THE VISITING NURSE STAFF AND THE PSYCHOSOCIAL NEEDS OF THE DYING PATIENT

by

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ABSTRACT

This study dealt with the question of whether the visiting nurse's method of approach to the dying patient was enhanced by an inservice program on the psychosocial aspects of death and dying.

The researcher designed a questionnaire of statements quoted from the literature to test knowledge of nursing practice, patient and family needs, social attitudes, and common fallacies about death and dying. In addition, the nurse's attitudes toward death and dying were obtained by utilizing selected items of a questionnaire. The two tools were combined and used as a pretest and posttest to measure differences of knowledge and attitudes of nursing staff before and after a specifically designed inservice program was presented on death and dying.

The sample consisted of all eight nurses employed in a small Visiting Nurse Service in southern Arizona. The inservice program on the psychosocial aspects of death and the dying patient was presented in three segments over a period of one month.

The data, although not statistically significant as a result of the sample size, showed a trend in the nurse's responses, when comparing the pretest and posttest, toward a change in approach to the dying patient. Comparison of
responses supported the belief that educational preparation of nurses in the psychosocial aspects of death and dying may change the quality of care given to the terminally ill patient and his family.
CHAPTER 1

INTRODUCTION

The fear of death is a basic human emotional response. Man can ignore death and at times postpone it but he can never escape it (Heinemann 1972). The concept of the dual feeling in dying is analogous with Fitzgerald's (1936:11) statement that: "The test of a first rate intelligence is the ability to hold two opposed ideas in the mind at the same time and still retain the ability to function. One should, for example, be able to see that things are hopeless and yet be determined to make them otherwise." Is this not what nursing education has tried to accomplish, but has yet to do? According to Strauss (1964:75), "the education of nurses has focused attention on the saving of lives and has offered little training in the art of helping patients to live with an untreatable disease."

As a public health nursing supervisor, in a large Visiting Nurse Service Agency, this researcher became concerned about the visiting nurse's ability to communicate with the dying patient and his family. Through site observations, the nurses were found to be skilled in the technical aspects of their role, but were unaware of the dynamics of the dying process and unable to communicate comfortably with
the dying patient and his family. As a result, the patients expressed feelings of being alone and isolated within their own environment.

Often the visiting nurse has the opportunity to work with the patient throughout the course of his illness until his final hospitalization. The nurse has the added advantage of being able to work together with the patient and his family. The nurse who is properly trained in the psychosocial aspects of the dying process, and when given adequate support, can be instrumental in helping the patient and his family through the dying process. This does not negate meeting the physical needs of the patient, but should complement and provide comfort and care as indicated.

The nurse needs to be made aware of her own feelings toward death and dying and how these affect her ability to deal with the patient and his family. Quint (1966:51) suggests:

Perhaps we need to remind ourselves from time to time that patients who are dying are not just dying. They are also living. Whether or not they have the opportunity to live this final human experience to the fullest—each in his own way—is influenced in a great measure by us who take care of them.

Statement of the Problem

The specific problem identified for study was: To what degree is the visiting nurse's method of approach to the dying patient enhanced by a planned inservice program on the psychosocial aspects of death and dying?
The problem is worthy of study because nurses, regardless of the patient setting, "need to develop an understanding of the grieving process which characteristically accompanies a fatal diagnosis. Knowing and recognizing the steps allows the nurse to evaluate the emotional status of the patient and his family" (Fond 1972:56). This information is vital to assessing all relationships and prepares the nurse to handle the patient and family situation better (Fond 1972).

The problem is significant to nursing because according to Quint (1967:107), "nursing students are prepared for the physical and technical aspects of care of the dying but rather poorly prepared for the psychosocial matters that come up in nursing practice. Nurses need to face the reality that care for the dying is essentially a nursing problem." It is nurses and their colleagues who deal with the day-to-day tasks of helping these people and their families live with the physical, social, and psychological consequences of the illness (Quint 1967).

**Delimitations**

This study was restricted by the following factors:

1. The sample of nurses was small.

2. The sample was composed of the nursing staff from a small Southwestern Visiting Nurse Service.
3. The participating nurses were aware of the researcher's interest in death and dying and this may have influenced their responses.

4. Selected aspects of death and dying were explored.

5. The validity of the conclusions is no more accurate than the responses given by the nurses.

6. The sample was composed of only females.

Conceptual Framework

This comparative study was based on Kubler-Ross's (1969) extensive studies of the dying patient and the Gestalt-Field Theory of Learning as described by Bigge (1964).

In past generations epidemics accounted for a great many deaths. To lose an infant or young child within a family was not uncommon. With the advent of vaccines, antibiotics, and better medical care, many illnesses have been controlled or eradicated. Consequently, people are living longer and the incidence of malignant and chronic disease is on the increase.

According to Kubler-Ross (1969:2), "in our own unconscious, death is never possible in regard to ourselves . . . and our unconscious cannot distinguish between a wish and a deed." For example, the child who wishes his mother dead because she did not gratify his needs, is traumatized by her actual death even if the event is not closely linked
in time with his destructive wish. He will always blame himself for all or part of her death. The adult, on the other hand, experiences shame, guilt, and grief with the loss of a significant person. The grief process always has some degree of anger associated with it. Unfortunately, most people do not admit to this anger and disguise it in other ways, thereby extending the grief process and often never resolving the loss (Kubler-Ross 1969).

In the past, death was a fearful event. For example, the American Indians, following a death, shot arrows into the air to keep the evil spirits away. Today, at military funerals, shots fired into the air represent the same symbolic ritual. This indicates that man's attitudes toward death and dying have not basically changed. Death is still a fearful and frightening happening (Kubler-Ross 1969).

In the past, people were more likely to die at home rather than in the hospital. In this setting, the dying person was in a familiar environment with his family and children around him. Dying at home is not only easier for the person but for his family, especially his children who can share in the preparatory grief and from this experience will grow up realizing that death is a part of life.

Today, most people die in the hospital rather than at home. This change of environment has made dying a lonely, impersonal, and mechanical experience.
Kubler-Ross (1969:7), "The more we are making advances in science, the more we seem to fear and deny the reality of death." For example, after a person dies, he is made to look as though he were asleep. If the person does die at home, the children are not included but sent away until it is all over. Currently research is being done that will allow people in the future to be deep frozen following their deaths to await the day when science and technology have advanced enough to defrost them and return them to life and society.

The value that society places on the dying person is another area to be considered. Social value is usually determined by such characteristics as age, intelligence, occupation, and family position. An individual who has the potential to serve his country as a leader receives more attention and heroic measures than the "skid-row bum," for example. The death of a child is viewed as a greater loss than the death of an elderly person who is thought to have lived a complete, full life.

Although there is a need to avoid the issue of death, Kubler-Ross emphasizes that each individual will have to face it sooner or later. Therefore, this study of comparing the methods of nurses' approaches to the dying patient and his family is partly based on Kubler-Ross's (1969:16) recommendations that "if all of us could make a start by contemplating the possibility of our own personal death, we may
effect many things, most important of all the welfare of our patients, our families, and finally, perhaps our nation."

