DEATH ANXIETY IN OCCUPATIONAL THERAPY STUDENTS

A THESIS

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CHAPTER I

THE PROBLEM AND ITS SETTING

Statement of the Purpose

The purpose of the study was to determine what relationship, if any, exists between death education and death anxiety levels of occupational therapy students. Few studies are present in death and dying literature regarding the death anxiety levels of health care specialists in comparisons to their professional education. The present study intended to measure anxiety levels in quantifiable terms using a self-reported, non-projective measure.

Subproblems

The first subproblem was to determine whether death anxiety levels of occupational therapy student groups differ as measured by the pretest.

The second subproblem was to determine whether occupational therapy students who did receive the death education unit exhibit different levels of death anxiety than students who did not receive the death education unit

as measured by the posttest.

The third subproblem was to determine whether death anxiety levels of occupational therapy students differ with respect to demographic characteristics.

Null Hypotheses

There is no significant difference between death anxiety levels of occupational therapy student groups as measured by the pretest.

There is no significant difference between death anxiety levels of occupational therapy students who did receive the death education unit and occupational therapy students who did not receive the death education unit as measured by the posttest.

There is no significant relationship between death anxiety levels of occupational therapy students with respect to demographic characteristics.

Definition of Terms

Affect state. An affect state refers to a transient or momentary feeling or emotion of a person.

Anxiety. Anxiety is a term used to identify a diffuse feeling of distress or apprehension in response to a threat.

Closed-form questionnaire. A closed-form questionnaire is a self-reported survey in which an individual chooses from a set of provided responses. The individual selects the response which most nearly approximates his own (Warwick & Lininger, 1981).

Death. Death is a condition determined by competent medical personnel after monitoring the following criteria.

a. unreceptivity and unresponsiveness; total unawareness of external stimuli

b. no movements or breathing; observable by a physician for at least one hour

c. no reflexes; central nervous system activity absent

d. no brain activity; flat electroencephalogram (Hardt, 1979).

Death anxiety. Death anxiety is a term used in identifying an emotional response to death and dying. Specific components may include fear of the dying process, fear of death, fear of the results or consequences of death, fear of the death or dying of others, etcetera.

Death education. Death education refers to formal training designed to increase a knowledge base of the process of dying. Related topics may include euthenasia, griefwork, mourning, hospice care, etcetera.

Death education unit. Death education unit refers

to a specific series of classes taught by the writer. The unit is employed as the dependent variable in this study.

Occupational therapy. Occupational therapy is the art and science of directing man's participation in selected tasks to restore, reinforce and enhance performance, facilitate learning of those skills and functions essential for adaptation and productivity, diminish or correct pathology, and promote and maintain health. Its fundamental concern is the capacity, throughout the life span, to perform with satisfaction to self and others those tasks and roles essential to productive living and the mastery of self and environment (American Occupational Therapy Association, 1972).

Occupational therapy student(s). For the purpose of this study, occupational therapy student refers to any member of the experimental or control group who is presently enrolled in a sophomore level theory class as part of the required course work in the occupational therapy curriculum.

Personal philosophy. The collective attitudes of an individual, positive or negative, constitute his personal philosophy.

Registered occupational therapist. A registered occupational therapist is an individual who has success-

fully completed the national certification examination for occupational therapist, registered and who has paid the American Occupational Therapy Association certification and registration fee (American Occupational Therapy Association Handbook, 1978).

Vicarious learning. Vicarious learning is the process of sharing in another's experience by imagined participation. This method is used to develop a student's capacity to deal with real life problems through simulated experiences.

Abbreviations

OTR is the abbreviation used for a registered occupational therapist.

OTS is the abbreviation used for an occupational therapy student.

AOTA is the abbreviation used for the American Occupational Therapy Association.

DAS is the abbreviation used for the Templer Death Anxiety Scale.

Assumptions

The first assumption was that many persons experience some degree of anxiety in conjuction with the

subject of death and dying.

The second assumption was that each person has a personal philosophy regarding living and dying.

The third assumption was that a personal philosophy and an anxiety state change according to current states of physical and mental health.

The fourth assumption was that the attitudes comprising a personal philosophy may be examined with the use of a self-reported survey.

The fifth assumption was that the Templer DAS is a valid measure of attitude, specifically death anxiety.

The sixth assumption was that persons respond honestly on the Templer DAS; that responses given accurately reflect their true feelings.

Delimitations

Although the study intended to determine what differences, if any, exist in death anxiety levels between the experimental and control groups, sample size and selection may have decreased the ability to generalize findings to other groups. The sample size was small and demographically narrow. Respondents were limited to one southwestern woman's university. The results may have reflected the educational philosophy of this particular

school, regional or cultural differences, or environmental influences peculiar to the area.

While the closed-form style of questionnaire facilitated analysis and computation of the data and increased its consistency, it did not allow for subjective response. The response choices provided did not allow for explanation of motivation and they may have been inappropriate responses for some individuals (Turney & Robb, 1971). This study did not take into account any long term effects or attitudinal changes which might have been of greater statistical significance than findings collected within the six hours of instruction. The experimental methodology required participants to respond to vicarious means of learning rather than clinical experience.

Limitations

Respondent's previous experience with death may have influenced the results of the study. Some student's philosophies may have been so consolidated that no statistically significant change could be noted for them within the six hours of instruction. Physical and mental health of respondents at the time of testing may have also influenced the results of the study. Respondents may have

answered as they anticipated their instructor wanted them to or in some manner not reflective of their honest feelings. Some respondents may have considered questions to be an invasion of privacy and consequently may have been less willing to give accurate answers. Even if respondents wished to give accurate replies, they may have had faulty memories or perceptions which affected the quality of their responses (Turney & Robb, 1971).

