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The efficacy of a death education course for registered nurses and registered nursing students

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The Efficacy of a Death Education Course for Registered Nurses and Registered Nursing Students

By

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Hon.B.A. University of Ottawa, 1980
B.A. University of Ottawa, 1978
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School of Nursing 1974

Thesis

Submitted in partial fulfillment of the requirements for the Master of Arts degree
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Waterloo, Ontario
1982

One year of my life is bound

in this thesis.

What a year!

Acknowledgments

This page is dedicated to Dr. Robert F. Morgan, Ms. Charlotte A. Gibson and my thesis committee:

Dr. Stephen A. Chris

Dr. Delton J. Glebe

Dr. Frederick R. Binding

...thank you

ARCHABOLOGISTS DIG PSYCHOLOGISTS

A thousand years from now archaeologists dig and find evidence "psychologists" had been there. They dig up tools - it turns out tools, research tools, were very important to these people, and try to piece together the life patterns of these people.

They found two kinds of tools suggesting there were two different groups of psychologists. There were those who used "hard" tools and those who used "soft" tools.

The ones who used "hard" tools lived by trapping for small game. They set their traps (called "experiments" or "laboratories") and at the end of the day would go to see what they had caught in their traps. They'd find rats, rabbits, or pigeons, and sometimes parts of larger animals - a human eye or brain, a foot, an ear - but never larger animals intact.

Those with the soft tools used "nets". They caught larger animals in the nets, even groups of larger animals, but they could never hold them. The animals always got away.

In order to become a member of the tribe one had to make his own tool, a very arduous and painstaking process, which was called "graduate school". It was important to make a tool that looked different from anyone else's tool. If it looked too much like someone else's tool it was considerable cause for shame. There was an exception. If one's tool looked like the tools made in the shop of the old toolmaker that one worked with, it was not considered cause for shame, but a sign of respect.

Once one had made one's tool, and was accepted into the tribe there seemed to be some different patterns. Mysteriously, some buried their tools ten feet under the ground, left the tribe, and were never heard from again. Others sat and polished their tools for the rest of their life.

Moral: The freedom of academic freedom is largely academic.

Philip Rosenthal
Spring (1974)

Abstract

The purpose of this research was to determine the efficacy of a death education course on death anxiety and meanings toward dying for a group of registered nurses and registered nursing students. The dying and death course Quality Intervention with the Dying was 12 hours in duration, three hours per week for four weeks. The dependent variables were death anxiety which was measured by Templer's Death Anxiety Scale (1970) and meanings toward dying as measured by a modified Twenty Statements "What is Death?" Test (Bakshis, Correll, Duffy, Grupp, Hilliker, Howe, Kawales & Schmitt, 1974). The participants were tested before the course, immediately following the treatment and one month later.

The findings indicate that death anxiety did not change for the registered nurse group immediately following the treatment or one month later. The death anxiety of the registered nursing student group did not decrease immediately following the treatment but did decrease significantly one month later.

The responses to the modified Twenty Statements "What is Death?" Test indicated that the two experimental groups perceived dying as a subject area that should be discussed more often immediately following the treatment but this

perception was not maintained one month later. Other changes were not apparent immediately following the treatment for the registered nurse group yet the final outcome indicated that this group perceived dying less negatively one month later. The treatment evoked a strong emotional response in the nursing student group immediately following the course but the impact of the treatment was not maintained one month later.

The results suggest that this type of intervention programme has more lasting effects on the registered nurse group in comparison to the nursing student group.

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The Efficacy of a Death Education Course for Registered Nurses and Registered Nursing Students

Introduction

Dying and death are common experiences in the hospital environment. Nurses more often than any other health care personnel have the greatest amount of contact with the dying individual (Coyne, 1976; Fochtman, 1974; Glasser & Strauss, 1965; Kubler-Ross & Worden, 1977; Royal Victoria Hospital Report, 1976; Shusterman & Sechrest, 1973; Stoller, 1980; Warren, 1976). The nurse however, is not adequately prepared during his/her education and employment to deal effectively with the psychosocial needs of the dying individual and his/her family (Coyne, 1976; Fleming, 1976; Fochtman, 1974; Kastenbaum, 1967; Quint, 1967).

The purpose of this thesis is to determine the efficacy of a dying and death course: Quality Intervention with the Dying, on death anxiety and meanings toward death for a group of registered nurses and registered nursing students.

Chapter I

Review of the literature

The review of the literature is divided into five sections. These sections are attitudes of nurses toward dying and death, attitudes of nursing students toward dying and death, attitudes of nursing home personnel toward dying and death, theories relating to nurses behavior, and courses and seminars used as intervention strategies for nurses dealing with dying and death.

Attitudes of Nurses toward Dying and Death

According to Mandel (1981) fatigue, absenteeism and expostulation against the institution in which nurses are employed, result from a lack of awareness and freedom to express emotions experienced while caring for a dying individual. Mandel investigated the attitudes about death held by oncology nurses who worked in a hospital, nursing home and in the community. The nurses were divided into five groups to respond to statements related to their work. The issues that disconcert nurses most when working with chronically ill or dying individuals were expressed as a) the anger and guilt experienced, b) anxiety, c) lack of

skill and power, d) a sense of feeling overwhelmed, e) overidentification, f) depression and sadness, g) avoidance of the dying individual and h) confusion over the role of a nurse involved in the situation. Nurses cope with personal feelings about the individual's death through humour, an active personal life, and a belief in themselves that they are meeting the physical and psychological needs of the client.1. Concurrently, nurses recognize that one person is unable to meet the total needs of all clients and therefore deny issues surrounding aging, disease and death. Sharing thoughts, feelings and concerns with colleagues and other health care professionals was perceived as an effective coping strategy.

Shusterman and Sechrest (1973) investigated nurses' attitudes toward death and how these attitudes related to age, nursing experience, and death rate on the hospital unit. The nurses involved in the study were resistant to the investigation and therefore definitive conclusions were difficult. However, as age and experience increased for nurses, fear of death of others decreased while satisfaction with traditional care of the dying increased. Death anxiety and death rate on hospital wards were unrelated. Overall, Shusterman and Sechrest concluded that death anxiety appeared to be unrelated to many personality characteristics in the group of nurses studied.

The attitudes of professional and nonprofessional

nurses about dying children and death from three hospitals were compared on age, education, clinical area and experience (Fochtman, 1974). Attitudes toward death were assessed from reponses to a 24 item Likert scale questionnaire designed by the author. The concepts measured were: a) fear of death, b) religious orientation, c) desire for control over death, d) adequacy of educational preparation in nursing to deal with dying children, e) feelings regarding the prolongation of life and f) degree of composure in conversational situations with dying children and their families.

Educational or clinical experience did not affect attitudes towards death in this group of nurses. Differences were however, found on the basis of clinical area in which they worked. Those who worked with terminally ill children (in comparison to those who worked with children on benign and acute wards) were less likely to apply life saving measures, that is, to be less "recovery oriented" and more care and comfort directed. They had significantly less difficulty interacting with dying children and their families. This research indicated that it is the type, rather than the length of exposure to dying individuals which determines a nurse's attitude toward dying and death.

Gow and Williams (1977) results are discrepant with the finding of Fochtman in that type of agency was not related

to nurses' perception of dying and death. They compared nurses employed by community agencies, acute hospitals and chronic care facilities. Nurses who were greater than thirty years of age had more positive attitudes about caring for the dying.

Gow and Williams suggested that education and clinical training may be worthwhile in order to teach younger nurses what age has seemed to have taught older nurses about caring for the dying individual. The researchers caution that the low response rate from the acute hospital population makes it difficult to generalize these findings.

Folta (1965) found that nurses viewed death as peaceful, controlled, predictable, and as a natural termination of the life process but at the same time, death was perceived with a high degree of anxiety. Folta explained that these contradictory findings resulted because the response to the semantic factors measured death as an abstract concept while the anxiety scale measured death as a personal threat, and the sacred-secular scale measured death as a metaphysical phenomenon. She concluded that death is a complex multi-faceted constellation.

Palo Stoller (1980-81) examined the relationship between death related fears and the difficulty nurses experience when involved with dying and death in a hospital setting. The Lester (1967) subscales (fear of death of self, fear of death of others, fear of dying of self, fear

of dying of others), were used to measure fear of dying and death. The hospital situations were described through eleven statements which reflected a) nurse's presence at the moment of death, b)proximity to a dead body, c) provision of nursing care and d) unstructured interaction. The group of nurses was subdivided into categories of registered nurses and licenced practical nurses to determine if there were any response differences based on education.

The responses made by registered nurses indicated that death related fears effect responses to situations which required interaction with dying individuals, but had little influence over presence at the time of death, proximity to a dead body or provision of nursing care. The researcher suggested that defensive strategies used by the nurse break down during interaction with the dying client.

For the group of licenced practicing nurses, death related fears explained responses to situations when death was unanticipated, if they were left alone with the dead individual, and in an unstructured situation (when there was no specific task to perform). Although the licenced practicing nurses had greater death related fears and more difficulty in some areas in comparison to the registered nurses, this did not seem to influence or create difficulty for this group during interaction with the dying individual.

Palo Stoller concluded that the uneasiness in dealing with dying and death reported by the nurses in her study "is

more than a reflection of general fears related to dying and death" and fears related to dying and death promote "uneasiness in situations in which the nurse is unsure of the appropriate behavior" (1980-81, p. 93).

Popoff (1975) conducted a death and dying survey which involved 15,430 registered nurses from the United States and Canada. He found that the number of dying individuals the nurses had contact with had no influence on the nurses' fear of his/her own death. "This suggests that coming to terms with one's own death is not necessarily the result of cumulative experience with death and dying. Rather, in some cases it occurs as a one-time learning event." (Popoff, 1975, p. 17)

Popoff reported the following findings. Seventy percent of the survey respondents reported that they had received strength and support from a dying client. Nurses who felt confident in their ability to meet the psychosocial needs of a dying individual experienced satisfaction at least occasionally when caring for a dying individual (74%). Positive feedback from dying individuals or their families, feelings of fulfillment, and self confidence in providing care to the terminally ill client were correlated. Sixty-two percent of the nurses found that caring for a dying individual was more demanding than caring for a seriously ill individual. Seventy-seven percent of the nurses felt that priority care should be given to the dying

individual. Overall, these results indicate the need for nurses to develop the skills necessary to provide quality care for the dying individual since involvement provides feedback which leads to feelings of satisfaction and self confidence in providing terminal care.

Attitudes of Nursing Students toward Dying and Death

Golub and Reznikoff (1971) compared nursing students and graduate nurses using a questionnaire designed by Shneidman (1970). Differences were found between the two groups (not attributable to age), in the following areas: a) the influence of psychological factors upon death - graduate nurses, more so than student nurses ($p<.05$) believed that psychological factors influenced death; b) autopsy - graduate nurses were more agreeable than student nurses to having an autopsy done on themselves ($p<.001$); and c) life maintenance efforts - graduate nurses were less likely to respond with all possible efforts to maintain life than student nurses ($p<.01$).

There were no differences in responses among the group of graduate nurses when they were compared on the basis of nursing specialty and years of nursing experience. The authors suggested that nurses acquire and retain common attitudes through their nursing education and these attitudes are maintained through an identification process

with graduate nurses as a group.

Ohyama, Furuta and Hatayama (1978) studied the death anxiety of nursing students as a means to examine how the adolescent copes with death when immersed in the situation. They found that nursing students in the initial stages of training displayed higher death anxiety than the control group of students. After three years of nursing education and training, the nursing students anxiety decreased. Ohyama, Furuta and Hatayama suggest that nursing students are able to organize coping mechanisms which help them deal with death, by their third year of school.

Yeaworth, Kapp and Winget (1974) investigated the difference between freshmen and senior nursing students on attitudes and beliefs about dying and death. The results indicated that important shifts in attitudes related to dying and death occurred during their education. This influence was reflected in a greater awareness of feelings, more open communication and less stereotyped attitudes. The researchers suggest that observation studies are needed to determine if these attitude changes influence subsequent professional behavior.

Attitudes of Nursing Home Personnel toward Dying and Death

Howard (1974) looked at the way in which experience with dying individuals affected attitudes toward death. She chose nursing aides rather than registered nurses to eliminate the possible influence of education on attitudes toward death. Her findings indicate that witnessing a death in a nursing home creates an avoidance pattern toward dying individuals. Specifically, Howard states that "long-term employees and those who have witnessed a death are more likely to avoid conversations about death, to discourage others from engaging in such conversations, and to shield the patient from the fact of his own impending death" (Howard, 1974, p. 56). Attitudinal training for nursing aides was suggested.

Attitudes toward death among registered nurses, licensed practical nurses, nursing aides and nursing students were studied using a semistructured interview schedule by Pearlman, Stotsky and Dominick (1969). Overall, the results indicated that although the more skilled registered nurses and licenced practical nurses had more contact with dying individuals, they felt uncomfortable discussing death issues with the dying person. They favoured

further training related to dying and death issues. In contrast, the less experienced group felt more comfortable talking with dying individuals and felt inservice was unnecessary. Differences in religious background were noted: Catholic vs non-catholic personnel found comfort through their religion and tended to be more composed while interacting with the dying.

Theories Relating to Nurses Behavior

The initial step necessary before a nurse is able to interact effectively with a dying individual, involves recognition and expression of emotions and concerns related to this task (Bunch & Zahra, 1976; Chandler, 1976; Coyne, 1976; Crary & Crary, 1975; Eaton, Jr., 1976; Jacobi, 1976; Klagsbrun, 1970; Kneisl, 1968; Lowenberg, 1976; Powell, 1976; Sonstegard, Hansen, Zillman & Johnston, 1976). In the past, this aspect of patient/client care was not taught in nursing schools (Quint, 1967).

