaves of autumn on the trees, and closing my eyes, I hear the rustle of the leaves and the bird sounds in the air. I climb out of the canyon and follow the path past ancient canals to places where ancient corn had grown. I walk to the top of the "Palace of the Sun." I walk along the wall--the sun on my face--the wind in my hair--the warmth of stone underfoot. I am free of all feelings of anxiety and worry. I am at peace

with the world around me. The sun warms my body, and I see the gold and orange warm colors engulfing my body. It feels restful and pleasant. I am happy that this is my special place. I am glad that I can visit it whenever I like. You may share my special place whenever you like."

Teaching/learning strategies utilized to meet the objective included: lecture/discussion, handouts for participants, guided imagery.

Home Module II

Completion of this module will enable the participant to:

1) Identify individual perceptions and experiences about dying and death.
2) Increase awareness of patient and family grief reactions.

Activities and strategies to achieve these objectives

1) Exercise "Death & Dying: A brief personal inventory" (in Thanatopics, Knott, Ribar, Duscon, & Kling, 1982, p. 88).

This exercise enabled the participant to identify some of his/her perceptions, experiences, and personal

issues about dying and death. This inventory included ten items regarding death and dying. Each item required only a brief answer. Death and dying issues such as death experience, lifestyle and behaviors, expectations for "afterlife," bioethical quandaries regarding death, body disposition, etc. were included.

2) Exercise "Guidebook of Important Information and Funeral Preparation." This exercise assisted the participant in identifying his/her present preparedness level in the event of death or incapacitation through illness or accident. These booklets were donated by a local mortuary.

3) Selected readings:

These readings focused on patient and family grief reactions.

1. "Common fallacies about dying patients," (A. Weisman in E. Shneidman, 1984).
2. "A grief observed," (C.S. Lewis in E. Shneidman, 1984).
3. "Dying patients and their families: how staff can give support," (Kneisl, 1974).

Session III

Improving Nursing Care of Dying Clients and Their Families

Following this session the participant will be able to:

1) Identify the nurse's role in providing care to dying clients and their families.
2) Share personal feelings and anxieties about providing nursing care to dying clients and their families.
3) Identify methods by which an individual can work through his/her anxieties about death and dying.
4) Identify nursing interventions that would help a dying client "live" until his/her death.
5) Describe nursing interventions that would assist dying clients and their families process their grief.

Agenda:

Review and sharing of home assignments

Video "The Ameche Family"

Discussion of client management

Break

Presentation and sharing (Guest speaker, Cynthia

Harris, Hospice Coordinator, Dixie Medical Center)

Post-test administration, CEU certificates and course evaluations

Dismiss

Objective 1

1) Identify the nurse's role in providing care to dying clients and their families.

A video showing the grief of a family was viewed. The nurses were to identify how the family might rely on the health professional for guidance through the grief process. Video presentation: "A Family in Grief: The Ameche Story."

This video presents the story of grief and bereavement of the Alan Ameche family. Paul Ameche, Alan's 22-year-old son, was killed in a car accident in 1981. This is the story of the personal struggles that each family member faces in dealing with the tragedy of the death of a loved one. The footage was shot six months after Paul's death. The film focuses on the family reactions of pain, anger, grief, guilt, and the emergence of family love and support amidst the pain. (Produced by Group Two Productions, Incorporated, Baltimore, MD. Distributed by Research

Press, Champaign, IL).

The nurse's role in providing care to dying clients and their families was discussed. This role was identified as providing interventions which facilitate movement toward achievement of the tasks of both the dying individual and the family members. Physiological, psychological, developmental, social, cultural and spiritual factors were identified as important.

Objectives for intervention. Weisman (1972) identified objectives for intervention with the dying individual as:

1) Safe conduct for the dying.
2) Significant survival and dignified dying.
3) Appropriate death.

Nursing interventions. Nursing interventions for each client need to incorporate combinations of the following actions or skills: resource identification, problem solving, advocacy networking, information giving, coordination of health care team, assisting family to coordinate helpers, family conferencing, active listening, teaching, caregiving, negotiation, affirmation, values clarification,

realistic goal setting, exploration, conflict resolution, referral, bereavement support, strength/weakness identification (Blues & Zerwekh, 1984, pp. 260-261).

Teaching/learning strategies utilized to meet the objective included: video presentation, transparencies for overhead use, lecture/discussion, handouts for participants.

