ATTITUDES OF ONCOLOGY NURSES TOWARD CANCER

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ELIZABETH BARRIE, B.S.N.

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ABSTRACT

ELIZABETH BARRIE

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
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The purpose of this study was to answer the following question: What are the attitudes of oncology nurses toward cancer? A nonexperimental, descriptive design was utilized to determine nurses' attitudes toward cancer; 47 oncology nurses selected by convenience sampling completed an attitude inventory. The attitude inventory administered to the oncology nurses was the Cancer Attitude Inventory developed by Donovan, Hohloch, and Coulson.

Using descriptive statistics, it was determined that oncology nurses possess favorable attitudes toward cancer. In addition, using Dunn's post hoc simultaneous comparison procedure, data indicated that Master's prepared nurses have a significantly ($p \leq .01$) more positive attitude toward cancer than do Associate degree nurses.

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CHAPTER 1

INTRODUCTION

Cancer is a complex, chronic disease that has an impact on the patient, the patient's family, health care professionals, and society as a whole. In comparison with other diseases, cancer is unequalled in the degree of anxiety it produces. The full emotional impact of cancer on society is only partially revealed by studying the mortality and morbidity statistics of the disease. Anxiety plays a central role in the lives of people who must face the diagnosis, treatment, and prolonged follow-up of cancer (Donovan & Pierce, 1976).

Thus, for persons who develop cancer and nursing personnel who must deal with cancer patients, it is necessary to develop favorable attitudes to alleviate negative attitudes that have so long been associated with cancer. Nursing personnel are not immune to the fear, the frustrations, the denial, and the guilt that cancer may cause. For nurses to help patients in the best possible way, they must learn to deal with these feelings. Whether the course of the patient's disease calls for rehabilitation and continuing care, or results in death, the nature of that care is important (Donovan & Pierce, 1976).

The improved methods of combining chemotherapy, radiation, and surgery have led to prolonged remissions and increased survival time, dramatically changing the prognosis for many cancers. As the prognosis for patients with various cancers improves, the relationship between nursing personnel and cancer patients is of increasing importance. Thus, it is the purpose of this research to examine nurses' attitudes toward cancer and cancer patients.

Statement of Problem

Little is known about the actual attitudes toward cancer of nurses who work primarily with cancer patients on a daily basis. Therefore, the question addressed in this study is: What are the attitudes of oncology nurses toward cancer?

Justification of Problem

Care of the cancer patient involves a holistic approach encompassing and utilizing the physical, biological, and psychosocial sciences. Nursing is one of the disciplines considered essential to planning for and implementing comprehensive care of the cancer patient (Harrop, 1967). The nurse is the person who has the greatest opportunity to help patients make an early adjustment to illness which will form a basis for the remainder of care.

Through their contact with the public, nurses have the opportunity to foster a greater awareness of and confidence in the value of early diagnosis and treatment (Davison, 1965). It is important that the information given by nurses reflects a positive attitude to alleviate needless anxieties that may be felt by the public. The nurse should examine his/her philosophy toward cancer and dealing with cancer patients to prevent any interference with the patient's ability to adjust to cancer and its treatment. The nurse's perception of the diagnosis may communicate his/her attitude toward the patient and family through nonverbal behavior (Bouchard, 1976).

Research into the attitudes of physicians, nurses, and other health care personnel has suggested that strong emotional reactions are frequently evoked in persons treating cancer patients (Tichenor & Rundall, 1977). It has also been shown that attitudes of health care providers have been identified as one of the barriers to the effective use of the health care system by patients (Hayes, 1975). Therefore, the present study was designed as a beginning effort to identify the attitudes toward cancer of nurses who work with cancer patients.

Conceptual Framework

The concept of attitude provided a framework for identifying the attitudes of registered nurses toward cancer patients. How individuals react psychologically to cancer will be much affected by their attitudes and beliefs about malignant disease.

According to Lemon (1973), attitude is one of the most ubiquitous of all the terms used in social science. A person's attitude usually influences his/her behavior. Therefore, a positive or negative attitude generally produces positive or negative behavior (Brooks, 1979). Attitudes have the emotional propensity, based on an individual's past experiences, to cause a favorable or unfavorable reaction toward a psychological object (Remers, 1954). An attitude represents a personal disposition common to individuals, but possessed to different degrees, which is indicative of a person's general feeling of favorableness or unfavorableness toward some stimulus object. The addition lies in the two phrases, "common to individuals" and "possessed to different degrees" (Remers, 1954, p. 362). The former presents the concept that once attitudes are formed they determine the individual's reactions in a characteristic way, while the latter infers there are varying degrees of difference among attitudes (Remers, 1954).

Attitudes are the result of learned behavior and are developed and organized through an individual's experience with the environment. Overt behavior displayed by individuals is often used to infer attitudes. Adapting to environmental changes and circumstances is a life-long process which may subject individuals to attitudinal changes as they encounter new situations. Attitudes can be externally influenced by one's interactions with the environment and by socialization and education. One's behavior is presumably more influenced by attitudes than one's perceptual and verbal response to his/her environment (Remers, 1954). Among the essentials for the accomplishment of the social sciences' integration into society is the amelioration of attitudes commendatory toward public responsibility, social relations and social change (Remers, 1954).

Allport's (1954) definition of attitude is generally accepted. He stated that:

> An attitude is a mental and neural state of readiness, organized through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related. (p. 43)

What individuals believe about cancer will, according to Allport's definition, influence what they do about it. As more is known about cancer attitudes, the behavior relating to cancer may become more predictable thus making it

possible to alter that behavior in a positive way to improve morbidity and mortality (Brooks, 1979).

The origins of cancer attitudes can be found in the three major theories that have been developed in association with attitude. One theory stresses the importance of learning, one stresses the effect of incentives, and one stresses the importance of consistency between attitude and behavior in the same person (Warren & Johoda, 1973).

According to Thurstone (1969), the concept of attitudes is utilized to indicate the intensity of a positive or negative affect for or against a psychological object. Thus, a psychological object is any symbol, person, phrase, slogan, or idea toward which people can differ as regards to a positive or negative affect. These attitudes can extend from a chance association to an immutable opinion attending some object. An attitude is evidenced by consistency in response to social objects which infers they are learned. This is congruent with the almost universally accepted assumption about attitudinal behavior which is that it is learned (Lemon, 1973). The social environment provides an atmosphere in which attitudes are assimilated. Therefore, a person may not be cognizant of incorporating attitudes from his/her social environment (Sawrey & Telford, 1967).

Although there is no single definition of attitudes acceptable to all, there are areas of agreement which

subsist. Campbell (1973) observed that responses toward most objects are prefaced by attitudes toward these objects which in a proximal sense determine these responses. This type of behavior is an extrinsic attribute of an attitude. The persistence of attitudes is another area of common agreement. Thus, attitudes developed in childhood are often difficult to change as one approaches mid life. A third area of agreement refers to the individual's intention to behave in particular ways, or to one's actual behavior, with regard to the attitude object (Lemon, 1973).

