CORRELATES OF DEATH ANXIETY IN HOSPICE STAFF

by

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STATEMENT BY AUTHOR

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF TABLES</td>
<td>vi</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>vii</td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Purposes</td>
<td>4</td>
</tr>
<tr>
<td>Conceptual Framework</td>
<td>4</td>
</tr>
<tr>
<td>Hypotheses</td>
<td>8</td>
</tr>
<tr>
<td>2. REVIEW OF THE LITERATURE</td>
<td>9</td>
</tr>
<tr>
<td>Death Anxiety in the General Population</td>
<td>9</td>
</tr>
<tr>
<td>Sex and Marital Status</td>
<td>9</td>
</tr>
<tr>
<td>Educational Level</td>
<td>11</td>
</tr>
<tr>
<td>Age</td>
<td>11</td>
</tr>
<tr>
<td>Residence</td>
<td>12</td>
</tr>
<tr>
<td>Religious Beliefs and Preferences</td>
<td>12</td>
</tr>
<tr>
<td>Psychological Variables</td>
<td>14</td>
</tr>
<tr>
<td>Death Related Cues and Situations</td>
<td>15</td>
</tr>
<tr>
<td>Death Anxiety and Health Care Givers</td>
<td>16</td>
</tr>
<tr>
<td>3. METHOD</td>
<td>22</td>
</tr>
<tr>
<td>Subjects</td>
<td>22</td>
</tr>
<tr>
<td>Instruments</td>
<td>23</td>
</tr>
<tr>
<td>Denial and Acceptance as Variables</td>
<td>24</td>
</tr>
<tr>
<td>Procedure</td>
<td>28</td>
</tr>
<tr>
<td>4. ANALYSIS OF DATA</td>
<td>30</td>
</tr>
<tr>
<td>Description of the Sample</td>
<td>30</td>
</tr>
<tr>
<td>Hypothesis One</td>
<td>32</td>
</tr>
<tr>
<td>Hypothesis Two</td>
<td>32</td>
</tr>
<tr>
<td>Hypothesis Three</td>
<td>32</td>
</tr>
<tr>
<td>Hypothesis Four</td>
<td>33</td>
</tr>
<tr>
<td>Hypothesis Five</td>
<td>35</td>
</tr>
<tr>
<td>Summary</td>
<td>38</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>5. DISCUSSION AND CONCLUSIONS</td>
<td>40</td>
</tr>
<tr>
<td>Changes in Amount of Death Anxiety</td>
<td>40</td>
</tr>
<tr>
<td>Changes in the Nature of Death Anxiety</td>
<td>41</td>
</tr>
<tr>
<td>Relationship of Data to Conceptual Framework</td>
<td>44</td>
</tr>
<tr>
<td>Relationship of Findings to Research Tool</td>
<td>46</td>
</tr>
<tr>
<td>APPENDIX A: MODIFIED TEMPLAR DEATH ANXIETY SCALE</td>
<td>47</td>
</tr>
<tr>
<td>APPENDIX B: SCORING KEY FOR TEMPLAR DEATH ANXIETY SCALE</td>
<td>49</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>50</td>
</tr>
</tbody>
</table>
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Death Anxiety Scores During Hospice Experience</td>
<td>31</td>
</tr>
<tr>
<td>2. Comparison Item by Item between High and Low Scorers on Modified Templar DAS</td>
<td>34</td>
</tr>
<tr>
<td>3. Self Reported Life Changes</td>
<td>37</td>
</tr>
</tbody>
</table>
ABSTRACT

Contact with dying persons brings awareness of one's own mortality into consciousness, creating "death anxiety" which in existential thought is seen as motivating toward personal growth. At manageable levels, anxiety can result in movement toward a more meaningful daily existence.

Death anxiety scores of 44 nursing caregivers in an inpatient hospice unit were examined to determine the amount and nature of change in death anxiety and the caregivers were asked to describe changes in themselves or their lives as a result of hospice nursing. The appropriateness of the research tool, a modified version of the Templar Death Anxiety Scale for a hospice setting, was examined.

Results showed a lowering of death anxiety at the end of three months, no significant change between the third and sixth month, and no significant difference in three month scores between those who resigned between the third and sixth months, and those who continued at least six months. Those who completed six months reported a high proportion of changes described as more competent, more meaningful, and more fulfilled. Regardless of death anxiety scores, the majority of subjects reported positive changes. Further study is planned, analyzing this data using a scoring system devised by a panel of hospice personnel.
CHAPTER 1

INTRODUCTION

In recent times, there has been increasing concern for providing humane and skilled care for the dying. The quality of that care has been associated with the attitudes and anxiety of health care providers.

More and more persons in our society are dying from chronic conditions and degenerative processes, which require extended periods of care and support for patients and their families and friends as they anticipate and experience death and dying.

Modern technological advances in medicine focus on life saving and life sustaining systems, and give relatively little importance to helping patients and their primary group members face and deal with death as an outcome. Too often, the dying person suffers from more than the disease process itself, being also the victim of attitudes and practices that tend to isolate and demoralize during this particularly vulnerable time.