Objectives 2 and 3

2) Share personal feelings and anxieties about providing nursing care to dying clients and their families.

3) Identify methods by which an individual can work through his/her anxieties about death and dying.

During this session the nurses were encouraged to share personal feelings and anxieties about providing nursing care to dying clients and their families. Their experiences in the hospital setting along with the assignments in Home Module II were used to stimulate sharing.

Some of the anxieties expressed regarding care for the dying included: fear of own death, difficulty in knowing what to say, fear of saying the wrong thing,

discomfort with high doses of pain medication, use of patient-controlled analgesia pumps, avoidance of discussion of death, distress with goal-setting and realistic expectation, anger and denial of client and family, etc.

Suggestions for working through own fears and anxieties included: focus on personal values, prepare for death, increase knowledge about pain and medication, increase knowledge about death and dying processes, openly discuss death issues, get in touch with feelings, relaxation techniques, exercise, etc.

Teaching/learning strategies utilized to meet these objectives included: lecture/discussion and home assignment sharing.

Objectives 4 and 5

4) Identify nursing interventions that would help a dying client "live" until his/her death.

5) Describe nursing interventions that would assist dying clients and their families process their grief.

Client Aspects of Terminal Illness. Client aspects of terminal illness was presented by Cynthia Harris, Hospice Coordinator.

Ms. Harris related her personal experience with a near-fatal chronic illness. She expressed the difficulties in relating with health professionals while critically ill. She stated that the greatest concerns of the end-stage client are the fears of abandonment and isolation.

Ms. Harris expressed the need for the nurse to always keep in mind that his/her personal emotions affect the ability to give care. The nurse must stay in tune with feelings and be honest in confronting these feelings. One's reaction to a client is rooted in the denial or acceptance of one's fears. She continued that a major tactic to avoid "burnout" is to allow oneself to feel true feelings. One must learn to face fears and express real emotions when involved in stressful situations.

How does one engage in suffering and stay compassionate?

1. Become comfortable with "being" for the client and not so much in "doing" for the client.
2. Focus on what the person needs of others most "right now."
3. Be honest and "real" to the individual.

4. Offer self.

Ms. Harris related to the nurses comments that her hospice patients most desperately wanted to communicate. Each of these statements was discussed. Behavioral manifestations were identified. The following nursing interventions were identified as appropriate to alleviate the negative behaviors.

1. "Don't make me feel invisible." Talk directly to the patient. Do not talk to others in a low voice acting like the patient is not in the room. Make eye contact when providing care.

2. "Don't belittle me for hurting." Focus on pain. Treat pain as an important issue. Do not withhold pain medication because of personal discomfort with providing narcotics. Teach patient about pain and medication.

3. "Don't treat me as though I'm mentally diminished because I'm physically disabled." Do not speak too loudly or too slowly to the patient. Work with patient on highest mental functioning possible. Include patient in issues that pertain to him/her.

4. "Don't treat me as if I am already dead." Include patient in plan of care. Set goals for the future.

Encourage family to include patient in family issues. Be positive, uplifting, happy. Laugh. Enjoy the patient.

5. "Don't offer help that is of no help." Focus on patient needs. Do not engage in unnecessary and trivial activities. Take time to talk with and understand the patient as a person.

6. "Don't avoid me because you're sad. Let me know that and we can cry together." Don't let personal fears and emotions become barriers to communication. Be honest with self and with the patient about concerns and fears.

Teaching/learning strategies utilized to meet these objectives included: lecture/discussion, handouts for participants.

Conclusion. Session III was concluded with a story about death by Richard Kalish (1985, pp. 2-4) entitled "The Horse on the Dining Room Table." This story expressed the importance of being comfortable with discussions about death and dying. It emphasized the need to face our fears and anxieties about death.

APPENDIX B

COVER LETTER AND CONSENT FORM:

EXPERIMENTAL GROUP

MASTER OF SCIENCE PROGRAM
NURSING

UNIVERSITY OF NEVADA, LAS VEGAS
4505 MARYLAND PARKWAY • LAS VEGAS, NEVADA 89154 • (702) 739-3004

January 1990

Dear Registered Nurse:

Registered nurses involved in patient care are expected to provide care to the total person. Frequent exposure to clients who are experiencing the dying and grieving process may feel overwhelming. This may lead to increased anxiety levels of the nurse in dealing with the dying client and his/her family. By lowering a nurse's personal death anxiety level it is hoped that the nurse will be more effective, compassionate, and supportive when providing care interventions. It is also hoped that lower anxiety levels will help the nurse feel better about his/her delivery of quality care.