Importance of the Study

The 1970's have seen the advent of reopening death as a socially acceptable topic. Parallel movement in the art of medicine reveals that fulfillment of the abstract human needs of identity and dignity and self-worth is as essential in giving life its meaning as the maintenance of biological and physical needs, definable and concrete. Occupational therapists deal with many aspects of human need at all stages of human development. Their professional education is geared toward a comprehensive overview of human need, including basic theory and treatment philosophy. In order to deal with death, the final stage of human development, it is important for therapists to come to terms with their feelings and attitudes. As the helping professions, particularly occupational therapy,

become more fully aware of their special roles in dealing with people at the time just prior to death. The attitude formation process may be just as variable as the personal experiences brought to it. Lester, Kniesel, and Getty (1974) studied the influences of education and experience on fear of death in college students, with findings supporting the need for more formal instruction in the area of death and dying. Formal data collection and analysis combined with other substantial evidence will help to fill the need in justifying the legitimacy of changes in, additions to or the maintenance of academic programming in the professional occupational therapy curriculum.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

Introduction

The countryside of medieval Europe was reported to have been dotted with hospices (Stoddard, 1978). Historically, a hospice was something of a way-station where travelers stopped along their pilgrimages for sustenance and rest. The weary and ill were nursed to health and any that died were buried by their host. In those days, life itself was perceived as a journey, a pilgrimage which naturally ended in death. Dying can be a long journey today, its arduous passage a result of modern medicine. Lofland (1978) wrote that medical technology has advanced so far in the deceleration of mortality, that it is now questionable whether the prolongation of life is truly desirable. In his Republic, Plato mentioned that in the instance a person became diseased throughout, it was not the practice to extend a lifespan in discomfort, but to allow a peaceful death, supported in well-ordered communities by members who dutifully looked out for their fellow citizens (Cornford, 1955).

The concept of community support for its members in

the final stage of life then is not new. Like being born, dying is a process which requires assistance. We are present for one another in body and spirit, bringing tangible help and intangible awareness as necessary, said Stoddard (1978). In agreement, Pattison (1977) expressed the idea that no man dies alone but in relationship to his family and friends. There exists a resonant impact of the dying process on other people, and of those significant others on the dying person. The subject of death is not a new one, however it has been a subject taboo in daily discussion, a modern reflection of the manner in which man refuses to accept his own end. America is a death-denying society, consequently we see a breakdown in the ability of its citizens to cope with the situation of modern dying.

History of Death Education

Western civilization reveals its death denying society from the point man enters into life. Nursery rhymes and fairy tales seem to change death from a natural process into something which happens only to the wicked. In some of these stories, death is frequently seen as a temporary condition, reversible if there is a handsome prince or a magic spell. Modern day man is not the first to deny death. In Tolstoy's short story, "The Death of

Ivan Ilych", the title character suffered from denial. Friends and family of Ivan Ilych adopted the lie that he was only ill, not dying. He felt forced to become a party to the lie, never having the courage to confront it (Purtilo, 1973). This classic tale holds a powerful argument for death education; that is, exploring one's own mortality can be a highly effective means for making a necessary and beneficial inquiry into personal beliefs and behaviors while alive (Wass, 1979).

Death education has become a widely valued topic within the past ten years. It is in the spotlight today because of the concurrent biomedical revolution and socio-cultural evolution (Knott, 1979). Social movement not only creates new activities and organizations but also reshapes concepts and ideology. Multiple symposia and conferences have taken place since the start of the 1970's illustrative of this movement. Recent surveys (Knott, 1979) indicated rapid growth of courses concerning death-related topics at the post-secondary level. The United States Senate appointed a subcommittee to study the recent boom in the aging population and its subsequent impact on the social strata. This shift in the social movement seems to reveal the emergence of death and dying as a topic of new fad and fashion.

The field of psychology has delved into the study of human behavior more fully than any other. Studies encompass a wide range of subject matter; individual and group differences of feelings concerning death and dying with respect to age, sex, personality, and religious preference. In America, Kübler-Ross (1969) has done extensive work interpreting and discussing the different stages people go through when they are faced with the prospect of death. In psychiatric terms, she described defense mechanisms and coping skills used in dealing with this difficult situation. Initial attempts at establishing the Chicago death and dying seminar met with various degrees of resistance and, in some cases, with open hostility. Once the seminar was established, attitudes changed drastically, most notably those of attending hospital physicians. While Kübler-Ross' work is undoubtedly the most famous in this area, many other theorists have attempted to describe the development and unfolding of the dying process. Each describes in detail his own view of the craft and process of dying. Kübler-Ross' view is neither correct nor incorrect, and is only one model which describes five common components of the total emotional response to death. Perhaps it is too oversimplified to encompass all that transpires in

the human mind, but it has served to generate much interest in and concern for the dying person.

Death Education Today

Recent growth in the aging population and the social/medical revolution as mentioned earlier both influenced the recent concern of the health professional in evaluating his role with the terminally ill. The porportion of persons likely to die in hospitals and related institutions has grown, increasing the contact between the helping professions and the dying (Nash, 1977). Obviously, educational preparation and goals vary among persons who practice in different specialties. In order to deal effectively with the patient who is near death, caregivers must learn to interpret and manage different facets of the dying process. Wass (1979) suggested that learning about death as a fact of life seems most beneficial before one is actually bereaved or faced with dying.

In their book, Worden and Proctor (1976) stated that a potentially ominous subject becomes less threatening the more it is investigated. They suggested that when a person willingly increases his death awareness, he seldom wishes to return to his previous state of unaware-

ness. Death education refers not only to death itself but also to our feelings about it. It refers to our own mortality and how we view ourselves in relation to the macrocosm we live in. It has to do with personal values and ideals, how we communicate between ourselves, and the effect we have on the immediate world around us. Morgan (1977) suggested that introspection can deepen the quality of our lives and of our relationships.

Feifel (1973) described death as the ultimate reflection of human existence. He implied that coming to terms with one's own mortality is essential in acquiring sufficient perspective for everyday life. It is necessary in acquiring wisdom for decision making, from the mundane choices to major life events concerning mate and career. Ethical and moral choices acquire broader meaning when they are made with the perspective of the life span. Pragmatic goals for death education include the need to be well informed as a consumer of goods and services for the dying and their families. Providing information about funerals, body disposition, extended care, postmortem bequests, etcetera, is appropriate anticipatory preparation.

Another appeal of death education is the value found in learning coping behaviors. Establishing a

repertoire of functional coping skills can serve as a buffer against other types of personal pain and loss. Exploring perspectives surrounding grief and mourning help us to cope with and resolve feelings of loss due to death, whether the survivor-victim is oneself or a significant other (Knott, 1979).

Leviton (1977) and Wass (1979) both enumerated goals for death education. Some inclusions were the elimination of taboos and anxieties established by our respective cultures, and communication and interaction skills between caregivers and survivors that require practice before they are needed. Sharing information about arrangements, wills, inheritance taxes, death criteria, etcetera, maximizes pertinence of the education. Information may be interpreted as it is most relevant to each individual. While the primary responsibility for content and formal structure of any course in death education falls to the instructor, the students in such a course influence the material and the means by which it is taught. The needs and interests of the students should be expressed to shape the content into its most relevant form.

