NURSES' ATTITUDES ON DEATH AND DYING

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CHAPTER 1

INTRODUCTION

Despite an increase in death education, America remains a death-avoidant society. The attitude of society toward death seems to be characterized by the denial of the reality of death. This denial by members of the health care system emphasizes the prolongation of life at all costs (Barton, 1977).

Nurses are confronted with the task of making the act of dying as smooth a process as possible. Yet, the nurses' role in meeting the needs of dying patients and their relatives is seldom clearly defined. The absence of norms as to appropriate behavior toward the dying person creates a situation where no one involved knows what to do. This produces a social death for the dying patient (LeRoux, 1977).

Fulton (1965) suggested that Americans react to death as they would a communicable disease; they avoid, deny, disguise, and make the subject an object of macabre humor. Rose's (1962) symbolic interaction theory explains how nurses are encultured into the larger death-avoidant society and how the fear of death may never be forgotten.

Because nurses' attitudes are acquired through acculturation in the wider society that is death-avoidant oriented, death education is incorporated into the nursing curricula in hopes that the students' anxieties and attitudes about death can be changed. A change in attitude can ultimately be reflected in the nurses' behaviors of caring for the individuals and families experiencing dying, death, and bereavement.

Within the health care system, some nurses are involved intensively in the care of dying patients and their families while others are not. This study explored these two groups of nurses' attitudes toward death. If attitude differences between the two groups of nurses can be reflected in subsequent professional behavior, perhaps care of the dying patient can be improved.

Problem of Study

Controlling for age and formal death education, this study compared the attitudes on death and dying of nurses who regularly work with dying patients to those of nurses who do not regularly work with dying patients.

Justification of Problem

Death and dying have been taboo topics for many years. In American society, many people have a fear of death. As Krant (1974) observed, fear is frequently a property of the unknown. Contributing to this fear is the fact that death seems to be an unacceptable topic of conversation.

Nurses' attitudes toward death are acquired through acculturation in the wider society and can seriously affect their behavior as professional practitioners. Conflicting attitudes about death may interfere with the nurses' abilities to provide compassionate and understanding care (Quint, 1973). Bowers, Jackson, Knight, and LeShan (1975) timed the interval between the sounding of a bedside call and the nurses' response and found that nurses took more time to respond to calls from patients listed as terminally ill than patients who were not terminally ill.

As long as nurses use the cure of the patient as a sign of success, they will be embarrassed by the dying patient who symbolizes failure. Embarrassment often induces nurses to use the strategy of denial which only intensifies the anguish of dying patients (Reck, 1977).

The nurse is the professional person with the major responsibility for dealing with a dying patient and his family. In a study by Hammons (1971), widows identified the nurse as the most helpful person in the hospital.

Studies by Glasser and Strauss (1968), Kimball (1971), and Kubler-Ross (1978) indicated that nurses' empathy with patients and families is greater than that of doctors. The authors noted, however, that nurses expressed frustration and anger in regard to what they could do when caring for the dying.

Bormann and Bormann (1972) observed that many nurses rated talking with a dying patient as one of the most difficult tasks. Nurses appear to be ambivalent in their reactions toward death. They apparently view the deaths of other people as controlled and predictable but feel anxiety when the threat becomes personal (Norris, 1955; Quint & Strauss, 1964).

Kubler-Ross (1975) described the attitudes of nurses toward death and dying. She indicated that when nurses were asked for cooperation in relation to their work with the dying patient, initially the nurses would cooperate. However, this cooperation was tinged with an angry attitude and inappropriate remarks. This anger appeared

to subside as the nurses felt more comfortable in caring for the dying patient.

Glaser and Strauss (1965) and Greenberg (1964) found that nurses may use the traditional physician-nurse role to hide their feelings about death. They refer patient and family questions to the doctors and avoid direct confrontation with sensitive topics by keeping a professional air when in the dying patient's room.

Kastenbaum (1967) designed a study using nurses' verbal respones to dying patients' statements and found over 80% of the responses to be denial, changing the subject, or reassurance. An example of a reassurance response was "You're doing so well now. You don't have to feel you are going to die." Less than 20% of the nurses entered into discussion of the patients' thoughts and feelings. Kastenbaum concluded that the clear tendency was for nurses to "turn off" the dying patients' statements about death.

Nurses are thrust into a very difficult position by having to provide intimate care for the dying while usually having relatively little influence over the treatment philosophy or regimen. A problem for nurses working with the dying is that the contact is so

personal. This contact has to do directly with the patient's dying body and with his reactions to his medications and procedures. A mutuality develops between the nurse and patient which envelops the former in the fate of the latter. This is especially true when an effort is made to provide continuity of care by reducing the number of nurses who minister to a terminally-ill patient (Schowalter, 1975).

Padilla, Baker, and Dolan (1977) indicated that nurses need further education about death in order to be aware of their own feelings. In addition, they need to develop skills that will enable them to deal with dying patients in a therapeutic and realistic manner. Glaser and Strauss (1965) stated that unless care and concern are made an accountable aspect of health care, individualized attention will continue to be met by a few select persons who are concerned about them as individuals.

In the last decade, death education has been increased throughout the United States and has been incorporated into nursing curriculums so that the nurses' anxieties about death do not block the process of helping the dying patient (Yeaworth, Kapp, & Winget, 1974). Fulton and Langton (1964) suggested nurses be reoriented

to the grief process as described by Lindemann (1944). Nurses need to end hypocrisy and the avoidance of death and learn to accept the process of dying. Glaser and Strauss (1965) recommended that nurses learn more about working with dying patients during their educational experience. LeRoux (1977) found that professionals were unprepared to cope with the psychological and spiritual needs of the dying person.

Nurses who are working with the terminally ill may benefit from an increased knowledge about death. Researchers indicated that working with the dying person can be a learning and growing experience (Kubler-Ross, 1978; Schowalter, 1975; Yeaworth et al., 1974). There is no other counseling with any other type of patient where it is so important to remove the white coat and be a human being. Those who have experienced such moments will agree that working with the dying patient is not all depressing; it can be instructive, gratifying, and, at times, a beautiful experience. Schowalter (1975) found that nurses who made any effort to understand death also gained a better understanding of life.

There are nurses who are working exclusively with dying patients and their families on cancer units. Have

these nurses benefited from the increase in death education? Are their attitudes about death different from nurses who rarely care for the dying patient?

This study investigated differences in attitudes of nurses who frequently work with the dying and nurses who rarely care for the dying patient. This information should be valuable to other nurses, especially those that are reluctant to care for the terminally ill.

Theoretical Framework

Attitudes about death have evolved throughout history from centuries of ideas and thought. The mystery of death has been the center of religious and philosophical thought (Cutter, 1974). In American society, there is an attitude that death is fearful and must be avoided. Nurses are acculturated in this death-avoidant society and are confronted with the mental health problems that arise from the culture's conflicting concepts about death (Fulton and Langton, 1964). Rose's (1962) symbolic interaction theory assists in explaining the relationship between the concepts of culture attitudes, values, and death, and it provided the theoretical framework of this study.

Symbolic interactionist theory was developed in Germany and America. American theorists included C. H.

Cooley, John Dewey, J. M. Baldwin, W. I. Thomas, and George Mead. Rose (1962) restated the theory in a simple, systematic, and researchable form.

Rose's (1962) symbolic interaction theory is a social psychological framework which explains man's distinctive characteristics that make man's behavior different from that of the other vertebrates. According to this theory, man lives in a symbolic and physical environment. Man learns through communication about common or shared symbols and the symbols have common or shared meanings and values. Through symbols man has the capacity to stimulate or influence others, and man can learn meanings and values from other men. Because man has a complex brain and a vocal apparatus, man has a special capacity for symbolic communication. Man's communication, which also includes nonverbal communication, is a social process in which two or more people contribute to the communication process. One person may speak a symbol, but the second person has to ascribe the meaning or value to the sound.

Through communication of symbols, man has a culture. Rose (1962) defined culture as an elaborate set of meanings and values shared by members of a society.

Culture guides much of man's behavior. Through the learning of culture and subcultures within societies, men are able to predict other's behaviors, gauge their behavior to each other, and take on roles with common symbols, meanings, and values. Within this culture, man can play many roles. Some roles conform to societal expectations; while others are deviant.

Rose (1962) theorized that man learns the requirements for behavior and conforms most of the time. This learning process is socialization. Most cultural expectations are not specific, but instead set limits for permissible behavior and, hence, the individual has some "freedom of choice" in roles and situations. Within a culture, there are conflicting cultural expectations, especially when an individual moves from one culture or subculture to another. In other words, all men are born into a society and are socialized to some degree to behave within the expectations of its culture.

Rose (1962) explained the process of socialization in three stages. The individual first learns through some psychogenic process, such as trial and error, and is "habituated" to a sequence of behavior and events. Secondly, the learner begins to understand the meaning of

a symbol because others' define it for the individual. This symbol may remain fixed in meaning and value or take on added meaning and value with new experiences. The third stage of socialization occurs when the learner attempts to communicate the perceived symbol and meaning to others.

The socialization process also occurs in subcultures. Man learns within societies' general cultures as well as within distinctive groups or subcultures. One may change subcultures and may drop or retain group affiliations as the individual matures. Socialization never ceases; society and its groups are continually creating new meanings and values. New learning may occur. This may include learning to not use the old meanings any longer. Rose (1962) called this social change. "Old" groups, cultural expectations, and personal meanings and values may be dropped, but they are not forgotten. This retention of "old" meanings is also an integration of newly acquired meanings with existing meanings.

This integrated, cumulative, evaluated symbolic learning is an ability of man and a major focus of Rose's (1962) symbolic interaction theory. A person can never "unlearn" something; only "relearning" is possible in

order drastically to modify learning. One's self-conception once learned affects an individual's behavior throughout life. An old meaning or habit may be broken, but the self-conception is not forgotten. The resultant behavior is an outcome of a struggle between the old self-conception and the newer one.

Symbolic interaction theory explains the relationships among society, culture, death, and education. Nurses are acculturated into a death-avoidant society. They learn about death through communication about common or shared symbols and meanings. Through symbols, teachers have the capacity to stimulate or influence others and nurses can learn new meanings and values for the subculture of nursing. Because culture guides much of the nurses' behavior through the process of socialization, nurses can be expected to be fearful of death.

The nurse learns the appropriate response or behavior through role taking. Nursing has traditionally relied on role modeling as a learning strategy especially in the achievement of attitude objectives and clinical area (de Tornyay, 1971).

Educators socialize students into the subculture of nursing and the learners understand the symbols and then

communicate their meaning to others. As nurses learn new meanings, old meanings may become less appropriate, but they are not forgotten. Their attitudes about death may have different meanings, but nurses will not forget their culture's fear of death. This attitude remains a part of their self-conceptions. With an increase in death education, nurses have attemped to relearn in order to drastically modify previous learning. Some nurses have decided to work exclusively with dying patients and thus are acculturated into another subculture. Other nurses have chosen not to work with dying patients. If the subculture of nurses who work regularly with dying patients have different attitudes toward death because they have altered society's death avoidant attitude and relearning has occurred, the attitude scores of subcultures or different groups of nurses would be different. In other words, the two groups of nurses would have significantly different attitude scores as measured by the Questionnaire for Understanding the Dying Person and His Family developed by Yeaworth et al. (1974). This study explored nurses' attitudes toward death to find out if those nurses who work regularly with dying patients were more flexible, open, and honest in their attitudes toward

dying patients than those nurses who do not work regularly with dying patients.