In conjunction with Kubler-Ross's research on death and dying, Bigge succinctly presents a synopsis of the Gestalt field psychologist's school of thought. He presents the school's definition of intelligence as "that capacity to act with dependable foresight which is the product of the interaction of a person and his perceived (psychological) environment" (Bigge 1964:279). This is displayed by the individual's ability to solve problems in his area of interest. This concept assumes that the problem solving ability, although influenced by hereditary factors, is conducive to change, and can be enhanced through education (Bigge 1964). The thought is that through education, if the individual is given the opportunity to learn the process, to practice problem solving, and to achieve generalized insights about it, most new problems will be approached more intelligently than before.

Learning, on the other hand, is regarded as "a change in knowledge, skills, attitudes, values, or beliefs, that may or may not have anything to do with change in overt behavior" (Bigge 1964:278). In other words, learning is essentially a process of developing new insights or modifying old ones. Bigge believes that learning is a purposive, explorative, imaginative, and creative process. He maintains that insights occur if an individual, when pursuing
his purposes, sees new ways of utilizing the elements of his environment, including his own bodily structure. Insights are not to be considered totally from an objective viewpoint, but rather as interpretation of what one perceives in his environment and what action can be taken. For example, in the teacher-student relationship, the teacher can acquaint the student with his insights, but these do not become insights for the student until the student sees the meaning for himself and adopts them as his own.

In terms of behavior's relationship to learning, Gestalt theorists suggest that psychological behavior is not directly observable but must be inferred. They maintain that not only may change in behavior occur without learning, but that learning may occur without observable changes in behavior.

The emphasis of this theory of learning is on experience rather than behavior, with experience defined as, "an interactive event in which a person comes to see and feel the consequences of a given course of action, through acting and seeing what happens" (Bigge 1964:110). Therefore, one does not necessarily learn by doing except in so far as one's doing contributes to one's change in cognitive structure. In order for learning to occur, doing must be accompanied by the realization of the consequences. Thus, learning occurs as a result of experience.
In conclusion, it is their belief that the transfer of learning occurs because of "perceptual similarities between two situations and that it is in the form of generalizations, concepts, or insights which are developed in one learning situation and are usable in others" (Bigge 1964:278). A person must want to try and solve new problems using the insights gained through previous experience. In order to do so, he must perceive common factors in different situations, and apply his knowledge appropriately with the desire to benefit from the outcome.

As this theory suggests, learning is a process of building onto already acquired knowledge and experience through the acquisition of new insights and the opportunity to experiment with them. The intent of this study was to present an inservice program based on Kubler-Ross's (1969) psychosocial theory of death and dying to a small group of visiting nurses to test this theory of learning.

**Assumptions**

The following assumptions form the foundation for this study:

1. People are prone to fear death.
2. Nurses are as likely to fear death as the general population.
3. Nurses have limited preparation in their education to work with the psychosocial needs of the dying patient.

4. Nurses are afraid to talk to the dying patient about death.

**Definition of Terms**

For the purpose of this study, the following definitions of terms were utilized:

1. **Visiting Nurse Staff**: The nurse who assists the sick individual at home in the performance of those activities that will contribute to his recovery (or peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. In addition to administering technical procedures and giving physical care, the contemporary role of the visiting nurse calls for intelligent use of communication skills (Leahy and Cobb 1966). The terms visiting nurse and nurse are used interchangeably throughout this study.

2. **Inservice Program**: This term means "a planned educational experience provided in the job setting and closely identified with service, in order to help a person perform more effectively as a person and as a worker" (National League for Nursing Steering Committee 1970).
3. **Psychosocial Aspects**: A general term which refers to the psychological and social factors which have a direct or indirect effect on how the dying person perceives and copes with his terminal illness.

4. **Enhance**: This term means to elevate the nurse's level of ability to incorporate both the physical and psychosocial needs of the patient in her method of approach by increasing her knowledge and self awareness as measured by comparing the nurse's responses on the pretest and posttest questionnaire.

5. **Approach**: The method used to meet the physical and psychosocial needs of the dying patient.

A statement of the problem for study, the conceptual framework, the study's delimitations, assumptions, and the definitions of terms were presented in this chapter. A review of the literature is presented in Chapter 2.
CHAPTER 2

REVIEW OF THE LITERATURE

The review of literature focused on a brief historical view of the psychosocial aspects of the dying patient, the experience of dying, the health professional's attitudes toward death and dying in relation to the patient, and recommendations for change in the method of approach to the dying patient and his family.

**Historical Viewpoint**

Traditionally, the psychosocial needs of the dying patient were met by the clergy and relatives within a strong, stable, extended family structure. Physicians healed wounds and relieved the suffering caused by illness, but were not involved with the beginning or end of life. That was the job of the midwife and the clergy (Heinemann 1972).

With changing social patterns and advances in medical technology, man's birth and death moved from his home to the more impersonal environment of a hospital. The physician replaced the midwife and the clergy. Heinemann (1972:20) maintains that, "this has cast a role for the physician for which he is ill equipped, for a relationship that had traditionally been accepted by the clergy as a sacred trust has devolved by default upon the physician."
Exclusion of the clergy at the time of death is partly the result of changing attitudes toward religion. Theology, which for centuries tried to establish the meaning of life and justification for death, failed to recognize the need for adaptation to changing religious requirements, and this has contributed to the lack of religious faith among many people today. Furthermore, the loss of traditional family structure because of urbanization and the restless mood of our present society has curtailed the emotional support of the terminally ill individual (Heinemann 1972).

**Experience of Dying**

The experience of the dying patient has been examined extensively and reported in the literature by Kubler-Ross (1971) who conducted open-ended interviews with dying patients. She identified five distinct phases of the dying process: denial and isolation, in which the patient refuses to believe he is terminally ill; anger, characterized by a feeling of "Why me? Why not someone else?"; bargaining, wherein the individual makes a deal with God in return for extra time; depression, either reactive which comes from nonacceptance of his illness or preparatory which comes from grieving for future losses and is a step toward acceptance; and acceptance, the final stage, in which the
individual feels he has said all he has to say, finished all
his business, and is ready to die.

In Kubler-Ross's (1971) experience with dying
patients, she found that most patients know they are dying
and believed that, with few exceptions, patients should be
told when they have a serious illness. She reports that the
patients have said they would like to be told under two
conditions: one is that the person telling them allows for
some hope, and the second is that "you are going to stick it
out with me, not desert me, not leave me alone" (Kubler-Ross
1971:56).

Hinton (1963) found in his study through inter­
viewing and observing the dying patients that they felt less
anxious when given time and the opportunity to explain their
fears and needs to the hospital staff. Another finding was
that the patients elicited their requirements for help in
terms of companionship, a need to feel secure, a need to
have control of their physical symptoms, and to know that
medical and nursing care was available.

