EFFECT OF PERSONAL AND PROFESSIONAL DEATH EXPERIENCE ON THE DEATH ANXIETY OF NURSES

by

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This thesis has been approved on the date shown below:

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GLORIA DiCENSO  Date
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It is my wish that this study be dedicated to my grandmother, Anna Benham, and my aunt, Lorraine Benham, whose untimely deaths due to terminal cancer made my work worthwhile and very personally meaningful. With their pride and dignity left intact, they gave strength to our entire family to deal with their deaths as they wished, with love and respect. I miss them both very much.
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This study determined the effect of personal and professional death experience on death anxiety of nurses and whether this anxiety decreases with increased personal and professional experience.

A questionnaire developed by this investigator measured the personal and professional death experience of nurses. Also, the Death Anxiety Scale was used to measure death anxiety of these same nurses. Seventy-four (general hospital, public health, and mental health) nurses were surveyed over a two-week period during regularly scheduled staff meetings. Data were analyzed statistically using descriptive frequency statistics and the Spearman rho correlation to assess psychometric properties of the investigator's Personal and Professional Death Experience (PPDE) questionnaire. Findings indicated that there was no significant relationship between PPDE score and level of death anxiety. There was found no significant relationship between personal death experience and death anxiety and between professional death experience and death anxiety. These findings were related to the fact that the questionnaire did not attempt to identify the emotional (as well as the cognitive) component of personal and professional death experience or the
direction of its impact, which would certainly affect the level of death anxiety.
CHAPTER 1

INTRODUCTION

Since the deaths of the majority of individuals in this country occur within the confines of a hospital, personnel frequently become intimately involved in this process (Quint, 1967). Although it has not always been clearly recognized, the hospital staff as well as the family are psychologically vulnerable to feelings of loss when a patient dies. Thus defensive strategies develop to protect the staff from intense emotional involvement (Glaser and Strauss, 1965).

Since there is also some evidence suggesting that death experience may lead to an increase in death anxiety (Lester, 1974), the effect of death experience still appears to be a relevant question. Not only is the effect of death experience during the educational process relevant in terms of modifying attitudes but also of significance may be the effect of personal and professional death experience previous to the specific death and dying education. We do know that an individual's reactions to a death are influenced by many personal and social factors and that a student's first professional encounters with death profoundly affects how that person will cope as a practicing nurse (Quint, 1967).
Behaviorally, we also know many nurses avoid hospital work which might bring them into contact with dying patients while many others develop what might be called passive avoidance of contact of dying patients (Quint, 1967). What we do not appear to know is what the relationship is (if any) between personal and professional death experience or what impact this experience might have on the individual nurse as measured by her level of death anxiety. Kubler-Ross (1969) has emphasized that individuals must take a hard look at their own attitudes toward death and dying before they can be helpful with terminally ill patients without feeling undue anxiety or other discomfort. Therefore, it is imperative that nurses become aware of and deal with their attitudes toward death and then realize how such attitudes affect their practice (Quint, 1967).

Since the attitudes and behavior of those caring for the dying determine what comfort and dignity the individual experiences, and the identified mechanism for change is education, there has been an increased interest in the area of death education for both professionals and laymen (Green and Irish, 1971). The writer first became interested in death and dying and the education of this process when teaching such a course to junior and senior nursing students. The basic untested assumption for providing education in the field was, and still is, that high death anxiety and aversive reactions to death result from nonexperience with death.
Thus to decrease the anxiety of those caring for the dying, it is necessary to bring these persons into contact with death (Denton and Wisenbaker, 1977).

**Purpose**

The purpose of this study was to evaluate the relationship between personal and professional death experience and death anxiety among nursing personnel.

**Statement of Problem**

This study investigated these problems: What is the effect of personal and professional death experience on the death anxiety of nurses? Does personal and professional death experience decrease the anxiety of persons caring for the dying?

**Hypotheses**

Death anxiety of nurses is positively related to personal and professional death experience. Death anxiety of nurses diminishes with increased personal and professional death experience.

**Definitions**

The following definitions were used:

1. **Dying** and **terminally ill** are used interchangeably and indicate a progressive, degenerative physical process of the organism, whose inevitable (but time undefined) outcome is physical death.
2. **Personal death experience**: feelings experienced as a result of witnessing, vicariously experiencing, and/or participating at the physical death of others.

3. **Professional death experience**: involvement and/or completion of an educational program or course defined as specifically dealing with the process of death and dying.

4. **Death anxiety** and **death fear** are used interchangeably, with death as the referent, indicating the presentation of diffuse apprehension, increased biologic activity, reduced behavioral efficiency, and defensive avoidance (Kanfer and Phillips, 1967) to symbolic or actual death stimuli.

**Conceptual Framework**

Although many emotional responses are acquired by means of direct experience (conditioning), affective learning frequently occurs through vicariously aroused emotions. For example, phobic behaviors frequently arise from witnessing others either respond fearfully toward, or be injured by specific things (Bandura, Blanchard, and Ritter, 1968; Bandura and Menlove, 1968).