Caregivers distance themselves from the dying for the following reasons (Fleming, 1976): a) Inner perturbation stemming from feelings of vicarious suffering, vicarious disintegration, or personal anxiety about death; b) Educational deficiencies in nursing and medical training; and c) Lack of a verbal response repertoire from which to draw when interacting with the dying (p. 14).

Quint Benoliel (1974) suggests that nurses require the following perspectives to develop a humanistic orientation while caring for the dying: a) knowledge of the social, cultural, emotional, psychological, and biological dimensions of death as a human experience. b) Opportunities to identify, resolve, and accept feelings related to dying and death. c) An understanding of the social context within which behavior of the dying individual and family occur as well as appropriate assessment skills.

Glasser and Strauss (1965; Quint, 1966) present four types of awareness contexts which determine the patterns of interaction between the dying individual, his/her family, and the health care team. These include: 1. Closed awareness - this occurs when the client is not aware of his/her impending death but everyone else is aware of the situation. 2. Suspected awareness - this occurs when the client suspects what others are aware of, and the client attempts to confirm the suspicion. 3. Mutual pretense awareness - occurs when everyone pretends that the other is not aware of the situation although it is obvious that the individual is dying. 4. Open awareness - occurs when health care personnel and the client are aware of the situation and interact and respond to it appropriately.

Nurses learn to protect themselves from situations which may cause emotional upset, loss of control or to perform inadequately in their role as professionals (Quint,

1966). This task is difficult in all four awareness contexts but particularly during closed, suspected, and mutual pretense awareness. Two types of conversations that are stressful to the nurse are a) conversations in which the nurse must not reveal information to the dying individual (the physician has chosen not to inform the individual of his/her diagnosis/prognosis), and, b) those in which the individual wants to talk about his/her dying, but the nurse is unwilling or unable to do so.

Health care personnel working on a cancer unit perceived the clients as "walking dead" individuals (Klagsbrun, 1970). Klagsbrun suggested that this perception of the clients logically led to feelings of guilt in the nursing staff, which resulted in covert rejection of the clients' emotional needs. Weekly group consultation and discussion meetings exploring the dynamics of the nurses' feelings resolved the initial problems identified by the nurses and led to innovative methods in self-care for the dying individuals.

The relationship to death as a source of stress for nurses working in an intensive care area was examined by Price and Bergen (1977). The authors found that two conflicting themes emerged within the group of nurses. One theme centered around a sense of failure - in not being able to control illness and death. The other theme was that of doing "too much" for their clients and not allowing the

individual to die with dignity. The nurses were unable to define their relationship to death, according to Price and Bergen, because "unconsciously, the boundary was blurred between their awareness of being responsible for the care of an ill or dying patient and their feelings of being responsible for the occurance of the patients' illness or death" (Price & Bergen, 1977, p. 234). Although this conflict remained unresolved for the nurses, the identification of the problem and the conflict experienced, resulted in less diffuse feelings of anxiety for the nurses involved.

Vachon, Lyall and Rogers (1976) suggest that nurses have difficulty dealing with death because of the traditional female socialization process which discourages independence and competition in women. They feel that the death of an individual a) challenges the nurses need to nurture (to be a loving, caring individual and surrogate mother), b) increases her empathic sensitivity because of her role as careperson, and c) challenges harmonious relationships (which she has been taught to maintain at all expense) with other health care members. Anxiety results from the nurse's perception of the dying individual's needs and the nurse's need to continue to function as a nurse to other clients. Coping behaviors used by nurses to dissipate the anxiety without upsetting the status quo include covert criticism directed to the doctors and hospital - for

allowing this type of situation to occur, as well as displacement of negative feelings onto their nursing colleagues.

The authors found that the intervention of group meetings for nurses working in a cancer hospital, allowed nurses to recognize, understand and support one another in their feelings toward dying individuals and death.

Health care professionals find it difficult to provide an emotionally supportive environment for each other because they have learned to hide emotions, value detachment and to present emotional aloofness when confronted with death (Eaton, Jr., 1976). Death of an individual in the hospital is perceived as failure in the health care profession. Eaton suggests that doctors and nurses need to do their own "grief work" when an individual for whom they are caring dies. This type of grieving is different from the grief one experiences with the loss of a loved one. Grieving for a deceased client involves the sharing of feelings about the individual with colleagues and other health care members who participated in the client's care.

Care for the dying in an institution can be improved, according to Quint (1967, p. 246) by cooperative planning between medical staff and nurses, and by providing mutual support and guidance.

Ways to offer the nurse support to alleviate feelings of aloneness and isolation which he/she may experience when

interacting with a dying individual are a) reassurance that the nursing hierarchy is available for consultation and support when needed; b) a well defined support system among colleagues; and c) specific consultation time set aside for the nurse and his/her supervisor. (Sonstegard, Hansen, Zillman and Johnston, 1976)

Sonstegard et al. (1976) suggest that the nurse needs to work through the five stages of death and dying which are presented by Kubler Ross (1969). The five stages are denial and isolation, anger, bargaining, depression and acceptance.

Kastenbaum (1967) identified false reassurance, denial of death, changing the subject, fatalism (we are all going to die sometime) and discussion as the five responses made by staff when a dying individual initiates a conversation about death. When responses made by attendants and licenced practical nurses were combined, 82% of the participants chose responses other than discussion. Kastenbaum suggests that these results reflect a lack of knowledge regarding the appropriate response, rather than an inability to deal with this subject area.

Reardon Castles and Beckman Murray (1979) in contrast, defend the nurses' behavior toward the dying individual. They state "the constraints on nurses' time and nurses' behavior imposed by organizational policy and health system power hierarchies are not realistically addressed in the literature" (Reardon Castles & Beckman Murray, 1979, p.1).

The authors present information about organizational theory and suggest that nurses need to understand and integrate themselves into the power structure of the hospital as an institution, before change can occur.

Courses and Seminars Used as Intervention Strategies for Nurses Dealing with Dying and Death

Brown (1980) examined the effects of an inservice death education programme for nursing staff working in a chronic care hospital. The goals of the course (which was comprised of 10, one hour sessions) were to sensitize the nurses toward their own feelings about dying and death and to determine if this sensitization influenced the provision of terminal care. The results indicated that registered nurses and registered nursing assistants, increased their psychosocial knowledge of dying and death but, the registered nursing assistants reported a decreased confidence in their psychological care skills subsequent to the course. The nurses' death anxiety as measured by Templer's Death Anxiety Scale (1970) did not decrease significantly. Nurses who participated, reported increased communication among themselves and among other health care members. (Other health care personnel were given the opportunity to participate in the seminars.)

An unobtrusive measure used in this study was a content analysis of the nursing notes recorded in clients' charts, by the nurses who participated in the educational inservice programme. The randomly selected nursing notes which were examined before, during and after the course, indicated a greater awareness by the nurses, to the psychological needs of their clients. The nurses notes also indicated that nurses were not able to assess the meaning of the expressed needs, nor were they able to plan an intervention strategy based on the perceived needs of the dying individual.

In concluding, Brown suggested that a similar inservice education programme be provided to nursing home personnel, as they are the health care members who have the greatest contact with dying individuals in the present health care system in Canada.

Pearson (1980) investigated the effects of a 2 hour and thirty minute death education seminar on a group of student practical nurses. She used a pretest, posttest control group design in which the experimental group attended the death education seminar and the control group attended regular classes. There were no significant differences in death attitudes following the seminar, between the two groups.

Laube (1977) offered a two day workshop for nurses entitled "Grief in Life Threatening Situations". The researcher embedded Templer's Death Anxiety Scale (1970)

within the last 25 items of the Minnesota Multiphasic Personality Inventory (MMPI). The participants were pretested before the workshop, posttested immediately after the workshop, four weeks and three months later. There were no significant differences in nurses level of death anxiety immediately following the workshop however, the nurses' death anxiety did decrease significantly one month post workshop. This effect was not maintained for the three month posttest.

The effects of a small group counseling experience on the attitude of nurses (employed in high risk areas of the hospital), toward death and dying individuals was measured by Miles (1976). She compared nurses who registered for the course and experienced treatment, nurses who registered for the course but were placed on a waiting list, then experienced treatment (control group), nurses who did not register for the course (control group), and freshmen students from a local university (control group). The results indicate that the groups of nurses who experienced treatment developed a more positive attitude toward death and dying clients.

Murray (1974) studied the effect of a death education programme on the death anxiety of thirty registered nurses. There were no significant decreases in death anxiety (measured by Templer's Death Anxiety Scale, 1970), during the programme however, the nurses' anxiety did decrease

significantly four weeks following the programme. The author suggests that the decrease in death anxiety four weeks post programme may have occurred because the nurses were able to reflect upon, utilize and integrate the information received from the death education programme.

The Attitude, Behavior Change Programme (ABC), was an educational programme for nurses implemented at the City of Hope National Medical Center. The purpose of the programme was to teach nurses to communicate therapeutically with dying individuals and their families. The programme was thirty hours in length, and was comprised of ten sessions of classroom teaching and five sessions of clinical practice. It took place five days per week for a three week period.

Three quasi-experimental studies were designed to examine the impact of the ABC programme on nurses degree of comfort and skill when interacting with dying individuals, and to evaluate the impact upon the clients cared for by these nurses.

Padilla, Baker and Dolan (1975) found that participation in the programme by nurses significantly increased their knowledge in the area of thanatology. Nurses also developed more positive attitudes toward interactions with dying clients, and there was an increase in the number of expressive, client centered statements written per kardex while the number of instrumental, task oriented statements decreased.

Clients cared for by the nurses involved with the programme were less depressed, less hostile, and less anxious (as measured by the Multiple Affect Adjective Checklist), than clients cared for by nurses who were not involved with the programme.

Statement of the Purpose

The purpose of the present research is to determine if a course Quality Intervention with the Dying was an effective intervention strategy for decreasing death anxiety and creating more positive meanings toward dying individuals and death for a sample of registered nurses and registered nursing students.

Experimental Hypotheses

The experimental hypotheses that govern this research are:

1. The treatment will decrease the death anxiety for the group of registered nurses as measured by Templer's Death Anxiety Scale (DAS). Death anxiety will decrease immediately following the treatment and will remain decreased one month later.

2. The treatment will decrease the death anxiety for the group of registered nursing students as measured by Templer's Death Anxiety Scale (DAS). Death anxiety will decrease immediately following the treatment and will remain decreased one month later.

3. The treatment will have a positive influence on the meaning* of dying and death for the group of registered nurses as measured by the modified Twenty Statements "What is Death?" Test. The meaning of dying and death will become more positive immediately following the treatment and will remain positive one month later.

4. The treatment will have a positive influence on the meaning of dying and death for the group of registered nursing students as measured by the modified Twenty Statements "What is Death?" Test. The meaning of dying and death will become more positive immediately following the treatment and will remain positive one month later.

*Meaning is defined on page 32.

Chapter II

Method

Registered nurses and registered nursing students in Southwestern Ontario were offered a 12 hour dying and death course: Quality Intervention with the Dying. Both registered nurses and registered nursing students were included in this study to determine for which group this type of intervention stategy is most effective. The course was offered to the participants without a registration fee in return for the research data.

Participants

The total number of participants (two experimental and two matched control groups) in this study was 145. The group of registered nurses and the matched control group were employees of four hospitals in Southwestern Ontario. The registered nurse control group was matched according to the number of participants from each of the hospitals. That is, if 10 registered nurses from the experimental group came from one specific hospital, approximately 10 registered nurses from that hospital were part of the control group. Each registered nurse in the experimental group was asked to

recruit one or two registered nurses from their specific nursing specialty area to act as the registered nurse control group. Nurses were asked to recruit one or two nurses to ensure that the control group would have an equal or greater number of participants in comparison to the experimental group. It was explained to the registered nurse experimental group that this was a task they were being asked to complete since all the nurses who expressed a desire to participate in the course and research were given the opportunity to do so. (The needs of the nurses as well as the needs of the researcher were taken into account. Therefore, all the nurses who expressed an interest in the programme were accepted into the programme, rather than accepting only the ideal number to accommodate the research project.) There were 42 participants in the registered nurse experimental group and 45 participants in the registered nurse control group.

There were 48 participants in the registered nursing student group, 19 in the experimental group and 29 in the control group.

The registered nursing students were taken from two schools of nursing. The experimental group was from one school of nursing and the registered nursing student control group was from another school of nursing in Southwestern Ontario.

It was necessary to go to another school of nursing for

the control group to prevent contamination of the control group. Nursing students have frequent clinical conferences as part of the nursing education process. Each conference group involves 6 - 10 nursing students. Initially 50 percent of the nursing students expressed an interest in participating in the dying and death course, therefore making it possible that the information learned from Quality Intervention with the Dying would be shared with their classmates during the clinical conferences. In the hospital setting, there is a clinical conference following each eight hour shift that the nursing students work. Both groups of registered nursing students were pretested five months prior to their date of graduation. The dying and death modules in the schools of nursing were completed during the winter term of the first year.

Procedure

The registered nurses in the four participating hospitals were given an information sheet which described the dying and death course and explained that it was part of a research project. The nursing supervisor distributed the information sheets to each head nurse in the hospital who in turn, made them available to their staff nurses. The course was offered without a registration fee in return for the nurses' cooperation in completing three questionnaire

packages. Those who were interested in participating were asked to print their name and telephone on the information sheet and to return it to the nursing office by December 21, 1981. See Appendix A.

The registered nursing students were given a similar information sheet which described the dying and death course and explained that it was part of a research project. The information sheets were distributed while they were gathered as a class. The students who were interested in the research were asked to print their name and telephone number on the information sheet and to return it to the researcher. The students who were not interested in participating were asked to return the information sheet to the researcher blank. This was done to ensure that the nursing students would not be pressured in any way, to participate. See Appendix A.

