EXPERIENTIAL FACTORS IN DEATH ANXIETY

A Dissertation

Presented to

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In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

By

Marina S. Granich

May, 1976

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ABSTRACT

Anxiety about death was explored in relation to amount of clinical experience with death, manifest anxiety, locus of control and comfort with religious position.

Subjects (Ss) were 34 pre-nursing students from the University of Houston, 44 junior year nursing students from Texas Women's University, and 61 senior year nursing students from Texas Women's University. These Ss were grouped into four groups which were differentiated on two dimensions: total amount of clinical experience and amount of clinical experience with death. One of the groups had had much clinical experience with death (senior year nursing students with high clinical death experience). The other three groups served as controls for either effect of clinical experience (pre-nursing students), level of training in nursing school (junior year students) or amount of death experience (senior year nursing students with little clinical death experience). Within groups, Ss were also differentiated as to whether their scores on manifest anxiety, locus of control and religious comfort measures fell into a high, medium or low category.

It was hypothesized that a high amount of clinical experience in dealing with death would result in lower death anxiety and concern about death. The assumption underlying this was that people over a period of time of dealing with death become desensitized to the anxiety involved in observing the deaths of others. Thus, the expectation was that Ss in the senior high death experience group would have lower death

anxiety and death concern scores than Ss in other groups and that this would be true regardless of where their scores fell on the manifest anxiety, locus of control or comfort with religious position dimensions. Findings in the research literature indicated that these latter three variables influenced level of death anxiety.

The dependent measures were Ss' scores on the Death Anxiety Scale (Templer, 1970) and the Death Concern Scale (Dickstein, 1972).

Analyses of the data did not show group membership (amount of clinical experience with death) to have a significant effect on either death anxiety or death concern scores. The effect of level of manifest anxiety on both death measures was significant at the .01 level. The effects of degree of comfort with religious position on both death measures was significant at the .05 level. Therefore, the expectation that amount of clinical experience with death would be a more important determinant of death anxiety and death concern than certain intrapersonal variables was not supported by the data. In the case of two such variables, manifest anxiety and comfort with religious position, the opposite was found to be the case. The third variable, locus of control, was not found to have any significant effect on either death measure.

It was suggested that problems in the way in which amount of clinical experience with death was operationalized and problems with the validity of the measuring instruments may have been involved in the failure of the hypotheses to

be supported by the data. In particular, the measures used did not take into account the specific aspects of death such as who was dying and under what circumstances, but tended to treat death as a global, abstract entity. The way in which desensitization to death was conceptualized may not have been sufficiently complex; an alternative model of the process was offered. The relevance of styles of handling affect, in particular repression versus sensitization, was discussed.

It was concluded that both individual differences and environmental factors are important to consider in doing death attitude research. N=1 studies were seen as a research strategy appropriate to this task in terms of the control over relevant variables they would provide. The significance of the present research for nursing education was discussed.

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CHAPTER I

INTRODUCTION

This study examines the relative effects of experiential versus intrapersonal factors on the level of death anxiety and sensitivity to death issues in individuals. Although there may be individual differences in death anxiety, experiential factors may override the effect of these intrapersonal factors.

Background and Statement of Problem

Until quite recently, little attention has been paid to the topic of death in psychological literature. This lack is understandable in terms of the taboo our society imposes on the topic of death (Feifel, 1961). Paying too much attention to death or admitting fear of it are not regarded as favorable attitudes in our culture. As Crown, O'Donovan and Thompson (1967) found in their study of attitudes toward death, if one cannot confront death with equanimity and perspective, it is considered better that the topic be avoided altogether.

The few studies that have been done on death are clinical and descriptive rather than experimental. The general pattern of some more recent studies has been to focus on the relationship between some personality parameter and feelings about death. A few studies have looked at the impact of experiential factors (e.g., actual observance of death), but in these studies, there were poor controls on the amount and type of exposure to death.

The psychological relevance of actual observation of

death upon death anxiety and sensitivity toward death issues is of particular importance to those in the medical profession. Their value system focuses on the overcoming of death. Feifel (1969) refers to death, with regard to the medical profession, as a "...threat to professional narcissism..." (p. 293).

Studies indicate that while medical personnel are in constant contact with death, they tend to avoid confronting the emotional reality and personal meaning of death. Caldwell and Mishara (1972), attempting to conduct death-attitude research with physicians found that out of 73 physicians approached, only 13 agreed to be interviewed when informed that the interview concerned the topic of dying. Howard (1974) and Pearlman, Stotsky and Dominick (1969) investigated death attitudes of nursing home personnel having varying amounts of clinical experience with death. Both groups of researchers came up with similar results. They found that those who had more experience with death were less willing to discuss death with dying patients, compared to individuals who had had less clinical experience with death.

It is likely that the tendency of medical personnel to avoid in-depth confrontation with death serves an adaptive function. The research literature indicates that initial encounter with death is a very anxiety-arousing and cognitively sensitizing one; when first confronting the actual experience of someone dying, individuals tend to be emotionally overwhelmed and preoccupied with thoughts of the

experience (Lester & Kam, 1971; Kazzaz & Vickers, 1969). Such a state is not conducive to competent professional performance. Therefore, individuals must find ways to monitor their thoughts and feelings to survive professionally. Avoidance strategies, such as those described above, may serve such a function. Kastenbaum and Aisenberg (1972) write about this in relation to the nursing profession. In a discussion of the lack of training relevant to dealing with death in the nursing profession, they write:

> (it is) no wonder that she may lean heavily upon unexamined cultural values and attitudes. Nor should we be hasty in asking her to abandon the self-protective rituals that enable her to function within the vicinity of the terminal patient (p. 225).

Quint (1967), similarly, discusses the professional routines and rituals which nurses use in handling themselves in encounters with dying patients.

The avoidance strategies which seem to predominate among medical personnel in relation to handling experiences with death, form a contrast to what the research literature indicates is in the best interests of dying patients. Research findings underscore the desire of most patients for candor on the part of medical staff and family about the seriousness of their illness (Kasper, 1959; Kubler-Ross, 1969, 1974, 1975).

The major focus of this study is on the impact of actual experiencing another's death on death anxiety and sensitivity toward death issues. Findings in the research literature also point to the involvement of individual predispositions

in these variables. Level of general anxiety has been found to be positively related to level of death anxiety (Dickstein, 1972; Farley, 1971; Sarnoff & Corwin, 1959; Tolor & Reznikoff, 1969). Although findings on the relationship of locus of control to death anxiety are conflicting, some studies have found that death anxiety is positively related to externality of locus of control (Tolor & Reznikoff, 1967). Studies of the relationship between religious attitudes and death anxiety have resulted in mixed results. Some studies have found a negative relationship between degree of religious involvement and level of death anxiety (Maring & Wrightsman, 1965; Templer, 1972a; Williams & Cole, 1968). Other studies have found no such relationship (Siegman, 1961; Templer & Dotson, 1970). Burrows (1971), attempting to explain the inconsistency in these findings, demonstrated that it was comfort with religious position rather than degree of religious involvement, per se, that was the critical factor in the level of death anxiety in his subjects.

Although the relative effects of individual differences versus experiential factors on death anxiety and sensitivity toward death issues could technically have been studied on any sort of subject population, a medical population was chosen. Subjects were nursing students from Texas Women's University and pre-nursing students from the University of Houston. There were two basic reasons for using this population. One concerned the practical relevance of the research question to the medical profession. The other involved

issues of experimental design.

The practical relevance of the study to the nursing profession has already been alluded to above. Mention has been made of the observation that individuals in the medical professions tend to avoid dealing with death in an in-depth way. This avoidance tendency was contrasted with the needs of the terminal patient for candor. Thus far, in the literature, studies concerning avoidance strategies among medical personnel have been theoretical and descriptive rather than quantified. A well-controlled study that provided documentation of such avoidance strategies would be valuable in implementing changes in the training of medical personnel that would better enable them to deal with death in a way that would be more in keeping with patient needs.

Using a nursing student population facilitated maintenance of experimental controls. The few studies in the literature that have attempted to examine the impact of actual observation of death, have had poor controls over the extent and nature of the death experience. Also, controls over past history and other relevant demographic and experiential factors have been poor. By using a nursing student population it was possible to overcome some of the obstacles to experimental control.

Two basic assumptions underlie the hypotheses of this study:

1) The response to death involves affective and cognitive components. On an affective level, death stimuli are anxiety

arousing. People cannot, for long, function in a state of high anxiety. One way of handling the anxiety is through physically avoiding the anxiety-arousing stimulus. Where this is not possible, people adjust through blocking out thoughts pertaining to death and the accompanying affect; thus, they become desensitized to death.

2) Although there may be individual differences in levels of experienced death anxiety, increasing the amount of exposure to high death-risk situations, will override the effect of these intrapersonal factors.

A basic assumption of the study is that the phenomena under investigation are measurable. Hypotheses were not stated in the form of the null hypothesis because the entire premise of the study is that different experiential situations and individual differences do produce differences in the independent variables. The .05 level of significance was required for acceptance of the hypotheses.

Hypotheses

Under conditions of the present investigation, the following hypotheses are formulated:

1. Senior year nursing student Ss exposed to a high death contact environment will manifest significantly lower death anxiety and death sensitivity than Ss who have had limited or no exposure to observing the death of others.

2. Senior Ss exposed to a low death observation environment only, will not differ significantly from junior year Ss or from pre-nursing Ss on measures of death anxiety and death sensitivity.

3. Ss with relatively high manifest anxiety scores who have been exposed to a high death environment will have lower death anxiety and death sensitivity scores than Ss who have had limited or no exposure to death. The scores of these Ss will be lower than those of Ss with low manifest anxiety scores who have limited or no exposure to death.

4. Ss with relatively high externality scores (locus of control) who have been exposed to a high death environment will score lower on death anxiety and death sensitivity measures than Ss who have had limited or no exposure to death even if they have low externality scores.

5. Ss who express relatively low comfort with their religious position who have been exposed to a high death environment will score lower on death anxiety and death sensitivity measures than Ss who have had limited or no exposure to death even if they indicate a high degree of comfort with their religious position.

Chapter two of this dissertation presents a review of the research literature on which the study is based. A description of the Ss, methodology, procedure and way in which the data was treated is contained in Chapter three. Chapter four presents the results. A discussion of the implications of the results and suggestions for future research is included in Chapter five.

CHAPTER II

REVIEW OF RELEVANT LITERATURE

Most studies in the area of death start with the assumption that death is a ubiquitously anxiety-arousing phenomenon. Some researchers have not accepted this assumption, untested, and have attempted to validate it. Alexander, Colley and Adlerstein (1957) using the GSR as the dependent measure, found that male college students responded with greater emotional intensity to words logically related to death than to equivalent words that were not related to death. This study was replicated with a sample of males ranging from five to sixteen years of age; the results were similar to those of the first study (Alexander & Adlerstein, 1958). A perceptual defense paradigm has also been used in validating the notion that the thought of death is anxiety-arousing. Golding, Atwood and Goodman (1966), using a tachistoscope, found that the mean number of trials to recognition for words related to death was significantly greater than that for neutral words.

On the level of molar behavior, the observation of death appears to operate as an aversive stimulus (Kastenbaum & Aisenberg, 1972). Glaser and Strauss (1966) observed patterns of interaction in six hospitals and extensively documented aversive behavior in the form of distorted communication, game-playing and other defensive maneuvers among those who were assigned to care for dying patients. For instance, nurses tried to place responsibility for the death watch on others and patients were often left to die alone.

Actual observations of death appear to have a strong impact upon individuals. Brulin, Thurman and Chandler (1970) discuss the impact of witnessing the death of fellow patients on surviving patients on a coronary care unit. An increase in anxiety symptoms, both physiological and psychological was observed in these patients. Kazzaz and Vickers (1968) documented the panic that occurred on a ward when two patients died. Lester and Kam (1971) found that subjects who had experienced the death of a close friend or relative in the past five years thought of their own death more frequently, were more inclined to entertain thoughts of some specific disease, were more likely to picture death as horribly painful, and were more likely to be depressed by cemeteries.

All of the hypotheses of this study involve the underlying assumption that people evolve ways of dealing with the discomfort of encountering death stimuli. That is, the thought of death is defended against as are other anxiety-arousing phenomena. As Kastenbaum and Aisenberg (1972) write:

> Frequently, death fear seems to be a self-limiting reaction. One can remain intensely perturbed for only so long. The momentary panic induced by death or any other threatening stimulus is likely to be replaced by other emotional responses, defensive postures, somatic symptomatology or coping reactions (p. 99).