Vicarious emotional conditioning results from the observation of others experiencing positive or negative emotional effects. For example, research specific to acquisition included recordings of subjects' autonomic
responses obtained during a film of a primitive puberty ritual of an Australian tribe, in which a boy underwent a crude genital operation. The aversive responses were noticeably heightened when the scenes included pain cues from the young native whereas they were reduced significantly with the inclusion of commentary and deletion of vocal pain (Speisman et al., 1964).

Often we shelter children from the dying experience, feeling we are protecting them, and according to Kubler-Ross (1975), we create fear that may not be there. Frequently, children are presented with either a direct death experience of strong emotional involvement marked by fear, or more often vicariously through parental figures, and since the general culture offers little direction, the specific content of our adult attitudes is left to individual experience (Dumon and Foss, 1972). Thus, many nursing students may enter their profession with preexisting aversive responses and avoidance behaviors even before they are presented with the first opportunity for a positive direct experience.

Since the emotional state of another person is not directly observable, the intensity is inferred from the presence of the stimulus as well as the behavioral cues of the subject (Berger, 1962). Berger also acknowledges the real possibility of erroneous impressions being acquired; i.e., the mother who responds fearfully to seeing her child
fall, even though the child is uninjured. This then represents a case of pseudovicarious instigation.

Studies by Miller, Caul, and Mirsky (1967) attempted to explain the potency of affective expressions as conditioned aversive stimuli. They found that if affective expressions have been repeatedly followed by emotional consequences for the observers, affective social cues alone gradually attain the power to evoke emotional reactions.

Conditioning in humans frequently involves mediation through the concept of empathy, which may also increase the maintenance of the response (Bandura and Rosenthal, 1968). Thus individuals react more emotionally to the sight of a person undergoing painful stimulation when asked to imagine their own response in the same situation (Stotland, Shaver, and Crawford, 1966), the result being enhanced vicarious arousal (Stotland, 1969).

Since, in this culture, death is a "taboo topic" as well as an outcome which we shall all face (often wrought with negative affective material), our response to observation of others experiencing any stage of the process is often strong and aversive (Feifel, 1963).

Aversive emotional responses and resultant avoidance behaviors may be extinguished, as well as acquired vicariously. One applicable method is observation of the modeling of anxiety-provoking situations without suffering the adverse consequences (Bandura, 1969). Bandura further
explains that for modeling to be most effective, it must provide exposure to the feared object or situation on a gradual basis and accompanied by positive affective expressions by the model. Research indicates that modeling can also produce generalizations of anxiety beyond that encountered in the treatment setting and provides lasting endurance of the extinction (Bandura, Grusec, and Menlove, 1967).

Symbolic modeling (i.e., movies), although somewhat less effective, can be increased in potency when a multiple-symbolic model treatment is employed (Bandura and Menlove, 1968). It is important to note that the modeling experience (whether symbolic or live) must be presented in a carefully planned consistent manner as well as adequately sequenced to produce maximum beneficial results.

Bandura et al. (1968) conducted an extensive study which involved treatment of snake phobias in adolescents. The treatment included live modeling, desensitization (Wolpe, 1958), symbolic modeling, and a control group. They found that symbolic modeling and desensitization produced substantial reduction in fear responses, and live modeling combined with guided participation eliminated snake phobias in virtually all subjects (92%). Specifying the treatment even further, Ritter (1969) showed that modeling accompanied by physically guided performance produced more changes than
with verbally guided enactment, which in turn was superior to brief demonstration alone.

Three processes have been delineated that contribute to production of the significant change produced by modeling. These include observation of the fearless performance by the model without aversive consequences, incidental information received about the feared object, and direct personal contact with the feared object with no adverse effects (Bandura, 1969).

Of particular interest to the subject of death and dying are the applications of social-learning procedures which have attitudinal consequences. Symbolic modeling and desensitization produced favorable changes in attitudes toward the feared object. Bandura and associates found the greatest and most lasting attitudinal changes resulted from the live modeling and practice group treatment (Bandura et al., 1968).

While the fear of death is probably universal, Americans are characterized by serious attempts at self-deception. It is doubtful that these attempts at repression are successful and may as a result even intensify a person's fear of death (Larsen et al., 1974). The reduction of this fear and the resultant avoidance behaviors must be modified significantly before nursing personnel can be helpful with the terminally ill patient.
If the model of vicarious learning is accepted, it may indicate that the more intimate experience a person has had with death (assuming it has not traumatized the individual), the more she will be desensitized and accepting of death (Larsen et al., 1974). The awareness of personal and professional death experience outside an educational system identified as dealing with the death and dying process may have some relevance to the outcome of that educational experience.
CHAPTER 2

REVIEW OF THE LITERATURE

This review of literature focuses on the formation of attitudes toward death and dying, variables identified specific to nursing personnel in terms of death anxiety, the effectiveness and/or ineffectiveness of death and dying education, and the relationship between death anxiety and death experience.

Death Attitude Formation

Schilder and Weschler (1934) conducted an early study on death formation in children. They stated that sometime before the age of six a child begins to express interest in the process of death. This interest is rarely expressed as fear, but rather in terms of a state of deprivation; i.e., loss of a loved one, to which they apparently unconsciously connect death.