Smith, Bruner, and White (1956) examined the motivational determinants of attitude and found a considerable amount of agreement between the functions they enumerate. The authors viewed attitudes as functioning as motivators, leading to experience, and being instrumental in achieving satisfying personal relationships with others. Attitudes officiate as arbitrators between the internal expectations of the individual and the external environment. Attitudes cannot be forecasted by one's internal character or environment alone, but by the equalization of the two. Thus, cancer patients are especially susceptible to attitudes of those around them: friends, family, nurses, and physicians.

A person's attitude is often a tenaciously held belief which is why it is difficult to alter (Summers, 1970).

Abelson (1970) observed that favorable attitudes are developed towards objects which facilitate the attainment of an individual's needs. Smith et al. (1956) spoke of the social adjustment function of attitude, e.g., the function which attitudes can serve in facilitating relationships between people. According to Smith et al., holding certain attitudes has a function in facilitating identification with certain reference groups or with significant others. Abelson (1970) noted there was a greater opportunity for an opinion change if the individual is one of high credibility. Thus, an individual of high esteem would have more influence in initiating an attitude change than an ordinary person.

Three main areas seem to have been considered by psychologists with respect to origin and change in attitudes:

1. Via exposure, association, and reinforcement.
2. Via persuasive communication.
3. Via self-discrepant behavior (a shortfall between what you think and what you do). (Brooks, 1979, p. 456)

The evidence seems to be that attitudes of significant others are adopted. These later either become modified or are reinforced unchanged through one of the above processes. In the case of cancer attitudes, nurses will play a key role for the public as significant others (Brooks, 1979).

Smith et al. (1956) stated that a person can utilize attitude change as a method to sustain equalization between

internal and external demands. According to Smith et al. resistance is often ascribed to change; therefore change should not be initiated for minor events. Some individuals have a tendency to vary attitudes quicker than others, as a result of changing events. Thus, in a study by Davison (1965), nurses who cared for at least five patients who were "cured" of cancer developed a more positive attitude toward the disease than those nurses who cared for patients who were not cured.

Conditions that expedite change are viewed as a variation in the relation of the attainment of personal goals and values, a change in social situations, or an alteration in ego-defensive or externalization functions. The method of change entails a deviation in the symmetry of the three conditions. Change is subject to any of the preceding conditions and the importance one places on them at a particular time (Smith et al., 1956). Thus, when changes are advantageous to the patient, every attempt should be made to accomplish change.

Therefore, the attitudes conveyed to the patient with cancer will be influenced by the nurse's personal attitudes about the symptoms, diagnostic procedures, and treatments used in the control of cancer. To effectively care for these patients, it is essential that the nurse examine his/her own attitudes. Those beneficial to patients should

be employed in their care; those which may have a deleterious effect on patients should be modified (Browning, 1973).

The application of the concept of attitude provides a framework in which to study nurses' attitudes toward cancer. Attitudes play a major role in nurses' communication and treatment of patients. Thus by erasing negative attitudes, nurses can advance to develop new knowledge of more sensitive and skilled approaches in cancer patient care.

Assumptions

In this study, the following assumptions were derived:

1. What individuals believe about cancer will influence their behavior towards it.
2. Nurses' attitudes, acquired through acculturation, can affect their actions as professional practitioners and interfere with or enhance their abilities to provide compassionate and understanding care.

Research Question

The following research question was addressed:

What are the attitudes of oncology nurses toward cancer?

Definition of Terms

For this study, the following terms were defined:

Attitude--an attitude is a mental and neural state of readiness, organized through experience, exerting a directive or dynamic influence upon the individual's responses to all objects and situations with which it is related (Allport, 1954). Attitudes will be measured by the scores obtained from the Cancer Attitude Inventory (Donovan, Hohloch, & Coulson, 1979, cited by Donovan, 1979).

Oncology nurse--a registered professional nurse who plans, assigns, supervises, and evaluates nursing care of cancer patients, as well as to give cancer patients the nursing care that requires the judgment and specialized skills of a registered nurse in an oncology setting.

Registered professional nurse--an individual who has graduated from a school of nursing whether at the hospital, associate or collegiate level who has proven basic competency in nursing skills and has passed the Nursing State Board Examination (Emmite, 1981).

Limitations

The investigator recognized that the following factors could affect the results and generalizability of the study:

1. Convenience sampling was utilized as a nonprobability sampling technique. Thus generalizability of the results beyond the units sampled is not possible.

2. A possible bias may have been introduced because of the method of selecting the subjects.

Summary

Cancer poses one of the greatest anxiety-producing threats in our society. Therefore it is imperative to positively influence the philosophy of nurses who work with cancer patients. The care received by cancer patients can be greatly influenced by the attitudes of nurses toward cancer and toward caring for individuals with a diagnosis of cancer.

Research dealing with attitudes toward cancer on the part of nurses has been found to be quite limited. Therefore, the proposed research was an effort to determine nurses' attitudes toward cancer.

A review of literature is presented in Chapter 2. The procedure for collection and treatment of data is addressed in Chapter 3. The analysis of data is described in Chapter 4. An overview of the study is discussed in Chapter 5.

CHAPTER 2

REVIEW OF LITERATURE

To gain a better understanding of how attitudes toward cancer have a direct bearing on the ability to intervene with a cancer patient, the investigator reviewed the literature for studies regarding: (a) the meaning of cancer, (b) professional attitudes toward cancer, and (c) behaviors and attitudes of nurses toward cancer.

The Meaning of Cancer

Cancer is unequivocally the most feared and anxiety producing disease known. Brooks (1979) compiled a list of fears from various research studies which play an important role in forming attitudes about the health care system, hospitalization, and illness. They are:

Fear of the Medical World in General Including:
(a) doctors (who cause pain in the process of treatment)
(b) hospitals (where the individual lacks control of events)
(c) operations (which mutilate and change one's self image and one's life)
(d) other patients (who make demands not normally experienced)

Fear of Separation from Family Including:
(a) by hospitalization
(b) by loss of responsiveness
(c) by loss of independence
(d) by loss of social interaction
(e) by death

Fear of the Disease Itself
(a) pain
(b) social stigma
(c) deformity and mutilation
(d) disability
(e) relative social isolation
(f) helplessness
(g) death (p. 454)

Donovan and Pierce (1976) reported the prevailing attitudes toward cancer and the cancer patient are affiliated with fear. Brooks (1979) stated that cancer has etched a very fearful imprint in the public's mind. Cancer is viewed for the most part as very ominous and inevitably incurable. The word cancer propagates feelings of dread, anxiety, and fear in many people because of the chronicity and debilitation often associated with its treatment and eventual outcome. Cancer evokes a primary emotion of fear, which may translate into rejecting or isolating behaviors exhibited toward the cancer patient. Each aspect of cancer care owes its existence, continuation, or demise to attitudes. These attitudes or belief systems have explicit implications for the nurse caring for cancer patients.