Studies pertaining to individuals in situations that threaten life provide documentation for this notion of defense. Abrams (1965) in a study of patients about to undergo open-heart surgery, observed that denial was utilized to reduce and cope with preoperative anxiety and threat of death. Feifel

(1969) studied terminally and seriously ill patients and observed that avoidance and evasion strategies became intensified, especially at a nonconscious level, when an individual realized that death was possible in the near future. He found that denial was the major coping technique used by individuals to deal with the idea of personal death. Kubler-Ross (1968; 1974) presents a five-stage model of the process of coping with death. Her five stages primarily describe different ways individuals defend against accepting the reality of an impending death. The studies of Howard (1974) and Pearlman, Stotsky and Dominick (1969), which have already been discussed, indicate the tendency of medical personnel to avoid dealing in any depth with their emotional and intellectual responses to death.

As well as being intrapsychic phenomena, defenses have their interpersonal manifestations. Kalish (1966) found that people maintain a large social distance between themselves and a dying person. To define someone as a deviant is one way to distance oneself from him. Wheeler (1973) suggested that the dying person be regarded as a deviant in the medical subculture. In his study he found that physicians' attitudes toward dying persons bore a greater similarity to those held toward deviant persons than to other comparison individuals.

The first and second hypotheses of this study involve the idea that the more an individual observes the death of other people, the more emotionally and cognitively desensitized to this experience he or she will become. Thus, it is

assumed that emotional and cognitive attitudes toward death will be similar. Studies document this assumed relationship. Lester (1966) in a study of suicidal individuals, found that those who feared death more avoided thinking about death less. Lester and Lester (1970), using a perceptual defense paradigm, found that subjects with a higher fear of death had relatively lower thresholds for words related to the active process of dying. Extrapolating from these studies, individuals with lower anxiety about death also think about death less often.

The third hypotheses of this study concerns the effects of manifest anxiety on death anxiety scores. The rationale underlying the hypothesis is that high manifest anxiety subjects will also be more highly anxious about death. The nature of the relationship between death anxiety and anxiety in general, has become a source of controversy in the literature. The tendency in the literature on death has been to treat fear of or anxiety about death as something separate from other sorts of fear or anxiety. This tendency to treat death anxiety as unique has been questioned by some researchers. Studies done pertaining to the question have yielded mixed results.

Sarnoff and Corwin (1959) investigated the relationship between castration anxiety and the fear of death. They found that high castration anxiety subjects showed a greater increase in their fear of death, as measured by a verbal scale, after arousal of their sexual feelings than did subjects who had a low level of castration anxiety. Dickstein

(1972), Farley (1971), and Tolor and Reznikoff (1969) have all found significant positive correlations between their death anxiety measures and measures of general anxiety. In contrast, Hoblit (1972) presented subjects with death stimuli and observed no rise in post-exposure anxiety levels. Lucas (1972) compared measures of general anxiety and death anxiety in three separate groups of subjects and found that the intercorrelations among the six general anxiety measures was generally positive and more significant than the correlation between the general anxiety and death anxiety scores.

The fourth hypothesis in this study concerns the effects of locus of control score on death anxiety. The locus of control (I-E) scale measures beliefs about the nature of the world. A high score reflects the belief that events that happen to an individual are not subject to internal control. In line with this, death anxiety scores should be positively related to externality. The individual who is concerned about death is focusing upon an event which is assumed to be inevitable and beyond individual control. Such concern should be related to the more general belief that one's fate does not reflect one's actions but rather the press of external forces. Conversely, the individual with low concern about death should be more attuned to internal factors as determinants. The research results concerning this relationship are equivocal. Tolor and Reznikoff (1967) found that subjects with external expectancies had significantly greater overt death anxiety than subjects with internal expectancies. In contrast,

Dickstein (1972) did not find any correlation between death concern and externality. Dickstein suggests that the discrepancy between the two findings may have been due to the fact that Tolor and Reznikoff used only males as subjects, whereas, his sample included both males and females.

The fifth hypothesis investigates the effect of religious factors on death anxiety. Religious systems deal with major existential issues; supreme among these is the question of death. The unknown tends to be a source of anxiety for people; death is one such unknown. Religious systems give structure to death, thus decreasing the ambiguity surrounding it and its capacity to arouse anxiety. People are less anxious about facing a new situation when they have some idea of what to expect. In view of all of this, it is reasonable to expect that the religious beliefs of an individual would be involved in his response to the idea of death.

Templer (1972a) studied death anxiety in persons who were very involved in religion and found that those who had stronger religious convictions and attachments, attended religious functions more frequently, were certain of a life after death and interpreted the Bible literally, had lower death anxiety. Martin and Wrightsman (1965), similarly, observed religious participation to be significantly and negatively correlated with death concern measures. Williams and Cole (1968) also found religiosity to be inversely related to death anxiety.

Other studies have failed to find a significant relationship

between religiosity and death anxiety. Templer and Dotson (1970) failed to find a significant relationship between the death anxiety scale scores of their college student subjects and several variables of religious affiliation, belief and activity. Siegman (1961) did not find religiosity to be a significant source of variance in his subjects' fear of death scores. Burrows (1971), in view of the variant results in the literature, suggested that perhaps it is not religiosity per se that is the factor in death anxiety. He hypothesized that fear of death would be greater in subjects who were not comfortable about their religious position (whether they were religious or non-religious) than in subjects who were comfortable with their position; his hypothesis was confirmed.

Studies have been done to investigate whether sex differences exist in death attitudes. Lester (1970c; 1971; 1972) has found that women express a greater fear of death. Selvey (1973) also found women to have a greater fear of death, although the sexes were not found to differ in their preoccupation with it. Lowry (1966) thematically analyzed stories subjects constructed about death. In the stories of female subjects, the themes most frequently evidenced were those of violence, loss and mutilation. In contrast, the most prevalent themes in the males protocols were failure and frustration. Lowry interprets these differences as being reflective of male-female differences, in general. According to him, these differences consist in females being more oriented toward emotional experience and males being socialized to be

more concerned with goal achievement. Selvey (1973) also found women's stories about death to contain significantly more loss themes than did those of males. Among elderly subjects, several groups of researchers have found no sex difference in death concerns (Christ, 1961; Rhudick & Dibner, 1961).

There have been no reports of significant correlations between death anxiety measures and age (Jeffers, et al., 1961; Kalish, 1963; Lester, 1972; Martin & Wrightsman, 1965; Rhudick & Dibner, 1961; Swenson, 1961; Templer, Ruff & Franks, 1971).

Diggory and Rothman (1961) studied the relationship between death anxiety and socio-economic status. Among their conclusions were that the middle-class fears the pain of dying more than the upper and lower classes. Farley (1971), in contrast, found that higher death anxiety subjects tended to be of a higher socio-economic level.

Several geriatric studies on death attitudes included data on the effect of education on death anxiety. Swenson (1961) reported that less educated elderly people tended to evade the issue of death more than those with more education. However, Christ (1961) and Rhudick and Dibner (1961) did not find amount of schooling to be a factor.

A major assumption of this study is that over a period of time of observing the deaths of others, all nursing students develop a similar way of coping with the situation. That is, they become cognitively and emotionally desensitized to the death and dying they encounter in their clinical experience. This desensitization is an intrapersonal defensive

process, but one that is shared by an entire group. Thus, some social reinforcement of the defense likely occurs. Studies which concern the influence of the beliefs of significant others on individuals' attitudes toward death are of relevance here. Lucas (1972) found a significant correlation between general anxiety and death anxiety for husbands and wives. Templer, Ruff and Franks (1971) found that the scores of both male and female adolescents, on their Death Anxiety Scale, correlated most highly with the scores of parents of the same sex. Lester (1970) obtained similar results using female subjects; he found that the fear of death of female students significantly resembled the fear of death of their mothers but not of their fathers. All of these findings indicate that the fear of death is subject to social influences.

Studies concerning the death attitudes of nurses or nursing students are sparse and often not well designed. Golub and Renzikoff (1971) compared the death attitudes of nursing students and graduate nurses, testing the hypothesis that the nurse's professional education and experience influenced her attitudes toward death. The six questions asked of the subjects had little to do with personal thoughts or feelings toward death; they concerned attitude toward autopsy, suicide prevention, life-maintenance efforts, heart transplant, terminal illness and whether or not psychological factors are involved in death.

A study done by Lester, Getty and Kneisl (1970) is

methodologically sounder in that it used a psychometrically more acceptable measure. Their scale measured attitudes toward the process of death and dying. Studies on the reliability and validity of the scale had been done. The major prediction of the study, that the fear of death and dying would decrease with increased academic preparation among nurses, was not supported by the data. However, there were differences between groups apart from level of academic preparation. The three groups in the study were undergraduates, graduate students and nursing school faculty. Many variables, such as age, amount of clinical experience, clinical experience with dying patients were not controlled and thus may have been confounding factors.

A study by Howard (1974) which investigated attitudes toward death in relation to amount of time nursing home personnel had spent in caring for terminally ill patients, used poorly controlled observational and interview data. Pearlman, Stotsky and Dominick (1969) explored the attitudes toward a diversity of death issues among assorted nursing home personnel. They constructed a questionnaire for the study but the reliability and validity of the instrument are unknown. One of their findings, employing this questionnaire, was that those who had had more clinical experience in dealing with death were less willing to openly confront death issues.

As has already been discussed, there appears to be a contradiction between the prevailing medical ethos of avoiding openness about death and the needs of patients. The literature

indicates that most patients desire candidness on the part of the medical staff with regard to the seriousness of their illness. Chandler (1965) studied elderly cardiovascular and cerebrovascular patients who lived with the recognition that death could occur at any moment. The relationships of these patients with the staff were disturbed. These patients had an unspoken fear of death that pervaded all of their interpersonal relations. They did not express their death concerns directly but through hostile acting-out. Chandler organized groups of these patients and nursing personnel, with the aim of providing an opportunity for the patients to be open about their fears. As was anticipated, the group sessions provided patients with a verbal release for their apprehensions and the acting-out diminished.

Diaz (1969) and Schmiedeck (1972) and Vernick and Karon (1965), with reference to diverse settings and patients populations, stress that open communication about the anxiety inherent in dying or being in the presence of dying individuals is important. Zinker and Fink (1966) found that terminally ill patients, when apprised of their prognoses, manifested an adjustment equal to or better than that seen in similar patients who had not been so informed.

The methodology of studies of death anxiety is far from uniform. Lester (1967c) has suggested that this may be what accounts for the equivocal findings in the research literature.

Direct methods have been used in the majority of studies. These, basically, consist of two sorts of instruments,

questionnaires and scales. The most widely used of these two, is the scale. Of the death anxiety scales developed and used, the most popular are those of Boyar (1964), Dickstein (1972), Lester (1967a), Lester and Collett (1969), Livingston and Zimet (1965), Sarnoff and Corwin (1959), and Templer (1970). The questionnaires are less systematic in terms of content, being largely specific to the purpose of the particular study (Camerson, 1968; Christ, 1961; Crown & O'Donovan, 1967; Dominick, 1969; Jeffers, Nichols & Eisdorfer, 1961; Kalish, 1963; Middleton, 1936; Pearlman, Stotsky & Dominick, 1969; Schneidman, 1970).

Projective techniques have been used by some researchers. In this area, interpretation of TAT cards has been the most prevalent method (Lowry, 1966; Paris & Goodstein, 1966; Rhudick & Dibner, 1961; Selvey, 1973). In these studies, projective results are typically analyzed according to some preset thematic system.

Feifel (1959, 1973a,b), Feifel and Branscombe (1973), Feifel and Hermann (1973) and Feifel and Jones (1968) have used a method that is a combination of direct and projective techniques. They conceptualize their method as focusing on different levels of awareness. Conscious fear of death is tapped by direct questioning. Fantasy notions about death are obtained by means of a bipolar adjective rating task. A word association task is used to measure ideas that are below the level of awareness.

Tachistoscopic methods have been used in studies employing

a perceptual defense paradigm (Golding, Atwood & Goodman, 1966; Lester & Lester, 1970). Two studies employed the GSR (Alexander & Adlerstein, 1959; Alexander, Corey & Adlerstein, 1957).

Data obtained from clinical observation formed the basis of several studies (Abrams, 1965; Brulin, Thurman & Chandler, 1970; Cappon, 1970; Chandler, 1965; Diaz, 1969, Searles, 1961; Vernick & Karon, 1965; Zinker, 1966).

This chapter reviewed the literature on studies of death attitudes. It has shown this area to be, as yet, limited in terms of concepts and methodology. Studies, typically, consist of exploring the relationship between a paper and pencil measure of death anxiety and one other variable. The research, in general, does not appear to be well controlled.

The next chapter deals with subjects, methodology, procedures and treatment of the data in the present research.