Dumont and Foss (1972) spoke about childhood development of death attitudes in terms of experiencing social death (Riley, 1968). Social death is defined as a child's first experience with death usually occurring as an indirect experience, between the ages of three and eight years. The child's attitude is influenced when he affectively discerns the meaning of death through the loss of someone with whom
she or her parental figures are emotionally close. When speaking to the issue of children's fear of death, Dumont and Foss feel it is the unnatural state of the corpse and the feeling of strangeness and discomfort expressed by the adults in the environment which provide the basis for this fear. He parallels the discussion of death in our society with that of sex. The usual evasion and deception is felt to be more harmful than helpful. This is further hampered by our society’s absence of cultural direction. Dumont and Foss (1972) claim our attitudes toward death become more sophisticated and fixed by the end of adolescence and during young adult years. Thus, children progress from non-awareness of death to a clearer but not unified concept.

In terms of our attitude toward death as young adults, Thorson (1977) measured death anxiety among college students, in terms of sex, field of study, and personality traits. He found increased fear on the part of females, social workers expressing the highest levels of death anxiety, and business majors the lowest. Specific to personality, he stated the following: "One might picture the person low in death anxiety as being more masculine, assertive, and pragmatic and the one high in death anxiety as more feminine, passive, and empathetic" (Thorson, 1977, p. 858).

Specific to medical and nursing personnel, it is felt that personal fears influence how candidly we discuss
death with patients as well as influencing how we perceive the patient's feelings (Mount, Jones, and Patterson, 1974). These fears are influenced by our experiences with and exposure to death particularly during nursing education (Quint, 1967).

Golub and Reznikoff (1971) tested the attitudes of nursing students and graduate nurses. Their findings suggest nursing attitudes are formed early in the career through an identification process of her reference group and role models; i.e., the professional nurse.

Death Anxiety: Its Effect On Nursing Personnel

Recently, several studies have been done in an attempt to isolate factors affecting nursing attitudes toward the dying patient.

In terms of settings, Shusterman and Sechrest (1973) found no significant difference in attitude in terms of employment locations/specialties in which nurses spent the majority of their time. These findings were further verified by several other studies (Gow and Williams, 1977; Golub and Reznikoff, 1971; Campbell, 1976). At least two studies dealt with personnel working in geriatric settings where the exposure to death and dying is expected to be the highest (Kazzaz and Vickers, 1968; Pearlman, Stotsky, and Dominick, 1969). Both studies indicated personal feelings were generally handled by avoidance and denial, Mount et al,
(1974) surveyed attitudes of personnel and patients in a teaching hospital. They did feel it significant to comment on the minority of nurses and doctors who responded to the survey. Of particular interest was the patient responses indicating they felt attending physicians the least aware of the patient's emotional needs.

Age is another variable specifically investigated by researchers. Increased age appeared to indicate a willingness to discuss death and dying and/or resulted in less expression of fear of the death of other persons (Mount et al., 1974). Older nursing personnel also appeared to be more satisfied with the traditional medical model care (Shusterman and Sechrest, 1973). One possible interpretation is offered by Ross (1978), who feels the older personnel have worked through their own death anxiety. In contrast, Pearlman et al. (1969) state that younger personnel were more open. Their interpretation of findings was that the less experienced personnel tended to be less defensive. Campbell (1976) found no significant correlation between age and attitudes toward the dying patient.

Closely aligned to the age variable is the amount of experience with dying patients. It has already been stated that settings where personnel are apt to be more exposed to the death process does not appear to be clearly significant. Some studies (Golub and Reznikoff, 1971; Campbell, 1976) found little or no differences in attitudes based on years.
of nursing experience and determined the amount of contact with death was not the major attitudinal determinant. In contrast, Shusterman and Sechrest (1973) claimed more experienced nurses express less fear of death of other persons.

Religion is frequently mentioned in terms of dealing with the dying patient. Kazzaz and Vickers (1968) considered religion a prime factor in developing attitudes toward the dying patient. There is evidence that older, more experienced nursing personnel rely more on the interaction of clergy to deal with dying patients (Pearlman et al., 1969). Campbell (1976) felt a significant difference in attitude based on degree of religiosity, but distinguished this from religious affiliation.

Other variables, such as marital status and personality have been suggested for research but no significant findings or relevance appears to be available in the literature at present.

Death Education Effectiveness

Educational formats developed for nurses and other hospital personnel specific to death and dying have been varied in type as well as effect. They included, among others: psychodrama (Kazzaz and Vicker, 1968), reading literature relevant to death and dying and writing a paper on the literature as well as a didactic component (Wagner, 1964), and role playing and recalling writing about personal
involvement plus a didactic component (Drummond and Blumberg, 1962).

Murray (1974) evaluated the effectiveness of a death education program for 30 female nurses. The format included: lecture-discussions, audiovisual presentations, group process interactions, and role-play and sensitivity exercises for six, one and one-half hour sessions spaced one week apart. Test-retest and four-week follow-up were accomplished. No difference was found from pre- to posttest; however, a significant reduction in death anxiety occurred from pretest to follow-up and from posttest to follow-up. He concluded that reflection on the course material and utilization of knowledge in practice manifested itself by lowered death anxiety on follow-up.