As a graduate student in the Department of Nursing at the University of Nevada, Las Vegas, I am conducting a research study to explore the effects of a continuing education course on death and dying and selected demographic characteristics on the death anxiety level of registered nurses. If you agree to participate in the study, you will be asked to participate in an eight-hour continuing education course on death and dying. Each of three class sessions will be two hours in length augmented by two one-hour home modules. The sessions will be held weekly over three weeks. You will receive a packet of materials to complement the course. This packet will include learning activities, selected readings on death, grief, and dying, and information specific to the objectives outlined in the sessions. Seven point two (7.2) hours of continuing education units will be available for the participants of the course. These will be awarded through the Utah Nurses' Association and Dixie Medical Center.

You will be asked to complete a biographical information sheet as well as a questionnaire on death anxiety. The death anxiety questionnaire will be completed prior to the first class session, immediately following the final class session, and again six weeks following the course. It will take between five and ten minutes to complete the questionnaire and biographical information.

Your participation in this research study is entirely voluntary. I believe that you will find the time spent rewarding and valuable. If you wish a copy of the results of the study, I will be pleased to mail a summary of findings when results become available.

Please be assured of the confidentiality of the information collected for this study. Your answers will not be linked to your name and the information obtained will be used and reported as grouped data only. Your name will be used only to compile individual surveys, to record CEU information, and to keep attendance records.

Thank you for your interest, cooperation, and support.

Sincerely,

Susanne F. Wilkey, R.N., B.S.N.
Graduate Student, Department of Nursing
University of Nevada, Las Vegas

I consent to participate in a research study concerning the death anxiety levels of registered nurses. I understand that participation will consist of completing an eight-hour continuing education course presented by Susanne F. Wilkey, R.N., B.S.N., Graduate Student, Department of Nursing, University of Nevada, Las Vegas in conjunction with Dixie Medical Center Department of Education. I understand that all information that is requested is to remain confidential and that results will be reported as grouped data only. All data pertaining to my participation will be identified by code number and the information will be used for research purposes only. I realize that there will be no charge for the course or for the continuing education credits. I am aware that I will not be reimbursed for time spent in the course unless I have made personal arrangements with my employer.

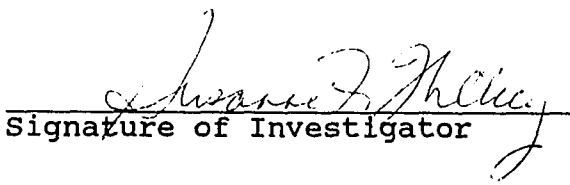
I have been made aware that my continued participation in the course is necessary to receive the continuing education credits from the Utah Nurses' Association. I have been informed of the nature of the study and of the importance of continuing my participation throughout the study in order to allow for the collection of accurate data. However, I do understand that my consent and participation is completely voluntary and that I have the right to withdraw from the study at any time.

Any questions or concerns may be directed to Susanne F. Wilkey, R.N. at 801-628-2738 or to Dr. Vicky Carwein at 702-739-3004.

I understand the information that has been provided to me regarding this study and my participation in it. All of my questions have been answered to my satisfaction. My signature, below, indicates that I consent to participate in the study.

_____ _____

Signature of Participant Date



_____ _____

Signature of Investigator Date

APPENDIX C

COVER LETTER AND CONSENT FORM:

CONTROL GROUP

MASTER OF SCIENCE PROGRAM
NURSING

UNIVERSITY OF NEVADA, LAS VEGAS
4505 MARYLAND PARKWAY • LAS VEGAS, NEVADA 89154 • (702) 739-3004

January 1990

Dear Registered Nurse:

Registered nurses involved in patient care are expected to provide care to the total person. Frequent exposure to clients who are experiencing the dying and grieving process may feel overwhelming. This may lead to increased anxiety levels of the nurse in dealing with the dying client and his/her family. By lowering a nurse's personal death anxiety level it is hoped that the nurse will be more effective, compassionate, and supportive when providing care interventions. It is also hoped that lower anxiety levels will help the nurse feel better about his/her delivery of quality care.