Further examination of why cancer is feared as much as it has been theorized and some of the suggested reasons reported by Clark (1975) are as follows:

1. Cancer may occur without warning.

2. Cancer may metastasize to other body tissue if not checked.
3. After a certain period of growth, cancer cannot be cured.
4. Cancer is a tissue wasting disease.
5. Advanced cancer often causes intractable pain.
6. Cancer creates an attitude of hopelessness in the patient, the patient's family, and the physician.
7. Diagnosis of the disease may be difficult; therapy may be inadequate.
8. Therapy is often mutilative.
9. The causes of many cancers are unknown.
10. Cooperation from the patient does not guarantee successful treatment (p. 1).

Much of the literature reviewed supported the premise that the public's conception of cancer is one of a horribly painful, and above all, incurable disease. McIntosh (1974) stated this belief is so intrinsic that for many a diagnosis of cancer is synonymous with death. He also indicated that because cancer is such a pervasive health problem in society, it has more impact on people's biological, psychological, emotional, and social stability than any other disease.

Further support for the public's fear of cancer was found in an opinion survey by Williams, Cruickshank, and

Walker (1972). They reported that two-thirds of the general public think that cancers are the most common causes of death, with over one-half considering them to be the most alarming group of diseases, and a fifth believing that cancers are never curable.

Professional Attitudes Toward Cancer

Physicians interviewed by Oken (1961) described cancer in profoundly negative terms. Easson (1967) also reported the presence of pessimistic attitudes about cancer among physicians and medical students. Konior and Levine's (1975) study noted that oncology fellows during their second or third month of fellowship experienced uniform but transient depression. Padilla, Baker, and Dolan's (1975) study of health care personnel indicated that health professionals perceived cancer as stronger, crueler, more anxiety provoking, more unfair, sadder, and more worthless even than death. Brooks (1979) stated that while physicians do not dictate health attitudes any more than other health workers do, the anxiety and incomprehension which accompany cancer are generally established by the physician's attitude in and toward the treatment of the disease and the cancer patient.

In an article conveying an oncology surgeon's viewpoint, Stehlin and Beach (1966) discussed attitudes

toward cancer and, although they referred to physicians and specifically to surgeons, their statements may also pertain to nurses. The authors proposed that the association of oncologists and their patients should be revealing, veracious and perpetuate "hope within a framework of reality" (p. 100). They emphasized that "incurable" and "hopeless" are not equivalents, perceiving incurability as a condition of the body, and hopelessness as an attitude of mind. Therefore, whether one suffers from or is treating cancer with an unfavorable prognosis, an optimistic frame of mind can be utilized in learning about the disease, oneself, and others.

As stated earlier, studies done by Easson (1967) on the problem of pessimism among general practitioners and medical and nursing students, however, revealed that lack of knowledge and pessimism prevailed. Retrospectively, Clark (1975) noted that although more knowledge had been obtained about cancer in the last 25 years than in all the aggregate years of civilization, there still remains numerous physicians in private practice and academic settings whose medical philosophies reflect negative attitudes pertaining to cancer treatment. Clark further contended there could be more enthusiasm about the anticipated dissolution of pessimism regarding cancer

therapy among physicians and nurses if more knowledge about the availability of new treatment modalities was disseminated to medical and nursing students. This new knowledge could provide a propitious framework in which physicians and nurses could be challenged to view cancer as a corrigible disease.

Studies by Oken (1961), Peck (1972), and Wakefield (1973) verified the observation that cancer patients and their physicians undergo many entanglements in establishing effective and unbiased communication. These studies further stressed that physicians may be unable to handle this particular situation because of their own uncertainties and negative attitudes concerning cancer and cancer patients. Hayes (1975) noted that the attitudes of health care providers have been identified as one of the barriers to effective use of the health care system by patients. He added that since attitudes frequently determine behaviors, the attitude and behavior of health care professionals relating to cancer patients is of great importance.

Kratz (1978) reported that whether a person seeks medical advice too soon or too late is based on fear, which is the salient point in interpreting people's cancer-related behavior. She stated the reason for this fear can

probably be found in the behavior of health professionals, many of whom assume that cancer is a disease which cannot customarily be disclosed to the affected person and this fact in itself is commensurate to propagate fear. The author concluded that if the diagnosis of cancer assuredly solicits fear and hopelessness in the patient and his family, attempts must be taken to use the nursing profession to help allay the fears of the public.

Behavior and Attitudes of Nurses Toward Cancer

While many aspects of cancer nursing are discussed in the literature, there has been limited research dealing with attitudes toward cancer on the part of the nurse. A study was initiated by Hohloch and Coulson (1968) because they believed that there was repeated evidence that senior nursing students in an advanced nursing course exhibited different feelings and reactions in caring for cancer patients than in caring for patients with another diagnosis. Thus, a cancer attitude inventory was developed by Hohloch and Coulson to measure students' attitudes toward caring for cancer patients. The Cancer Attitude Inventory was administered to senior nursing students when they began a 10-week course in Advanced Nursing, which was designed around the leading causes of death, and when they completed the course. The findings of the study revealed that the change in attitude

toward the cancer patient that occurs in a 10-week period is insignificant.

Rowe ("Attitudes in Nursing," 1965) emphasized the influence of hospital staff nurses' attitudes. She indicated that their attitudes could enhance or deter patient care, the service to families, and the educational environment of student nurses and others who are learning. She suggested that nurses' therapeutic attitudes as they provided treatment could be as efficacious for the patients' conditions as any analgesic. Davison (1973) observed that the nurses' role as an educator of the public about cancer is both inescapable and vital, since the public holds in such high esteem the nurses' opinions on matters of health and disease. However, Brooks (1979) noted that there were no studies which investigated the specific ways in which nurses influence the public's attitudes toward cancer.

Bouchard (1976) noted that dealing with cancer patients poses a major problem to many nurses because of nurses' fears and lack of understanding of the disease process. This apprehension could impede the nurses' ability to properly care for cancer patients, as they may employ avoidance behaviors. According to Donovan and Pierce (1976) many nurses, although they frequently encounter cancer and caring for cancer patients, are unfamiliar

with and fearful of the disease. More specifically, the author stated there is evidence that the fear of cancer may prevent nurses from learning more about the disease and may impair their ability to cope with the anxiety associated with it.

Nurses and physicians are more acutely aware of the failures in cancer care than the lay public. Results of Davison's (1965) study indicated that many nurses were dissatisfied with the care given to cancer patients as well as despondent about the prognosis for cancers. This raises a serious barrier to any attempt to improve public attitudes toward cancer, since such unwarranted pessimistic views are likely to be passed on to members of the general public. While members of the nursing and health care professions may consider themselves more apprised this is not evidenced by the studies done by Davison (1965) and Williams et al. (1972). Those from the health care professions who were involved in these studies demonstrated pessimism similar to the general public. Additionally, Craytor, Brown, and Morrow's (1978) literature review indicated that nurses, like the general public, viewed cancer as a fearsome disease that inevitably leads to death, and nurses share their attitudes of helplessness with society.

Interestingly, Thompson (1978) noted that a British study rated nurses favorably in their communicative interactions with cancer patients. It was believed that the nursing staff had a double advantage over the medical staff because: (a) the nursing staff had more intimate contact with patients than the medical staff, and (b) the patients believed that nurses were easier to approach than a physician because they were more accessible.