Two studies which involved an education component and pre- and posttesting of senior nursing students produced conflicting data (Hopping, 1977; Hardt, 1976). Hopping's inconclusive results indicating that attitudes toward death and dying can be altered in a positive manner by a nursing curriculum were based on the finding that the course was not associated with an increased score on the posttest. She pre- and posttested 40 senior nursing students within the interval of one semester, one-half of whom voluntarily enrolled in the death education course. Overall, students in the study group showed a more positive attitude toward death, although it was felt that students chose to
participate in the course because they felt they could cope with the problems involved and/or that the control group avoided the course because they were unsure of their ability to cope with it.

Hardt (1976) pre- and posttested college sophomores and juniors (non-nursing) presenting a total 45-hour education component in between. His conclusion was that the attitude one begins with determines to a large extent the amount or type of change which can occur. Although a positive change in attitude took place, he felt it is easiest to change or modify attitudes toward death among those who present the more unfavorable attitudes. His conclusion was to only guardedly support death and dying education.

Three studies (not involving nursing personnel) indicated negative results. Two of these (Bell, 1975; Knott and Prull, 1976) found that the experimental group had increased frequency of thoughts of death, although no changes in fear of death. The third study (Mueller, 1976) indicated no differences in level of death anxiety following the curriculum.

Death Anxiety in Relation to Personal and Professional Death Experience

As indicated previously, some studies examining death experience in an employment setting found little or no difference in attitudes based solely on years of nursing experience (Golub and Reznikoff, 1971; Campbell, 1976). Some
evidence has also been offered to question the effectiveness of formalized death education (Bell, 1975; Knott and Prull, 1976; Hopping, 1977; Hardt, 1976). It is important to note that virtually all of the studies which have demonstrated effectiveness have employed programs which, in addition to or in place of, didactic formats, have elements of an experiential and personally involving nature; i.e., live interaction with a dying patient, or explicit focusing on personal feelings about death.

Martin and Collier (1975) decided two factors were most significant in terms of affecting attitudes toward death and dying in nursing students: (1) personal encounters with death and their effect and (2) situations provided within the format which permits personal examination of attitudes and experiences related to death. In Pearlman et al. (1969) studies, 57% of the participants indicated they felt actual direct experience during nursing training was necessary.

At least two studies (Denton and Wisenbaker, 1977; Hopping, 1977) partially support the assumption that death experience decreased death anxiety and Larsen et al. (1974) claim increased experience with death may produce an increasingly negative attitude, particularly if that experience involves an intimate relationship.

Denton and Wisenbaker's (1977) findings indicate that the relationship between death experience (as defined
as the death of family member or close emotional attachment) and death anxiety did not support the hypotheses that death experience and death anxiety are inversely related; whereas the relationship between death experience (as defined as death of a non-relation or without emotional attachment) and death anxiety indicated support for the hypothesis that death experience and death anxiety are inversely related. They also found that nurses (high work experience) had higher death anxiety than nursing students (low work experience) even though the nurses had more death experience.

Larson et al. (1974) began with the assumption that the more intimate experience a person has had with death (provided the experience has not traumatized the individual), the more he will be desensitized and accepting of death. A survey containing a death attitude scale was administered to 20 male physicians, 32 male university professors, and 58 undergraduate and graduate students of both sexes. The results showed no difference between scores of physicians and professors, and the difference between scores for these same groups and for students did not reach statistical significance. Correlations between sex, age, satisfaction, self-esteem, and attitudes toward death were not significant. However, the higher the education, the more negative the attitudes toward death. Positive attitudes toward death also correlated low with exposure to the death of acquaintances and unknown persons, but not with exposure to death of
immediate family or close personal friends. Larsen et al. concluded that death of non-intimates may reduce fears attributed to the unknown without trauma and this may partially explain the positive correlation between positive attitudes toward death and number of non-intimate deaths.

Summary

There is evidence that our adult attitudes toward death and dying may begin to take form as early as the age of six, usually as an indirect experience (vicarious conditioning). Young adults entering college appear to have already developed somewhat fixed attitudes. As young adults, nursing students are exposed to their first professional experience with death and dying. The student's response may not only be based on the trauma of the experience itself, but also on the same process of vicarious conditioning (identification, in this case) as in their childhood, in terms of appropriate professional behavior as displayed by instructors and other nurses.

The literature suggests that specific identifiable variables (i.e., age, setting, religion, etc.) appear to have limited significance in terms of the expected attitudes or resultant behavior.

In terms of the effectiveness of specific death and dying education, virtually all the studies which demonstrate positive changes in attitudes employ elements in the format
which involve an experiential and personally involving nature; i.e., live interaction with dying patients, or focusing on personal feelings. This direct contact may result in either confirming or denying those attitudes which may have been previously learned by vicarious conditioning. There appears to be limited literature which speaks directly to this issue of the relationship between our previous personal and/or professional death experience (direct and/or indirect), and our attitude toward the dying patient as measured by death anxiety.
CHAPTER 3

METHOD

This research was designed to explore the following problems: What is the effect of personal and professional death experience on the death anxiety of nurses? Does personal and professional death experience decrease the anxiety of persons caring for the dying? The chapter includes an explanation of the research format utilized, description of the sample, provisions made for the protection of human subjects, development of the research tool used, and the mechanics for collecting data.