One week before the course was scheduled to begin, the researcher contacted each participant by telephone to confirm his/her registration in the course. (Each participant was again contacted the day the course was to begin because a paralyzing snowstorm postponed the commencement of the course by one week.)

Setting

The dying and death course Quality Intervention with the Dying was held at Wilfrid Laurier University. A consent form was signed by the participants before any information was collected (Appendix B). The first questionnaire package was completed immediately before the course began, and the second questionnaire package was completed immediately after the course was over, at Wilfrid Laurier University. The third questionnaire package was completed one month later in a classroom setting at the individual hospitals and schools of nursing.

The matched control groups were initially asked to complete a consent form (Appendix B) and two questionnaire packages which were administered one month apart in a classroom setting at each hospital and the school of nursing. The participants were then contacted a third time to complete an additional questionnaire package which was the equivalent to the package given to the experimental group one month after the course. Twenty registered nurses in the control group and 15 registered nursing students agreed to complete the third questionnaire package.

Dying and Death Course

The dying and death course Quality Intervention with the Dying was conducted by Dr. Delton Glebe, Dean, Waterloo Lutheran Seminary. The course was 12 hours in duration, three hours per week for four weeks.

The perspectives needed to develop a human orientation while caring for the dying individual suggested by Quint Benoliel (1974) were the dimensions of the course. The perspectives, as stated earlier are a) knowledge of the social, cultural, emotional, psychological and biological dimensions of death as a human experience. b) Opportunities to identify, resolve and accept feelings related to dying and death. c) An understanding of the social context within which behavior of the dying individual and family occur as well as appropriate assessment skills. The psychodynamics of the grief reaction were explained in the first class by Dr. Glebe. Dr. Peter Van Katuyk, the Director of Interfaith Pastorial Counseling was the guest lecturer for class two. He discussed family systems and loss. Eleanor Wasserman, a Registered Nurse and Oncology Co-ordinator at Mount Sinai Hospital in Toronto lectured on patient and family reaction to terminal illness at the third class. The fourth class involved a grief reaction exercise, some lecture and discussion directed by Dr. Glebe.

It was necessary for the participants to attend a

minimum of three classes to be included in the research.

Research Feedback

Research feedback was provided to each participant. See Appendix C.

Dependent Variables

The dependent variables were death anxiety which was measured by Templer's Death Anxiety Scale (1970) and meanings toward death as measured by a modified Twenty Statements' "What is Death?" Test (Bakshis et al., 1974). Each questionnaire package was introduced by a cover letter which provided instructions for the participants. The cover letters for the pretest, posttest one and posttest two for the experimental groups are presented in Appendix D. The cover letters for the first testing session, the second testing session and the third testing session for the control groups are presented in Appendix E.

Templer's Death Anxiety Scale (DAS)

Templer (1970, 1971; Templer & Ruff, 1971) has developed a death anxiety scale composed of true and false questions related to death. The reliability and validity

of the DAS has been established (Templer, 1970). The test - retest reliability of the DAS is .83. The correlation coefficient between the DAS and Boyar's Fear of Death Scale (1964) is .74.

The score is based on the tabulation of the items the participant chooses which are the same as the true - false key for the scale. A high score on the death anxiety scale indicates a high level of death anxiety. "Although no actual norms have been established for the Death Anxiety Scale (DAS), a considerable amount of relevant data has been collected both during and subsequent to its construction and validation" (Templer & Ruff, 1971, p. 173). Scale scores range from 0 - 15. Normal individuals score from 4.5 to 7.0 with a standard deviation of 3. Psychiatric patients with high death anxiety had a mean score of 11.62 with a standard deviation of 1.96. Females score slightly higher on the DAS than males (Templer & Ruff, 1971). Murray (1974) found that nurses had a DAS score of 6.70 with a standard deviation of 2.34 before a death education programme and 6.36 with a standard deviation of 2.04 one month following the programme. This test was selected for the research because it is reliable, valid and can be completed quickly. See Appendix F.

The Twenty Statements "What is Death?" Instrument

The Twenty Statements "What is Death?" test, developed by Bakshis, Correll, Duffy, Grupp, Hilliker, Howe, Kawales and Schmitt (1974), is a new method of operationalizing "meanings" individuals have toward death. It is "uniquely appropriate for tapping the social, symbolic, and contradictory meanings that are often held of death" (Bakshis et al., 1974, p. 161). "The term "meaning" stems from the symbolic interactional tradition in sociology, involves a broader context than the attitude concept, and focuses upon the probable "plans of action" that actors attribute to social objects, and their relationship to the individual and joint or social acts of persons."(Bakshis et al., 1974, p. 161) "A social object may be defined as any thing, idea, event, or state of affairs to which distinctive meaning is attached by the norms of a given group".(Kuhn, 1964, p. 659) The Twenty Statements Test (TST) was originally developed by Kuhn and McPartland (1954) to measure self attitudes.

Twenty numbered blank lines are provided for the participant to respond to the question "Who Am I?". According to Bakshis, et al., (1974, p. 162) the TST has the following major advantages:

1. It involves a sociological-social psychological

conception of the self as the individual relates himself to the social context into which he has been socialized, including the positions he occupies, the roles he enacts, the identities he has internalized, the reference groups and reference individuals with which he has become positively or negatively identified, and the social objects and categories that have become meaningful to him and toward which his thoughts and actions are directed.

2. The TST elicits the set of salient and conscious cognitive and evaluative attitudes that the actor has toward his own person as a social object.

3. The theoretical assumptions behind, the methodological assumptions of, and the results generated via the TST have been recently subjected to careful and extensive scrutiny (Spitzer & Stratton, 1971).

4. The TST is the most frequently used sociological measure of the self (Spitzer & Stratton, 1971, p. 5).

5. "The quantity of validity information available on the TST is at least equal to or greater than that available on other instruments of

self-concept."(Spitzer & Stratton, 1971, p. 65)

6. There are numerous scoring procedures that can be applied to the TST (Spitzer & Stratton, 1971).

7. The TST can be reliably coded (Spitzer & Stratton, 1971).

8. Variables operationalized from the TST have been found to be correlated with a wide variety of "behaviors"(Spitzer & Stratton, 1971, p. 73-111).

9. The TST can be administered with a minimun of effort.

10.The format of the TST can be extended to other social objects (Spitzer & Stratton, 1971, Schmitt & Grupp, 1973).

11.The TST is compatible with certain aspects of symbolic interactionism and reflects the following assumptions: the self is a social object and consists of a complex set of meanings, the actors' perspectives are representative of reality, and meanings and social objects exist in clusters.

For the Twenty Statements "What is Death?" instrument (Bakshis et al., 1974) twenty numbered blank lines are provided for the participant to respond to the question "What is Death?". This test was originally administered to 79 registered nurses who had experience and exposure to death. Seventeen coding categories were generated by the authors based on the "What is Death?" protocals. Test responses were coded twice by independent coders. The reliability index (the number of statements coded by two independent coders into a category was divided by the total number of all the statements coded by two independent coders into the category, and multiplied by 100) ranged from 80 to 96 percent.

The Twenty Statements "What is Death?" instrument was modified for this research so that the participant was requested to respond to the question "What is Dying?". It was felt that the question "What is Death?" was passive or after the fact, whereas, "What is Dying?" would tap the more active process of dying and death. Dr. Raymond Schmitt, one of the co-authors of the Twenty Statements "What is Death?" Test was personally contacted by telephone in December, 1981 regarding this modification. Dr. Schmitt agreed that the "What is Dying?" question was more process oriented and that "What is Dying?" may, in fact, be a better statement because of the "symbolic interaction". He also felt that the 17 categories derived from the "What is Death?" instrument

would still apply but cautioned that additional categories may need to be created in a post hoc manner.

See Appendix G for a copy of the modified Twenty Statements "What is Death?" Test.

Background Information Questionnaire

This questionnaire was developed by the researcher to gather additional information about the participants. This questionnaire was administered to the experimental and control groups as part of the pretest questionnaire package. A self report absenteeism question was included because nurses in general cope with death related problems by avoidance and non-involvement (Quint Benoliel, 1976). If one could visualize a continuum of avoidance strategies, emotional detachment would fall on one extreme and absenteeism on the other extreme.

See Appendix H for a copy of the Background Information Questionnaire.

Follow Up Questionnaire (Experimental Group)

This questionnaire (see Appendix I) was included in the second questionnaire package which was administered to the experimental group immediately following the completion of the dying and death course. Question one was taken from Miles (1976) to determine if the participants perceived a change in themselves regarding their attitude toward dying clients. Question two was asked to determine whether the participants perceived a change in their ability to meet the psychosocial needs of the dying client. An assessment of the quality of nursing education with regard to dying and death was included (question 3) to determine if the situation had changed. Quint (1967) states that nurses are inadequately prepared in their nursing education to deal with this aspect of client care.

Follow Up Questionnaire (Control Group)

This questionnaire (see Appendix J) is similar to the Follow Up Questionnaire which was completed by the experimental groups. This questionnaire was administered to the control group.

Questionnaire Three (Experimental Groups)

See Appendix K for a copy of Questionnaire Three.

Chapter III

Results

Hypothesis one was not supported. The death anxiety of the registered nurses did not decrease immediately following the treatment or one month later. Hypothesis two was partially supported. The death anxiety of the registered nursing students did not decrease immediately following the treatment but did decrease significantly one month later. Hypothesis three was partially supported. The registered nurses significantly decreased the number of negative statements about dying one month following the treatment but this decrease was not apparent immediately following the course. Immediately following the course registered nurses perceived dying as a subject that should be discussed. This perception was not maintained one month later. The registered nurse control group decreased the number of positive statements about dying during the second testing period (posttest one). Hypothesis four was partially supported. The registered nursing students significantly increased the number of discussion about death statements and affective, reminiscing statements immediately following the treatment. These increases were not maintained one month later.

Additional analyses of self report questions indicate that the two experimental groups perceived a change in their attitudes toward dying patients and felt more able to meet the social psychological needs of a dying client after the treatment. Seventy-three percent of the participants perceived their nursing education as inadeqately preparing them to meet the social psychological needs of a dying client.

Statistical Analyses

A priori contrasts for the pretest, posttest one and posttest two were tested by the *t* statistic for the four groups of participants.

Table one represents the percentage of registered nurses representing each participating hospital.

Table 1

Percentage of Registered Nurses Representing Each Participating Hospital

Hospital	Experimental Group		Control Group	
	Number	Percent of total group	Number	Percent of total group
A	25	60%	23	51%
B	11	26%	15	33%
C	5	12%	7	16%
D	1	2%	-	-
Total	42		45	

Major Analyses

Death Anxiety: Templer's Death Anxiety Scale (1970)

Table two presents the mean death anxiety scores of the four participating groups.

Table 2

Death Anxiety Scale Mean Scores

Group	Pretest			Posttest1			Posttest2		
	$\bar{x}$	SD	(n)	$\bar{x}$	SD	(n)	$\bar{x}$	SD	(n)
Reg. N. Experimental	7.5	2.4	(42)	7.6	2.1	(42)	7.0	2.3	(42)
Reg. N. Control	7.6	2.4	(45)	7.3	2.8	(45)	6.6	3.2	(20)
Student Experimental	7.8	2.8	(19)	7.7	2.8	(19)	6.8*	2.9	(19)
Student Control	8.3	2.4	(29)	7.5	2.8	(29)	7.5	3.3	(15)

*$p < .01$

Hypothesis one predicted that the treatment would decrease the death anxiety for the group of registered nurses as measured by Templer's Death Anxiety Scale (DAS). This decrease was to occur immediately following the treatment and to remain decreased one month later. Hypothesis one was not confirmed. The death anxiety did not

decrease immediately following the treatment or one month later for the experimental group of registered nurses.

The death anxiety did not decrease on the second testing period (posttest one) or the third testing period (posttest two) for the registered nurse control group.

Hypothesis two predicted that the treatment would decrease the death anxiety for the group of registered nursing students as measured by Templer's Death Anxiety Scale (DAS). This decrease was to occur immediately following the treatment and to remain decreased one month later. Hypothesis two was partially confirmed. The death anxiety for the nursing student experimental group did not decrease immediately following the course Quality Intervention with the Dying. However, it did decrease significantly one month later, $t(18)=3.17$, $p<.01$.

The death anxiety did not decrease on the second or third testing period for the nursing student control group.

Figure one summarizes the results of Templer's Death Anxiety Scale for the four participating groups.

