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A comparative study of hospice vs nonhospice nurses' attitudes toward death and dying and level of death anxiety

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toward death and dying and level of death anxiety**

Harber, Debra Panko, M.S.N.

University of Nevada, Las Vegas, 1990

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A COMPARATIVE STUDY OF HOSPICE VS.
NONHOSPICE NURSES' ATTITUDES
TOWARD DEATH AND DYING AND
LEVEL OF DEATH ANXIETY

by

Debra Panko Harber

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

Master of Science

in

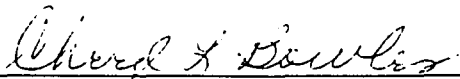
Nursing

Department of Nursing
University of Nevada, Las Vegas
November, 1990


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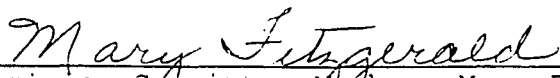
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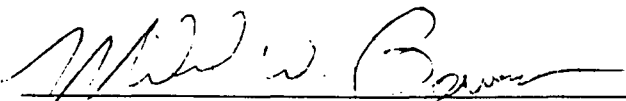
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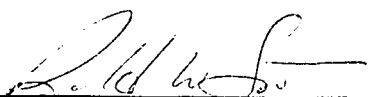
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Las Vegas, Nevada
November, 1990

Abstract

The purpose of this descriptive survey was to assess nurses' attitudes toward and anxiety associated with death and dying, and examine factors which may be related to death attitude and death anxiety. Kubler-Ross' theory on death and dying and Roy's adaptation model served as the framework to guide the research process.

The study asked five questions. (1) Is there a difference between hospice nurses and nonhospice nurses in their attitude toward death and dying? (2) Is there a difference between hospice nurses and nonhospice nurses in level of death anxiety? (3) What characteristics are related to death attitudes of hospice and nonhospice nurses? (4) What characteristics are related to death anxiety of hospice and nonhospice nurses? (5) What is the relationship between death anxiety and attitude toward death and dying for hospice and nonhospice nurses?

The attitudes of hospice nurses and nonhospice nurses were assessed using Hopping's (1976) Death Attitude Indicator and death anxiety was measured using Templer's (1970) Death Anxiety Scale. Subjective information was obtained and examined in order to assess variables which may be related to death attitude and death anxiety.

The dependent variables in this study were death anxiety and attitude toward death and dying. The independent variable was the work setting of the nurses, hospice compared to nonhospice. A convenience sample of 60 nurses, thirty nurses from each work setting was surveyed.

Frequency analyses were conducted to describe the sample. T tests were computed to assess if there was a significant difference between hospice nurses and nonhospice nurses in death anxiety and attitude toward death and dying. Findings indicated the hospice nurses had a more positive attitude toward death and dying and also had a lower level of death anxiety.

Through Pearson Product Moment correlation and one-way analysis of variance, independent variables highly correlated with attitude toward death and dying and death anxiety were identified. The variable that seemed to be related to attitude toward death and dying for both the hospice and nonhospice group was frequent exposure to death and dying. For the nonhospice group the more funerals attended also was influential in shaping a more positive attitude toward death and dying.

Upon examination of the variables possibly related to level of death anxiety for the hospice group, no significant relationships were found. On the other hand the category of

the dying person was related to death anxiety for the nonhospice nurses. The nonhospice nurses who had experienced the death of a family member had a lower level of death anxiety than the nurses who had experienced the death of a patient.

A Pearson Product Moment Correlation was also computed to assess any relationship between death anxiety and attitude toward death and dying for hospice and nonhospice nurses. No relationship was found between the two dependent variables.

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Table of Contents

	Page
Abstract	iii
List of Tables	ix
List of Appendices	xi
Chapter	
1. Introduction to the Problem	1
Purpose of the Study	2
Review of Literature	3
Death Anxiety and Attitude toward Death and Dying	4
Attitude toward Death and Dying	6
Death Anxiety	19
Theoretical Background and Conceptual Framework	30
Assumptions of the Study	37
Research Questions	38
Definition of Terms	38
Summary	40
2. Methodology	42
Research Design	42
Sample	43
Instruments	43

Table of Contents (continued)

Chapter	Page
Death Attitude Indicator	43
Death Anxiety Scale	45
Procedure	47
Analysis of Data	49
3. Results	51
The Sample	51
Research Questions	63
Reliability	69
4. Discussion, Conclusions, and Implications	70
The Sample	70
Research Questions	72
Reliability of DAI	84
Reliability of DAS	87
Findings related to Theoretical Framework	88
Limitations of the Study	94
Implications for Nursing	95
Recommendations	96
References	118

List of Tables

Table	Page
1. Frequency Distributions for Hospice and Nonhospice Groups by Demographic Variables Race, Marital Status, Years of Nursing Experience, and Time in Current Position (Hospice Group n = 38, Nonhospice Group n = 31)	52
2. Frequency Distribution for Hospice Group (n = 38) by Years of Experience in Hospice	56
3. Frequency Distributions for Religious Affiliation, Belief in a Supreme Being and Commitment to Religious Practices (Hospice Group n = 38, Nonhospice Group n = 31)	58
4. Frequency Distributions of Individual Subject Scores Reported for Hospice Subjects (n = 38) and Nonhospice Subjects (n = 31) on the DAI	61
5. Frequency Distribution of Individual Subject Scores in the Hospice (n = 38) and Nonhospice Groups (n = 31) on the DAS	62
6. T-test for comparing Hospice Group and Nonhospice Group Scores on the DAI	64
7. T-Test for Comparing Hospice Group and Nonhospice Group Scores on the DAS	65
8. Pearsons' Product Moment Correlations for DAI Scores with Number of Funerals attended for the Nonhospice Group (n = 31)	65

Table	Page
9. One-Way ANOVA for DAI scores and Experience in an Environment with Frequent Death for the Hospice Group (n = 38)	67
10. One-Way ANOVA for DAI Scores and Experience with Frequent Death for the Nonhospice Group (n = 31)	67
11. One-Way ANOVA for DAS Scores and the Category of the Dying Person for the Nonhospice Group (n = 31)	68

List of Appendices

Appendix	Page
A. Cover Letter and Consent	99
B. Death Attitude Indicator	101
C. Death Anxiety Scale	107
D. Subjective Information Sheet	109
E. Permission for Use of Templer's Death Anxiety Scale.....	113
F. Permission for Use of Hopping's Death Attitude Indicator	115
G. Approval: Human Subjects Rights Committee, Department of Nursing, University of Nevada, Las Vegas	117

CHAPTER 1

Introduction to the Problem

In the past 20 years there has been an upsurge in the literature on death and dying. One theory on death and dying proposed by Elizabeth Kubler-Ross (1969) emphasized that individuals must be able to evaluate their own feelings toward death and dying before they can cope with caring for terminally ill individuals. According to this theory, the nurse needs to identify his\her own feelings toward death and dying and cope with them before he\she can be helpful to terminally ill clients.

The literature suggested that death and dying is an area that many nurses have difficulty coping with. It has also been suggested that nurses experience anxiety in caring for dying clients (Murray, 1974; Laube, 1977; Denton & Wisenbaker, 1977). Death in American society carries with it a negative connotation (Mullins & Meriam, 1983). Often nurses use defense mechanisms such as denial to cope with their feelings about death (Mood & Lick, 1979). They are uneasy caring for and communicating with a terminally ill or dying client (Stoller, 1980). Feelings such as anxiety, fear, inadequacy and inexperience have been associated with caring for the dying and usually affect communication

between the client and the nurse (Lev, 1986a; Yeaworth, Winget, & Kapp, 1974). Lack of communication between the client and the nurse isolates the client from a source of support, can influence the client's ability to adapt to his\her own death and ultimately hinder the quality of care given (Mullins & Merriam, 1983a; Kirschling & Pierce, 1982).

Purpose of the Study

The purpose of this descriptive study was to examine nurses attitudes toward death and dying, as well as their level of death anxiety, and identify factors that may be related to the attitudes and anxiety expressed.

In the comparison of death attitude and death anxiety, if hospice nurses and nonhospice nurses are found to differ, it may be possible to identify factors such as religious preference, education, age of the nurse, personal experience with death and professional experience with death which may have influenced the differences in death anxiety and attitude toward death and dying (Eliopoulos, 1979). Identifying some of the factors that correlate with death anxiety and attitude toward death and dying may provide information that can be used in nursing education for better preparation of nurses.

Better preparation may assist the nurse in developing a

more positive attitude toward death and dying, a decreased level of death anxiety and lead to improved communication between the nurse and the dying individual. Better communication between the nurse and the patient is a factor which has been shown to improve the quality of care.

In summary, this study assessed attitudes of nurses toward death and dying and their level of death anxiety. Thirty nurses currently working in an out-patient or an in-patient hospice environment, and 30 nonhospice nurses currently working on a medical-surgical unit were sampled. The attitude toward death and dying and death anxiety of the two groups of nurses were compared. Factors which may affect attitude toward death and dying and death anxiety, including, education, years of experience as a nurse, age of the nurse and religious conviction were examined. Through the examination of nurses' attitudes and death anxiety it is hoped that factors which appear to influence these variables can be identified and incorporated into improved preparation of nurses to care for dying individuals.

Review of Literature

To date, many articles and books on death and dying are available. A substantial number of articles were written from personal experiences without validation from empirical

research. However, there has been research done on death and dying regarding attitudes of nurses and characteristics of nurses who care for the dying. While these studies are not entirely the same as the current study the information is considered applicable in helping to support the need to examine the attitudes of nurses who work with dying individuals and those who do not. Examining attitudes and factors which contribute to these attitudes may assist in determining interventions which could influence nurses' attitudes toward death and dying, level of death anxiety and hopefully improve patient care.

Gow and Williams (1977) compared both death anxiety and death attitude because they felt death anxiety was a generalized state that might serve as an intervening variable of attitude toward death. Since personal experiences and attributes of nurses contribute to attitude (Fishbein, 1967), death anxiety will also be measured and compared.

Death Anxiety and Attitude toward Death

Practice Setting

Gow and Williams (1977) studied differences of death anxiety and attitude toward death between 235 nurses working in chronic care, acute care and community care agencies. They

found significant differences between the groups on anxiety scores. Another significant finding was the chronic care agency nurses were older, less anxious regarding death and had more positive attitudes toward death and dying. The researcher concluded the difference was not due to the type of agency but rather the differences in the characteristics of the nurses. Nurses 40 years of age and older had a more positive attitude and a lower level of death anxiety in caring for the dying than their younger colleagues.

These results may be somewhat biased due to the difficulty the researchers had in response rate. The response rate between groups was unequal. There may also have been pressure within the smaller agencies to participate leading to bias in the sample and restricted ability to generalize.

Thompson (1985) also measured both death anxiety and death attitudes. In the study, nurses' anxiety and attitudes toward dying were compared using three nursing services in a large acute hospital. Fifty two nurses from surgical, pediatric and palliative units were compared. The study revealed the palliative unit nurses to experience more death anxiety than either the surgical unit or the pediatric unit nurses. Although, death anxiety was higher for the palliative nurses, attitude toward death was more positive.

The palliative nurses felt less uneasy about caring for the dying, more useful and felt caring for the dying was rewarding.

The findings from this study are questionable because the attitude instrument was constructed by the investigator and there were only six items which assessed the nurses' feelings about death in the hospital.

Both of the above studies attempted to demonstrate that low death anxiety would be related to a more positive death attitude. Unfortunately, the findings of the two studies were inconsistent. Due to these inconsistencies, a need to further investigate both death anxiety and death attitude seems appropriate. No other studies measuring both death attitude and death anxiety were available to the researcher.

Attitude toward Death and Dying

Practice Setting

Fochtman (1974) conducted a comparative study of pediatric nurses' attitudes toward death and dying. The nurses were compared based on the type of ward in which they were working. The sample consisted of 57 pediatric nurses from three hospitals who worked in one of three clinical areas; a benign ward (orthopedics) where death rarely occurs, an acute ward (ICU) where death frequently occurs

suddenly and a terminal ward where death occurs frequently but usually over a period of time.

Significant differences in the nurses' attitudes toward death and dying were found based on clinical areas in which the nurses worked. The nurses on the terminal wards found thoughts of their own death disturbing, while the other nurses were less disturbed. The nurses on the terminal wards questioned if they were afraid of death, while the nurses on the benign wards were definitely fearful. Based on these findings, the investigator concluded that the kind of nursing practice is related in some way to attitudes expressed.

No correlation was found between attitude and educational experience or the amount of clinical experience. The key variable identified by Fochtman (1974) to be influential in attitude toward death and dying was the prolonged and repeated exposures of the nurses to individual clients and their families. Although pediatrics is very different than caring for adults, this study is included to support differences may exist based upon the type of ward in which the nurse works.

Glaser and Strauss (1965) suggested, different work situations and nursing units are influential in shaping attitudes toward working with the dying. They felt that

different nursing units are characterized by different task structures, for example the tasks associated with hospice are to comfort and care for the client, and mortality rates. Because of this, each unit has it's own philosophy in working with the dying where the unit actually has an emotional climate which encourages a particular reaction to death. The above studies seemed to agree.