Vernon (1970) described the isolation that may be imposed on a dying person when the dying state is not recognized or allowed to be real by those persons near him. This imposed isolation may result in profound depression or psychosis.

The importance of having others accept a person's dying status was also discussed by Imaru (1975). Since acceptance of our own being,
that is, our sensing that we are significant as a person, depends on our knowing that we are accepted by someone outside ourselves, it seems that patients would only fully experience the grief process at their own death when they feel acceptance of their dying by other persons close to them.

While Quint (1965) observed that the nurse is frequently the first person to be approached by the dying patient with a need to talk about what is happening to him, Kastenbaum (1967) studied nurses' verbal responses to dying patient statements and found over 80 percent of responses were reassurance, denial, or changing the subject.

Bowers (1975) timed nurses' reactions to call lights, and found it took a significantly longer time for nurses to respond to those patients listed as terminal. Schoenburg and Carr (1972) also noted this tendency of hospital personnel to disengage themselves from the patient, and thought it might be related to the personnel's inability to face the inevitability of their own death.

Quint (1966) observed nurses relating to dying persons, and catalogued the commonly used defenses employed by them to allay anxiety. These defenses were: avoidance of the patient; relating to the patient as a thing rather than as a person; evading conversation with patients; wearing a bland facial expression; avoiding emotional involvement; being preoccupied with other patients who will recover; avoiding talk about the future; maintaining a busy air; engaging in selective listening; controlling the conversation; and, avoiding defining the patient as dying.
The idea that fear of death is culturally induced and therefore will be present in all persons who enter programs of nursing education, was discussed by Fulton (1976) and Benoliel (1974), who stressed the importance of nurses overcoming their anxiety about death in order to avoid adopting a callous exterior with which to protect themselves from the fear of death. Quint and Strauss (1964) observed that nurses are frequently unable to deal therapeutically with dying persons unless, through circumstances outside their professional education, they have become comfortable with the reality of death.

One result of the conscious effort to improve the lot of the dying patient has been the appearance of a specialized organization for treatment known as hospice care. Hospices provide palliative and supportive care for terminally ill patients. The word hospice in medieval times referred to way stations for pilgrims and travelers where they could be replenished, refreshed and nursed.

In modern times, hospices provide care for persons traveling through life's last cycle. The whole family is the unit of care, and care extends through the mourning process and the bereavement period. Emphasis is placed on symptom control and on preparation for and support during the patient's death. As described by Stoddard (1978), Saunders (1977) and Ingles (1974), hospices seek to enhance the quality of a patient's living during the dying process, within the context of his own unique world view and value system.

In hospice programs, nursing caregivers confront the reality of death and anticipation of death on a daily basis. There is value
placed on openness about death when the patient seeks that from caregivers. In this setting, nursing caregivers are expected to be able to deal with their own feelings effectively enough to allow patients and families to explore and to experience their own feelings about death and the dying process.

More knowledge is needed about how nursing caregivers deal with their anxiety about death in a setting which does not allow them as much opportunity to use defense mechanisms. In addition, it would be useful to know more about what happens to the levels of anxiety about death, in order to build in support systems in treatment facilities that deal with dying patients.

**Purposes**

One purpose of the study is to determine the extent of change in nature and amount of death anxiety of nursing caregivers following intense involvement with dying persons in a hospice setting.

A second purpose is to determine how the caregivers perceive themselves or any part of their lives to be changed as a result of their hospice experience.

**Conceptual Framework**

The work of two existential writers, Soren Kierkegaard and Rollo May, are relevant to a consideration of death anxiety. Kierkegaard (1944) understood anxiety to be oriented toward freedom. In contrast to the merely vegetative or animal life, he thought the distinctive characteristic of the human being was in the capacity to
have conscious awareness of the broad range of possibilities in life. He saw man as one who is constantly beckoned by possibilities, who is capable of conceiving what might be, and who is capable of carrying that into actuality.

The capacity for freedom, however, brings with it anxiety, and the person who confronts freedom also experiences anxiety. Whenever possibility is visualized by an individual, anxiety is also likely to be present in the same experience. Kierkegaard viewed anxiety to be present when the reality of the freedom to choose one's potentials is allowed to come into conscious awareness but before the reality of this freedom has materialized.

Anxiety is created from within, when a person confronts potentialities for life and recognizes that there is freedom to choose them, but this very possibility gives rise to the tendency to deny the new potential because it involves losing present security.

Kierkegaard likened anxiety to dizziness, connected with the experience of the awareness of freedom, and thought that in running from anxiety, one lost the most precious opportunities for the emergence of the self. He conceived of the self as being developed and in operation when a person is able to view both psyche and soma with freedom and act on this freedom. Anxiety in Kierkegaard's view stemmed from failure to accept the freedom to be a mature self.

To Kierkegaard, anxiety indicated that there is human conflict over whether to move creatively toward actualizing one's possibilities. Anxiety will continue to operate unless the individual either moves
away from it by blocking conscious awareness of it, or moves to achieve his potential of being a more mature self.