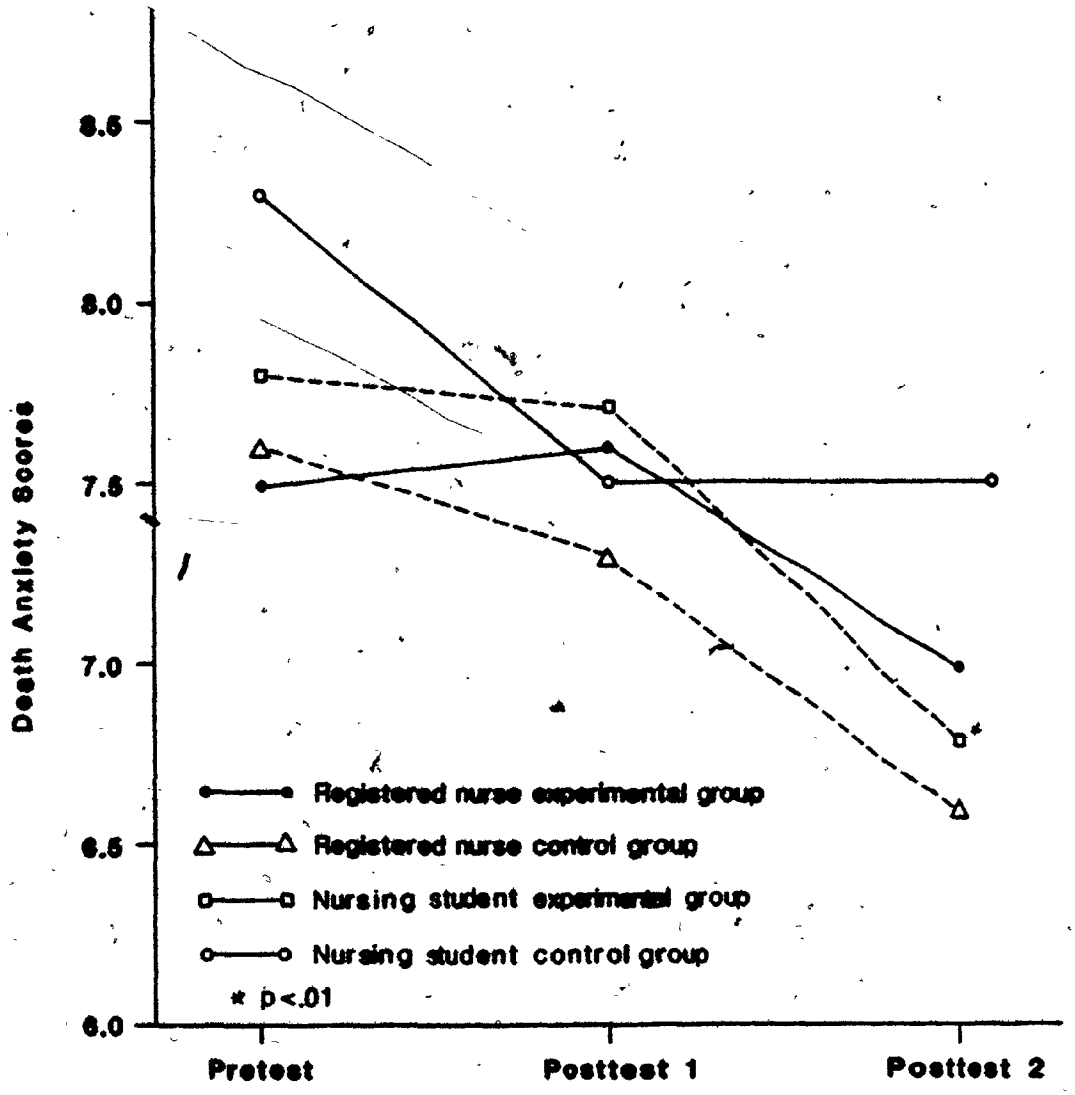

Figure 1 Templer's Death Anxiety Scale (1970) Scores for the Participating Groups

The modified Twenty Statements "What is Death?" Test (Bakshis et al., 1974)

The responses to the modified Twenty Statements "What is Death?" Test were content analysed by the researcher and one other independent analyst. Each statement was categorized into the 17 categories developed by Bakshis et al. (1974). The coding schemes for the 17 categories are presented in Appendix L.

The percent reliability was calculated by dividing the number of statements in which the two analysts were in agreement by the total number of statements and multiplying by 100. The reliability ranged from 75 percent to 100 percent with a mean of 94 percent.

The statements that did not fall within the 17 categories were compiled into an 18th category on the initial analysis. Each statement in the 18th category was recorded on individual index cards and sorted into nine additional categories according to theme by the researcher. The statements were recategorized by the second analyst. It was necessary for both analysts to agree upon the theme in which each statement was sorted. The statements coded as 18 were then coded into the nine additional categories by the researcher. A random sample of questionnaires was recoded by the second analyst into the additional nine categories. The percent reliability was calculated by dividing the number of statements in which the two analysts were in agreement by the total number of statements randomly

selected, and multiplying by 100. The reliability ranged from 95 percent to 100 percent with a mean of 96 percent. The coding schemes for the additional nine categories are presented in Appendix M.

The number of times that each category was chosen by the four participating groups was tallied. Furthermore, the mean number of times each category was chosen was compared with a priori contrasts between a) the pretest and the posttest one, b) the pretest and the posttest two, and c) the posttest one and the posttest two. This indicated if the responding had changed immediately after the treatment and one month later, from the pretest score. The mean number of times that each category was chosen for the four participating groups are presented in Appendix N.

Four of the 26 categories specifically indicate positive or negative meanings toward dying and death. The remaining 22 categories have themes that indicate a neutral connotation toward dying.

The four categories which were used to determine if the treatment had a positive change effect on the meaning of dying and death for the participating groups are:

Category seven: General Favourable Reference

Any statement that contains (1) a direct or (2) indirect (3) favourable reference.

Category eight: Explicit Unfavourable Reference

Any statement that contains (1) an explicit (2) unfavourable reference.

Category 17: Explicit Discussion of Death

Statements that (1) explicitly (2) indicate that death should be discussed or (3) is hard to talk about.

Category 27: Affective, Reminiscing Reference

Any statement that has a (1) positive affective quality or indicates that dying is (2) a time to reminsce or (3) a time to say goodbye.

Hypothesis three predicted that the treatment would have a positive influence on the meaning of dying and death for the group of registered nurses as measured by the modified Twenty Statements "What is Death?" Test. The meaning of dying and death was to become more positive immediately following the treatment and to remain positive one month later. Hypothesis three was partially supported. The results of this hypothesis are presented according to the four categories outlined earlier which were used to determine if the treatment had a positive change effect on

the meaning of dying and death.

Figure two summarizes the results of the modified Twenty Statements "What is Death?" Test for the registered nurses.

Category seven: General Favourable Reference statements

It was predicted that the number of general favourable reference statements would increase immediately following the treatment and remain increased one month later for the registered nurse experimental group. There was not a significant increase in the number of favourable reference statements for this group.

The registered nurse control group recorded a significantly lower number of favourable reference statements from the the first testing session (pretest) to the second testing session (posttest one), $t(44)=2.35$, $p<.05$. The decrease in general favourable reference statements was not evident on the third testing period (posttest two).

Category eight: Explicit Unfavourable Reference statements

It was predicted that there would be a significant decrease in the number of explicit unfavourable statements for the registered nurse experimental group immediately following the treatment and one month later. However, there

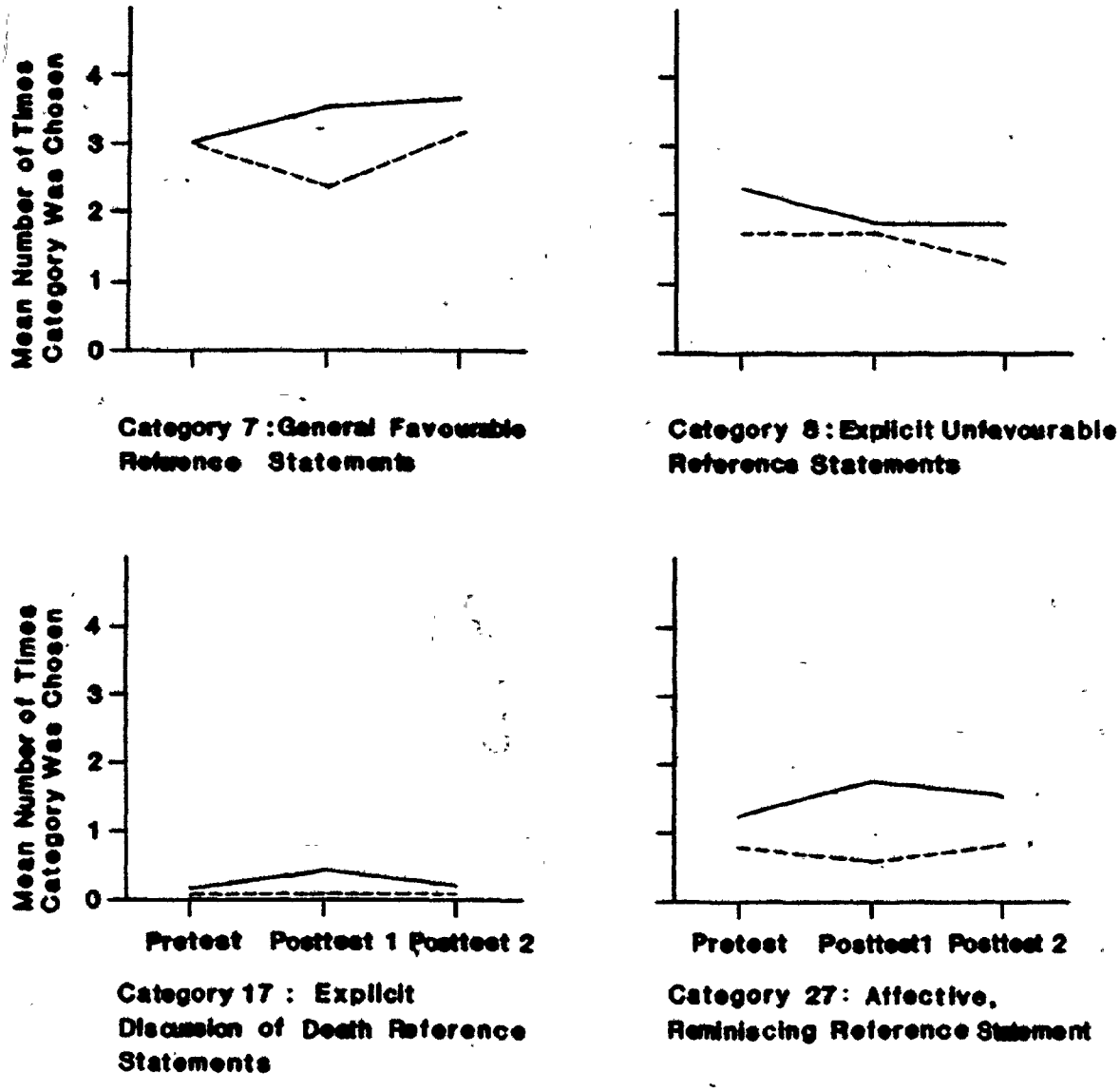

Figure 2 Mean Number of Times the Registered Nurses Chose the Four Categories Which Indicate Positive Meanings Toward Dying and Death

was not such a decrease in the number of explicit unfavourable statements for the registered nurses immediately following the treatment. There was a significant decrease in the number of unfavourable reference statements for this group one month following the treatment, $t(41)=2.01$, $p<.05$.

There was no change in the number of explicit unfavourable reference statements for the registered nurse control group during the second testing period (posttest one) or during the third testing period one month later.

Category 17: Explicit Discussion of Death statements

It was predicted that the number of explicit discussion of death statements would increase significantly immediately following the treatment and one month later. The registered nurse experimental group did significantly increase the number of explicit discussion of death statements immediately following the course, $t(41)=-2.94$, $p<.01$. However, this increase was not maintained one month later.

The control group did not show any change in this category.

Category 27: Affective, Reminiscing Reference statements

The number of affective, reminiscing reference statements was predicted to increase for the registered

nurse experimental group immediately after the treatment and one month later. However, there was actually no change in the number of affective, reminiscing reference statements immediately following the course or one month later for this group of participants.

There was no change in the number of affective, reminiscing statements for the registered nurse control group during the second testing period (posttest one) or one month later during the third testing period.

Hypothesis four predicted that the treatment would have a positive influence on the meaning of dying and death for the experimental group of registered nursing students as measured by the modified Twenty Statements "What is Death?" Test. The meaning of dying and death was to become more positive immediately following the treatment and to remain positive one month later. Hypothesis four was partially supported. The results of this hypothesis are presented according to the four categories used to determine if the treatment had a positive change effect on the meaning of dying and death.

Figure 3 summarizes the results of the modified Twenty Statements "What is Death?" Test for the nursing students.