Conversely, these advantages caused problems. Menzies (1960) found that protracted contiguity with patients propagated anxiety. Patient centered nursing, which promotes the greatest certainty of care for the patient, may yield circumstances of encumbered communications that exceed the nurse's coping mechanisms. The author added that traditional task oriented nursing displaces the element of intimacy and lessens the support accorded to the patients, but circumvents potentially formidable interpersonal relationships. To further support the above findings, Benoliel (1971) noted that anxiety pertaining to cancer is experienced not only by those suffering from the disease but also by others in close proximity with them.

To further illustrate the effect of health care professionals' attitudes, a study was done by Marks and Sachar (1973). The study was concerned with undertreatment

of medical inpatients with narcotics. Since the pain experienced by cancer patients commonly necessitates narcotics, and since the attitudes of the attending health care professionals designate how narcotics are used in this care, these variables were studied.

A questionnaire by Marks and Sachar (1973) regarding narcotic usage was completed by 15 obstetrical/gynecological, 20 surgical, and 26 medical nurses in a medical center hospital. Of the medical nurses, 60% said narcotics should be dispensed as repeatedly as necessary to completely alleviate pain, whereas 70% of surgery and 50% of obstetrical/gynecological nurses thought adequate narcotics should be given to lessen pain only so it is noticeable but not unbearable. A total of 75% of obstetrical/gynecological and medical nurses believed physicians customarily prescribe the correct narcotic dosage for their patients, whereas only 30% of surgical nurses agreed. Moreover, 80% of obstetrical/gynecological and surgical nurses affirmed that patients with chronic painful disorders are less responsive to narcotics, while only 54% of medical nurses agreed. Of surgical and medical nurses, 80% to 92% felt that a PRN order of meperidine should be used parsimoniously to avert addiciton and side-effects, while only 57% of obstetrical/gynecological nurses concurred.

As a result of their findings, Marks and Sachar (1973) inferred that negative attitudes toward pain and narcotics among health professionals were associated with a failure or reluctance to dispense narcotics to cancer patients in the most expedient manner. The study recognized that there is a plurality of nurses in all clinical areas who possess incorrect data regarding narcotics. Also, those nurses who are most likely to care for cancer patients with chronic pain because of the clinical areas in which they work are those who are least bountifully bestowed toward the administration of adequate narcotic dosage. Thus, the authors concluded that narcotics had been remarkably underprescribed by physicians and patients were extraordinarily underdosed by their nurses.

Haley (1975) reported that clinical experience with nurses suggested that the nurse's views of other people with cancer are conditioned by one's personalized beliefs and experiences with cancer and, particularly, one's thoughts about the disease and its meaning if they had cancer. The hospital nurse who usually only sees the patients admitted for major surgery and those who are in the terminal stages of cancer will have a different perspective from the clinic nurse who has gotten to know many "cured" patients through long follow-up.

The effect instituted by the emotional climate encompassing the nurse upon his/her attitudes toward cancer and cancer patients was addressed in a report from the National Cancer Institute (Blumberg, Flaherty, & Lewis, 1980). The report stated that both patients and medical personnel assume that the physicians, the nurses, and the other health professionals are exempt from the stress, anxiety, and fallacies indigenous to cancer. Yet, in reality, the report suggested that health professionals are exposed to equivalent emotions and fears that their patients encounter, and they dispense with those emotions and fears in a similar fashion by utilizing anger, denial, and avoidance. The report further suggested that if these defense mechanisms are excessively proliferated, they can segregate the nurse from patients and co-workers (Blumberg et al., 1980).

LeShan (1964) noted that "deep psychological isolation, the loss of ability to relate and to love, lowers the fight for health" (p. 109). Thus, the author surmised that the competency of the health professional to advocate mental and physical well-being for his/her patients can be devitalized by his/her beliefs and attitudes associated with cancer. Health professionals, like their patients, may perceive cancer as subsequently leading to death.

Thus, the realization that death is inevitable and that one may be powerless to prevent it may promote both internal conflicts and stress for health professionals.

Paulen and Kuenstler (1978) reported in an article on patient/family support groups that nurses are similar to the general population in that they may be averse to mention the word "cancer." They suggested nurses may discover it arduous to examine the significance of patients' repeated questions dealing with death and dying and the outcome of the disease process. Paulen and Kuenstler's concern was that the nursing profession would not be able to benefit cancer patients if the critical issues could not be explored. The authors related that once nurses were able to reconcile their feelings related to cancer, not only were they able to help patients talk about cancer, but also to increase their veracity in communicating with cancer patients and their families.

According to Newlin and Wellisch (1978), in an article related to stress-producing factors in oncology nursing, the emotions of the oncology nurse are more vulnerable than those of the oncologist. This is not because the oncologist has less pathos toward the cancer patient, but that the oncology nurse is more frequently subjected to the emotional fluctuations and tumult of the cancer patient

and the family. The authors listed many of the reactions of nurses and some of the most important and recurring have been:

> (a) the feeling that the whole world has cancer,
> (b) cancer phobia among nurses,
> (c) mourning each patient's diagnosis,
> (d) identification with patients and families,
> (e) frustration at inability to completely alleviate the patient's physical pain,
> (f) frustration at inability to alleviate patient's and family's emotional pain,
> (g) conflict over involvement in experimental therapy or therapy which causes painful or unpleasant side effects,
> (h) conflict caused by time required for providing physical care and time required for providing emotional support,
> (i) frustration over difficulties in nurse-physician and patient-physician relationships, and
> (j) depression and mourning related to progression of disease or death. (Newlin & Wellisch, 1978, p. 449)

Dickinson (1973) investigated nurses' perceptions of the care of dying cancer patients and found that nurses felt confident accommodating most physical needs of patients, and especially those patients with a favorable attitude who maintained physical independence, and those who had families who coped well. However, these nurses were not adequately prepared in areas of interpersonal relations and communication skills. The study indicated that these were important skills in the care of dying cancer patients. Similarly, Vachon, Lyall, and Freeman (1978) reported that when nurses in one cancer center were asked about their

major difficulty in nursing, their response was: dealing with patients' feelings about illness, prognosis, and death. The authors concluded that although these nurses were endeavoring to acknowledge patients' psychosocial needs, they felt impeded because of their perceived fear of illness and death, and their knowledge about interpersonal relationships and communication skills was in arrears.

The preceding review of literature provides evidence that attitudes of fear, pessimism, helplessness, and frustration found in the nursing profession with regard to cancer patients can affect the quality of their care. Due to the nature of their profession, nurses have more opportunity for contact with cancer patients than do any other members of the health team. Barckley (1958) reported that evading conversation with the patient or intense preoccupation with task-oriented duties were behavioral tendencies used to avoid the patient's questions about illness and its prognosis. Knowles (1962) noted that performing the daily routine of nursing care, the nurse usually sees more of hospitalized cancer patients and is more aware of their needs than any other health professional, and therefore, has the greatest opportunity for developing a positive interpersonal relationship. Quint (1965) found

that both nurses and physicians used avoidance tactics. Nurses displayed their evasion of cancer patients by: (a) using body language which impeded the patient in initiating conversation with the nurse, and (b) using communicative interactions to change the subject when the patient's conversation created uneasiness for the nurse. Yet, Quint (1967) was of the opinion that there is a general cultural pattern of withdrawal from the dying patient and that nurses have not been able to exempt themselves from this pattern.