While Kierkegaard saw anxiety arising from man's conflict over whether to allow himself a full existence, Rollo May (1977) discussed anxiety as arising from threats of non-existence, which include not only threat of physical death, but the threat of a meaningless life, severe threats to self esteem, or threats against the values that are important to one's identity. While anxiety about death is the most usual form and symbol for this anxiety, the threat of non-being lies in the psychological and spiritual realms as well.

May stressed that non-being is an inseparable part of being, and that to grasp what it means to exist, one needs to grasp the fact that one might not exist. Without the awareness that death will be a real and inescapable part of one's future, existence itself tends to be unreal and characterized by lack of self awareness. But, with the confronting of non-being, existence takes on vitality, plus immediacy, and the individual experiences a heightened consciousness of himself, his world, and others around him.

May thought that the desire to give form to life arises from our human anxiety about our own death, and this anxiety is what sharpens our need to create, and enlivens our imagination about life.

The confronting of death gives life a more positive reality and makes the individual experience real, absolute and concrete. Death is the one fact of life that is not relative but absolute, and awareness of this is what gives one's existence and hourly activities
an absolute quality. To May, the problem of managing anxiety is to reduce it to lower levels and then to use this anxiety as stimulation to increase one's awareness, vigilance, and zest for living.

On the surface, these two existential writers seem to be discussing different theories, Kierkegaard (1944) stating that anxiety arises from conflict over achieving one's potential as a human being, and May (1977) stating that anxiety arises from threats to one's existence or identity as a human being. However, the two can be seen as two sides of the same coin, and can be in operation at the same time. For purpose of this study, the following is an attempt to synthesize theories and serve as assumptions underlying the study:

1. Contact with dying persons brings into conscious awareness the fact of one's own mortality.
2. There is conflict because to confront his mortality would allow him to more fully experience his present existence, and yet he is threatened by the awareness of his mortality.
3. Anxiety is the result.
4. If the individual experiences a great deal of anxiety, it can lead to his blocking conscious awareness of his own mortality.
5. If the individual experiences moderate anxiety, it can lead him to enlarge and enrich his existence and to incorporate the idea of his own mortality into his view of himself.
Hypotheses

The following hypotheses were tested:

1. Among those who do hospice nursing for at least three months, anxiety will be higher at the end of three months than at the beginning of employment.

2. Among those who do hospice nursing at least six months, anxiety will be less at the end of six months intense involvement with dying persons than it was at the end of three months.

3. Among those who terminated employment before six months, anxiety will be greater than among those who completed six months employment.

4. Among those who scored high on the scale at six months, and those who scored low, there are differences in the nature of specific aspects of death anxiety.

5. Among those who complete six months employment, those who have low anxiety will make statements indicating that there had been enlarging or enriching changes in themselves or their lives.
CHAPTER 2

REVIEW OF THE LITERATURE

This review of literature focuses on two areas, the literature on anxiety about death among the general population, and studies done on death anxiety among health care givers.

In studies among the general population, demographic variables such as sex and marital status, educational level, age, residence, religious beliefs and preferences, and recent death of family member or friend have been examined. In addition, some psychological variables have been examined, some of which seem pertinent to the process of denial and acceptance of death as it relates to death anxiety.

Death Anxiety in the General Population

**Sex and Marital Status**

In studying sex and marital status differences in death anxiety, Lester (1971) and Ray and Najman (1974) found that males had greater anxiety, while Templar, Lester and Ruff (1974), Lester (1967), Templar and Ruff (1971), and Berman and Hayes (1973) found that females had higher death anxiety.

Several studies showed no difference between the sexes in regard to death anxiety. These were Templar and Dotson (1970), Middleton (1936), Handol (1969), Jeffers, Nichols and Eisdorfer (1961), and

Lester (1970) found that men were more likely to think about death and dying, but had less negative affective reactions. Selvey (1973) found that women were more concerned with what would happen to the members of their families after death.

Diggory and Rothman (1961) found that females tended to fear the consequences of what would happen to their bodies after death more than men. Women also feared more the possible pain of dying. Men feared the loss of purposive activities more than women, and feared loss of ability to care for dependents.

Cole (1978-79), in a random study of 150 residents of a community, used Templar's (1970) Death Anxiety Scale, and found that:

1. Married females had higher death anxiety scores than married males, although not significantly.
2. Single males had higher death anxiety scores than married males.
3. Married males with children were less anxious about death than married males without children.
4. Single males had greater death anxiety scores than single females.

The research, thus far, does not show any consistent data to support or to reject the association of marital roles or any differences between men and women in death anxiety. The differences in findings about sex and marital status differences do not appear to be contingent upon the different scales that were used. Both sexes have been found to have greater death anxiety with the same scale. As
Lester (1967) pointed out, more relevant variables would need to be incorporated into sex differentiation research.

**Educational Level**

Studies relating education to death anxiety have showed differing results. Berman and Hays (1973) noted a positive correlation between education and death anxiety, while Cole's (1978-79) finding that educational level was negatively correlated with death anxiety supported similar findings by Diggory and Rothman (1961) and Swenson (1961). Christ (1961) and Rhudick and Dibner (1961) found no significant relationship between amount of schooling and death anxiety. It may be that education is not a significant variable by itself, since it does not necessarily reflect how one views death, or death in relation to oneself.