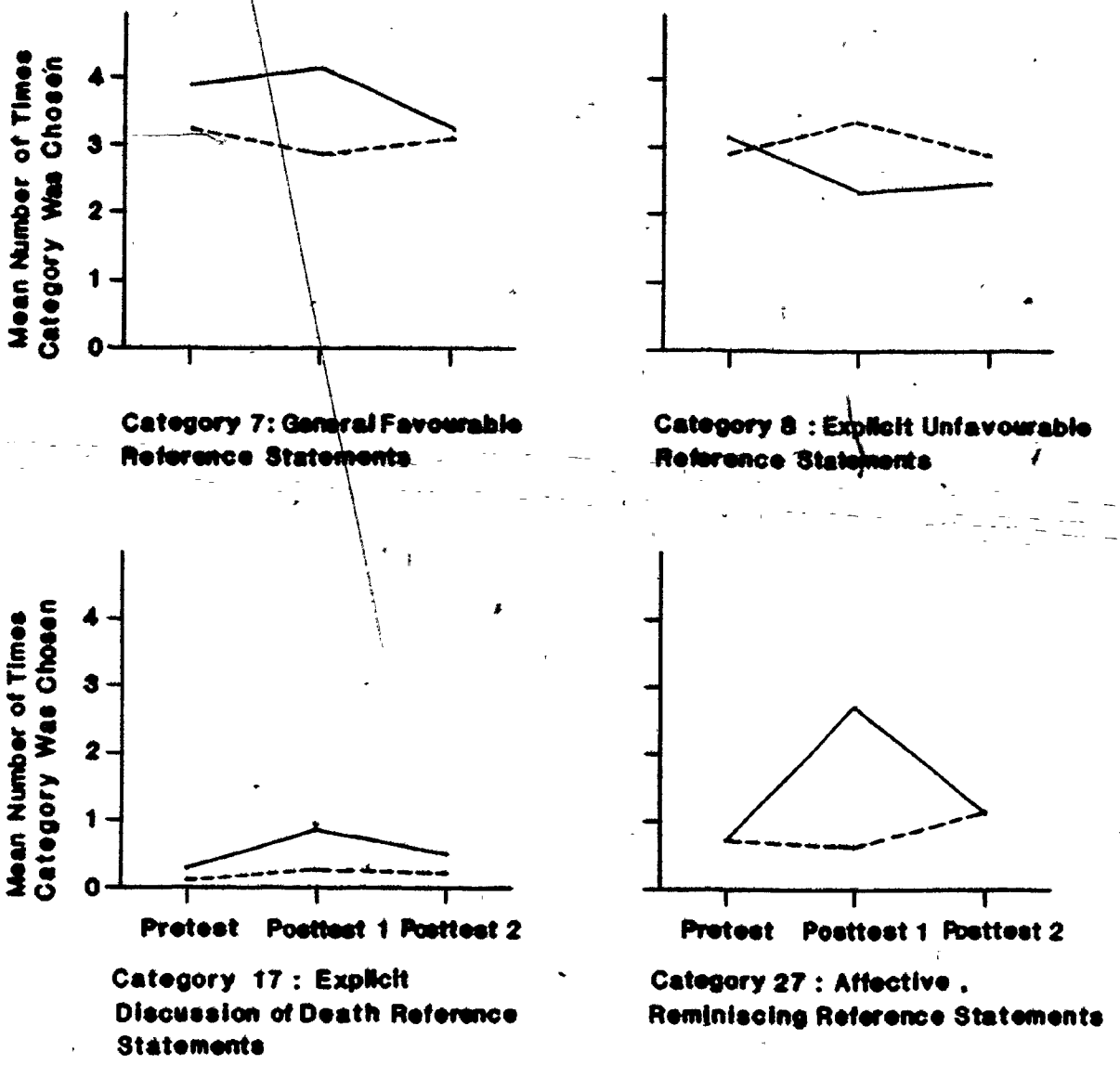

Figure 3 Mean Number of Times the Nursing Students Chose the Four Categories Which Indicate Positive Meanings Toward Dying and Death

Category seven: General Favourable Reference statements

It was predicted that the number of general favourable reference statements would increase immediately following the treatment and one month later for the nursing student experimental group. However, there was not a significant increase in the number of favourable reference statements for this group.

There was no change in the number of favourable reference statements made for the nursing student control group during the second testing period (posttest one) or one month later (posttest two).

Category eight: Explicit Unfavourable Reference statements

It was predicted that there would be a significant decrease in the number of explicit unfavourable reference statements for the nursing student experimental group immediately following the treatment and one month later. There was no change in the number of explicit unfavourable reference statements immediately following the course or one month later for this group.

The student control group did not change in their responding for this category during the second testing period (posttest one) or one month later (posttest two).

Category 17: Explicit Discussion of Death statements

It was predicted that the number of explicit discussion of death statements would increase significantly immediately following the treatment and one month later. The nursing student experimental group significantly increased the number of explicit discussion of death statements immediately following the treatment $t(18)=-2.46$, $p<.05$. This increase was not maintained one month later.

There was no change in the number of explicit discussion of death statements for the student control group during the second testing period (posttest one) or during the third testing period, one month later.

Category 27: Affective, Reminiscing Reference statements

The number of affective, reminiscing reference statements was predicted to increase for the nursing student experimental group immediately after the treatment and one month later. There was a significant increase in the number of affective, reminiscing reference statements immediately following the course for the student experimental group, $t(18)=-3.90$, $p<.01$. However, this increase was not maintained one month later.

There was no change in the number of affective, reminiscing reference statements for the student control group during the second testing period (posttest one) or one

month later during the third testing period.

The results of the modified Twenty Statements "What is Death?" Test for the experimental groups are presented in Table 3.

Table 3

Summary of the modified Twenty Statements "What is Death?" Test

Categories	Pretest $\bar{x}$ (SD)	Posttest1 $\bar{x}$ (SD)	Posttest2 $\bar{x}$ (SD)
Registered Nurse Experimental Group			
7	3.04 (2.35)	3.45 (2.18)	3.57 (2.42)
8	2.40 (2.19)	1.92 (1.71)	1.92* (1.77)
17	.11 (.32)	.42** (.59)	.26 (.44)
27	1.26 (1.86)	1.76 (2.00)	1.50 (1.70)
Nursing Student Experimental Group			
7	3.94 (1.80)	4.10 (1.76)	3.26 (1.93)
8	3.15 (2.16)	2.42 (2.09)	2.52 (2.11)
17	.26 (.73)	.89* (1.14)	.47 (.96)
27	.84 (.95)	2.78** (2.12)	1.21 (1.65)

** $p < .01$ from the pretest score

* $p < .05$ from the pretest score

To summarize, the findings of the major analyses indicate that Hypothesis one was not supported. The death anxiety of the registered nurses did not decrease immediately following the treatment or one month later. Hypothesis two was partially supported. The death anxiety of the registered nursing students did not change immediately following the treatment but did decrease significantly one month later.

Hypothesis three was partially supported. The registered nurses decreased significantly the number of explicit unfavourable reference statements one month after the treatment but this decrease was not apparent immediately following the course. The explicit discussion of death reference statements increased significantly immediately following the course but was not maintained one month later. The registered nurse control group significantly decreased the number of general favourable reference statements during the second testing period (posttest one) but this decrease was not maintained one month later.

Hypothesis four was partially supported. The number of explicit discussion of death statements and the number of affective, reminiscing reference statements increased significantly following the treatment for the registered nursing student experimental group. These increases were not maintained one month later.

Additional Analyses

Self Perception of Attitude Change

The experimental groups were asked two questions to determine if they had perceived a change in their attitude and ability to care more effectively for a dying individual. The first question asked the participants if the course had changed their attitudes toward dying patients. The second question asked the participants if they felt more able to meet the psychosocial needs of a dying patient after the course.

Sixty-nine percent of the registered nurses reported that their attitude had either changed a little or had definitely changed (24% reported a little, 45% reported yes).

Ninety-five percent of the registered nursing students reported that their attitude had either changed a little or had definitely changed (42% reported a little, 53% reported yes).

For the second question, 88 percent of the registered nurse group and 95 percent of the registered nursing student group felt more able to meet the social psychological needs of a dying individual after the educational experience.

One hundred percent of both groups (registered nurses experimental group and registered nursing student experimental group) reported that they would encourage their

colleagues to take a similar course. Ninety-three percent of the registered nurse experimental group and 100 percent of the nursing student experimental group reported that they would take another course of a similar nature in the future. Response bias should not play a role in these results since the data were gathered anonymously.

Nursing Education

Seventy-three percent of the participants perceived their nursing education as inadequately preparing them to meet the psychosocial needs of a dying individual.

Absenteeism Self Report

There were no significant decreases in the number of working days absent for any of the participating groups. However, the absenteeism actually increased significantly for the nursing student experimental group during the time they were attending the course, $t(18)=-2.24$, $p<.05$.

The requirements of the nursing students curriculum at school were particularly demanding during Quality Intervention with the Dying. Perhaps this explains why the absenteeism increased for this group while the course was in progress.

Chapter IV

Discussion

To summarize, the results indicate that death anxiety did not change for the registered nurses immediately following the treatment or one month later. The death anxiety for the registered nursing students did not decrease immediately following the treatment but did decrease significantly one month after the course. The responses from the modified Twenty Statements "What is Death?" Test indicated that the registered nurses did not decrease the number of explicit unfavourable reference statements about death immediately following the treatment. There was however, a significant decrease in the number of explicit unfavourable reference statements one month later.

Registered nurses and registered nursing students perceived dying as a subject area that should be discussed more often immediately following the course, but this perception was not maintained one month later. The registered nursing students responded with a significantly greater number of affective, reminiscing reference statements about death immediately following the course but this increase was not maintained over time. The registered nurse control group significantly decreased the number of positive statements about dying during the second testing period (posttest one).

The self report questions indicate that the registered nurses and the students perceived a change in their attitudes toward dying individuals and felt more able to meet the psychosocial needs of a dying client. The majority of the participants perceived their nursing education as inadequately preparing them to meet the social and psychological needs of a dying individual.

The death anxiety scores for the registered nurse experimental group did not decrease significantly immediately following the treatment or one month later. The absence of actual death anxiety score norms for registered nurses makes this finding difficult to interpret. Normal individuals score from 4.5 to 7.0 with a standard deviation of three, with females scoring slightly higher than males (Templer & Ruff, 1971). The intent of this research is not to decrease the death anxiety scores to the lowest possible score because a very low death anxiety score may actually indicate a lack of "healthy" concern for death related issues. The absence of death anxiety score norms for registered nurses makes it difficult to predict the ideal score for participants after a death education programme. The registered nurses may already fall within a desirable death anxiety score range, indicating that additional decreases would be unlikely.

The death anxiety results for the group of registered nursing students in this research are similar to those found by Laube (1977) and Murray (1974). The death anxiety of the

registered nurses in Laube's study did not decrease immediately following a two day workshop but did decrease one month later. This decrease was not maintained three months later. Laube suggested that a two day workshop was not sufficient time for nurses to work through their feelings to reduce their death anxiety during all testing sessions.

Murray (1974) measured the death anxiety of registered nurses following a six week death education programme. Each weekly session was one and one half hours in length. She found that death anxiety did not decrease immediately following the programme but did decrease significantly one month later. Murray stated that "the interim following the completion of the course may have provided the nurses with time for reflection upon their feelings and attitudes toward death. Another possibility is that during this period they had an opportunity to utilize, personally or professionally, the information received during the course." (p. 1250)

It is interesting to note that the studies which have utilized Templer's Death Anxiety Scale as a dependent measure (Brown, 1980; Laube, 1977; Murray, 1974) and the present research, reported no decrease in death anxiety or reported a decrease one month after the treatment. This absence of decrease or delay in decrease may indicate that the participants have "personalized" the dying and death course content. It is difficult, for example, to discuss the grief reaction of the family without a great deal of

reflection and introspection. The last class of Quality Intervention with the Dying involved a "grief exercise". The participants were divided into dyads as part of the grief exercise and were instructed to share a "joy" and a "pain" with the other. It was implicit that the "pain" referred to a pain or sorrow associated with grief. The recipient was to experience or empathize with the other's joy and pain, then to exchange positions and repeat the exercise. The grief exercise was an intense experience for the participants and it demanded a great deal of reflection and introspection. It might be speculated that there is a contradiction in measuring death anxiety for individuals who have recently had potent experiential learnings concerning death. It might be argued that introspection is a necessary component to ensure the efficacy of a death education programme, but introspection of one's own death may not as a consequence be reflected in a lower death anxiety score. Briefly then, it is quite possible that the death anxiety scores did not decrease immediately following the treatment because the course provided the opportunity for the participants to get in touch with their own feelings about death and the idea that loss is inevitable. An increased sensitivity toward the finiteness of life is unlikely to lead to a lowered death anxiety.

In keeping with this frame of reference, it may be a contradiction to predict that death anxiety would decrease following a death education programme. In retrospect, the

purpose of the course as treatment was not to desensitize the participants. In fact, the purpose was to sensitize the participants to death related issues. Ohyama et al. (1978) examined the influence of nursing education on nursing students' death anxiety. They argued that "it is highly questionable that direct self-report measures can be used as indicators of death anxiety" and that "low scoring subjects simply may not be so much concerned with death." (p. 30)

The significantly lowered death anxiety scores for the nursing student experimental group can be interpreted three ways: a) The lower scores one month following the treatment may be, as Murray (1974) suggested, an indication that this group needed additional time to reflect upon their feelings and attitudes related to dying; b) It may indicate as Ohyama et al. (1978) suggested, that the students were less concerned about death related issues one month later; or c) The students significantly decreased their death anxiety scores within the range of normal scores for this population which would provide no additional information regarding the efficacy of the treatment.

In other words, it is difficult to interpret the results of the death anxiety scores for the registered nurse experimental group or the nursing student experimental group without the availability of actual norms for these populations. One must question the appropriateness of the death anxiety scale as a tool to assess the efficacy of a death education programme until these norms are established.

The responses from the modified Twenty Statements "What is Death?" Test indicated that the two experimental groups perceived dying as a subject area that should be discussed more often, immediately following the treatment. This perception was not maintained one month later. As Mandel (1981) reported, sharing thoughts, feelings and concerns with colleagues was perceived by nurses as an effective coping strategy while caring for the terminally ill or dying individual. The increase in the number of explicit discussion of death reference statements was not reported one month later. One would hope however, that once this coping strategy is learned, it then becomes incorportated into the participants' repertoire of behaviors. The nurse is able to meet the psychosocial needs of a dying individual more effectively only if he/she is able to recognize and express emotions related to dying and death. (Bunch & Zahra, 1976; Chandler, 1976; Coyne, 1976; Crary & Crary, 1975; Eaton, Jr., 1976; Jacobi, 1976; Klagsbrun, 1970; Kneisl, 1968; Lowenberg, 1976; Powell, 1966; Sonstegard, Hansen, Zillman & Johnston, 1976)

The opinions of the registered nurses from one of the participating hospitals will be presented to add support to this speculation. This discussion occured during a debriefing session. After the results of the study were presented, a nurse inquired "So, where does this leave us?". (This group of nurses appeared disappointed that there was no "magic" that resulted from the course.) The nurse was

answered by her colleagues. One individual suggested that attitudes about dying and death are formed very early and that perhaps death education should be integrated into the elementary schools. Another nurse felt that religion played a major role in developing attitudes about death. A third individual stated that personal experience with death influenced the way in which a nurse interacted with a dying patient. The type of patient was discussed. One nurse felt that it was different caring for a patient who is dying slowly as in terminal illness in comparison to caring for a sudden or acute death. The conversation carried on from there. A nurse said "for example, do you remember Mr. X?". The group remembered him and a small vignette of what he was like followed. A second vignette of another patient was presented. Suddenly it was apparent that this group of registered nurses was doing what Eaton Jr. (1976) called "grief work", and together they were sharing feelings and emotions related to dying and death.