There are reasons why it has been difficult to study
the dying and why the literature reflects little research in
this area. Hinton (1971:39) reports, "the reluctance to
study dying people contrasts with the enthusiasm for
investigating fatal diseases. The thought of intruding into
intense personal feelings, the fear of causing distress and
dislike of facing personal death, all contribute to this
reluctance." He concludes his statements by saying that "until physicians feel reasonably confident that a research worker will not leave a trail of dismantled emotional adjustments, their sense of responsibility for their patients will not sanction investigations unless there is evidence of careful thought for the conduct of the study" (Hinton 1971:39). Kubler-Ross (1969) expressed the same difficulty in gaining permission from physicians to talk to their patients about dying when she first began her research into the experience of dying.

Hinton (1971) recommends that more studies are needed in the area of the changes which occur with the passage of time during terminal illness. Specifically, how attitudes toward dying evolve and how people's views change after discussion of their prognosis. To do this, we must educate the professionals first.

According to Glaser and Strauss (1968:62), who have done extensive research on the dying patient, "the experience of dying is quite intense and is shaped by the individual's personal history of illness, his characteristic way of responding to stress, the nature of the terminal illness, and the interactions he has with others during his dying period."

**Health Professionals' Attitudes Toward Death and Dying**

Since nurses have more contact with the dying patient than any other group of personnel, their response to
death and dying, and the patient's response to their behavior, are quite important in determining the context of dying. According to Quint (1966) Americans are characteristically prone to avoid talking openly about the process of dying and they tend to be unwilling to tell the dying patient that he is dying. The paradox is that when health personnel are queried, they want to know and be told their diagnosis. In essence, doctors and nurses have the same attitudes toward talking about dying as laymen in this society, and their educational experience has done little to change them. "Doctors and nurses are trained primarily to cope with the technical aspects of death. As students they are taught what to do to save lives or to avoid errors, but have little training in how to talk to dying patients and their families" (Strauss, Glaser, and Quint 1964:73).

Two studies were recently published that substantiated the theories behind this study. Yeaworth, Kapp, and Winget's (1974:20) comparative study of freshmen and senior students and their attitudes toward dying patients revealed that "compared to freshmen, the responses of senior students indicated greater acceptance of feelings, more open communication, and broader flexibility in relating to dying patients and their families." These findings indicated that important shifts in attitudes about death and dying can result from nursing education. The second study by Lester, Getty, and Kneisl (1974:50) compared the attitudes of death between
undergraduate and graduate students and nursing faculty. They hypothesized "that the fear of death and dying decreased with increased academic preparation." The data supported this hypothesis.

Participant observation studies of nursing behaviors elicited toward the dying patient have been conducted by Quint in the hospital setting. In one study (Quint 1966), the conclusion was that society's fear of death is carried over into the hospital culture and is reflected in the avoidance behaviors of the hospital staff toward dying patients. In another study, Quint (1967) concluded that nurses should not wait to be told by the physician or wait for the patient to ask for help, but they should take the initiative in talking to both. Finally, in a study conducted by Quint (1965:132), she inferred that "little change in nursing practice can be expected as long as the social and psychological aspects of patient care remain essentially unaccountable and less important than the highly technical life-saving procedures which modern medicine continues to emphasize." For example, hospital personnel are not held accountable for the interpersonal aspects of patient care in the same way that they are held responsible for carrying out certain technical procedures.

A recent study by Golub and Reznikoff (1971), which included fifteen public health nurses in the sample, indicated that nursing may be getting ready to redefine its
professional role. Their research revealed that the nurses wished to be informed if they had a terminal illness, and also felt that others in the same situation should be informed. In addition, they concluded that "nurses appear to acquire common attitudes early in their professional experience and these remain comparatively stable throughout their nursing careers" (Golub and Reznikoff 1971:508).

Crane (1970:314) states that "Studies indicate that communication between dying patients and both staff and relatives is poor." This can be explained by the fact that interactions with persons who have no future is frustrating in our culture. Such individuals suffer a sharp loss in social value. Unfortunately, health professionals' attitudes toward these patients are very different from their attitudes toward patients for whom some hope remains. The latter are socially rewarding because they can be made objects of heroic life-saving measures. The dying patient's role, on the other hand, tends to be defined negatively rather than positively. He is expected not to be difficult, not to complain (Crane 1970).

Crane (1970:316) feels that more studies of health professionals' attitudes toward dying patients and the fear they arouse in those who come in contact with them would be helpful because "perceptions of death may influence behavior toward and by dying persons."
Heinemann (1972:29) states that, "the need to train personnel to learn to understand death and face up to it when another human being is dying and in need of emotional support is obvious. The need is more acute because of medical technology having the ability to prolong the process of dying making it more stressful for relatives and more expensive and troublesome for society at large."

Sheldon and his colleagues (1970) conducted a pilot study of terminally ill patients from the standpoint of their socio-emotional management using the team approach. That is the only study the researcher located in the literature that is indicative of action being taken to measure what health professionals are currently doing to meet the psychosocial needs of the dying patient. Although the study's primary emphasis was on the team approach, there were some interesting conclusions drawn pertinent to nursing. To begin with, the nurses found it difficult to respond to sadness about death either in themselves or the patients. Secondly, the nurses did not differentiate legitimate sadness from clinical depression. Thirdly, the nurses encountered a problem with their change in role: that of spending more time talking to the patients and their families rather than in the traditional role of bedside care. They began to realize that this, too, was a form of treatment. Finally, in time, the nurses began to understand the value of their opinions and of the information they
gathered at the bedside while participating in the team meetings.

**Recommendations for Change**

McCarron (1973:51) reports that, "if nursing is defined as helping someone meet his needs as he perceives them, then the nurse is responsible for accepting that person's individuality." How does the nurse accomplish this task? First, the nurse must recognize that the person brings with him his own life style and that he will most likely face death as he has all the other circumstances of his life. Secondly, the nurse will need to accept his cultural and social values even though they are unlike her own. Thirdly, and most important, the nurse must meet the person's needs and not her own. Finally, by listening carefully, and observing what the person is saying verbally and behaviorally, the nurse can evaluate the person's request for help (McCarron 1973). As many nurses have found, listening to another person talk about the personal meaning of death can be a psychologically exhausting experience, but a very meaningful one.

Quint (1969:297) suggests that, "it is when the nurse becomes less professional and more human that she provides the personalization of care that patients want." How does the nurse personalize her care? Quint (1969) recommends talking with the patient while taking care of his
medical needs; looking into his eyes and responding to what
she senses he feels; and exchanging her thoughts, feelings,
and ideas with him. Quint (1969:297) states, "it is true
that the nurse is in the position to provide for the
patient's emotional well-being, but I do not think she can
do so until the system includes some organized means for
providing emotional support to the nurses themselves."

To conclude the statements found in the literature
that recommend changing the nurse's method of approach to
the dying patient, Quint (1967:64) charges the nursing pro-
fection with the following:

If we in nursing really believe that people have
the right to a humane and dignified death, we must
be willing to help create an environment in which
the psychosocial needs of the patient do not get
lost in the high priorities and social rewards
attached to saving lives. We must be willing to
move into new kinds of role relationships with
physicians, patients, and the many other health
workers involved in the system.

