EFFECTS OF TRAINING IN DEALING WITH DEATH AND DYING ON ATTITUDES TOWARD DEATH AND DYING OF PRACTICING NURSES: IMPLICATIONS FOR COUNSELING

A THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF MASTER OF ARTS

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF EDUCATION

BY

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DENTON, TEXAS

AUGUST, 1980

Acknowledgements

Much appreciation is expressed to Dr. Louis E. Shilling, Dr. Clifton T. Sparks and Dr. David D. Marshall, members of the Advisory Committee, as well as to Lillie M. Biggins, Sarah Moody and Ruth Brock for their help in completing this study.

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CHAPTER I

INTRODUCTION

The last decade has seen an increase in the study of death and dying in the American culture. Grief and its process have been outlined and defined. Professionals who work with the dying and bereaved have begun to be enlightened about the problems surrounding the acceptance of death.

The medical and counseling professions (clergy included) are the most closely involved with death and dying. Hence, they are the professions which have begun to focus on the rewards and difficulties the subject yields. Experts in the two fields point out the need for further endeavor into education and support for those affected by death both professionally and personally. This study attempts to explore one aspect through which both fields can work together to benefit the dying and bereaved.

Statement of the Problem

Since the hospital is the scene of the final months, hours, or minutes of most dying persons, it would logically be the primary area for enlightenment on the subject of

death and dying. Within the confines of the hospital, the target population would be the nurses who are the most closely involved with patient care. It is the nurses who are involved daily with the patients and, very often, with the patients' families as well. The problem, then, is to see if training in dealing with death and dying affects positively the attitudes of nurses toward death and dying.

Statement of the Purpose

The purpose of this study is to compare the attitudes toward death and dying of practicing nurses with two or fewer years of nursing experience and those with more than two years of nursing experience who have and have not had training in dealing with death and dying.

This study intends to test the following hypothesis:

There is a difference in attitudes toward death and dying between experienced nurses who have had prior training in dealing with death and dying and experienced nurses with no prior training in this area. If the hypothesis is supported, it will support the need for counselors to train and/or to counsel with hospital staff concerning death and grief.

Significance of the Study

This study seeks to substantiate the positive effects

of training in dealing with death and dying, thereby opening an avenue of specialization for counselors as leaders of seminars for, trainers of, or counselors to hospital staff in coping with death and grief of patients and patients' families as well as, ultimately, their own death. Although it is hoped that positive attitudes of nurses affect patients' attitudes positively, this study does not intend to test this aspect. M. D. Anderson Hospital and Tumor Institute in Houston, Texas has a staff counselor for this purpose and more recently has added a counselor for the nursing staff specifically to help with the stress, depression and other emotional problems encountered in the daily care of seriously ill and terminally ill patients (McDonald, Note 1). The services of such counselors could probably be of help in hospitals other than those dealing with such seriously ill patients, as well. Such counselors might also be of service to medical and nursing schools for students in the clinical phases of their education who are newly exposed to "losing" patients with all the emotional turmoil such situations bring.

Definitions

Attitude is the sum total of one's inclinations and feelings, prejudice or bias, preconceived notions, ideas, fears, threats and convictions about any specified topic

(Thurstone, 1967).

Training consists of any seminar, course or workshop of any time limit.

CHAPTER II

REVIEW OF LITERATURE

Death has long been a taboo subject in the American culture. Euphemisms are used to refer to it. Children are shielded from it. It is, however, a part of the life process which is denied, hidden and avoided as much as possible. "Death is as much a part of human existence, of human growth and development as being born" (Kubler-Ross, 1975, p. x). Kubler-Ross talks of "the increased fear of death, the rising number of emotional problems and the greater need for understanding of and coping with the problems of death and dying: (1969, p. 2) in the past few decades.

People no longer die in the comfort, familiar surroundings, and peace of their own homes as once was customary. "The majority of Americans can expect to die in a hospital or in a home for the aged" (Kavanaugh, 1972, p. 5). Now they are isolated in depersonalizing hospitals among strangers to whom the very presence of a dying patient is a painful and uncomfortable reminder of their failure or inability to restore health, which is after all their purpose and the reason for which so many years were

spent in training (Kubler-Ross, 1975). After death, the patient is usually whisked away to a funeral home where his body is chemically preserved and his face is painted and made up to look "real" or alive (Lifton & Olson, 1975). Death is still denied at the funeral stage.

Kubler-Ross (1975) and others in the field of thanatology find that the study of and work with the dying, instead of being morbid and terribly depressing, can be one of the most gratifying experiences possible. These experts believe that education about, acceptance and understanding of death and the grief process are of great importance to the mental health of this culture.

Death Education for Nurses

Kubler-Ross was a professor of psychiatry in 1965 when four theology students at the Chicago Theological Seminary approached her for assistance in a research project. Thus began one of the first interdisciplinary seminars on death and dying. Those involved were clergy, nurses, doctors, student nurses, medical students, and theology students. The families of dying patients were ultimately involved in this and subsequent seminars. The seminar included interviewing hopelessly ill patients and family members and subsequent discussions of these interviews (Kubler-Ross, 1969). From the publicity of her first book, interest was

aroused nationally. More and more health professionals, lay people and institutions became involved with the needs of the terminally ill and their families through seminars, lectures and workshops (Kubler-Ross, 1974). Various medical and nursing schools and theological seminaries began inviting Kubler-Ross to speak to them. Many books and journal articles were written for members of the health and social work professions as well as for the general public. Kubler-Ross has made many speaking engagements on the subject throughout the nation and the world (Kubler-Ross, 1975).