CHAPTER III

METHOD

Subjects

Subjects (Ss) were 34 pre-nursing students from the University of Houston, 44 junior-year nursing students from Texas Women's University and 61 senior-year nursing students from Texas Women's University.

Instruments

Death anxiety was operationalized through administering Templer's (1970) Death Anxiety Scale (DAS). The scale consists of 15 items to which an answer of either true or false is given. A test-retest reliability of .83 and an internal consistency of .76 have been reported for the scale. The social desirability and agreement tendency response sets did not correlate significantly with DAS scores. The scale's validity was assessed in two separate studies. In one of these, psychiatric patients who were judged to have high death anxiety were found to have significantly higher DAS scores than control patients. In the other, DAS scores were found to correlate significantly with those of another death anxiety scale, Boyar's (1964) Fear of Death Scale and also with a sequential word task. The scale has been used in several studies (Templer, 1971; Templer, 1972a; Templer, 1972b; Templer & Dotson, 1979; Templer, Reiff & Franks, 1971). The scale is presented in Appendix A.

Sensitivity to death issues was operationalized by administering Dickstein's (1972) Death Concern Scale (DCS).

This scale consists of 30 items, each containing 4 response alternatives. For the first 11 items the alternatives are: often, sometimes, rarely and never. The score for each item may vary from 1 to 4; 1 always represents a response of never and 4 always represents a response of often. The response alternatives for the remaining 19 items are: I strongly disagree, I somewhat disagree, I somewhat agree, I strongly agree. The response alternatives are always presented in the same order. To control for an acquiescence response set, the items are phrased so that agreement represents high death concern on 11 items and disagreement represents high death concern on 8 items. The scale items and direction of scoring are presented in Appendix B. The internal consistency, in all administrations of the scale, has been above .85. The test-retest reliability was .87.

Construct validity of the DCS was examined by investigating its relationship with the Manifest Anxiety scale, the State-Trait Anxiety Inventory, the Repression-Sensitization Scale, the Internal-External Scale and the Edwards Personal Preference Schedule. All but one of the hypotheses about the construct validity of the scale have been confirmed. Death concern is positively related to state anxiety, trait anxiety and sensitization for females and to manifest anxiety for males and females. No relationship was evident between death concern and externality.

General anxiety was measured by administering the Taylor Manifest Anxiety Scale (TMAS). Taylor (1953) presents the

studies demonstrating normative data, reliability and concurrent validity for the 28 item true-false scale. The scale, along with directionality of scoring is presented in Appendix C.

Locus of control was measured with Rotter's (1966) 29 item forced-choice Internal-External Scale (I-E). Rotter (1966) presents the studies demonstrating split-half and test-retest reliability, normative data and discriminant and construct validity for the scale. Berman and Hays (1973), Dickstein (1972) and Tolor and Reznikoff (1967) have used the scale in death anxiety research. The scale is presented in Appendix D.

A questionnaire was constructed to obtain pertinent demographic and experiential data. Two forms of the questionnaire were used; one for pre-nursing students and the other for the Texas Women's University students. These questionnaires are presented in Appendix E. Data from this questionnaire were used to assign senior-year nursing students to either the high or low death condition. Senior-year Ss were asked to list all the rotations in which they were currently or had been involved in during the previous semester. These rotations were then categorized as offering either high or low death exposure, according to the nursing instructors who made the ratings. They had statistics about the death rates in the various clinical placement settings available and made their judgment as to high and low death exposure according to these. Information about comfort with religious beliefs was

obtained from a self-rating on a Likert type scale included on the questionnaire. The cover sheet for all materials is presented in Appendix F.

In addition to the above measures, a post-experiment interview was administered to selected Ss. These Ss were the extreme scorers on the death measures in the high death exposure group. The interview was oriented toward exploring how Ss reacted to and handled themselves in clinical encounters with death. A copy of the interview format and interview protocols are presented in Appendix G. A total of 15 interviews were done. Of these, 9 were with extreme low scorers and 7 were extreme high scorers.

Procedure

There were four groups of Ss differing in amount of total clinical experience and amount of clinical experience with death. The groups are described in Table 1. All of the junior year Texas Women's University Ss had an identical curriculum. The senior year Texas Women's University Ss also had an identical curriculum and clinical experience with the exception that some students had more experience on clinical rotations where death frequently occurred than other students.

Nursing school clinical rotations were judged as either high or low death exposure by three Texas Women's University nursing professors. Senior year Ss were classified as high death exposure or low death exposure depending upon the number of rotations they had had that were classified as high death exposure. High death exposure seniors were considered to be

TABLE 1

Composition of Groups in the Study

Group 1
Pre-nursing students from the University of Houston: no clinical experience (N = 34)
Group 2
Junior year nursing students from Texas Women's University: clinical experience, but no clinical death exposure (N = 44)
Group 3
Senior year nursing students from Texas Women's University: low clinical death exposure (N = 30)
Group 4
Senior year nursing students from Texas Women's University: high clinical death exposure (N = 31)

those Ss who had had one or more high death rotations in both the fall and spring semesters and low death exposure seniors were Ss who had not had any high death rotations in either the fall or spring semesters.

The possibility existed that although a S had had a number of clinical rotations technically judged to be high death exposure, she might never have come into actual contact with dying patients. To examine this possibility, the relationship between the amount of clinical experience on high death rotations and the actual number of dying patients dealt with was examined. Number of dying patients was obtained from an item on the questionnaire. The correlation between death exposure and number of dying patients for Ss in the high death exposure group was significant ($r=.47$, $df=30$, $p < .01$). Thus, the way in which high death exposure was defined in the study appears to be representative of the Ss' recalled actual clinical experience with death.

It was assumed that the variables of manifest anxiety, locus of control and degree of religious comfort would be randomly distributed throughout the groups. This assumption was checked by means of simple analyses of variance and no significant differences between groups were found. These findings are shown in Table 2.

Ss were approached in a classroom situation. Pre-nursing students, juniors and seniors were all in separate classes. The experimenter went into the classroom along with the instructor and introduced herself in the following way:

TABLE 2

Summary of Analyses of Variance on the Effect of Group Membership on Variables Included in the Study

Variable	F	p
Manifest Anxiety	1.32	> .10
Locus of Control	.13	> .10
Religious Comfort	1.55	> .10
Age	2.83	> .10
Socio-economic status	.85	> .10
Personal Death Experience	.50	> .10
Religious Involvement	2.51	> .10

df = 3/135 on all variables

> I am a graduate student in psychology. I am doing a study on the influence of personality factors and attitudes on situations nurses encounter during their nursing activities (for the pre-nursing group, the words "you will encounter when you become nurses" were substituted).
>
> I will get the information I need from the booklet I will shortly pass out to you. There are five questionnaires in the booklet. The first one concerns your feelings about issues which you probably confront (will confront) in your nursing training and in your daily lives. The second one involves your feelings about death. The third questionnaire concerns your personal comfort and situations which may make people feel either comfortable or uncomfortable. The fourth one is designed to find out the way in which certain important events in our society affect different people. The last questionnaire involves general information such as your age, marital status, etc.
>
> Read the instructions on each questionnaire carefully and answer all of the questions according to the directions. It is important that you answer all of the questions.
>
> All of the information you write in the booklet will be completely anonymous, as your name appears nowhere on the materials. The information I obtain will be used only within the limits of professional ethical considerations as set forth by the American Psychological Association.

After all of the testing material was turned in, Ss were thanked for their cooperation and told that they would, eventually, be informed of the results of the study. This will be done by means of a mailed summary of the study and results when the dissertation is completed. Ss were asked not to discuss their participation in the study, since other students would be answering the questionnaires and prior knowledge of the study might affect their answers.

Senior-year nursing Ss were informed that some of them would be contacted for brief follow-up work. The extreme high and low scorers on the death measures were contacted by

phone and asked to make an appointment for an interview for the purpose of further exploring their clinical experience with death. All but two of the Ss contacted for the interview kept the appointment.

Treatment of the Data

Scores on the DAS and DCS were analyzed by a one-way simple randomized analysis of variance design (Lindquist, 1953). The program used, Balanova, adjusted for unequal numbers in groups. This same analysis procedure was also used for the variables of manifest anxiety, locus of control, degree of religious comfort, socio-economic status, degree of religious belief age and non-clinical personal experience with death.

A 3x4 factorial analysis of variance was used to test for differences between groups on the DAS and DCS with Ss divided into high, medium and low categories within groups on the manifest anxiety, locus of control and religious comfort variables. Analyses were done for each of these variables, separately. Individual t-test comparisons (Winer, 1962) were used to compare specific cell means, as dictated by the hypotheses. In the case of all three variables, comparisons were made between the DAS or DCS cell means for the high Ss in Group 4 and the cell means of low Ss in the other three groups. The size of the difference between cell means necessary for a 't' significant at both the $p < .01$ and $p < .05$ levels was calculated in each instance. The actual differences between cell means were compared to this and judged

as to significance.

To determine the extent to which factors other than amount of exposure to death affected DAS and DCS scores, regression analyses were done for DAS and DCS. A step-wise multiple regression program was used in the analysis.

Regression analyses were done with Ss grouped in three different ways. The original groups in the study differed in whether or not they had any clinical exposure to death; groups 1 through 3 had not had this exposure and group 4 had. Therefore, the number of variables available for inclusion in the regression equation was greater for Group 4 than for the other three groups; the variables of amount of clinical exposure to death and number of patient deaths did not apply to these groups. The ways in which the regression equations were done is as follows: groups 1-3, group 4, groups 1-4 without death variables included in the predictor pool. Regression analyses were done separately for DAS and DCS.

The interview protocols were read by a psychology professor and a clinical psychology graduate student. They intuitively formulated hypotheses as to how the high death measure scorers differed from the low scorers. They perceived the relevant differentiating dimensions to be:

(1) degree of anxiety present
(2) degree of emotional expressivity
(3) emphasis on professional competence
(4) emphasis on coping with emotions
(5) denial of anxiety

The first and second dimensions seemed to correlate positively with DAS and DCS scores and the last three dimensions

seemed to have an inverse relationship with these scores.

To explore the hypotheses, 3 clinical psychology interns rated the protocols on each of the 5 dimensions using a 5-point Likert scale. Inter-rater reliability between pairs of raters, when agreement was considered as either exact agreement or a one-point difference, was sufficient for the purpose of the study. These reliability coefficients between pairs of raters were as follows: rater 1/rater 2: .71; rater 2/rater 3: .69; rater 1/rater 3: .69. When only exact agreements were considered, inter-rater reliability was lower. Under these conditions, the reliability coefficients were: rater 1/rater 2: .37; rater 2/rater 3: .35: rater 1/rater 3: .35.

Product-moment correlation coefficients were calculated between the average of the three judges ratings on each of the five dimensions for the interview protocols and combined DAS and DCS scores.

CHAPTER IV

RESULTS

Relationship Between Death Measures

Death anxiety and death concern were conceptualized as independent dimensions. However, statistical data show that the scores on the two measures are not independent, but highly correlated ($r=.63$, $df=137$, $p<.01$). This relationship was found within all four groups. Table 3 shows these correlations.

Death Environment

The first two hypotheses concerned the effect of amount of clinical experience in high death exposure situations on death anxiety (DAS) and death concern (DCS) scores. It was hypothesized that Ss who were exposed to a high death environment would have lower death anxiety and death concern scores than other Ss. The effect of amount of clinical exposure to death on DAS scores was not significant ($F=1.99$, $df=3/135$, $p>.10$). There was no significant effect of clinical exposure to death on DCS scores ($F=1.11$, $df=3/135$, $p>.10$). Thus, the data appear to provide no support for the first and second hypotheses.

Table 4 presents the descriptive statistics of the DAS and DCS scores. As can be seen, even though the fourth group had the greatest amount of clinical exposure to death, their scores were not lower, as had been predicted, than those of the other groups. As can be seen from Table 4, the group

TABLE 3

Correlations Between Death Anxiety and Death Concern Scores

Group 1 (N=34)	Group 2 (N=44)	Group 3 (N=30)	Group 4 (N=31)
.71**	.63**	.53**	.67**

**$p < .01$

TABLE 4

Group Means and Standard Deviations for the Death Anxiety Scale and Death Concern Scale

		Death Anxiety	Death Concern
Group 1 (N=34)	X	6.76	66.94
	SD	2.61	9.73
Group 2 (N=44)	X	6.86	70.39
	SD	2.87	9.19
Group 3 (N=30)	X	7.23	71.00
	SD	2.73	10.49
Group 4 (N=31)	X	6.97	69.77
	SD	2.74	10.40

with the least amount of training and clinical exposure to death (Group 1) had the lowest group mean for both DAS and DCS scores. A curvilinear trend is observable in the group means. The group means for both measures get progressively higher going from the first to the third group, and in the fourth group, they go down again. Thus, the means of Group 4 (high death exposure seniors) were lower than those of Group 3 (low death exposure seniors). The trend in these last two groups is suggestive of the expected effects of amount of clinical exposure to death.