**Age**

Cole's (1978-79) results showed that older persons evidenced lower death anxiety, which corroborated the findings by Diggory and Rothman (1961) and Nehrke, Bellucci, and Gabriel (1977-78).

Studies which reported no significant relationship between age and death anxiety are Christ (1961), Rhudick and Dibner (1961), Swenson (1961) and Jeffers et al. (1961).

Older persons may have more experience with death of peers, friends, relatives, and therefore have either learned some acceptance of death or deny death on a conscious level. Generally, age does not seem to consistently affect death anxiety, once childhood is past, and mental development is complete.
Residence

In studying the influence of residence, Shrut (1958) administered a questionnaire for self appraisal of health, adjustment, participation in current activities, a sentence completion test, and the thermatic apperception test.

Shrut (1958) found that elderly persons who lived independently showed less fear of death than persons in a facility for the elderly, while Swenson (1961) found that elderly persons in residences for the aged had more positive attitudes toward death than those living alone, and that urban or rural situations had no effect on attitudes toward death.

Nehrke et al. (1977-78) found that elderly persons who lived independently in the community were significantly more anxious than elderly who lived in public housing or nursing homes.

Type of residence itself does not seem a significant variable. A finding such as Swenson's (1961) may reflect that residents look forward to death as a release from disability and dependency. Another explanation is that in age segregated housing, there is more chance for the older persons to experience death of peers and come to accept it as a possibility for themselves.

Religious Beliefs and Preferences

In a large study of a number of personal and demographic variables, Feifel (1974) found that self reportings of religiousness were positively associated with measures of personal fear of death.
Both Ray and Najman (1974) and Cole (1978-79) found that having no religious preference was related to lower death anxiety. Martin and Wrightsman (1964) found no association between fear of death and religious attitudes, but those who participated more in religious activities had less fear.

Diggory and Rothman (1961) compared the fears of the different perceived consequences of death. The pain of death was least feared by Protestants, more by Catholics and most by Jews. Catholics feared life after death more, and Jews feared it least. Any religious view increased the fear of the affective consequences of one's death on others.

Feifel (1974) failed to find any differences between healthy and terminally ill patients in death anxiety regardless of their religious persuasion. Selby (1977) found no significant differences in persons reporting intensity of religious beliefs or lack of religious beliefs, while Kreiger, Epting, and Leitner (1974) found no significant differences in amount of threat about death felt by believers and non-believers in a life after death.

The lack of agreement among study results linking fear of death and measures indicating religiosity may reflect the ineffectiveness of either religious status or religiosity as reported by self in dealing with fear of death. A more pertinent question to ask might be: if religious beliefs and practices do not affect death anxiety, why do they not?
Psychological Variables

Psychological variables were examined by Diggory and Rothman (1961), who stated that what people fear most in life is loss of opportunity to pursue the goals most important to them. They thought the greater the need for achievement of those goals, the more death will seem to threaten achievement needs. They pointed out that need to achieve is different from actual achievement.

Nogas, Schweitzer, and Grumet (1974) found no correlation between need for achievement and level of death anxiety, but in the same study they did find high inverse relationship between death anxiety and sense of competence. There was no interaction effect between need for achievement and sense of competence.

These contradictory results may reflect the fact that the measures used for sense of competence and the need for achievement were measuring only limited aspects of sense of competence and need for achievement, both being oriented toward social and interpersonal skills, rather than self actualization.

Nehrke et al. (1977-78) studied 120 elderly persons; 40 who lived in private nursing homes, 40 who lived in public housing, and 40 who lived independently. The group who lived in public housing had the highest level of life satisfaction, the lowest death anxiety, using Templar's (1970) Death Anxiety Scale, and the most internal locus of control. The group who lived in a nursing home were less satisfied with life, had even lower death anxiety, and the most external locus of control. Locus of control is a measure of one's perception of the extent to which he is an active, causal agent in determining his own
history or in obtaining the reinforcers he values. An internally con-
trolled person would view reinforcement as contingent upon his behavior, 
while an externally controlled person would view luck, chance or fate 
as the controlling factor.

In age segregated living arrangements, residents come into more 
frequent contact with the process of dying and death itself -- such 
persons might either come to accept death as a part of their conscious 
awareness, or might deny it. In either case, low anxiety scores might 
result. Another possible explanation of these results is that persons 
may come to accept their personal lack of internal control, and so not necessarily fear death more.

Death Related Cues and Situations

The experience of death of friends or family members has been 
reported to have contradictory correlations with death anxiety. Cole 
(1978-79) found that anxiety was lower about death if a family member 
or friend died in the past year, which contradicts Selvey's (1973) 
results in which death of acquaintances or family members increased 
the fear of death.

The idea that death anxiety might be blocked unless studied 
under experiential conditions has been examined by Selby (1977), 
Meissner (1959) and Templar (1971).