Still, such training is not always a required part of the curriculum for medical and nursing students. The questions asked of Kubler-Ross by medical personnel indicate the need for education in this area (Kubler-Ross, 1974). Southwestern Medical School in Dallas is in the process of setting up, in the second and fourth year curricula, a program on death and dying to be incorporated into the existing curriculum which will be required next year (Stone, Note 2). At Dallas Baptist College Nursing School, there are some lectures and discussion in the sophomore year when oncology is covered and in the junior and senior years in medical and surgical nursing. There is also one-to-one interaction with the clinical instructor if the subject arises during the clinical phase of instruction (Tickle,

Note 3). At All Saints Episcopal School of Vocational Nursing, the subject of death and dying is covered through lectures, discussions and role-playing in classes in basic nursing skills, geriatrics, mental health, and pediatrics (Barrett, Note 4). At Texas Woman's University Nursing School, the subject is covered in required junior year courses in medical-surgical, psychiatric, obstetric, and pediatric nursing and in the required senior year course in complex problems. The amount of emphasis placed on death and the grief process in these courses depends upon the professor and his or her comfort with the subject (Buckles, Note 5). At Baylor University School of Nursing, the required junior year course, Nursing Assessment for Health Promotion, covers the psycho-social and physiological aspects of death and dying. During the clinical phase of study, if a student's patient dies, there is a post conference held with eight other students and a clinical instructor for discussion of the case and the feelings involved (Eager, Note 6). At the University of Texas at Arlington Nursing School, death and dying was officially included in a course in nursing care at developmental stages of life beginning in January, 1980. The subject is integrated into various content areas of the curriculum; the extent to which it is covered again depends on the professor. This school does have a clinical elective at the

graduate level which is an individual case study of a dying person and his family (Burns, Note 7).

Several studies of nurses' attitudes toward death and dying advocate educational experience as the tool to help nurses deal with death and the dying process. Such educational experience in nursing schools is a prime target area but there is also a great need for such education for those nurses already in the work force practicing nursing. Counselors or counseling, per se, would most likely be involved in the educational experience outside the nursing school arena but counselors could be involved as consultants in the development and application of programs in the nursing curriculum (Quint, 1967).

Quint discussed the problems encountered by student nurses and presented proposals for change in the nurse education system. She stated that

> the variations in reported experience suggested that what students learn about the care of dying patients takes place as much by chance as by advance planning and that schools of nursing give relatively little consistent attention to teaching about death, and particularly to the interactional problems associated with the dying process. (p. 3)

An example of this is student assignments to patients. Without careful planning, it often happens that some students can complete their training with no contact with a dying patient while others may have, starting with their

first patient assignment, multiple encounters with dying patients, the effect of which can be very negative and even drives some students away from the nursing profession. In all of the schools in Quint's study, the curricula stressed the life-saving goals of nursing practice. Emphasis tended to be on procedures and activities rather than conversational interaction. Quint believes nurse teachers to be the key to providing the educational experience beneficial to dealing with the death and dying situations to be faced by students. "The extent to which a nurse teacher is comfortable in teaching about nursing care involving the dying patient is greatly influenced by her own prior personal experience with death" (p. 55). Nurse teachers need regular support in the difficult task of being supportive of students who are learning to interact more openly with dying patients. Since

> it appeared that nursing students are not being prepared to assume responsibility for many of the complex and serious problems nurses meet in practice . . . (and) there is every indication that nurses who work in hospitals will encounter more, rather than fewer, problems in which death or dying is a significant feature (p. 227),

changes in the educational process were proffered. The focus would be on patient well-being, that is physical and psychological care. In the first year, there needs to be more content about death as related to cultural patterns

and societal values as the basis for open discussions before students are assigned to patients. There needs to be systematic and planned assignments to dying patients, both observational and participative, under relatively controlled conditions so that the probability of students' having bad experiences which foster a retreat from dying patients would be lessened. There needs to be an environment in which the student can directly confront such feelings as helplessness, frustration and hopelessness with support and direction from teachers. There is a need to raise the level of teacher preparation for the difficult task of teaching about death as a nursing phenomenon.

Coyne (1977) proposed a conceptual framework for death education for nurses. She focused on the lack of an organizational structure of the knowledge of death and dying. To construct this framework, she employed Rogers' (1970) theory of nursing, which combines the natural sciences and the philosophy of humanness, with the basic tenets of existentialism, which view human nature in its wholeness--physical and emotional.

Coyne agreed with Quint (1967) on several points: (a) that the educational preparation of the nurse-teacher influences the student who becomes the nurse who encounters the dying patient and the way she chooses to approach

this encounter, (b) that there is a high value attached to life-saving procedures and technical activities to the detriment of personalizing services to the dying, (c) that many nursing students continue to graduate without any experience with a dying person, and (d) that there is a need for planned experiences with dying persons within an organized structure of death education. Coyne felt that, since nurses are part of a larger group who do not witness and experience death because people are no longer dying at home surrounded by family members and friends but are dying more and more in medical institutions where nurses play a major part in the care of dying persons, they have a double need for education in death and dying for their own well-being as well as that of the patients they care for. She believes that death needs to be viewed more as a normal human situation rather than as a biological and technical function.