Education

Since education has been identified as a factor that contributes to attitude toward death and dying, many studies have been done comparing nursing students at various stages of their education. In a study by Yeaworth, Winget and Kapp (1974), attitudes of 69 senior nursing students were compared with those of 108 freshman nursing students. It was found that the seniors were more accepting of their feelings toward death and dying. They were able to communicate more openly about death and were more flexible in relating to dying clients and their families than the freshman nursing students. They believed this was due to the additional academic preparation that the senior nursing students had in the area of death and dying.

In another study comparing different levels of education with attitude toward death and dying, 128 nursing

students, 66 graduates and 62 nursing faculty were assessed at a New York University School of Nursing (Lester, Getty and Kneisel, 1974). A significant relationship was found between fear of caring for the dying client and academic preparation. Findings showed a decrease in fear associated with the care of the dying client when the nurse had more academic preparation.

Wheeler (1980) also studied the relationship between educational preparation and care the dying client received. In a sample of 84 community health nurses, it was found that baccalaureate nurses ranked total care of the dying client and follow up with the family more important than the diploma and the associate degree nurses. The associate degree and the diploma nurses ranked physical care of the dying client as more important. The researcher concluded that the education of the nurses was positively correlated with the quality of care the dying client received.

The above studies all seem to agree. Academic preparation seemed to have a positive effect on attitude toward death and dying.

Death Education

Death education has also been mentioned in the literature as being influential in the shaping of attitude

toward death. Shoemaker, Burnett, Hosford and Zimmer (1981) stated that education has been effective in changing attitudes of professionals toward death and dying. In their study, they gave a ten week adult education course at a California community college entitled, "The Hospice Approach to Death and Dying". The subjects included were 93 of the 140 males and females who were still enrolled in the final session of the 11 week course. At the conclusion of the classes, they found that the participants had significantly more positive attitudes towards death and dying after having completed the course than before.

Fleming and Brown (1983) investigated whether or not a death education course would have an impact on the care given to dying clients by nurses. They analyzed charts to assess care given to the clients by 130 nurses in a long-term care hospital in Ontario, Canada. The charts were first analyzed prior to the death education sessions and then again after completion of the classes. Chart analysis indicated an increase in charting in the subjective section of the nursing notes after the sessions on death. This was found to be true for the registered nurses, but not for the assistant registered nurses. The assistant registered nurse in Ontario, Canada has less than a diploma in nursing.

Another interesting finding was that subjective charting increased more during the evening and night shifts. The authors attributed this increase to more available time to chart on the evening and night shifts, an increase in the clients' feelings of loneliness and fearfulness in the evening and night shifts, and/or an increase in desire of the client to express their feelings during these shifts. Although these findings are interesting, they may be invalid due to lack of a homogenous sample, the subjective nature of the data and/or lack of control of researcher bias.

Hopping (1977) completed a descriptive study to test whether there was a change in attitude of nursing students toward death after taking a clinical course and to also validate a questionnaire entitled Death Attitude Indicator. Forty senior nursing students were included in the sample. The experimental group consisted of twenty nursing students who had enrolled in a course entitled " Nursing Care of the Adult Patient with Malignant Neoplastic Disease". The control group consisted of 20 nursing students randomly chosen from the senior class who were not enrolled in the course.

The author assumed that there was no difference in attitude toward death between the two groups prior to the course based on pre-test scores. At the conclusion of the

course, the two groups were compared using the t test and no significant difference was found in attitude towards death and dying. Results did indicate that experience with a family death affected attitude toward death in a negative way. A significant difference was found between the group who emphasized a religious affiliation and those who did not. The group that indicated religious affiliation reported a more positive attitude toward death.

The most obvious limitation was the content of the clinical course. The course content was not on attitude toward death and dying. This may explain why there was no difference in attitude scores of the students after the clinical course.

Another limitation may be the time frame associated with post-testing. Other studies have suggested using a longitudinal study design based on the belief that the interim following the completion of a course in death and dying may provide time for reflection of attitudes toward death thus changing attitudinal scores (Murray, 1974). The Hopping study allowed only three months before post-testing. The questionnaire also needs further validation testing.

Lev (1986a, 1986b) conducted a longitudinal study comparing baccalaureate nursing students and graduates who had completed a hospice nursing course with a similar group

who had not. The students and graduates who had not completed a course expressed a desire to enroll in one if it were offered. Due to the longitudinal nature of the study (1980-1985), only 6 baccalaureate students and 69 graduate nurses were included in the study. Results showed that for all subjects, the number of years of experience did not affect attitude toward death and dying. In the group who received the hospice course, less fear of death and fewer avoidance behaviors were noted. The author noted that 63 percent of the students and graduates who had taken the course chose to work in oncology nursing as opposed to 30 percent of those who had not had the course. These results seem to support a need for additional education in death and dying in order to promote a more positive attitude.

Golub and Reznikoff (1971) felt that education and experience with dying individuals would have an impact on attitude toward death and dying. They compared attitudes toward death and dying of nursing students with those of graduate nurses and found that attitude toward death and dying did not change in relation to nursing specialty or the number of years of experience as a nurse. However, the more experience the nurse had with dying clients, the less likely he/she was to try and prolong life. The results also suggested the more death education a nurse had, the better

the care received by the dying client.

In summary, most of the studies seemed to suggest a more positive attitude toward death and dying was achieved with a course in death and dying. However, one study did not support death education as a variable that improved attitude toward death and dying but found other variables that did seem to correlate with a more positive attitude toward death and dying. Another difference between studies was the time frame and course content which may account for the differences in findings.

Exposure to Death

While there is much debate about academic preparation influencing attitude toward death and dying, some researchers believe that an increase in exposure to dying clients changes attitude. Popoff and Funkhouser (1975) found that nurses who infrequently dealt with death were more likely to become discouraged, depressed and felt incapable of providing technical and psychological care when they did encounter it.

Coolbeth and Sullivan (1984) studied attitudes toward death of 115 nursing students. The students were separated into four groups based on exposure to death: no exposure to death, personal exposure, academic exposure, and personal

and academic exposure. The results indicated that academic exposure had the most significant effect on attitude. Personal exposure accounted for some change in attitude but the difference was too small to be statistically significant. The researcher concluded personal exposure had an additive effect as evidenced by increased attitude scores in the group with both academic and personal exposure. The two studies suggested exposure to death did have some effect on attitude. The latter study seemed to indicate that exposure alone was not entirely responsible for a significant change in attitude.

Years of Nursing Experience

Researchers have hypothesized that years of nursing experience would have an effect on attitude toward death and dying. Stoller (1980) compared the impact of number of years of nurses' work experience with their anticipated response to situations involving death and dying. The sample consisted of 62 registered nurses (RN's) and licensed practical nurses (LPN's).

Years of experience was found to be significant for both RN's and LPN's. Years of experience was found to be of assistance to the LPN's in finding ways to alleviate or cope with uneasiness that caring for the dying generates. This was

not true for the RN's. Years of experience actually increased the uneasiness of caring for dying clients for the RN's.

The researcher concluded that these differences may be attributed to actual work situations. The registered nurses have more structured nurse client contact and less direct experience with the dying. Whereas, the licensed practical nurse were able to engage in more frequent contact and more conversation thus helping to develop effective coping mechanisms in the management of the dying.

Another interesting finding in this study was that the younger nurses were more inclined to assign greater importance to meeting the psychosocial needs of the dying client than the older nurses, who focused primarily on physical needs. The investigator concluded that this evidence suggests that age may also play a role in attitude, or it may be attributed to the educational background of the nurse. The older nurse had not had courses in death and dying nor did their curriculum focus on psychosocial needs of the clients.

Age

The following literature offered information in regards to death and dying but did not support the statements with empirical data. Denton and Wisenbaker

(1977) suggested that age may affect the extent of the death experience. Huyck and Hoyer (1982) also suggested that individuals of different ages will have different attitudes toward death. They suggested that aging and approaching one's own death may be related to one's attitude toward death. Middle aged persons were thought to be more fearful and negative toward death. If age is correlated with attitude toward death, then age of the client may affect the nurse's attitude toward death.

Popoff and Funkhouser (1975) postulated that nurses had more difficulty dealing with dying children than with dying adults. This may be true due to society's emphasis on youth and the negative connotations associated with death. Therefore, death of a young person is seen as a greater loss than the death of an elderly person. Based on these authors perceptions it appears that age of the care giver and the age of the client may both have an effect on attitude toward death.

In an article written about nurses who work with children who are seriously ill and may die, Coody (1985) stated that it is necessary for the nurse to come to terms with feelings about illness and death before initiating supportive interventions. Since the perception of death is thought to directly influence the delivery of care

(Mullins and Merriam, 1983a), it was suggested that in order to deal constructively with feelings about working with the dying, one has to come to terms with one's own concept of death.

Coming to terms with one's own death was also emphasized by Kubler-Ross (1969). She stated that the nurse experiences stages of the dying process in conjunction with the dying person they are caring for. Nurses are commonly observed avoiding contact with the dying person or telling the dying person to "cheer up". Care givers tend to maintain a distance from the dying person as a way of avoiding human feelings or experiencing loss (Germain, 1980).

Eliopoulous (1979) concurred with Kubler-Ross in saying that denial of death and the dying process is often expressed by nurses. Denial is often observed in the nurses' avoidance of the dying person, discouragement of the client from dealing realistically with death or the instillation of false hopes for both the client and the family (Germain, 1980).

In an article by Mullins (1981) it was stated that it takes longer for a nurse to answer a call bell of a dying person than other clients. This social distancing affects the social, psychological and physical condition of

the dying person and further leads to feelings of isolation and helplessness. Helplessness is reinforced as communication with the nursing staff is cut off.

Religion

While religion is thought to play a role in the shaping of attitude toward death and dying, and it has been suggested in the literature, most studies did not focus on the impact of religion. Hopping (1977) included religion as a variable in her study of nursing students' attitudes toward death. Belief in a supreme being was compared with total score on the Death Attitude Indicator. A t-test was computed. Twenty nine respondents reported their belief in a supreme being on the positive end of the continuum. Eleven respondents reported a negative or neutral response. The investigator found a significant difference in the means between the two groups. The group that indicated a belief in a supreme being scored higher, indicating a more positive attitude than the group who had given a negative or a neutral response.

Death Anxiety

Death Education

In a study of the effect of death education on death

anxiety Murray (1974) randomly selected thirty nurses from 330 registered nurses employed at a New York Hospital. The course consisted of six one and one half hour sessions one week apart. Templer's Death Anxiety Scale (1969, 1970) was used to measure death anxiety at three points in time; prior to the course, at the conclusion of the course and again four weeks later.

The researcher concluded that death anxiety for nurses decreased significantly four weeks after the death education class. This finding suggests that with an increase in education and a resultant decrease in anxiety, attitude toward caring for the dying should be influenced in a more positive way. The researcher also recommended the need for longitudinal studies in the measurement of death anxiety.

Laube (1977) also studied the effects of a death and dying workshop on the death anxiety level of participating nurses. A two day workshop entitled "Grief in Life Threatening Situations" was organized and conducted. Forty four nurses volunteered to participate in the study. Templer's Death Anxiety Scale was administered as a pre-test and then again as a post-test. The post-test was given at the end of the workshop, four weeks after the workshop and again three months after the workshop.

The results indicated a significant decrease in the

scores from the pretest compared to the test one month after the workshop. Therefore, the researcher concluded that a two day death and dying workshop did significantly reduce the levels of death anxiety from the beginning of the program to one month following the program. At the three month testing the scores continued to be lower than the pre-test but had risen slightly above their one month post workshop level. The researcher concluded that a two day workshop may not have provided sufficient time to work through feelings.

Mullins and Merriam (1983a, 1983b) also examined the effects of a two day seminar concerning nurses and their response to the dying client. This study included 138 nurses from four nursing homes.

The purpose was to ascertain if exposure to information on death and dying resulted in greater knowledge about death and dying, if there was a more positive attitude toward the elderly and if there was a change in death anxiety. The findings indicated that subjects showed a significant increase in knowledge regarding death and dying but there was no change in attitude toward the elderly. Death anxiety was shown to be significantly increased after the seminar. Due to the differences in education among subjects and lack of homogeneity within and across the control and experimental groups, the findings of this study may be biased.

Another two day workshop was conducted to measure the effects of a death awareness program on level of death anxiety. In Murphy's (1986) study, 150 registered nurses attended a sixteen hour, two day workshop. A control group of 150 registered nurses who did not attend the workshop was drawn from area hospitals. All subjects were tested for level of death anxiety three times; prior to the start of the workshop, at the close of the workshop and one month following the workshop. Templer's Death Anxiety Scale was utilized.

The investigator found those nurses who attended the two day workshop had significantly decreased their level of death anxiety following the workshop. The investigator concluded that the decrease in level of death anxiety was achieved due to voluntary participation in the educational program with that outcome in mind.

Telbian (1981) compared a volunteer sample of 100 nurses from four general hospitals with regard to death anxiety. The nurses were separated into two groups, those who had attended a workshop or course on death and dying some time in their past and those who had not. Thirty eight of the fifty seven who attended such a course had attended within the past five years. Only three had attended in the past year. The results indicated that those nurses who had

a course in death and dying had significantly less anxiety toward death than those who had not.

The researcher stated it was uncertain if the lower scores on death anxiety were due to attending a death and dying course or if persons who have lower death anxiety are more likely to attend such a course. If education was the reason for the lower scores these data support those of Murray (1974) and Laube (1977) who found no significant change in death anxiety immediately after a course on death and dying but found a significant decreasing death anxiety after one month.