Manifest Anxiety and Death Environment

Hypothesis three involved the assumption that amount of clinical exposure to death would be a more powerful determinant of DAS and DCS scores than Manifest Anxiety Scale (MAS) scores. Results of analyses indicate that the opposite is true.

Table 5 shows the results by analysis of variance of the effects of amount of clinical exposure to death and MAS on DAS scores. As can be seen from this table, the main effect of MAS was significant at the .05 level, whereas the effect of death exposure did not reach significance. The interaction between the two main effects was also not significant. Results similar to those found with the DAS variable were observed with DCS. Table 6 presents these results. As can be seen in the table, the effect of MAS on DCS was significant at the .05 level. The effect of death exposure and the interaction between MAS and death exposure did not reach significance.

TABLE 5

Summary of the Analysis of Variance of the Effects of Amount of Clinical Exposure to Death and Manifest Anxiety on Death Anxiety Scores

Source	df	MS	F
Death Exposure (A)	3/127	2.70	.45
Manifest Anxiety (B)	2/127	99.04	16.40**
A x B	6/127	9.29	1.54

**$p < .01$

TABLE 6

Summary of the Analysis of Variance of the Effects of Amount of Clinical Exposure to Death and Manifest Anxiety on Death Concern Scores

Source	df	MS	F
Death Exposure (A)	3/127	56.97	.73
Manifest Anxiety (B)	2/127	1402.32	18.06**
A x B	6/127	132.32	1.70

**$p < .01$

The prediction of hypothesis three was that DAS and DCS scores of Ss in the high clinical death exposure group (Group 4) would be lower than those of Ss in the other groups regardless of what their MAS scores were. Specifically, it was predicted that the mean DAS and DCS scores for Ss in Group 4 who fell in the high MAS category would be even lower than those of low MAS Ss in the other three groups. The results do not support this hypothesis and, in fact, suggest the opposite to be true.

Table 7 shows mean DAS scores in relation to level of MAS. As can be seen from Table 8, the cell mean of Ss in the high MAS cell of Group 4 was not lower than those of the low MAS cells of the other groups, as had been predicted, but significantly higher in all cases ($p < .01$). Table 9 shows mean DCS scores in relation to level of MAS. The results here are similar to those found in the case of DAS. As is observed in Table 10, the cell means of Ss in the high MAS cell of Group 4 was not lower than those of the low MAS cells of the other groups, as had been predicted, but significantly higher in all cases ($p < .01$).

Locus of Control and Death Environment

Hypothesis four involved the assumption that amount of clinical exposure to death would be a more powerful determinant of DAS and DCS scores than Locus of Control (I-E) scores.

Table 11 shows the results of the analysis of variance of the effects of amount of clinical exposure to death and

TABLE 7

Mean Death Anxiety Scores in Relation to Levels of Manifest Anxiety (MA)

		Low MA	Medium MA	High MA
Group 1	$\bar{X}$	6.53	5.86	7.58
	N	15	7	12
Group 2	$\bar{X}$	3.88	6.38	9.13
	N	8	21	15
Group 3	$\bar{X}$	5.20	7.29	8.18
	N	5	14	11
Group 4	$\bar{X}$	5.69	6.89	8.89
	N	13	9	9

TABLE 8

Difference Between Group 4 High Manifest Anxiety (HMA#4) Cell Mean on Death Anxiety Scale and Low Manifest Anxiety (LMA) Cell Means on Death Anxiety Scale in Group 1 (LMA#1), Group 2 (LMA#2), Group 3 (LMA#3), and Group 4 (LMA#4)

	Difference
HMA#1-LMA#2	+2.36*
HMA#4-LMA#2	+5.01**
HMA#4-LMA#3	+3.70**
HMA#4-LMA#4	+3.20**

* difference needed for $p < .05 = 2.17$

** difference needed for $p < .01 = 2.84$

TABLE 9

Mean Death Concern Scores in Relation to Levels of Manifest Anxiety (MA)

		Low MA	Medium MA	High MA
Group 1	$\bar{X}$	65.20	67.29	68.92
	N	15	7	12
Group 2	$\bar{X}$	58.50	70.29	76.87
	N	8	21	15
Group 3	$\bar{X}$	62.40	70.79	75.18
	N	5	14	11
Group 4	$\bar{X}$	68.85	67.00	78.22
	N	13	9	9

TABLE 10

Difference Between Group 4 High Manifest Anxiety (HMA#4) Cell Mean on Death Concern Scale and Low Manifest Anxiety (LMA) Cell Means on Death Concern Scale in Group 1 (LMA#1), Group 2 (LMA#2), Group 3 (LMA#3), and Group 4 (LMA#4)

	Difference
HMA#1-LMA#1	+13.02**
HMA#4-LMA#2	+19.72**
HMA#4-LMA#3	+15.82**
HMA#4-LMA#4	+12.47**

**difference needed for $p < .01 = 10.17$

TABLE 11

Summary of the Analysis of Variance of the Effects of Amount of Clinical Exposure to Death and Locus of Control on Death Anxiety Scores

Source	df	MS	F
Death Exposure (A)	3/127	1.47	.20
Locus of Control (B)	2/127	22.04	3.02
A x B	6/127	6.74	.92

locus of control on DAS scores. As can be seen from this table, neither of the main effects, death exposure and I-E, nor their interaction reached the .05 level of significance. However, the effect of level of I-E on DAS fell just short of $p. < .05$. Results similar to those found with the DAS variable were observed with DCS. Table 12 presents these results. As can be seen from this table, neither amount of clinical exposure to death nor I-E had a significant effect on the DCS variable. The interaction of these two variables was also not significant.

The prediction of hypothesis four was that DAS and DCS scores of Ss in the high clinical death exposure group (Group 4) would be lower than those of Ss in the other groups regardless of what their I-E scores were. Specifically, it was predicted that the mean DAS and DCS scores for Ss in Group 4 who fell in the high I-E category would be even lower than those of low I-E Ss in the other three groups. Results do not provide support for this hypothesis.

Table 13 shows mean DAS scores in relation to level of I-E. As can be seen from Table 14, none of the cell means of Ss in the low I-E cells of the first three groups differed significantly from that of Ss in the high I-E cell of Group 4. Results were similar in the case of the DCS variable. Tables 15 and 16 present these results.

Religious Comfort and Death Environment

Hypothesis five involved the assumption that amount of clinical exposure to death would be a more powerful determinant

TABLE 12

Summary of the Analysis of Variance of the Effects of Amount of Clinical Exposure to Death and Locus of Control on Death Concern Scores

Source	df	MS	F
Death Exposure (A)	3/127	112.53	1.17
Locus of Control (B)	2/127	17.83	.19
A x B	6/127	149.49	1.56

TABLE 13

Mean Death Anxiety Scores in Relation to Levels of Locus of Control (I-E)

		Low I-E	Medium I-E	High I-E
Group 1	$\bar{X}$	5.31	8.42	6.67
	N	13	12	9
Group 2	$\bar{X}$	6.47	7.57	6.33
	N	15	17	12
Group 3	$\bar{X}$	6.30	7.33	8.09
	N	10	9	11
Group 4	$\bar{X}$	6.89	7.25	6.70
	N	9	12	10

TABLE 14

Difference Between Group 4 High Locus of Control (HIE#4) Cell Mean on Death Anxiety Scale and Low Locus of Control (LIE) Cell Means on Death Anxiety Scale in Group 1 (LIE#1), Group 2 (LIE#2), Group 3 (LIE#3), and Group 4 (LIE#4)

	Difference
HIE#4-LIE#1	-1.39
HIE#4-LIE#2	- .23
HIE#4-LIE#3	- .40
HIE#4-LIE#4	- .19

TABLE 15

Mean Death Concern Scores in Relation to Levels of Locus of Control (I-E)

		Low I-E	Medium I-E	High I-E
Group 1	$\bar{X}$	63.00	72.92	64.67
	N	13	12	9
Group 2	$\bar{X}$	71.67	68.12	72.00
	N	15	17	12
Group 3	$\bar{X}$	72.39	68.33	71.91
	N	10	9	11
Group 4	$\bar{X}$	70.00	71.50	67.50
	N	9	12	10

TABLE 16

Difference Between Group 4 High Locus of Control (HIE#4) Cell Mean on Death Concern Scale and Low Locus of Control (LIE) Cell Means on Death Concern Scale in Group 1 (LIE#1), Group 2 (LIE#2), Group 3 (LIE#3), and Group 4 (LIE#4)

	Difference
HIE#4-LIE#1	+4.50
HIE#4-LIE#2	-4.17
HIE#4-LIE#3	-4.89
HIE#4-LIE#4	-2.50

of DAS and DCS scores than Religious Comfort (RC) scores. Results of data analyses indicate the opposite to be the case.

Table 17 shows the results of the analysis of variance of the effects of amount of clinical exposure to death and RC on DAS scores. As can be seen from this table, the effect of death exposure was not significant. The effect of RC reached the .05 level of significance. The interaction between death exposure and RC was not significant. Results similar to those found with the DAS variable were observed with DCS. Table 18 presents these results. As is shown in this table, the effect of RC on DCS was significant at the $p < .05$ level. Neither the effect of death exposure on DCS nor the interaction between the two main effects were significant.

The prediction of hypothesis five was that DAS and DCS scores of Ss in the high clinical death exposure group (Group 4) would be lower than those of Ss in the other groups regardless of what their RC scores were. Specifically, it was predicted that the mean DAS and DCS scores for Ss in Group 4 who fell in the low RC category would be even lower than those of high RC Ss in the other three groups. The findings here are mixed.

Table 19 shows mean DAS scores in relation to level of RC. As can be seen from Table 20, the DAS cell mean of Ss in the low RC cell of Group 4 was not significantly different from that of any of the high RC cell means in the other three groups. Thus, these data do not support hypothesis five.

TABLE 17

Summary of the Analysis of Variance of the Effects of Amount of Clinical Exposure to Death and Religious Comfort on Death Anxiety Scores

Source	df	MS	F
Death Exposure (A)	3/127	.70	.09
Religious Comfort (B)	2/127	26.62	3.51*
A x B	6/127	.64	.08

*$p < .05$

TABLE 18

Summary of the Analysis of Variance of the Effects of Amount of Clinical Exposure to Death and Religious Comfort on Death Concern Scores

Source	df	MS	F
Death Exposure (A)	3/127	81.61	.84
Religious Comfort (B)	2/127	321.74	3.31*
A x B	6/127	74.14	.76

*$p < .05$

TABLE 19

Mean Death Anxiety Scores in Relation to Levels of Religious Comfort (RC)

		Low RC	Medium RC	High RC
Group 1	$\bar{X}$	7.18	7.27	5.92
	N	11	11	12
Group 2	$\bar{X}$	8.00	7.17	5.86
	N	6	24	14
Group 3	$\bar{X}$	7.86	7.33	6.20
	N	7	18	5
Group 4	$\bar{X}$	7.50	7.56	6.26
	N	8	9	14

TABLE 20

Difference Between Group 4 Low Religious Comfort (LRC#4) Cell Mean on Death Anxiety Scale and High Religious Comfort (HRC) Cell Means on Death Anxiety Scale in Group 1 (HRC#1), Group 2 (HRC#2), Group 3 (HRC#3) and Group 4 (HRC#4)

	Difference
LRC#4-HRC#1	-1.58
LRC#4-HRC#2	-1.64
LRC#4-HRC#3	-1.30
LRC#4-HRC#4	-1.24

Findings with the DCS variable were somewhat different. Table 21 presents mean DCS scores in relation to levels of RC. As can be seen from Table 22, the differences between the high RC cell means in Groups 1 and 3 and the low RC cell mean in Group 4 were significant at the .05 level. In the case of Group 2, the difference was not significant. In all of these instances, the low RC cell mean of Group 4 was higher than that of the high RC cells in the other groups. This is the opposite of what was predicted in hypothesis five.

Regression Analyses

Table 23 presents the results of the regression analysis with DAS as the criterion done with Ss from Group 1, Group 2, and Group 3. The multiple R for the criterion variable and predictors was .50 and R^2 was .25. These were statistically significant ($F=10.98$, $df=3/101$, $p < .01$). Thus, the predictor variables used appear to be real predictors of the DAS criterion variable. As can be seen from Table 23, three predictor variables, in order of decreasing significance, manifest anxiety, socio-economic status and degree of religious comfort contributed significantly to the change in R^2.