There have been some studies done to assess attitudes of nursing students who have had various educational experiences dealing with death and dying. Snyder, Gertler and Ferneau (1973) studied changes in nursing students' attitudes toward death and dying as a measure of curriculum integration effectiveness. This curriculum involved an introductory freshman course called Communications which

employed lectures on dealing with dying patients and a six month group experience to facilitate the students' ability to assess and deal with their own reactions to various student experiences, including care of dying patients. Second year students study the process of mourning and grief in greater depth and usually have experiences in caring for dying patients due to more clinical contact hours. The third year (senior) students study pathological grief reactions and special problems of caring for geriatric, terminally ill and medical/surgical patients in more detail during the psychiatric nursing experience. Freshman and senior students were given the Social Concerns Subscale which deals with feelings, thoughts and activities concerning personal death or death of relatives and friends. There was a consistent trend with the progression, from freshmen to seniors, away from the "frequently" to "never" responses in all questions. The authors felt that

> the tendency . . . in the course of nursing education is to reflect less on personal feelings about death and dying, but not deny them extensively. This last fact could be attributed to the curriculum described above, in that the extent of the denial is not as great as one might expect from the study of non-medical professionals, and reflects rather an acceptance of, and degree of comfort with, feelings and thoughts of death. (p. 296)

Yeaworth, Kapp and Winget (1974) compared freshman and senior students in a baccalaureate nursing program in

their attitudes toward death and dying persons. The curriculum of this program included experiences in caring for dying patients, classes on loss, grief and death, small group discussions and the availability of one-to-one counseling for those students who take care of dying patients. The responses of the senior students indicated greater acceptance of feelings, more open communication and broader flexibility in relating to dying patients and their families. The overall findings of the study suggested that important shifts in attitudes concerning dying and death can result from the nursing education. Suggestions for a longitudinal study to verify attitude shifts, for observational studies to determine if such attitude changes are reflected in subsequent professional behavior, and for studies using similar instruments to incorporate assessment of faculty attitudes, as well, were made. Martin and Collier (1975) assessed attitudes toward death of third year baccalaureate nursing students before and after exposure to curricular experiences related to death consisting of readings, viewing videotapes of interviews with dying patients, a two hour seminar and discussion on "Death, Grief, and Grieving", and direct and/or indirect contact with dying patients (not available or assigned to all participants). The responses of the posttesting showed

changes in attitude among the participants. A great majority perceived positive changes in feeling more comfortable talking about death and more prepared to deal with death, including their own. Most participants cited the seminar discussion as the most important factor affecting their attitude changes with care of a dying person as a secondary factor and suggested such seminars for future death education programs. The authors feel that it is difficult to classify attitudes as positive and negative and it would be more helpful to determine effective involvement with dying persons by defining such involvement in behavioral terms. Hopping (1977) tested whether a change in attitude toward death and dying was associated with a clinical course on cancer treatment by comparing 40 senior nursing students, half of whom took the course. The results showed no change in attitude in either group from pre- to posttesting but, overall, students in the study group showed more positive attitudes toward death. This author also recommended a longitudinal study of the question be conducted. He believes that death education for nurses should be continued but the objective of such education be to teach nurses how to talk about feelings of patients with patients and about personal feelings with someone else (counselor). He indicated that the halo ef-

fect is in operation in such testing and there is room to question any instrument which purports to indicate attitudes toward death.

Of the four studies on changes in attitudes of nursing students toward death and dying, three showed positive changes (Martin & Collier, 1975; Snyder et al., 1973; Yeaworth et al., 1974). These findings tend to support the contentions of Quint (1967) and Coyne (1977) that there is a dire need for changes in current nursing education concerning death and dying for the sake of nurses and dying patients and their families.

Attitudes of Nurses

Five studies were found that measured results of workshops or counseling sessions. One study with nurses (Murray, 1974) used a program of six one and one-half hour sessions a week apart including lecture-discussion, audio-visual presentations, group dynamics, role-playing, and sensitivity exercises with relevant readings distributed at the end of each session. Templer's (1970) Death Anxiety Scale was administered at the beginning of the first session, upon completion of the program, and four weeks after program completion. There was a decrease in anxiety from pretest to posttest 1 and from posttest 1 to posttest 2. The decrease was significant only from posttest 1 to post-

test 2. This was thought to be due to the participants' having time to reflect on feelings and attitudes toward death or having time to use, personally or professionally, the information received in the program. The author concluded that the fact that a reduction of death anxiety occurred provides support for the contention of Templer, Ruff and Franks (1971) that anxiety is not a fixed entity but rather a state that is sensitive to environmental events, including therapeutic intervention. However, another study with college students (Bohart & Berglund, 1979) found no significant difference between the control and treatment groups. The treatment included building trust and sharing personal experience, exposure to a mortuary, exposure to personal feelings about death, and exposure to a person with a terminal illness with a live or videotaped model to observe. Another study (Laube, 1977) with nurses used a two-day session of lectures, films, small group discussion, and experiential work. Templer's (1970) Death Anxiety Scale was imbedded in the last 25 questions of the Minnesota Multiphasic Personality Inventory to render those items less obvious to the participants in a pretest, immediate posttest, and one-month and three-month post-workshop tests. Anxiety decreased in all posttests but was significant only in the one-month post-workshop testing. A fourth especially well-conducted study (Miles,

1976) used a six-week course entitled "Coping with Death and Dying in High Risk Areas of Hospitals" which employed films, audiotapes of dying persons, and the play, "You Didn't Know My Father", with discussion, sharing personal feelings and experiences, and role-playing. There were four groups of subjects, two treatment and two control groups. Both treatment groups took the course but at different times. The control groups were nurses involved in high death risk areas of hospitals who did not take the course and freshman nursing students at a local university. Instruments used were the Death Anxiety Semantic Differential Parts I and II and the Attitude Toward Dying Patients Questionnaire for pre- and posttesting. It was concluded that the course had an impact on changes in attitudes toward both death and dying patients. The author pointed to the need for more study to be done to find suitable instruments for assessing attitudes toward death due to the complexity of studying and assessing attitudes.