Assumptions

The assumptions for this study were:

1. Nurses are acculturated into a death-avoidant society.

2. Nurses are socialized into the subculture of nursing and into specialty subcultures.

3. Through death education, nurses can relearn in order to modify previous learning about attitudes toward death and dying.

Hypothesis

With age and formal death education controlled, there is no difference in the attitude scores toward death and dying of nurses who care for the dying patient on a regular basis and nurses who do not care for the dying patient on a regular basis as measured by the Questionnaire for Understanding the Dying Person and His Family.

Definition of Terms

The following terms were defined for the purpose of this study.

1. Attitude on death and dying--a complex, structured, psychological tendency to respond in a consistent way to the concept of death and dying. Attitudes toward death and dying were measured by the Questionnaire for Understanding the Dying Person and His Family developed by Yeaworth, Kapp, and Winget (1974). Low scores indicated flexibility in interpersonal relationships, desire for open communication around critical issues, and concern for the psychological status of dying patients and their families. High scores indicated an overall profile of rigidity of attitudes and showed lack of insight into psychological factors influencing the self and others.

2. Formal death education--an organized, structured workshop, seminar or class with curricula pertaining to information about death and the process of dying.

3. Nurses--persons licensed as registered nurses. Two groups of nurses were selected: (a) those associated with two cancer nursing societies in a Southwestern state and (b) those selected from that state board of nursing.

4. Regular basis--recurring consistently at least daily within the nurse's employment.

Limitation

The limitation of this study was that the amount of informal death education may have varied among the subjects.

Summary

In America's death-avoidant culture, there exits a subculture of nurses who work regularly with dying patients. Through formal and informal death education, this subculture of nurses could relearn and modify previous learning about their attitudes toward death and dying. This research investigated whether these nurses have attitudinal differences when compared to other nurses who do not regularly caare for dying patients.

CHAPTER 2

REVIEW OF LITERATURE

Within America's death avoidant culture, the hospital team has become the master of death. Nurses who come face-to-face with dying patients daily must find ways to behave openly and therapeutically with the terminally-ill client. This chapter presents a review of literature dealing with the concept of death, American attitudes about death, death education and anxiety, death attitudes of health professionals, and cancer nursing and death.

Conceptualization of Death

Throughout history, death has been a mystery and a core of religious and philosophical thoughts. Many concepts, philosophies, and attitudes about death have evolved from centuries of ideas and thoughts. Birth and death are both inevitable and expected, but the birth process is considered normal whereas dying is regarded, in most cultures, as pathological (Cutter, 1974).

Death and dying have been taboo topics for many centuries. Farberow (1963) and Norris (1955) suggested that the American culture places tremendous value on youth and, to a considerable extent, ignores aging and dying as

part of the life process. Death from old age is frightening to people in such a death-avoidant culture (Neugarten, 1968). In contemporary American society, people never die, they "pass away." They are never dead, they are "departed," as if death were only an extended vacation from the vicissitudes. Many people have an inbred fear of death. As Krant (1974) observed, "fear is frequently a property of the unknown" (p. 49). Death seems to be an unknown dimension of the living. Because death is an unacceptable topic of conversation, the concept of death becomes even more mysterious and fearful. Talk about death usually results in embarrassment, invasion of private life, or pretense (Knutson, 1970). People fear death and try to deny that it exists because they find it unexplain-able or they have not learned how to deal with it (Bunch & Azhra, 1976).

Death is more than a biological state; it is a psychological reality that affects all people by taking the life of someone loved, or one's own life (Mullins, 1981). Dying is a social experience as well as a biological one (Quint, 1966).

Death can be a growing experience for the person dying and significant others. Kubler-Ross (1969) believed

that when dying persons were offered an opportunity to participate in an honest relationship with a health professional, they become involved in a psychological process which progresses through five stages. After working through the stages, the patient is truly free to achieve a death with dignity.

American Attitudes Toward Death

Nurses are acculturated in this death avoidant society and are confronted with the mental health problems that arise from culture's conflicting concepts about death (Fulton & Langton, 1964). As shown in many animated productions, death is not presented as a permanent state. Society appears to support the notion that death is somehow unreal and less than serious. Death in American society generally has negative connotations and it is socially taboo to discuss death in a general conversation. Americans usually reach adulthood with little opportunity to experience death or grief (Quint, 1969).

Although in most cultures death is not an anticipated event, the death denial so characteristic of American society is a relatively recent development. At the turn of the century, death was accepted as a part of life

(Mount, 1974). Few persons died in hospitals, and children were not isolated from death (Krant, 1974).

Present-day medical practice and hospital care are in contrast to trends at the turn of the century. Now approximately 80% of the deaths in the United States occur in hospitals (Aries, 1974). Institutional philosophy and physicians' attitudes significantly affect clients' deaths. With the exception of hospitals specifically designed for the terminally ill, hospitals' philosophies usually embrace the concept of cure and return to maximum functioning. Recognition of life's end is not included in these philosophies; therefore, death is not an acceptable goal (Kohn, 1976; Shneidman, 1971).

Today Americans are becoming increasingly dependent on the idea that medical science, government, and the health care system are responsible for the health and comfort of society. Philosophically, Americans believe modern technology will solve all problems and crises will not occur. In light of this philosophy, death and loss become increasingly threatening. Families and patients expect a cure through medical technology. The advancement of modern medical technology has transformed the hospital into a foreign and threatening place. It has provided

the health team with the ability to maintain a person with a poor prognosis for an extended period of time (Dracup & Breu, 1978).

Avoidance of the human aspect of dying is perpetuated by the health professional's use of obscure language and the prevalent consumer's philosophy that views mortality as a treatable condition. The process of dying involves a consumer's demand for increased technological management (Illich, 1974). The terminally ill expect the health care system to assume responsibility for transforming the experience of dying from a personal challenge into a treatable problem (Sinacore, 1981).

Death seems to assume different meanings at different life stages. The child, adolescent, adult, and aged all perceive death differently. Factors which may contribute to personal definitions of death include ability to conceptualize expectations of self and life experiences (Folta, 1965).

Many studies have examined death and dying attitudes for different age groups. The life of a child has great social value, and the death of that child is more significant than the death of an older adult. The parents often feel responsible for the death of a child (Glaser &

Strauss, 1964; Stoller, 1980). The greater the patient's social loss characteristics, the greater will be the effect of that patient's death on the health team members (Mullins, 1981).

Havighurst's (1971) findings indicated that married respondents (20-29 years) were most concerned about their spouses and children when they thought about their own death. The younger respondents (20-24 years), most of them unmarried, were most concerned about leaving their families behind and about how the loved survivors would be able to cope with their grief. Concern for themselves and any suffering they might undergo was deemed relatively unimportant except for the hardships it would impose on loved ones. Those in their early 20s expressed concern that they had not lived life to its fullest or that they had not aaccomplished anything worthwhile with their lives; therefore, fear of death itself was seldom mentioned as a major concern.

Kimball (1971) found that women with dependent children viewed their own death as abandonment of their children and that this view generated overwhelming guilt feelings which were difficult to resolve. Married men in their 30s were concerned about the welfare of their

families, specifically, financial security. In both sexes, the fear of pain and prolonged dying reoccurred frequently as well as the fear of the enforced end of productivity.

The middle-aged person usually has binding family responsibilities and his death means a complete upheaval of the family (Duvall, 1967). Neugarten (1968), in a study about death attitudes of middle adulthood, found that the principle concern was welfare of children, spouse, and other loved ones. Financial security for the survivors was an overriding problem for both sexes. Attitudes of the subjects seemed to reflect an ever-present dread of separation which appears as a threat at all ages.

The lives of the elderly are seldom highly valued and, therefore, their deaths are not highly disturbing (Mazzola & Jacobs, 1974). The developmental task of aging is to adjust to the loss of one's spouse (Duvall, 1967). Lieberman (1970), in his study of late adulthood (70-78 years), indicated that a majority of the elderly expressed concerns related to the unnecessary prolongation of life and being allowed to die with dignity and without pain. The majority of the subjects indicated no concern about

what happened after death; however, a strong religious belief seemed to provide great comfort. According to Neugarten (1968), fear of death is more common in older persons who do not report religious preferences, who have lower intellience-quotient (IQ) tests scores, who have experienced rejection in the past, or who are depressed. Generally, the elderly reported they fear death less than they fear prolonged illness, dependence, incapacitation, or pain, all of which brings threats of rejection, isolation, and loss of social role, self-determination, and dignity. Some elderly persons looked forward to death as a reunion with loved ones, or welcome it because they have already become socially dead in their own and others' eyes.

Riley (1970), in a cross-sectional survey of the adult population of the United States, found that most of the respondents thought that death was not as tragic for the one who dies as for the survivors. Only a small percentage thought of death in terms of suffering, and most subscribed to the idea that it is sometimes a blessing.

Despite an increase in death education, America remains a death-avoidant society. The attitude of society

toward death seems to be characterized by the denial of the reality of death. This denial in the health care system emphasizes the prolongation of life at all costs (Barton, 1977). Although Americans are beginning to acknowledge and talk about death as a part of the life process; it is still a taboo subject in current society. Americans have built-in defenses against being hurt by death. Death is likened to sleep and survivors can go about their life as if the deceased is only asleep. Public displays of emotion are not considered appropriate; restraint and composure are accepted models in happiness and grief alike (Marks, 1976).

Death Education and Death Anxiety

In the last decade, death education has been increased throughout the United States and has been incorporated into the nursing curriculum so that nurses' anxieties about death do not block the process of helping the dying patient (Yeaworth et al., 1974). Researchers found the professionals were unprepared to cope with the psychological and spiritual needs of the dying person (LeRoux, 1977). Fulton and Langton (1964) suggested nurses be reoriented to the grief process as described by Lindemann (1944). Glaser and Strauss (1965) recommended

that nurses learn more about working with dying patients during their educational experience. Nurses need to end hypocrasy and the avoidance of death and to learn to accept the dying process.

Death and dying is becoming more and more a topic of open interest. This is demonstrated by the increase in publications, workshops, lectures, classes offered, and general interest. Feifel's (1959) The Meaning of Death was a help to legitimize the study of and teaching about death. Feifel indicated that the study of death and dying is a valid and necessary area for scientific inquiry for the behavioral scientist. According to Feifel, death is more than merely an isolated personal event. An awareness of personal death, acknowledgemment of vulnerability, and the constraints of time affect not only individual behavior but social conduct as well.