Schools of thought vary as to when death education should take place. Leviton (1977) suggested that both

formal and informal death education should be developmental and systematic. The traditional view sees children as acquiring an outlook mature enough to encompass death at age nine or ten. The more current view explains that children understand mortality on a gut level at a younger age. Realistically, the appropriate age to introduce a child to death probably differs from one child to the next depending on his interest and various encounters with death. Recurrent exposure throughout the entire life experience would seems to be most meaningful. During adolescence and young adulthood, attitudes become more fixed and internalized, however, death continues to elicit strong emotional influences. A personal philosophy of life and death continues to grow and change through old age. Opportunities throughout life for reflection and integration of ideas into a personal belief system will endure longer than bombardment at any one stage of development.

Lectures, conferences, and courses about death and dying are occurring with increasing frequency, expanding the availability of death information to the public. Several colleges and universities in Colorado offer fully accredited courses on death and dying available to the general public and to health professionals on undergraduate and graduate levels.

Health Professionals and Death Education

Research conducted in the past ten to fifteen years has not produced a unified set of findings in regard to attitudes, behaviors, and feelings of health professionals towards death. Little literature is available relating death anxiety to professional education received. Feifel (1963) hypothesized that some individuals enter a medical profession because they fear death more than other people fear it. They hope to protect themselves from death by gaining knowledge. Other theorists conclude that fear of death results from regular exposure to it (Feifel & Hanson, 1977). We are certainly faced with a chicken and egg phenomenon.

Schools of medicine and nursing instruct their students primarily in the technical aspects of dealing with patients. Practicing physicians today have little or no formal education in coping with the needs of the dying patient and his family (Kavanaugh, 1974). Skills in coping with these nonmedical needs of the terminally ill are generally acquired by individual incentive or through the acquaintance of an exceptional role model. One physician wrote that neither in school, in training, nor in twenty-five years of practice was he able to initiate a discussion specifically about death with more than three or four

colleagues (Stevens, 1971). A concerted effort toward educating health professionals on this subject seems to have started with Kübler-Ross' interdisciplinary seminar on death. This accredited course for the medical school and the theological seminary in Chicago was attended by nurses, inhalation therapists, aides, orderlies, priests, social workers, rabbis, and occupational therapists.

Multiple organizations now exist with public education in mind. The Euthenasia Council, the Foundation of Thanatology, and the Forum for Death Education are a few of the larger groups. Concern for Dying, an active educational organization, distributes copies of the living will, provides specific directives to physicians regarding state death-act legislation, organizes and sponsors a student program, provides legal advisory service, and other outreach services as well as multi-media resources. Concern for Dying tailors its programming to suit the needs of its learners, including the general public, the clergy, the media, hospital administration, social workers, the medical, nursing, and legal professions. Books, films, slideshows, and newsletters are available to educate the populace about death. Lobbying efforts and the creation of new medical branches and organizations reflect the modification of the social structure to care for the dying.

Gammage, McMahon, and Shanahan (1976) noted minimal literature regarding terminal illness as part of a formal educational process for the occupational therapist. They found the proposed role of the occupational therapist with the terminally ill patient to be neither clearly nor attractively defined. They identified specific insufficiencies in forming affective and cognitive objectives for classroom learning in this area. In order to make use of information on the subject of death and dying, the occupational therapist needs to be able to assess the stages of dying a person experiences, his defense mechanisms, and emotional reactions of self, patient, and family. Occupational therapists may also appraise similar emotional reactions exhibited by rehabilitative patients. Oelrich (1974) stated that therapists are frequently unprepared for the accompanying psychological problems which arise in dealing with dying patients. Information compiled with the help of the Professional Development Division in the American Occupational Therapy Association (1980) provided a current update on the education and role of the occupational therapist in the care of the dying.

In her unpublished manuscript regarding attitudes of occupational therapists toward death and dying, McKee (1981) found no significant difference between the amount

of death education received and a therapist's willingness to discuss feelings about death and dying. This finding would seem to indicate that while death education was not part of the formal coursework for occupational therapy students, it did provide sufficient training for adequate patient interaction. The AOTA Professional Development Division (1980) also considered that occupational therapists' education and training allows them the capability of a special contribution to treatment of the dying patient. There is a potential for occupational therapy to develop a unique role in caring for the dying patient and his family.

Appraisal of Death Anxiety

In testing attitudes, it is desirable to use an instrument with the following criteria: high test-retest reliability, construct validity, brevity, plain wording, simplicity in administration, ease of scoring. Three basic methods of assessment are employed in research on the topic of death anxiety, interview, projective techniques, and questionnaires. Few attempts at establishing the validity or reliability of these instruments are reported in the literature (Templer, 1970).

Interview procedures are designed to obtain

information by some type of verbal interaction. While the intimate nature of the interview process suggests a high value in collecting data about personal convictions, the investigation of a sensitive topic, such as death, may be threatening. Subjects may be unable or reticent to reveal this information. Discussions which intrude too far into private territory tend to activate the defenses of the respondent. These procedures may be time consuming and depend partially on clinical impressions. They are difficult to analyze in a measurable form.

Research projectives are somewhat more easily measured, as the following examples indicate. In the Thematic Apperception Test (TAT), a subject is presented with a picture and asked to tell a story about it. Death concern is disclosed by the frequency with which the topic arises in storytelling. Word association tests seeks rapid responses to verbal clues. Time delays and galvanic skin responses are considered to reveal emotional investment with the topics of which the stimuli are symbolic. Unlike the TAT, sentence completions and word association tests require a subject to work as quickly as possible. The first reponse comming to mind is considered to be the most representative of his true attitudes (Dumont, 1972). Validity is also debatable with projectives. Conventional

projectives are also difficult to quantify according to a specific criteria.

A closed-form questionnaire in which an individual chooses from a set of provided responses seems the most functional in obtaining quantifiable data. Respondents may answer more honestly on a paper and pencil task than in a face to face interview and may feel more reassured of confidentiality. This type of information is easy to code and analyze when questions are written as measurably finite. This type of self-administered survey is found to be preferable when the study deals with personal or emotionally laden topics (Warwick & Lininger, 1975).