Another study (Kubler-Ross & Worden, 1977-78) assessed attitudes and experiences of death workshop attendees during a four year period. A large percentage of the attendees were women who were nurses. It was found that nurses tended to anticipate a sense of disbelief as their reaction to learning of having a terminal illness. A significant

number of nurses would not tell their families about their fatal illness because they did not want any pity although 76% of all attendees favored telling their families. Nurses were more likely to put their trust in their parents as a resource for help when dying. Nurses experienced the most difficulty in working with young patients who, they felt, were dying "out of season." Unfortunately, there was no post-workshop questionnaire done to detect any changes in attitudes. It was noted that the sample is not a typical or representative group of health care professionals. In conclusion, the authors state that, since only 8% were able to find their first experience with death acceptable and 78% projected feelings of anger, being cheated, disbelief, depression, tension and anxiety upon being told of having a terminal illness, "we are faced with a poorly prepared group of 'helpers' whose role is supposed to be a reassuring, quiet listener to those who are faced with their impending death" (p. 104) especially considering that these were health care professionals who were willing to attend lectures and workshops on death and dying and obviously sensitive to their needs and problems with the topic.

Two studies involving support or counseling groups for nurses but not involving empirical testing were found.

One study (Schowalter, 1975) dealt with pediatric nurses' dreams of death as discussed in ongoing weekly staff meetings. These meetings provided nurses support and understanding from the physicians and other staff members as well as some voice in the policy of the individual child's care. Thus attention was paid to the needs of the dying patient and those individuals who were providing his care. At one of these meetings, it was discovered to be common for nurses to dream of patients before and after their deaths. In discussing the dreams at various times, it was found that they had a consistent pattern of content and were perceived as wish fulfillments (patients came back to life) fused with remorse or guilt about the lack of success in treatment. Common problems of fear of premature burial, guilt from feelings toward difficult patients, loss of personal dignity or humanity of the dying patient, and injustice of death during childhood were discussed. The second study (Price & Bergen, 1977) involved the relationship to death as a source of stress for nurses on a coronary care unit. Counseling sessions with a psychiatrist were requested by these nurses to deal with their feelings that things were "crazy." Stressful confusion was found in feelings of not being able to do enough to save a life while doing too much and interfering with nature and of

being responsible for the care of an ill or dying patient and of being responsible for the occurrence of the patient's illness or death. Fears of being a failure and personal death were underlying conflicts. The authors conclude that it appears "that the question of constructing a meaningful relationship to death still remains largely under the taboo of silence in medicine as well as in society" (p. 237).

Three (Laube, 1977; Miles, 1976; Murray, 1974) of the five studies measured changes in attitudes or anxiety following workshop or counseling experience. One study (Bohart & Berglund, 1979) found no significant difference and one study (Kubler-Ross & Worden, 1977-78) recorded only pre-workshop attitudes. Two authors (Laube, 1977; Miles, 1976) recommended further studies along the same lines and with other medical personnel. Two studies (Price & Bergen, 1977; Schowalter, 1975) indicated that nurses need and respond to group support and discussions of problems and feelings associated with death and dying even though such interaction may not solve or cure their problems with the topic.

Experience

Another facet of study on dealing with death and dying involves work experience, i.e., area or specialty of nurs-

ing as well as number of years practicing nursing. Several studies investigating the effects of work experience on attitudes of nurses toward death and dying have been made.

Two studies were made comparing attitude or anxiety of nursing students and graduate nurses. Golub and Reznikoff (1971) compared attitudes about suicide and death of experienced professional nurses and first year nursing students to test the hypothesis that nurses' professional education and experience influenced their attitudes toward death. Statistically significant differences were found. Intragroup comparisons of graduate nurses according to nursing specialties and years of nursing experience showed remarkable similarities in attitudes and indicated that nurses appear to acquire common attitudes early in professional experience which remain comparatively stable throughout their nursing careers. Denton and Wisenbaker (1977) attempted to test the hypothesis that experience with death and dying is inversely related to death anxiety. Responses to two of the three death experience questions supported the hypothesis. However, when controlling for experience on the second question (Have you ever seen a person die? If yes, have you seen a violent death?), nurses (higher death experience) had higher death anxiety than nursing students (low death experience). This finding has

significance concerning the approach to death education of nurses and other medical personnel.

Two other studies concentrated on nursing home personnel. Pearlman, Stotsky, and Dominick (1969) found a relatively more open attitude in less experienced personnel (students) who felt they could talk about death with a dying patient easily and directly while more experienced personnel tended to feel uneasy in this situation. Those nurses having more experience with death favored instruction regarding management of the dying and experience with dying patients in training personnel to deal with death. On the other hand, those having less experience with death stressed having courses and seminars on ministering to the dying rather than actual experience with the dying during training. This study also indicated that nurses with more experience with death are more likely to avoid the dying and feel more uneasy discussing death with dying patients. Howard (1974) found that work experience in a nursing home encouraged avoidance of death in his study on death attitudes of nurse aides. Nurse aides were chosen over registered nurses to control for the possibility of training in school which could influence attitudes toward death. There was no conclusive finding.

Other studies dealt with attitudes of medical person-

nel in various areas of medical care. Geizhals (1975) compared attitudes toward death and dying of occupational therapists and intensive-care unit nurses. The occupational therapists were of three groups: (a) those who had worked with dying patients, (b) those who had worked with dying patients only as students, and (c) those who had never worked with dying patients. The nurses were those who chose to work in a setting in which they had to deal with life and death situations. A questionnaire which measures death anxiety was completed by the voluntary participants. It was found that the three choices for each question were often not sufficiently distinct or applicable for the respondents' answers. However, some trends in the data appeared. The nurses tended to be younger than the occupational therapists and nurses and occupational therapist group b gave the most anxious answers. Both these groups were of average younger ages than the other two groups so the differences may be due to age. The author concludes also that the results may have less to do with the ability to measure death anxiety than with factors of age and religion (There was a question dealing with funeral practices which are precluded by some religions.). Gow and Williams (1977) attempted to relate variations in anxieties toward death and dying to the type agency in which the

nurses work, to the experiences of caring for the dying, and to the nurses' demographic characteristics. They gave an anxiety scale, an Osgood semantic differential scale (attitude scale) and a work staisfaction scale to randomly selected, consenting nurses from chronic and acute care hospitals and community care agencies. The major determinants for the attitude scale were anxiety, care and age, in order of importance. Age was strongly related to anxiety and care, and agency was related only to care.