In a study of 116 voluntary subjects, half of whom were stu-
dents and half of whom were local church members, Selby (1977) found 
that death anxiety did not seem to be related to any of his personal 
and demographic variables which included age, numbers of deaths among
relatives or close friends within the last two years. Death anxiety was, however, found to be associated with reports of personal reactions in a situation directly related to death -- funerals. He thought that situations presenting death related cues provided their own death.

Death Anxiety and Health Care Givers

Physicians. Feifel (1965) studied physicians, medical students, and a control group of nonmedical personnel. He found that the physicians had a greater fear of death than the medical students, who in turn had greater fear than the control group. He speculated that people choose careers in health fields because of their fear of death, and use their technical competence and life protecting activities to help control their own personal death concerns.

Nurses. Feeling discomfort when a patient brings up the topic of his death was strongly linked to responses indicating that they had not come to grips with fear of their own death, in a study of 15,000 nurse respondents by Popoff (1975). Nurses who had once felt certain they might die in a relatively short time tended to be less anxious and uncomfortable than nurses who had not had such experience.

Ross (1978) examined the concept that a nurse's awareness of her own concerns about death is important to treatment of dying persons, using a fantasy of the nurses's own life and death in relating to her response to dying patients' statements. He found that explanation of personal concerns about death does increase the ability to communicate more openly and to have more congruous interactions with dying patients.
Several studies have compared attitudes of nursing personnel who are experienced and less experienced. Pearlman, Stotsky, and Dom­
inick (1969) found that the nursing assistants who had worked in a nursing home the longest time had the greatest difficulty discussing death with dying patients. Howard's (1974) finding was similar, showing that reluctance to discuss death with patients increased with those nursing assistants who had been employed for more than one year.

Experienced nurses had more death anxiety than nursing students with little or no experience in seeing an actual death, as shown in a study of 76 nurses and nursing students reported by Denton and Wisen­baker (1977).

Gow and Williams (1977) compared nurses in hospitals and public health agencies, and found no significant differences in their atti­tudes toward death and dying. There was, however, a significant differ­ence between older and younger nurses, with older nurses having lower anxiety scores.

In a study comparing nursing graduates with nursing students, Golub and Reznikoff (1971) reported no difference in attitude scores between the graduates and the students. The researchers thought that unless something intervened, nurses could tend to acquire attitudes from role model nurses which would remain relatively fixed.

Folta (1965) found no significant differences in the nurses' attitudes when she compared groups of nurses from a university hospital, a religious hospital, and a public general hospital. The registered nurses did have higher anxiety levels, however, than the administrators, licensed practical nurses and attendants. She also noted that when
death was discussed in the abstract, respondents used such words as peaceful, graceful, and meaningful, but when death was personalized, it invoked high anxiety. This finding reinforces studies in the general population which indicate that death related cues and situations are more likely to elicit death anxiety.

Glaser and Strauss (1965) provided a framework for examining how varying levels of awareness about death may affect patient care. They defined four types of awareness contexts, based on the shared knowledge of the defined and actual state of the dying person by the person himself and those participating in his care. The contexts are closed awareness, suspected awareness, mutual pretense awareness, and open awareness.

In closed awareness context, personnel keep information from the patient so he does not know he is dying. In the suspected awareness context, the patient may guess about whether personnel think he is dying. In the mutual pretense awareness context, both patient and personnel pretend that they do not know he is dying. An open awareness context occurs when both patient and personnel know the patient is dying and there is affirmation of this in the form of caring behaviors. They observe these contexts may be employed as defensive maneuvers against anxiety. Nurses were also thought to avoid too much anxiety and to maintain their professional composure through periods of avoidance and noninvolvement with the patient.

Yeaworth, Kapp, and Winget (1974) compared scores of freshmen and of senior nursing students on a questionnaire for understanding the dying person and his family. They reported significant shifts in
attitudes between the two groups, which they attributed to the effect of experiential education.

Increased education was related to decreased fear of death in a study of nursing students and nursing faculty, by Lester, Getty, and Kneisl (1974). This finding did have exceptions however. When the increased education was associated with clinical involvement with dying persons, the fear of death was not significantly decreased.

In a study of nursing students before and after a two day seminar on the subject of death and dying, Martin and Collier (1975) reported that 80 percent of students felt more prepared for their own death and were more able to talk about death comfortably. The investigators thought that the main factors influencing students' attitudes toward death at the onset of the seminar were situations which permitted personal examinations of attitudes toward death, such as personal encounters with death.

Murray (1974) in a similar study, reported that 30 randomly selected graduate nurses' death anxiety was not significantly changed immediately after completion of a six week course (one session per week for six weeks), but was decreased significantly four weeks after completion of the course. Murray speculates that in the four week interval, the nurses may have had the opportunity to utilize, personally or professionally, the information received during the course.

Using a small group of nursing students who had elected to take a course with some content on death and dying, Hopping (1977) concluded that there was no sign of significant shift toward more positive attitudes toward death.
Laube (1977) examined the amount of death anxiety of registered nurses before and after a two day didactic and experiential workshop, then one month and three months thereafter. There was no significant difference immediately after the workshop, but it did decrease significantly one month after the workshop, and remained below the preworkshop level at three months after completion of the workshop.