Dickstein (1977-78) hypothesized that persons who are more threatened by death should appear more anxious on a trait anxiety measure. He found that the Tolar and Reznikoff (1968) Death Anxiety Scale and the Templer (1970) Death Anxiety Scale each correlated significantly with this type of measure. In addition, Dickstein (1972, 1975) performed further validation studies of his own Death Concern Scale. Durlak (1972) described a variety of scales used in examining fear of death. These purportedly measured the degree to which respondents consciously confront death. Schneidman, Parker, and Funkhouser (1970) developed a closed-form questionnaire which appeared in

Psychology Today magazine and which helped to bring the issue of personal attitudes about death into the public eye. Using parts of this questionnaire, Golub and Reznikoff (1971) compared attitudes of nursing students at different educational levels.

In 1969, Templer presented information on his construction and validation of the Death Anxiety Scale (DAS). The DAS underwent item analysis, reliability studies, and further validation procedures (Templer, 1970). The Minnesota Multiphasic Personality Inventory was used in order to establish construct validity. Internal consistency and test-retest reliability was also determined. Comparison with the Boyar (1964) Fear of Death Scale revealed a high correlation coefficient of +.74. Values significant at the .05 level were found in correlation with the Manifest Anxiety Scale and the Welsh Anxiety Scale. From this, Templer (1970) determined that death anxiety correlated positively with general anxiety. Montefiore (1973) reported further on Templer's work involving the collection of relevant data for means and standard deviations of "normal" scores for the DAS. Many researchers have used spinoffs of Templer's and Schneidman's questionnaires for a variety of populations, attempting to examine information about existing attitudes

regarding death-related topics. Considering the complexity of attitudinal change, it may be difficult to demonstrate statistically significant differences in death anxiety during a short time period. It is important to consider whether evaluation of the short or long term effects of educational programming is most appropriate (Simpson, 1979).

CHAPTER III

METHOD

Sample

Subjects of this study were twenty-eight occupational therapy students currently enrolled in two sophomore theory classes of a southwestern woman's university. Written permission was sought and obtained from the dean of the occupational therapy school (see Appendix A). Correspondence with the dean described the independent variable, means of assessment, and planned participation of the subjects. The participants were chosen solely on the basis of enrollment in the required theory classes of the undergraduate occupational therapy curriculum at this campus. This non-random selection is incidental or convenience sampling technique. The control and experimental groups were anticipated to be demographically narrow. The "life tasks" class group who received educational instruction from the writer represents the experimental group. The "testing" class who received no specific instruction from the writer represents the control group. The groups numbered thirteen and fifteen members respectively.

Design

The study intended to examine death anxiety of occupational therapy students in relation to death education received. The independent variable of the study was an instructional unit entitled "Death and Dying" taught by the writer. The dependent variable of the study was any change in death anxiety after receiving this instruction. The study was quasi-experimental in research design because it was not possible to guarantee randomness of group composition. The pretest-posttest design methodology employed a two-week death education unit as the independent variable. Testing and control of the independent variable took place in the same classroom normally used for the class, at the regularly scheduled time. Pre testing of the experimental subjects took place prior to exposure to the two-week unit. Post testing took place at the close of the unit.

Materials

Data were collected by means of a closed-form questionnaire, the Templer Death Anxiety Scale. (See Appendix B for the student form of the DAS.) This self-reported survey requires five to ten minutes administration time. An additional five to ten minites was required to

collect demographic information. (See Appendix C for demographic questionnaire.) Selection of the test instrument was discussed within the review of the literature. To recapitulate, the Templer DAS was selected because of ease of administration, brevity, and extensive validation procedures employed in its construction. Additionally, relevant data is available for means and standard deviations of "normal" scores (Montefiore, 1973). The DAS was hand scored by the writer according to the key (see Appendix D).

Data Collection

Each subject received a cover letter enumerating writer qualifications and a description of the study (see Appendix E). The letter also explained the informed consent necessary for participation in the study. The study was exempt from full review of the Human Subjects Review Committee as stated in the Guidelines for Research Involving Human Subjects, effective September 17, 1981.

The first session of the instructional unit "Death and Dying" was used for the DAS pretesting of and demographic data collection from the experimental group. The instructional unit consisted of four one and one-half hour class sessions spread over a two-week period. The

students received a combination of lecture material, values clarification tasks, and vicarious learning experiences (see Appendix F). The posttest DAS (identical to the pretest) concluded the final teaching session of the instructional unit. The control group was given the pretest during the first fifteen minutes of a regularly scheduled class session at the same point during the school semester. Posttesting took place two weeks later.

Statistical Analysis

T-testing was used with pretest scores to determine any difference between groups. The posttest data were compared by the analysis of covariance technique (ANCOVA), suggested by Borg and Gall (1971) for quasi-experimental reasearch of this design. Two randomly selected classes could be compared using a t-test or analysis of variance. Conclusions drawn would assume homogeneity of sample groups. Since this study dealt with non-randomized groups, the results of either of those tests could have been invalid. In the ANCOVA, the posttest means are compared using the pretest means as a covariate. This statistical method is useful in reducing the effects of non-randomized groups by analyzing the variability of posttest scores due to the influence of treatment and experimental error.

CHAPTER IV

RESULTS

Twenty-eight students participated in the study. Identical pre and post tests were administered to the control and experimental groups. Each test was hand scored in comparison with the test key (see Appendix D). Each answer which matches this key was scored with one point. The sum of these points is the whole number score for that respondent. Possible scores range from 0 to 15. Low numerical scores indicate low death anxiety; high scores indicate high death anxiety. Templer and Ruff (1971) reported means of normal participants between 4.5 to 7.0; with standard deviations of slightly more than 3.0. Pretest scores for the experimental group (X_a) ranged from 4 to 12 with a mean score ($\bar{X}_a$) of 6.31 and a standard deviation of 2.21. Experimental posttest scores (Y_a) ranged from 2 to 10 with the mean ($\bar{Y}_a$) equaling 5.92 and a standard deviation of 2.32. Control pretest scores (X_b) ranged from 2 to 12 with a mean ($\bar{X}_b$) equaling 6.47 and a standard deviation of 3.23. Control posttest scores (Y_b) ranged from 3 to 12 with a mean ($\bar{Y}_b$) equaling 7.93 and a standard deviation of 3.06. (See Table 1.)