Table 24 presents the results of the regression analysis with DCS as the criterion done with Ss from Group 1, Group 2, and Group 3. The multiple R for the criterion variable and predictors was .49 and R^2 was .24. These were statistically significant ($F=10.58$, $df=3/101$, $p < .01$). Thus, the predictor variables used appear to be real predictors of the DCS criterion variable. As can be seen from Table 24, three

TABLE 21

Mean Death Concern Scores in Relation to Levels of Religious Comfort (RC)

		Low RC	Medium RC	High RC
Group 1	$\bar{X}$	68.18	67.73	65.08
	N	11	11	12
Group 2	$\bar{X}$	70.83	70.04	70.79
	N	6	24	14
Group 3	$\bar{X}$	74.86	71.78	62.80
	N	17	18	5
Group 4	$\bar{X}$	74.25	70.67	66.64
	N	8	9	14

TABLE 22

Difference Between Group 4 Low Religious Comfort (LRC#4) Cell Mean on Death Concern Scale and High Religious Comfort (HRC) Cell Means on Death Concern Scale in Group 1 (HRC#1), Group 2 (HRC#2), Group 3 (HRC#3) and Group 4 (HRC#4)

	Difference
LRC#4-HRC#1	+9.13*
LRC#4-HRC#2	+3.46
LRC#4-HRC#3	+11.45*
LRC#4-HRC#4	+7.61

*difference needed for $p < .05 = 8.99$

TABLE 23

Results of Regression Analysis with DAS as Criterion Including Ss from Group 1, Group 2, and Group 3: Significant Predictor Variables

Predictor	Beta Weight	df	F
Manifest Anxiety	.39	1/101	19.56**
Socio-economic Status	-.19	1/101	4.97*
Religious Comfort	.17	1/101	3.67*

*$p < .05$

**$p < .01$

TABLE 24

Results of Regression Analysis with DCS as Criterion Including Ss from Group 1, Group 2, and Group 3: Significant Predictor Variables

Predictor	Beta Weight	df	F
Manifest Anxiety	.43	1/101	24.40**
Socio-economic Status	-.21	1/101	5.99*
Religious Belief	.15	1/101	3.10*

*$p < .05$

**$p < .01$

predictor variables, in order of decreasing significance, manifest anxiety, socio-economic status and degree of religious belief contributed significantly to the change in R^2.

Table 25 presents the results of the regression analysis with DAS as the criterion done with Ss from Group 4 only. The multiple R for the criterion variable and predictors was .55 and R^2 was .31. These were statistically significant ($F=11.75$, $df=1/27$, $p<.01$). Thus, the predictor variables used appear to be real predictors of the DAS criterion variable. As can be seen from Table 25, only one predictor variable, manifest anxiety, contributed significantly to the change in R^2.

Table 26 presents the results of the regression analysis with DCS as the criterion done with Ss from Group 4 only. The multiple R for the criterion variable and predictors was .57 and R^2 was .33. These were statistically significant ($F=13.20$, $df=1/27$, $p<.01$). Thus, the predictor variables used appear to be real predictors of the DCS criterion variable. As can be seen from Table 26, only one predictor variable, manifest anxiety, contributed significantly to the change in R^2.

Table 27 presents the results of the regression analysis with DAS as the criterion done with all Ss. The multiple R for the criterion variable and predictors was .49 and R^2 was .24. These were statistically significant ($F=14.00$, $df=3/130$, $p<.01$). Thus, the predictor variables used appear to be real predictors of the DAS criterion variable. As can be

TABLE 25

Results of Regression Analysis with DAS as Criterion Including Ss from Group 4 Only: Significant Predictor Variables

Predictor	Beta Weight	df	F
Manifest Anxiety	.55	1/27	11.74**

**$p < .01$

TABLE 26

Results of Regression Analysis with DCS as Criterion Including Ss from Group 4 Only: Significant Predictor Variables

Predictor	Beta Weight	df	F
Manifest Anxiety	.57	1/27	13.20**

**$p < .01$

TABLE 27

Results of Regression Analysis with DAS as Criterion Including All Ss: Significant Predictor Variables

Predictor	Beta Weight	df	F
Manifest Anxiety	.40	1/130	26.89**
Socio-economic Status	-.16	1/130	4.37*
Religious Comfort	.15	1/130	3.93*

*$p < .05$

**$p < .01$

seen from Table 27, three predictor variables, manifest anxiety, socio-economic status and degree of religious comfort contributed significantly to the change in R^2.

Table 28 presents the results of the regression analysis with DCS as the criterion done with all Ss. The multiple R for the criterion variable and predictors was .44 and R^2 was .20. These were statistically significantly ($F=32.01$, $df=1/132$, $p<.01$). Thus, the predictor variables used appear to be real predictors of the DCS criterion variable. As can be seen from Table 28, only one predictor variable, manifest anxiety, contributed significantly to the change in R^2.

Relationship Between Manifest Anxiety Death Measures and Other Variables

Of all the predictor variables included in the regression equations, manifest anxiety, consistently accounted for the greatest portion of the variance in both DAS and DCS. This variable was found to be moderately correlated with both DAS ($r=.44$, $df=137$, $p<.01$) and DCS ($r=.44$, $df=137$, $p<.01$). Religious comfort was also significantly correlated with DAS ($r=.24$, $df=137$, $p<.01$) and DCS ($r=.16$, $df=137$, $p<.05$). The locus of control variable was not significantly correlated with either DAS ($r=.11$, $df=137$, $p>.10$) or DCS ($r=.05$, $df=137$, $p>.10$). Locus of control was more highly correlated with manifest anxiety than with either of the death measures. The correlation between locus of control and manifest anxiety was .20 ($df=137$, $p<.05$). The correlation between religious comfort was .20 ($df=137$, $p<.05$). Degree of religious belief

TABLE 28

Results of Regression Analysis with DCS as Criterion Including All Ss: Significant Predictor Variables

Predictor	Beta Weight	df	F
Manifest Anxiety	.45	1/132	31.23**

**$p < .01$

correlated negatively but significantly with manifest anxiety ($r=.17$, $df=137$, $p<.05$), but not with either DAS ($r=.08$, $df=137$, $p>.10$) or DCS ($r=.04$, $df=137$, $p>.10$).

Interview Data

The correlations between rated degree of anxiety present and death measure scores was not significant ($r=.07$, $df=13$, $p>.10$). The ratings on degree of emotional expressivity did not correlate significantly with death measure scores ($r=-.26$, $df=13$, $p>.10$). Death measure scores did correlate significantly with rated emphasis on professional competence ($r=.97$, $df=13$, $p<.01$) and the emphasis on coping ratings ($r=.60$, $df=13$, $p<.05$). The denial of anxiety rating was not significantly correlated with death scores ($r=-.34$, $df=13$, $p>.10$).

Summary of Results

From the above, the following may be said about the status of the hypotheses of the study. The data provide no support for hypotheses 1 or 2. Hypothesis 3 was not supported by the results and the data showed the exact opposite to be true. Hypothesis 4 was not supported. Hypothesis 5 was not supported, and in the case of the DCS variable, the opposite appeared to be true.

CHAPTER V

DISCUSSION

The first two hypotheses stated that Ss exposed to a high death contact environment would have significantly lower death anxiety and death concern scores than other Ss. These hypotheses were not supported by the results. There were no significant differences between groups on death anxiety and death concern measures.

A statistically nonsignificant trend in the data was observed. There was a gradual upward progression in group means from the first to the third group, and in the fourth group, the means on both death scales fell. This approximated the expectation that high clinical exposure to death would result in lowered death anxiety and death concern scores. Relative to a comparison group of seniors with low death exposure, senior-year nursing students with high death exposure had lower death anxiety and death concern scores.

It is possible that the way in which clinical experience with death was operationalized, in the research, was not sufficient to produce the expected death desensitizing effects. Amount of clinical experience with death was defined by number of rotations spent in a high death exposure nursing school rotation. Nursing school rotations are eight weeks in length. During this time, students are involved in coursework, in addition to being closely supervised and graded in their clinical work. Perhaps the limits and responsibilities of the student role shelter them from fully experiencing the

death and dying they encounter. Another possibility is that the eight week length of the rotations is too short a time period for the hypothesized desensitization effects to become operative.

There may also have been another limitation inherent in the way in which clinical experience with death was defined in this research. The highness or lowness of the amount of death exposure in the various nursing school rotations was defined by nursing professors on the basis of death rate statistics of the rotation placements. It was assumed that Ss who had been in high death exposure rotations would have come into contact with death on a frequent basis. This was checked out through a self-report by Ss of the actual number of dying patients they had dealt with on their rotations. The correlation between this number and the number of high death exposure rotations was highly significant. However, the possibility of falsification of memory cannot be ruled out. Perhaps, Ss in an effort to impress the experimenter, indicated they had had more direct contact with patient deaths than they actually had.

It is possible that the measuring instruments used in the study were of limited validity. Both instruments consisted primarily of questions concerning negative feelings toward death. On the death scales, death tended to be treated without differentiation as to who was dying or under what circumstances. One thing that emerged in the post-experimental interviews on the extreme high and low scorers

on the death measures, was that situational factors were important determinants of Ss' attitudes toward a particular death. Who died and under what circumstances were seen as important. That is, was the patient young or old, were they suffering, how long had they been sick.

The basic premise of the study was that the longer an individual is in contact with death, the more desensitized she will become to the whole event. The desensitization was assumed to consist of a blocking from awareness of both affective (anxiety) and cognitive components of the response to death stimuli. In retrospect, it appears that this conceptual model may have been insufficiently complex to describe the way in which people respond to the experience of observing the death of other people.

In keeping with the original premise, it is probable that an individual's experience of the thought of death does change the longer she is confronted with dealing with dying people. However, rather than becoming desensitized to all facets of death and dying, it is possible that sensitivities become more differentiated. That is, death and dying are no longer mysterious strangers, but familiar events. Part of this familiarization might be that the individual no longer reacts to death in the abstract, but as a real life event which is slightly different each time it occurs. Thus, the relevant information for an individual would no longer be simply that a death has occurred, but rather who died and under what conditions. These specific facts would become

the determinants of how an individual would think and feel in response to the occurrence of a death. A death surrounded by one particular set of circumstances might be more emotionally and cognitively arousing for an individual than a death under another set of circumstances. For example, an individual might react more strongly to the death of a person her own age who died suddenly than to the death of an old person who had died a painful lingering death.

The results of the present research indicate that, within the limitations of the way in which death anxiety was operationalized, individual differences play a more important role in determining level of death anxiety and death concern than does simple exposure to the observation of death. In contrast to the lack of statistically significant effects with the experiential variable, two intrapersonal variables, manifest anxiety and religious comfort, were observed to have statistically significant effects on DAS and DCS scores. This finding is consistent with reports in the literature. However, in the case of the locus of control variable, no significant effects on either of the death measures were observed. This is in agreement with the findings of some studies in the literature (Dickstein, 1972) and in contrast to other studies (Tolor & Reznikoff, 1967). All of this suggests that in terms of understanding death attitudes, manifest anxiety and religious comfort are more relevant dimensions than locus of control.

In particular, the way in which an individual handles

anxiety, in general, appears to be particularly relevant to understanding how she will handle the anxiety involved in experiencing the death of others. In all of the regression analyses done, the manifest anxiety variable accounted for the major portion of the variance in the criterion variables of DAS and DCS. This means that, in the present research, a S's manifest anxiety score was the best single piece of information from which to predict her DAS and DCS scores. The post-experimental interviews done with extreme high and low scorers on the death measures provide some qualitative insights into this. Transcripts of these interviews are included in Appendix G.

What distinguished high and low scorers on the death measures was that the high scorers tended to focus on the anxious feelings they experienced during their encounters with death. They valued confronting these feelings for the sake of confronting them rather than for any external reason such as being better able to perform nursing duties; they valued being aware of their feelings and expressing this awareness.

There seemed to be three categories of low death measure scorers. Some low scorers were also in touch with feelings, but in contrast to the high scorers, tried to handle or change these feelings so that they would not be so intrusive regarding their clinical work. Focus on professional competency, action and mastery of technique tended to be very prominent among low scorers; if there was any anxiety about

terminal situations, it tended to be focused on ability to sustain competence to handle life or death medical emergencies. Several low-scoring Ss focused on the importance of not getting too involved with patients for fear that it would get in the way of their capacity to act professionally. One S was consciously aware both of denying and wanting to deny anxiety and all other negative aspects of the situation and of the self-protective implications of this. In at least two low death anxiety Ss, the low score seemed to be a result of a genuine working through of feelings about death, as a result of the experience of the death of a close friend or relative.