The experimental groups were asked two self report questions immediately following the treatment. In response to the question which asked if they felt their attitudes had changed after the course, 69% of the registered nurses and 95% of the nursing students reported a self perceived change. The responses to the second question indicated that 88% of the registered nurses and 95% of the nursing students felt more able to meet the psychosocial needs of a dying individual after the treatment. The responses to these self

report questions indicate that the participants did perceive a change in themselves following the treatment.

The registered nursing students expressed a significantly greater number of affective, reminiscing reference statements immediately following the treatment however, this increase was not maintained one month later. The affective, reminiscing reference statements appeared to represent the true "quality" reference statements about dying. The quality of the statements are reflected in the following examples.

What is Dying?

A chance to experience life more deeply than ever before.
Dying is growth producing.
A time to really see and feel all life around you.
Dying could be a time to reach out to others who do not understand its reasons.
A learning and growing experience for the nurse of the dying patient.
An event that should be met with understanding of those caring for the dying person.
A time to reflect on past life and make the most of the time left.
An awareness of the quality of one's own past.
A time to reflect on what our life meant.
Saying goodbye to our loved ones.
Dying is a time of reconciliation.

In contrast to the short term effects of the treatment for the nursing student group, the registered nurse group significantly decreased the number of explicit unfavourable reference statements one month after the course. This decrease was not apparent immediately following the treatment.

It is unclear why the gains made immediately following the course for the registered nursing students were not maintained one month later. It may be possible that the concepts learned from Quality Intervention with the Dying were clouded and deemed less important by the students one month later. The rapid presentation of diverse information which is characteristic of nursing education during the interim of the testing sessions may be responsible for this finding.

The registered nurse control group reported a significantly less number of general favourable reference statements during the second testing period (posttest one). There does not seem to be an explanation for this decrease particulary because the same decrease did not occur for the nursing student control group.

Overall, it seems that the treatment evoked a strong emotional response in the nursing student experimental group immediately following the course. This was reflected in the significant increase in the number of "quality" affective, reminiscing reference statements reported at that time. However, the impact of the treatment was not maintained one

month later.

In comparison, the treatment appeared to evoke less emotional responding in the registered nurse experimental group immediately after the treatment, yet the final outcome indicates a more permanent influence on this group. The significant decrease in the number of explicit unfavourable reference statements and the group discussion described earlier supports this view. Clearly, the two groups responded differently to the treatment. Perhaps the more experienced registered nurses were able to reflect and integrate their past experience with the concepts presented in the course.

The results of this research have the following implications.

1) There is a need to develop innovative tools that will reliably measure attitudes about dying and death.

2) Direct behavioral observation would indicate more accurately the efficacy of future intervention programmes for nurses who interact with terminally ill or dying individuals.

3) The quality of death education in nursing programmes needs to be assessed. Programme curricula must include death education that emphasizes the psychosocial needs of a terminally ill or dying individual.

4) Death education needs to be an ongoing process for nurses rather than a one time occurance, to be most effective.

The original design of this research was to determine if a paradigm in Community Psychology called The Educational Pyramid (Seidman & Rappaport, 1974) was an effective intervention strategy for nurses interacting with dying individuals. The pyramid structure was chosen because of its ability to provide an ongoing educational programme.

The Educational Pyramid applied to a university setting involves an experienced psychologist who serves as a supervisor and consultant to graduate students. The graduate students, in turn, act as supervisors and consultants to undergraduate students who provide direct care service to the community.

The Educational Pyramid satisfies four needs of Community Psychology.

> First, it includes a conceptual methodological schema for understanding and evaluating the impact of community interventions at multiple levels of society. Second, it offers a model for training future professionals and nonprofessionals in their specific career goals. Third, the paradigm calls for rigorous and systematic evaluation of human service programs. Fourth, and most obviously, the paradigm allows for

efficient deployment of mental health manpower (Seidman & Rappaport, 1974).

This model applied to the hospital setting was to involve a thanatologist to serve as teacher, supervisor and consultant to a group of nursing unit supervisors. The unit supervisors (head nurses, assistant head nurses) were to in turn, act as teacher, supervisor and consultant to their nuring staff. The nursing staff would then receive the information from the thanatologist through their superviors, as an ongoing educational process.

The Educational Pyramid was initially chosen as the most desirable intervention strategy for the following reasons.

1. It would have taught nursing supervisors (head nurses, assistant head nurses) the information and techniques needed to provide staff inservice education in the area of dying and death. This would have had the potential for an ongoing educational process on the individual hospital ward/unit involved. The nursing supervisors' learning may have been facilitated and consolidated by teaching the same information to the staff nurses.

2. It would have provided the opportunity for nurses to study the psychodynamics of the grief process and to identify ways in which they could meet the psychosocial

needs of their clients. Outside courses are difficult to attend because of rotating shift work.

3. The design of The Educational Pyramid would have allowed the dying and death course to relate to practical situations on the nursing unit.

4. It would have enhanced the quality of care given to the clients by the nurses.

5. The course conferences (the course taught to the nursing staff by the supervisor) could have addressed the specific ward needs because the teacher (nursing supervisor) would have been familiar with the unit and the unit nurses.

6. The nurses' motivation for this emotionally charged health care area would have been high, as the nurses would have had the opportunity to experience the course with their peers in a familiar environment. It may have developed or enhanced a support system for the ward nurses.

7. The cooperative support system inherent in The Educational Pyramid would not have placed financial demands on the participants.

8. The opportunity for involvement in The Educational Pyramid was offered to four hospitals in Southwestern

Ontario. It would have therefore had the capacity for impact on several health care facilities at once.

Unfortunately, the research review boards of the four hospitals indicated that the time constraints of the unit supervisors deemed this intervention impractical.

To summarize, the purpose of this research was to determine the efficacy of a death education course on death anxiety and meanings toward dying for a group of registered nurses and registered nursing students. The dying and death course Quality Intervention with the Dying was 12 hours in duration, three hours per week for four weeks. The dependent variables were death anxiety which was measured by Templer's Death Anxiety Scale (1970) and meanings toward dying as measured by a modified Twenty Statements "What is Death?" Test (Bakshis, Correll, Duffy, Grupp, Hilliker, Howe, Kawales & Schmitt, 1974). The participants were tested before the course, immediately following the treatment and one month later.

The findings indicate that death anxiety did not change for the registered nurses immediately following the treatment or one month later. Death anxiety of the student group did not decrease immediately following the treatment but did decrease significantly one month later.

The responses to the modified Twenty Statements "What is Death?" Test indicated that the two experimental groups

perceived dying as a subject area that should be discussed more often immediately following the treatment but this perception was not maintained one month later. Other changes were not apparent immediately following the treatment for the registered nurse group yet the final outcome indicated that this group perceived dying less negatively one month later. The treatment evoked a strong emotional response in the student nurse group immediately following the course but the impact of the treatment was not maintained one month later.

The results suggest that this type of intervention programme has more lasting effects on the registered nurse group than on the nursing student group.

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Footnote

1. Webster's (1971) Third International Dictionary defines the noun "patient" as "one that suffers, endures, or is victimized" (p.1655). The noun "client" is defined as "a person served by or utilizing the services of a social agency or public institution" (p.422). It seems appropriate to use the term "client" rather than "patient", as an initial attempt to change the perception of a hospitalized individual from passive recipient of care, to active participant in services provided by a hospital.

APPENDIX A
INFORMATION LETTERS

Course Available to Registered Nurses and Nursing Students

Quality Intervention with the Dying is a dying and death course which will be taught by Dr. Delton Glebe at Wilfrid Laurier University. This course is part of a research project for my M.A. thesis. The course will be 12 hours in duration, three hours per week for four weeks. It will include discussion, audio visual aids, optional readings, and guest lecturers. The course will be held Monday evening 7PM to 10PM, January 11, 1982 to Monday February 1, 1982. This course will be offered to you without a registration fee in return for your cooperation.

You will be given three series of questionnaires. They will be given to you before the course begins, after the course is over and one month later. No reference will be made to the hospital in which you are employed, the school of nursing, or to you as an individual in my research.

If you would like to participate in this course, please print your name and telephone number below and I will telephone you to confirm your registration in the course and the exact location of the course.

Thank you for your time and consideration. I appreciate it a great deal.

Sincerely yours,
Sheila Connolly
Sheila Connolly, Reg.N.
M.A. Student
Wilfrid Laurier University

Robert Morgan, Ph.D.
Department of Psychology
Wilfrid Laurier University

Please print:

Name:_____

Telephone number:_____

Please return this form to Nursing Office by Monday December, 21, 1981

Course Available to Registered Nurses and Nursing Students

Quality Intervention with the Dying is a dying and death course which will be taught by Dr. Delton Glebe at Wilfrid Laurier University. This course is part of a research project for my M.A. thesis. The course will be 12 hours in duration, three hours per week for four weeks. It will include discussion, audio visual aids, optional readings, and guest lecturers. The course will be held Monday evening 7PM to 10PM, January 11, 1982 to Monday February 1, 1982. This course will be offered to you without a registration fee in return for your cooperation.

You will be given three series of questionnaires. They will be given to you before the course begins, after the course is over and one month later. No reference will be made to the hospital in which you are employed, the school of nursing, or to you as an individual in my research.

If you would like to participate in this course, please print your name and telephone number below and I will telephone you to confirm your registration in the course and the exact location of the course. If you prefer not to participate, return this form to the researcher blank.

Thank you for your time and consideration. I appreciate it a great deal.

Sincerely yours,
Sheila Connolly

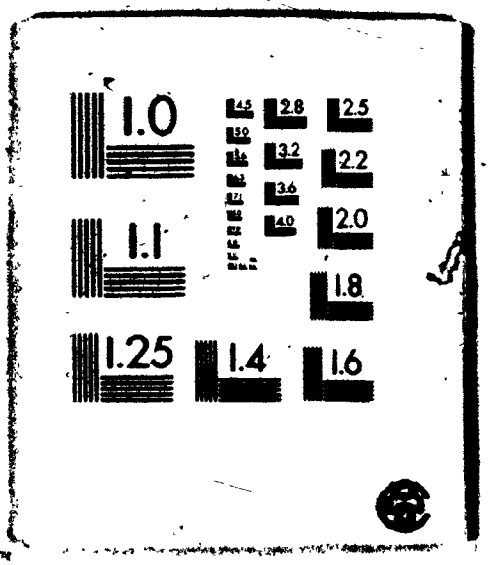
Sheila Connolly, Reg.N.
M.A. Student.
Wilfrid Laurier University

Robert Morgan, Ph.D.
Department of Psychology
Wilfrid Laurier University

Please print:

Name: _____

Telephone number: _____



APPENDIX B
CONSENT FORMS: EXPERIMENTAL AND CONTROL GROUPS

Consent Form: Experimental Groups

'Quality Intefvention with the Dying' is a dying and death course which will be taught by Dr. Delton Glebe at Wilfrid Laurier University. This course is part of a reseach project for my M.A. thesis. The course will be 12 hours in duration, three hours per week for four weeks. It will include discussion, audio visual aids, optional readings and guest speakers. The course will be held Monday evening 7 PM to 10 PM, January 11, 1982 to Monday February 1, 1982. This course will be offered to you without a registration fee in return for you cooperation.

You will be given three series of questionnaires. They will be given to you before the course begins, after the course is over and again one month later. No reference will be made to the hospital in which you are employed, the school of nursing, or to you as an individual in my research.

The research project and results will be explained to you the last week of April. Thank you for your time and consideration.

Sincerely yours,

Sheila Connolly

Sheila Connolly, Reg.N.
M.A. Student
Wilfrid Laurier University

Robert Morgan, Ph.D.
Department of Psychology
Wilfrid Laurier University

I agree to participate in the research being conducted by Sheila Connolly. I have read and understood the above information. I understand that I am free to withdraw consent and participation at any time, but agree to inform the researcher of this decision if it occurs.

I agree to participate:

yes_____

no_____

Signature:_____

Date:_____

Consent Form: Control Groups

The following questionnaire package is part of a research project with registered nurses and nursing students for my M.A. thesis. If you agree to participate you will be given two series of questionnaires. You will be asked to complete the first package now and the second package in one month. No reference will be made to the hospital in which you are employed, the school of nursing, or to you as an individual in my research.

The research project and results will be explained to you the last week of April. Thank you for your time and consideration.

Sincerely yours,
Sheila Connolly

Sheila Connolly, Reg.N.
M.A. Student
Wilfrid Laurier University

Robert Morgan, Ph.D.
Department of Psychology
Wilfrid Laurier University

I agree to participate in the research being conducted by Sheila Connolly. I have read and understood the above information. I understand that I am free to withdraw consent and participation at any time.

I agree to participate:

yes_____

no_____

Signature:_____

Date:_____

APPENDIX C
PARTICIPANT FEEDBACK

Hello again:

My thesis is finally complete and on its way to be bound. The purpose of my research was to determine the efficacy of a death education course on death anxiety and meanings toward dying for a group of registered nurses and registered nursing students. The dying and death course Quality Intervention with the Dying was 12 hours in duration, three hours per week for four weeks. The dependent variables were death anxiety which was measured by Templer's Death Anxiety Scale (1970) and meanings toward dying as measured by a modified Twenty Statements "What is Death?" Test (Bakshis, Correll, Duffy, Grupp, Hilliker, Howe, Kawales & Schmitt, 1974). The participants were tested before the course, immediately following the treatment and one month later.

The findings indicate that death anxiety did not change for the registered nurse group immediately following the treatment or one month later. The death anxiety of the nursing student group did not decrease immediately following the treatment but did decrease significantly one month later.