The review of literature revealed copious amounts of
information on death and dying which became redundant after
a time. Interestingly, there is little formal research on
this subject documented in the literature. The studies that
are available were conducted in hospital settings and in
only two instances included the public health nurse. One
was Golub and Reznikoff's (1971) in their study of nurses'
attitudes toward death and Sheldon et al.'s (1970) study of
the socioemotional management of the dying patient. However
in these studies, the emphasis was on the nurse in the hospital setting.

Based on the findings in the review of literature, the researcher designed, planned, and implemented this comparative study. The study design is described in more detail in Chapter 3.
CHAPTER 3

RESEARCH DESIGN

This chapter presents an explanation of the design of the study, methods of data collection, and techniques for analyzing the data.

Design of the Study

The focus of this study was the visiting nurse, her knowledge and understanding of the dynamics of the dying process, and her ability to meet the psychosocial needs of the dying patient and his family. The study dealt with the question of: To what degree is the visiting nurse's method of approach to the dying patient enhanced by a planned inservice program on the psychosocial aspects of death and dying?

The study was designed to: (1) compare the visiting nurse's method of approach to the dying patient and his family prior to a planned inservice program on death and the dying process and her method of approach at the termination of the program; (2) provide the nurse with the opportunity to examine her own attitudes toward death and dying through the independent variable of an inservice program; and (3) measure the dependent variable, which is the degree of change in the nurse's method of approach to the dying
patient. A meeting was arranged by the researcher with the Director of the Visiting Nurse Service. The focus of the meeting was on the researcher's interest in presenting an inservice program on the visiting nurse's role in dealing with the psychosocial aspects of care of the dying patient and his family in the home setting. The content of the program was discussed and the tools for the collection of the data, the fact sheet and questionnaire, were presented. The Director agreed with the researcher that the visiting nurse's limited ability to meet the psychosocial needs of the dying patient and his family was a problem. The Director consented to allow the researcher to conduct the inservice program and collect the necessary data to complete the study.

The inservice program was given in three separate sessions for a total of three and one-half hours. The first two sessions were a week apart and the final session was held four weeks later. The objectives of the inservice program for the nurses were as follows:

1. To become more aware of her own attitudes toward death and their implication in the provision of care to the dying patient.

2. To develop a greater understanding of the dynamics of the dying process to enhance the nurse's approach to the patient and his family.
3. To develop insight into the societal, cultural, and technological changes which necessitate the education of health professionals involved in the care of the dying patient.

4. To identify the visiting nurse's role as an important component of the health care team in the provision of quality care to the dying patient and his family.

The first session began with an introduction to the subject of death and dying. A general outline of the in-service program was presented (Appendix A). The program objectives and a bibliography were given to the nurses for their use. The nurses were then given a pretest that consisted of three parts, a fact sheet (Appendix B) and a questionnaire with two components (Appendix C) with explanation as to how to complete the instrument.

Following the pretest, the researcher presented a historical background of the development of attitudes toward death and dying and a discussion of those individuals who provided the care at the time from a sociological, cultural, technological, and educational point of view. Having examined these areas from a historical standpoint, the researcher then discussed them in terms of the present and future relative to the dying patient, his family, and the health professional.
The next area of discussion dealt with: (1) the dynamics of the dying process; (2) an introduction to the role of the visiting nurse with the dying patient and his family, emphasizing family-centered versus patient-centered care; and (3) the use of observation and communication skills. The first session concluded with summation of the material presented and a brief question period.

During the second session, one week later, Elizabeth Kubler-Ross's film, "Until I Die," was shown to provide the nurses with an opportunity to observe a health professional using observational and communication skills while meeting the psychosocial needs of the dying patient. Following the film, there was a discussion of the group's reactions to the film, the interpersonal relationship skills utilized by Dr. Ross, and a discussion of what implications this had for their role with the dying patient and his family. The session ended with a brief summary of the content of the film and the expectation that the nurses would begin to identify and work with the psychosocial needs of their terminally ill patients.

The third session was planned so that the interval of time would give the nurses an opportunity to begin to assimilate the material presented in the first two sessions. The final session was a discussion of the nurse's current experiences with terminally ill patients and their families. With each situation discussed, the group was supportive to
the nurse presenting, and assisted in establishing a plan of care. The remainder of the session was given to the post-test, which consisted of the multiple choice and quotation questionnaire. The program was concluded with a summary of the total content and a brief question period.

Sample

The sample consisted of the eight visiting nurses employed in a small Visiting Nurse Service in southern Arizona.

Sources of Data

The sources of data for this study were eight visiting nurses. The data were collected during the first and last sessions of the inservice program.

A fact sheet was designed by the researcher which elicited the following information about each nurse (Appendix B): (1) age, (2) sex, (3) religion, (4) marital status, (5) education, (6) length of time since basic nurses' training, (7) years of nursing experience and area, and (8) data concerned with the most recent encounter with a dying person.

The researcher designed a questionnaire of statements quoted from the literature which encompassed the areas of nursing practice, patient and family needs, social attitudes, and common fallacies about death and dying. In addition, information regarding the nurse's attitudes toward death and dying were obtained by employing a portion of the
multiple choice questionnaire designed by Shneidman in conjunction with Parker and Funkhouser of Stanford University (Shneidman 1970). The two questionnaires were combined and used as the pretest and posttest for the purpose of comparison (Appendix C).

Instrument for Data Collection

The measuring instruments were the fact sheet and the questionnaire which was given as a pretest and a posttest. The fact sheet was given to the nurses in order to obtain general background information.

Data to test the nurse's attitudes toward death were collected utilizing a portion of Shneidman's (1970) multiple choice questionnaire. Golub and Reznikoff (1971: 504) used six items "that were particularly relevant to nursing experience and practice" from this questionnaire in their study of nursing attitudes toward death. The researcher used the same six items. The questions sampled concepts of death in general, expectations of one's own death, and attitudes about suicide and the prolongation of life.

The portion of the questionnaire containing the quotations from the literature consisted of nineteen statements divided into the following categories retaining the numbers used in the questionnaire:
A. Nursing Practice

1. "The high value attached to life-saving responsibilities within the nursing and hospital subculture has created an environment in which recovery care carries higher priority than comfort care" (Quint 1967: 34).

3. "Nurses need to develop an understanding of the grieving process which characteristically accompanies a fatal diagnosis" (Fond 1972:56).

5. "Nurses themselves need to face reality that care for the dying is essentially a nursing problem" (Quint 1967:36).

7. "Nurses can better manage their interactions with both the patient and the family (as well as their own composure) if the doctor lets them know where the patient is in time, and what he has told the family" (Quint 1966:54).

9. "A helping relationship is one in which at least one of the partners has the intent of promoting the growth, development, maturity, improved functioning, improved coping with life of the other" (Rogers 1969, 154).

10. "The nurse should be observant of the family's behavior which might indicate grieving for the patient prior to his death" (Benolial 1972:156).

13. "Good listeners are helpers. In order to do this we must stop and spend some time dealing with our own thoughts and feelings about death so that we won't be afraid to hear what the patient is feeling and telling us about his death" (McCarron 1973:52).