> The results suggest that to modify nurses' attitudes toward death and dying, attention should be focused on the nurses and the attitudes and anxieties they bring to their work. The key appears to be to modify the nurses' attitudes and anxieties either through educational or clinical experiences. Perhaps formal learning experiences could serve to teach younger nurses what they would appear to learn through aging.
>
> In summary, the personal experiences and attributes of nurses primarily determine their attitudes toward death and dying. Even though agencies provide a milieu in which the nurses practise, agencies have minimal effect on the attitudes of nurses. (Gow & Williams, 1977, p. 198)

Popoff (1975) surveyed nurses as to their feelings about death and dying. The respondents replied to a questionnaire in a nursing journal. Most of the respondents dealt with dying patients two or three times a month and their reactions differ somewhat from those with little or no contact with dying patients. Those with little or no contact were more likely to feel discouraged or depressed by con-

tact with and were less certain of their ability to provide technical care and manage psychological needs of terminally ill patients. Regardless of amount of contact with dying patients, only about half of all respondents had come to terms with their own deaths, suggesting that coming to terms with one's own death is not necessarily the result of cumulative experience with death and dying. Satisfaction and self-confidence in ability to provide care to terminal patients seem to go hand in hand. Amount of contact with dying persons does not appear to affect ease in discussing death and dying with a patient. Feeling comfortable or uncomfortable when a patient brings up the topic of death seems strongly linked to personal acceptance or non-acceptance of death.

It appears that work experience does affect attitudes and anxieties of nurses concerning death and dying. Three studies (Denton & Wisenbaker, 1977; Howard, 1974; Pearlman et al., 1969) tend to support the fact that, contrary to assumptions made in some death education, increased experience with death and dying increases anxiety or avoidance behaviors in nurses. Two studies (Geizhals, 1975; Gow & Williams, 1977) indicated age and anxiety were inversely correlated while the results of another study (Pearlman et al., 1969) refute this finding. It seems that all these findings support Quint's (1967) and Kubler-Ross'

(1973) contentions that there is a concomitant need for support and counseling during work experience for nursing students and practicing nurses.

Behaviors and Roles

In addition to attitudes and feelings about death and dying patients, some attention has been paid to behaviors and roles of nurses in dealing with dying patients and/or the families of dying patients. Freihofer and Felton (1976), under the assumption that it is the responsibility of the nurse to assist individuals and families through illness, suffering and death, used a Q-sort of nursing behaviors arranged by dying patients and their loved ones according to what specific supportive behaviors are deemed as more desirable than others. Responses indicated that aspects of physical comfort were given higher priorty than being allowed to express emotions which is at variance with experts and literature in the field of thanatology. Also, the respondents desired that most nursing behaviors be directed toward the support, comfort and ease of suffering of the patient rather than toward the relative. Ross (1978) described the problems of nurses' personal death concerns and how they effect their responses to dying patient statements. The subjects, 40 registered nurses and 18 licensed practical nurses, aged 23 to 66, were given

the Death Concern Scale, the Thematic Aperception Test, and responded to seven videotaped dying-patient statements prior to treatment. Treatment involved relaxation exercises, audiotaped guided fantasy of personal life and death and discussion of fantasies. After the discussion, subjects were readministered the seven dying-patient statements and the Death Concern Scale. Both sets of responses to dying-patient statements were rated as to openness or closedness of response (allowing further conversation with patient or not). Findings showed 29% of the subjects whose pre-treatment responses were rated as closed had post-treatment responses rated as open. The implication is that the treatment was successful in increasing the awareness of personal death concerns and the ability to respond more openly and interact more congruently with dying-patient statements. Keith and Castles (1979) described expected and observed behavior of nurses and terminal patients. It was noted that, since socialization and training are geared toward the return to health, the development of norms which specify appropriate behavior toward persons with a clearly limited future is inhibited. Since involvement with dying patients is not without risk and discomfort, it is no wonder that nurses develop strategies to decrease involvement and direct contact with such patients by concentrating on objects, tasks or equipment rather than on

the patient as a person. Although most patients agreed with instrumental behavior (doing something for physical comfort) as the most appropriate and most frequently observed behaviors for nurses, the majority reported the most distressing aspects of their illnesses involved social and psychological factors which might have been alleviated by more expressive behavior (related to emotional equilibrium) from the nurses. Such behaviors require more time from the nurses which can result in the patients' being considered "problem" patients, putting them in a double bind.

Two other articles suggest that nurses assume roles of therapist or counselor to bereaved families. Crowder, Yamamoto and Simonowitz (1976) described a pilot training program to prepare registered nurses in occupational health service to use crisis intervention techniques with county employees who had experienced a recent death in their family. The training program was a series of eight weekly one-hour presentations on crisis theory, signs and symptoms of morbid grief reactions, and illustrations of specific interventions and techniques of interviewing and evaluation along with relevant readings on crisis intervention and bereavement. There were not enough completed cases in counselee or control groups to make conclusions about the efficacy of the therapeutic approach in comparing the two

groups. However, most individuals in both groups expressed their appreciation that someone in the bureaucracy was concerned about their emotional well-being during their bereavement. The present participating nurses reported increasing comfort in discussing bereavement issues and decreasing anxiety about dealing with death and dying. Winder and Elam (1978) proposed that nurses are good choices as therapists to help with the extreme distress of all members of a cancer patient's immediate family. Since they are accepted into the family's home setting and are readily accepted in the role of caregiver (usually physical care), nurses are the logical choice for emotional caregiving as well. Kubler-Ross (1969) indicated that the terminally ill patient cannot be helped in a really meaningful way if his family is not included.