Thus, the researcher concluded that the effects of a death education course may be slow to develop. The researcher suggested a need to study the longitudinal effects of death education on death anxiety.

In contrast, Chodil and Dulaney (1984) found no change in attitude of critical care nurses after a death and dying workshop. Using Templer's Death Anxiety Scale, they assessed the death anxiety of eight critical care nurses prior to a death and dying workshop, during the workshop, four weeks after the workshop and again three months later.

The results showed no decrease in death anxiety for these nurses at any of the points in time tested. The results may be biased due to the small sample size, the self

selection of the candidates and the select area of practice. Another possible limitation to consider is the time element between the measurements of anxiety. It would have been interesting to see the results if there was more time allotted between the subjects' administration of the scale. Results may also be influenced by familiarity with the instrument.

Most of the above studies found a decrease in death anxiety after a death anxiety workshop. One study was not consistent in those findings (Chodil and Dulaney, 1984). Possible reasons for the difference in findings were discussed above.

Age

In a study of the relationship between death anxiety and attitude toward the elderly Eakes (1985) surveyed 159 full-time nursing staff members in six nursing homes. It was hypothesized that the greater the death anxiety the more negative the attitude toward the elderly. The sample included registered nurses, licensed practical nurse and nurses aides. The findings showed that the subjects held negative attitudes toward the elderly and these attitudes were negatively correlated with death anxiety. The researcher suggested that a negative attitude toward death

may be a predictor of the devaluation of old age. Due to the differences in background of participants it would be difficult to generalize these findings.

Practice Setting

Another study compared level of death anxiety between two groups of nurses who worked in hospice versus nonhospice settings. The convenience sample consisted of 468 nurses who either subscribed to a hospice newsletter or were members of the American Nurses Association (Peace & Vincent, 1988). The hospice nurses had significantly more education in the area of death and dying. It was thought that due to more education, the hospice nurses would have a significantly lower death anxiety. The findings did not support this belief. Although mean scores for the hospice nurses were lower they were not significantly lower than the nonhospice nurses in level of death anxiety as measured by Templer's Death Anxiety Scale. This finding is questionable due to the nature of the sample selection. Any nurse who subscribed to the hospice newsletter but was not currently working in hospice was grouped with the nonhospice nurses. Thus, some of these nurses could have had previous hospice preparation or experience and this could explain why no significant differences were found between the two groups of nurses.

Exposure to Death

In another attempt to determine factors or nursing characteristics responsible for death anxiety, Reissetter and Thomas (1986) correlated quality of nursing care and characteristics of 210 nurses caring for terminally ill patients with level of death anxiety using Templer's Death Anxiety Scale. The researchers examined quality of nursing care indices which included communication, continuity of care, and family care. Demographic data such as personal, professional, and educational experience was also examined. After examining quality of nursing care indices and demographic data, the researchers concluded that frequent exposure to death lowers death anxiety and helps the nurse to meet the needs of the dying person. While these conclusions were anticipated, this study may not be reliable because self report was used to measure quality of care. Observational data may have given the study more validity.

Religion

Templer and Lonetto (1986) surveyed 390 religious persons who had attended at least one church retreat. Two hundred and sixty seven subjects completed the Death Anxiety Scale and a religion inventory. Those who considered themselves more religious, attended religious

functions frequently, believed in life after death and believed in the bible had lower scores on the Death Anxiety Scale than those subjects who did not indicate a strong religious attachment.

Leming (1975) found a similar correlation between religion and death anxiety. In this study 403 Latter Day Saints participated. Those who had a strong religious commitment had the least amount of death anxiety. Interestingly those with a moderate religious commitment had a higher level of death anxiety than both the highly religious individuals and the least religious persons.

The relationship between death anxiety and religion was also studied by Aday (1984-1985). In this study 181 students were surveyed using Templer's Death Anxiety Scale and a Belief in Afterlife Scale. The students who attended church weekly had the lowest death anxiety. The students who only attended monthly had the highest level of death anxiety, including those students who rarely or never attended.

All three of the studies found a lower death anxiety with those persons who had a very strong religious commitment. Two of the studies also suggested a higher level of death anxiety in the moderately religious group than both the highly religious and the least religious

individuals.

The large amount of research on death and dying appears to show conflicting results. There is strong evidence that one variable alone is not responsible for the shaping of death anxiety or attitude toward death. The development of attitude and level of anxiety toward death appears to be a multivariate\multidimensional phenomenon.

In summary, the relationship between the nurse and the client is of great importance in the overall management of the client's care. After the client hears the news about death, the awkwardness still continues. It is during this time that the nurse must be available for continual support. Casteldine (1986) stated that the nurse is needed even more after the client hears of his\her impending death. He believed that the ability of each individual to express his\her own feelings about death through communication with others helps in coming to terms with death. This was recommended for both the dying client and the nurse. Unfortunately, many nurses are not prepared for this type of situation, feel uncomfortable and are ineffective because they have not come to terms with their own deaths.

Since most deaths occur outside of the home, usually in a hospital or nursing home type setting, nurses have the most contact with the dying. Dying represents what most

human beings fear, the unknown, and what we all know is unavoidable. The first and most important step in improving nursing care for the dying client is for the nurse to understand his\her own feelings and attitudes about death and dying (Mullins, 1981; Casteldine, 1986; Woods, 1984 and Kubler-Ross, 1969). How nurses perceive the act of dying; whether it is painful, a blessing, or they feel indifferent, influences the way they interact with the client and the treatment they give (Mullins and Merriam, 1983). The nurse needs to recognize any difficulties encountered when he\she works with the dying client and steps should be taken to deal with these difficulties. Negative feelings need to be recognized and dealt with so these feelings do not affect the nurses' relationship with the clients, families and their co-workers.

By comparing attitudes of hospice nurses versus nonhospice nurses, it is hoped that some of the factors either personal or professional that influence attitude toward death and death anxiety will be identified. Factors such as age, religious beliefs, exposure to death, experience as a nurse and education were previously identified as being influential in the shaping of attitude toward death and dying and level of death anxiety. It is hoped that through the comparison of the two groups of

nurses in this study, attitudes toward death and dying, death anxiety and some factors responsible for differences in attitude and anxiety level will be clarified. Due to the conflicting findings from previous studies further clarification is needed.

Through identification and clarification of the factors that influence attitude toward death, it may be possible to better prepare nurses to care for dying clients. Improvement in the ability to predict nurses attitudes toward death may assist in staffing those areas where death occurs more frequently. With better preparation, nurses may be able to improve attitude toward caring for the dying individual. A better attitude toward death gives confidence, hope and reassurance to the client and family. Communication is open and quality of care is improved.

Theoretical Background and Conceptual Framework

The conceptual framework to guide this study is based on Kubler-Ross' theory on death and dying and the Roy Adaptation Model. Kubler-Ross' theory was chosen because it is the most widely used and accepted model on death and dying. Kubler-Ross emphasized that individuals must cope with their own feelings about death and dying before they

can be effective in helping others cope.

Roy's Adaptation Model was chosen because it focuses on the nurse and the nurse/client relationship and the variables under investigation fit well with Roy's categories. Another benefit of using Roy's model is that it conforms with Kubler-Ross' staging theory of death and dying. Roy emphasized adaptation and viewed positive coping measures as adaptation.

According to Roy (1984), death is viewed as an inevitable dimension of life. The concept of death not only affects the dying individual but also the care giver who must adapt and learn a new role to care for and relate to a dying individual. Adaptation to any new role is determined by the stimuli present during life closure. Life closure is defined as, " a role which concludes and brings together the dimensions of one's life" (Roy, 1984, p. 499). The stimuli present, such as, the disease process, the uniqueness of the dying individual and the persons with whom the dying interact, affect the outcome of adaptation or role change of the dying individual. Problems arise when the dying person must interact with a care giver, nurse and/or individual who is inexperienced, ill-equipped or fearful of death. The lack of care giver adaptation poses a threat that a change in role performance for the client may never

be learned.

Roy's model identified the person as a holistic system that responds to both internal and external stimuli. These stimuli affect the behaviors that are exhibited by the individual.

According to Roy, an individual is confronted by focal, contextual and residual stimuli. In the case of the dying individual, the focal stimulus, or the stimulus that is most immediately confronting the individual, is death. Contextual stimuli are all the other stimuli present in the immediate environment that confront the individual, such as, family, friends, clergy and health care professionals. Contextual stimuli have an effect on the outcome of the situation which in this case is the dying process. Residual stimuli are all those factors that may be affecting behavior but the effects have not been validated, such as attitudes, beliefs and coping abilities. For whatever reason, the person may not be aware of the influence of these factors, and/or it may not be clear to the observer what factor is having an effect. A good example would be a person who is frightened of a painful death. He\she may have forgotten watching a loved one die in pain as a child. Because the person never mentioned such an experience, an observer can only consider this as a possible cause of the fear. Residual

stimuli are those environmental factors within or without the person whose current effects are unclear. Once the stimulus is validated the stimulus is no longer a residual stimulus but is considered contextual.

To thoroughly assess all the contextual stimuli, one must examine all the relationships present in the dying persons immediate environment. These stimuli may include family, friends, clergy and professional members such as the doctors and nurses. These people all have an effect on life closure for the dying person.

Roy terms all those individuals that interact with the dying client as either stimuli regulators or stimuli nonregulators. Stimuli regulators are those people who help the dying person adapt to life closure or death. Conversely, stimuli nonregulators, for whatever reason, cannot effectively interact with the dying person and hinder the client's adaptation to life closure. In order for the nurse to be a stimuli regulator, he\she must learn new behaviors for being the interacting person in the helper role. For this study, the helper role is identified as the one who helps the client die with dignity.

Residual stimuli also affect the situation. These stimuli are not readily seen or identified. These include

attitudes, traits and coping abilities of the client as well as the attitudes, traits and coping abilities of the people around him\her. Once these residual stimuli are revealed they become contextual stimuli. Residual stimuli are significant in the ability of the dying client to successfully complete life closure since life closure or death is an internal struggle (Roy, 1984).

For nurses to learn new behaviors and be more effective in caring for the dying client, they need to assess and make adaptations in each of the four adaptive modes as described by Roy (1984). In the physiologic mode, the nurse may no longer need to center his\her attention around performing technical skills to prolong life but to provide comfort. In the self-concept mode, feelings of powerlessness, uselessness, hopelessness and anxiety all decrease self-concept and one's feeling about his\her own abilities. This has an impact on the nurse since the health profession as a whole has emphasized cure as the goal of health care. The nurse's role function will change with the dying client. The nurse no longer has wellness as the goal in caring for the dying client. The focus becomes helping the dying client deal with his\her own death. Therefore, role conflict for the nurse may occur. The interdependence mode of the model is also involved. Working in stressful

environments increases the need for the nurse to have supportive relationships with family, friends, fellow co-workers and the church. These supportive relationships are important for assisting the nurse to cope with feelings of death anxiety, separation anxiety, feelings of loss and possibly feelings of failure. With support needs met, the nurse can be more effective in caring for the dying client.

Because Roy considers death and the dying process as adaptive behavior, the Kubler-Ross staging theory of death and dying seems appropriate to link with Roy's framework. The staging theory of death consists of five stages. These adaptive stages include denial, anger, bargaining, depression and acceptance. The denial stage is characterized as a stage of disbelief. The patient feels this can not be happening to him. This is a normal reaction and allows time for the patient to let the news sink in.

The second stage or the anger stage, usually occurs when the stage of denial cannot be maintained. The patient may ask "why me?". Feelings of rage, envy and resentment are common.

The third stage is bargaining. Patients make bargains or promises frequently with God. These bargains are made in an attempt to postpone death.

The fourth stage is depression. This stage occurs when the dying person faces the losses that he\she has already encountered, such as health and independence, and the losses that dying brings, loss of family, friends and future living. During this stage the patient may also feel unnecessary guilt and shame for the sadness he\she has brought to family and friends.

Finally, the last stage is acceptance. Acceptance is viewed as a coming to terms with reality, a gradual separation from people, life, ties and roles. The patient holds on to memories and finds peace.

The dying person, significant others and care givers may exhibit any of these stages at any time. They may also go back to a previous stage. All of these stages are considered adaptive behaviors that may be exhibited by the dying person, family, close friends and professional care givers.

Roy advocates that education and exposure of the nurse to the dying person decreases the level of fear of death and dying and promotes adaptation for the nurse towards death, death anxiety and the dying process. Therefore, death education and exposure to death may be methods to assist the nurse to take on the role of stimuli regulator in caring for the dying and therefore aid the client in their adaptation

toward their own death.

By studying the nurse, who is considered a contextual stimulus and his\her attitudes, which are residual stimuli, we may be able to better explain and predict what factors are influential in shaping the nurses' death anxiety as well as attitude toward death. Through clarification and explanation of the factors that are significant in the development of attitude toward death and dying and the factors significant for death anxiety, we may be able to identify the preparation needed to promote a positive attitude toward death and dying, decrease the level of death anxiety and enhance the skills of nurses who care for dying individuals. A positive attitude and decreased level of death anxiety of the nurse will ultimately lead to better quality care for dying individuals and their families.

Assumptions of the Study

It is assumed that the nurses who participate in the study are willing to fill out the questionnaires in their entirety. It is also assumed that the respondents will answer the questionnaires truthfully. Finally, as suggested by the literature, it is assumed that attitude cannot be measured directly, but must be inferred through life experience factors, personal opinions, beliefs and feelings

and through behaviors (Hopping, 1977).