Subsequently, other publications which discuss alternative concepts of death and dying have appeared. Kubler-Ross in 1969 published a best-selling book entitled On Death and Dying. During the 1960s the first systematic attempts to introduce death education in the college setting occurred. While a variety of symposia and workshops on death and dying were organized after the

publication of Feifel's (1959) book, the first significant symposium on death education was held at Hamline University, St. Paul, Minnesota, in 1970. Organized by two sociologists, Green and Irish, the two-day conference attracted over 2,000 people from all walks of life. Subsequently, proceedings of the conference were published in 1971 and served to stimulate interest in the field (Elliot, 1972).

Padilla, Baker, and Dolan (1977) indicated that nurses need further education in order to be aware of their feelings about death. In addition, they need to develop skills that will enable them to deal with dying patients in a therapeutic and realistic manner. Glaser and Strauss (1965) stated that unless care and concern are an accountable aspect of health care, individualized attention will continue to be met by a few particular persons who have been moved to be concerned about the dying as individuals.

The fear of death and dying decreases with increased academic preparation (Lester, Getty, & Kneisl, 1974; Padilla et al., 1977). Lester et al. (1974) studied attitudes toward death of nursing undergraduate and graduate students and nursing faculty. These researchers

found that the fears of death and dying decreased with increased education. They found no significant differences between the subgroup classifications of clinical specialization but suggested further investigation was necessary using a larger sample.

Researchers have demonstrated that death education lowers death anxiety among nurses (Murray, 1974; Telban, 1981; Templer, 1969). Laube (1977) and Murray (1974) found that death anxiety had decreased significantly 4 weeks following a death and dying course. Laube (1977) reported decreased death anxiety levels 1 month and 3 months after the 2-day workshop; however, there was no significant difference between the respondent's death anxiety levels before and after the workshop. The lowered death anxiety levels may be the result of the information that the nurses received from dying patients as a result of their positive responses toward death and a subsequent "willngness to examine their feeling about death" and "spend more time with dying patients" (Laube, 1977, p. 117).

Research has failed to provide conclusive evidence concerning the relationship of death education and death anxiety and locus of control. In a study by Yarber,

Gobel, and Rublee (1981) nursing students participating in a death education course showed no significant change in the dimensions of death anxiety or in locus of control orientation. Bell (1975) and Wiltmaier (1979-1980) did not find a significant reduction in nurses' death anxiety after a course on death and dying.

In a study by Hammond (1981), hospice training did not significantly alter the 10 volunteers' attitude scotes toward death and dying as measured by the Questionnaire for Understanding the Dying Person and His Family developed by Yeaworth et al. (1974). The subjects' mean score before the training was 78.3 (SD = 15.69, range = 48). After completing the hospice training, the mean score was 72.2 (SD = 13.71, range = 40). The researcher discussed several factors which may have influenced this unexpected result. One of the factors Hammond (1981) discussed was the limitation in terms of the instrument used in that the tool may not measure what it intends to measure.

Many of the death anxiety studies involve subjects that are enrolled in death education classes. Graham-Lippitt (1981) found that students enrolled in death education classes were less death-denying than those not

involved in the class. This finding supported Bluestein's (1975) conclusion that death education students "may have fewer hang-ups with respect to death or fewer needs to repress death-related feelings and experiences" (p. 217). It is unlikely that a course on death and dying will have an immediate impact on attitudes that are founded on generalized religious or traditional values (McDonald, 1981).

Researchers have studied variables that affect the death anxiety level. Templer, Ruff, and Frank (1971) found no significant relationship between age and level of anxiety. They found that females had higher levels than did males and that intimate relationships may affect the degree of death anxiety. Iammarino (1975) found higher levels of death anxiety in children living with one parent instead of both parents. Templer (1972) reported no significant correlation between death anxiety levels of smokers and nonsmokers nor death anxiety and extroversion. He did report correlations between the amount of smoking and death anxiety and death anxiety and neuroticism. Trent, Glass and McGee (1981) found that people who had lower death anxiety felt more comfortable in talking with someone close about that person's terminal illness than

did people who had high death anxiety. Those subjects who felt "resolved to accomplish something in life" or who felt "pleasure in being alive" (Trent et al., 1981, p. 165) had lower death anxiety.

Negative results have been obtained when attempting to decrease death anxiety by using behavior techniques and therapies (Bell, 1975; Kirby & Templer, 1975; Knott & Prull, 1976; McClam, 1980; Mueller, 1976; Pettigrew & Dawson, 1979; Testa, 1981). Pettigrew and Dawson (1979) suggested the absence of demonstrated efficacy could reflect that death anxiety was a trait rather than a state of being.

Authors differ in their reports of the relationships between religion and death anxiety. According to Templer (1972), death anxiety is lower in religiously involved people. Iammarino (1975) found that death anxiety levels correlated with specific religious denominations as follows (from highest to lowest correlations): no religious preference, other, Catholic, Jewish, and Protestant. However, Templer and Dotson (1970) showed no significant relationship between death anxiety and religious preferences. Berman and Hayes' (1973) research findings suggested that the relationship is weak between

death and after life belief. Stewart (1975) found that students who were active participants in several specific religious activities, who perceived themselves as being highly religious and near to God, and who were high in internal control, tended to be less fearful of death than persons who were not.

Formal and informal academic preparation have been shown to lower death anxiety levels. Reports of the relationship between religious preference and fear of death are inconclusive and vary widely. Researchers have failed to decrease death anxiety by using behavioral techniques and concluded that the fear of death was a trait rather than a state.

Death Attitudes of Health Professionals

Attitudes of physicians and nurses seem to reflect general social attitudes. While treating seriously-ill or dying patients, they are involved with their own feelings as well as those of their patients. Most of their education has emphasized the necessity of remaining cool, calm, and unemotional. However, families and patients might misinterpret such behavior as uncaring and unconcerned. On the other hand, showing undue concern may cause families to lose confidence in their physician (Kavanaugh, 1974).

A study by Feifel(1967) compared members of different professional groups and indicated that medical students and physicians tend to be people who are afraid of death and that physicians fear death more than do members of other professional groups. As Morrison (1973) stated, "There is nothing in the technological training of physicians that equips them to deal with questions of ethical, aesthetic, or human value" (p. 40).

Research indicated that persons working with dying patients find discussion about death difficult and avoid it if at all possible. Kasper (1959) believed that physicians are giving death and dying "no more attention than one gives to a period at the end of a moving, impressive novel" (p. 119). Feifel's (1969) work indicated that doctors are still more reluctant to inform patients than patients are about being informed. Oken (1968) studied 219 physicians and found that 88% preferred not to tell cancer patients of an unfavorable prognosis. Kram and Caldwell (1969) found that general physicians, more than any other professionals, recommended evasion rather than telling the patients the truth. It has been suggested that most doctors see death as a failure

(Barton, 1977; Glaser & Strauss, 1972; Kasper, 1959; Kavanaugh, 1974; Kubler-Ross, 1974; Rogers, 1951).

Drummond (1970) reported some institutional trends in the specialty of thanatology. Greene (1974) suggested that it is unlikely that "our culture will permit the physician to make a living administering to dying patients" (p. 94). There is not likely to be a medical specialty in thanatology.

When a dying patient enters the hospital, both the patient and his family relinquish control over the patient's course of dying. The staff's attitudes and behavior patterns determine to a large degree the social context in which dying occurs (Stoller, 1980). The nursing staff is particularly important in shaping the experiences of the dying; it spends more time with the patient than other health professionals and is most directly responsible for fulfilling the patient's immediate needs (Shusterman & Sechrest, 1973).

Since nurses have more contact with the dying patient than any other group of personnel, their response to the patient and the patient's response to their behavior, are quite important. The nurses' perception of the act of dying, i.e., as painful, indifferent, or a blessing,

influences the treatment the dying patient will receive (Feifel, 1959).

The way in which nurses interact with dying patients is related to their attitudes toward death and dying and to the nursing behaviors learned during their formal education and early work experience. The literature has shown that, in general, nurses experience anxiety over death (Folta, 1965; Lester et al., 1974; Pearlman, Stotsky, & Dominick, 1969). Golub and Reznikoff (1971) compared attitudes of graduate nurses and nursing students toward death. They concluded, because of similarities between the groups of nurses, that "nurses appear to acquire common attitudes early and these remain comparatively stable throughout their nursing career" (p. 508). Lester et al. (1974) supported the findings that a nurse's professional education does influence her attitudes toward death. Furthermore, these researchers found that the nursing students and faculty were less likely to fear the dying of others as compared to fearing the death of self, the dying of self, or the death of others.

The literature on nurses' attitudes toward death and dying patients indicated that early in their careers,

death is encountered while caring for dying patients and is experienced as stressful (Menzies, 1960; Quint, 1966; Schoenberg, 1969; Williams & Williams, 1959). As a result of the anxiety produced by death and dying patients, nurses tend to avoid pain by controlling feelings, by developing professional detachment that helps them withdraw emotionally from such patients, and by focusing on rituals and tasks instead of people (Glaser & Strauss, 1965; Menzies, 1960; Quint, 1966; Schoenberg, 1969; Sudnow, 1967; Vreeland & Ellis, 1969). A death-avoidant attitude-behavior complex makes it difficult for nurses to be comfortable and therapeutic when interacting with dying patients (Padilla et al., 1977).

The nurses' fear of death is an irrational belief and results in indequate care of the terminally-ill patient. Several writers have suggested that a fear of death interferes with the professional's ability to deal adequately with the dying patient (Bulger, 1963; Glaser & Strauss, 1965; Kubler-Ross, 1969; Quint, 1973).

If the physician chooses to avoid the subject of death, the attending nurse is placed in the awkward position of having to answer difficult inquiries from distressed patients and families. At present, the nurse's

preparation for this task would appear to be inadequate (Fulton & Langton, 1964). Schoeburg, Carr, Peretz, and Kutscher (1972) noted that fear of death extends to nurses who have had minimal opportunity to handle their own emotional reactions to death. In addition, nurses received meager support from others which would enable them to care for dying patients. This disengagement of nurses from patients may protect them from grief and the withdrawal may be related to the nurses' inability to face the inevitability of their own deaths.

Yeaworth et al. (1974) measured nursing students' attitudes toward death and dying. The responses of the senior nursing students compared to the freshman nursing students indicated greater acceptance of feelings, more open communication, and broader flexibility in relating to dying patients and families. The researchers concluded that important shifts in death and dying attitudes can result from formal nursing education.

The major purpose of a hospital is to help people recover from their illnesses. This purpose is not as relevant when the patient is dying (Garfield, 1965). As long as nurses count only the cure of the patient as success, they will be embarrassed by the dying, who

symbolize their own failure. This embarrassment often induces them to pursue strategies of denial that only intensify the anguish of the dying (Reck, 1977). When nothing more can be done, Browning and Lewis (1972) suggested that the nurse's attitude changes from one of helping the patient improve to one of providing satisfying comfort for the dying patient. The nurse requires flexibility and uses many personal strategies for maintaining professional composure in this situation. Nurses make use of composure tactics to protect themselves from personal involvement. Nurses are particularly vulnerable to deaths of patients whom they like, have known for long periods of time, or whose death carries a high social loss. They can also be vulnerable because of involvement with the family.