15. "The education of nurses has focused attention on the saving of lives and has offered little training in the art of helping patients to live with an untreatable illness" (Strauss 1964:130).
17. "The practice of nursing is that behavior which results from the combination of knowledge, feelings, and observations about an individual patient's condition transferred into definite actions which will help the patient to regain his autonomy and meet his need for help as he perceives it" (McCarron 1973:50).

19. "If we in nursing really believe that people have the right to a humane and dignified death, ... we must be willing to move into new kinds of role relationships with physicians, patients, and the many other health workers involved in the system" (Quint 1969:298).

B. Patient and Family Needs

12. "The experience of dying is quite intense and is shaped by the individual's personal history of illness, his characteristic way of responding to stress, the nature of the terminal illness, and the interaction he has with others during his dying period" (Glaser and Strauss 1968:62).

14. "Dying, as many patients have expressed to us, has become not only more lonely and more isolated, but very often more impersonalized, dehumanized, and mechanized" (Kubler-Ross 1971:55).

C. Social Attitudes

4. "The emotional needs of the sick have not changed but the attitudes of society toward these needs have" (Heinemann 1972:26).

11. "The fear of death is a learned attitude and is related to the social trends of the time" (Fond 1972:55).

D. Common Fallacies About Death and Dying

2. "Fear of death is the most natural and basic fear of man. The closer he comes to death, the more intense the fear becomes" (Weisman 1972a:29).
6. "While man recognizes that death is universal, he cannot imagine his own death" (Weisman 1972a:13).

8. "Physicians can deal with all phases of the dying process because of their scientific training" (Weisman 1972a:30).

16. "Dying people do not want to know what the future holds. Otherwise they would ask more questions" (Weisman 1972a:29)

18. "Pain is the primary source of suffering in terminal illness and there can be no effective psychological management until pain can be controlled" (Weisman 1972a:132).

The nurses responded to these statements on a scale from strongly agree to strongly disagree. The decision to use a four point scale was based on the researcher's intent to obtain a definite answer from the respondents as opposed to a five point scale where there is an opportunity for indecisiveness.

The questionnaire was pretested on a group of fifteen public health nurses in Colorado. Having recently experienced an extensive inservice program on the dying patient, they felt the content of the questionnaire was pertinent and offered no suggestions for changes. The researcher was then ready to begin the collection of the data.

**Analysis of the Data**

The raw data from the fact sheet and the pretest and posttest questionnaire were transcribed onto punched cards for tabulation. Frequency distributions were computed for
the fact sheet and the questionnaires to compare the number of responses and percentages. Age and years of nursing experience were used as intervening variables. After tabulation, the categories established were compared and differences, similarities, and correlations were noted and reported.

The findings and their statistical interpretation are described in Chapter 4.
CHAPTER 4

PRESENTATION AND ANALYSIS OF DATA

In this chapter the characteristics of the sample as a whole are described. The findings from the questionnaire, pretest, and posttest comparisons are reported and analyzed to determine if the visiting nurse's method of approach to the dying patient was enhanced.

Characteristics of the Sample

To obtain the sample of nurses utilized in this study, the researcher contacted the Director of the Visiting Nurse Service to gain permission to conduct an inservice program with the visiting nurses on the psychosocial aspects of the dying patient. The entire sample consisted of eight nurses.

Data completed by the nurses on the fact sheet included the following: age, sex, religion, marital status, education, length of time since basic training, years of nursing experience delineated by area—Medicine, Surgery, Obstetrics, Pediatrics, Public Health, School Health or Other. These data, plus the item pertaining to the recency of interaction with a dying patient, are used to describe the nurses in the following paragraphs. The profile of the
distribution of characteristics of the visiting nurse group are shown in Table 1.

The nurses in the sample ranged from twenty-two to forty-nine years of age with a mean age of 29.87 years and a standard deviation of 9.12 years. The frequency tabulation showed that four members of the sample were between the ages of twenty-two and twenty-nine, three were thirty to thirty-nine, and one was between forty and forty-nine years of age.

All eight members of the sample were females. Three nurses were single, four were married, and one was divorced. Four nurses in the study were of Protestant faiths, three were Catholic, and one declared no religious belief.

The educational background of the nurses ranged from that of licensed practical nurse to baccalaureate level nurse. Three were licensed practical nurses of whom one had had one year of college. One nurse had an associate degree while two nurses were diploma school graduates. Two nurses were graduates of a generic baccalaureate program.

For the entire sample, the length of time since basic nursing training ranged from one to eleven years. There were five nurses who had received their basic education one to five years ago. One nurse graduated six to ten years ago and two nurses graduated eleven years ago.

The length of nursing experience for the total sample ranged from one to eleven years. One nurse had had
<table>
<thead>
<tr>
<th>Nurse</th>
<th>Age</th>
<th>Sex</th>
<th>Religion</th>
<th>Marital Status</th>
<th>Education</th>
<th>Time Since Basic Training</th>
<th>Length of Experience</th>
<th>Recency of Interaction with Dying</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>32</td>
<td>F</td>
<td>Catholic</td>
<td>M</td>
<td>LPN and 1 year college</td>
<td>11 years</td>
<td>10 years</td>
<td>4 months</td>
</tr>
<tr>
<td>02</td>
<td>32</td>
<td>F</td>
<td>None</td>
<td>D</td>
<td>Diploma</td>
<td>11 years</td>
<td>11 years</td>
<td>Currently</td>
</tr>
<tr>
<td>03</td>
<td>34</td>
<td>F</td>
<td>Seventh Day Adventist</td>
<td>M</td>
<td>LPN</td>
<td>5 years</td>
<td>5 years</td>
<td>2 weeks</td>
</tr>
<tr>
<td>04</td>
<td>24</td>
<td>F</td>
<td>Catholic</td>
<td>S</td>
<td>Baccalaureate</td>
<td>2 years</td>
<td>2 years</td>
<td>2 months</td>
</tr>
<tr>
<td>05</td>
<td>22</td>
<td>F</td>
<td>Non-denominational</td>
<td>S</td>
<td>Baccalaureate</td>
<td>1 year</td>
<td>1 year</td>
<td>Currently</td>
</tr>
<tr>
<td>06</td>
<td>49</td>
<td>F</td>
<td>Presbyterian</td>
<td>M</td>
<td>LPN</td>
<td>7 years</td>
<td>7 years</td>
<td>2 months</td>
</tr>
<tr>
<td>07</td>
<td>23</td>
<td>F</td>
<td>Baptist</td>
<td>M</td>
<td>Associate</td>
<td>4 years</td>
<td>1 year</td>
<td>1 month</td>
</tr>
<tr>
<td>08</td>
<td>23</td>
<td>F</td>
<td>Catholic</td>
<td>S</td>
<td>Diploma</td>
<td>1 year</td>
<td>1 year</td>
<td>Never</td>
</tr>
</tbody>
</table>
one year experience and been out of school for four years. The remainder of the distribution was unchanged in relation to the time since basic training and years of experience.