TABLE 1

PRE AND POSTTEST SCORES OF THE

EXPERIMENTAL AND CONTROL SUBJECTS

Experimental Group			Control Group		
Subject	Pretest X_a	Posttest Y_a	Subject	Pretest X_b	Posttest Y_b
101	4	4	114	2	6
102	4	4	115	2	3
103	5	2	116	3	4
104	5	7	117	4	4
105	5	9	118	4	7
106	5	4	119	5	9
107	6	5	120	5	5
108	6	4	121	6	10
109	7	7	122	8	12
110	7	6	123	8	11
111	7	10	124	8	10
112	9	8	125	9	6
113	12	7	126	10	10
. . . . .			127	11	11
. . . . .			128	12	12
N=13			N=15		
Sum=	82	77	Sum=	97	119
Mean	6.31	5.92	Mean	6.47	7.93
S.D.	2.21	2.33	S.D.	3.23	3.06

On examination of the raw data it was apparent that minimal difference exists between death anxiety levels of the control and experimental groups as measured by the DAS pretest. Control and experimental groups showed a pretest mean of 6.47 and 6.31 respectively. Computation of a Student's-t test revealed a value of t = .15 with 26 degrees of freedom (df). Welch's approximation to the t-t-test resulted in t = .15 with df = 25. These calculated values were insufficient to show a significant difference between means. We accepted the first hypothesis for this study that there is no significant difference between occupational therapy student groups as measured by the pretest.

Of the thirteen experimental subjects, three post-test scores reflected an increase in death anxiety, three scores showed no change, and seven scores reflected a decrease in death anxiety. Of the fifteen control control subjects, nine posttest scores indicated increased death anxiety, four scores showed no change, and two scores reflected a decrease in death anxiety. Total differences were a five point decrease and a twenty-two point increase for the experimental and control groups respectively. Table 2 lists individual subject differences between pre and posttest scores.

TABLE 2

INDIVIDUAL SUBJECT DIFFERENCES

BETWEEN PRE AND POSTTEST

Experimental Group				Control Group			
Subject	X_a	Y_a	d	Subject	X_b	Y_b	d
101	4	4	0	114	2	6	+4
102	4	4	0	115	2	3	+1
103	5	2	-3	116	3	4	+1
104	5	7	+2	117	4	4	0
105	5	9	+4	118	4	7	+3
106	5	4	-1	119	5	9	+4
107	6	5	-1	120	5	5	0
108	6	4	-2	121	6	10	+4
109	7	7	0	122	8	12	+4
110	7	6	-1	123	8	11	+3
111	7	10	+3	124	8	10	+2
112	9	8	-1	125	9	6	-3
113	12	7	-5	126	10	10	0
. . . . .				127	11	11	0
. . . . .				128	12	11	-1
$\bar{X}_a$=6.31	$\bar{Y}_a$=5.92		Σd=-5	$\bar{X}_b$=6.47	$\bar{Y}_b$=7.93		Σd=+22

For an accurate comparison of groups, arithmetical adjustments were made for any slight advantage of one group over the other by using the analysis of covariance statistical technique. The data were computed with a portable calculator in a single-classification ANCOVA using the step-by-step formula and guidelines offered by Shefler (1980). The results of this analysis revealed that the experimental group scored significantly lower on the posttest than did the control group. The ANCOVA comparison of posttest scores is given in table 3. Statistical calculations yielded an F ratio of 5.77 (df = 1,25). The level of significance was determined to meet and exceed the .05 level. On this basis, the second null hypothesis was rejected. There is a significant difference between death anxiety levels of occupational therapy students who did receive the death education unit and occupational therapy students who did not receive the death education unit.

Demographic characteristics were examined for the experimental and control groups. (Raw data are reported in Appendix G.) Information concerning age, religious affiliation, first personal involvement, and role of religion were compared in contingency coefficients with pre and posttest scores. Information concerning experience

TABLE 3

ANALYSIS OF COVARIANCE: COMPARISON OF POSTTEST SCORES

Source of variation	SS	df	MS	F
Education	25.31	1	25.31	5.77**
Within	109.65	25	4.39	
Education + within	134.95			

* Templer Death Anxiety Scale scores are covariate factors
** meets or exceeds .05 level

with formal death education was compared with pretest scores.

The contingency coefficient provides a measure of the degree of relationship between two varaibles. Once a chi-square has been determined, further computation yields a contingency coefficient. A large degree of discrepancy between observed frequencies and expected frequencies indicates the degree of relationship between variables is high. Expected frequencies are those which would exist if there were no relationship between variables. When frequencies are similar, the relationship is small.

Contingency coefficients for item 1 (age), item 3 (religious affiliation), and item 5 (first personal involvement) are reported in table 4. Appendix H indicates frequency of answers on the demographic questionnaire for experimental and control groups. The categories of sex and highest level of education completed were insufficient for comparison due to the confines of the sample (items 2 and 4). Twenty-seven participants in the study were female, one experimental subject was male. Seven control and twelve experimental subjects reported some college education. One control and eight experimental subjects reported holding an associate of arts degree. No subjects reported having a bachelors degree or higher level of

TABLE 4

CONTINGENCY COEFFICIENTS OF

DEMOGRAPHIC CHARACTERISTICS

Demographic Item	Experimental Group		Control Group	
	Pretest	Posttest	Pretest	Posttest
1. Age	.27	.42	.53	.62
3. Reported religion	.43	.53	.61	.65
5. First involvement with death family/ nonfamily	.33	.34	.44	.22
11. Role of religion in development of death attitudes	.51	.51	.56	.66
15. Amount of formal death education	.60		.48	

A small correlation coefficient implies a correspondingly small relationship between variables. A large correlation coefficient indicates a high degree of relationship.

education.

Both experimental and control groups reported most frequently that five to ten years of age was the time they were first aware of death (item 6). Family discussion of dying (item 7) varied for both groups from no discussion to being talked about openly. Childhood concept (item 8) of what happens after death was described as "heaven-and-hell" by the majority of experimental and control subjects. These attitudes changed for both groups, encompassing a scatter of the concept choices provided in item 9. Reported influence on death anxiety (item 10) was also scattered. Both groups reported a wide range of influence.

Experimental and control groups reported similar characteristics for item 12 in the frequency with which they thought about dying. Both presented a majority who thought occasionally about death. Other subjects stated in similar porportions that they frequently or rarely thought about death. The most frequently supplied answer for item 13, the meaning of death, was termination of this life but with survival of the spirit, followed closely by subjects who did not know what death meant to them (for all subjects). The majority of experimental subjects reported uncertainty about what might happen if there is a life after death as the most disagreeable aspect of death.