The responses to the modified Twenty Statements "What is Death?" Test indicated that the two experimental groups perceived dying as a subject area that should be discussed more often immediately following the treatment but this perception was not maintained one month later. Other changes were not apparent immediately following the treatment for the registered nurse group yet the final outcome indicated that this group perceived dying less negatively one month later. The treatment evoked a strong emotional response in the nursing student group immediately following the course but the impact of the treatment was not maintained one month later.

The results suggest that this type of intervention programme has more lasting effects on the registered nurse group in comparison to the nursing student group.

The one artifact finding I discovered from my thesis was that nurses are truly compassionate individuals. This discovery was the most rewarding aspect of my thesis.

I wish you all the best with your future professional endeavors. Thank you for your ongoing interest and cooperation.

Sincerely yours,
Sheila Connolly

If you have any further questions or comments please contact me at 884-1970 Ext.371

APPENDIX D
COVER LETTERS: EXPERIMENTAL GROUPS

The following set of questionnaires is one of three packages you will be asked to complete during this research project. It is important to fill out each questionnaire in the order in which it is presented. Please do not look ahead before you begin.

Please respond to the questions honestly and completely. This package will take approximately 20 minutes to complete. You will be identified by a six digit number (birthdate: month, day, year) which you will compose. It can be your own birthdate or it can belong to someone else. You are the only person who will know the identifying number you are using. This identifying number is needed to match the questionnaire package which is completed before the course with the two you will complete after the course. Please remember your number and identify each questionnaire package with it. No reference will be made to the hospital in which you are employed, the school of nursing or to you as an individual.

The research project will be explained to you the last week of April. The exact purpose of these questionnaires cannot be explained to you at this time as that might affect your responding. Again, thank you.

Sincerely yours,

Sheila Connolly

Sheila Connolly, Reg.N.
M.A. Student
Wilfrid Laurier University

Robert Morgan, Ph.D.
Department of Psychology
Wilfrid Laurier University

Please identify this package with your identifying number here:

_____
(Birthdate: month, day, year)

Please check one of the following:

Nursing Student ___

Registered Nurse ___

The following set of questionnaires is the second of three packages you will be asked to complete during this research project. It is important to fill out each questionnaire in the order in which it is presented. Please do not look ahead before you begin.

Please respond to the questions honestly and completely. The package will take approximately 20 minutes to complete. You will be identified by the six digit number (birthdate: month, day, year) which you have composed. This identifying number is needed to match this questionnaire package with the one you completed before the course. Again, thank you.

Sincerely yours,

Sheila Connolly

Sheila Connolly, Reg.N.
M.A. Student
Wilfrid Laurier University

Robert Morgan, Ph.D.
Department of Psychology
Wilfrid Laurier University

Please identify this package with your identifying number here:

_____
(Birthdate: month, day, year)

If you are a nursing student please check the following:

Nursing Student ___

If you are a Registered Nurse or RNA please check the following:

Registered Nurse ___

RNA ___

The following set of questionnaires is the final questionnaire package you will be asked to complete during this research project. It is important to fill out each questionnaire in the order in which it is presented. Please do not look ahead before you begin.

Please respond to the questions honestly and completely. The package will take approximately 20 minutes to complete. You will be identified by the six digit number (birthdate: month, day, year) which you have composed. A copy of the research results will be sent to you as soon as they are available. Again, thank you.

Sincerely yours,

Sheila Connolly

Sheila Connolly, Reg.N.
M.A. Student
Wilfrid Laurier University

Robert Morgan, Ph.D.
Department of Psychology
Wilfrid Laurier University

Please identify this package with your identifying number here:

_____

(Birthdate: month, day, year)

If you are a nursing student please check the following:

Nursing Student ___

If you are a Registered Nurse or Registered Nursing Assistant Please check the following:

Registered Nurse ___

RNA ___

APPENDIX E
COVER LETTERS: CONTROL GROUPS

The following set of questionnaires is one of two packages you will be asked to complete during this research project. It is important to fill out each questionnaire in the order in which it is presented. Please do not look ahead before you begin.

Please respond to the questions honestly and completely. The package will take approximately 20 minutes to complete. You will be identified by a six digit number (birthdate: month, day, year) which you will compose. It can be your own birthdate or it can belong to someone else. You are the only person who will know the identifying number you are using. This identifying number is needed to match the questionnaire package which you will complete now, with the package you will complete in one month. Please remember your number and identify both questionnaire packages with it. No reference will be made to the hospital in which you are employed, the school of nursing, or to you as an individual.

The research project and results will be explained to you the last week of April. The exact purpose of these questionnaires cannot be explained to you at this time as that might affect your responding. Again, thank you.

Sincerely yours,

Sheila Connolly, Reg.N.
M.A. Student
Wilfrid Laurier University

Robert Morgan, Ph.D.
Department of Psychology
Wilfrid Laurier University

Please identify this package with your identifying number here:

_____
(Birthdate: month, day, year)

Please check one of the following:

Nursing Student ___

Registered Nurse ___

The following set of questionnaires is the second of two packages you will be asked to complete during this research project. It is important to fill out each questionnaire in the order in which it is presented. Please do not look ahead before you begin.

Please respond to the questions honestly and completely. The package will take approximately 20 minutes to complete. You will be identified by the six digit number (birthdate: month, day, year) which you have composed. This identifying number is needed to match this questionnaire package with the one you completed one month earlier. Again, thank you.

Sincerely yours,

Sheila Connolly

Sheila Connolly, Reg.N.
M.A. Student
Wilfrid Laurier University

Robert Morgan, Ph.D.
Department of Psychology
Wilfrid Laurier University

Please identify this package with your identifying number here:

_____
(Birthdate: month, day, year)

If you are a nursing student please check the following:

Nursing Student ___

If you are a Registered Nurse or RNA
Please check the following:

Registered Nurse ___
RNA ___

Thank you for completing this third set of questionnaires. It is the final questionnaire package you will be asked to complete. It is important to fill out each questionnaire in the order in which it is presented. Please do not look ahead before you begin.

Please respond to the questions honestly and completely. The package will take approximately 20 minutes to complete. You will be identified by the six digit number (birthdate: month, day, year) which you have composed. A copy of the research results will be sent to you as soon as they are available. Again, thank you.

Sincerely yours,

Sheila Connolly

Sheila Connolly, Reg.N.
M.A. Student
Wilfrid Laurier University

Robert Morgan, Ph.D.
Department of Psychology
Wilfrid Laurier University

Please identify this package with your identifying number here:

_____
(Birthdate: month, day, year)

If you are a nursing student please check the following:

Nursing Student ___

If you are a Registered Nurse or RNA
Please check the following:

Registered Nurse ___

RNA ___

APPENDIX F
TEMPLER'S DEATH ANXIETY SCALE

Please respond to the following statements by circling either true or false.

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 talk about 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 G
MODIFIED TWENTY STATEMENTS "WHAT IS DEATH?" TEST

In the space provided below, please give twenty statements in answer to the question "What is dying?". Give these answers as if you were giving them to yourself, and not someone else. Move right along without hesitation until you are finished.

What is Dying?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

APPENDIX H
BACKGROUND INFORMATION QUESTIONNAIRE: EXPERIMENTAL AND CONTROL GROUPS

Background Information

1. Have you taken a course about dying and death in the past?

Yes ___ No ___

2. Please specify if yes: _____

_____

3. Approximately, how many dying patients have you cared for during your nursing career or ward experience?

0 ____
1-5 ____
5-10 ____
10-20 ____
20+ ____

4. How long has it been since you cared for your last dying patient?

1 week ____
1 month ____
6 months ____
greater than 1 yr. ____
not applicable ____

5. Have you experienced the death of a close friend or relative within the last two years?

yes ____
no ____

6. How many days were you absent from either work or school during the last 20 working or school days?

_____ day(s)

7. Please specify the type of nursing specialty area in which you are presently employed as a Registered Nurse.

_____

or

Please specify the type of nursing specialty area you would like to pursue when you have completed your nursing education.

_____

*The stems of questions 3,4 were taken from Miles, 1976.

APPENDIX I
FOLLOW UP QUESTIONNAIRE
EXPERIMENTAL GROUPS

Follow Up Questionnaire

1. Do you feel your attitude toward dying patients has changed in the last month?

no ____

a little____

yes ____

2. Do you feel more able to meet the social psychological needs of a dying patient now, than before the dying and death educational experience?

yes ____

no ____

3. Do you feel your nursing education adequately prepared you to meet the social psychological needs of a dying patient?

yes ____

no ____

4. How many days were you absent from either work or school during the last 20 working or school days?

____ day(s)

5. During the course Quality Intervention with the Dying, which of the following classes did you attend?

class #1 ____

class #2 ____

class #3 ____

class #4 ____

The stem of question 1 was taken from Miles, 1976.

Please add any comments with regard to this research and/or the course Quality Intervention with the Dying.

Be as creative as you like.

APPENDIX J
FOLLOW UP QUESTIONNAIRE: CONTROL GROUPS

Follow Up Questionnaire

1. Do you feel your nursing education adequately prepared you to meet the social psychological needs of a dying patient?

yes _____

no _____

2. How many days were you absent from either work or school during the last 20 working or school days?

_____ day(s)

3. Please add any comments with regard to this researh and/or questionnaires you have completed.
Be as creative as you like.

APPENDIX K
QUESTIONNAIRE THREE: EXPERIMENTAL GROUPS

Questionnaire Three

1. How many days were you absent from either work or school during the last 20 working or school days?

_____day(s)

2. Will you take another course in dying in death in the future?

yes___

no___

3. Would you encourage your colleagues to take a course in dying and death?

yes___

no___

APPENDIX L
CODING SCHEMES FOR THE 17 TST CATEGORIES

Category one: Explicit Soul Reference

Any statement that contains (1) an explicit reference (2) to the soul or spirit (3) within a religious context is to be included.

Include

soul leaves the body
leaving the mortal body that houses the soul
continuation of spiritual life
leaving of the spirit

Exclude

death is a soul searching experience

Category two: Explicit God Reference

Any statement that contains (1) an explicit reference (2) to God, Jesus, Holy Spirit, or their equivalents, is to be included

Include

life with God
meeting my maker
end of allotted time to serve Jesus

Category three: Explicit Reference to Another Life

Any statement that contains (1) an explicit reference (2) to another life is included.

Include

another life
new life with Savior
eternal life
passing into another world
Heaven
Hell
Purgatory

Exclude

the beginning
being close to God
meeting loved ones
transition
eternity
leaving of the spirit
immortality

Category four: Religious Reference

Any statement that contains (1) a direct or (2) indirect (3) religious reference is included. *All statements from categories one, two and three are included.

Direct

soul leaves body*
meeting God*
a new life*
death is due to satan
death is in the ten commandments

Indirect

reunion
welcome to those prepared
penalty
time for joyous celebration
must face reality of one's wrongs

Exclude

peace
freedom
contentment
may be beautiful
doorway to eternity

Category five: Favourable Religious Reference

Any statement that contains (1) a direct or (2) indirect (3) favourable (4) religious reference is included. Only statements coded in category 4 are to be considered.

Direct

rejoicing of the soul
better life
peace with God
glory soon
reward
Heaven

Indirect

life with God
being close to Jesus
beginning of eternal life
beginning
entering the kingdom of God
meeting friends

Exclude

leaving of the spirit
absence of soul from body
changing from one life to another
end of time to serve God
beckoning of God
a soul changing its house

Category 6: Explicit Unfavourable Religious Reference

Any statement that contains (1) an explicit (2) unfavourable (3) religious reference is included. *Only statements coded in category 4 are to be considered.

Include

Hell
Purgatory
fear for the unsaved
damnation

Category seven: General Favourable Reference

Any statement that contains (1) a direct or (2) indirect (3) favourable reference is included. *Statements in category five are to be included.

Direct

rejoicing of the soul*
Heaven*
release from pain
end of worries
blessing for old people
meeting friends
rejoining loved ones

Indirect

life with God*
being close to Jesus*
death is an adventure
fulfillment of a promise
beginning of something new
beginning of new life
peace
life hereafter

Exclude

quiet
solitude
transition
pass into eternity
an experience
final sleep

Category eight: Explicit Unfavorable Reference

Any statement that contains (1) an explicit (2) unfavourable reference is included. *All statements included in category six are included.

Include

Hell*
fear for the unsaved*
sadness
uncertainty
blackness
pain
big dark question mark
body decays

Exclude

mystery
irreversable
time of soul searching

Category nine: Explicit Reference to Reunion with Reference Others

Any statement that contains (1) an explicit reference (2) to a reunion with (3) a deceased reference other eg. family, friends or loved ones, is included.

Include

going to join relatives
I will see my mother again
meeting of former loved ones

Exclude

meeting at the grave
reunion
bringing family closer together

Category ten: Explicit Reference to Loss of Reference Other

Any statement that (1) explicitly (2) describes the loss (3) of a reference other eg. family, friends or loved ones, is included.

Include

loss of a friend
missing a loved one
doing without someone I love

Exclude

separation
loss of something dear to you

Category eleven: Explicit Reference to Reference Others From the Perspective of the Deceased

Any statement that (1) explicitly (2) describe reference others, eg. family, friends or loved ones (3) from the perspective of the deceased are included. This variable includes two types of statements - the reunion references in category nine and the statements that depict departures from the reference others.

Include

going to join relatives*
I will see my mother again*
leaving friends behind

Exclude

meeting at the grave
reunion
separation
loss of a friend**
doing without someone I love**

*Statements in category nine are included.
** Statements in category 10 must be considered carefully to determine if they refer to the perspective of the deceased.

Category twelve: Biological Reference

Any statement that contains (1) a direct or (2) indirect reference (3) to the absence of vital signs is included. Body parts are frequently mentioned in these statements.