The recency of interaction with a dying person ranged from currently to four months ago. One nurse denied ever having been involved with a dying person. Two nurses were interacting with a dying person currently. Another nurse had been involved as recently as two weeks before the inservice and the remaining five nurses had been in contact with a dying person from one to four months previously.

In general, the characteristics of the sample group showed a group of eight nurses who ranged in age from twenty-two to forty-nine years of age with one to eleven years of experience. The factors of religion, marital status, education, and years of nursing experience provided variation but were not significant as a result of the small sample size.

**Analysis of Findings**

To analyze the findings of this study, the raw data were transferred from the fact sheet, the pretest, and posttest, to punched cards for computer analysis. The researcher, through the use of the computer, determined frequency distributions for the data from the pretest and posttest questionnaires. The number of responses and percentages are reported and analyzed. In addition, the fact sheet data were correlated with the questionnaires to determine the
relationships involved in the nurses' attitudes toward death and dying, nursing practice, patient and family needs, social attitudes, and common fallacies about death and dying.

The multiple choice portion of the questionnaire investigated the nurse's concepts about death in general, expectations of their own death, attitudes about suicide, and medical care of the dying. The answers to the questionnaire items with frequencies and percentages for the pretest and posttest are summarized in Table 2. The presentation and discussion are limited because of the small sample size.

In regard to the first question, five respondents or 62 per cent of the nurses on the pretest and posttest firmly believed that psychological factors can influence death. The other 37.5 per cent on both the pretest and posttest tended to believe that psychological factors can influence death. There was no change in response.

Responses on the pretest and posttest with respect to the question of wanting to be told if they had a terminal diagnosis, six or 75 per cent of the sample responded "yes" and 25 per cent responded "no" versus 100 per cent responding "yes" on the posttest. That is, two persons changed opinion on the posttest. In neither case did the respondents state "it would depend on the circumstances."

The responses to the question about approval of having an autopsy done on themselves showed four or 50 per
<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Pretest</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychological Factors:</strong></td>
<td>A. I firmly believe they can.</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>To what extent do you believe</td>
<td>B. I tend to believe they can.</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>that psychological factors can</td>
<td>C. I am undecided or don't</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>influence (or even cause) death?</td>
<td>D. I doubt that they can.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Terminal Illness:</strong></td>
<td>A. Yes</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>If your physician knew that</td>
<td>B. No</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>you had a terminal disease and</td>
<td>C. It would depend on the</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>a limited time to live, would</td>
<td>circumstances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>you want him to tell you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Autopsy:</strong></td>
<td>A. Approve</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>How do you feel about having</td>
<td>B. Don't care one way or the</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>an autopsy done on your body?</td>
<td>other.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. Disapprove</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>D. Strongly disapprove.</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Suicide Prevention:</strong></td>
<td>A. In every case.</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>To what extent do you believe</td>
<td>B. In all but a few cases.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>suicide should be prevented?</td>
<td>C. In some cases, yes.</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>D. In no case; if a person</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>wants to commit suicide, society has no right</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>to stop him.</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Percentage calculations applied to N count for each question.
<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Pretest</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Life Maintenance Efforts:</td>
<td>A. All possible effort: transplantation, kidney dialysis, etc.</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>What efforts do you believe ought to be made to keep a seriously ill person alive?</td>
<td>B. Efforts that are reasonable for that person's age, physical condition, and pain,</td>
<td>5</td>
<td>62.5</td>
</tr>
<tr>
<td></td>
<td>C. After reasonable care has been given, a person ought to be permitted to die a natural death.</td>
<td>3</td>
<td>37.5</td>
</tr>
<tr>
<td></td>
<td>D. A senile person should not be kept alive by elaborate artificial means.</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Heart Transplantation:</td>
<td>A. Yes, to anyone.</td>
<td>7</td>
<td>87.5</td>
</tr>
<tr>
<td>Would you be willing to donate your heart for transplantation (after you die)?</td>
<td>B. Yes, but only to a relative or friend.</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>C. I have strong feeling against it.</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>D. No.</td>
<td>1</td>
<td>12.5</td>
</tr>
</tbody>
</table>
percent approved, 25 per cent did not care, 12.5 percent disapproved, and 12.5 per cent strongly disapproved on the pretest. On the posttest, six or 75 per cent approved, 12.5 per cent did not care, and 12.5 per cent disapproved, representing a shift of one person from strongly disapprove to approve.

The respondents' approval of suicide prevention in some cases was four or 50 per cent, in all cases was three or 37.5 per cent, and in no case was 12.5 per cent. On the posttest, the one respondent who had taken the strong negative stance toward suicide prevention moved to a more open position.

On the question concerning life maintenance efforts, five or 62.5 per cent of the respondents in the pretest felt reasonable effort should be made to keep the seriously ill patient alive and three or 37.5 per cent felt that the patient ought to be permitted to die a natural death after reasonable care has been given. However, the posttest revealed 100 per cent of the sample believed that reasonable effort should be taken. In each instance, none of the nurses chose to provide all possible effort or to save a senile person.

In addressing the question of heart transplantation, seven or 87.5 per cent of the sample would donate their heart to anyone and 12.5 percent did not want their heart transplanted at all. In the posttest comparison, the person
who previously strongly objected moved to the position of
donation to anyone.

In Part B of the multiple choice portion of the
questionnaire, the responses were varied although not
statistically significant. An incidental finding was that
one nurse claimed to have not had any previous contact with
a dying person.

The data revealed no statistical significance
between the variables of age and length of experience as a
result of the sample size.

The quotation portion of the questionnaire investi-
gated the nurse's concepts about nursing practice, patient
and family needs, social attitudes, and common fallacies
about death and dying. Table 3 summarizes the answers to
these categories in the questionnaire by comparison of the
means and standard deviations of the pretest and posttest.
The presentation and discussion is limited by the small
sample size.

The first category, nursing practice, showed the
same mean score of 1.687 for the pretest and posttest. A
variation in the standard deviation from 0.236 on the
pretest to 0.300 on the posttest indicated a change and
wider distribution of the responses. This was not suffi-
ciently large, however, to be of statistical significance.

The second category, common fallacies about death
and dying, showed similar findings. The mean score of 2.700
Table 3. Comparison of Pretest and Posttest Means and Standard Deviations with Respect to Categories

<table>
<thead>
<tr>
<th></th>
<th>Pretest</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Standard Deviation</td>
</tr>
<tr>
<td>Nursing Practice</td>
<td>1.687</td>
<td>0.236</td>
</tr>
<tr>
<td>Fallacies</td>
<td>2.700</td>
<td>0.239</td>
</tr>
<tr>
<td>Social Attitudes</td>
<td>2.438</td>
<td>0.678</td>
</tr>
<tr>
<td>Patient and Family Needs</td>
<td>1.750</td>
<td>0.802</td>
</tr>
</tbody>
</table>

N = 8

on the pretest changed slightly to 2.525 on the posttest. The standard deviation was 0.239 on the pretest and 0.301 on the posttest again signifying a shifting of responses and wider distribution but not of statistical significance.