A painful death was reported most frequently for the control group for the same question (item 14). Contingency coefficients are reported for item 11 (role of religion) and 15 (experience with formal death education) in table 4.

Contingency coefficients listed in table 4 show little relationship between pre or posttest scores and age or first personal involvement. It is not possible to draw definitive conclusions about death anxiety levels and specific religious beliefs from this limited sample. These observations may suggest some connection between death anxiety and certain types of beliefs. No strong relationship was apparent between pre or posttest scores and the role of religious beliefs in the development of attitudes about death and dying for the control or experimental group. Control and experimental subjects reported prior death education ranging from no hours of exposure to many hours of exposure spent in special workshops and seminars. Subjects also described a variety of situations involving exposure to death and dying which did not involve formal death education. For this reason, no particular trend was noted between this item of formal death education and DAS prescores.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

The purpose of the study was to determine the extent of death anxiety in occupational therapy students following participation in a unit of educational instruction entitled "Death and Dying". The instructional unit included information about psychological stages of dying, cultural attitudes, consumer information, and values clarification. Students enrolled in two sophomore theory courses were chosen as control and experimental subjects. Both groups completed pre and posttests using the Templer DAS. Only the experimental group received the instructional unit concerning death and dying.

As anticipated, ANCOVA revealed a significant decrease in death anxiety from pre to post test for the experimental group in comparison to the control group. Care must be exercised in drawing conclusions regarding the relationship between death anxiety and death education because of methodological issues such as those mentioned in the limitations of the study. In concurrence with Tobacyk and Eckstein (1980-81), the study does support the notion that participation in death education does change

death anxiety. A further implication of the study is that anxiety increases after exposure to the topic of death, in this case via the pretest, when no education takes place. While it is possible to have a high level of death anxiety and still accept death as a natural process, students participating in death education have an opportunity to develop new beliefs and values, new philosophies with which to confront the subject of death (Dahl, 1980).

This study raises various questions for continued investigation. Study variations could examine other influences on death anxiety, content of death education, and implications for professional attitudes. In order to address problems encountered during this study and to address future research on this topic, the writer offers these recommendations.

1. Investigation of futher methods to best evaluate death anxiety in the affective domain. Future studies may make use of other evaluative forms or instruments which allow for extemporaneous writing and/or subjective responses.
2. Expand sample selection to include a diversity of subjects. A broader sample should help decrease regional or cultural differences, environmental influences, or specific educational philosophies which may have effected this study. Study replication with a larger sampling and

a more random selection may increase the probability of reliable data.

3. Study replication increasing time between pre and post-testing to explore long term effects and attitudinal changes resulting from the death education unit.

4. Examine more fully death education provided in the occupational therapy curriculum and its influence on death anxiety.

5. Examine death anxiety of occupational therapy students at different times throughout their professional education to give a more comprehensive view of change in relationship to the educational process.

6. Compare death anxiety levels of other populations (nursing, physical therapy or social work students) with those of the present study.

Death anxiety is a complex matter. Feifel (1973) stated that each individual nurtures diverse cultural, historical, and religious beliefs about what happens when we die. These personal beliefs provide us a frame of reference with which we may confront death and which help to give those confrontations meaning. The paradox is that dying is a universal experience, yet man cannot imagine his own end. In this study, the writer has intended to support the significant worth of death education.

APPENDIX A

LETTERS SEEKING AND OBTAINING PERMISSION

April 8, 1982
1820 Ruddell #130
Denton, Texas 76201

Dean
School of Occupational Therapy
Box 22909, TWU Station
Denton, Texas 76204

Dear Mrs. Pershing,

In partial fulfillment of the master of arts degree, I am writing a thesis entitled Death Anxiety in Occupational Therapy Students. I would like to request permission to survey two sections of the sophomore theory class for the purpose of data collection. The Templer Death Anxiety Scale, a closed form questionnaire, will be used, and demographic data collected on an accompanying questionnaire. Thank you for your assistance.

Dissertation/Theses signature page is here.

To protect individuals we have covered their signatures.

TWU Texas Woman's University
P.O. Box 23718, Denton, Texas 76204 (817) 382-5336
SCHOOL OF OCCUPATIONAL THERAPY

April 12, 1982

Nancy E. Krusen, OTR
1820 Ruddell, #130
Denton, Texas 76201

Dear Nancy:

This is to give you permission to survey two sections of the sophomore theory class for the purpose of data collection using the closed form questionnaire, "The Templer Death Anxiety Scale."

We are pleased that you want to use our student population for your thesis.

Dissertation/Theses signature page is here.

To protect individuals we have covered their signatures.

APPENDIX B

TEMPLER DEATH ANXIETY SCALE

STUDENT FORM

Below is a series of general statements. Please indicate whether you agree or disagree with them. Record your opinion in the blank next to each item, according to the following scale:

A - Agreement D - Disagreement

Read each item and decide quickly how you feel about it. Record your first impressions. Please answer every item.

_____1 I am very much afraid to die.

_____2 The thought of death seldom enters my mind.

_____3 It doesn't make me nervous when people talk about death.

_____4 I dread to think about having an operation.

_____5 I am not at all afraid to die.

_____6 I am not particularly afraid of getting cancer.

_____7 The thought of death never bothers me.

_____8 I am often distressed by the way time flies so very rapidly.

_____9 I fear dying a painful death.

____10 The subject of life after death troubles me greatly.

____11 I am really scared of having a heart attack.

____12 I often think about how short life really is.

____13 I shudder when I hear people talking about World War III.

____14 The sight of a dead body is horrifying to me.

____15 I feel that the future holds nothing for me to fear.

APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

Demographic Data

and Personal Questionnaire

1. Age:_____

2. Sex:_____

3. Religious affiliation:_____

4. Highest level of education completed:
   a. some college
   b. associate of arts degree
   c. bachelors degree
   d. some graduate work
   e. masters degree
   f. doctoral degree

5. My first personal involvement with dying was with
   a. grandparent or great-grandparent.
   b. parent.
   c. broyher or sister.
   d. other family member.
   e. friend or aquantaince.
   f. stranger.
   g. public figure.
   h. pet or animal.

6. To the best of my memory, I was first aware of death
   a. under three years of age.
   b. three to five.
   c. five to ten.
   d. ten or older.