As a graduate student in the Department of Nursing at the University of Nevada, Las Vegas, I am conducting a research study to explore the effects of a continuing education course on death and dying and selected demographic characteristics on the death anxiety level of registered nurses.

If you agree to participate in the study you will be asked to complete a biographical information sheet as well as a death anxiety questionnaire. The questionnaire and biographical information will take between five and ten minutes to complete. The death anxiety questionnaire will be completed twice. A pre-test will be administered followed nine weeks later by the post-test. No other surveys, questionnaires, or interventions will be requested.

Your participation in this research study is entirely voluntary. I believe that you will find the time spent interesting and intriguing. If you wish a copy of the results of the study, I will be pleased to mail a summary of findings when results become available.

Please be assured of the confidentiality of the information collected for this study. Your answers will not be linked to your name and the information obtained will be used and reported as grouped data only. Your name and address will be used only to compile individual surveys, to mail out the post-tests, and to mail a summary of findings.

Thank you for your interest, cooperation, and support.

Sincerely,

Susanne F. Wilkey, R.N., B.S.N.
Graduate Student, Department of Nursing
University of Nevada, Las Vegas

I consent to participate in a research study concerning death anxiety levels of registered nurses by Susanne F. Wilkey, R.N., B.S.N., Graduate Student, Department of Nursing, University of Nevada, Las Vegas in conjunction with Dixie Medical Center Department of Education. I understand that all information that is requested is to remain confidential and that results will be reported as grouped data only. All data pertaining to my participation will be identified by code number and the information will be used for research purposes only. I realize that there will be no charge to me for participating in this research.

I have been informed of the nature of the study and of the importance of continuing my participation throughout the study in order to allow for the collection of accurate data. However, I do understand that my consent and participation is completely voluntary and that I have the right to withdraw from the study at any time.

Any questions or concerns may be directed to Susanne F. Wilkey, R.N. at 801-628-2738 or to Dr. Vicky Carwein at 702-739-3004.

I understand the information that has been provided to me regarding this study and my participation in it. All of my questions have been answered to my satisfaction. My signature, below, indicates that I consent to participate in this study.

_____ _____

Signature of Participant Date

_____ _____

Signature of Investigator Date

APPENDIX D

DEATH ANXIETY SCALE AND BIOGRAPHICAL INFORMATION TOOL

APPENDIX E

PERMISSION FOR USED OF

TEMPLER'S DEATH ANXIETY SCALE

CSPP

BERKELEY ALAMEDA
FRESNO
LOS ANGELES
SAN DIEGO
PRESIDENT'S OFFICE

FRESNO CAMPUS

October 24, 1989

Susanne F. Wilkey, RN, BSN
Box 466
Washington, UT 84780-0466

Dear Ms. Wilkey:

Thank you for your recent letter. You most certainly have my permission to use my Death Anxiety Scale (DAS) for your Master's thesis. Since it is not on the commercial market, there is no payment for its use.

Feel free to contact me for any additional information or advice (209/486-8420).

Sincerely,

Donald I. Templer

Donald I. Templer, PhD
Professor of Psychology

DIT:tlp

APPENDIX F

APPROVAL:

HUMAN SUBJECTS' RIGHTS COMMITTEE,

DEPARTMENT OF NURSING, UNLV

UNIVERSITY OF NEVADA, LAS VEGAS

PROTOCOL FORM APPROVAL SHEET

FOR RESEARCH INVOLVING HUMAN SUBJECTS

Log Number: _____

Title of Project: EFFECTS OF AN EIGHT-HOUR CONTINUING EDUCATION COURSE ON ~~THE DEATH ANXIETY LEVELS OF REGISTERED NURSES~~

Investigator: SUSANNE F. WILKEY

After reviewing this proposal the members of the Dept. of Nursing Human Subjects Review Committee have indicated below their approval/disapproval of this proposal.

Signature of Committee Members	Approve	Disapprove
Margaret Davis	X	
Marlene LaMascus	X	
Susan Rush Michael	X	

The above named project is hereby approved/disapproved (circle one)

Date: 12/13/89

Margaret Davis
Committee Chairman's Signature

REFERENCES

References

Aday, R.H. (1984-1985). Belief in afterlife and death anxiety: Correlates and comparisons. Omega, 15, 67-75.