Some articles have been written concerning the expected and observed behaviors of nurses in dealing with dying patients and their families (Freihofer & Felton, 1976; Keith and Castles, 1979; Ross, 1978). Other articles dealt with specific roles for nurses in dealing with the bereavement of patients' families.

Counselors' Role

The education and support of nurses can be furthered by the skills of counselors. Counselors can be of service

in setting up educational programs in nursing schools as well as conducting workshops, discussion groups and similar activities for those nurses who are actually working with dying patients and their families, as students and practicing nurses.

Bascue and Krieger (1974) indicate that counselors need to prepare themselves to deal with death and dying by investigating available information on death and related topics, by exploring their own feelings and beliefs on the subject and by developing a foundation for providing services to clients who have death-related problems. They also believe counselors can be of help in aiding other professionals attend to death as a potential client problem for referral to counseling and for helping clients themselves.

Steele (1974) discussed counselors' methods for helping the dying and bereaved. The suggestions are: letting people express their feelings, educating people to the normality and stages of grief, helping family and friends relate to the dying person, helping young people explore feelings about death, overcoming their own fears of death, and aiding in memorializing the dead.

The counselor's job in helping people deal with death and dying appears to be threefold. The first part is to

educate themselves about the stages of the grief process. The second is to educate other professionals, especially medical, about the potential problems their clients may experience related to death. The third is to use methods and techniques to educate and help clients work through the grief process or other problems stemming from death and dying.

Summary

The literature indicates both a need for education of nurses in dealing with death and dying and acceptance of such education, via coursework, workshops or counseling, by nurses. Three out of four studies (Martin & Collier, 1975; Snyder et al., 1973; Yeaworth et al., 1974) of changes in attitudes of nursing students toward death and dying showed positive changes in these attitudes. These studies support the voluminous works of Coyne (1977) and Quint (1967) which advocate that nursing school curricula include specific and structured programs on death education. Three of four studies (Laube 1977; Miles, 1976; Murray, 1974) on workshop or counseling experience measured definite changes in attitudes or anxiety with post-tests following the experiences. Also, the indications of two other studies (Price & Bergen, 1977; Schowalter, 1975) that nurses need and respond to group support and discus-

sions of problems and feelings when dealing with death and dying point to the need and efficacy of education outside nursing school, in the everyday work situation.

Further evidence advocating the need for support and education of the working nurse in the area of death and dying comes from studies that show that work experience affects the attitudes and anxieties of nurses concerning death and dying. Three studies (Denton & Wisenbaker, 1977; Howard, 1974; Pearlman et al., 1967) report that increased experience with death and dying increases anxiety and avoidance behavior in nurses. Such evidence supports contentions (Kubler-Ross, 1973; Quint, 1967) that there is a need for support during the work experience of nursing students and practicing nurses.

Articles dealing with behaviors and roles of nurses show that education and support for nurses who work with dying patients and the families of dying patients is necessary in order to satisfy the needs of such patients and their families.

Concerning the counselor's role in education and support, two articles (Bascue & Krieger, 1974; Steele, 1974) suggested preparation and methods for dealing with the dying and bereaved. Suggestions included: Exploring their own feelings about death, education of other professionals

to recognize potential death-related problems in clients and content of or methods of conducting counseling sessions.

CHAPTER III

RESEARCH DESIGN

Subjects

The target population for the study was full-time registered nurses at county hospitals in a large, urban area of north Texas. The 185 subjects were randomly selected from rosters of nurses at the two hospitals in participation. Of those nurses randomly selected, 104 voluntarily chose to sign consent forms and fill out anonymous personal data and death attitude questionnaire forms.

Instrumentation

The instrument chosen to assess the nurses' attitudes toward death and dying was Form B of Hardt's (1975) death attitude instrument which is a Thurstone Equal-Appearing Interval attitude scale. This form "demonstrated a higher degree of statistical validity than Form A" (Hardt, 1975, p. 97). For Form B, concurrent and construct validities were of acceptable values: concurrent correlation was .84 and construct correlation was .98 (Hardt, 1975, p. 97). A reliability coefficient of .87 was produced for Form B by using the split half method of reliability with the Spearman-Brown "Prophecy Formula" serving as an adjustment for-

mula as noted by Hardt (1975). The scale is constructed so that the statements which are considered positive have a greater numerical value than those considered negative. Hence, more positive attitudes have higher scores. Scores are the mean value of all statements checked.

This instrument was chosen over other instruments because of its generality. This researcher feels that attitudes toward personal, patient, family member, etc. death combine into a general attitude toward death. This conception of attitude is in agreement with Thurstone's definition of attitude (See p. 3). Also, it would be most difficult to control for specific instances of death experience in order to compare individual or group scores.

Procedure

1. The approval of the Human Research Review Committee of Texas Woman's University was sought and obtained.

2. Written permission from the hospitals involved was obtained.

3. Written consent forms were signed by subjects choosing to participate in the study.

4. The data gathering instruments were distributed in various manners: some were distributed and collected by the researcher, some were given to head nurses who distributed and collected them, others were distributed and

collected by the director of nursing at the hospital.

5. Two way ANOVA was used to compare the scores of the questionnaires. The program was run in the Texas Woman's University Computing Center.