When these subjective observations were quantified and empirically tested through ratings by judges, the expected relationships were not observed. The correlations between the judges' ratings on the five dimensions: degree of anxiety present, degree of emotional expressivity, emphasis on professional competence, emphasis on coping, and denial of anxiety, and death scores were not significant in 3 of 5 comparisons. In two cases, those of the ratings on emphasis on professional competence and coping, the obtained correlations between judges' ratings and death scores were significant, but in the opposite direction to that expected. In the absence of significant statistical evidence, no definite conclusions can be drawn about the validity of the hypotheses. They, intuitively, appeared to be true for some Ss, but apparently were not generalizable across protocols. Therefore,

they still remain interesting speculations and possible guidelines for further exploration.

The concept which seems to unify the diverse observations about the interviews and the five dimensions on which they were rated was that of absence or presence of openness to emotional reactions to experience, including anxious reactions. This openness contrasts with defensive distortion of feelings. The literature provides some evidence that this may be an important dimension to investigate. Tolor and Reznikoff (1967) found that sensitizers had significantly higher death anxiety scores than repressors. The repression-sensitization dimension can be conceptualized as a measure of the tendency to be aware of and expressive of affective experience.

Apart from how an individual handles anxiety, in the present research, there appeared to be other factors which were predictors of DAS and DCS scores. Knowledge of the socio-economic affiliation of Ss appears to add information about the way in which they will respond to the idea of death. In two out of three sets of regression analyses performed, socio-economic status was the second best predictor of scores on both death measures. An individual's socio-economic status tends to be a powerful determinant of her group affiliation and lifestyle. Any particular style of life is associated with a gamut of behavioral and belief systems which influence the individual. Among these systems would be the typical ways in which the individuals in the group encounter

life events such as death.

Variables related to religious beliefs were the third best predictors of the death scores. Religious systems provide explanations of and expectations for life's unknowns; death is the ultimate unknown. In providing some set of expectations surrounding death, religious systems alleviate or modulate some of the anxiety that comes from confronting the unfamiliar.

In none of the regression analyses was more than 33% of the variance in the criterion variables accounted for by the predictor variables included in the equations. This indicates that factors other than those involved in the variables included in the equations must be accountable for the variance in the death measure scores. That is, other factors than those included in this research, are better predictors of death anxiety and death concern scores. The repression-sensitization dimension has previously been discussed as one possibility.

As has already been mentioned, in all of the regression equations, the manifest anxiety variable, consistently, accounted for the greatest portion of the variance in both criterion measures. The correlation between the MAS variable and both death measures was highly significant and positive. The correlation between the two death measures was, similarly, positive and highly significant.

One way to interpret this information would be to say that all three of the scales are measuring the same factor

or trait. This trait might be the tendency of an individual to be willing to admit to anxious or negative feelings, as is required on all three of the measures. Another perspective would be to focus on this similarity among the three scales. All of the scales use similar methods to measure what they define, conceptually, as independent phenomena. Such similarity in method would tend to blur the discriminability of the phenomena under study. Thus, the large amount of shared variance between MAS and both death measures that is indicated in the high correlations and regression equations, could be more reflective of similarities in method than similarities in the actual phenomena themselves. Conversely, the observation that only one-third of the variance in the criterion measures was ever accounted for could be traced to dissimilarities between predictor measures in terms of trait measured or measurement method.

It is interesting to note that in the regression analyses for the fourth group, the manifest anxiety variable accounted for more of the variance in the death measures than it did in analyses of groups that did not have the high clinical death experience. A hypothetical explanation of this is as follows: The MAS measures the tendency to experience and express the experience of anxiety. This tendency to be anxious is a general trans-situational one. This generality would indicate that anxiety is capable of being elicited by many sources. In a given environment, some features are more anxiety provoking than others. It is possible that

over a period of time in a given environment, an individual's anxiety tends to become focused upon the cues with the greatest anxiety arousing potential. According to this reasoning and assuming that death has a high anxiety arousal potential, in an environment where deaths frequently occur, an individual's anxiety should become assimilated to death stimuli. That is, the cause of anxious feelings will most often be attributed to something related to death. Individuals who experience more anxiety, in general, should experience more anxiety in relation to death and dying. Over a period of time in a high death exposure environment, high manifest anxiety individuals should become, predictably, highly death anxious.

To this point, the discussion has focused on individual differences in death attitudes and situational factors (exposure to death of others) as if they were independent of each other. A more complex conceptual approach which focused on the interaction between these two sorts of factors would likely be of greater explanatory and predictive value.

A reconceptualization of the effects of long term exposure to observing the deaths of others has already been offered. This model involved desensitization to death as an abstract global event and sensitization to specific forms of death over a period of time of exposure to observing the deaths of others as a regular event. Specific forms of death included variables such as age of the dying person, their degree of suffering, amount of personal investment on the part of the nursing student. Degree of personal identification

with the dying person is seen as a crucial concept in determining the way in which the caretaker will react. In line with the individual difference/situational factor model, it is suggested that all individuals undergo the desensitization-resensitization process but that the way and degree to which they will experience the deaths they observe is determined by internal response sets, such as general anxiety level, and repression-sensitization.

The idea of response to death has, so far, been discussed as if it were a pattern that is a fixed one, an adjustment an individual makes and never changes. However, the clinical literature, in particular, the works of Elizabeth Kubler-Ross (1969, 1975) strongly indicate that the response to idea of death is not a static once and for all adjustment, but a mutable process occurring through time. Kubler-Ross postulates five distinct stages in the process of death and dying. They are denial, anger, depression, bargaining and acceptance. However, she makes it clear that these stages are largely heuristic in nature and that, actually, their sequence and duration are flexible. Attainment of a certain stage does not mean that an individual will remain there for long. Even a person who has apparently reached the stage of acceptance with regard to a particular death, on a certain day, on the following day may be denying the death.

A research approach that takes into account the complexities of death attitudes is needed. To date, most research in the area has dealt with death attitudes in relation to very

broad parameters. This focus on relatively few dimensions and constructs has impeded the development of death research. What needs to be done next is to explore what are the relevant parameters of the human response to death. This would involve casting aside, temporarily, the preoccupation with trying to understand response to death in terms of existing theoretical frameworks. A good deal more empirical data is needed before accurate theorizing is possible. The N=1, longitudinal case study approach might be a research tactic well suited to the needs of the area. With this design, observational data that would reflect the finer nuances of the ways in which people react to experiencing the death and dying of others could be collected.

Within the limitations imposed upon the present research by design and methodology, several relevant pieces of information emerge. It appears that regardless of amount of actual observation of death in a clinical setting, nursing students who are anxious, in general, will also express more anxiety about death. Nursing student Ss who are more comfortable with their religious beliefs, appear to be less anxious about the issue of death.

Level of death anxiety score, of itself, probably does not provide adequate information about how an individual will handle the experience of another's death. As was seen in the post-experimental interviews, a low score on the death measures was found both in individuals who tended to defend against anxious feelings and in individuals who had worked

through their fear of death. Conversely, high death measure scorers appeared to be more sensitive to the emotional issues involved in encountering death.

The literature on death and dying indicates that a necessary trait for effectively working with dying patients, is an ability to honestly confront emotional issues involved in experiencing death. In terms of the findings of the present research, it appears that either high or low death measure scorers may possess this trait. The significance of a particular score can be interpreted only in the context of the total functioning of an individual.

As has already been mentioned, individuals who are comfortable with their religious beliefs, tend to be less anxious about death. This might imply either of two things about a particular person. A person who is comfortable with her religious position might feel so resolved on the issue of death that she no longer considers it an issue subject to examination and discussion. This could make her rigid and intolerant of the feelings of other people about death. In her dealings with dying patients, this might be a severe handicap should she be confronted with someone whose ideas differed from her own. On the other hand, feeling comfortable about religious beliefs could have the effect of making a person secure enough to openly deal with issues surrounding death. This would be a benefit in clinical situations involving dealing with terminal patients. Thus, as in the case of general anxiety, the meaning of the level of a

particular factor in the individual case, is of great importance.

This focus on the meaning the level of a certain variable has in the individual case, has implications for nursing student selection and training. On the basis of the findings of this research, there do not appear to be any cut and dried ways to predict how an individual will respond to observing the death of another. The actual level of death anxiety and death concern was shown to be related to certain other variables. However, it is suggested that for the actual meaning of these scores, they must be examined within the context of the total person.

Thus, it is difficult to say exactly what proportion of this or that trait would constitute the ideal nurse for working with terminally ill patients. In a general sense, she would be a person who was sensitive to and able to deal with her own feelings and those of people with whom she came into contact. Nursing training programs could foster the evolution of such a sort of nurse through encouraging self-exploration in their students and by including in the curriculum, theoretical and experiential training in human interaction.

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APPENDIX A

Death Anxiety Scale

This questionnaire concerns your feelings about issues which you probably confront in your nursing training and in your daily lives. Answer the questions by circling either True (T) or False (F), depending upon what your answer is. In some instances, you may have trouble deciding between T and F, because your answer seems to fall somewhere in between; in such cases, choose the answer that seems to be accurate most of the time.

Do not leave any questions unanswered.

T F 1. I am very much afraid to die.

T F 2. The thought of death seldom enters my mind.

T F 3. It doesn't make me nervous when people talk about death.

T F 4. I dread to think about having to have an operation.

T F 5. I am not at all afraid to die.

T F 6. I am not particularly afraid of getting cancer.

T F 7. The thought of death never bothers me.

T F 8. I am often distressed by the way time flies so very rapidly.

T F 9. I fear dying a painful death.

T F 10. The subject of life after death troubles me greatly.

T F 11. I am really scared of having a heart attack.

T F 12. I often think about how short life really is.

T F 13. I shudder when I hear people talking about a World War III.

T F 14. The sight of a dead body is horrifying to me.

T F 15. I feel that the future holds nothing for me to fear.

APPENDIX B
Death Concern Scale

This questionnaire concerns your feelings about death. Read each item and answer it by circling the number from 1 to 4 which you think best fits your response. Be sure to answer all items.

The following answer scale will be used for items 1-11.

1 (never) 2 3 4 (often)

1.	I think about my own death.	1	2	3	4
2.	I think about the death of loved ones.	1	2	3	4
3.	I think about dying young.	1	2	3	4
4.	I think about the possibility of my being killed on a city street.	1	2	3	4
5.	I have fantasies of my own death	1	2	3	4
6.	I think about death just before I go to sleep.	1	2	3	4
7.	I think of how I would act if I knew I were to die within a given period of time.	1	2	3	4
8.	I think about how my relatives would act and feel upon my death.	1	2	3	4
9.	When I am sick I think about death.	1	2	3	4
10.	When I am outside during a lightning storm I think about the possibility of being struck by lightning.	1	2	3	4
11.	When I am in an automobile I think about the high incidence of traffic fatalities.	1	2	3	4

For the rest of the items, the numbers will have a different meaning:

1 I strongly disagree
2 I somewhat disagree
3 I somewhat agree
4 I strongly agree

Go ahead and circle the number that you think best represents your answer.

12.	I think people should first become concerned about death when they are old.	1	2	3	4
13.	I am much more concerned about death than those around me.	1	2	3	4
14.	Death hardly concerns me.	1	2	3	4

15. My general outlook just doesn't allow for morbid thoughts.	1	2	3	4
16. The prospect of my own death arouses anxiety in me.	1	2	3	4
17. The prospect of my own death depresses me.	1	2	3	4
18. The prospect of the death of my loved ones arouses anxiety in me.	1	2	3	4
19. The knowledge that I will surely die does not in any way affect the conduct of my life.	1	2	3	4
20. I envision my own death as a painful, nightmarish experience.	1	2	3	4
21. I am afraid of dying.	1	2	3	4
22. I am afraid of being dead.	1	2	3	4
23. Many people become disturbed at the sight of a new grave but it does not bother me.	1	2	3	4
24. I am disturbed when I think about the shortness of life.	1	2	3	4
25. Thinking about death is a waste of time.	1	2	3	4
26. Death should not be regarded as a tragedy if it occurs after a productive life.	1	2	3	4
27. The inevitable death of man poses a serious challenge to the meaningfulness of human existence.	1	2	3	4
28. The death of the individual is ultimately beneficial because it facilitates change in society.	1	2	3	4
29. I have a desire to live on after death.	1	2	3	4
30. The question of whether or not there is a future life worries me constantly.	1	2	3	4

APPENDIX C

Locus of Control (I-E) Scale

Instructions:

This is a questionnaire to find out the way in which certain important events in our society affect different people. Each item consists of a pair of statements lettered a or b. Please select the one statement of each pair (and only one) which you more strongly believe to be the case as far as you are concerned. Be sure to select the one you actually believe to be more true than the other rather than the one you think you should choose or the one you would like to be true.