Social attitudes showed a small variation in the mean of 2.438 on the pretest to 2.188 on the posttest. The standard deviation went from 0.678 on the pretest to 0.458 on the posttest. Although not significant, the figures indicated a noticeably narrower spread of scores in the posttest.

The patient and family needs mean ranged from 1.750 on the pretest to 1.563 on the posttest. The standard deviation went from 0.802 on the pretest to 0.417 on the posttest indicating a tightening of the range of scores.

A Pearson Correlation Coefficient was done on the four categories of the quotation portion of the questionnaire
comparing the pretest and posttest responses. Table 4 summarizes these findings.

Table 4. Pearson Coefficient Comparison Between Categories Pretest and Posttest

<table>
<thead>
<tr>
<th>Category</th>
<th>Pearson Coefficient</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Practice</td>
<td>.1593</td>
<td>.353</td>
</tr>
<tr>
<td>Fallacies</td>
<td>.3572</td>
<td>.193</td>
</tr>
<tr>
<td>Social Attitudes</td>
<td>.1581</td>
<td>.354</td>
</tr>
<tr>
<td>Patient and Family Needs</td>
<td>-.4804</td>
<td>.114</td>
</tr>
</tbody>
</table>

An area of practical significance in these findings was the inverse relationship between nursing practice and common fallacies. Those in the sample who scored high in the area of nursing practice, tended to score low, that is, they did not recognize the common fallacies on the pretest. Conversely, on the posttest, those who scored high in the area of nursing practice, scored high on the common fallacies. This indicates that the sample group did not recognize the common fallacies about death and dying until after the inservice.

The data from the fact sheet when correlated with the pretest and posttest indicated no significant difference, primarily because of the sample size.
The data as presented represent, essentially, the findings of the study. The next chapter will present the conclusions and recommendations.
This chapter presents the conclusions and recommendations of this comparative study dealing with the question: To what degree was the visiting nurse's method of approach to the dying patient enhanced by a planned in-service program on the psychosocial aspects of death and dying?

Because of the small sample, there was no statistical significance in the comparison of the pretest and posttest responses. The demographic data when compared with the pretest and posttest also proved statistically insignificant.

However, some interesting trends appeared within the pretest and posttest data indicating that change had taken place. The multiple choice portion of the questionnaire revealed that psychological factors were believed to influence death by 62 per cent of the nurses. In addition, there was a shift from 75 per cent to 100 per cent of the nurses who wished to be informed if they had a terminal illness. The nurses' responses changed from 50 per cent to 75 per cent approval of having an autopsy. There was a small increase in the response to suicide prevention in some
cases from 50 per cent to 62.5 per cent. In the area of life maintenance efforts, the shift was from 62.5 per cent to 100 per cent to provide reasonable efforts to the seriously ill person. The final area, heart transplantation, showed a change from 87 percent to 100 per cent consent to donate the organ to anyone. The researcher concluded from this shift in the nurses' responses that the inservice program influenced the nurses' attitudes toward death and dying.

The inverse relationship in the correlation coefficient between nursing practice and common fallacies was statistically significant. This indicated that those nurses who scored high on the pretest in nursing practice, scored lower on the common fallacies. On the posttest, the nurses who scored high in nursing practice tended to score high on the common fallacies. This indicates that they did not recognize the common fallacies until after the inservice program.

Conclusions
From the data presented in the preceding pages, the following conclusions are derived:

1. The data, although not statistically significant as a result of the small sample size, showed a trend in the nurses' responses, when comparing the pretest
and posttest, toward a more open approach to the dying patient.

2. The inverse relationship found between the categories of nursing practice and common fallacies indicated that change had taken place in this area.

3. The inservice program provided an opportunity for the nurses to become aware and deal with their attitudes toward death and dying and realize how such attitudes affect their practice.

4. Through open discussion of dying patients and their families, it is likely that some dissonance within the nurses could have been reduced.

5. The inference was made that nurses' attitudes in regard to death do not vary a great deal from those of the general public.

6. An incidental finding was that one participant claimed to have had no contact with a dying person.

**Recommendations**

Based on the findings and conclusions of this study, the following recommendations are made:

1. Replicate the study, using a larger sample.

2. Conduct a longitudinal study which is observational to determine whether change in the nurses' method of approach is reflected in their subsequent professional behavior.
3. Establish multidisciplinary seminars in facilities where staff must deal with death and dying.

4. Make available resource persons who will provide guidance and support to the nurses when they are caring for terminally ill patients.

5. Encourage nurses to utilize one another as resource people when faced with a terminally ill patient.

6. Provide nursing students with experiences in caring for the dying patient in conjunction with classes on loss, grief, and death; small group discussions and one-to-one counseling should be available to students during this experience.

7. Conduct a study on those individuals involved with teaching death and dying to determine their attitudes toward death and dying.
CHAPTER 6

SUMMARY

This study dealt with the question of to what degree the visiting nurse's method of approach to the dying patient was enhanced by a planned inservice program on the psycho-social aspects of death and dying.

The theoretical framework was based on Kubler-Ross's (1969) extensive studies of the dying patient and the Gestalt-field theory of learning as described by Bigge (1964). The theory suggests that learning is a process of building onto already acquired knowledge and experience through the acquisition of new insights and the opportunity to experiment with them. An inservice program based on Kubler-Ross's psychosocial theory of death and dying was presented to a small group of visiting nurses to test this theory of learning.

The literature supported the need for nurses to have the opportunity to become aware of and examine their own attitudes toward death and dying and to realize how such attitudes affect their practice.

The data for this comparative study were collected and measured through the nurses' responses to the pretest and posttest questionnaire. The sample of nurses consisted
of the complete nursing staff of eight visiting nurses employed in a small Visiting Nurse Service in southern Arizona.

The delimitations of the study were: (1) the sample of nurses was small, (2) the sample was composed of only females, (3) the participating nurses were aware of the researcher's interest in death and dying and this may have influenced their responses, and (4) only selected aspects of death and dying were explored.

Although there was no statistically significant difference when comparing the pretest and posttest, the data revealed a trend toward a more open approach to the dying patient on the part of the nurses. The demographic data when compared to the responses on the pretest and posttest proved statistically insignificant.

The inverse relationship found between the categories of nursing practice and common fallacies about death and dying revealed acknowledgment of the fallacies, following the inservice program, indicative of education in this area.

The multiple choice portion of the questionnaire when comparing the pretest and posttest, indicated a shift in the nurses' responses suggesting that the content of the inservice program influenced their attitudes toward death and dying. The sample as a whole believed that psychological factors influence death; that suicide should be prevented in some cases; that reasonable effort should be taken with the
seriously ill person, that they personally wanted to be told they had a terminal illness; and that they would donate their hearts for transplantation to anyone.