Nurses have special relationships with the terminally ill, in contrast to other hospital staff, because nurses and patients usually are together long enough to establish a relationship (Garfield, 1965). Nurses are thrust into a very difficult position by having to provide intimate care for the dying while usually having relatively little influence over the treatment, philosophy, or regimen. The difficulty for nurses working with the dying is that their

contact is so personal. They deal directly with the patient's dying body and with his reactions to his medications and procedures. A closeness develops between the nurse and patient. This is especially true when an effort is made to provide continuity of care by reducing the number of nurses who care for a terminally-ill patient.

To prevent isolation and avoidance of dying patients by their families, nurses must become aware of their feelings toward death (Hampe, 1975). Awareness of one's emotions allows for a change in behavior. Admitting the child-likeness of death related attitudes requires uncommon humility. These attitudes lie buried under multiple layers of "oughts" and "shoulds" acquired at home and in professional training (Kavanaugh, 1976).

Nurses must understand their own values, attitudes, and needs as well as have a clearer understanding of societal values (Mullins, 1981). Nurses may view patient's deaths as reminders of their own mortality and contacts with dying patients as rehearsals for their own dying process and/or that of persons close to them (Vanden Berge, 1966; Weissman, 1972). The dying patient is a

symbol of what every human fears and what nurses know they too must face eventually (Browning & Lewis, 1972).

To understand their feelings about death, nurses also need support from their colleagues. Nurses need to communicate their feelings and receive feedback in order to resolve their own feelings about death and provide support to dying patients (Browning & Lewis, 1972). Discussing their concerns with colleagues enables the nurse to become more open to responses about death from dying patients (Ross, 1978).

The attitudinal and behavioral responses toward dying patients, characteristic of many nurses today, are included in the report of a research project carried out by three nurses at the City of Hope Medical Center (Padilla et al., 1977). The report indicated that nurses need further education in order to be aware of their own feelings about death. In addition, they need to develop skills that will enable them to deal with dying patients in a realistic and therapeutic manner. Likewise, the reearchers suggested that studies are needed to test whether education programs on dying and death effectively change nursing practice. The literature indicated that nurse faculties, students, hospital instructors, and

practitioners need help in developing acceptable attitudes toward death and need therapeutic verbal interaction skills with dying patients (Benoliel, 1970; Glaser & Grauss, 1965; Quint, 1969).

Nurses' attitudes about death are acquired through acculturation in the wider society and can seriously affect their behavior as professional practitioners. Conflicting attitudes about death may interefere with the nurse's abilities to provide compassionate and understanding care (Quint, 1966).

There appears to be no commonly accepted social behavior to guide the nurses behavior when a patient dies. Usually the only pertinent guidelines are those of the hospital that specify how the deceased person is to be processed out of the hospital system (Mullins, 1981). Hoggart and Spilka (1978-1979) reported that 79.7% of the nurses in their study felt that the nursing profession places more emphasis on the preservation of life than on palliation and symptomatic care of the dying, and 61.5% claimed that their education was inadequate in preparing them to support and comfort the dying patient.

Greater attention to the dying process in society and within the nursing curriculum could be expected to affect

the findings in earlier research that physicians and nurses encountered difficulty in providing care for dying patients. However, researchers continue to report that nurses are still not equipped to care for dying patients and show obvious discomfort with regard to questions about emotional needs of dying patients (Benoliel, 1970; Denton & Wisenbaker, 1977; Keck & Walther, 1977). In a study of nurses and nursing students, Denton and Wisenbaker (1977) found that nurses working in high death areas had higher death anxiety than nursing students even though these nurses had more experience in caring for dying patients.

The nurses' feelings of uneasiness in caring for dying patients may be related to normative ambiguity or uncertainty about how to act in a particular work setting. Neither the larger culture nor the occupational subculture provide adequate normative guidelines to care for the dying patients (Stoller, 1980). For instance, Kubler-Ross (1975) found that nurses believe that they should control their own emotions, but at the same time be sympathetic to the terminally-ill persons's needs.

Stoller (1980) found that the nurse's uneasiness associated with interaction with dying patients increased as the nurses accumulated nursing experience. In this

study, the licensed practical nurses developed coping mechanisms to help them relieve the uneasiness associated with caring for dying patients. However, the registered nurses became more uneasy in caring for dying patients as they gained nursing experience with dying patients, and they did not increase their ability to cope with dying or death.

Bormann and Bormann (1972) observed that many nurses rated talking with a dying patient as one of their most difficult tasks. Nurses appear to be ambivalent in their reactions toward death. They apparently view it as controlled and predictable in terms of others, but feel anxiety when the threat becomes personal (Norris, 1955; Quint & Strauss, 1964).

Kastenbaum (1967) designed a study using nurses' verbal responses to dying patients' statements and found over 80% of the responses to be reassurance, denial, or changing the subject. Less than 20% entered into discussion of the patient's thoughts and feelings which led Kastenbam to concluude that the clear tendency was to "turn off" the dying patient's statement about death.

Frequently patients are denied the privilege of expressing their feelings and those around them are not

adept at facing the issues surrounding death. The health care professional's main objective is to heal and prolong life and death offends that profession. Their own fear of death and attitudes often leads the health care professional to dodge discussions of death with the patient and relatives (Mann, 1974).

Many nurses attempt to avoid emotional association with death by engaging in activities that prevent contact with dying patients. Increased technology has enabled the nurse to "care" for the machines rather than the patient. Administering increased dosages of pain medication can make the patient socially dead and unable effectively to communicate (Mullins, 1981).

Nurses who work in intensive care, coronary care, and other high death areas place emphasis on saving life. With continual exposure to patients who are in a stage of uncertainty, the nurse has a difficult time coping with death (Quint, 1966; Sobel, 1969; Williams & Williams, 1959). These nurses are more likely to develop avoidance strategies (Quint, 1969). Sobel (1969) found that the staff of a coronary care unit often supported the patient's denial to protect themselves from being exposed

to the patient's feelings of anger, bitterness, helplessness, sorrow, and hopelessness.

Nurses tend to reward patients for maintaining a denial of death, as this denial protects the nurses from socioemotional involvement, and the likelihood of facing the reality of their feelings about death. In turn, patients are made to feel dependent on the nurse and to feel grateful for the care given. These activities obviously affect the social and psychological condition of the dying patient during the last days in the hospital (Mullins, 1981).

In a survey of 15,430 nurses' feelings about death and dying, 90% of Popoff's (1975) 10 respondents reported that they had confidence in providing technical care to the dying, but only 58% indicated confidence in giving psychological care for the terminally ill. One-half reported that they had come to terms with death to a great extent; whereas one-third had partially come to terms and about one-eighth had yet to confront their own morality.

Hampe (1975) noted that grieving spouses expected the health professionals to behave decently toward them--in other words, "to be courteous and friendly." Freihofer and Felton (1976) showed that the dying patient as well as

the family members of the dying person desired the nursing behavior be directed toward support, comfort, and ease of suffering of the fatally ill.

Amenta (1981) described chacteristics of nurses who work well with the dying patient. These characteristics include:

1. The nurse should not have experienced a personal crisis or loss within a year to 18 months. Once a personal crisis has been resolved the nurse may be more suited to providing terminal care.

2. To work effectively with dying patients, nurses need a high tolerance for uncertainty.

3. Nurses working with dying patients tend to prefer human relationship activities such as patient teaching and counseling over technical skill aspects of nursing.

4. Nurses engaged in terminal care rarely feel depressed, are optimistic, have a high sense of purpose and high self-esteem, and enjoy working in groups or teams.

These nurses also seem to have well-developed outside interests and/or rich, stable family lives. The most suitable candidates are well-rounded people who have other

worlds of reference and the support of significant persons outside the work environment (Amenta, 1981).

Kubler-Ross (1969) described what occurs when one tries to get close to the dying person. There is no other counseling with any one patient where it is so important to take off one's white coat and just be a human being. Those who have experienced such moments will agree that working with the dying patient is not all depressing. It can be instructive, gratifying, and, at times, a beautiful experience. Yeaworth, Kapp, and Winget (1974) found that important shifts in attitudes about death and dying can result from nursing education. Schowalter (1975) found that nurses that made any serious approach to understand death also ended with a better understanding of life.

Cancer Nursing and Death

Few people permit themselves to indulge in thoughts about death. When death suddenly forces itself on the professionals, they are ill prepared to go through the experience. "The stigma attached to the dying cancer patient is familiar; nurses working on the cancer ward share the common attitude" (Baider & Porath, 1981, p. 47). The process of coping with death is likely to be congruent

with the individual's ways of dealing with other experiences of life (Corr, 1978) although individuals may revert to earlier problem-solving patterns (Jackson, 1977).

Glaser and Strauss (1964) suggested that some deaths can be rationalized more easily by nurses, thereby reducing guilt and grief feelings. Examples of patients whose death is more readily accepted by staff are suicides, criminals, patients with intense pain, the terminally ill, patients with brain damage, and the aged patient. Glaser and Strauss also suggested that it may be harder to rationalize death caused by an accident or caused by an unanticipated medical or surgical complication. They indicated that it may be harder to rationalize the death of a patient who has become a significant other by long residence on the nursing division. These deaths seem to take on a different meaning than those previously described.

Different hospital units are characterized by different mortality rates and different "sentimental orders" or patterns of mood which allow nurses to organize their activities and reactions around the "normal" rate of patient deaths. A death in the emergency room does not have the same subjective impact on the nursing staff as

does a death in a pediatric unit (Glaser & Strauss, 1968). Stoller (1980) suggested research should be conducted to focus on what impact various hospital settings have regarding negative feelings nurses experience when working with dying patients.

Encounters with death and dying are common for health professonals in high-risk areas of hospitals such as intensive care units, cancer wards, burn units, emergency rooms, and high-risk infant nurseries (Miles, 1980). Two surveys concerning the nurse and death have revealed the frequency with which nurses deal with death. The research by Popoff (1975) indicated that 35% of the subjects and 60% of the intensive care nurses deal with dying individuals once a week or more. The majority of the nurses noted that they interact with the dying at least two to three times a month. Hoggart and Spilka's (1978-1979) study of nurses revealed that 43.4% encountered dying patients frequently or very frequently, while only 29% rarely interacted with the terminally ill. Miles (1980) studied nurses that work in high-risk death areas of hospitals and found that a course on death and dying did have an impact on the attitudes of nurses who attended

the program. These nurses had a more positive attitude toward death and dying patients.

Nurses perceive cancer patients as being slightly different from noncancer patients in their increased potential for irritability and for exhibiting periods of overt hostility and aggressiveness toward others (Morrow, Craytor, Brown, & Fass, 1976). Service to the cancer patient is value-laden. Nurses learn to value the healthy body, self-sufficiency, stoicism, protecting patients and relatives from dreaded diagnoses, living to the exclusion of dying, and to equate the diagnosis of cancer with a death sentence. Such attitudes can stifle potentialities of both the cancer patient and nurse in the health care situation (Marino, 1976; Millerd, 1977).