7. When I was young, the subject of dying was talked about in my family
   a. openly.
   b. with some sense of discomfort.
   c. only when necessary and then with an attempt to exclude me.
   d. as though it were a taboo subject.
   e. never recall any discussion.

8. My childhood concept of what happens after death is best described as
   a. heaven-and-hell:
   b. after-life
   c. asleep
   d. cessation of all physical and mental activity
   e. mysterious and unknowable
   f. something other than the above
   g. no concept
   h. can't remember

9. Today my concept of what happens after death is
   a. heaven-and-hell:
   b. after-life
   c. asleep
   d. cessation of all physical and mental activity
   e. mysterious and unknowable
   f. something other than the above
   g. no concept

10. My present attitudes toward dying have been most influenced by
   a. death of someone close.
   b. specific reading.
   c. religious upbringing.
   d. introspection and meditation.
   e. ritual (eg., funerals).
   f. television, radio, or motion pictures.
   g. longevity of my family.
   h. my health or physical condition.

11. The role that religion has played in the development of my attitudes about dying is
   a. very important.
   b. rather important.
   c. somewhat, but not major.
   d. relatively minor.
   e. none at all.

12. I think about dying
   a. very frequently (at least once a day).
   b. frequently.
   c. occasionally.
   d. rarely (no more than once a year).
   e. very rarely or never.

13. To me, death means
    a. the end; the final process of life.
    b. the beginning of life after death.
    c. a joining of the spirit with a universal cosmic consciousness.
    d. a kind of endless sleep; rest and peace.
    e. termination of this life but with survival of the spirit.
    f. don't know.

14. To me, the most disagreeable aspect of my death would be I'd
    a. no longer be able to have experiences.
    b. be afraid what might happen to my body.
    c. be uncertain what might happen to me if there is a life after death.
    d. no longer be able to provide for my family.
    e. cause grief to my relatives and friends.
    f. not be able to complete all my plans and projects.
    g. die painfully.

15. My personal experience with formal death education consists of
    a. no hours.
    b. one or two hours.
    c. a section of a class.
    d. a special workshop or seminar.
    Please list and describe any previous formal death education:

APPENDIX D

TEMPLER DEATH ANXIETY SCALE

SCORING KEY

Key	Content
T	I am very much afraid to die.
F	The thought of death seldom enters my mind.
F	It doesn't make me nervous when people talk about death.
T	I dread to think about having an operation.
F	I am not at all afraid to die.
F	I am not particularly afraid of getting cancer.
F	The thought of death never bothers me.
T	I am often distressed by the way time flies so very rapidly.
T	I fear dying a painful death.
T	The subject of life after death troubles me greatly.
T	I am really scared of having a heart attack.
T	I often think about how short life really is.
T	I shudder when I hear people talking about World War III.
T	The sight of a dead body is horrifying to me.
F	I feel that the future holds nothing for me to fear.

APPENDIX E

STUDENT COVER LETTER

Dear Student,

I am an occupational therapist currently enrolled at Texas Woman's University. As a masters candidate, I am writing a thesis entitled Death Attitudes of Occupational Therapy Students in partial fulfillment of this graduate degree.

Occupational therapists deal with many aspects of human need at all stages of human development. In order to deal with needs arising during the final stage of life, it is important for us to come to terms with our feelings and attitudes. Formal death education is one means of increasing our knowledge base of the process of dying and of exploring our philosophy of life and death. Data collection and analysis of these attitudes will help to justify changes in, additions to or the maintenance of educational programming in this area.

I would appreciate your help with this study by filling out the attached questionnaire and demographic data sheet. All information provided by your responses will remain confidential. These data will be used in aggregate form, reported in an anonymous manner.

Your informed consent is necessary for participation in this study. Such a statement of consent clarifies:

I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

Thank you for your assistance. I appreciate the time and cooperation you give by completing these forms.

Sincerely,

Nancy E. Krusen, OTR
Master of Arts candidate
Occupational Therapy
Texas Woman's University

APPENDIX F

TEACHING OUTLINE

DEATH AND DYING

Teaching Outline

Day One:

1. Read and explain thesis cover letter and informed consent to participate in the study.

2. Give pretest DAS and Demographic Data Sheet.

3. Describe importance of the topic, overview of subject matter to be covered, and options about dying.

4. List organizations associated with dying.

5. Define terms:
   - brain death
   - somatic death
   - biological death
   - clinical death
   - social death
   - thanatology

6. List Kübler-Ross' five stages of dying. Discussion.

7. "Draw a picture of death. You do not have to be an artist, just draw what death looks like to you." Sharing of pictures.

Day Two:

1. List Temes' three stages of grief. Compare with Kübler-Ross' stages. Discussion.

2. List and discuss various cultural attitudes:
   - death denying
   - death desiring
   - death defying
   - death accepting
   - death as a reward
   - legends and myths of different cultures

3. List and discuss fears associated with death
   - pain
   - isolation
   - the dying process
   - unknown
   - punishment
   - impending loss
   - loss of control
   - end of opportunity

4. Discuss coping skills. Explore role of rehabilitation and the occupational therapist with the terminally ill.

Day Three:

1. Define terms. Compare and contrast.
   euthenasia
   active/positive euthenasia
   passive/negative euthenasia
   palliative care
   hospice care
   legal definition of death - Harvard Medical School

2. Discuss occupational therapy hospice programs and care.

3. Describe Natural Death Act legislation, universal donor cards, Living Wills.

4. Review for objective test on day four.

Day Four:

1. Discuss funeral arrangements and costs.

2. Discuss wills and family register of information.

3. Show and tell of literature, etc. Handout reference list to complete set given.

4. Objective/subjective test.

5. Posttest DAS and closing comments.

APPENDIX G

RAW DATA: INDIVIDUAL RESPONSE

Subject #	Pre/Post Scores	Demographic Item #				
		1	2	3	4	5
101	4/4	23	M	None	a	e
102	4/4	20	F	Catholic	a	a
103	5/2	21	F	Catholic	a	a
104	5/4	22	F	Lutheran	a	a
105	5/7	32	F	None	a	a
106	5/9	20	F	Non-denom.	a	a
107	6/5	33	F	Unitarian	b	e
108	6/4	20	F	Catholic	a	h
109	7/10	21	F	Church of Christ	a	e
110	7/6	21	F	Baptist	a	a
111	7/7	21	F	Baptist	a	a
112	9/8	24	F	Catholic	a	h
113	12/7	21	F	Episcopal	a	a