Research Questions

- (1) Is there a difference between hospice nurses and nonhospice nurses in their attitude toward death and dying?
- (2) Is there a difference in death anxiety level between hospice and nonhospice nurses?
- (3) What characteristics of hospice and nonhospice nurses are related to attitude toward death and dying?
- (4) What characteristics of hospice and nonhospice nurse are related to death anxiety?
- (5) What is the relationship between death anxiety and attitude toward death and dying for hospice and nonhospice nurses?

Definition of Terms

- (1) Hospice nurse - defined as any registered nurse who is currently working with dying clients in either the 20 bed, private, free standing hospice in Las Vegas or any nurse who is currently working full or part time (less than 32 hours per week) for the private hospice or the county health district providing hospice care in the clients home. These nurses must have at minimum, attended an educational

orientation program for the position.

- (2) Nonhospice nurse - defined as any registered nurse currently working full or part time (less than 32 hours per week) on a medical-surgical unit at a selected 445 bed acute care community hospital in Las Vegas. These nurses must not have had experience working in hospice. Lack of experience in hospice will be confirmed after checking the subject information sheets. Medical-surgical nurses were chosen to comprise the group because previous studies also used medical-surgical nurses to compare and contrast differences between the traditional role of the nurse and that of hospice nurses (Thompson, 1985 & Amenta, 1984).

Furthermore, medical-surgical nurses were recommended to the researcher by the director of staff development as being the group that would have the least amount of exposure to death and dying.

- (3) Attitude toward death is " the sum total of a person's inclinations and feelings, prejudice or bias and convictions about death" (Hopping, 1977, p. 444). It is developed and organized through experience and produces a tendency to act or react

in a certain manner when confronted by specific stimuli (Allport, 1967, & Oppenheimer, 1966). According to Lemon (1974), attitude is difficult to measure. Attitude can not be measured directly but must be inferred (Fishbein, 1967). The attitudes can be inferred from both the nurses's beliefs about providing care and the nurse's actual behavior. Attitude is measured in this study by Hopping's Death Attitude Indicator (Hopping, 1977).

- (4) Death Anxiety - described as " a more generalized state, whereas attitudes are more object related" (Gow & Williams, 1977, p. 191). It was defined as " the expression of diffuse apprehension, the object of which is not clearly understood or recognized" (Folta, 1965, p. 232). Death anxiety is measured by Templer's Death Anxiety Scale (Templer, 1970).

Summary

In conclusion, an overview of the literature related to death and dying and death anxiety was presented. Previous research on nurses' attitudes toward death and dying and death anxiety was reviewed. The literature points out many

of the inconsistent findings with regard to differences in nurses' attitude toward death and dying and level of death anxiety and possible reasons for those differences. Since the data are inconclusive, it appears that there is a need for further research in the areas of death and dying and death anxiety. Providing consistent findings, promoting a positive attitude toward death and dying and decreasing death anxiety may improve nurses' abilities to provide good quality care.

The conceptual framework was also presented involving the Roy Adaptation Model and Kubler-Ross' theory of death and dying as they relate to the dying individual and the nurse. Roy's framework of adaptation appears to follow from Kubler-Ross' theory of death and dying because Roy identified Kubler-Ross' five stages of death and dying as adaptive behaviors.

Finally, the assumptions and research questions were presented. Relevant terms used in the study were identified and conceptually and operationally defined.

Chapter 2

Methodology

This chapter describes the design of the research study and the variables involved. A description of the strengths and weaknesses of the design is also presented.

The population under investigation and the selection of a sample is discussed. The instruments, Templer's Death Anxiety Scale and Hopping's Death Attitude Indicator are explained (see Appendix B and C). The procedure for data collection and data analysis is also explained. A restatement of the research questions and the assumptions of the study is made at the conclusion.

Research Design

This study involved the use of an ex-post-facto retrospective survey approach. The literature showed many factors may have an effect on death attitudes and death anxiety and most are not amenable to being manipulated. Therefore, neither a true experimental nor quasi-experimental design was appropriate to compare nurses' attitudes toward death and death anxiety.

The two dependent variables for this study were attitude toward death and dying and death anxiety. The independent

variable was membership in either the hospice or nonhospice group of nurses. Each group of nurses was surveyed to assess attitude toward death and death anxiety. For the purpose of this study, Templer's Death Anxiety Scale and Hopping's Death Attitude Indicator were utilized to compare death anxiety and attitude toward death and dying of hospice nurses with those of nonhospice nurses.

Sample

The population studied included any registered nurse in the Las Vegas area working in the field of nursing. The sample was taken from the population of all nurses currently working in a hospice setting in either an inpatient or outpatient environment or a nonhospice setting in the Las Vegas area. A convenience sample of 69 nurses, 38 hospice and 31 nonhospice were surveyed from the three agencies that agreed to participate in the study.

Instruments

Death Attitude Indicator

The Death Attitude Indicator (Hopping, 1977) was used to measure attitude toward death and dying. It has two parts (see Appendix B). Part I consists of 24 statements rated on a five point Likert type scale which address

personal feelings, opinions, beliefs and behaviors related to death. Part II has four multiple choice questions and one fill in question which are related to the person's life experiences. The instrument is self explanatory.

Individual responses on Part II were compared to the score on Part I. Time to complete the two part survey was estimated at 10 minutes.

Hopping's Death Attitude Indicator (1977) was originally a 50 item tool. It was reviewed by a panel of experts and judged to have content validity. The tool was pretested with an unspecified sample. As a result of the expert review, item analysis and pretesting, the instrument was altered and includes 24 items. Only items with a discrimination coefficient greater than .30 were retained and new items were developed. A test-retest reliability was calculated at $r = .64$, significant at the $p = .05$ level ($t = 2.101$) for Hopping's sample. No further reliability and validity assessments were reported.

The instrument has a five point graphic rating scale with equal appearing intervals so the respondent may indicate degrees of response. The scoring key accommodates for degree of response by treating the responses that fall between lines by adding 0.5 to the score. The scale is scored from four to zero, with four indicating the most

positive response. Two is considered a neutral response. Some items were reverse scored in a random pattern. For items 1, 2, 3, 4, 5, 6, 7, 12, 13, 14, 15, 17, and 22, the extreme left slash mark was equal to zero. The next slash mark was equal to 1. The middle slash mark was equal to 2. The next slash mark was equal to 3. The extreme right slash mark was equal to 4. For items 8, 9, 10, 11, 16, 18, 19, 20, 21, 23, and 24, the scoring was reversed with the extreme left slash mark equal to 4 and the extreme right slash mark equal to zero.

Death Anxiety Scale

Templer's Death Anxiety Scale was used to compare death anxiety of hospice nurses with that of nonhospice nurses (see Appendix C). This instrument is a 15 item questionnaire. The subject responds to each item by indicating whether the statement is true or false as applied to the subject. It is self explanatory. Scores range from zero to fifteen, with the higher score indicating greater death anxiety. The DAS is scored by tabulating the number of answers that agree with the scoring key. The statements which are keyed "true as applied to you" include: 1, 4, 8, 9, 10, 11, 12, 13, 14. The statements which are keyed "false as applied to you" include: 2, 3, 5, 6, 7, 15. Estimated time

to complete the tool was approximately 5-10 minutes.

Originally 40 items were devised in the construction of the instrument. Those items were rated on the basis of association with death anxiety by a clinical psychologist, two graduate students in clinical psychology and four chaplains. They were instructed to rate each item from one to five. The average rating was calculated and those items with a rating below 3.0 were discarded. Nine items were discarded.

Item analyses were computed to determine internal consistency. Those items with a point biserial coefficient significant at the .10 level in two out of three analyses were retained, leaving 15 items which make up the final instrument.

Test-retest reliability was computed on 31 subjects who agreed to complete the DAS again three weeks after the first administration. The Product-Moment Correlation coefficient of $r = .83$ was attained between the two sets of scores. Boyar's Fear of Death Scale (1964) was used to determine the validity of the Death Anxiety Scale. Boyar's Fear of Death Scale (1964) was the most adequate death anxiety instrument previously developed (Templer, 1970). A correlation between the Fear of Death Scale and the Death Anxiety Scale was reported as $r = .74$, significant at the .01 probability level.

Although validation of the Hopping tool is limited, and the uniqueness of Templer's tool to measure anxiety has not been fully substantiated, these two tools appeared to be the best available to assess attitude toward death and death anxiety. Templer's tool in particular was one of the only tools that was consistently utilized in other research studies.

Additionally, there was a subject information sheet designed for this study. Demographic data included the variables of race, marital status, sex, age, religious preference, religious beliefs, length of time at present position, length of time as a nurse, length of time in hospice, work setting, average age of clients he\she cares for, educational level and experience in death education. These variables were included because the literature on death and dying suggested these factors may have an effect on attitude toward death and death anxiety (see Appendix D).

Procedure

The research proposal was submitted to the Department of Nursing's Human Subjects' Rights Committee at the University of Nevada, Las Vegas (see Appendix F). Additionally, consent was obtained from the institutional internal review board of each of the three facilities.

After permission was obtained from the Human Subjects' Rights Committee and each institution involved, dates for upcoming nursing staff meetings were obtained from the respective supervisors and appointments to attend those meetings were made.

The researcher attended staff meetings at each facility, described the study and asked the nurses to complete the questionnaire. Thirty one nonhospice nurses were surveyed from two medical surgical units at a 445 bed acute care community hospital. The researcher attended six staff meetings to include all three shifts over a two day period.

The researcher also attended the monthly staff meeting at the county health district and at a private, non-profit, twenty bed hospice in Las Vegas. The study was described and the questionnaires were handed out by the researcher. Thirty eight hospice nurses were surveyed from the two institutions.

The researcher distributed the two instruments in random order to subjects to help account for effects of one instrument on responses to the other. Participants were asked to read the cover letter which explained the study (see Appendix A). Participants were then asked to complete

the questionnaires and the subject information sheet in their entirety and return them to the researcher upon completion. The researcher was present, in the same room at all agencies during the time the questionnaires were completed to answer any questions.

Participation was entirely voluntary. Subjects remained anonymous. No known risks were identified for either the agencies or the nurses who consented to participate. Return of the completed questionnaire was considered as consent to participate. Subjects were told that the results would be made available to those who requested them.

Analysis of Data

Frequency analyses were conducted to describe the sample. A Pearson Product-Moment Correlation coefficient was computed to compare the responses for the two instruments (Templer's Death Anxiety Scale and Hopping's Death Attitude Indicator). The computation of a Pearson Product-Moment Correlation coefficient was done to determine the relationship between death anxiety and death attitude for the two groups.

T-tests were computed to determine differences in death attitudes and death anxiety between the two groups of nurses. The t-test is the statistical method of choice to

compare hospice nurses' and nonhospice nurses' death anxiety and attitude toward death and dying because there is only one dichotomous independent variable, the work setting of the nurses. The two dependent variables death attitude and death anxiety, were analyzed separately with the independent variable.

After determining differences between the two groups of nurses with regard to attitude toward death and dying and death anxiety levels, it was important to identify any sample characteristics that may be related to attitude toward death and dying and death anxiety for the two groups of nurses. Initial descriptive analyses were performed to identify demographic variables which might be significantly related to the DAI scores and the DAS scores for each nurse group (hospice and nonhospice). The potentially significant variables were then examined for their relationship to the DAS and DAI scores for each group using Pearsons' Product-Moment Correlation and one-way analysis of variance (ANOVA). The Statistical Package for Social Sciences (SPSSX) program was used for analysis (SPSSX, 1983).

Chapter 3

Results

The Sample

The convenience sample of registered nurses (n = 69) was taken from three health care agencies in the Las Vegas area. Thirty one of the subjects were sampled from a 445 bed, acute care community hospital. These subjects represented the nonhospice group of nurses. Thirty eight subjects were sampled from a 20 bed private hospice and the county health district to represent the hospice group. The data collection occurred during May and June 1990. All subjects volunteered to participate.

Frequency distributions for variables such as race, marital status, nursing experience, time in current position and years in hospice are presented in Table 1. The hospice group ranged in age from 28 years to 60 years with a mean of 43.23 years and a median of 46 years. The nonhospice group ranged in age from 24 years to 66 years with a mean of 40.38 years and a median of 38 years. Both the hospice group and the nonhospice group had two male participants.