Design of Study

The study used a questionnaire format to elicit attitudes, responses, and experience concerning death and death anxiety. The personal and professional death experiences of nursing personnel were correlated with their anxiety about death to identify any relationship between death experience and anxiety. The death experience questionnaire and the death anxiety (DAS) inventory were administered to practicing nurses to measure their death anxiety and their personal and professional death experience.

In addition, demographic data collected included: (1) age, (2) sex, (3) religious preference, (4) professional
education, (5) years employed in nursing, and (6) clinical area of preference.

The Sample

The population for this study consisted of 100 registered nurses and licensed practical nurses employed at a local hospital and the county public health department of a rural northeastern community. All nursing personnel employed at both agencies were asked to participate in the study. The sample consisted of those nurses who volunteered after the nature, purpose, and demands of the study had been explained.

Limitations

1. All subjects were volunteers from medical care facilities in the rural community of St. Lawrence County, New York State.

2. There was no way of accounting for the differences in the quality and quantity of nursing education backgrounds of the subjects.

Protection of Human Subjects

The investigator took a number of measures to insure the protection of the human subjects volunteering for the study. A research proposal outlining the design and purpose of the research was presented to The University of Arizona Human Subjects Committee for approval, to insure the
protection of the rights of the human subjects. Before the subjects were asked to volunteer, the nature, purpose, and demands of the research were explained thoroughly to the subjects and time allowed for questions. The subjects were then asked to carefully read and consider signing a Subject's Consent Form (Appendix A) which again explained participation. After time was allowed for questions, subjects were asked to fill out the questionnaires if they were still willing to volunteer.

A coding system was utilized to insure confidentiality. The questionnaires were numbered, and to each was attached a Subject's Consent Form with the identical number. Thus, the test scores could be identified by this number. The investigator was the only individual to have access to these forms connecting subjects to their test results and confidentiality was carefully guarded.

**Research Tool**

Death Anxiety Questionnaire (DAS)

The instrument which provided measurement of death anxiety for this study was the Death Anxiety Scale developed by Templer (1970). It was composed of 15 True or False items which measure death anxiety. The scale was constructed from an initial pool of approximately 40 items by a subjective rating procedure. Internal consistency and test-retest reliability were determined as .76 and .83,
respectively. Templer established validity by two separate procedures: (1) presumable high death anxiety psychiatric patients who were found to have significantly higher DAS scores than control patients (11.62 vs. 6.77 with a t value of 5.79, p > .01) and (2) DAS scores correlated significantly with Boyar's (1964) FODS scale, another death anxiety questionnaire, .74, p > .01.

Personal and Professional Death Experience Questionnaire (PPDE)

The instrument which provided measurement of personal and professional death experience (PPDE) was developed by this investigator. It was composed of 19 True or False items which measure the personal and professional death experiences of nursing personnel. The instrument was constructed from an original pool of 17 items that could be scored True or False. Questions were obtained from a study of the research literature and items suggested and critiqued by fellow professionals at this investigator's request. Two clusters of items were identified: (1) personal death experience and (2) professional death experience with approximately an equal number of each included.

A pilot study was accomplished with fellow professionals in an effort to determine clarity of items. The pilot test resulted in the modification of seven questions and the addition of one question. Statements will be made
in the chapter on analysis and discussion of data concerning consistency, validity, and test-retest reliability.

**Collection of Data**

After appropriate agency administration approval was obtained, the investigator made arrangements to contact the nursing personnel of the local general hospital and the county public health department during regularly scheduled nurse staff meetings over a two-week period. The investigator introduced herself to the subjects and explained the purpose, nature, and structure of the research. Each individual was handed a packet containing the PPDE and DAS questionnaires (Appendix B) with the same coding number appearing on the Subject's Consent Form. The investigator asked each person to read the Subject's Consent Form carefully, ask any questions they might have, and then to sign the form if they were willing to participate. The voluntary nature and confidentiality of participants was emphasized and the investigator reiterated that she would be available to share and explain individuals' scorings on the questionnaires with those who wished the feedback.
CHAPTER 4

ANALYSIS AND DISCUSSION OF DATA

In order to answer the research questions, "Is there a positive relationship between personal and professional death experience and death anxiety?" and "Does death anxiety decrease in response to increased personal and professional death experience?" the hypothesis of relationship and direction was tested by analyzing the data produced.

For convenience of analysis and discussion of the data related to the hypothesis, the results are organized in the following fashion: (1) demographic data of the subjects, (2) analysis of the instruments employed in the study, and (3) the analysis of the data specifically related to each of the hypotheses.

Description of the Sample

A total of 74 subjects voluntarily participated in this study. Of these, 16 were employed as public health nurses (22%) and 58 were employed in a small rural hospital (78%). Since only two male nurses participated, their data were deleted, providing a homogeneous female sample.

Professionally, 13 participants were LPN's (19%) and 61 were RN's (81%). The majority reported their religious preference as Roman Catholic (50%) and 30 indicated
Protestant (41%). The other 9% were unspecified. Of those indicating clinical preference, there was a heterogeneous distribution with all nursing departments in the general hospital represented, as well as public health and mental health nursing.