Subject #	Demographic Item #									
	6	7	8	9	10	11	12	13	14	15
101	c	e	g	e	h	d	d	f	c	c
102	c	a	b	f	a	c	c	d	g	c
103	b	a	a	b	c	b	c	e	f	a
104	c	e	a	d	g	d	d	b	c	a
105	b	c	a	b	a	b	c	e	c	c
106	b	b	a	f	d	c	c	d	b	d
107	c	a	e	e	a	b	c	f	a	d
108	c	b	a	f	c	b	c	e	e	a
109	c	d	e	a	c	b	b	b	e	b
110	d	a	a	b	a	c	d	e	a	a
111	c	e	e	g	d	a	c	f	c	b
112	b	a	a	a	a	b	b	e	c	c
113	c	e	a	b	c	b	c	e	c	a

Subject #	Pre/Post Scores	Demographic Item #				
		1	2	3	4	5
114	2/6	20	F	None	a	a
115	2/3	29	F	Catholic	b	c
116	3/4	23	F	None	a	e
117	4/4	25	F	Catholic	b	f
118	4/7	22	F	Christian	b	d
119	5/9	24	F	Catholic	b	c
120	5/5	32	F	None	b	e
121	6/10	20	F	Baptist	b	a
122	8/12	21	F	Methodist	a	f
123	8/11	20	F	Disciples of Christ	a	h
124	8/10	23	F	Church of Christ	a	g
125	9/6	27	F	Protestant	b	e
126	10/10	21	F	Holiness	a	f
127	11/11	20	F	Episcopal	a	a
128	12/11	22	F	Methodist	b	h

Subject #	Demographic Item #									
	6	7	8	9	10	11	12	13	14	15
114	d	c	h	d	h	e	d	a	e	d
115	c	e	a	b	c	a	d	c	g	a
116	b	e	g	g	g	d	d	f	c	a
117	b	a	a	d	d	d	d	e	g	d
118	b	a	a	a	c	a	b	b	g	a
119	d	b	a	a	a	b	c	e	e	c
120	d	e	a	e	b	e	d	f	f	a
121	c	e	a	a	a	a	c	e	b	c
122	c	a	a	b	f	b	a	f	a	d
123	c	e	a	a	c	b	c	e	c	a
124	b	b	a	f	h	d	b	d	f	d
125	c	a	a	e	d	d	c	f	g	a
126	b	b	c	a	c	a	c	e	e	c
127	c	a	a	e	a	d	c	b	g	a
128	c	e	h	b	g	c	c	e	g	c

APPENDIX H

RAW DATA: SUMMARY OF RESPONSE

SUMMARY OF RAW DATA

E=Number of experimental subjects
C=Number of control subjects

E	C	1. Age
3	4	20
5	2	21
1	2	22
1	2	23
1	1	24
0	1	25
0	0	26
0	1	27
0	0	28
0	1	29
0	0	30
0	0	31
1	1	32
1	0	33

		2. Sex
1	0	Male
12	15	Female

		3. Religious affiliation
3	3	None
4	3	Catholic
6	9	Protestant (including these religions)

Experimental	Control
1 Lutheran	
1 Unitarian	
1 Church of Christ	1 Church of Christ
2 Baptist	1 Baptist
1 Episcopal	1 Episcopal
	1 Christian
	1 Protestant
	1 Holiness
	2 Methodist
	1 Disciples of Christ

		4. Highest level of education completed:
12	1	a. some college
7	8	b. associate of arts degree
0	0	No subjects reported a bachelors degree or higher level of education (c,d,e or f).

E	C		
		5.	My first personal invlovement...
7	3		a. grandparent or great-grandparent
0	0		b. parent
0	2		c. brother or sister
1	1		d. other family member
3	3		e. friend or aquaintence
0	3		f. stranger
0	1		g. public figure
2	2		h. pet or animal
		6.	... I was first aware of death
0	0		a. under three years of age
4	5		b. three to five
8	7		c. five to ten
1	3		d. ten or older
		7.	When I was young,... dying was talked about...
4	5		a. openly
2	3		b. with some sense of discomfort
2	1		c. only when necessary and then with an attempt to exclude me
1	0		d. as though it were a taboo subject
4	6		e. never recall any discussion
		8.	My childhood concept was...
8	11		a. heaven-and-hell
1	0		b. after-life
0	1		c. asleep
0	0		d. cessation of all physical and mental activity
3	0		e. mysterious and unknowable
0	0		f. something other than the above
1	1		g. no concept
0	2		h. can't remember
		9.	Today my concept is...
2	5		a. heaven-and-hell
4	3		b. after-life
0	0		c. asleep
1	2		d. cessation of all phys. and ment. activity
2	3		e. mysterious and unknowable
3	1		f. something other than the above
1	1		g. no concept

E	C		
		10.	My present attitudes have been influenced by
5	3		a. death of someone close
0	1		b. specific reading
4	4		c. religious upbringing
2	2		d. introspection and meditation
0	0		e. ritual
0	1		f. television, radio or motion pictures
1	2		g. longevity of my family
1	2		h. my health or physical condition
		11.	The role of religion is
0	4		a. very important
7	3		b. rather important
4	1		c. somewhat, but not major
2	5		d. relatively minor
0	2		e. none at all
		12.	I think about dying
0	1		a. very frequently
2	2		b. frequently
8	7		c. occasionally
3	5		d. rarely
0	0		e. very rarely or never
		13.	To me, death means
0	1		a. the end; the final process of life
2	2		b. the beginning of life after death
0	1		c. a joining of the spirit with a universal cosmic consciousness
2	1		d. a kind of endless sleep; rest and peace
6	6		e. termination of this life but with survival of the spirit
3	4		f. don't know
		14.	The most disagreeable aspect of death is
2	1		a. no longer... have experiences
1	1		b. afraid what might happen to my body
6	2		c. uncertain what might happen if there is life after death
0	0		d. no longer able to provide for my family
2	3		e. cause grief to my relatives and friends
1	2		f. unable to complete plans and projects
1	6		g. die painfully

E	C	
		15. My experience with death education consists of
5	7	a. no hours
2	0	b. one or two hours
4	4	c. a section of a class
2	4	d. a special workshop or seminar

Subjects reported a variety of exposures to death and dying which did not fall into the categories of formal death education. These included a family member who was a funeral director, a volunteer in an organized hospice, and one student who encountered multiple deaths in her family within the recent past.

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