A large percentage of subjects from each group were caucasian, 14 (45.2%) subjects in the nonhospice group and 31 (81.6%) subjects in the hospice group. Only 2 (5.3%)

Table 1

Frequency Distributions for Hospice and Nonhospice Groups by Demographic Variables Race, Marital Status, Years of Nursing Experience, Time in Current Position (Hospice Group n = 38, Nonhospice Group n = 31)

Race	Hospice		Nonhospice	
	Frequency	Percent	Frequency	Percent
Caucasian	31	81.6	14	45.2
Black	2	5.3	0	0
Asian	0	0	6	19.4
Filipino	0	0	2	6.5
Other	5	13.2	9	29.0
Total	38	100.0	31	100.0

Marital Status	Hospice		Nonhospice	
	Frequency	Percent	Frequency	Percent
Single	3	7.9	1	3.2
Married	28	73.7	22	71.0
Divorced	5	13.2	5	16.1
Separated	0	0	1	3.2
Widowed	1	2.6	0	0
Living Together	1	2.6	2	6.5
Total	38	100.0	31	100.0

(Table continues)

(Table continues)

Education	Hospice		Nonhospice	
	Frequency	Percent	Frequency	Percent
AD	9	23.7	14	45.2
Diploma	11	28.9	4	12.9
AD other	1	2.6	0	0
BSN	11	28.9	9	29.0
BS	5	13.2	4	12.9
MSN	1	2.6	0	0
Total	38	100.0	3	100.0

Nursing Experience in Years	Hospice		Nonhospice	
	Frequency	Percent	Frequency	Percent
1 to 2	1	2.6	2	6.5
3 to 5	6	15.8	5	16.1
6 to 10	7	18.4	9	29.0
10+	24	63.2	15	48.4
Total	38	100.0	31	100.0

(Table continues)

(Table continues)

Time in Current Position in Years	Hospice		Nonhospice	
	Frequency	Percent	Frequency	Percent
1	8	21.1	5	16.1
1 to 2	13	34.2	1	3.2
3 to 5	7	18.4	8	25.8
6 to 10	6	15.8	11	35.5
10+	4	10.5	6	19.4
Total	38	100.0	31	100.0

subjects from the hospice group were black. Nine (29%) subjects from the nonhospice group chose the "other" category but did not indicate race and 6 (19.4%) reported they were of asian descent.

The majority of the subjects from both groups were married, 28 (73.7%) in the hospice group and 22 (71%) in the nonhospice group. Five (13.2%) subjects in the hospice group and 5 (16.1%) in the nonhospice group were divorced.

Educational background was varied. In the hospice group 11 (28.9%) indicated a Bachelors degree as the highest level of education, 11 (28.9%) had a diploma and 9 (23.7%) had an associate degree in nursing. In contrast, 14

(45.2%) subjects in the nonhospice group held an associate degree in nursing, 9 (29%) had a bachelor of science in nursing, 4 (12.9%) had a diploma and 4 (12.9%) indicated a bachelor's degree in another field. There was one (2.6%) subject who indicated a master of science in nursing in the hospice group.

Years of nursing experience ranged from one year to over ten years. Twenty four (63.2%) subjects in the hospice group reported over 10 years of nursing experience, 7 (18.4%) reported 6 to 10 years, and 1 (2.65) indicated 1 to 2 years of experience.

For the nonhospice group 15 (48.4%) reported nursing experience greater than 10 years, 9 (29%) reported 6 to 10 years, and 2 (6.5%) had only 1 to 2 years of nursing experience.

Time in current position was assessed. Nonhospice nurses' time at their current job ranged from 1 year to greater than 10 years. Eleven (35.5%) subjects reported 6 to 10 years, 8 (25.8%) reported 3 to 5 years, and 6 (19.4%) reported more than 10 years in their current position. For the hospice nurses, 13 (34.2%) had 1 to 2 years in their current position, 8 (21.1%) had 1 year, 6 (15.8%) had 6 to 10 years, and 4 (10.5%) remained at the same position for

Table 2

Frequency Distribution for Hospice Group (n = 38) by YearsExperience in Hospice

Hospice Experience in Years	Frequency	Percent
1	14	36.8
2	6	15.8
3	2	5.3
4	3	7.9
5	3	7.9
6	4	10.5
8	2	5.3
10	2	5.3
12	1	2.6
16	1	2.6
Total	38	100.0

greater than 10 years.

Previous experience in an area of frequent death and dying was also assessed. Twenty seven (71.1%) of the hospice nurses indicated experience in other areas where death occurs frequently. Only 14 (45.2%) of the nonhospice nurses reported experience in an area with frequent death

and dying. The areas most reported were the intensive care unit and nursing home facilities.

For the hospice group years of experience in the hospice field are outlined in Table 2. Hospice nurses' years of experience in the hospice field ranged from 1 to 16 years with 14 (36.8%) reporting only one year experience. The nonhospice group had no experience in hospice.

Frequency distributions for religious affiliation, belief in a supreme being and commitment to religious practice are presented in Table 3. The subjects in the hospice group were predominantly catholic or protestant. Twelve (31.6%) were catholic, 11 (28.9%) were protestant, 7 (18.4%) were mormon and 5 (13.2 %) indicated no religious affiliation. In the nonhospice group, 16 (51.6%) indicated they were catholic, 8 (25.8%) protestant and 4 (12.9%) reported no religious affiliation.

The majority of the sample did indicate belief in a supreme being. Thirty five (92.1%) subjects in the hospice group indicated belief in a supreme being, 2 (5.3%) were not sure, and 1 (2.6%) reported no belief. For the nonhospice group, 29 (93.5%) reported they believed, 1 (3.2%) was not sure, and 1 (3.2%) indicated no belief.

The majority of the subjects in both groups indicated a

Table 3

Frequency Distribution for Religious Affiliation, Belief in a Supreme Being and Commitment to Religious Practices for Hospice (n = 38) and Nonhospice Subjects (n = 31)

Religious Affiliation	Hospice		Nonhospice	
	Frequency	Percent	Frequency	Percent
Catholic	12	31.6	16	51.6
Protestant	11	28.9	8	25.8
Mormon	7	18.4	2	6.5
Christian Science	2	5.3	1	3.2
Jewish	1	2.6	0	0
None	5	13.2	4	12.9
Total	38	100.0	31	100.0

Belief in Supreme Being	Hospice		Nonhospice	
	Frequency	Percent	Frequency	Percent
None	1	2.6	1	3.2
Believe	35	92.1	29	93.5
Not Sure	2	5.3	1	3.2
Total	38	100.0	31	100.0

(Table continues)

(Table continues)

Religious Commitment	Hospice		Nonhospice	
	Frequency	Percent	Frequency	Percent
Strongly Committed	16	42.1	5	16.1
Committed	9	23.7	14	45.2
Somewhat Committed	8	21.1	5	16.1
Not Committed	3	7.9	2	6.5
Not Sure	2	5.3	5	16.1
Total	38	100.0	31	100.0

commitment or a strong commitment in their religious practices. When grouping the strongly committed with the committed, 65.8% of the hospice group and 61.3% of the nonhospice group reported commitment to religious practices. Only 3 (7.9%) subjects from the hospice group and 2 (6.5%) subjects from the nonhospice group indicated no religious commitment.

One hundred percent of the subjects from the hospice group had been with a dying person at or near the time of death. Twenty nine (93.5%) of the subjects from the nonhospice group reported being with a dying person at or

near the time of death.

Subjects were asked to select a category describing the dying person. For the nonhospice group, 15 (48.4%) reported the dying person was a patient, 12 (38.7%) indicated an immediate family member, 1 (3.2%) reported a relative, and 1 (3.2%) reported a close friend. For the hospice group, 26 (68.4%) reported the dying person was a patient, 11 (28.9%) indicated an immediate family member, and 1 (2.6%) reported a stranger.

All subjects in both the hospice and nonhospice groups had attended at least one funeral. Funeral attendance for the hospice group ranged from 1 to 99 with a mean of 24 and a median of 17.5 funerals. For the nonhospice group, funeral attendance ranged from 1 to 20 with a mean of 7.12 and a median of 5 funerals.

Client ages reported by the nonhospice nurses ranged from 6 to 64 years with a mean of 47.87 years and a median of 50 years. Client ages reported by the hospice group ranged from 35 to 70 years with a mean of 56.68 years and a median of 60 years.

Frequency distributions for hospice and nonhospice nurse scores on the Death Attitude Indicator (DAI) are presented in Table 4. The mean score for the hospice nurses on the DAI was 67.14 with a standard deviation of 5.51. The

Table 4

Frequency Distributions of Individual Scores Reported for
Hospice Subjects (n = 38) and Nonhospice Subjects (n = 31)
on the DAI

Hospice			Nonhospice		
Score	Frequency	Percent	Score	Frequency	Percent
56.00	1	2.6	48.00	1	3.2
58.00	1	2.6	50.00	1	3.2
60.00	2	5.3	53.00	1	3.2
60.50	2	5.3	55.00	2	6.5
62.00	1	2.6	56.00	1	3.2
64.50	1	2.6	56.50	1	3.2
65.00	1	2.6	57.00	1	3.2
65.50	2	5.3	57.50	1	3.2
66.50	1	2.6	58.00	2	6.5
67.00	5	13.2	58.50	2	6.5
67.50	1	2.6	59.00	1	3.2
68.00	4	10.5	60.00	1	3.2
68.50	1	2.6	62.00	2	6.5
69.00	2	5.3	63.00	1	3.2
69.50	2	5.3	64.00	2	6.5
70.00	2	5.3	64.50	1	3.2
72.00	2	5.3	66.00	1	3.2
72.50	1	2.6	67.00	1	3.2
73.00	3	7.9	68.00	2	6.5
74.00	3	7.9	68.50	1	3.2
			69.00	1	3.2
			71.00	2	6.5
Total	38	100.0	72.00	1	3.2
			73.50	1	3.2
			Total	31	100.0

mean = 67.14

mean = 61.72

S.D. = 5.51

S.D. = 6.61

Table 5

Frequency Distribution of Individual Subject Scores in the Hospice (n = 38) and Nonhospice (n = 31) Groups on the DAS

Score	Hospice Frequency	Percent
1.00	1	2.6
2.00	3	7.9
3.00	1	2.6
4.00	6	15.8
5.00	6	15.8
6.00	3	7.9
7.00	8	21.1
8.00	5	13.2
9.00	4	10.5
10.00	1	2.6
Total	38	100.0
mean = 5.89	S.D. = 2.27	

Score	Nonhospice Frequency	Percent
1.00	2	6.5
2.00	1	3.2
3.00	1	3.2
5.00	3	9.7
6.00	2	6.5
7.00	2	6.5
8.00	6	19.4
9.00	4	12.9
10.00	2	6.5
11.00	5	16.1
12.00	1	3.2
13.00	1	3.2
14.00	1	3.2
Total	31	100.0
mean = 7.93	S.D. = 3.31	

mean score for the nonhospice group on the DAI was 61.72 with a standard deviation of 6.61.

Frequency distributions for hospice and nonhospice nurses scores on the Death Anxiety Scale (DAS) are presented in Table 5. The mean score for the hospice group on the DAS was 5.89 with a standard deviation of 2.27. The mean score for the nonhospice group on the DAS was 7.93 with a standard deviation of 3.31.

Research Questions

1. Do hospice nurses and nonhospice nurses differ in attitude toward death and dying?

The mean score on the DAI for the Hospice group was compared with the mean score for the nonhospice group using the Student t-test. The results were significant at the $p = .05$ level ($t = -3.71$, $p = .000$) (see Table 6).

2. Do hospice nurses and nonhospice nurses differ in level of death anxiety?

The mean score on the DAS for the hospice group was compared with the mean score for the nonhospice group using the Student t-test. The results were significant at the $p = .05$ level ($t = 3.02$, $p = .004$) (see Table 7).

3. What characteristics of hospice and nonhospice nurses are related to attitude toward death and dying?

Table 6

T-test for Comparing Hospice Group and Nonhospice Group on
the DAI

Group	n	x	S.D.	D.F.	T Value	2 Tailed Probability
Hospice	38	67.144	5.512			
				67	-3.71	.000
Non Hospice	31	61.7258	6.612			

Initial descriptive analyses were performed to identify demographic variables which might be significantly related to the DAI scores for each nurse group (hospice and nonhospice). These potentially significant variables were then examined for their relationship to the DAI scores for each group using Pearsons' Product-Moment correlation and one-way analysis of variance (ANOVA).

The DAI scores for the hospice subjects were compared with number of funerals attended, age, patient age, and years in hospice for the hospice group using the Pearson Product Moment Correlation. No significant correlations were found.

Pearson Product Moment Correlation coefficients for DAI

Table 7

T-test for Comparing Hospice Group and Nonhospice
Group Scores on the DAS

Group	n	x	S.D.	D.F.	T Value	2 Tailed Probability
Hospice	38	5.894	2.275			
				67	3.02	.004
Non hospice	31	7.935	3.316			

Table 8

Pearsons' Product Moment Correlations for DAS Scores with
Number of Funerals Attended for the Nonhospice Group
(n = 31)

	x	S.D.	r	p
Number of Funerals	7.125	5.142	.4314	.008

scores with how many funerals attended and age for the nonhospice group showed a significant correlation between attitude and how many funerals were attended ($r = .4314$, $p = .008$) (see Table 8).

Using analysis of variance the DAI scores for the hospice subjects were compared to the variables of time in current position, experience in an environment with frequent death and dying, category of the dying person, and religion for the hospice group. The group ($n = 27$) that reported experience in an environment with frequent death and dying scored higher on the DAI. This characteristic was found to significantly affect attitude ($F = 4.781, p = .0354$) for the hospice group who had experience with frequent death (see Table 9).

The DAI scores for the nonhospice group were compared with previous experience with death and dying using the one way analysis of variance. Those subjects who reported experience with frequent death and dying ($n = 14$) scored higher than those who had not had that experience in the nonhospice group. This characteristic was significantly related to attitude toward death and dying for the nonhospice group ($F = 6.841, p = .0140$) (see Table 10).