Present research indicates these attitudes and behaviors still exist. Studies by Padilla et al. (1975), Benton (1978), and Stoller (1980) demonstrated that nurses generally do not personalize their interactions with patients and presumably will avoid contacts with dying patients. A study by Maguire and Anders (1978) supported the view that staff who care for cancer patients may employ avoidance behaviors. In this study, patients with suspected breast cancer and diagnosed breast cancer were observed daily and questioned in detail about the staff members' visitations. Although there was considerable staff-patient interaction, the psychosocial needs of the patients were tenuously discussed. Instead, the nursing staff perspicaciously demonstrated a preference for

discussion of nonthreatening topics. While the staff indicated that lack of sufficient time was the primary reason for the failure to discuss psychological problems, this premise could not be substantiated. While most patients frequently saw individual staff members, the staff simply did not utilize their time in the most expeditious manner.

Kyle (1964) found that cancer patients who received only physical nursing care were more prone to negative personality reactions and less able to institute realistic goals after hospitalization than those patients who received supportive nursing care. Furthermore, the stamina that patients required to confront disease-related crises was augmented by an accepting relationship with supportive nurses. Additionally, Craytor et al. (1978) found in reviewing the literature that the effect of positive attitudes on cancer patients has been documented by research studies.

Klagsbrun (1970) observed that oncology nurses' emotional reactions to cancer notably transformed the emotional atmosphere of an inpatient cancer unit which provided an environment in which patients became less clinically depressed, more physically active and functionally mobile. Buehler (1975) reported that the ability

of cancer patients to be optimistic about their future and content with the stresses of their treatment was attributed to the hopeful attitude of the staff of a radiation therapy clinic. Meares (1980) reported that under opportune situations, the attitudes of the nurse and physician can serve as a viable force in promoting the patient's defense to produce regression of cancers. The author stated that the nurse usually sees more of the hospitalized cancer patient and is more aware of patient needs than any other health professional. Therefore, the manner in which the nurse's attitude augments that of the physician is an important factor in the development of the psychological treatment of cancer. Meares emphasized that the "attitude of mind" will be a factor in the type of care that is being given.

Finally, Marino (1981) observed that there has not been any attitudinal studies of how nurses currently view cancer. However, she is of the opinion that interest and participation in organizations such as the Oncology Nursing Society and efforts to establish guidelines for standards of care for cancer patients is an indicator that nurses are forming more favorable attitudes toward cancer and caring for cancer patients.

Summary

The literature reviewed indicated that a fear of cancer is a universal concern for both the patient and health care professional, while other articles addressed attitudes toward cancer. The literature denoted that negative attitudes of health care providers toward cancer are injurious to patient care while positive attitudes aggrandize patient care. With this background of supportive evidence, this investigator desired to study oncology nurses' attitudes toward cancer.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

A nonexperimental, descriptive study utilizing the Cancer Attitude Inventory (Donovan, 1979) was conducted to determine nurses' attitudes toward cancer. The sample was chosen in accordance with stated criteria.

Setting

The setting for this study was a large metropolitan area in the southwestern United States. Questionnaires were completed by subjects in their own homes.

Population and Sample

The target population was nurses known to care for cancer patients only. The sampling procedure was a non-probability approach using a sample of convenience. The sample consisted of 50 volunteer subjects. The 50 subjects were selected from a list of nurses, compiled by the investigator, who were known to work primarily with cancer patients.

Protection of Human Rights

Initially, approval from the Human Research Review Committee of Texas Woman's University was obtained

(Appendix A). The subjects' rights were protected by the following:

1. Providing information as to the purpose of the study.
2. Utilizing a cover letter to enlist the participation of the subjects in the study (Appendix B).
3. Providing confidentiality through the use of code numbers and elimination of personally identifying information on the data collection form.
4. Informing participants that responses would only be known as a group result.
5. Stating that each participant had the right to disengage her/himself from the study at any time.
6. Informing the participants of possible risks or benefits evolving from the study.

Instruments

Two instruments were used in the study. These instruments included the subject's Demographic Data Record and the Cancer Attitude Inventory (Appendix B).

1. Subject's Demographic Data Record--this was designed to yield data on demographic variables such as subject's age, education, marital status, years active in nursing, years working with cancer patients and personal experience with cancer (Appendix B).

2. Cancer Attitude Inventory--The Cancer Attitude Inventory developed by Donovan, Hohloch, and Coulson (Donovan, 1979) was used to determine nurses' attitudes toward cancer. Permission for use of the instrument was obtained from Marilee Donovan (see Appendix C). The Cancer Attitude Inventory is a Likert-type scale consisting of 52 items. The subjects are asked to respond to the items in one of five ways: completely agree, agree, neutral, disagree, and completely disagree. Each item received a rating from one point to five points in computing the final score. Positive items were rated five for "completely agree," while negative items were rated one for "completely agree."

A factor analysis to examine construct validity of Donovan et al.'s (Donovan, 1979) instrument was performed on pretest surveys of 205 subjects. Factor 1 consists of items that deal with open communication and the hopeful aspects of cancer and cancer nursing. Factor 2 consists of the remaining items which are the antithesis of the items in Factor 1. Factor 2 is labeled as hopelessness (Donovan, 1979).

Alpha coefficients for the Cancer Attitude Inventory were computed by Cronbach's alpha for data obtained by four administrations of the test. The ranges for the

reliability coefficient were .48 to .52. Cronbach's alpha was done on data obtained from the subjects of the present study to establish further reliability. Cronbach's alpha was .86 for these data.

Data Collection

Upon approval from the Human Research Review Committee of Texas Woman's University, data collection began. Ten days were allotted for data collection. A cover letter, the combined Demographic Data Record and the Cancer Attitude Inventory and a stamped, self-addressed return envelope were mailed to the 50 selected oncology nurses. Subjects were asked to complete the attached data sheet and questionnaire within 10 days. Forty-seven (94%) questionnaires were completed and returned.

Treatment of Data

The Subject's Demographic Data Record provided descriptive information on the subjects who participated in the study. A summary of the demographic data was provided with the calculation of measures of central tendency and frequency distributions. In addition, a Kruskal-Wallis one-way analysis of variance was used to determine if attitudes differed relative to the demographic variables.

The subjects were asked to indicate their degree of agreement or disagreement with each statement in the attitude inventory. The responses were combined to form a composite score, the aim of which was to signify the individual's position, relative to that of others, on the attitudinal favorability/unfavorability continuum. A total score was derived by the summation of scores assigned to each item, which in turn was scored according to the direction of favorability expressed (Polit & Hungler, 1978). The mean scale score was used to determine positive or negative attitudes. A mean scale score of 0-2.49 was indicative of negative attitudes, a 2.50-3.50 mean scale score was indicative of neutral attitudes, and 3.51-5.00 was indicative of positive attitudes.