The review of the literature indicated that cancer is seen as anxiety provoking, malignant, and hopeless (Abrams, 1966; Antonovsky, 1972; Olson, 1974). In a study of 1,770 Jewish adults, Antonovsky (1972) found that cancer was less preventable and less understood than either heart disease or cholera. These subjects were more pessimistic and perceived the consequences of having cancer as most serious in relation to the other diseases. The image of cancer suggested a "pervasive and highly

consensual anxiety" (Antonovsky, 1972, p. 383). Nurses on the oncology ward come face-to-face with death on a daily basis and must find ways to cope with it (Baider & Porath, 1981). The nurses require a reevaluation of their role, related not to curing, but to improving care. Support provides them with the feedback and stimulation necessary to appreciate their unique work.

Dunphy (1976) commented that prior to working with cancer patients he thought the solution to cancer was clear-cut early diagnosis followed by radical surgical excision. However, personal experiences changed his attitude to a view of cancer and its treatment as an individual and unpredictable process. In a study of atttidudes of nurses and nursing students toward cancer, Felton, Reed, and Perla (1981) found that their subjects doubted the value of aggressive treatment and highly valued patients' abilities to cope with knowledge of cancer. They also showed strong endorsement of favorable attitues regarding the value of early diagnosis and the importance of accepting death. These researchers found that nurses and nursing students believed that openly revealing a cancer patient's diagnosis and prognosis is highly desired by the patient, psychosocially therapeutic,

and markedly increases the effectiveness of nursing intervention. Felton's et al. subjects also believed that their attitudes were influenced more by personal experience than by statistics.

Even though nurses may be able to rationalize the deaths of cancer patients more easily than noncancer patients, the process of dying may take on a different meaning. Nurses can become close to these patients with cancer during their long residence on their units. These nurses who face death on a daily basis must develop attitudes and effective coping mechanisms related not to curing but rather to improving care for the terminally-ill person. Researchers found that nurses value individuality, openness, and flexibility as well as the concept of accepting death. Cancer nurses are in a unique position of being able to reevaluate and change their attitudes toward death in their service to individuals who are dying of cancer.

Summary

Throughout history, death has been described as a frightening and unexplainable mystery and also a social, biological, psychological, and growing experience. Despite an increase in death education in America's death

avoidant society, the process of dying has become less personal and visible. Research has failed to provide conclusive evidence concerning the relationship between death and death anxiety. Because health professionals' attitudes reflect general social attitudes, caring for dying patients remains an anxiety-producing experience for many nurses and makes it difficult for them to behave therapeutically. The nurse's role remains poorly defined and produces a social death for the dying patient. Nurses are more comfortable with technical aspects of care rather than communicating and learning from dying patients. Cancer nurses come face-to-face with death daily. They must find ways to cope with death. Their role and attitudes must not be aimed at curing but rather at improving nursing care for dying patients.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

This descriptive comparative study followed the procedure for collection and treatment of data based on the three attributes established by Fox (1976): (a) this research was based on an important professional problem, (b) all elements of professional significance were included in the survey, and (c) each element was representative within itself. The two-group posttest design was used in this study (Polit & Hungler, 1978).

In this study, the independent variable was whether the nurses do or do not work with dying patients on a regular basis. The dependent variable was the nurses' attitudes toward death and dying as measured by the Questionnaire for Understanding the Dying Person and His Family.

Setting

The subjects included in this study lived in two metropolitan areas in the Southwestern portion of the United States. The population of the two metropolitan

areas in 1979 were approximately 750,000 people and 320,000 people.

Population and Sample

The population was comprised of female, Caucasian nurses who were associated with either two associations for cancer nurses or a Southwestern state board of nursing. The women with obvious first and last names of Hispanic origin and all men were deleted from the lists provided by the three agencies. Using a convenience sampling, questionnaires with cover letters were sent to the 87 registered nurses belonging to the two oncological nursing societies. After numbering the names provided by the state board of nursing and using a random sampling table, 54 registered nurses were sent questionnaires (Appendix A) accompanied by a cover letter (Appendix B).

Sixty-five of the questionnaires were returned. Four subjects were deleted based on their demographic data in that they were not Caucasian females. The sample consisted of 61 Caucasian female subjects who were registered nurses. Thirty-seven of the subjects were registered nurses who worked regularly with dying patients, and the

other 24 subjects were nurses who infrequently worked with dying patients.

Protection of Human Subjects

The rights of the subjects were protected by the researcher. The Texas Woman's University Graduate School granted permission for the researcher to conduct this study (Appendix C). A letter was sent to the organizations (Appendix D) and an agency consent (Appendix E) to participate in this study was obtained from the two oncological nursing societies and a Southwestern state board of nursing. This study did not require review by the Human Subjects Research Review Committee because it was classified as Category I according to federal regulations (Appendix F). This category includes survey and questionnaire research where the subjects are not identified and there is the least amount of physical risk to subjects.

The nurses were contacted by mail and invited to participate in this study. The study was described and included the following elements.

1. An explanation of the procedure followed.
2. A description of the mental or emotional discomforts associated with the study.
3. A description of the benefits to expect.

4. A disclosure of any appropriate alternative procedures which could have been advantageous to the subject.

5. An offer to answer any inquiries concerning the research procedure.

6. The instruction that the subject was free to withdraw her consent and discontinue participation in the program at any time.

7. The disclaimer that no medical service or compensation is provided to subjects by Texas Woman's University as a result of injury from participation in the research.

A statement relating that the return of the questionnaire would be construed as the respondents' consents for participation and a request that the subjects not sign their names on the questionnaire were placed on each page of the questionnaire. The subject's anonymity was protected as the data collected contained no identifying information. The subjects were given the researcher's telephone number so that they could make inquiries regarding the study and withdraw from the study at any time.

Instrument

This study used an instrument developed by Yeaworth, Kapp, and Winget (1974) to assess attitudes on death and dying, entitled Questionnaire for Understanding the Dying Patient and His Family. The questionnaire consists of a paper-and-pencil inventory and is divided into two parts (Appendix A). This instrument was developed to measure nursing students' attitudes toward death and dying. Permission to use the instrument was obtained from Yeaworth (Appendix G).

Part I consists of 50 items or statements. The subjects indicate agreement or disagreement with each statement on a 5-point scale. Only 33 of these items are used for scoring. Therefore, the possible range of scores is 33 to 165 points. The 17 items not included in the scoring consists of statements which do not have a bearing on the dependent variable. An example of an item not scored is "Dying is a painful process" (Appendix A).

In scoring Part I, numerical weights of 1 to 5 are assigned to 14 items, beginning with 1 for "strongly agree" to 5 for "strongly disagree." Nineteen items have reverse directions of weights, beginning with 5 for "strongly agree" to 1 for "strongly disagree". All the

items are listed in the Key for Scoring the Questionnaire for Understanding the Dying Patient and His Family (Appendix H). A total score is obtained by summing the values of each statement. A low score indicates flexibility in interpersonal relationships, a desire for open communication about critical issues, and concern for the psychological status of dying patients and their families. A high score indicates rigidity in interpersonal relationships, lack of insight concerning psychological factors of dying patients, and emphasis on the physical needs of the terminally ill.

Part II requested demographic data of the respondent. Areas include sex, age, religion, professional status, educational preparation, and experiences with death. Part II also includes a question to determine the independent variable of how regularly the respondents care for dying patients in their employment.

Reliability and validity have been established for the questionnaire. The internal consistency reliability was reported to be .72 using the alpha coefficient. Administering this questionnaire in conjunction with the Rotter I-E Scale and the Defense Mechanism Inventory to adult students established construct validity. The

correlation coefficient was not reported (Yeaworth et al., 1974).

Data Collection

Addresses of registered nurses who work regularly and who do not work regularly with dying patients were obtained from three sources. Data were collected by mailing a cover letter and the Questionnaire for Understanding the Dying Person and His Family and Part II, the demographic data to the nurses' home addresses. A stamped, return addressed envelope was also included. As the questionnaires were returned, they were checked for usability: the four questionnaires that were returned from noncaucasian or male subjects were not included in the sample. The recordkeeping activity consisted of assigning each questionnaire a number. This recordkeeping activity assisted the researcher in assembling the results and monitoring the return rate.

Treatment of Data

To test the hypothesis that, with age and formal education controlled, there is no difference between attitudes on death and dying of nurses who work regularly and who do not work regularly with dying patients, the data were scored and analyzed in the following manner. A

score was assigned to each subject on the basis of the 33 items in Part I of the Questionnaire. Mean scores, ranges, and standard deviations were calculated for the two groups of nurses. Age and formal death education were controlled by using the analysis of covariance to determine whether the two groups of nurses' attitudinal scores were significantly different. The level of significance was set at .05.

Part II of the questionnaire requests demographic data. These data were used to describe the sample population and were presented using frequencies and percentages.

CHAPTER 4

ANALYSIS OF DATA

Nurses' attitudes toward death were surveyed using the Questionnaire for Understanding the Dying Person and His Family. Data were collected and analyzed to determine whether there were any differences in attitude scores of nurses who work regularly with dying patients and of nurses who do not work regularly with dying patients where variables of age and formal death education were controlled. Questionnaires were sent to 87 registered nurses who are associated with oncological nurses societies and 54 registered nurses selected from a Southwestern state board of nursing. This chapter includes a description of the demographic characteristics of the sample and the findings of this study using the analysis of covariance to test the hypothesis of this study.

Description of Sample

Ethnic background and sex were controlled and only Caucasian females were included in the sample. Both groups of nurses had at least 41% of the nurses under the age of 35 years. Forty-six percent (17) of the nurses who worked regularly with dying patients, and 41% (10) of the

subjects who did not work frequently with dying patients, were under the age of 35 years. A larger percentage, 84% (31), of the nurses who work with dying patients were under 45 years of age compared to 66% (16) of the nurses who did not regularly care for dying patients. Seventy-seven percent (47) of the total number of subjects were under the age of 45 years. Table 1 illustrates the ranges of ages of the respondents.

Table 1

Ages of the Subjects

Age (Years)	Nurses Who Work Regularly with Dying Patients	Nurses Who Do Not Work Regularly with Dying Patients	Total Nurses
Under 25	1 (3%)	2 (8%)	3 (5%)
26-34	16 (43%)	8 (33%)	24 (39%)
35-44	14 (38%)	6 (25%)	20 (33%)
45-54	5 (13%)	4 (17%)	9 (15%)
55 or older	1 (3%)	4 (17%)	5 (8%)
Total	37 (100%)	24 (100%)	61 (100%)

The majority (52%) of the subjects were married, but a greater percentage (32%) of the nurses who work with dying patients regularly were divorced compared to 13%

of the nurses who do not work regularly with dying patients. Thirteen of the total number of subjects were never married, and 15 were divorced. Fewer (49) of the nurses who work with dying patients frequently were married, and a greater number (32%) of this group were divorced compared to the nurses who do not work with dying patients regularly. There was a larger percentage (29%) of the respondents who do not work with dying patients who were never married. The respondents' marital status is described in Table 2.