Aries, P. (1984). Five variations of four themes. In E. Schneidman, Death: Current perspectives (3rd. ed.) (pp.62-72). Palo Alto, CA: Mayfield.

Bandura, A. (1969). Principles of behavioral modification. New York: Holt, Rinehart & Winston.

Benoliel, J. (1987-1988). Health care providers and dying patients: Critical issues in terminal care. Omega, 18, 341-363.

Blues, A. (1984). Hospice philosophy of appropriate care. In A. Blues and J. Zerwekh, Hospice and palliative care (pp. 1-9). Orlando, FL: Grune & Stratton.

Blues, A., & Zerwekh, J. (1984). Hospice and palliative care. Orlando, FL: Grune & Stratton.

Chinn, P., & Jacobs, M. (1983). Theory and nursing: A systematic approach. St. Louis: C.V. Mosby.

Chodil, J., & Dulaney, P. (1974). Continuing education on dying and death. Journal of Continuing Education in Nursing, 15(1), 5-8.

Cole, M. (1978-1979). Sex and marital status differences in death anxiety. Omega, 9, 139-147.

Combs, D.C. (1978). The role of death education in increasing and decreasing death anxiety and increasing death acceptance. Unpublished doctoral dissertation, New Mexico State University.

Denton, J.A., & Wisenbaker, V.B. (1977). Death experience and death anxiety among nurses and nursing students. Nursing Research, 26(1), 61-64.

Eddy, J., & Alles, W. (1983). Death education. St. Louis: C.V. Mosby.

Fleming, S., & Brown, I. (1983). The impact of a death education program for nurses in a long-term care hospital. The Gerontologist, 23(2), 192-195.

Fries, J.F. (1986). The future of disease and treatment: Changing health conditions, changing behaviors, and new medical technology. Journal of Professional Nursing, Jan-Feb, 10-19.

Getto, D. (1984, October 21). Facing your own mortality, Milwaukee Journal, Lifestyle section, pp. 1+.

Gonda, T., & Ruark, J. (1984). Dying dignified: The health professional's guide to care. Reading, MS: Addison and Wesley.

Harper, B. (1977). Death: The coping mechanism of the health professional. Greenville, SC: Southeastern University Press.

Horn, C. (1985, January 13). Doctors, too, must learn to cope with death. Washington Post, pp. B1 & B4.

Humphrey, M. (1986). Effects of anticipatory grief for the patient, family member, and caregiver. In T. Rando (Ed.), Loss and anticipatory grief (pp. 63-80). Lexington, MS: D.C. Heath.

Kalish, R. (1985). Death, grief, and caring relationships (2nd ed.). Monterey, CA: Brooks/Cole.

Kane, A.C., & Hogan, J.D. (1985-1986). Death anxiety in physicians: Defensive style, medical specialty, and exposure to death. Omega, 16(1), 11-22.

Kastenbaum, R.J. (1986). Death, society and human experience (3rd ed.). Columbus, OH: Charles E. Merrill.

Kastenbaum, R., & Aisenberg, R. (1972). The psychology of death. New York: Springer.

Kneisl, C.R. (1974). Dying patients and their families: How staff can give support. In N. Schnaper, J.W. Annis, L. Roose, et al. Management of the dying patient and his family (pp. 143-149). New York: MSS Information.

Knott, J.E., Ribar, M.C., Duscon, B.M., & Kling, M.R. (1982). Thanatopics. Kingston, RI: SLE Publications.

Kubler-Ross, E. (1969). On death and dying. New York: MacMillan.

Kubler-Ross, E. (1975). Death: The final stage of growth. Englewood Cliffs, NJ: Prentice-Hall.

LaGrand, L. (1988). Changing patterns of human existence: Assumptions, beliefs, and coping with the stress of change. Springfield, IL: Charles C. Thomas.

Laube, J. (1977). Death and dying workshop for nurses: Its effect on death anxiety levels. International Journal of Nursing Studies, 14, 111-120.

Leming, M.R. (1975). The relationship between religiosity and the fear of death. Ann Arbor, MI: University Microfilm International. (University Microfilm No. 76-11,304).

Lester, D., Getty, C., & Kneisl, C.R. (1974). Attitudes of nursing students and nursing faculty toward death. Nursing Research, 23(1), 50-53.