In some instances you may discover that you believe both statements or neither one. In such cases, be sure to select the one you more strongly believe to be the case as far as you are concerned.

Please be sure to answer every item, this is a measure of personal belief so obviously there are no right or wrong answers.

For each item, indicate the statement you more strongly believe to be true by circling a or b.

1. a. Children get into trouble because their parents punish them too much.
   b. The trouble with most children nowadays is that their parents are too easy with them.
2. a. Many of the unhappy things in people's lives are partly due to bad luck.
   b. People's misfortunes result from the mistakes they make.
3. a. One of the major reasons why we have wars is because people don't take enough interest in politics.
   b. There will always be wars, no matter how hard people try to prevent them.
4. a. In the long run people get the respect they deserve in this world.
   b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.
5. a. The idea that teachers are unfair to students is nonsense.
   b. Most students don't realize the extent to which their grades are influenced by accidental happenings.
6. a. Without the right breaks one cannot be an effective leader.
   b. Capable people who fail to become leaders have not taken advantage of their opportunities.
7. a. No matter how hard you try some people just don't like you.
   b. People who can't get others to like them don't understand how to get along with others.

8. a. Heredity plays the major role in determining one's personality.
   b. It is one's experiences in life which determine what they're like.

9. a. I have often found that what is going to happen will happen.
   b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10. a. In the case of the well-prepared student there is rarely if ever such a thing as an unfair test.
    b. Many times exam questions tend to be so unrelated to course work that studying is really useless.

11. a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
    b. Getting a good job depends mainly on being in the right place at the right time.

12. a. The average citizen can have an influence in government decisions.
    b. This world is run by the few people in power, and there is not much the little guy can do about it.

13. a. When I make plans, I am almost certain that I can make them work.
    b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14. a. There are certain people who are just no good.
    b. There is some good in everybody.

15. a. In my case getting what I want has little or nothing to do with luck.
    b. Many times we might just as well decide what to do by flipping a coin.

16. a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
    b. Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.

17. a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.
    b. By taking an active part in political and social affairs the people can control world events.

18. a. Most people don't realize the extent to which their lives are controlled by accidental happenings.
    b. There really is no such thing as "luck".

19. a. One should always be willing to admit mistakes.
    b. It is usually best to cover up one's mistakes.

20. a. It is hard to know whether or not a person really likes you.
    b. How many friends you have depends upon how nice a person you are.

21. a. In the long run the bad things that happen to us are balanced by the good ones.
    b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. a. With enough effort we can wipe out political corruption.
    b. It is difficult for people to have much control over the things politicians do in office.

23. a. Sometimes I can't understand how teachers arrive at the grades they give.
    b. There is a direct connection between how hard I study and the grades I get.

24. a. A good leader expects people to decide for themselves what they should do.
    b. A good leader makes it clear to everybody what their jobs are.

25. a. Many times I feel that I have little influence over the things that happen to me.
    b. It is impossible for me to believe that chance or luck plays an important role in my life.

26. a. People are lonely because they don't try to be friendly.
    b. There's not much use in trying too hard to please people, if they like you, they like you.

27. a. There is too much emphasis on athletics in high school.
    b. Team sports are an excellent way to build character.

28. a. What happens to me is my own doing.
    b. Sometimes I feel that I don't have enough control over the direction my life is taking

29. a. Most of the time I can't understand why politicians behave the way they do.
    b. In the long run the people are responsible for bad government on a national as well as a local level.

APPENDIX D

Taylor Manifest Anxiety Scale

This questionnaire concerns personal comfort and situations which may make people feel either comfortable or uncomfortable. Indicate how you feel about these things by either circling T(true) or F (false), according to what your answer is. In some instances you may have trouble deciding between T and F because your answer seems to fall somewhere in between; in such cases, choose the answer that seems to be accurate most of the time. Do not leave any questions unanswered.

T F 1. I do not tire quickly.

T F 2. I am often sick to my stomach.

T F 3. I am about as nervous as other people.

T F 4. I have very few headaches.

T F 5. I work under a great deal of strain.

T F 6. I cannot keep my mind on one thing.

T F 7. I worry over money and business.

T F 8. I frequently notice my hand shakes when I try to do something.

T F 9. I blush as often as others.

T F 10. I have diarrhea ("the runs") once a month or more.

T F 11. I worry quite a bit over possible trouble.

T F 12. I practically never blush.

T F 13. I am often afraid that I am going to blush.

T F 14. I have nightmares every few nights.

T F 15. My hands and feet are usually warm enough.

T F 16. I sweat very easily even on cool days.

T F 17. When embarrassed I often break out in a sweat which is very annoying.

T F 18. I do not often notice my heart pounding and I am seldom short of breath.

T F 19. I feel hungry almost all the time.

T F 20. Often my bowels don't move for several days at a time.

T F 21. I have a great deal of stomach trouble.

T F 22. At times I lose sleep over worry.

T F 23. My sleep is restless and disturbed.

T F 24. I often dream about things I don't like to tell other people.

T F 25. I am easily embarrassed.

T F 26. My feelings are hurt easier than most people.

T F 27. I often find myself worrying about something.

T F 28. I wish I could be happy as others.

T F 29. I am usually calm and not easily upset.

T F 30. I cry easily.

T F 31. I feel anxious about something or someone almost all of the time.

T F 32. I am happy most of the time.

T F 33. It makes me nervous to have to wait.

T F 34. At times I am so restless that I cannot sit in a chair for very long.

T F 35. Sometimes I become so excited that I find it hard to get to sleep.

T F 36. I have often felt that I faced so many difficulties I could not overcome them.

T F 37. At times I have been worried beyond reason about something that really did not matter.

T F 38. I do not have as many fears as my friends.

T F 39. I have been afraid of things or people that I know could not hurt me.

T F 40. I certainly feel useless at times.

T F 41. I find it hard to keep my mind on a task or job.

T F 42. I am more self-conscious than most people.

T F 43. I am the kind of person who takes things hard.

T F 44. I am a very nervous person.

T F 45. Life is often a strain for me.

T F 46. At times I think I am no good at all.

T F 47. I am not at all confident of myself.

T F 48. At times I feel that I am going to crack up.

T F 49. I don't like to face a difficulty or make an important decision.

T F 50. I am very confident of myself.

APPENDIX E

Demographic Information Questionnaires

General Information Questionnaire
(Form Used for Pre-nursing Ss)

1. What year of school are you now in? (Circle one)

Freshman Sophomore Junior Senior Post-Baccalaureate

2. Do you have a nursing degree?

Yes No

3. How old are you? _____

4. Rate your parents' socioeconomic status:

1 under $5,000 (per year)
2 $5,000-$10,000
3 $10,000-$20,000
4 over $20,000

5. Indicate your sex: male female

6. What is your marital status?

Single Married Separated Divorced

7. What is your religious orientation?

1 Catholic
2 Jewish
3 Protestant
4 other--please indicate _____
5 None

8. How would you rate yourself in terms of your religious beliefs?

1 nonreligious
2 somewhat nonreligious
3 somewhat religious
4 religious

9. Rate yourself in terms of how comfortable you are with your religious beliefs or lack of religious beliefs:

1	2	3	4	5	6	7
very comfortable		somewhat comfortable		somewhat uncomfortable		very uncomfortable

10. How much recent personal experience with death have you had?

    1 none
    2 more than 5 years ago
    3 within 1-5 years
    4 within past year

11. What is your intended area of specialization in the nursing field?

12. Have you ever taken any seminars concerning the topic of death?

13. Have you done reading on the topic of death?

14. Have you ever been involved in any sort of group or individual discussions aimed at helping you to handle death?

15. Have you had any field experience in nursing? Yes No

    If you have, how often have you encountered death in this experience?

    1 never
    2 infrequently
    3 frequently
    4 very frequently

16. If your answer was "yes" on Question 13: How many patients with whom you were actually working died?

General Information Questionnaire

(Form Used for Texas Women's University Ss)

Social Security # _____

1. What year of school are you now in? (circle one)

   Junior Senior

2. How old are you?

3. Rate your parents' socioeconomic status?

   1 under $5,000 (per year)
   2 $5,000-$10,000
   3 $10,000-$20,000
   4 over $20,000

4. Indicate your sex: male female

5. What is your marital status?

   single married separated divorced

6. What is your religious orientation?

   1 Catholic
   2 Jewish
   3 Protestant
   4 other--please indicate _____

7. How would you rate yourself in terms of your religious beliefs?

   1 nonreligious
   2 somewhat nonreligious
   3 somewhat religious
   4 religious

8. Rate yourself in terms of how comfortable you are with your religious beliefs or lack of religious beliefs:

1	2	3	4	5	6	7
very comfortable		somewhat comfortable		somewhat uncomfortable		very uncomfortable

9. How much recent personal experience with death have you had?

   1 none
   2 more than 5 years ago
   3 within 1-5 years
   4 within past year

10. List the nursing rotations you had this past fall and currently are on. Be sure to include electives and locations of the rotations.

    Fall:

    Spring: (current)

11. How many of your past or current nursing rotations have been on wards where patients frequently died?

12. How many patients with whom you were actually working died?

13. How involved were you in the care of the patients indicated in Question 12?

14. What is your intended area of specialization?

15. Have you ever taken any seminars concerning the topic of death?

16. Have you ever been involved in any sort of group or individual discussions aimed at helping you to handle death?

17. Have you done reading on the topic of death?

APPENDIX F

Cover Sheet for Testing Materials

Please fill out each of the 5 questionnaires according to the directions at the beginning of each one. Be sure to answer all of the questionnaires and all of the items on each questionnaire.

When you finish one questionnaire, go onto the next one, and so forth, until you have completed the last one. Do them in the order they are presented in the booklet. After you have finished one questionnaire, go on to the next one and so forth until you have finished them all. As soon as you are finished with the booklet, hand it in. Please do not consult with your classmates concerning any of the questionnaires.

All of your answers to the questionnaires will be kept strictly confidential.

Thank you for your cooperation.

APPENDIX G

Post-Experimental Interview Format and Protocols

My name is Marina Granich. I'd like to ask your cooperation in gaining more information concerning your reactions to death and your experiences on the high death wards on which you worked.

1. What experiences have you had working in clinical settings where patients frequently died?

2. How involved were you with the patients there?

3. What was it like working on the high death wards as opposed to working on other wards?

4. How did you feel about working with seriously ill or terminally ill patients before you started working on (name of high death unit).

5. Did you experience any anxiety about going to (name of unit).

6. Did you find yourself going through any changes about dealing with dying patients during your rotation?

7. How did you handle any anxieties (feelings) you experienced while working with dying patients?

8. Did you find yourself becoming more comfortable about working with dying patients as you spent more time on the unit?

9. How has the meaning of death changed for you as a result of your experience of working with dying patients?

10. What kinds of issues struck you as important to keep in mind when working with dying patients?

low 1 scorer

1. ER, ICU, Medical unit.

2. Not very.

3. Wouldn't want to go into dying person's room..because I don't know about life and death.

4. My feelings didn't change that much..I didn't know if I would do the right thing...all the tubes were scary.

5. Yes...if I had no formal orientation...didn't know how things worked...I stayed away from a trauma until I felt I knew what to do.

6. After death and dying seminar felt she should be more responsible to patients to talk...still hasn't learned to accept it.

7. Talking with people were more experienced...asked others about procedure...learned not to be so nervous because it's just another person who needs care...do job to save them.

8. No longer so leary...dying is just another stage...have to help patients prepare for their concept of future life.

9. Doesn't view death so badly emotionally...not so frightened...because I have had information about death.

10. Sit down and talk and see if they have any unfinished business...are they prepared for death...it's so easy to avoid dying patients.

low 2 scorer

1. ICU: CCU; Neuro-ICU; Oncology.

2. Only really with one.

3. More exciting, more going on...when I keep active I feel more useful and involved.

4. Didn't bother me...when you get to know patients more it bothers you...as you get attached it bothers you.

5. Yes, but it was more the fact that it was a new rotation.

6. Not really...V.A. cancer unit is inhuman...an open ward with other patients around...I felt a loss in that I felt maybe I had not done all I could do..there's a sense of doom because all of them would die...this made me anxious and I didn't want to get too close to anyone because you knew they'd die.

8. I didn't get more comfortable...I just didn't get involved or so attached.

9. I see that death can happen to anybody, including myself... I more fear disfigurement, and catastrophes than actual death...life and death are close together.

10. Let patients be out of hospital as much as possible. Deal with patients...if they don't want to admit they're going to die, let them deny it...be sensitive to patient and family needs. Don't let the patient be too isolated... try to talk to the patient and provide emotional support.

low 3 scorer

1. Newborn ICU; ICU; CCU

2. Not very

3. Is more tension. You know something will happen..if you can't do anything, you just wait around until the patient dies..anxious, worried.