Table 2

Marital Status of Subjects

Marital Status	Nurses Who Work with Dying Patients	Nurses Who Do Not Work Regularly with Dying Patients	Total Nurses
Never married	6 (16%)	7 (29%)	13 (21%)
Married	18 (49%)	14 (58%)	2 (52%)
Divorced	12 (32%)	3 (13%)	15 (25%)
Widowed	1 (3%)	0 (0%)	1 (2%)
Total	37 (100%)	24 (100%)	61 (100%)

Thirty-six percent of the sample studied were Catholic, while 42% were Protestant. There was an equal

number (15) of Catholics as Protestants in the group of nurses who were caring for dying patients routinely. Almost half (46%) of the nurses who do not work regularly with dying patients were Protestant, while only seven (29%) were Catholic. Table 3 classifies the subjects' religious preference responses.

Table 3

Religious Preference of Subjects

Religious Preference	Nurses Who Work Regularly with Dying Patients	Nurses Who Do Not Work Regularly with Dying Patients	Total Nurses
Protestant	15 (40%)	11 (46%)	26 (43%)
Catholic	15 (40%)	7 (29%)	22 (36%)
Jewish	1 (3%)	0 (0%)	1 (2%)
Other	4 (2%)	5 (21%)	9 (15%)
No response	2 (5%)	1 (4%)	3 (5%)
Total	37 (100%)	24 (100%)	61 (100%)

Forty-seven percent of the sample identified their religious belief as strong. Thirty-three percent responded that their intensity of religious belief was moderate. More than 51% of the nurses who work regularly with dying patients identified their religious belief as strong compared to 41% of the nurses who do not work

regularly with dying patients. The response to the question of the subjects' intensity of their religious beliefs are presented in Table 4.

Table 4

Intensity of Religious Belief of Subjects

Intensity	Nurses Who Work Regularly with Dying Patients	Nurses Who Do Not Work Regularly with Dying Patients	Total Nurses
Strong	19 (51%)	10 (41%)	29 (47%)
Moderate	12 (32%)	8 (33%)	20 (33%)
Weak	3 (8%)	3 (13%)	6 (10%)
None	2 (5%)	3 (13%)	5 (8%)
No response	1 (3%)	0 (0%)	1 (2%)
Total	37 (100%)	24 (100%)	61 (100%)

Over half of the subjects maintained a strong belief in an after life as illustrated in Table 5. Forty-six percent of the nurses who work regularly with dying patients and 67% of the nurses who do not work regularly with dying patients strongly believed in an after life. Sixteen percent of those nurses who care for dying patients and 12% of those who do not care for dying patients responded negatively to the statement,"I have a

strong belief in an after life." Thirty-one percent of the subjects gave no response to this question.

Table 5

Strong Belief in an After Life

Response	Nurses Who Work Regularly with Dying Patients	Nurses Who Do Not Work Regularly with Dying Patients	Total Nurses
Yes	17 (46%)	16 (67%)	33 (54%)
No	6 (16%)	3 (12%)	9 (15%)
No response	14 (38%)	5 (21%)	19 (31%)
Total	37 (100%)	24 (100%)	61 (100%)

The educational background of the sample varied with the nurses who did not care for dying patients frequently holding degrees from higher levels of education than the nurses who regularly care for dying patients. Seventy-one percent of the nurses who do not work regularly with dying patients held bachelor of science degrees, master's degrees, or doctor of philosophy degrees; whereas, 78% of the nurses that cared for dying patients had either diploma or associate degrees. Overall, the educational background for 64% of the subjects was the associate degree in nursing (41%) and the bachelor of science in

nursing (23%). Table 6 summarizes the responses to this demographic data.

Table 6

Education of Subjects

Education	Nurses Who Work Regularly with Dying Patients	Nurses Who Do Not Work Regularly with Dying Patients	Total Nurses
Diploma	10 (27%)	1 (4%)	11 (18%)
Associate Degree	19 (51%)	6 (25%)	25 (41%)
Bachelor of Science	4 (11%)	10 (42%)	14 (23%)
Master's in Nursing	4 (11%)	5 (21%)	9 (15%)
Doctor of Philosophy	0 (0%)	2 (8%)	2 (3%)
Total	37 (100%)	24 (100%)	61 (100%)

The majority (68%) of the nurses who work daily with dying patients responded positively to the question: "Did your nursing education include curricula on death and dying?" Eleven (46%) of the nurses who do not work regularly with dying patients answered yes. Thirty-two percent of registered nurses that work regularly with dying patients responded negatively to this question, while the majority (54%) of the other group of nurses

answered no. Table 7 summarizes the response of the subjects to this question.

Table 7

Nursing Education on Death and Dying

Curricula	Nurses Who Work Regularly with Dying Patients	Nurses Who Do Not Work Regularly with Dying Patients	Total Nurses
Yes	25 (68%)	11 (46%)	36 (59%)
No	12 (32%)	13 (54%)	25 (41%)
Total	37 (100%)	24 (100%)	61 (100%)

Seventy-five percent of both groups of nurses had attended a workshop or class with formal education pertaining to death and dying. As illustrated in Table 8, the percentages from the groups were very similar.

In this study, the subjects were asked whether anyone in their immediate family had died. Eighty-five percent of the subjects had lost a family member. Slightly more (87%) of the nurses who work regularly with dying patients responded affirmatively to this question compared to 83% of the other group of nurses. Eight percent of the nurses who work regularly with dying patients and 12.5% of the

nurses who do not work regularly with dying patients had not lost an immediate family member. Three of the subjects gave no response. Table 9 describes the responses given to this question by the subjects.

Table 8

Formal Education on Death and Dying

Response	Nurses Who Work Regularly with Dying Patients	Nurses Who Do Not Work Regularly With Dying Patients	Total Nurses
Yes	28 (76%)	18 (75%)	46 (75%)
No	9 (24%)	3 (25%)	15 (25%)
Total	37 (100%)	24 (100%)	61 (100%)

Table 9

Death of Immediate Family Member

Response	Nurses Who Work Regularly with Dying Patients	Nurses Who Do Not Work Regularly with Dying Patients	Total Nurses
Yes	32 (87%)	20 (83%)	52 (85%)
No	3 (8%)	3 (13%)	6 (10%)
No response	2 (5%)	1 (5%)	3 (5%)
Total	37 (100%)	24 (100%)	61 (100%)

The subjects were also asked to identify the members of their immediate family who had died. The two groups of nurses were similar with five subjects responding that all of their immediate family was alive. The average score on the questionnaire of these five subjects was 65.4. Seventy-nine percent of the subjects were bereaved by the death of a grandparent, 39% had lost other family members, and 38% had experienced the death of their father. Table 10 summarizes the data that were obtained.

Table 10

Personal Experience with Death of Family Member

Family Member	Nurses Who Work Regularly with Dying Patients	Nurses Who Do Not Work Regularly with Dying Patients	Total Nurses
Father	14 (38%)	9 (38%)	23 (38%)
Mother	7 (19%)	4 (2%)	11 (18%)
Sister	3 (8%)	2 (8%)	5 (8%)
Brother	4 (11%)	0 (0%)	4 (7%)
Grandparent	30 (81%)	18 (75%)	48 (79%)
Other	14 (38%)	10 (42%)	24 (39%)
No response	3 (8%)	2 (8%)	5 (8%)

Note: Respondents could respond more than once to a question.

The majority (89%) of the nurses who work regularly with dying patients were also actively employed in cancer nursing. Eleven percent of these nurses were not employed in oncological nursing. A majority (54%) of the nurses who do not work regularly with dying patients responded negatively to the question "Are you actively employed in cancer nursing?" Eleven (46%) of the this group responded positively to this question. Table 11 illustrates the distribution of the subjects' responses.

Table 11

Nurses Actively Employed in Cancer Nursing

Response	Nurses Who Work Regularly with Dying Patients	Nurses Who Do Not Work Regularly with Dying Patients	Total Nurses
Yes	33 (89%)	11 (46%)	44 (72%)
No	4 (11%)	13 (54%)	17 (28%)
Total	37 (100%)	24 (100%)	61 (100%)

Although the nurses who work regularly with dying patients tended to be younger in age, they had slightly more experience in caring for the dying. Half of the nurses who do not care for the dying on a regular basis had below 5 years of experience working with the dying. Fifty-four percent of the nurses who work regularly with

dying patients had either 5 to 10 or 10 to 15 years of caring for dying patients. Four (17%) of the nurses who do not work regularly with dying patients had over 25 years of this experience. Table 12 illustrates these findings.

Table 12

Years of Experience Caring for Dying Patients

Number of Years	Nurses Who Work Regularly with Dying Patients	Nurses Who Do Not Work Regularly with Dying Patients	Total Nurses
Under 5	14 (38%)	12 (50%)	26 (42%)
5-10	13 (35%)	4 (17%)	17 (28%)
10-15	7 (19%)	2 (8%)	9 (15%)
15-20	1 (3%)	2 (8%)	3 (5%)
20-25	1 (3%)	0 (0%)	1 (2%)
Over 25	1 (3%)	4 (17%)	5 (8%)
Total	37 (100%)	24 (100%)	61 (100%)

Findings

This study pertained to the nurses' attitudes toward death and dying using the Questionnaire for Understanding the Dying Person and His Family. Controlling for age and formal death education, the hypothesis tested was that there is no significant difference in the attitude

scores toward death and dying of nurses who do care and do not care for the dying patient on a regular basis The possible range of scores was 33 to 165 points. A low score indicated flexibility in interpersonal relationships, a desire for open communication about critical issues, and a concern for the psychological status of dying patients and their families. High scores indicated rigidity in interpersonal relationships, lack of insight concerning psychological factors of dying patients, and emphasis on the physical needs of the terminally ill.

The number of subjects in each group was 37 nurses who work regularly with dying patients and 24 nurses who do not work regularly with dying patients. The mean score of the nurses who regularly worked with the terminally ill was 66.33, with a range of 39 to 93 and a standard deviation of 9.87. The mean score of the nurses who did not work with dying patients was 61.58, ranging from 45 to 83 and having a standard deviation of 8.93. These data are presented in Table 13.

Age and formal death education were controlled by using the analysis of covariance to determine whether the two groups of nurses' attitudinal scores were significantly different at the .05 level.

Table 13

Means, Ranges, and Standard Deviations of Attitudinal Scores

Type of Work	Mean	N	Range	SD
Nurses who work regularly with dying patients	66.37	37	39-93	9.87
Nurses who do not work regularly with dying patients	61.58	24	45-83	8.93

The means and adjusted means for each group are given in Table 14. The equality of the slope for age and formal death education was not found to be statisticaly different ($F(2,55) = .19$, $p = .83$); therefore, the assumption that the coefficients of the regression lines of scores on age and formal education within each group are equal was fulfilled.

It was found that the adjustment made by the covariance was significant ($F(1,57) = 4.42$, $p = .016$). Of the two covariants, age ($t(59) = 2.87$, $p = <.01$) was significant and formal education ($t(59) = 1.13$, $p = 0.27$) was not significant. A significant difference was found to exist between the two groups on the adjusted scores [$F(1,57) = 5.80$, $p = .019$]. Therefore, the null hypothesis was rejected. The group of nurses that provided

Table 14

Adjusted Means of the Attitude Scores

Type of Work	N	Group Mean	Adjusted Group Means	Standard Error
Nurses who work regularly with dying patients	37	66.32	66.72	1.489
Nurses who do not work regularly with dying patients	24	61.58	60.97	1.85

care for dying patients on a regular basis scored higher than the group of nurses that did not care for the dying regularly. In other words, the nurses who cared for dying patients on a regular basis were more rigid in insight concerning psychological factors of dying patients, and emphasized the physical needs of the terminally ill more than the nurses who did not regularly care for dying patients. Table 15 presents the data obtained utilizing the multifactor covariants.