Social Workers. Harper (1977) observed social workers as they worked with dying patients. She identified phases that seemed associated with the length of time the social workers were employed.

Stage I was the first three months employment, and was marked by much intellectualization, with the social workers providing much tangible service and occupying themselves with learning the procedures of the job. They experienced some discomfort and anxiety, but felt secure in their professional knowledge.

Stage II, from three to six months, brought more anxiety, as well as guilt and frustration, and there was a dawning realization of the magnitude of the area of practice. The social workers increased their emotional involvement with patients.

Stage III lasted from six to nine months, and was characterized by marked anxiety, feelings of depression, much exploration of their own feelings about death, and over identification with the patients' situations. There was little intellectualization during this period.

During Stage IV, from nine to twelve months of employment, was one of more comfort. The social workers developed strong ties with
patients and families and coped with the loss of the relationships. They felt productive and were mostly free from anxious concern about their own death.

One year to two years of employment was referred to as Stage V, and during this period, the social workers showed increased self awareness, ability to accept the potential for death and loss, and increasing ability to give themselves in activity for the patients, and in emotional involvement with them.

To summarize the review of literature, much of the apparent contradiction in results of death anxiety studies may reflect the fact that low scores may be the result of either death acceptance attitudes or death denying attitudes. Demographic variables seem to have little correlation with death anxiety measures, and psychological variables measure only limited aspects of the response to death.

Templar, Ruff and Franks(1971) pointed out that death anxiety is not a fixed state, but a state that responds to events in the environment, including helpful interventions. More attention needs to be directed toward studying the fluctuating meanings of death within the individual, rather than attention to differences between individuals.
CHAPTER 3

METHOD

This study was designed to explore the following problems: "What is the extent of change in the nature and the amount of death anxiety in nursing caregivers after nursing in a hospice setting?" and "How do the nursing caregivers perceive themselves or their lives to be different, correlated with their hospice experience?"

Subjects

The subjects for this study consisted of all 44 nursing assistants, registered nurses and licensed practical nurses who became employed as direct caregivers in the inpatient hospice setting during the duration of the study. They are part of a larger group of 53 staff of all kinds who were asked to take part in a study designed primarily to gather information for use in structuring orientation, ongoing education and staff support systems for the hospice. Excluded from the current study were ward clerks, secretaries, and supervisory and administrative staff.

The investigator took a number of measures to protect the human subjects in this study. Appropriate forms were submitted to the University of Arizona Ethical Review Committee. A proposal outlining the design and purpose of the study was presented to the University of Arizona College of Nursing.
The data used were from a larger study for which informed consent of the subjects had already been obtained. If subjects left portions of the larger study blank, or indicated that they did not wish to answer portions of the larger study, that was accepted. The consent forms were retained by the Hospice Home Care Coordinator, who preserves their confidentiality as the larger study continues.

The researcher used data already collected in a larger study. Results of Templar Death Anxiety Scores were coded in sequence, along with answers to the open ended questions.

The investigator used a coding system to ensure confidentiality. Data from each subject were given a number and a letter to designate successive testing results. The investigator alone has access to these forms which connect the numbers to the persons tested, and will guard the confidentiality of this information.

**Instruments**

Hypotheses one to four involved measuring and comparing death anxiety. The instrument which provided the measure of death anxiety is a modified version of the Templar Death Anxiety Scale (Templar 1970, see Appendix A). The original scale has been widely used and accepted for research in death anxiety. This instrument consists of 15 items to be answered true or false. The rating scale was modified for this study, i.e., a five-item Likert scale was used in place of the true-false format.

Death anxiety scales were scored, giving each test item a positive numerical value by transposing those scores from Templar's (1970)
original true-false format. The lower the total score, the lower the anxiety, and the higher the total score, the higher the anxiety.

The original, dichotomous Templar Death Anxiety Scale was demonstrated to have test-retest reliability between two sets of scores from tests administered to two groups three weeks apart (r = .83). Reasonable internal consistency was demonstrated with a coefficient of .76.

Construct validity was estimated by comparing a group of hospitalized psychiatric patients chosen for their high degree of variables that were important in studying death anxiety.

Meissner (1958) measures Pgr responses of 40 Roman Catholic seminarians to words symbolic of death and to control words, and found more affective responses to words symbolic of death. Templar (1971) found a positive correlation between death anxiety scores and the number of words relating emotionally to death, and he found a modest positive correlation between death anxiety and galvanic skin responses after presenting death related words.

There is importance in identifying situational cues that elicit anxiety. Death anxiety may not correlate with individual characteristics but correlations may be found in stressful situations related to death.

Denial and Acceptance as Variables

Swenson and Fulton (1965) assumed that death acceptance was the opposite of death anxiety.
In a study by Paris and Goodstein (1966), an apparent low level of death anxiety is not due necessarily to repression, but may indicate that death is not an anxiety producing stimulus for that person.

That idea was explored further by Weisman and Hackett (1961) who found that individuals who showed low levels of anxiety toward their deaths saw death as a closure that was both logical and appropriate, a fitting conclusion for their lives.