4. What characteristics of hospice and nonhospice nurses are related to level of death anxiety?

Potentially significant variables were also examined for their relationship to the DAS scores for each group using Pearsons' Product Moment Correlation and one-way ANOVA. Pearson Product Moment Correlation coefficients of

Table 9

One-Way ANOVA for DAI Scores and Experience in an
Environment with Frequent Death for the Hospice
Group (n = 38)

Dying Experience	n	x	S.D.	F ratio	F probability
Yes	27	68.333	3.733	4.7812	.0354
No	11	64.227	7.935		

Table 10

One-Way ANOVA for DAI Scores and Experience with Frequent
Death for Nonhospice Group (n = 31)

Experience with Frequent Death	n	x	S.D.	F ratio	F probability
Yes	14	64.857	5.901	6.8414	.0140
No	17	59.147	6.166		

Table 11

One-Way ANOVA for DAS Scores and the Category of the Dying Person for the Nonhospice Group (n = 31)

Category of Dying Person	n	x	S.D.	F Ratio	F Probability
Immediate Family	12	6.166	3.663	9.3565	.0052
Patient	15	9.733	2.374		

DAS scores with how many funerals attended, age, years in hospice and patient age for the hospice and nonhospice groups showed no significant correlations.

One-way ANOVA for DAS scores and the category of the dying person, religion, and time in current position for the hospice group showed no significant correlation.

One-way ANOVA for DAS scores and category of the dying person, nurses' race, years of experience in nursing, and level of education for the nonhospice group showed that category of the dying individual was significant for the category of immediate family member and the category of patient ($F = 9.356$, $p = .0052$). The category of other relative and the category of friend were deleted as they each had only one subject (see Table 11).

5). What is th relationship between death anxiety and

attitude toward death and dying for hospice and nonhospice nurses?

Pearsons' Product Moment correlations were used to determine the relationship between the DAI and DAS scores for the hospice and nonhospice nurse groups. No significant relationship was found in either the hospice ($r = .0142$, $p = .466$) or nonhospice group ($r = .1688$, $p = .182$) between the DAI and DAS.

Reliability

Due to the deletion of one of the items on the DAI and the previous low reliability reports for the DAI, a Cronbach alpha internal consistency reliability assessment was computed for the combined hospice and nonhospice groups ($n = 69$). Results indicated $r = .67$ for the DAI. The DAS was also assessed for internal consistency reliability using Cronbach Alpha for the combined groups. The Cronbach Alpha for internal consistency reliability was $r = .71$.

Chapter 4

Discussion, Conclusions and Implications

The purpose of this descriptive survey was to assess nurses' attitudes and anxiety associated with death and dying and examine related characteristics. The sample characteristics, findings related to each research question and the assessments of the instruments used for the survey are discussed.

Statistical analyses were selected depending on the nature of the variables under investigation. Frequency distributions, correlations and one-way analysis of variance were chosen to interpret the data. Pearson's Product Moment correlation was used to compare continuous variables. The Student t-test was chosen to compare differences between the two nursing groups for death anxiety and attitude toward death. Analysis of variance was chosen for certain variables because of its ability to compare differences between and among groups for categorical variables.

The Sample

The descriptive survey was conducted with a total sample of 69 registered nurses in the southern Nevada area (31 nonhospice and 38 hospice nurses). The sample was a convenience sample.

The method of data collection, as well as the groups of nurses chosen to participate may have influenced the results obtained. Because of the limited number of available hospice nurses, the sample was obtained from both a 20 bed hospice and the county health district. This limited sampling may have skewed the results because the role of the nurses at the county health district includes both hospice care and traditional nursing care. The subjects at the county health district were involved in both types of care and have a variety of both types of clients. Attitude toward death and dying and death anxiety may possibly have been affected by this overlap of experiences in the hospice group.

The nonhospice nurses were sampled from two medical surgical units at a 450 bed acute care community hospital. The units sampled were chosen by the director of staff development because of the low incidence of death and dying on these units. Thirty seven nurses were originally sampled. Six subjects were not included in the final survey. Two subjects were excluded because they were licensed practical nurses. Two subjects had received their baccalaureate degree in another country and were not yet recognized in the United States as registered nurses. Finally, two subjects had extensive experience in hospice and/or oncology.

Frequency data for the sample was presented in the previous chapter. The subjects from each group were predominantly female, caucasian, and either Catholic or Protestant. Only two males participated in each group. The majority of the nurses were married. The ages ranged from 24 years to 66 years. Demographically the subjects in each group were very similar to one another.

Research Questions

- 1) Do hospice nurses and nonhospice nurses differ in their attitudes toward death and dying?

Scores on the DAI did show a significant difference between hospice nurses and nonhospice nurses in attitude toward death and dying. The hospice nurses scored higher ($\bar{x} = 67.14$) than the nonhospice nurses ($\bar{x} = 61.72$, $p = .000$) indicating a more positive attitude toward death and dying for the hospice group. This difference between hospice and nonhospice nurses in attitude toward death and dying has previously been reported. It is believed that this difference is due in part to the different philosophies in patient care between the two groups and because of the amount of exposure to death and dying.

The findings of this study are supported by Glaser and Strauss (1965) who proposed that different nursing units are

characterized by different task structures. Because of the different task structures, each area has its own philosophy in working with the dying. This philosophy creates an emotional climate which encourages a particular reaction to death. This may help explain why hospice nurses would have a more positive attitude toward death and dying, as the focus of hospice is more on care rather than on cure.

The difference in attitude found in this study also agrees with the findings of Gow and Williams (1977). However, this difference in attitude toward death and dying between chronic care, acute care and community health nurses was attributed to age. They found the chronic care nurses had a more positive attitude toward death and dying but this was not related to the agency in which they worked. The nurses who worked in chronic care settings were older than the nurses from the other samples and it appeared that age rather than area in which the nurses worked was the influencing characteristic in their attitude toward death and dying.

The hospice group sampled for this study was also somewhat older ($\bar{x} = 43.23$) than the nonhospice group ($\bar{x} = 40.38$). However, no significant relationship between age and attitude was found.

- 2) Do hospice and nonhospice nurses differ in their level of death anxiety?

Hospice nurses were found in this sample to have significantly less death anxiety than the nonhospice group. The hospice nurses' mean score on the DAS was 5.894 as compared to the nonhospice nurses' mean score of 7.935. The lower score for the hospice nurses indicated a lower level of death anxiety.

Again this may be due to the different philosophies between the two groups of nurses. It may also be related to amount of exposure to death and dying. Finally, it may also be related to familiarity with the DAS or could be a result of the respondents answering the way they felt they were supposed to respond.

The inconsistencies in the literature make it difficult to draw conclusions regarding differences in level of death anxiety. Based on the present findings a difference does appear to exist for this sample.

3) What characteristics of hospice and nonhospice nurses are related to attitude toward death and dying?

The potential variables identified for the hospice group after the initial descriptive analyses were performed were age, patient age, years in hospice, how many funerals attended, time in current position, and experience in an environment with frequent death and dying. Using either

Pearson's Product Moment correlation, the Student t-test or one-way analysis of variance, depending on the variable being assessed, only one characteristic was found to be significantly related to DAI scores for the hospice group. Frequent experience with death and dying was significantly related to DAI scores ($F = 4.781, p = .0354$) for the hospice group.

The research findings of Popoff and Funkhouser (1975) agree with this finding. They stated that nurses who infrequently dealt with death were more likely to feel discouraged and depressed when they did encounter it. While the literature did not address professional exposure to death and dying, the findings of the present study support the notion that frequently exposing oneself to death and dying would have some effect on developing a more positive attitude.

The variable of age did not seem to have an effect on attitude toward death and dying for this study ($r = .0257, p = .439$). Gow and Williams (1977) found that nurses 40 years of age and older had a more positive attitude toward death and dying. It is uncertain why age was not related to attitude toward death and dying for this group. It may have been due to small sample size. Along with nurses' age, clients' age was assessed and no relationship was found with attitude toward death and dying ($r = .1423, p = .197$). This

may be related to the fact that the sample did not usually care for pediatric clients. As suggested by Popoff and Funkhouser (1975) nurses generally have more difficulty caring for the dying pediatric client than they do adults.

Years of experience in hospice was not significantly related to attitude toward death and dying ($r = .1124$, $p = .251$). Literature to support or negate this finding is not available. It is uncertain why this was not related to attitude toward death and dying.

Time in current position for the hospice group was also not related to attitude toward death and dying. But, upon examination of scores of those nurses with one to two years of experience ($\bar{x} = 65.642$) with those with at least three to five years of experience ($\bar{x} = 70.714$), the nurses who had been in the position for three to five years had a higher or more positive score on the DAI. Although not statistically significant, the nurses with greater than six years experience also had a higher score on the DAI ($\bar{x} = 67.800$) than the nurses with one to two years in his\her current position but had a lower score than the nurses with three to five years. This may be due to the small sample size. It would be interesting to repeat this assessment with a larger more evenly dispersed sample group.

For the nonhospice group, the variables of age,

how many funerals attended and frequent experience with death and dying were compared to attitude toward death and dying. The Pearson's Product Moment Correlation, Student t-test and one-way analysis of variance were again used depending upon the variable being assessed. Two variables were significantly related to DAI scores for the nonhospice group.

A significant correlation was found between how many funerals nonhospice nurses attended and DAI scores ($r = .4314$, $p = .008$). A one-way analysis of variance comparing attitude toward death and dying with frequent experience with death and dying was also significant ($F = 6.841$, $p = .014$). These variables were not specifically identified in the literature as having an effect on attitude toward death and dying. Personal, professional and academic exposure to death and dying were variables reported in the literature to have an effect on attitude toward death and dying. Number of funerals attended may be viewed as personal exposure and experience in an environment where there is frequent death and dying may be viewed as professional exposure.

Both the number of funerals attended and experience in an area where there is frequent death and dying are variables which increase exposure to death and dying for

the nonhospice nurses, either personally or professionally. The nurses who indicated they had attended more funerals and those who reported working in areas previously where there was frequent death and dying had higher DAI scores. The facilities where the nurses identified having experienced frequent death and dying were nursing homes and intensive care units.

As with the hospice group, exposure to death and dying seemed to positively effect the attitudes expressed for the nonhospice group. For nonhospice nurses, funerals and previous experience working in an area with death and dying may have been their only exposure to death. It seems reasonable that those nurses who reported these experiences would have higher scores on the DAI than those nurses who had never had any exposure or had minimal exposure to death and dying.

Similar to the hospice group, age was not significantly correlated with DAI scores for the nonhospice group ($r = -.050$, $p = .395$).

- 4) What characteristics of hospice and nonhospice nurses are related to level of death anxiety?

For the hospice group of nurses, the variables age years in hospice, patient age, how many funerals attended, religion, time in current position, and category in which

the dying person fit were examined to determine the relationship with DAS scores. No significant relationship was found for any of the variables with DAS scores. Some of these findings differ from those of previous studies. These differences may be attributed to sample size or the instrument used to measure anxiety. The hospice group was older than the nonhospice nurse group but this finding was not significantly related to death anxiety as measured by the DAS.

For the variables of years in hospice, time in current position, category in which the dying person fit, and how many funerals attended, no research was found to support or negate the present findings as they relate to death anxiety. For hospice nurses these variables may not have an effect because their exposure to death and dying and death anxiety is much more frequent.

As discussed in Chapter 1, numerous studies included religion as a variable which may be influential in level of death anxiety. These studies consistently found that those subjects who had a strong religious commitment also had a lower level of death anxiety. This finding may not have been significant due to the nature of the questions regarding religion and religiosity. A better instrument should try to address spirituality to assess for a relationship with death

anxiety.

A larger sample may have allowed for more variation with regard to the variables examined. Although, not statistically significant the nurses with greater than six years of experience ($\bar{x} = 5.600$) had a lower mean score on the DAS than the nurses with three to five years ($\bar{x} = 5.714$) experience and the nurses with one to two years experience ($\bar{x} = 6.095$).

The category of the dying person was examined for it's relationship to death anxiety. Although no significant relationship was found, it is interesting that those respondents who indicated the person was from their immediate family ($\bar{x} = 5.090$), as opposed to a stranger ($\bar{x} = 6.000$) or a patient ($\bar{x} = 6.230$), had lower scores on the DAS indicating a lower level of death anxiety. This may be explained again by the small sample size. One might also consider the effects of whether or not the subject expected the death as a possible explanation of differences in scores on the DAS. This factor was not investigated in this study but has been mentioned as a possible variable influencing individuals attitudes, anxiety and responses to death and dying (Lubkin, 1986, p. 34).

For nonhospice nurses the variables how many funerals attended, age, category in which the dying person fit,

years of experience in nursing, nurses' race and level of education were examined. A significant relationship was found for category of the dying individual. The subjects who responded that the individual was a member of his\her immediate family ($\bar{x} = 6.166$) had a lower score on the DAS than those who had been with a patient ($\bar{x} = 9.733$). This was also true of the hospice group as previously discussed. It is uncertain as to why subjects had a lower level of death anxiety associated with the death of an immediate family member. With the nonhospice group it may be due to the identified role of the nurse to cure the patient. Again expectancy of the death and whether or not the death was a lingering and\or painful death may also contribute to level of death anxiety (Lubkin, 1986, p.34).

Although race was not found to be significant for the nonhospice group between caucasian and asian group, the scores did indicate higher anxiety scores for the asian group ($\bar{x} = 10.833$). The caucasian group ($\bar{x} = 7.935$) and the group that responded "other" ($\bar{x} = 7.222$) did not differ significantly in mean scores on DAS. Those who responded "other" did not specify race.