4. Like any other rotation.

5. Not in particular...there is always anxiety about going to clinical.

6. Not really. I was well set before I started. I had an aunt whom I was very close to die when I was 16. At that time, I went through all the stages of grief and avoided the situation...now I can handle death better and feel that sometimes death is better.

7. Talking it out with classmate/roommate...I confronted my feelings over a period of time..I dealt with my feelings, first, alone and then with others.

8. Yes, there was less anxiety about what I would do "if"... I trusted my own competence more.

9. Death is a more comforting idea, it can be a release. I accept death more easily. If I had a certain disease I might choose death to treatment.

10. Talking about situation with patient and family if they so desire.

low 4 scorer

1. Nero-ICU; burn unit. neurology

2. Some...2 very close.

3. Felt the same.

4. Scared of the disease process.

5. Yes.

6. The more I knew about what I was doing regarding nursing the more I felt comfortable and able to handle it... there's a lot of intricate machinery and I wanted to feel I was doing my best. I feel incompetent being a student.

7. With the first one I cried and with the others I accepted it. I have had several friends who died and had to work through my feelings about this....God's will.

8. Yes. Initially it was a shock..I didn't know what to do. As I felt more competent, I felt more comfortable.

9. I see death as God's will. Sometimes, in nursing, you can do just so much.

10. Family is important...you must look at the family's emotional and economic-social-physical needs.

    Personal experiences: Uncle: he was isolated from family...has had two friends who committed suicide (most traumatic).

low 5 scorer

1. MD Anderson-terminal cancer; CCU; ICU

2. Direct patient care...would talk to patients at MD Anderson. Hard to say how involved I was, was too upset.

3. It was more depressing...at home I would think about it.

4. I was scared of it and wondering if I would ever learn to cope with it.

5. Yes. I tried to rationalize it. I wondered if I would come out with the attitude of being able to accept death.

6. and 7. I faced up to patients. At first I was hesitant to talk with patients and later on I wasn't. My fears will always be there, I just learned to cope with them better. In terms of facing patients, my greatest fear was when a patient was not aware of their terminal diagnosis; my fear was that I would let something slip. I came to realize that everyone will die.

8. Yes, it became easier to talk to them about death..as I encountered death I had to think about it and came to grips with it. It was a function of the age of the patient in terms of how I'd react to death...sometimes I was angry.

9. Before I saw death as something horrible. Now I don't see it as so horrible, but as a function of the age and suffering of the individual.

10. Always try to give patients the opportunity to talk about death, themselves, their families.
Keep family comfortable. Be considerate. Spend time with them...give dying patients priority care.

Death and dying seminar (helped her to deal with own death but dealing with the death of others is a different matter).

low 6 scorer

1. ICU-ER- Cancer

2. Responsible for care.

3. There's a feeling of intensity. Something could happen anytime. You're more alert. It didn't upset me. You can't get all involved in the fact that the patients are dying. It messes up your competence.

4. Didn't know what to expect..wondered how I would react.

5. Not in relation to the fact that patients would die.

6. None really, except I saw how alone the patients were and how they need some support.

7. After I left the ward, I didn't think about it. If a patient is suffering, death is a good thing.

8. Yes. The more experience I got, the more comfortable I felt.

9. No. It's determined more by my religious ideas.

10. Patients seemed extremely lonesome..there's nothing you can do if a person is dying, except to make them as comfortable as possible and if they can talk, let them sit and talk.

low 7 scorer

1. MD Anderson; ICU

2. Very attached.

3. Patients very supportive of each other...knew a lot about their illnesses. Families were there. There's no way of knowing when a person will die. Death is inevitable for everyone. Wasn't depressed, didn't think more about death.

4. Wasn't familiar with hospital routines. Had nothing to compare it to. Wasn't scared.

5. No.

6. No.

7. Was very attached to one patient and knew this patient would die...couldn't go in to see him at the end. This made me angry and I decided that I would have to make a readjustment regarding my attitude toward death, cope with it differently. I talked with my roommate and strengthened myself. I started to think about the patients and their families and forgot about myself. Decided that I couldn't be of any use to anyone if I were upset.

8. Yes. Just being there, I got to know them as people. It (Anderson) was a family-type environment where the morale was high. It gave me a sense of hope.

9. I value life more and am less complaining and ungrateful about my own health. Death has become something real for me, I have thought it through. Has always had strong Christian beliefs and believes in afterlife.

10. Is more concerned with supporting patients and keeping their morale up than thinking about death. Be honest and let them always hang onto the ray of hope. Patient should know all about his disease process. Families: it's important to know that they're a support rather than a hindrance to a patient.

low 8 scorer

1. OCU, PD, Nursing home.

2. 5...medication nurse...deeply involved.

3. I didn't think about death, it would destroy me.. Potentially it's depressing. You wouldn't want to work with anyone for fear they'd die.

4. Was scared of it.

5. A lot.

6. Still scared but I've never been a person to think about death a whole lot..there are too many things in life to look at the bad...too busy.

7. My father died and I used it as a back-up mechanism. I knew I could make it through a death and that I can pick up the pieces and go on. I expressed my feelings and felt better.

8. Somewhat...How do you talk to a person that's dying..I learned to see them as normal people who are very sick and try to help them make the most out of their last days.

9. Life is much more important..I don't look at the end, but get the most out of every day, because I know that I won't be there forever.

10. I never had thought of dying patients as being different, unless they wanted to talk about death.

low 9 scorer

1. Cancer hospital, CCU

2. If they were still coherent, I tended to back away. A few became close friends. The more critical and imminent death was, the better able I was to handle regarding physical care and emotional aspect of being there. People are afraid to die alone.

3. Like it better...like to help people and I feel more needed there.

4. No effect.

5. Not really.

6. Not aware.

7. If I found myself avoiding a patient, I sorted out my reasons for shying away. Typically I felt no anxiety.

8. I couldn't work where everyone was terminal. It's too uncomfortable. I need to be around some hope. I did get more comfortable about being around death.

9. It hasn't really changed..my religion determines my idea of death..my family was open about death. They treated it as a fact of life and accepted it.

10. Family should be there.
Patient has a right to make his own decisions. Patient should be able to die if he wants to (e.g., pull the plugs).
Give good care and support. The specifics depend upon the individual.

Personal deaths: grandfather, great-uncle.

high 1 scorer

1. Oncology unit at St. Joseph's...M.D. Anderson...ICU

2. Not very emotionally involved.

3. Atmosphere different. For example, at Methodist orthopedic unit everyone was concerned with getting well. On high death units there's a different perspective. The patients know they'll die. The basic issue is what you can do to make a person comfortable. It makes me depressed.

4. I dreaded going over to M.D. Anderson. I was afraid of it. It was frightening to think of working with a dead body.

5. I dreaded going there. I don't like working with critically ill patients who need a lot of care. I would rather work where patients are being prepared for life.

6. I dreaded M.D. Anderson the longer I stayed there.

7. Through my spiritual beliefs (Christian)...life after death...though I'm still afraid of dying...my beliefs helped me cope with death because they gave me a sense of hope.

8. I got to be more uncomfortable..hated it...anxiety and thinking about death increased the longer I stayed there.

9. It hasn't changed...I have always been a Christian.

10. The quality of your rapport with a patient...most important thing is to assist the patient to cope with the situation...help him with his unfinished business such as his family...give spiritual support by listening to patients.

high 2 scorer

1. ER: Ben Taub, St. Luke's, M.D. Anderson, ICU.

2. Very attached.

3. It got to you...more pressure on you...had to talk to someone or cry...depressed.

4. Scary...didn't know what to expect or what was expected of me...responsibility...afraid something I might do would hurt patient.

5. Yes.

6. I became not so afraid of being around them...had never had anyone to talk to about death before...my anxiety lessened. I saw how others handled death and died. It gave me strength. (if they can do it, so can I).

7. Talking to someone...crying...I thought a lot about my own death and how I would react to it.

8. Yes...the fear of the unknown is not there anymore. I think of the dying patient as just another patient. Now when I work with dying patients I don't think about death so much.

9. I realized that it is something we all have to face. Before it was more difficult to picture myself as dead.

10. Most nurses avoid dying patients but these patients need someone to talk to most of all. It's important to be there and to be considerate.

high 3 scorer

1. ER, CCU, ICU, Med Surgery

2. Not very.

3. It's different knowing that a patient will be OK..with critical patients, you're not sure they'll be OK..It makes you want to try harder. What happens to them depends on you. What you do does make a difference. This can create tension. If they make it you feel satisfied. If not, you become psychically numb and try not to let it get to you; you get calloused.

4. It frightened and upset me, I tried to avoid them.

5. Yes.

6. The more I worked with patients, the more I thought about death and what I could do for them and their families. I also thought more about my own death.

7. Numbing...talking with other students and older R.N.'s.. worked through part of upset, tuned out part...thought a lot about death.

8. Depended upon the patient...got more comfortable working with older people and sudden death cases...still not comfortable with young or middle-aged people getting terminal illness...I put myself in their situation and it makes me uncomfortable.

9. It's something that's a lot more real to me. Now it is something that could happen to me or someone I love.

10. Length of time is important. It is different when a patient is hanging on versus a sudden injury or death. You get numbed more in a sudden death. It is important to pay more attention to the family. They need help. I take more care to assess my own feelings in the situation (e.g., how am I coping with the situation).

high 4 scorer

1. Oncology units (2); stroke and spinal cord unit; ICU

2. One not too much; other 6 weeks.

3. Depressing...though some sense of hope...concern for life and death.

4. Was skittish about it...didn't know how to handle self... what to do if I got upset.

5. Yes.

6. Not really...there's still some anxiety.

7. Played piano...ran out on fire escape and yelled...had had a death and dying workshop...discussed stages of grieving and tried to pinpoint stages of grieving in myself and others.

8. Yes...I had some positive experiences which gave me good feelings I experienced sense of mastery and success in talking to one man in ICU...felt I helped him.

9. No real change...I still see death as a loss and departure.

10. Dealing with family and letting patient be with family... little things like a smile or holding a hand...human things important...important to focus on the person rather than the illness...don't be casual about the situation...had been upset that the other ICU staff were so casual about death...for example, open heart surgery important to the patient but to staff it's just another operation.

high 5 scorer

1. TC hematology, ICU, Ben Taub Med Surg..M.D. Anderson

2. Some feelings total care.

3. Aware that death may occur any moment..more apprehensive, feel pressure.

4. Would like to avoid it.

5. Yes (had lost a son due to cancer).

6. At M.D. Anderson had fear of going there...but saw that the patients there got the best of care and that they've accepted the fact that they are dying. This makes it easier to work with them.

7. Avoided patients...death of son (one and one-half years ago) kept coming up. Would see someone similar age group or illness and it would bring back old feelings. At first I asked not to go to Anderson, but I was told that I had to work through it, so I went into psychotherapy to work through and confront my feelings. I feel that you can't avoid such feelings..once I was inside M.D. Anderson, I saw that it was just another hospital with its routines.

8. Yes...I had to interview patients and discuss their illness with them. (They had open diagnoses there). Regarding their feelings about the diagnosis. It was easier to talk to them knowing they knew and accepted their diagnoses.

9. All patients at M.D. Anderson aren't morbid people. They accept death as part of life...there are no answers to questions such as "why."

10. Nurses tend to avoid terminally-ill patients. At Anderson every effort is made to keep patients alive in hope for a remission...until remission a patient needs much external assistance.

    Sympathy/empathy: important to share feelings and realize that many times they will want to discuss their illness and you should do it with them...don't leave them alone.

    Try to help family of patient...financial burdens... knew what they were going through.

high 6 scorer

1. ER (2 sem.)-ICU-Cancer (Methodist)

2. More patient and gentle with terminal patients...with 1 or 2, watched them deteriorate.

3. Trying to take in everything I saw (re: machinery)... didn't hit her that it was much more critical than anywhere else.

4. Prefers working in critical care areas...was looking forward to it.

5. Yes...was worried about not being able to function, e.g., slowing down and shaking when precision needed...didn't want to make any mistakes.

6. No real changes.

7. Attached myself to 1 of nurses and asked what she would do or asked patients general questions, e.g., are they in pain, need drink.

8. Still needs more training...is more confident that I can function.

9. No real change...depends upon circumstances...with chronic cancer patients death is a relief...sudden death is harder to take for family and others...used to think the younger the patient was the worse the death. Now I don't take age into consideration as much.

10. Dignity of patients...change bed linen, gowns more often... try to talk to them, be there...think of their families.

Doesn't feel she can handle effectively helping patients accept their own death.

Doesn't want to work with cancer patients (e.g., slow death)...would rather avoid confronting this sort of dying process.