Direct

wearing out of cell life
heart ceases to beat
cessation of cerebral function
body functions terminate

Indirect

termination of physical life
end of physical life

Exclude

exit
end of rat race
person ceases to have life
end of life
final sleep
end of mortal life

Category thirteen: Equalitarian Reference

Any statement that contains (1) a direct or (2) indirect (3) equalitarian view of death is included.

Direct

death takes all
no one escapes
being equal
death comes to all
cannot chose way to die

Indirect

death is inevitable
death favours no age

Exclude

death is ever present
part of nature's cycle

Category fourteen: Social Termination Reference

Statements that (1) directly or (2) indirectly (3) describe the end of life or (4) describe the end of some aspect of life in nonbiological terms are included.

Include

end of life
termination of mortal life
end of rat race
end of manual labour
loss of happiness
loss of loved ones
leaving of friends

Exclude

heart stops*
body functions terminate*
soul leaves body
release
separation
peace or happiness

*Statements coded in category 12 are not included.

Category fifteen: Cause of Death Reference

Any statement that (1) directly or (2) indirectly (3) refers to the cause of death is included. This variable concerns the cause of death. Statements that indicate why death occurred are included. Statements that indicate that body functions have ceased are not included.

Direct

murder
suicide
cancer
end result of killing
death is brought about by accidental shootings

Indirect

death may be seen on the highway

Exclude

pulse stops
heart stops

Category sixteen: Explicit Occupational Reference

Statements that (1) explicitly (2) reflect the nursing position role are included, "death is the young boy who died on my ward". The biological references (category 12) are not to be included.

Category seventeen: Explicit Discussion of Death

Statements that (1) explicitly (2) indicate that death should be discussed eg. "death should be talked about more" or (3) is hard to talk about eg. "doctors find death hard to talk about", are included.

Include

share feelings
feelings expressed

Category eighteen: The Statements that did not fall within the 26 categories.

APPENDIX M
CODING SCHEMES FOR THE EIGHT ADDITIONAL TST CATEGORIES

Category nineteen: Anger and Betrayal Reference

Any statement that contains (1) an explicit reference to (2) anger or (3) betrayal or (4) denial of one's own death in a non religious context is included.

Include

feeling betrayed
wishing you could wake up and realize it was not you
being angry

Exclude

God's way of punishing

Category twenty: Concret Rituals Reference

Any statement that contains (1) a reference to the rituals associated with death (2) absent of any associated emotional response.

Include

an expensive business
funeral
covering casket with dirt
graveside service
flowers, coffins, graveyards
morgue
lying in a casket all painted up

Exclude

wanting and needing to cry at the funeral
seeing a part of yourself buried in the ground
funerals bring closeness to family members
an event to be expressed by all ages

Category twenty-one: Alone, lonely, Quiet Reference

Any statement that describes dying as (1) alone, (2) lonely, (3) quiet or (4) silent are included in this category.

Include

a time to be alone
something you must face alone
can be lonely if no one is with you
something you must do by yourself
being totally by myself
not wanting to die alone, unattended
dying is a quiet, alone time
dying is silence

Category twenty-two: Time Reference

Any statement that has a direct reference to time is included.

Include

death sentence, 24 months, six months, six days
time
long
sometimes too soon
sometimes too late
slow and prologed
the future
an event that takes time and limits it
uncertainty of what time is left
something that can take years
death is movement through time

Category twenty-three: Age Reference

Any statement that makes a direct reference to age is included.

Include

getting older and closer to the end
is being old
aging and the elderly
more acceptable if the person is older
more difficult to accept if young
dying is easiest to cope with for older people who have "lived a good life" and hardest to cope with when it is a young person

Category twenty-four: Mysterious, Curious or Uncertain Reference

Any statement that refers to dying as (1) mysterious, (2) curious or has an (3) uncertain reference is included.

Include

mystifying
somewhat of a mystery sometimes
curiosity about the unknown
wondering what death will be like
I will never know until it happens
a wonder to all
difficult to define
something no one can explain

Exclude

fear of the unknown
big black question mark

Category twenty-five: Life cycle Reference

Any statement that refers to dying as (1) a process or (2) part of the life cycle is included.

Include

part of life cycle
stage in final life process
dust to dust
ashes to ashes
a natural thing
ongoing process
a natural aspect of life, where there is a beginning, there is an end
the consumation of that for which we were born
completing your life cycle

Category twenty-six: Grief and Sorrow Reference

Any statement that has a direct reference to (1) grief or (2) sorrow, is included.

Include

time of sorrow
a time to grieve
a period of grieving for family and friends
hopefully having accepted the grieving process
grieving for unmet goals

Category twenty-seven: Affective, Reminiscing Reference

Any statement that has a (1) positive affective quality or indicates that dying is (2) a time to reminisce or (3) a time to say goodbye, is included.

Include

a chance to experience life more deeply than ever before
is growth producing
a time to really see and feel all life around you
is finding another part of you growing
a learning and growing experience for the nurse of the dying patient
an event that should be met with understanding of those caring for the dying person
a time to reflect on past life and make the most of the time left
an awareness of the quality of one's own past
a time to reflect on what our life meant
a time of self reflection
saying goodbye to our loved ones
a time of reconciliation

APPENDIX N
TABLES 4 AND 5

Table 4

Mean number of responses chosen for the 26 categories in the modified Twenty Statements "What is Death?" Test for the registered nurses

		Experimental Group			Control Group		
		Pre test	Post test1	Post test2	Pre test	Post test1	Post test2
1.Explicit soul statements	$\bar{x}$	.30	.21	.16	.35	.33	.44
	SD	.56	.47	.37	.64	.70	.68
2.Explicit God statements	$\bar{x}$	.40	.19*	.26	.19	.17	.10
	SD	.82	.45	.58	.45	.44	.30
3.Another life statements	$\bar{x}$	1.33	.73**	.95	.95	1.04	1.00
	SD	1.11	.93	.98	.92	1.02	.97
4.Religious statements	$\bar{x}$	.19	.14	.19	.28	.17	.14
	SD	.50	.41	.45	.62	.53	.36
5.Favourable religious statements	$\bar{x}$	.30	.30	.35	.33	.26	.30
	SD	.46	.60	.65	.56	.49	.80
6.Unfavourable religious statements	$\bar{x}$	.04	.00*	.02	.08	.00**	.10
	SD	.30	.00	.15	.28	.00	.30
7.General favourable statements	$\bar{x}$	3.04	3.45	3.57	3.04	2.35*	3.19
	SD	2.35	2.18	2.42	2.35	1.55	2.60
8.Explicit unfavourable statements	$\bar{x}$	2.40	1.92	1.92*	1.73	1.80	1.35
	SD	2.19	1.71	1.77	1.58	1.87	1.78
9.Reunion with others statements	$\bar{x}$	.28	.09*	.19	.28	.15	.30
	SD	.50	.29	.45	.50	.36	.47
10.Loss of reference other statements	$\bar{x}$	1.00	.83	1.11	.88	.82	1.19
	SD	1.10	.88	1.17	1.13	1.26	1.57
11.Reference other from perspective of deceased	$\bar{x}$	1.59	1.38	1.80	1.15	1.31	1.44
	SD	1.51	1.08	1.36	1.10	1.34	1.66
12.Biological statements	$\bar{x}$	1.80	1.40	1.35	1.35	1.17	.80*
	SD	1.92	2.15	2.11	2.16	1.81	1.47

13.Equalitarian statements	$\bar{x}$	.50	.42	.52	.75	.53	.25
	SD	.70	.70	.74	1.26	.89	.44
14.Social termination statements	$\bar{x}$	2.61	1.88**	2.23	2.42	2.31	1.69**
	SD	1.83	1.54	1.64	1.73	1.92	1.21
15.Cause of death statements	$\bar{x}$	.14	.30	.21	.22	.66*	.25
	SD	.41	.71	.47	.42	.33	.55
16.Occupational statements	$\bar{x}$	.09	.14	.16	.11	.11	.10
	SD	.29	.52	.58	.48	.43	.30
17.Discussion statements	$\bar{x}$	.11	.42**	.26	.08	.06	.19
	SD	.32	.59	.44	.28	.25	.41
19.Anger statements	$\bar{x}$	.26	.30	.45	.06	.24	.14
	SD	.62	.68	.70	.25	.64	.36
20.Concrete rituals statements	$\bar{x}$	.69	.23	.57	.33	.31	.55
	SD	1.78	.61	1.32	.67	.73	1.05
21.Alone statements	$\bar{x}$	.42	.64	.66	.24	.33	.25
	SD	.80	.79	.72	.48	.56	.44
22.Time statements	$\bar{x}$	.23	.16	.16	.22	.42	.50*
	SD	.53	.53	.43	.63	.75	.94
23.Age statements	$\bar{x}$	.16	.95	.23	.19	.19	.14
	SD	.43	.29	.53	.45	.45	.36
24.Mysterious statements	$\bar{x}$	.11	.09	.14	.13	.08	.05
	SD	.32	.29	.35	.40	.35	.22
25.Life cycle statements	$\bar{x}$	.66	.95	.61	.39	.31	.39
	SD	.95	1.05	.98	.61	.63	.75
26.Grief statements	$\bar{x}$	.28	.26	.26	.13	.13	.30
	SD	.63	.44	.44	.45	.40	.80
27.Affective statements	$\bar{x}$	1.26	1.76	1.50	.82	.57	.80
	SD	1.86	2.00	1.70	1.33	1.03	1.10

** significant at .01
* significant at .05

Table 5

Mean number of responses chosen for the 26 categories in the modified Twenty Statements "What is Death?" Test for the nursing students

		Experimental Group			Control Group		
		Pre test	Post test1	Post test2	Pre test	Post test1	Post test2
1.Explicit soul statements	$\bar{x}$	.52	.15*	.21**	.37	.17	.13
	SD	.96	.37	.71	.82	.38	.51
2.Explicit God statments	$\bar{x}$	.57	.15*	.36	.24	.20	.26
	SD	.83	.50	.49	.57	.41	.45
3.Another life statements	$\bar{x}$	1.26	.89	.68*	1.48	1.17	1.06
	SD	1.44	1.28	1.15	1.37	.71	1.03
4.Religious statements	$\bar{x}$	.73	.26**	.15**	.34	.24	.19
	SD	.80	.45	.50	.55	.51	.56
5.Favourable religious statements	$\bar{x}$	.73	.52	.15	.31	.24	.33
	SD	1.44	.77	.37	.54	.43	.72
6.Unfavourable religious statements	$\bar{x}$	.05	.00**	.00**	.03	.06	.06
	SD	.22	.00	.00	.18	.25	.25
7.General favourable statements	$\bar{x}$	3.94	4.10	3.26	3.31	2.86	3.06
	SD	1.80	1.76	1.93	2.34	2.15	1.09
8.Explicit unfavourable statements	$\bar{x}$	3.15	2.42	2.52	2.89	3.44	2.93
	SD	2.16	2.09	2.11	2.05	1.93	1.43
9.Reunion with others statements	$\bar{x}$	.10	.15	.10	.24	.10	.13
	SD	.31	.37	.31	.43	.30	.35
10.Loss of reference other statements	$\bar{x}$	1.26	.47**	1.00	1.06	.82	1.33
	SD	1.24	.77	.66	1.09	.88	1.23
11.Reference other from perspective of deceased	$\bar{x}$	1.84	.94**	1.36	.79	1.17	1.13
	SD	1.50	.84	1.21	1.01	1.10	1.35
12.Biological statements	$\bar{x}$	.73	.26	.57	.72	.72	.39
	SD	.93	.45	.90	.84	.99	.63

13.Equalitarian statements	$\bar{x}$	.47	.31	.52	.82	.79	.93
	SD	.51	.58	.69	.96	.90	1.38
14.Social Termination statements	$\bar{x}$	2.63	1.57*	2.00	2.51	2.00	3.19
	SD	1.64	1.46	1.85	1.88	1.43	2.11
15.Cause of death statements	$\bar{x}$	.26	.05	.26	.27	.27	.60
	SD	.56	.22	.56	.59	.59	.63
16.Occupational statements	$\bar{x}$	.15	.21	.15	.13	.24	.46
	SD	.37	.71	.37	.35	.57	.74
17.Discussion statements	$\bar{x}$	.26	.89*	.47	.17	.27	.26
	SD	.73	1.14	.96	.46	.70	.79
19.Anger statements	$\bar{x}$	.57	.42	.52	.48	.55	.13
	SD	1.16	.83	.90	.73	.78	.35
20.Concrete ritual statements	$\bar{x}$	.21	.21	.47	.48	.62	.53
	SD	.41	.41	.84	.87	1.11	.63
21.Alone statements	$\bar{x}$	.42	.52	.36	.37	.48	.39
	SD	.69	.69	.59	.49	.57	.50
22.Time statements	$\bar{x}$	.31	.31	.36	.55	.44	.66
	SD	.58	.74	.49	1.05	.73	1.34
23.Age statements	$\bar{x}$	.26	.21	.15	.34	.31	.26
	SD	.45	.41	.37	.61	.66	.45
24.Mysterious statements	$\bar{x}$	.42	.36	.10	.17	.17	.33
	SD	.69	.68	.45	.38	.46	.48
25.Life cycle statements	$\bar{x}$	.63	.68	.73	.72	.44	.33*
	SD	.83	.67	.56	.88	.68	.61
26.Grief statements	$\bar{x}$	.42	.21	.42	.24	.24	.13
	SD	.60	.53	.69	.51	.43	.35
27.Affective statements	$\bar{x}$	.84	2.78**	1.21	.79	.68	1.19
	SD	.95	2.12	1.65	1.11	1.00	1.08

** significant at .01
* significat at .05