A Pearson Product Moment Correlation was computed to compare number of funerals and age with death anxiety. Although both variables had a negative correlation with

anxiety, indicating that as age or number of funerals attended increased anxiety level would decrease, this finding was not significant at the .05 level. The variable number of funerals attended had a bimodal distribution, which statistically affects the correlation analysis. A larger sample size may have produced more of a normal distribution for this variable.

Age was negatively correlated with death anxiety ($r = -.2506$, $p = .087$). Although not statistically significant, this finding is supported by Coolbeth and Sullivan (1986) who found that nurses 40 years of age and older had less death anxiety than younger nurses.

Years of nursing experience for nonhospice nurses were combined for a one-way analysis of variance. The categories of one to two years and three to five years were combined ($\bar{x} = 8.142$). These categories were combined because of the low number of subjects in the separate categories. The subjects with six to ten years of nursing experience ($\bar{x} = 6.333$) had a lower score than both the group with one to five years of experience ($\bar{x} = 8.142$) and the group of nonhospice nurses with more than ten years of nursing experience ($\bar{x} = 8.800$). The small sample size may have influenced this finding.

Finally, level of education was examined for the

nonhospice group. Interestingly, diploma nurses had the lowest mean score on the DAS ($\bar{x} = 6.500$). The associate degree nurses had the next lowest score ($\bar{x} = 7.714$) on the DAS. Nurses who had a BSN ($\bar{x} = 8.777$) or a bachelor's degree in another field ($\bar{x} = 8.250$) had the highest mean score. Due to the small number of subjects in each category, groups were combined to compute a one-way analysis of variance. Diploma nurses were grouped with associate degree nurses for a total of 18 nurses ($\bar{x} = 7.444$). BSN's were grouped with those nurses' who indicated a baccalaureate degree in another field ($\bar{x} = 8.615$). The difference was not statistically significant. The findings of this study do not agree with the findings of Lester, Getty and Kneisel (1974). In their study they compared fear of death with level of education and clinical specialization. They found that fear of death and dying decreased with increased education. Clinical specialization had no effect. It can be speculated that the diploma and associate degree nurses may have been providing nursing care longer than their associates with bachelor's degrees. If this is true, that may explain the slight difference in mean scores on DAS. Another reason for the lack of relationship between education and death anxiety may be the way in which education is measured. The content of nursing programs differ

and this may be why no relationship between education and death anxiety was found.

- 5) What is the relationship between death anxiety and attitude toward death and dying for hospice and nonhospice nurses?

No significant relationship was found between the DAI and DAS scores in either the hospice ($r = .0142$, $p = .466$) or nonhospice group ($r = .1688$, $p = .182$). This finding supports the discussion presented in Chapter 1 that death anxiety and attitude toward death and dying are two different concepts.

Gow and Williams (1977) examined the relationship between attitudes and anxiety. They described anxiety as being a more generalized state while attitude was more related to social objects. They treated anxiety as an intervening variable with attitude and conducted an analysis of covariance. No interaction effects were found.

In this study, the scales appear to be measuring different variables. Due to the questionable reliability and validity of both tools it is hard to make inferences regarding this finding. No other studies have compared these two tools.

DAI Reliability

Reliability and validity of the Death Attitude Indicator (DAI) is questioned for these subjects. The

Cronbach Alpha assessment for internal consistency was $r = .6725$ for this sample. This is a low reliability for an attitude scale. It is recommended that the internal consistency reliability be at least $r = .80$ (Polit and Hungler, 1983). Cronbach alpha for internal consistency assessment was not reported in the study by Hopping (1977).

For the purpose of this study, one of the items was deleted from the original DAI tool. The question, "If you had to choose a friend from the following, which group would you choose?" was deleted because of the prejudicial nature of the responses. The subject would have been asked to choose between "a jew, a black, and a mexican american or a cancer victim, a terminal child and a terminal elder". This investigator questioned how this particular item measured attitude toward death and dying and felt it to be prejudicial. Therefore, the item was deleted from the original instrument.

Several items on this scale may contribute to the low reliability. Three of the items (3, 5, and 8) if deleted would have raised the Cronbach alpha from between $r = .6758$ to $r = .6953$ for each item. All three of these questions had a negative correlation with the other items on the death attitude scale.

Because the internal consistency of the tool is in

question, the validity of the tool is suspect. These results indicate that the instrument may be measuring other concepts such as cultural and societal influences and/or general attitudes.

During the data collection, the investigator received comments from subjects regarding the DAI. Some nurses stated the rating response choices were prejudicial with regards to death and dying. For example, in question #2 "How do you see death?", the response choices ranged from never appropriate to a natural end of life. Other nurses stated they were not sure how they felt about death and did not know how to answer the questions. One additional comment was made regarding number of funerals attended. The nurse did not feel she could estimate the number of funerals attended because she had been to so many. Furthermore, the nurse did not understand what significance the number of funerals attended had on attitude toward death and dying.

The DAI should be used with caution due to the low reliability assessment, the comments offered by the subjects regarding the nature of the questions and also the scaling method used for responses. Although the tool was explained and directions were also written at the top of each questionnaire, most participants did not mark his/her response on the vertical lines evenly spaced across the

continuum. Most marked the response somewhere in between each vertical line. Although scoring procedures were given for those responses marked between the vertical lines this made the instrument difficult to score and interpret. It is unsure as to whether the respondents fully intended to mark their responses between the vertical lines or whether they did not listen, read or understand the directions. Only three respondents from the total sample marked his\her choice on the vertical lines on the continuum. It thus appears that subjects are confused about how to mark responses which would contribute to low reliability.

Reliability of DAS

Reliability and validity of the Death Anxiety Scale (DAS) is also questioned. The Cronbach alpha assessment for internal consistency was $r = .7114$ for this sample. This reliability assessment was lower than the $r = .76$ reported by Templer (1970).

Another study also reported a lower Cronbach alpha than Templer (1970). In a study by Warren and Chopra (1978-1979) 244 undergraduates and 64 helping professional were sampled to study the applicability of the DAS in other cultures. For this sample a Cronbach Alpha of $r = .65$ was identified.

With the considerable differences in reported internal

consistency assessments it is questionable if the tool is a reliable and valid measure of death anxiety for this group of subjects.

During data collection, many nurses expressed confusion regarding how they were to respond to the items.

They questioned if their response should have been from a personal or professional perspective. Two particular items in question were, "The thought of death seldom enters my mind" and "The thought of death never bothers me".

The respondents challenged these items because a nurse may think about death at work but not at home.

Another item challenged by many nurses was, "I dread to think about having an operation". This item was contested because most nurses felt his\her response would depend on the type of operation and if it were imminent. Although the DAS is the most commonly and frequently used death anxiety assessment scale, it appears that further validation is needed.

Findings Related to the Conceptual Framework

As discussed in Chapter 1, the nurse is considered a contextual stimulus because he\she usually has immediate contact with the dying client. The nurse has the ability to be a stimuli regulator, who is comfortable and experienced

with death and helps the dying individual adapt to death and the dying process. He\she may also be a stimuli nonregulator or someone who is inexperienced, ill equipped, fearful of death, and prevents or inhibits the dying individual's ability to adapt to life closure or death.

In order to assess contextual stimuli which may affect a dying clients' adaptation, the nurse and his\her residual stimuli must be examined. Residual stimuli were identified by Roy (1984) as stimuli not readily seen or validated but affect the behavior of the nurse and\or the dying client (i.e. attitudes, anxiety, beliefs and coping abilities).

For this study, the residual stimuli, attitude toward death and dying and level of death anxiety of hospice and nonhospice nurses was assessed. These stimuli were assessed to see if there was a difference between hospice and nonhospice nurses. The study findings showed that the sample of hospice nurses differed from the sample of nonhospice nurses in level of death anxiety with hospice nurses experiencing less death anxiety.

When measuring attitude toward death and dying of hospice and nonhospice nurses, the sample of hospice nurses again differed from the sample of nonhospice nurses. The hospice nurses for this sample scored higher on the DAI

indicating a more positive attitude toward death and dying. Based on these findings it would appear the hospice nurses would be more likely to function as stimuli regulators.

To further examine the nurse and possible reasons for the attitudes and level of death anxiety expressed, other residual stimuli were also assessed. Roy (1984) advocated that education and exposure to death and dying are stimuli which assist the nurse in adaptation of attitude toward death and dying, level of death anxiety and the dying process.

Unfortunately, the results for this sample of nurses did not confirm that education had any effect on attitude toward death and dying or level of death anxiety for either the hospice or the nonhospice group. It may be that other qualities of education rather than number of years of education may be related to attitude toward death and dying or death anxiety. This finding does not support the theory of Roy (1984) or Kubler-Ross with regard to education.

The potential stimuli assessed to examine the effect of exposure to death and dying on attitude toward death and dying and death anxiety included, how many funerals attended, time in current position, length of time as a nurse, length of time in hospice, prior experience in an area with frequent death and dying, whether the respondent

had been with a dying person and if so, whom (i.e. patient, relative or stranger). Exposure to death, in this sample did seem to have an some effect on attitude toward death and dying. Although not significant, the nonhospice nurses who had attended more funerals tended to score higher on the DAI indicating a more positive attitude. Those nonhospice nurses who had reported working previously in an area with frequent death and dying (i.e. intensive care unit or nursing home) also had a significantly higher score on the DAI ($\bar{x} = 64.857$) than those nonhospice nurses who had not had such experience ($\bar{x} = 59.147$). Experience in an area with frequent death and dying was also significant in promoting a more positive attitude for the hospice group. These findings agree with Roy (1984) and Kubler-Ross (1969) and suggest exposure does have a positive effect on attitude toward death and dying.

The residual stimuli of education and exposure to death and dying were also examined for any relationship to level of death anxiety. Education did not have a significant effect on level of death anxiety for either group sampled. For the nonhospice group, personal exposure seemed to have the greatest effect on level of death anxiety. Those who had experienced the death of a relative ($\bar{x} = 6.166$) scored significantly lower on the DAS

indicating a lower level of death anxiety than the nonhospice nurses who had only experienced the death of a patient ($\bar{x} = 9.733$). This may be due to the ideal traditional role of the nurse in the acute care setting which is to cure the patient. When the nurse in this type of setting can not cure the patient, it may lead to an increased level of death anxiety (Germain, 1980).

Other residual stimuli were also assessed because they were cited in previous research studies. These stimuli included, the nurses' age, the client age, race, marital status, sex, religious affiliation, religious belief, and religious practices. None of these stimuli were mentioned by Roy (1984) as being either positive or negative stimuli affecting attitude toward death and dying or level of death anxiety. Interestingly, none of these stimuli was significantly related to attitude toward death and dying or death anxiety for either group of nurses in this study.

Finally, death anxiety and attitude toward death and dying, both of which are considered residual stimuli, were assessed for any relationship between the two stimuli. According to Roy (1984), the fear of death or death anxiety affects attitude and the ability of the nurse to positively adapt to death and dying. Although the findings in both

groups were not statistically significant, the nonhospice group scores on the DAI were negatively correlated ($r = -.1688$, $p = .182$) suggesting that with a lower level of death anxiety the nurse would also have a more positive attitude toward death and dying. This finding does agree with Roy's framework. This negative correlation was not found for the hospice group ($r = .0142$, $p = .466$).

Gow and Williams (1977) found no relationship between attitudes expressed and level of death anxiety. Since Folta (1965) defined anxiety as an "expression of diffuse apprehension" in which the object of that apprehension is not clearly understood, it is not surprising that a significant relationship between the two concepts was not found.

Further research is recommended to examine the relationship between attitude toward death and dying and death anxiety. It appears that more valid tools to measure each of these concepts need to be developed.

In summary, using Roy's adaptation model combined with Kubler-Ross' theory on death and dying, the nurse was viewed as a contextual stimulus, and was assessed for the contextual and residual stimuli which may affect his\her behavior when caring for a dying individual. According to the Roy (1984) model, all of these stimuli have the

potential for affecting adaptation not only for the nurse but for the dying client as well. The study did support the combined Roy (1984) and Kubler-Ross (1969) framework suggesting that exposure to death and dying does have an effect on attitude toward death and dying and level of death anxiety. The effect of these stimuli on behavior or care of the dying client was not measured in this study.

Education and the other potential stimuli were not found to be related to attitude toward death and dying and death anxiety in this study. Further investigation of these stimuli will need to be done before they can be recognized as contextual stimuli affecting the nurse and possibly the client.

Limitations of the Study

There were several limitations to this study. The first, was the lack of valid and reliable measurement for death anxiety and attitude toward death and dying. Although there is a large amount of literature in the area of death and dying, there are no valid instruments which have been developed to measure attitude toward death and dying. Another limitation was the inability to manipulate the independent variables of membership to the hospice or nonhospice group. Due to the geographic area and small

number of nurses available to represent the study population, a convenience sample of all registered nurses in the hospice group were asked to participate. Membership in each group was predetermined prior to sampling by each individual nurse. The inability to obtain a random sample of nurses threatens the internal validity of the study because of lack of control of confounding variables. This also limits generalizability.

Finally, the literature identified many characteristics which may have an effect on attitude toward death and dying such as the nurses' age, patient age, education, religious belief, religious affiliation, religious commitment, years of experience as a nurse, death education, practice setting, and exposure to death. These factors are not amenable to manipulation or control, but certainly influence attitude at various levels.

Implications for Nursing

With the aging of America and the increase in chronic and terminal care, the nursing profession needs to come to grips with caring for the dying client. Most nurses feel inadequate, helpless and ill equipped to care for dying clients. Efforts need to be made to help the nurse adapt to death and dying.