Hypothesis

The following hypothesis was tested:

There is no statistically significant difference in attitudes toward death and dying between nurses with more than two years' experience who have had prior training in dealing with death and dying and those with the same experience and no prior training in this area, and between nurses with two or fewer years' experience who have had prior training in dealing with death and dying and those with the same experience and no prior training in this area.

Statistical Treatment

This study was a posttest only control-group comparison of two groups at two levels $\begin{matrix} R \times O_1 \\ R \times O_2 \end{matrix}$. Two way ANOVA was used to analyze group differences in attitude scale scores. ANOVA was distributed in a 2 x 2 matrix. The ANOVA test applied was a program designed by the University of Pittsburgh (SPSS-20) and run in the Texas Woman's University Computing Center.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

The problem this study addressed was whether training in dealing with death and dying affects positively the attitudes of nurses toward death and dying. The subjects of the study were randomly selected full-time registered nurses at county hospitals in a large, urban area in north Texas who voluntarily participated in filling out consent, personal data and death attitude questionnaire forms. The subjects were grouped according to years of experience and training or no training in dealing with death and dying.

The following hypothesis was tested and rejected:

There is no statistically significant difference in attitudes toward death and dying between nurses with more than two years' experience who have had prior training in dealing with death and dying and those with the same experience and no prior training in this area, and between nurses with two or fewer years' experience who have had prior training in dealing with death and dying and those with the same experience and no prior training in this area.

In Table 1, inexperienced nurses are that group with two or fewer years' experience and experienced nurses are

Table 1

Descriptive Data of Scores on Hardt's death attitude scale

Subject groups	N	$\bar{X}$	SD	Range
Inexperienced				
Untrained	14	3.0707	.5196	1.8 - 3.8
Trained	30	3.2627	.4466	1.5 - 3.9
Experienced				
Untrained	30	3.0013	.5496	1.8 - 4.5
Trained	30	3.2040	.4973	2.1 - 4.3

those with more than two years' experience. Trained denotes those nurses with training in dealing with death and dying; untrained, those with no training in dealing with death and dying. It is to be noted that the group of inexperienced and untrained nurses contained less than half the number of nurses in the other groups.

As Table 2 shows, there was no interaction between years of experience and training in dealing with death and dying, but there was a significant main effect difference in the training variable.

Table 2

ANOVA Results

Source of variation	Sum of squares	df	MS	F	p
Main effects	1.216	2	.608	2.410	.10
Years	.097	1	.097	.384	.54
Training	.967	1	.967	3.834	.05
2-way interaction	.001	1	.001	.003	.959
Years-Training	.001	1	.001	.003	.959
Explained	1.216	3	.405	1.607	.192
Residual	25.223	100	.252		
Total	26.439	103	.257		

CHAPTER V

DISCUSSION

Summary of Findings

The problem studied was whether training in dealing with death and dying affects positively the attitudes of nurses toward death and dying. The subjects were randomly selected from rosters of full-time registered nurses at participating county hospitals in a large, urban area of north Texas. The subjects who chose to participate filled out written consent, personal data and death attitude questionnaire forms. For comparison, subjects were grouped according to number of years of experience in nursing and training or no training in dealing with death and dying.

There was found to be significant difference ($p < .05$) between the scores of those nurses with training in dealing with death and dying and those nurses without such training although there was a small spread between the highest and lowest mean scores (.2614). The mean scores of all groups were above the median score of 3.0, indicating neutral to relatively positive attitudes. The scores of those with training were higher, indicating more positive attitudes. There was no interaction between number of

years of experience and training or no training in dealing with death and dying.

Conclusions

It is encouraging that training in dealing with death and dying, of whatever form or duration of time, appears to positively influence nurses' attitudes toward death and dying. More positive nurse attitudes toward death and dying can be seen as doubly beneficial: to the total well-being of the nurse, personally and professionally, and hence to the total care and consideration given to dying patients and their families by nurses.

There are, however, two points of caution which need to be considered in reference to this study's findings. The first is consideration of the halo effect intrinsic in the self-reporting of the death attitude questionnaire. It is possible that the subjects involved, aware of being participants in a study, chose answers which they perceived as more socially acceptable rather than those answers perceived as less socially acceptable on a personal and/or professional basis. There were, however, many choices of negatively-scaled answers. Hopping (1977) and Miles (1976) indicate, respectively, the need to question that any instrument can indeed measure attitudes toward death and the need for more study to be done relative to finding suitable

instruments for assessing attitudes toward death due to the complexity of studying and assessing attitudes. Various experts in the field of attitude theory and measurement (Fishbein, 1967) do believe that attitudes can be measured but do caution about definitions of attitude versus belief and measurements thereof.

It appears that since there was no interaction between training in dealing with death and dying and years of experience that training in this area helps even those nurses with many years of experience to cope with death and dying. It would seem that more experience with death and dying does not make death easier to accept.

Implications

Since this study, among others, indicates a more positive attitude toward death and dying occurs after education, training or counseling in dealing with death and dying, those in the helping field, notably counselors, have some responsibilities in meeting the needs of those involved with terminal illness or condition, be they health care professionals, terminal patients or families of terminal patients. Such responsibilities can be met by counselors' educating themselves about the aspects of the grief and dying processes, mental and physical. There is a need for development of educational or training programs

for those who are to help health care professionals, patients and families as well as educational or training programs for the health care professionals as students and/or working professionals. Techniques for conducting individual or group counseling sessions for professionals, patients and families of patients need to be learned, improved and developed by counselors. More study is needed in all these areas to determine the most useful or helpful approaches, programs and techniques.

Depending upon policy, hospitals utilize variously titled members of the helping professions, e.g. chaplins, social workers, and/or counselors to deal with staff grief and/or patient-family grief or other problems associated with hospitalization, illness, etc. The various members of the helping professions must work together toward accomplishing goals of meeting the needs of all involved with death and dying, personally and professionally.