Ray and Najman (1974) postulated that there is a continuum, those who shut out all thought of death, those who fear death and know it, and those who have devoted some thought and effort to coming to terms with death and indeed accept it with a minimum of anxiety. Their subjects, 206 students, were given the Templar Death Anxiety Scale, as well as a battery of other tests and socio demographic questionnaires. Ray and Najman concluded that Templar's scale had little possibility of sorting out "death deniers" from "death acceptors", and one might easily confuse highly adaptive with highly mal-adaptive persons.

Reporting that people who accepted death still felt some anxiety about it, they recommended proceeding with theory building that reconciles the micro level of activity (attitudes, motives, etc.), with the macro organization of group or culture, a point of view supported by Chasin (1971).

Nogas et al. (1974) classified 80 subjects' responses into Kastenbaum and Aisenberg's (1972) categories of personifications of
death, "macabre", "gentle comforter", "automoton", and "gay deceiver". "Macabre" images were those that were evil, decadent, cruel, violent, swift and disfigured. "Gentle comforter" images were soothing, slow, gentle, calm, wise and quiet, while "gay deceiver" category contained images that were enticing, cunning, poised, sophisticated, friendly but deceptive. Those images that were objective, unfeeling, nonhuman, brisk, efficient, impartial, merciless but polite were assigned to the "automoton" category.

Those who had high death anxiety responded mainly with "macabre" images, those who had moderate death anxiety responded with "gentle comforter" images and "automoton" images, and those with low anxiety had mainly "automoton" images.

Durlak (1973) found that those who accept death may think about it as often as those who are very threatened by it.

Kelly (1955) conceived of death as one example of a possible threat situation in the terms of his "personal construct theory."

Certain constructs are core, or essential, in that they help to maintain identity and a sense of continuing existence. Threat arises when a person realizes he no longer has ability to anticipate security within the environment. There is the awareness of inability to accurately predict events in the world, along with the awareness of some need to undertake systematic change in order to do so. Threat occurs when a person is aware of the coming of comprehensive change in one's core structures. From this point of view, death would not be threatening to persons whose systems were structured to anticipate death -- death would be consistent with the existing core.
A person who has not anticipated personal mortality would, on the other hand, experience extreme threat in an encounter with the fact that death is an unavoidable personal reality. Death is threatening to a person in proportion to the amount of systematic reorganization needed for him to see death as part of his personal reality, his "self".

Similarly, Kreiger et al. (1974) found that of 112 students studied, those who scored low on an index of threat of death were those who were more able to conceive of verbalization of their anxiety about death, with other psychiatric patients of the same age, sex, and diagnosis. The patients who verbalized a high degree of anxiety about death scored higher in the Templar scale than the other group. Construct validity for the scale was also shown by a correlation of .74 with the Boyar Fear of Death Scale.

Discriminate validity of the Templar scale was demonstrated by a correlation of $r = .36$ with the Welsh Anxiety Scale (Welsh 1956) and $r = .39$ with the Taylor Manifest Anxiety Scale (Taylor 1953). From these low positive correlations with measures of general anxiety, Templar was shown to be measuring something other than general anxiety.

For hypothesis number five, an open ended question was asked: "After being at the hospice six months, how has the experience changed you or any part of your life?" This part of the design was an attempt to distinguish whether low scores on the Templar Death Anxiety Scale indicate denial of conscious awareness, or acceptance, of death. Ray and Najman (1974) suggested that there is a continuum of those who block all conscious awareness of death, those who fear death and are
aware of it, and those who accept death with a minimum of anxiety because they have taken some actions to come to terms with death. Durlak's (1973) finding that those who accept death may think about it as often as those who are very threatened by it, also suggests that low death anxiety scores may need further clarification.

Procedure

An exploratory design was used to investigate the extent and nature of change in death anxiety in the nursing caregivers. Nursing caregivers' death anxiety was measured at the beginning of their hospice employment, at the end of three months, and again at six months. Harper (1977) observed that social workers experienced significant changes in their level of anxiety at six months and one year intervals in their involvement with dying persons. The investigator speculated that nurses involved in giving direct patient care on a daily basis might experience similar changes in their level of death anxiety in half the time. Three months and six months intervals were chosen as measurements for that reason.

The idea that death anxiety may change with experience with dying persons is supported by some reports in the literature. Yeaworth et al. (1974) found that there were shifts in attitudes which occurred as a result of experiential education. Increased education was found by Lester et al. (1974) to be an exception to the trend for increased education to be related to decreased fear of death, when education was associated with clinical involvement with dying persons. The study of Denton and Wisenbaker (1977) showed that experienced
nurses had more death anxiety than nursing students with little or no experience with dying patients.

Death anxiety scores were compared at employment, three months, and six months employment. In addition, scores of those who were employed for six months were compared with scores of those who were employed less than six months. Low scores were assessed for denial vs. acceptance of death, and the nature of differences on specific aspects of death anxiety were compared for high and low scores.
CHAPTER 4

ANALYSIS OF DATA

In order to explore the research questions "What is the extent of change in the nature and amount of death anxiety in nursing caregivers after nursing in a hospice setting?" and "How do nursing caregivers perceive themselves or their lives to be different, correlated with their hospice experience?", five hypotheses were tested.