This study suggested exposure to death and dying had a positive effect on both level of death anxiety and attitude toward death and dying. This may be important for the nurse to consider before taking a position in an area working with terminal clients. This finding may also be important for the nurse manager in hiring personnel to work with the dying. Further study needs to be implemented on nurses' attitudes, level of death anxiety and potential stimuli responsible for the attitudes and anxiety levels.

Recommendations

Reliable and valid tools to measure attitude toward death and dying and death anxiety need to be developed and utilized. Replication of this study using a larger sample and a more diverse population as well as random sampling is needed. The hospice sample should consist of nurses only working in that area rather than a sample of nurses who do both hospice and acute care.

Further research is recommended to determine what characteristics contributed to the differences in attitude toward death and dying and level of death anxiety. Replication studies of the characteristics that appear to be correlated with attitude toward death and dying and level of

death anxiety may provide useful information that may be beneficial for better staffing in areas where death frequently occurs.

The use of Roy's adaptation model and Kubler-Ross' theory on death and dying in future studies is needed to substantiate the validity of these conceptual frameworks as they apply to nursing care.

APPENDIX A
COVER LETTER AND CONSENT

Appendix A

Dear Nurse,

I am a Master's student in the Department of Nursing at the University of Nevada, Las Vegas and I am conducting a survey of nurses' feelings toward death and dying and what factors may influence those feelings. Identification of those factors may be of assistance in better preparing nurses to care for dying clients and ultimately improve the quality of care.

Attached you will find two questionnaires, labeled A and B and a subject information sheet labeled C. Numbers appearing on the lower right hand corner of the questionnaires and the information sheet are only for the purpose of keeping all the information together on each participant.

The questionnaires are completely anonymous and participation is voluntary. There are no known risks involved. The two questionnaires and the subject information sheet take a total of approximately 15-20 minutes to complete. Please check carefully to make sure you have answered all the questions.

Since response to the survey is voluntary, completion and return of the forms is considered your consent to participate. If you have any problems or questions completing the survey, please ask the researcher prior to returning the questionnaire.

Findings will be available to the participants at the conclusion of the research project if requested. If you are interested please contact me at the address or phone number below.

Thank you for your time and cooperation.

Sincerely,

Debra Panko Harber, RN, BSN
613 Mayfield Street
Las Vegas, NV 89107
(702) 877-9052

APPENDIX B
DEATH ATTITUDE INDICATOR

Appendix B

Part I

INSTRUCTIONS: Please place an x on the line following each question at the slash mark which best indicates where along the continuum your opinion, feeling or belief lies. There are no right and wrong answers. Your current opinions, feelings and beliefs are being sought. Please make sure you answer every question, unless instructed not to do so.

1. What does death represent to you?

/_____/_____/_____/_____/

Immobility and loss of control	A change in the state of existence
--------------------------------------	---

2. How do you see death?

/_____/_____/_____/_____/

Never appropriate	Natural end of life
----------------------	---------------------------

3. How do you believe your own death will occur?

/_____/_____/_____/_____/

Accident	Old age
----------	---------

4. Do you have a personal philosophy which includes clear conceptions about both life and death?

/_____/_____/_____/_____/

No	Yes
----	-----

5. Do you believe there is a higher power of some kind (i.e. God) functioning in the universe?

/_____/_____/_____/_____/

No	Yes
----	-----

From Instruments for use in Nursing Education Research (139-142) by B. L. Hopping, 1979, Boulder, CO: Western Interstate Commission for Higher Education. Copyright 1977 by the American Journal of Nursing. Reprinted by permission.

6. Should children be allowed to visit and/or be with a dying person?

/ _____ / _____ / _____ / _____ /
 No Yes

7. Should children attend funerals?

/ _____ / _____ / _____ / _____ /
 No Yes

8. When speaking about a person who has died, what term do you usually use?

/ _____ / _____ / _____ / _____ /	
Died or dead	Other, i.e., passed away, deceased, expired, etc.

9. Do you believe emotions should be

/ _____ / _____ / _____ / _____ /
 Expressed? Controlled?

10. How often do you talk about death with others?

/ _____ / _____ / _____ / _____ /
 Frequently Never

11. Would you introduce the topic of death into a social conversation?

/ _____ / _____ / _____ / _____ /
 No Yes

12. Do you believe a dying person wants to talk about his approaching death?

/ _____ / _____ / _____ / _____ /
 No Yes

13. Do you believe it is ever justified to label a person as dying, or terminal?

No / _____ / _____ / _____ / _____ / Yes

14. Would you volunteer to be with a dying patient?

No / _____ / _____ / _____ / _____ / Yes

15. If assigned to a dying patient, what would you most want to know?

/ _____ / _____ / _____ / _____ /	/ _____ /
How he felt about his dying status	His care plan, medications, and treatments

16. To counteract your anxiety while caring for a dying patient, what would you most likely do?

/ _____ / _____ / _____ / _____ /	/ _____ /
Care for him as quickly as as possible and leave	Use my physical presence and touch to signify my concern for him

17. Would you avoid being with a dying patient if it could be arranged without a lot of fuss?

No / _____ / _____ / _____ / _____ / Yes

18. What efforts should be made to keep an imminently terminal patient alive?

None / _____ / _____ / _____ / _____ / All
possible

19. If you have been with a dying person at or near the time of his death, how did you feel at the time?

/ _____ / _____ / _____ / _____ /
Empathetic Immobilized

20. If you have not been with a dying person at or near the time of his death, how do you think you might feel?

/_____/_____/_____/_____/_____/_____/

Empathetic Immobilized

21. How do you feel about telling another person he is dying?

/_____/_____/_____/_____/_____/_____/

This is cruel;	It is
most people don't	everybody's
want to know	right to know
	this

22. Does the possibility of nursing dying patients make you uneasy?

/_____/_____/_____/_____/_____/_____/

No Yes

23. When in the presence of a dying person, what are your feelings or expected feelings if you have not been in such a situation?

/_____/_____/_____/_____/_____/_____/

Helpful Helpless

Part II

INSTRUCTIONS: Please circle the answer that applies to you.

1. Have you ever been with a dying person at or near the time of his death?

A. yes

B. No

2. If you answer yes to the above, into which category(s) did this individual fit?

A. Immediate family

D. Acquaintance

B. Other relative

E. Stranger

C. Close friend

F. Patient

3. Have you ever attended a funeral?

A Yes

B. No

4. If you answered yes to the above, approximately how many? _____

5. To which of the following categories do you belong?

A. Member of a nuclear family. (Husband, wife, possibly children.)

B. Member of an extended family. (More than 2 generations living together.)

C. Self-supporting and living alone

APPENDIX C
DEATH ANXIETY SCALE

Appendix C

DIRECTIONS: Please indicate your age and sex, and then answer the 15 questions. If a statement is true or mostly true as applied to you, circle "T." If a statement is false or mostly false as applied to you, circle "F."

- | AGE _____ | MALE _____ | FEMALE _____ | |
|-----------|------------|--------------|---|
| T | F | | 1. I am very much afraid to die. |
| T | F | | 2. The thought of death seldom enters my mind. |
| T | F | | 3. It doesn't make me nervous when people talk about death. |
| T | F | | 4. I dread to think about having to have an operation. |
| T | F | | 5. I am not at all afraid to die. |
| T | F | | 6. I am not particularly afraid of getting cancer. |
| T | F | | 7. The thought of death never bothers me. |
| T | F | | 8. I am often distressed by the way time flies so very rapidly. |
| T | F | | 9. I fear dying a painful death. |
| T | F | | 10. The subject of life after death troubles me greatly. |
| T | F | | 11. I am really scared of having a heart attack |
| T | F | | 12. I often think about how short life really is. |
| T | F | | 13. I shudder when I hear people talking about a World War III. |
| T | F | | 14. The sight of a dead body is horrifying to me. |
| T | F | | 15. I feel that the future holds nothing for me to fear. |

From "The Construction and Validation of a Death Anxiety Scale" by D. I. Templer, 1970, Journal of General Psychology, 82, p. 167. Copyright 1969 by D. I. Templer. Reprinted by permission.

APPENDIX D
SUBJECTIVE INFORMATION SHEET

Appendix D

1. Marital Status
 - a. single
 - b. married
 - c. divorced
 - d. widow\widower
 - e. separated
 - f. living together

2. Race ____ Black ____ Caucasian ____ Other, please indicate _____.

3. Please circle your religious affiliation.
 - a. Catholic
 - b. Protestant
 - c. Jewish
 - d. Mormon
 - e. Christian Science
 - f. No religious preference
 - g. Other, please specify _____

4. Please circle the statement which best describes your religious beliefs.
 - a. Do not believe in a supreme being
 - b. Believe in a supreme being
 - c. I am not sure if I believe in a supreme being

5. On a scale of 1 - 5 how would you rate your religious practices?
 1. not committed
 2. somewhat committed
 3. not sure
 4. committed
 5. strongly committed

6. Length of time at your present position.
- a. < 1 year
 - b. 1 - 2 years
 - c. 3 - 5 years
 - d. 6 - 10 years
 - e. > 10 years
7. Number of years nursing experience since graduation.
- a. < 1 year
 - b. 1 - 2 years
 - c. 3 - 5 years
 - d. 6 - 10 years
 - e. > 10 years
8. Please indicate if you have previously worked in an environment which experiences frequent death and dying.
- a. yes
 - b. no
- If you answered yes to question 7, please indicate what area of nursing you were working. _____
9. What area of nursing do you currently work?
- a. Hospice
 - b. Nonhospice
10. If you work in a hospice setting, how many years of hospice experience do you have? _____
11. Work setting _____ in-patient or _____ out-patient?
12. Please circle your employment status.
- a. full time
 - b. part time
13. What is the average age of the clients you care for?

14. What is the highest level of education completed?

- Licensed practical nurse
- Hospital diploma
- Associate degree in nursing
- Associate degree in other
- Baccalaureate degree in nursing
- Baccalaureate degree in other
- Masters degree in nursing
- Masters degree in other
- Doctoral degree in nursing
- Doctoral degree in other

15. Have you had any formal training in death and dying? If yes, please explain, where, when and how long the training lasted. _____

APPENDIX E
PERMISSION FOR USE OF TEMPLER'S DEATH
ANXIETY SCALE

April 9, 1990

Ms. Debra Harber
613 Mayfield
Los Vegas, NV 89107

Dear Ms. Harber:

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

Enclosed find a DAS form that I have used since 1970, and a couple of articles pertaining to DAS construction, validation, items, scoring and norm-like information. One point is scored for each item answered in the keyed high death anxiety direction so that a DAS score could be as low as 0 or as high as 15. A Likert format for the DAS is described by McMordie in Psychological Reports, 1979, 44, 975-980. I have also enclosed a copy of the Templer-McMordie Death Anxiety Scale.

The book, Death Anxiety, by Richard Lonetto and Donald I. Templer (Hemisphere Publishing Corporation, Washington, 1986) reviews the correlates of death anxiety (age, sex, other demographic variables, parental resemblance, religion, personality, public health, psychopathology, occupation, behavior, death of significant others), factor analyses, death imagery, intervention, the measurement of death anxiety, and Templer's two-factor theory of death anxiety.

Feel free to contact me for additional information or advice, including help in preparation of a manuscript for a journal article if your findings are sufficiently interesting.

Sincerely,

Donald I. Templer

Donald I. Templer, Ph.D.
Professor of Psychology

DIT:amh

Enclosures

P.S. I also have a few pages from my books that deal with research with nurses.

APPENDIX F
PERMISSION FOR USE OF HOPPING'S
DEATH ATTITUDE INDICATOR



AMERICAN JOURNAL OF NURSING COMPANY
555 WEST 57TH STREET • NEW YORK, NEW YORK 10019
(212) 582-8820

115

March 1, 1990

Debra Panko Harber, RN, BSN
613 Mayfield Street
Las Vegas, Nevada 89107

Dear Ms. Harber:

Thank you for your letter of February 26, 1990
requesting permission to utilize a learning
tool entitled, "Death Attitude Indicator" authored
by Betty L. Hopping.

You have permission to utilize this tool providing
you use the following credit line:

Copyright 1977 The American Journal of Nursing
Company. From Nursing Research, March/April
1977, Vol. 26, #2. Used with permission.
All rights reserved.

Should you plan to publish your research in the
future, please inform us so that formal permission
applications can be filed.

Thank you for your cooperation.

GOOD LUCK!

Sincerely,

Gloria Gay
Permissions Coordinator

/gmg

APPENDIX G

APPROVAL: HUMAN SUBJECTS RIGHTS COMMITTEE,
DEPARTMENT OF NURSING, UNIVERSITY OF
NEVADA, LAS VEGAS

PROTOCOL FORM APPROVAL SHEET

FOR RESEARCH INVOLVING HUMAN SUBJECTS

Log Number: _____

Title of Project: Comparative Study of Hospice vs Nonhospice Nurses' Attitudes toward Death and Dying and Level of Death Anxiety

Investigator: Debra Panko Harbor

After reviewing this proposal the members of the Human Subject Rights Review Committee have indicated below their approval/disapproval of this proposal.

Signature of Committee Members

Approve Disapprove

Marylene Ramoncino

X _____

Carolyn E. Baker

X _____

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

Date: 5/7/90

Suzanne Ruth Michael
Committee Chairman's Signature

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