On a wider scope, the public in general would probably benefit from having more knowledge and resources for help in dealing with death and dying. This could feasibly be accomplished through various public and private institutions and the media. Schools, churches, civic or private organizations and clubs are some institutions which could conduct educational seminars on the subject. Television,

radio, newspapers, journals, and magazines can also provide information to the general public on death and dying. This would hopefully help to break the taboo of silence in American society regarding the subject of death.

Recommendations

It would be beneficial for this study to be replicated in another area of this state or in another state to see if the findings are comparable. It would have been interesting to have had pretest scores before training to compare with the posttest scores. Hardt (1976) conducted a study of attitude changes after classroom education on death and dying among college students. His findings indicate improvement of (more positive) attitudes of subjects after such intervention. An interesting finding was that it was easier to change attitudes toward death among those subjects with more unfavorable or negative attitudes than to alter more favorable attitudes. Further study of this implication is indicated to see if this finding would also be duplicated.

In the matter of specific types of training and what methods or techniques are the most effective, careful studies are needed. Methods such as discussion, counseling, encounters or interviews with dying patients, etc. need to be studied using pre- and posttesting to determine

which single or combinations of methods are most beneficial and effective. Controls of areas of nursing, years of experience and perhaps some demographic characteristics of the nurses involved would probably be useful in these studies. Attitude and anxiety scales would seem to be appropriate assessment instruments. It would also be beneficial for studies of attitude or anxiety levels of nurses in specific areas of nursing to be done to determine which, if any, nurses appear to be more susceptible to problems in dealing with death. These areas of nursing would then be target areas for concentration of training in dealing with death and dying.

Final Summary

As the literature indicates, certain types of training in dealing with death and dying can positively affect attitudes toward or lessen anxieties about death of nurses and other health care professionals. This study attempted to find out whether varied, unspecified training had a similar effect on full-time registered nurses working at county hospitals in a large, urban area of north Texas. Number of years of experience in nursing was another aspect which was considered. The scores used in the study were gathered from Hardt's death attitude scale, a Thurstone Equal-Appearing Interval attitude scale. The mean

scores of the groups in a 2 x 2 matrix were compared as was interaction between the groups by using two-way ANOVA. The main effect of training showed significant difference ($p < .05$) while experience and interaction of training and experience did not. There appears to be a need for more study in the areas of methods of training in dealing with death and dying and target areas of nursing practice for this training. The counselors who will be designing or giving the training need to educate themselves on the subject of death and dying and the methods used in training others to deal with death and dying, personally and professionally.

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Consent to Act as a Subject for Research and Investigation

1. I hereby authorize Franya S. Wilhelm to perform the following procedure(s) or investigation(s):

   To distribute anonymous personal information questionnaire and death attitude scale to volunteer subjects for completion.

2. The procedure or investigation listed in Paragraph 1 has been explained to me by Franya S. Wilhelm (Name).

3. (a) I understand that the procedures or investigations described in Paragraph 1 involve the following possible risks or discomforts:

   Cause me to recall grief and sad feelings about death. Cause me anxiety about my own death or that of someone important to me. Cause me to worry about death of patients under my care.

   (b) I understand that the procedures and investigations described in Paragraph 1 have the following potential benefits to myself and/or others:

   Provide data to support need for seminars or courses in nursing schools and other health care learning institutions and/or in hospitals for educating personnel in the area of death and dying for themselves, their patients and the families of patients.

4. An offer to answer all of my questions regarding the study has been made. If alternative procedures are more advantageous to me, they have been explained. I understand that I may terminate my participation in the study at any time.

5. NO MEDICAL SERVICE OR COMPENSATION IS PROVIDED TO SUBJECTS BY THE UNIVERSITY AS A RESULT OF INJURY FROM PARTICIPATION IN RESEARCH.

Subject's signature _____ Date _____

Personal Data Sheet

Age _____ Sex _____ RN _____ LVN _____ Other ___

College attended _____

Nursing School attended _____

Number of years practicing nursing since finishing nursing school _____

Area of nursing practice I work in (pediatrics, ICU, labor and delivery, etc.) _____

I have attended a seminar on death and dying. yes no

If yes, I attended the seminar in nursing school _____ while working as a nurse ____ other _____.

I have taken a course on death and dying. yes no

If yes, I took the course in nursing school ____ while working as a nurse _____ other _____.

The course/seminar was a required _____ an elective ____ course of the nursing curriculum.

Date(s) of recent death of someone I knew _____.

Please state relationship of person(s), i.e. patient, spouse, aunt, friend, neighbor, etc. _____

Remarks: _____

_____

_____

_____

The following items are not intended to test your knowledge. There are no right or wrong answers. Your responses are anonymous.

Directions: Read each item carefully. Place a check mark next to each item with which you Agree. No Marks next to items with which you disagree.

_____ The thought of death is a glorious thought.

_____ When I think of death I am most satisfied.

_____ Thoughts of death are wonderful thoughts.

_____ The thought of death is very pleasant.

_____ The thought of death is comforting.

_____ I find it fairly easy to think of death.

_____ The thought of death isn't so bad.

_____ I do not mind thinking of death.

_____ I can accept the thought of death.

_____ To think of death is common.

_____ I don't fear thoughts of death, but I don't like them either.

_____ Thinking about death is overvalued by many.

_____ Thinking of death is not fundamental to me.

_____ I find it difficult to think of death.

_____ I regret the thought of death.

_____ The thought of death is an awful thought.

_____ The thought of death is dreadful.

_____ The thought of death is traumatic.

_____ I hate the sound of the word death.

_____ The thought of death is outrageous.

Remarks: _____

_____