Summary

The procedures used for collection and treatment of data in this nonexperimental, descriptive study of nurses' attitudes toward cancer have been explained in this chapter. Chapter 4 presents the analysis of the data gained from this study.

CHAPTER 4

ANALYSIS OF DATA

A nonexperimental descriptive study was conducted to determine oncology nurses' attitudes toward cancer. This chapter presents the analysis of data gathered from the Cancer Attitude Inventory and the Demographic Data Sheet. The subjects in this investigation consisted of 47 oncology nurses. In this chapter a description of the sample is provided and the analysis of the data is presented.

Description of the Sample

The population consisted of nurses known to care for cancer patients only. The sampling procedure was a non-probability approach using a sample of convenience. The sample was composed of 47 subjects (94%) of the 50 oncology nurses to whom the inventory was mailed.

Subjects ranged in age from 19 to 55 years with the majority, 28 (56%) represented in the 26 to 35 year category. The majority, 25 (53%), of the subjects held a Bachelor of Science degree and were married. Years of general nursing experience ranged from less than 1 year to greater than 10 years with 28 (56%) subjects having 5 or more years of experience. However, data related to years

of experience working with cancer patients revealed that only 16 (34%) subjects had five or more years of experience. The majority, 36 (77%), of the subjects had had personal experience with cancer. Of these, three had cancer themselves (see Table 1).

Findings

The research question asked: What are the attitudes of oncology nurses toward cancer? To analyze the data, attitude scores from the questionnaire for each subject were determined.

The subjects' scores on the Cancer Attitude Inventory ranged from 3.4-4.6 with a mean of 3.9. It was determined that subjects who had scores above 3.5 possessed positive attitudes toward cancer. Forty-one subjects (87%) were in this category. Subjects who ranked within a 2.5-3.5 range were considered neutral; there were six subjects (13%) in this category. A negative attitude was indicated by those scores below 2.5. There were no subjects in this category. The frequency distribution of the scores can be found in Table 2.

Table 1

Age, Education, Marital Status, Years of Nursing Experience, Years of Cancer Nursing Experience, and Personal Experience with Cancer of 47 Oncology Nurses Who Participated in a Cancer Attitude Inventory

Variable	Frequency	Percentage
Age		
19-25	11	23.4
26-35	28	59.6
36-45	6	12.8
46-55	1	2.1
55+	1	2.1
Total	47	100.0
Education		
A.D.	4	8.5
Diploma	10	21.3
B.S.	25	53.2
M.S.	8	17.0
Total	47	100.0
Marital Status		
Single	17	36.2
Married	25	53.2
Divorced/Separated	5	10.6
Widowed	0	0.0
Total	47	100.0
Years of Nursing Experience		
0-1	1	2.1
1-2	5	10.6
3-5	13	27.7
5-10	16	34.0
10+	12	25.6
Total	47	100.0

Table 1 (Continued)

Variable	Frequency	Percentage
Years of Cancer Nursing Experience		
0-1	8	17.0
1-2	10	21.3
3-5	13	27.7
5+	16	34.0
Total	47	100.0
Personal Experience with Cancer		
Subject had cancer	3	6.4
Immediate family	7	14.9
Relative	16	34.0
Friend	10	21.3
None	11	23.4
Total	47	100.0

The Kruskal-Wallis one-way analysis of variance was used to determine differences between the demographic variables of age, marital status, general nursing experience, cancer nursing experience, and personal experience with cancer and scores on the Cancer Attitude Inventory. The level of significance was set at $p \leq .05$. No statistically significant differences between groups were found except for level of education which was significant at $p \leq .01$. In order to determine which groups were different on the educational variable, Dunn's post hoc simultaneous comparison procedure was employed. Results revealed that people with Master's degrees had a significantly more

Table 2

Frequency Distribution of Attitude Scores of 47 Oncology Nurses Who Participated in a Cancer Attitude Inventory

Score	Frequency	Percentage
4.6	1	2.1
4.5	2	4.2
4.3	3	6.4
4.2	4	8.5
4.1	3	6.4
4.0	7	14.8
3.9	4	8.5
3.8	6	12.7
3.7	5	11.0
3.6	4	8.5
3.5	2	4.2
3.4	6	12.7
Total	47	100.0

positive attitude toward cancer than did A.D. nurses. The other categories of nurses did not differ in their attitudes toward cancer. There were eight nurses (17%) with Master's degrees, of whom seven (15%) had scores of 4.1 or above (see Table 3).

Table 3

Ordered Mean Differences on the Cancer Attitude Inventory According to Educational Level of 47 Oncology Nurses

		ADN	Diploma	BS	MS
	Means	13.25	14.85	26.42	33.25
Diploma	14.85	1.60	0.00	-11.57	-18.40
BS	26.42	13.17	11.57	0.00	-6.83
MS	33.25	20.00*	18.40	6.83	0.00

*$p \leq .05$

Summary

The sample included 47 male and female oncology nurses, the majority of whom were married and held a Bachelor of Science degree or higher. Work experience in general was in excess of five years for the majority of subjects, while only 16 nurses had five or more years experience in oncology nursing. Positive attitudes toward cancer were demonstrated by 41 subjects while 6 subjects had neutral attitudes toward cancer. There were no subjects in this study who possessed negative attitudes.

There were no significant difference between the demographic variables of age, marital status, years as a nurse, experience with cancer patients and personal experience with cancer, in relation to a positive or negative

score, as determined by the Kruskal-Wallis one-way analysis of variance. There was, however, a statistically significant difference between educational level and attitude toward cancer. This was demonstrated by those nurses with a Master's degree having significantly more positive attitudes toward cancer than those with an Associate degree.

CHAPTER 5

SUMMARY OF THE STUDY

This study was conducted to determine oncology nurses' attitudes toward cancer. This chapter presents a summary of the study and a discussion of the findings, followed by conclusions and implications. Recommendations for further study conclude the chapter.

Summary

This nonexperimental descriptive study was conducted to identify oncology nurses' attitudes toward cancer. The setting was in a large metropolitan area in the Southwestern United States. The sample consisted of 47 oncology nurses selected from a list of nurses compiled by the investigator who were known to care for cancer patients only.

Data were collected using the Cancer Attitude Inventory (Donovan, 1979) which is a Likert-type scale consisting of 52 items. A mean score above 3.5 indicated a positive attitude toward cancer, while a mean score below 2.5 indicated a negative attitude toward cancer. A mean score between 2.5 and 3.5 was considered in the neutral range. The mean score for the group was 3.9, with 24 (51%) subjects

scoring 3.9 or above, and 23 (49%) subjects scoring below. The Kruskal-Wallis one-way analysis of variance was used to determine if there were significant differences in scores in relation to the demographic variables. No significant difference emerged with the exception of the educational level of subjects with Master's degrees. Subjects with Master's degrees had a more favorable attitude toward cancer than subjects with Associate degrees.