In conclusion, the findings, although of no statistical significance because of the small sample size, supported the belief that education of nurses in the psycho-social aspects of death and dying enhances the quality of care given to the terminally ill patient and his family. Therefore, it is recommended that nursing education and health care facilities provide programs geared to teaching nurses communication and interpersonal skills to deal better with the dying patient in addition to providing them with the opportunity to explore their own feelings and attitudes toward death.
APPENDIX A

GENERAL OUTLINE OF INSERVICE PROGRAM
PRESENTED TO THE VISITING NURSES

First Session

I. Introduction

II. Pretest

III. The Growth and Development of Attitudes Toward Death and Dying From a Historical Perspective
   A. Role as a child: fears and fantasies.
   B. Parental Role; Healthy versus Unhealthy Approach to Explaining Death
   C. Social and Cultural Contributions

IV. The Fear of Death: The Proponents of Denial versus Acceptance

V. Ambivalence of Attitudes Toward Death and Dying

VI. The Dying Process: Stages Outlined by Elizabeth Kubler-Ross

VII. Education of Professionals: Pro and Con

VIII. Introduction to the Psychosocial Needs of the Dying Patient and His Family: The Visiting Nurse's Role

IX. Question Period and Summation.
Second Session

I. Presentation of the film "Until I Die," featuring Elizabeth Kubler-Ross

II. Discussion of the film and interviewing techniques utilized by Dr. Ross

Third Session

I. Discussion of terminally ill patients currently carried by the nurses.

II. Discussion of interpersonal techniques in relation to the terminally ill patient; e.g., using silence, accepting, giving recognition, making observations, suggesting collaboration, giving information, and encouraging formulation of a plan

III. Posttest

IV. Questions and Concluding Statements
APPENDIX B

FACT SHEET

Directions: For the purpose of this study, please answer these general information questions. All information will be kept confidential. No names of participants will be released and no individual profiles will be reported.

1. Age _____ 2. Sex _ _ _ _ _  3. Religion__________
4. Marital Status _____ (S M W D)
5. Education: Associate ____ Baccalaureate _____
   Diploma _____ Post-Baccalaureate_____
   Other college background ____
6. Length of time since basic nursing school graduation _____
7. Years of nursing experience _____ in what areas?
   Medical ___________ years/months
   Surgical___________ years/months
   Obstetrics__________ years/months
   Pediatrics__________ years/months
   Public Health________years/months
   School Nursing_______years/months
   Other_______________years/months
APPENDIX C

MULTIPLE CHOICE QUESTIONNAIRE

Part I

A. Directions: Please circle one answer for each question.

1. To what extent do you believe that psychological factors can influence (or even cause) death?
   A. I firmly believe that they can.
   B. I tend to believe that they can.
   C. I am undecided or don't know.
   D. I doubt that they can.

2. If your physician knew that you had a terminal illness and a limited time to live, would you want him to tell you?
   A. Yes.
   B. No.
   C. It would depend on the circumstances.

3. How do you feel about having an autopsy done on your body?
   A. Approve.
   B. Don't care one way or the other.
   C. Disapprove.
   D. Strongly disapprove.

4. To what extent do you believe suicide should be prevented?
   A. In every case.
   B. In all but a few cases.
   C. In some cases, yes; in others, no.
   D. In no case; if a person wants to commit suicide, society has no right to stop him.

5. What efforts do you believe ought to be made to keep a seriously ill person alive?
   A. All possible effort: transplantation, kidney dialysis, etc.
   B. Efforts that are reasonable for that person's age, physical condition, mental condition, and pain.
   C. After reasonable care has been given, a person ought to be permitted to die a natural death.
5. D. A senile person should not be kept alive by elaborate artificial means.

6. Would you be willing to donate your heart for transplantation (after you die)?
   A. Yes, to anyone.
   B. Yes, but only to a relative or friend.
   C. I have a strong feeling against it.
   D. No.

These multiple choice questions are part of a questionnaire designed by Shneidman (1970) in conjunction with Parker and Funkhouser.

B. How recently have you been involved with a dying person?

   ________

   How long did this last? ________

   Was this person a patient? ________

   How old was this person? ________

   What was this person's diagnosis? ________

Part 2
Quotation Questionnaire

Directions: The following is a list of statements of concepts related to the nurse and the dying patient. You will probably agree with some of the statements and disagree with others. There are no right or wrong answers. Just indicate how you feel about each statement by circling your response. The letter codes mean:

SA--Strongly Agree
A--Agree
D--Disagree
SD--Strongly Disagree

1. "The high value attached to life-saving responsibilities within the nursing and hospital subculture has created
an environment in which recovery care carries higher priority than comfort care" (Quint 1967:34).

2. "Fear of death is the most natural and basic fear of man. The closer he comes to death, the more intense the fear becomes" (Weisman 1972a:29).

3. "Nurses need to develop an understanding of the grieving process which characteristically accompanies a fatal diagnosis" (Fond 1972:56).

4. "The emotional needs of the sick have not changed but the attitudes of society toward these needs have" (Heinemann 1972:26).

5. "Nurses themselves need to face reality that care for the dying is essentially a nursing problem" (Quint 1967:36).

6. "While man recognizes that death is universal, he cannot imagine his own death" (Weisman 1972a:13).

7. "Nurses can better manage their interactions with both the patient and the family (as well as their own composure) if the doctor lets them know where the patient is in time, and what he has told the family" (Quint 1966:54).

8. "Physicians can deal with all phases of the dying process because of their scientific training" (Weisman 1972a:30).
9. "A helping relationship is one in which at least one of the partners has the intent of promoting the growth, development, maturity, improved functioning, improved coping with life of the other" (Rogers 1969:154).

10. "The nurse should be observant of the family's behavior which might indicate grieving for the patient prior to his death" (Benolial 1972:156).

11. "The fear of death is a learned attitude and is related to the social trends of the time" (Fond 1972:55).

12. "The experience of dying is quite intense and is shaped by the individual's personal history of illness, his characteristic way of responding to stress, the nature of the terminal illness, and the interaction he has with others during his dying period" (Glaser and Strauss 1968:62).

13. "Good listeners are helpers. In order to do this we must stop and spend some time dealing with our own thoughts and feelings about death so that we won't be afraid to hear what the patient is feeling and telling us about his death" (McCarron 1973:52).

14. "Dying, as many patients have expressed to us, has become not only more lonely and more isolated, but very often more impersonalized, dehumanized, and mechanized" (Kubler-Ross 1971:55).

15. "The education of nurses has focused attention on the saving of lives and has offered little training in the art of helping patients to live with an untreatable illness" (Strauss 1964:130).
16. "Dying people do not want to know what the future holds. Otherwise they would ask more questions" (Weisman 1972a: 29).

17. "The practice of nursing is that behavior which results from the combination of knowledge, feelings, and observations about an individual patient's condition transferred into definite actions which will help the patient to regain his autonomy and meet his need for help as he perceives it" (McCarron 1973:50).

18. "Pain is the primary source of suffering in terminal illness and there can be no effective psychological management until pain can be controlled" (Weisman 1972:).

19. "If we in nursing really believe that people have the right to a humane and dignified death, ... we must be willing to move into new kinds of role relationships with physicians, patients, and the many other health workers involved in the system" (Quint 1969:298).
SELECTED BIBLIOGRAPHY