It was expected that the nurses who care for dying patients on a regular basis would learn to be more flexible, open, and caring in their interactions with dying patients. However, the unexpected result was found:

the nurses who regularly care for dying patients had lower scores or were more rigid and uncaring than the nurses who do not regularly care for dying patients.

Table 15

Difference in Attitude Scores with Age and Formal Education Controlled

Source	Sum of Squares	df	MS	F	p
Equality of coefficients between groups	32.00	2	16.00	0.19	0.826
Residual	4592.47	55	83.50		
Covariates of age and education	717.47	2	358.74	4.42	0.016
Residual	4624.47	57	81.13		
Between Groups	470.79	1	470.79	5.80	0.019
Within Groups	4624.47	57	81.13		
Total	5341.94	59			

Summary of Findings

Controlling for formal death education and age, this research compared the attitudes toward death of nurses who frequently cared for dying patients with attitudes of other nurses who did not regularly care for dying patients. In controlling for age and formal death education, the null hypothesis was rejected. There was a

significant difference in the attitude scores toward death and dying between the two groups of nurses. The nurses who care for dying patients on a regular basis had a higher mean score of 66.32 (adjusted mean = 66.72), while the nurses who do not regularly work with dying patients had a mean score of 61.58 (adjusted mean = 60.97). The unexpected result of this study was that the nurses who regularly work with dying patients were more rigid in their attitudes toward death and dying than the other nurses who did not regularly care for dying patients.

CHAPTER 5

SUMMARY OF THE STUDY

Within hospitals in the American culture, there is a subculture of nurses who have the responsibility of caring for dying patients on a regular basis. These nurses must find ways to behave openly and therapeutically with the terminally-ill client. This research investigated whether these nurses who work with dying individuals on a daily basis, have attitudinal differences compared to other nurses who do not work regularly with dying patients. This chapter includes a summary and discussion of the findings of this study, conclusions and implications of this study, and recommendations for further study.

Summary

Nurses are acculturated in this death avoidant society and are confronted with the problems that arise from culture's conflicting concepts about death (Fulton & Langton, 1964). Rose's (1962) symbolic interaction theory explains the relationship between the concepts of culture attitudes, values, and death and was the theoretical framework of this study.

In this descriptive comparative study, the independent variable was whether the nurses did or did not work with dying patients on a regular basis. The dependent variable was the nurses' attitudes toward death and dying as measured by the Questionnaire for Understanding the Dying Person and His Family (Yeaworth et al., 1974).

The sample utilized in this study consisted of 61 Caucasian female registered nurses living in the Southwestern United States. These nurses were associated with two oncological nursing societies and a state board of nursing in a Southwestern state. The rights of the subjects were protected during the research. The questionnaires were mailed to the subjects.

The literature was reviewed as it related to the following areas: (a) the concept of death, (b) American attitudes about death, (c) death education and anxiety, (d) death attitudes of health professionals, and (e) cancer nursing and death. Most of the literature supported a general death-avoidant attitude and a sense of ambivalence and denial of the general public and medical field. Even though an increase in interest is being shown in the area of death and dying, the literature supports a

great need for education and for nurses to find ways to cope with death in order to improve nursing care for dying patients.

The data were scored and analyzed in the following manner. Responses given to demographic data were utilized to describe the sample. Overall, the two groups of nurses were fairly similar. All the subjects were Caucasian females. Forty-four percent of the subjects were under 34 years of age with the nurses who work regularly with dying patients being slightly younger and the nurses who do not regularly work with dying patients having a larger percentage (34%) 45 years of age and older.

The majority of the subjects were married but a greater percentage (32%) of the nurses who work regularly with dying patients were divorced compared to 13% of the other group of nurses. Seventy-eight percent of the sample were either Protestant or Catholic. The nurses who regularly care for dying patients were evenly divided between the two religions while the nurses who do not regularly care for dying patients were divided into 46% Protestant and 29% Catholic. Eighty percent of the subjects responded that the intensity of their religious belief was either strong or moderate. Over half of the

subjects maintained a strong belief in an afterlife. Thirty-one percent of the subjects gave no response to this question.

The educational backgrounds of the two groups of nurses varied with 71% of the nurses who do not regularly care for dying patients having bachelor of science, master's or doctoral degrees. Seventy-eight percent of the nurses who regularly care for dying patients had either a diploma or an associate degree in nursing. The majority of the nurses who regularly work with dying patients attended schools where their nursing education included content on death and dying. Fifty-four percent of the other nurses responded that death and dying was not included in the nursing curriculum. However, 75% of both groups had received formal education on death and dying.

The two groups were similar in their responses to the questions regarding their personal experiences with death. Over 83% of both groups had lost a member of their immediate family. Seventy-eight percent of the subjects were bereaved by the loss of a grandparent, 39% had lost other family members, and 37% had experienced the death of their fathers.

Eighty-nine percent of the nurses who frequently cared for dying patients also were actively employed in cancer nursing. However, 46% of those nurses who did not care for dying patients were cancer nurses. The majority (54%) of the nurses who do not regularly work with dying patients were not actively employed as cancer nurses. Although the nurses who work regularly with dying patients tended to be younger in age, they had slightly more experience in caring for the dying.

The data were analyzed to test the hypothesis. A score was assigned to each subject on the basis of 33 weighted items in Part I of the questionnaire. Age and formal death education were controlled by using the analysis of covariance to determine whether the two groups of nurses' scores were significantly different ($F(1,57) = 5.80$, $p = .019$). Of the two covariants, only age was significant ($t(59) = 2.82$, $p < .01$). The nurses who cared for dying patients on a regular basis had higher scores than the other nurses. A high score indicated rigidity in interpersonal relationship, emphasis on physical care, and lack of insight into dying patients' psychological needs. A low score indicated flexibility in interpersonal relationships, openness, and a concern for

dying patients' psychological well-being. Therefore, the nurses who worked with dying patients regularly were significantly more rigid in the interactions as measured by the intrument than the nurses who did not regularly provide care for dying patients.

Discussion of Findings

Controlling for age and formal death education, the null hypothesis was rejected. There was a significant difference in the two groups of nurses' death attitude scores. The nurses who regularly care for dying patients were significantly more rigid in their attitudes. The discussion of these findings centers around the area of attitude in general, the limitations in terms of the instrument used, and characteristics of the subjects.

The literature on nurses' attitudes toward death and dying patients indicated that dying is stressful to nurses and that nurses tend to avoid pain by controlling feelings and developing professional detachment, focusing on rituals and tasks instead of people (Glaser & Strauss, 1965; Menzies, 1960; Quint, 1966; Schoenberg, 1969; Sudhow, 1967; Vreeland & Ellis, 1969; Williams & Williams, 1959). The subjects that provided care to dying patients regularly had more rigid attitudes toward death and dying

as measured by the Questionnaire for Understanding the Dying Person and His Family than the other subjects. Perhaps nurses who regularly work with dying patients develop rigid attitudes toward death and emphasize physical care rather than psychological care in order to deal with the stress involved in caring for dying patients. This rigidity in interpersonal relationships and less insight into the patient's psychological needs may help to emotionally to remove these nurses further away from the dying patients.

Because this questionnaire was not originally developed in order to measure acculturation into subcultures or different groups, the instrument may not be a valid measure of death and dying attitudes. Validity is a necessary component of research and if not present, can lead to inaccurate results (Simon, 1978). Construct validity was established by Yeaworth et al. (1974). However, it is possible that the tool does not measure what it intends to measure. The tool was originally designed to be used on students of nursing. It is possible that the tool cannot accurately measure attitudes toward death of subjects that are experienced registered nurses. The mean scores of the two groups of nurses in

the present study were lower, or more flexible, than the mean scores of the students reported by Yeaworth et al. (1974). Yeaworth and colleagues reported that the senior nursing students had a mean score of 67.77 with a standard deviation of 7.61. The mean score for the nurses in the present study who regularly work with dying patients was 66.33 with a standard deviation of 9.87. The mean score of the nurses in this study who did not work with dying patients was 61.58 with a standard deviation of 8.93.

Hammond (1981) questioned the validity of this instrument. She utilized the same intrument in her study of hospice volunteers and reported no significant difference in the scores of the subjects before and after hospice training sessions. Her before-training mean score was 78.3 while her after-training mean score was 72.2.

Freihofer and Felton (1976) showed that the dying patient as well as the family members of the dying person desired the nursing behavior be directed toward support, comfort, and ease of suffering of the fatally ill. The nurse is a professional person with the major responsibility for dealing with the dying patient and his family. Grieving widows identified the nurse as the most helpful person in the hospital, and the nurses' attitudes

or approach was the single most helpful measure identified by these widows (Hammons, 1971). As experienced health professionals, it is not surprising that the subjects of this study scored favorably on the Questionnaire for Understanding the Dying Person and His Family (Yeaworth et al., 1974). The registered nurses had lower mean scores than the student nurses' mean scores in Yeaworth's et al. study.

Lamerton (1978) suggested that it takes 12 to 18 months to become confident in working with the dying. Although the percentage of the subjects that had 12 to 18 months of this experience was not measured by this investigator, 42% of the sample had less than 5 years of experience in working with dying patients. It is possible that the subjects' wealth of experience with dying patients explains the relatively favorable attitudinal scores.

The relatively favorable scores of the subjects of the present study may have been the result of the death education the subjects had received. Yeaworth et al. (1974) found that important shifts in attitudes about death and dying can result from nursing education. Schowalter (1975) found that nurses that made any serious

approach to understanding death also had a better understanding of life. Seventy-five percent of the sample in the present study had received some type of formal death education, and 55% stated that death and dying was included in their nursing curricula.

The age of the subjects was a significant covariant. The older nurses were more open, caring, and flexible in their interpersonal relationship with dying patients.

The characteristics of the subjects may have influenced the unexpected results of this study, that the nurses who regularly work with dying patients were less caring and more rigid in their interactions with dying patients than nurses who do not work regularly with dying patients. The nurses who regularly work with dying patients were younger and less educated than the other group of nurses who do not regularly care for dying patients. Eleven of the nurses who do not regularly care for dying patients were actively employed in cancer nursing. Perhaps these nurses were able to score higher on the questionnaire because of their formal and informal education. Throughout the literature, there is evidence that formal education can lower death anxiety; this finding, however, was not supported by this study.

The review of literature also indicated that flexible, caring attitudes toward dying patients and their families is a desirable characteristic for health providers (Freihofer & Felton, 1976; Hampe, 1975). Perhaps this characteristic is an unrealistic expectation for health providers that do care regularly for dying patients.