Discussion of Findings

The major finding of this study was that oncology nurses surveyed possessed favorable attitudes toward cancer. Conversely, the literature reviewed supports a more negative attitude toward cancer. Davison (1965), Williams, Cruickshank, and Walker (1972), Padilla, Baker, and Dolan (1975) addressed the negative views held by nurses and health care professionals. Fear and lack of understanding of the disease process was cited by several authors (Bouchard, 1976; Brooks, 1979; Clark, 1975; Donovan & Pierce, 1976) as the major reason for the prevailing negative attitudes toward cancer.

Haley (1975) reported nurses' views toward cancer and cancer patients are conditioned by one's personalized beliefs and experiences with cancer. Paulen and Kuenstler (1978) observed that once nurses were able to reconcile

their feelings about cancer, they were able to help patients and their families discuss the physical and psychosocial effects of cancer more openly. Thus, the participants in this study may have been exposed to positive experiences with cancer and cancer patients, which may account for their favorable attitudes.

The nurses in this study may have had patient interactions which may have predisposed them to favorable attitudes. Dickinson (1973) examined nurses' perceptions of the care of dying cancer patients and found that nurses felt confident accommodating most physical needs of patients, especially those with favorable attitudes, physical independence and families that coped well. Thus, if nurses frequently encounter independent, optimistic patients with strong family support, more favorable views toward the care of cancer patients may be exhibited by them.

The findings of this study also indicated that favorable attitudes of oncology nurses may be related to the sampling procedure. The 47 subjects were selected from a list of nurses, compiled by the investigator, who were known to work primarily with cancer patients. Additionally, as the sample included oncology nurses, it can be assumed that their attitudes would be more favorable than the general nursing population, who have fewer contacts and

interactions with oncology patients. Continued association with cancer patients may provide a positive experience for many oncology nurses whose favorable attitudes are evidenced by the findings of this study.

In support of the findings of this study, Marino (1981) stated that interest and participation in oncology nursing organizations and establishing guidelines for patient care are indicators that nurses are forming more favorable attitudes toward cancer and cancer patients. Therefore, the present study seems to indicate that nurses have a proclivity for a favorable attitude toward cancer.

The findings of this study also indicated that Master's prepared nurses had a significantly more positive attitude toward cancer than did Associate degree nurses. The disturbing fact is that the nurses who have the most frequent contact with patients and the opportunity to interact with them are Associate degree or diploma nurses. These educational programs do not place the emphasis on interpersonal relationships and communication skills that BS or MS programs do. Vachon, Lyall, and Freeman (1978) found that nurses had difficulty meeting patient's psychosocial needs because of their lack of knowledge about interpersonal relationships and communication skills.

Conclusions and Implications

On the basis of the findings and within the limitations of the study, the following conclusions are offered:

1. Oncology nurses have positive attitudes toward cancer.
2. Attitudes of oncology nurses are not significantly influenced by age, marital status, nursing experience with cancer.
3. Master's prepared nurses have a significantly more positive attitude toward cancer than do Associate degree nurses.

The following implications for nursing practice are presented:

1. Associate degree nurses, who often have the fewest years of education, would benefit most from continuing education programs in cancer care.
2. Since oncology nurses have more positive attitudes toward cancer, cancer patients may receive better care in an oncology-oriented setting than in a general care hospital.

Recommendations for Further Study

The following recommendations are proposed as a result of the findings of this study:

1. The study should be replicated using a larger sample.
2. A similar study should be conducted in a large cancer institute in a different geographic locale.
3. An experimental study should be conducted to measure the attitudes of oncology nurses before and after an educational program.
4. A study should be conducted to compare the attitudes of nononcology nurses and oncology nurses toward cancer.

APPENDIX A

APPROVAL FORM

HOUSTON CAMPUS
HUMAN RESEARCH REVIEW COMMITTEE
REPORT

STUDENT'S NAME Elizabeth Barrie

PROPOSAL TITLE Attitudes of Oncology Nurses Toward Cancer

COMMENTS:

DATE: 7/6/81

Disapprove Approve

Disapprove Approve

Disapprove Approve

Disapprove Approve

ls

APPENDIX B

QUESTIONNAIRE PACKET

1116 Banks #16
Houston, Texas 77006
July 7, 1981

Dear Colleague,

I am enrolled in the graduate program at Texas Woman's University. As part of the requirements for a master's degree in medical-surgical nursing, I am writing a thesis on attitudes of oncology nurses toward cancer. The results of this study should give a clearer picture of nurses' attitudes toward cancer patients and help identify areas where change in attitude might increase the effectiveness of the nurses' role in the overall care of the cancer patient.

I would appreciate your cooperation in completing the attached data sheet and questionnaire. It will take approximately 15-20 minutes to complete. All information will be kept confidential. Your name will not appear anywhere on the survey. YOUR PARTICIPATION IS STRICTLY VOLUNTARY AND IT WILL BE ASSUMED THAT YOUR COMPLETION AND RETURN OF THE QUESTIONNAIRE INDICATE YOUR WILLINGNESS TO PARTICIPATE. No medical service or compensation is provided to subjects by the university as a result of injury from participation in research. After completion, please deposit in the self-addressed, stamped envelope that is enclosed with the other materials and mail. The findings of this study, reported in group format, will be available to you upon request to me.

If you have any further questions you can reach me at (713)526-7448. Thank you for taking time to participate in my study.

Sincerely,

Elizabeth Barrie

EB/rb

Enc.

DEMOGRAPHIC DATA SHEET

Please circle number of correct response.

Age:
1. 19-25
2. 26-35
3. 36-45
4. 46-55
5. 55+

Education:
1. A.D.
2. Diploma
3. B.S.
4. M.S.
5. Greater than M.S.

Marital Status:
1. Single
2. Married
3. Divorced/Separated
4. Widowed

How long have you been active as a nurse?

1. 0-1 years
2. 1-2 years
3. 3-5 years
4. 5-10 years
5. 10+ years

How long have you been working primarily with persons with cancer?
1. 0-1 years
2. 1-2 years
3. 3-5 years
4. 5+ years
5. I don't work primarily with cancer patients

Have you or anyone close to you had cancer?

1. I have had cancer
2. Child, spouse, parent, brother, sister
3. Grandparent, aunt, uncle, cousin
4. Friend
5. No

CANCER ATTITUDE INVENTORY

Directions: This Cancer Attitude Inventory tool has been designed to obtain your reactions to the statements it contains. You are not to respond to the truth or falsity of the statements it contains, but rather how you feel about the statement in question.

There are no "right" or "wrong" answers to these statements. Rather, you are asked to respond to the statements and categorize them based on the strength of your personal opinion.

If you completely agree with the statement, circle CA on the scale to the right of the appropriate statement number.

If you agree with the statement, circle A on the scale.

If you neither agree nor disagree with the statement, circle U on the scale.

If you disagree with the statement, circle D on the scale.

If you completely disagree with the statement, circle CD on the scale.