Analysis of Instruments

Personal and Professional Death Experience Questionnaire (PPDE)

To assess the psychometric properties of the PPDE, two statistical procedures were calculated: (1) measures of variation such as the mean and standard deviation and skewness and kurtosis (see Table 1) and (2) a correlation matrix (see Table 2). These first measures, which are sometimes known as moments (McNemar, 1962), describe the distribution properties of the PPDE. Skewness which measures the asymmetry of the distribution of scores in the case of the PPDE indicated that the two subscales of Personal (-0.123) and Professional (-0.661) experience had only a slightly asymmetrical property (clustered slightly to the right) since a value of 0 indicates complete symmetry and a negative value describes the degree of skewness to the right of the mean. The total PPDE score distribution, likewise, was skewed slightly to the right of the mean. The kurtosis of the PPDE scales which measures the relative peakedness or flatness of the distribution curve indicated that the
Table 1. Mean, Standard Deviation, Kurtosis, Skewness, and Range for the Personal and Professional Experience Scores, the Death Anxiety Score, and the Demographic Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Kurtosis</th>
<th>Skewness</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>33.66</td>
<td>10.71</td>
<td>0.430</td>
<td>1.044</td>
<td>20.00</td>
<td>64.00</td>
</tr>
<tr>
<td>Years of Nursing Experience</td>
<td>10.60</td>
<td>9.77</td>
<td>3.625</td>
<td>1.824</td>
<td>0.00</td>
<td>48.00</td>
</tr>
<tr>
<td>Personal Death Experience</td>
<td>7.03</td>
<td>1.50</td>
<td>-0.337</td>
<td>-0.123</td>
<td>3.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Professional Death Experience</td>
<td>6.00</td>
<td>1.09</td>
<td>0.880</td>
<td>-0.661</td>
<td>3.00</td>
<td>8.00</td>
</tr>
<tr>
<td>Total PPDE</td>
<td>13.03</td>
<td>1.81</td>
<td>0.004</td>
<td>-0.438</td>
<td>8.00</td>
<td>16.00</td>
</tr>
<tr>
<td>Death Anxiety Scale</td>
<td>6.85</td>
<td>2.66</td>
<td>0.010</td>
<td>0.345</td>
<td>2.00</td>
<td>15.00</td>
</tr>
</tbody>
</table>
Table 2. Spearman Rho Correlations Among the Demographic Variables, PPDE Scales, and the Death Anxiety Scale

<table>
<thead>
<tr>
<th>Variables</th>
<th>Age</th>
<th>Years of Experience</th>
<th>Personal Experience</th>
<th>Professional Experience</th>
<th>Total PPDE</th>
<th>Death Anxiety Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.8252</td>
<td>0.3423</td>
<td>-0.0633</td>
<td>0.2302</td>
<td>-0.0091</td>
<td>(p&lt;.001)</td>
</tr>
<tr>
<td>Years of Experience</td>
<td>0.2997</td>
<td>-0.0700</td>
<td>0.2146</td>
<td>-0.0318</td>
<td></td>
<td>(p&lt;.009)</td>
</tr>
<tr>
<td>Personal Experience</td>
<td>-0.0165</td>
<td>0.8070</td>
<td>0.0096</td>
<td></td>
<td></td>
<td>(p&lt;.889)</td>
</tr>
<tr>
<td>Professional Experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total PPDE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.0313</td>
<td>(p&lt;.001)</td>
</tr>
</tbody>
</table>
Personal scale was slightly flattened (-0.337) and the Professional (-0.880) scale was somewhat peaked around the mean. The total PPDE scores, however, suggested a normal distribution of the scores with kurtosis of .004. When compared to the properties of the Death Anxiety Scale which has already been studied closely, the PPDE compares favorably. On evaluating intercorrelation of the internal consistency of the scale, a nonsignificant Spearman correlation of -0.165 (see Table 2) indicated an independence of these scales from each other; that is, the Personal and Professional scales measured two independent concepts (Nunnally, 1967). These scales did, however, correlate positively with the total score indicating that they contributed positively and significantly to the total PPDE score.

Analysis of Hypothesis

The first hypothesis tested was: Death anxiety of nurses is positively related to personal and professional death experience. The subjects' PPDE scores were correlated with the DAS (Table 2). No significant relationships were found for any of the PPDE and DAS correlations. For the total PPDE and DAS correlation, the Spearman rho was .0313 which was not significant (p < .791). On the Personal Experience and Professional Experience variables, the Spearman correlations were -.0096 (p < .935) and .0096.
(p < .935) respectively. These latter correlations were also nonsignificant. The first hypothesis was therefore rejected.

Although at least two studies (Martin and Collier, 1975; Pearlman et al., 1969) indicated that personal encounters with death were necessary to positively affect attitudes, this researcher's study did not support their findings. The rejection of the hypothesis relates in particular to the Martin and Collier study, which like the PPDE assessed death experience in terms of personal encounters and structured situations. In other studies such as Larsen et al. (1974) which found that personal experience was related to positive effect of death, the present results also appear to negate these findings. On closer analysis of the Larsen et al. report, however, their results like the present findings indicate there was a nonsignificant relationship between exposure to death and positive attitude. Only in the case of exposure to the death of an immediate family member or close personal friend were the Larsen data applicable.