Lewis, C.S. (1984). A grief observed. In E. Shneidman (Ed.), Death: Current perspectives (3rd ed.) (pp. 223-225). Mountain View, CA: Mayfield.

Lockard, B.E. (1989). Immediate, residual, and long-term effects of a death education instructional unit on the death anxiety level of nursing students. Death Studies, 13, 137-159.

Lonetto, R, & Templer, D.I. (1986). Death Anxiety. New York: Hemisphere.

Louis, M., & Koertvelyessy, A. (1989). The Neuman model in nursing research. In B. Neuman, The Neuman system model (2nd ed.) (pp. 93-113). Norwalk, CT: Appleton & Lange.

Lucas, R.A. (1974). A comparative study of measures of general anxiety and death anxiety among three medical groups including patient and wife. Omega, 5, 233-243.

McCarthy, J. (1980). Death anxiety: The loss of self. New York: Gardner Press.

Miller, J. (1983) Coping with chronic illness: Overcoming powerlessness. Philadelphia: F.A Davis.

Murphy, P.A. (1986). Reduction in nurse's death anxiety following a death awareness workshop. Journal of Continuing Education in Nursing, 17(4), 115-118.

Murray, P. (1973). Death education and its effects on the death anxiety levels of nurses. Unpublished doctoral dissertation, University of Sarasota.

Murray, P. (1974). Death education and its effects on the death anxiety levels of nurses. Psychological Reports, 35, 1250.

Nelson, L.D., & Nelson, L.C. (1975). A factor analytic inquiry into the multidimensionality of death anxiety. Omega, 6, 171-178.

Neuman, B. (1982). Neuman systems model. Norwalk, CT: Appleton & Lange.

Neuman, B. (1989). Neuman systems model (2nd. ed.). Norwalk, CT: Appleton & Lange.

Osterweis, M., Solomon, F., & Green, M. (Eds.). (1984). Bereavement: Reactions, consequences, and care. Washington, D.C.: National Academy Press.

Parkes, C. (1972). Bereavement: Studies of grief in adult life. New York: International Universities Press.

Rando, T. (1986). Loss and anticipatory grief. Lexington, MS: D.S. Heath.

Schulz, R., & Aderman, D. (1978-1979). Physician's death anxiety and patient outcomes. Omega, 9, 327-332.

Shanfield, S. (1981). The mourning of the health care professional: An important element in education about death and loss. Death Education, 4, 385-389.

Shelley, A. (1984). Research methods in nursing and health. Boston: Little, Brown and Co.

SPSSX, Inc. (1983). SPSSX users' guide. New York: McGraw-Hill.

Stephenson, J. (1985). Death, grief, and mourning. New York: The Free Press.

Templer, D.I. (1970). The construction and validation of a death anxiety scale. The Journal of General Psychology, 82, 165-177.

Templer, D.I. (1971). The relationship between verbalized and non-verbalized death anxiety. Journal of Genetic Psychology, 119, 211-214.

Templer, D.I., Lester, D., & Ruff, C. (1974). Fear of death and feminity. Psychological Reports, 35, 530.

Templer, D.I., & Ruff, C.F. (1971). Death anxiety scale means, standard deviations, and embeddings. Psychological Reports, 29, 173-174.

Templer, D.I., Ruff, C.F., & Franks, C.M. (1971). Death anxiety: Age, sex, and parental resemblance in diverse populations. Developmental Psychology, 4(1), 108.

Walker, L., & Avant, K. (1983). Strategies for theory construction in nursing. Norwalk, CT: Appleton-Century-Crofts.

Warren, W.G., & Chopra, F.M. (1978-1979). Some reliability and validity considerations on Australian data from the Death Anxiety Scale. Omega, 9, 293-295.

Weisman, A. (1984). Appropriate and appropriated death. In E. Shneidman (Ed.), Death: Current perspectives (3rd ed.) (pp. 31-34). Mountain View, CA: Mayfield.

Weisman, A. (1984). Common fallacies about dying patients. In E. Shneidman (Ed.), Death: Current perspectives (3rd ed.) (pp. 223-225). Mountain View, CA: Mayfield.

Worden, J.W. (1982). Grief counseling and grief therapy: A handbook for the mental health practitioner. New York: Springer.

Worden, J.W., & Proctor, W. (1976). PDA: Personal death awareness. Englewood Cliffs, N.J.: Prentice-Hall.