1.	Patients with cancer are no more demanding upon the nurse than other patients are.	1. CA A U D CD
2.	Cancer can be effectively treated for long periods of time.	2. CA A U D CD
3.	Nursing a patient with cancer is depressing to the nurse.	3. CA A U D CD
4.	Nursing the patient with cancer is an anxiety producing experience.	4. CA A U D CD
5.	Nurses who work with patients with cancer develop feelings of hopelessness.	5. CA A U D CD
6.	Nurses should be willing to discuss the diagnosis of cancer with patients.	6. CA A U D CD
7.	Patients who have cancer behave in a disagreeable manner.	7. CA A U D CD

8.	No one can learn to "live with cancer" as they can with other illness.	8.	CA	A	U	D	CD
9.	There is no need to institute rehabilitation programs for patients with cancer.	9.	CA	A	U	D	CD
10.	Not all patients with cancer suffer pain.	10.	CA	A	U	D	CD
11.	Patients with metastatic cancer should receive chemotherapeutic agents.	11.	CA	A	U	D	CD
12.	Cancer is among the least curable of the major diseases.	12.	CA	A	U	D	CD
13.	Eventually, all patients with cancer become incapable of caring for themselves.	13.	CA	A	U	D	CD
14.	Patients with cancer should not be encouraged to talk about their illness.	14.	CA	A	U	D	CD
15.	Many patients with cancer will retain a healthy appearance.	15.	CA	A	U	D	CD
16.	Cancer is not a socially acceptable disease.	16.	CA	A	U	D	CD
17.	Patients with cancer should be informed of their diagnosis.	17.	CA	A	U	D	CD
18.	Persons who have cancer can enrich the lives of others around them.	18.	CA	A	U	D	CD
19.	Chemotherapeutic treatment of cancer holds much promise for the future.	19.	CA	A	U	D	CD
20.	Cancer is an "eating away" process.	20.	CA	A	U	D	CD
21.	Patients with cancer should be offered additional therapy when one method fails.	21.	CA	A	U	D	CD

22.	Patients with cancer should be encouraged to plan for a productive future life.	22.	CA	A	U	D	CD
23.	Patients who have cancer usually have a slow and painful death.	23.	CA	A	U	D	CD
24.	Living with cancer is better than living with severe disability resulting from its treatment.	24.	CA	A	U	D	CD
25.	Cancer can be prevented.	25.	CA	A	U	D	CD
26.	Patients with cancer do not emit any particular identifying odor.	26.	CA	A	U	D	CD
27.	Disfiguring surgery should be performed for patients with cancer to restore a healthful life.	27.	CA	A	U	D	CD
28.	Living with the disability which may result from the treatment of cancer is better than living with cancer.	28.	CA	A	U	D	CD
29.	The term cancer should not be associated with death.	29.	CA	A	U	D	CD
30.	Patients who have cancer have a long history of illness requiring supportive care.	30.	CA	A	U	D	CD
31.	There is always hope for persons with cancer.	31.	CA	A	U	D	CD
32.	Patients with cancer should not be treated with radical surgery.	32.	CA	A	U	D	CD
33.	The diagnosis of cancer is a death sentence.	33.	CA	A	U	D	CD
34.	There is no reason to be optimistic for the patient with cancer.	34.	CA	A	U	D	CD
35.	The only object of nursing care for a patient with metastatic cancer is to prolong his life.	35.	CA	A	U	D	CD

36.	Patients with cancer are not objects of pity.	36.	CA	A	U	D	CD
37.	Physicians should tell patients if their diagnosis is cancer.	37.	CA	A	U	D	CD
38.	It's depressing to work with cancer patients.	38.	CA	A	U	D	CD
39.	The course of cancer is similar to many other chronic diseases; such as emphysema and congestive heart failure.	39.	CA	A	U	D	CD
40.	I would want to know if my illness was cancer.	40.	CA	A	U	D	CD
41.	As a nurse I can help the cancer patient solve many of the problems he faces.	41.	CA	A	U	D	CD
42.	Generally speaking, cancer is a hopeless disease.	42.	CA	A	U	D	CD
43.	The terminal cancer patient should receive narcotic analgesics whenever he requests it.	43.	CA	A	U	D	CD
44.	There is little a nurse can do for the cancer patient.	44.	CA	A	U	D	CD
45.	People with cancer can refuse treatment.	45.	CA	A	U	D	CD
46.	Even if detected early, cancer usually kills.	46.	CA	A	U	D	CD
47.	Cancer patients should not be admitted to Intensive Care Units.	47.	CA	A	U	D	CD
48.	Many cancer patients are cured.	48.	CA	A	U	D	CD
49.	In general, cancer patients cope well with their diagnosis.	49.	CA	A	U	D	CD
50.	The family has the right to withhold information from the cancer patient about his disease.	50.	CA	A	U	D	CD

51.	Most cancer patients experience considerable pain.	51.	CA	A	U	D	CD
52.	In general, I would be comfortable talking with a cancer patient about his diagnosis.	52.	CA	A	U	D	CD

Adapted from Faith Hohloch and Mary Coulson while under contract with the School of Nursing, Medical College of Virginia and Marilee Donovan, NCI Contract NOI-CN-55186-07, University of Pittsburgh.

APPENDIX C

INSTRUMENT USE PERMISSION

October 16, 1980

Marilee Donovan, R.N.,Ph.D.
Coordinator Graduate Program
Rush College of Nursing
1743 West Harrison
Chicago, Illinois 60612

Dear Ms. Donovan:

I am presently in the Master's Program in Nursing at Texas Woman's University in Houston, Texas, and am interested in information on nurses' attitudes toward cancer and cancer patients.in preparation for my Master's Thesis.

I wish very much to use your Cancer Attitude Inventory to collect data in this project. Therefore, I would like to ask your permission to use the Cancer Attitude Inventory survey. I also would be especially interested in how your sample for the study was selected, and any other information or advice that would relate to the assessment of nurses' attitudes towards cancer.

I would very much appreciate your consideration and look forward to hearing from you.

Sincerely yours,
Elizabeth Barrie
Elizabeth Barrie, R. N.
1116 Banks #16
Houston, Texas 77006

RUSH-PRESBYTERIAN-ST. LUKES MEDICAL CENTER
1753 WEST CONGRESS PARKWAY, CHICAGO 60612

October 27, 1980

Elizabeth Barrie, R.N.
1116 Banks - #16
Houston, Texas 77006

Dear Ms. Barrie:

The sample for the original study as indicated in the attached were all nurses who took a continuing education course (2 weeks) at the University of Pittsburgh from 1975-78, plus some graduate students. It is currently used in several other programs around the country and they will share their data with us.

Items 1-36 are from Hohloch and Coulson; items 36-52 from the scale we developed at Pittsburgh. Current data indicate items 36-52 better than 1-36.

Good luck.

Sincerely,

Marilee Donovan

Marilee Donovan, R.N., Ph.D.
Coordinator, Graduate Program in
Oncology Nursing
Rush College of Nursing

MD/kh
Enclosure

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