The literature revealed that nurses rated the emotional care of the dying as very stressful. Ninety percent of Popoff's (1975) respondents reported that they had confidence in providing technical care to the dying, while only 58% indicated confidence in giving psychological care to the terminally ill. The attitudes of the nurses who regularly care for dying patients in this study were consistent with Popoff's finding. Emphasizing the technical care that these nurses feel confident to give, may also help them cope with the stress related to caring for dying patients regularly. Conversely, if they rated emotional care as more important and also felt less confidence in providing the psychological care, this lack of confidence may lead them to choose other types of work rather than regularly nursing dying patients.

Conclusions and Implications

Based on the findings of this study, the Questionnaire for Understanding the Dying Person and His Family may not have measured the acculturation of the subjects into a subculture with different attitudes toward death. The theoretical framework was not supported by the findings in this study. Working with dying patients regularly did not necessarily influence the nurses' attitudes toward death to be more flexible, open, and caring. It cannot be assumed that this subculture of nurses who work with dying patients were acculturated into a different culture with different attitudes toward death. These nurses did not necessarily alter the societal death avoidant attitude.

Recommendations for Further Study

Additional study in the area of death attitudes of nurses is recommended. Recommendations for further study include the following.

1. The study be repeated using another instrument that measures attitudes on death and dying.

2. A similar study be conducted using nurses from high risk death areas as compared to low risk death areas within health agencies.

3. Research be conducted to focus on what impact hospital settings have on nurses' attitudes toward death and dying.

APPENDIX A

The instrument, Questionnaire for Understanding the Dying Person and His Family, is a copyrighted tool and may be obtained from Yeaworth (see Appendix H).

RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS YOUR CONSENT TO PARTICIPATE IN THIS STUDY. PLEASE DO NOT SIGN YOUR NAME ON THE QUESTIONNAIRE SO THAT YOUR ANONYMITY MAY BE PROTECTED.

Part II

Please fill in the blank or check the category appropriate to you.

Sex: Male_____ Female_____

Age: Under 25__ 26-34__ 35-44__ 45-54__ 55 or older__

Marital status: __Never married
__Divorced or separated
__Married
__Widowed

Religious Preference: __Catholic __Protestant
__Jewish __Other

Intensity of religious belief:
__Strong __Moderate
__Weak __None
I have a strong belief in an after life. Yes__ No__

Ethnic Group:
__Caucasian __Black
__Native American __Mexican-American
__Oriental __Other

Education:
__Associate Degree Nurse
__Bachelor of Science in Nursing
__Other (specify)_____

Did your nursing education include curricula on death and dying. Yes__ No__

Have you ever received other formal education on death and dying (i.e., attended a structured workshop or class with curricula pertaining to death and dying)?
Yes__ No__

RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS YOUR CONSENT TO PARTICIPATE IN THIS STUDY. PLEASE DO NOT SIGN YOUR NAME ON THE QUESTIONNAIRE SO THAT YOUR ANONYMITY MAY BE PROTECTED.

Has anyone in your immediate family died? Yes__ No__

Relationship:	Your age then:
__Father	___
__Mother	___
__Sister	___
__Brother	___
__Grandparent	___
__Other close relative	___

Are you actively employed in cancer nursing? Yes__ No__

Do you care for dying patients every day in your employment? Yes__ No__

Approximate number of years you have been working with dying patients:

__Below 5 years __5-10 years
__10-15 years __15-20 years
__20-25 years __over 25 years

APPENDIX B

COVER LETTER FOR QUESTIONNAIRE

Dear

My name is Marcia Hess. I am a graduate student in nursing at Texas Woman's University. I am conducting a study with registered nurses to investigate their attitudes about death and dying. I received your name and address from _____(agency) who agreed to help me with my study.

Your participation would entail completing the attached questionnaire and returning it to me in the enclosed return envelope. There are two parts to the questionnaire, and it should take approximately 30 minutes to complete. Return of the completed questionnaire will be construed as consent to participate in this study.

It is necessary that I inform you that there may be emotional and/or mental risks involved in your participation in this study due to the topic of death and dying. Another risk is the possibility of a feeling that your privacy has been invaded. However, if you agree to participate in this study, it is important to know that your anonymity and rights will be protected. Your name will not be used in reporting the results of this study as it will be reported as group data. Also, no medical service or compensation is provided to you by Texas Woman's University as a result of injury from your participation in this study. You may withdraw from the study at any time. The results of this study will be furnished to you upon request.

I will be available to answer any questions for your concerning this study. Feel free to contact me at 838-9789. Thank you for your assistance with this study.

Sincerely,

Marcia Hess, R.N.
Graduate Student
Texas Woman's University

Enclosures

APPENDIX C

TWU Texas Woman's University
P.O. Box 22479, Denton, Texas 76204 (817) 383-2302, Metro 434-1757, Tex-An 834-2133
THE GRADUATE SCHOOL

September 21, 1982

Ms. Marcia Hess
1527 West Jacinto
Mesa, AZ 85202

Dear Ms. Hess:

I have received and approved the Prospectus for your research project. Best wishes to you in the research and writing of your project.

Sincerely yours,

Robert S. Pawlowski
Provost

ap

cc Dr. Beth Vaughan-Wrobel
Dr. Anne Gudmundsen

APPENDIX D

COVER LETTER TO AGENCIES

Agency Name
Address

Dear

I am a graduate student in nursing at Texas Woman's University. I am conducting a study with registered nurses to investigate their attitudes about death and dying. Specifically this study is comparing the attitudes of nurses who work regularly with dying patients with those nurses who do not work regularly with dying patients.

Enclosed is a copy of my thesis proposal, the questionnaire I will be sending to the participants, and an agency permission form. Along with your agency's permission, may I have the names and addresses of nurses who might be willing to participate in the study. Enclosed is a return envelope.

I will be very willing to meet with you if there are any problems that you or your agency feel we should discuss. You may reach me at 838-9789 or 264-2492, ext. 583.

Please indicate whether you would like me to share the results of my study with your agency. Thank you for your assistance.

Sincerely,

Marcia Hess, R.N.
Graduate Student
Texas Woman's University

Enclosures

APPENDIX E

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS 76204

DALLAS CENTER
1810 INWOOD ROAD
DALLAS, TEXAS 75235

HOUSTON CENTER
1130 M. D. ANDERSON BLVD.
HOUSTON, TEXAS 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE _____

GRANTS TO Marcia Hess
a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

Nurses Attitudes toward Death and Dying

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

Date: August 25, 1982

_____
Signature of Agency Personnel

Marcia Hess RN
Signature of Student

Beth C Vaughn-Wrobel RN Ed.D.
Signature of Faculty Advisor

* Fill out and sign three copies to be distributed as follows: Original-Student; First copy - agency; Second copy - TWU College of Nursing.

GP:GEN 13
07026074 cd

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS 76204

DALLAS CENTER
1810 INWOOD ROAD
DALLAS, TEXAS 75235

HOUSTON CENTER
1130 M. D. ANDERSON BLVD.
HOUSTON, TEXAS 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Phoenix Oncology Nursing Society

GRANTS TO Marcia Hess, R.N.
a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

Nurses Attitudes toward Death and Dying

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

Date: August 26, 1982

Signature of Agency Personnel

Marcia Hess RN
Signature of Student

Ruth C Vaughan Wrobel RN, Ed.D
Signature of Faculty Advisor

* Fill out and sign three copies to be distributed as follows: Original-Student; First copy - agency; Second copy - TWU College of Nursing.

GP:GEN 13
07026074 cd

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS 76204

DALLAS CENTER
1810 INWOOD ROAD
DALLAS, TEXAS 75235

HOUSTON CENTER
1130 M. D. ANDERSON BLVD.
HOUSTON, TEXAS 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE_____

GRANTS TO Marcia Hess
a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

Nurses' Attitudes toward Death and Dying

The conditions mutually agreed upon are as follows:

1. The agency ~~(may)~~ (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report. NA
3. The agency (wants) (does not want) a conference with the student when the report is completed. NA
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan. NA
5. Other Send a list of RN names to above named student.

Date: 8-2-82

Signature of Agency Personnel

Marcia Hess RN
Signature of Student

Beth Clayton-Wrobel RN, Ed.D.
Signature of Faculty Advisor

* Fill out and sign three copies to be distributed as follows: Original-Student; First copy - agency; Second copy - TWU College of Nursing.

GP:GEN 13
07026074 cd

APPENDIX F

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

PROSPECTUS FOR THESIS/DISSERTATION/PROFESSIONAL PAPER

This prospectus proposed by: Marcia Nering Hess

_____ and entitled:

Nurses' Attitudes on Death and Dying

Has been read and approved by the members of (his/hers) Research Committee.

This research is (check one):

__X__ Is exempt from Human Subjects Review Committee review because it was classified as Category I according to federal regulations. This category includes survey and questionnaire research where the subjects are not identified.

_____ Requires Human Subjects Review Committee review because _____

_____

Research Committee:

Chairperson, Betty C. Vaughan-Wrobel

Member Lois Hough

Member Margaret McElroy

Dallas Campus __X__ Denton Campus ____ Houston Campus ____

APPENDIX G

THE UNIVERSITY OF NEBRASKA MEDICAL CENTER
42ND STREET AND DEWEY AVENUE
OMAHA, NEBRASKA 68105

COLLEGE OF NURSING
OFFICE OF THE DEAN

October 6, 1983

Marcia Hess, B.S.N.
8312 E. Snyder Rd.
Tucson, AZ 85749

Dear Ms. Hess:

I am sorry to learn that we did not give you specific permission to utilize the questionnaire for understanding the dying patient and his family. Ms. Winget is the one who did most of the developmental work on the questionnaire, so I usually have deferred to her in terms of giving permission. I am certain that she implied permission in sending you the questionnaire and the information on "Validity and Reliability." The questionnaire has been used by a large number of nursing students for thesis or senior baccalaureate research projects. I see no problem in your using it for your thesis. When you speak of publishing your thesis, I need clarification. If you are speaking of putting a copy of the instrument in your bound thesis, this should be acceptable. If you are speaking of submitting a paper based on your thesis to a journal for publication and including the entire instrument for publication, then I think you should request permission to do this directly from Ms. Winget. She is presently out of the country until October 17, 1983. Ms. Winget can be reached through the Department of Psychiatry, College of Medicine, University of Cincinnati Medical Center, Cincinnati, Ohio 45267.

I hope we have not caused you any delay in completing your thesis.

Sincerely,

Rosalee C. Yeaworth, R.N., Ph.D.
Professor of Nursing
Dean, College of Nursing

RCY:daf

APPENDIX H

SCORING KEY

QUESTIONNAIRE FOR UNDERSTANDING THE DYING PERSON AND HIS FAMILY

Items Not Scored (N=17)	Negative Items Scored "Strongly Agree" as 5 to "Strongly Disagree" as 1 (N=19)	Positive Items Scored "Strongly" Agree" as 1 to "Strongly Disagree" as 5 (N=14)
3	1	2
5	4	6
12	7	8
20	9	16
22	10	17
24	11	18
25	13	23
27	14	26
28	15	33
30	19	36
32	21	38
35	29	42
39	31	46
45	34	50
47	37	
48	40	
49	41	
	43	
	44	

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