The above cited studies, therefore, suggest that the definition of death experience is a critical variable in their findings. The results of the present study depend upon the definition that death experience is either personal or professional. In the case of personal experience, the PPDE mixes immediate family encounters with other personal
encounters such as the witnessing of violent death. As Larsen et al. (1974) indicate, there may be a crucial difference between immediate family and those personal experiences which this study did not factor out. In the final analysis, this study cannot indisputably reject previous research findings, but adds to the conceptual framework that death experience can be viewed from a number of different and often unrelated perspectives.

The second hypothesis tested was: Death anxiety of nurses diminishes with increased personal and professional death experience. Since the correlations between the PPDE and DAS were close to zero and nonsignificant, the direction of the relationships was not indicated. The hypothesis was, therefore, rejected in this study. In light of the first hypothesis and its discussion, the data again indicate that the definition of death experience for this type of research is all-important. An additional factor in the discussion of the above hypothesis is that, in the present study, there were no significant relationships between years of experience as a nurse and the total PPDE ($r = .2146, p < .066$) and DAS ($r = -.0318, p < .788$). The finding again suggests that it is not experience per se, but rather the type of experience, that affects death anxiety.
CHAPTER 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

A summary of the research follows with conclusions from the data specified and related to the conceptual framework. Recommendations are included and are based on accumulated data.

Summary

This research was undertaken to investigate the effect of personal and professional death experience on the death anxiety of nurses and whether this anxiety decreases with increased personal and professional death experience. Two hypotheses were tested: (1) death anxiety of nurses is positively related to personal and professional death experience, and (2) death anxiety of nurses diminishes with increased personal and professional death experience. The instrument which provided measurement of nurses' personal and professional death experience was a questionnaire of nineteen items developed by this investigator. In addition, the Death Anxiety Scale (Templer, 1970) was used to measure the death anxiety of the same nurses. Seventy-four nurses were surveyed over a two-week period during regularly scheduled staff meetings. Raw data were analyzed using descriptive frequency statistics and the Spearman rho
correlation to assess the psychometric properties of the investigator's PPDE questionnaire. This instrument, when compared with the DAS in terms of validity and reliability, was found to compare favorably. Data indicated that there was no significant relationship between total PPDE scores and levels of death anxiety. Also, personal death experience indicated no significance in terms of levels of death anxiety. There also appeared to be no relationship between professional death experience and death anxiety. Based on these analyses of the data, the first hypothesis, that death anxiety of nurses is related to personal and professional death experience, was rejected. The second hypothesis, that death anxiety of nurses diminishes with increased personal and professional death experience, was also rejected, since when there is no significant relationship, there can be no direction.

Conclusions

The investigator concluded that although no significant relationship between personal and professional death experience and the level of fear of death was found, the study did have merit. It has already been stated that the investigator's questionnaire was essentially valid in eliciting that which it was intended to. This investigator concluded that although the cognitive component of personal and professional death experience was measured, the emotional
component of those experiences was not. This, in fact, may be the variable that must be identified to adequately test the hypotheses. In terms of the conceptual framework, the investigator's tool did not attempt to identify whether the emotional conditioning produced by experiences with death was positive (desensitizing the individual to his own fear) or negative (traumatizing the individual). This factor would certainly affect the level of death anxiety. Thus, although the investigator's questionnaire included items which involved direct and vicarious affective learning experiences (Bandura et al., 1968; Bandura and Menlove, 1968), it did not include provisions for measuring the direction or intensity of the impact. Another factor not addressed by the investigator was the age at which the personal and professional death experiences occurred. Since we did not know the age that the subjects experienced personal encounters with death or dying, the investigator assumed a fair percentage may have occurred during childhood. As Dumon and Foss (1972) indicated, children are frequently presented with either a direct death experience marked by fear, or vicariously through parental figures marked by evasion and deception. Thus, the age at which the experience occurred may significantly affect the direction of impact. As stated previously, many nurses may enter into their profession with preexisting aversive responses. In terms of professional death experience, either formal or informal, the
investigator's questionnaire (as already indicated) did not attempt to determine whether the individual defined the experience positively or negatively. We assumed that formal professional death experiences (involvement and/or completion of an educational program or course designed specifically to deal with the process of dying) are presented as positive direct experiences designed to decrease death anxiety by vicariously extinguishing aversive emotional responses (Bandura, 1969). Unfortunately, we did not know to what degree these nurses entered the course with, or maintained, preexisting aversive response and avoidance behaviors. Specific to informal professional death experience (reading professional books or journal articles dealing with the dying process, or discussions with peers), we do know that nursing attitudes are affected and/or formed early in the career through an identification process of her reference group (role models) (Golub and Reznikoff, 1971), but the investigator did not determine what direction that attitude may have been or how it may have been affected by time. The findings shed little light on the issue of the relationship between personal and/or professional death experiences. The investigator concluded that the factors that determine the level of personal death anxiety and thus our attitudes toward dying patients, are not clearly delineated or understood. It was further concluded that extensive investigation is appropriate and necessary in this area.
Recommendations

From the preceding conclusions, the investigator makes the following recommendations for further research.

1. Replication of this study with basically the same methodology with following additions and modifications:

   a. The investigator questionnaire should include provisions for requesting subjects to include the age at which each encounter with the dying process occurred, and the direction of impact; i.e., positive or negative, to assess the emotional as well as cognitive component. This might be accomplished with a Likert type scale.

   b. The investigator questionnaire should include provisions for requesting subjects to include definitive information concerning formal professional experience; i.e., length, type of curriculum, as well as the direction of impact, in an attempt to identify consistency and significant variables.

   c. Utilization of other established instruments to measure death anxiety; i.e., Death Concern Scale (Dickstein, 1972), to assist in developing multiple measuring instruments with higher reliability.
2. Nursing educators should consider the need for determining the attitudes toward the dying process and the level of death anxiety of students before any curriculum is implemented to better direct their experiences to produce the desirable outcome.

3. Design a study to determine how personal and/or professional death experience is translated into subsequent clinical practice.
APPENDIX A

SUBJECT'S CONSENT FORM

I understand that Dale McBride, R.N., a graduate student in Psychiatric-Mental Health Nursing at The University of Arizona, is conducting a study entitled "The Relationship Between Personal and Professional Death Experience and Death Anxiety Among Nursing Personnel." The main purpose of this study is to collect data to determine the effect of personal and professional death experience on the death anxiety of persons caring for the dying. It is hoped that the information will benefit nursing educators as well as others in the nursing profession.

I understand that my participation is voluntary and involves completing a 34-item questionnaire made up of statements about death experience which I will be asked to answer either True or False. This will take me approximately 15 minutes. I will be asked to complete the questions on ______________. I also understand that I am free not to participate or to withdraw with no ill will.

I understand that the investigator will be available to answer any questions I may have about the study or any of the items in it and that she will be available to share and explain the results of my questionnaire following completion if I so desire.

I understand that all confidentiality will be insured. I will be asked to sign my name to a card attached to the questionnaire with an identification number on it. This number will also appear on the questionnaire. I understand the researcher will be the only person who will have access to this card which connects my name with the questionnaire I fill out and that this will remain completely confidential.

I understand that data and results of the research will be shared with faculty and students who are interested and that it will be printed in a thesis which will be available in The University of Arizona libraries.
I have read the above "Subject's Consent." I understand the nature and demands of the project and I am willing to participate.

I also understand that this consent form will be filed in an area designated by the Human Subjects Committee with access restricted to the principal investigator or authorized representatives of the particular department.

Subject's Signature __________________________ Date _____

Witness Signature __________________________ Date _____
APPENDIX B

QUESTIONNAIRE

PLEASE CIRCLE TRUE OR FALSE FOR EACH OF THE FOLLOWING:

T  T  1. I have read books and/or viewed television presentations on death and dying.

T  F  2. I have attended a wake or funeral with an open casket.

T  F  3. I have witnessed the time of death of a person (other than a family member).

T  F  4. I have been present at the time of death of a family member.

T  F  5. I have been present during the dying process of a family member.

T  F  6. I have experienced a situation where, I believe, I was close to death.

T  F  7. I have mourned the death of a close friend (or relative) although I was not present at the time of death.

T  F  8. I have witnessed what, I perceived, was a violent death.

T  F  9. I have attempted suicide.

T  F  10. My family and I have discussed death plans (i.e., funeral and burial arrangements) with each other.

T  F  11. I have family members whose professions involved contact with death and dying (i.e., morticians, coroners, physicians, nurses, and policemen, etc.).

T  F  12. I have read professional books or journal articles dealing with death and dying.

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T  F  13. My professional training included a course dealing with death and dying.

T  F  14. I model my response to dying patients from the behavior of my fellow nursing professionals.

T  F  15. My fellow employees openly discuss death and dying.

T  F  16. In my duties (past and/or present) I encounter dying patients.

T  F  17. At work (past and/or present) I encounter dying patients.

T  F  18. In my duties (past and/or present) I handle or deal with dead bodies.

T  F  19. At work (past and/or present) I have received an in-service course (workshop) on death and dying.

T  F  20. I am very much afraid to die.

T  F  21. The thought of death seldom enters my head.

T  F  22. It does not make me nervous when people talk about death.

T  F  23. I dread to think about having to have an operation.

T  F  24. I am not at all afraid to die.

T  F  25. I am not particularly afraid of getting cancer.

T  F  26. The thought of death never bothers me.

T  F  27. I am often distressed by the way time flies so very rapidly.

T  F  28. I fear dying a painful death.

T  F  29. The subject of life after death troubles me greatly.

T  F  30. I am really scared of having a heart attack.

T  F  31. I shudder when I hear people talking about a World War III.
T  F  32. I often think about how short life really is.
T  F  33. The sight of a dead body is horrifying to me.
T  F  34. I feel that the future holds nothing for me to fear.

35. Age: ______
36. Sex: ______
37. Religious preference: ______
38. Professional education: ______________________
   ______________________
   ______________________
39. Years employed in nursing: ______
40. Clinical area of preference: ________________