For four of the hypotheses, various statistical analyses were used, including calculation of means, standard deviations, and t tests. The criterion for statistical significance was set at \( p < .05 \) (Downie and Starry 1977). For the fifth hypothesis, an open ended question was examined with content analysis.

Description of the Sample

Table 1 shows the means of various groups tested. The largest number of resignations (16 out of a total of 24 resignations) occurred before the third month of employment. A comparison of all subjects who resigned with all subjects who remained employed shows little difference in means of scores at employment and at the end of six months, but does show a considerable difference in means of scores at three months, with lower scores by subjects who resigned.
Table 1. Death Anxiety Scores During Hospice Experience

<table>
<thead>
<tr>
<th>Staff Still Employed</th>
<th></th>
<th></th>
<th>Staff Resigned</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td></td>
<td>When Tested</td>
<td>n</td>
<td></td>
</tr>
<tr>
<td>Employed less than</td>
<td>7</td>
<td>45.3</td>
<td>0 months</td>
<td>16</td>
<td>47.2</td>
</tr>
<tr>
<td>3 months</td>
<td></td>
<td>45.3</td>
<td>(orientation)</td>
<td></td>
<td>47.2</td>
</tr>
<tr>
<td>Resigned before</td>
<td>4</td>
<td>43.7</td>
<td>0 months</td>
<td>3</td>
<td>44.3</td>
</tr>
<tr>
<td>3 months</td>
<td></td>
<td>43.7</td>
<td>3 months</td>
<td></td>
<td>44.3</td>
</tr>
<tr>
<td>Resigned after</td>
<td>12</td>
<td>44.7</td>
<td>0 months</td>
<td>3</td>
<td>44.3</td>
</tr>
<tr>
<td>6 months</td>
<td></td>
<td>44.7</td>
<td>3 months</td>
<td></td>
<td>44.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>41.7</td>
<td>3 months</td>
<td></td>
<td>35.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>42.1</td>
<td>6 months</td>
<td></td>
<td>39</td>
</tr>
</tbody>
</table>

x of orientation scores = 44.57

x of 3 month scores = 45.2

x of 6 month scores = 42.1

x of orientation scores = 45.3

x of 3 month scores = 38.9

x of 6 month scores = 39
Hypothesis One

For the first null hypothesis, that death anxiety is no different or less at the end of three months than it was at employment, Templar Death Anxiety scores of all 22 subjects who were employed at least three months were compared at employment and at the end of three months.

The means of the group when they were newly employed was 44.4 (s.d. = 5.17), compared to a mean of 41.1 (s.d. = 6.84) at the end of three months. The paired t test score (t = 2.52, d.f. = 21, 21, p < .01) was significant in the opposite to the predicted direction however. Therefore, the null hypothesis was not rejected.

Hypothesis Two

For the second null hypothesis, that anxiety will be no different or greater at the end of six months than it was at the end of three months, Templar Death Anxiety scores of 15 subjects were compared at the end of three months employment and at the end of six months employment. The mean of scores at three months was 40.7, and at the end of six months was 42.1. The standard deviation of the two groups was 7.30 for three months and 6.13 for six months. The paired t test score (−.96), is not significant at the criterion level. Thus, the null hypothesis was not rejected.

Hypothesis Three

For the third null hypothesis, that anxiety will be no different or less among those who terminate at the end of three months than
among those who complete six months employment, the seven subjects who resigned after three months were compared with the 15 subjects who completed six months of employment.

The means of death anxiety scores for the group at three months was 42.7 (s.d.=6.39), compared to a mean of 42.1 (s.d.=6.13) at the end of six months. The t score (.20) of these two unequal groups was not significant at the criterion level, and the null hypothesis was not rejected.

Hypothesis Four

For the fourth null hypothesis, that there is no difference in the nature of specific aspects of death anxiety among high and low anxiety groups, high and low scorers among those who were employed six months were compared. As shown in Table 2, on eight of 15 scale items, there were significant differences between high and low scores (p<.05, critical t value 2.02).

Those scale items that were different were: "I am very much afraid to die," "It doesn't make me nervous when people talk about death," "I am not at all afraid to die," "I fear dying a painful death," "The subject of life after death troubles me greatly," "I am really scared of having a heart attack," "I shudder when I hear people talking about World War III," and "The sight of a dead body is horrifying to me."
Table 2. Comparison Item by Item between High and Low Scorers on Modified Templar DAS

<table>
<thead>
<tr>
<th>Scale Items</th>
<th>Means Low Scorers</th>
<th>High Scorers</th>
<th>Standard Deviation Low Scorers</th>
<th>High Scorers</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>2.06</td>
<td>3.19</td>
<td>.55</td>
<td>1.11</td>
<td>-3.73*</td>
</tr>
<tr>
<td>2.</td>
<td>3.35</td>
<td>3.94</td>
<td>1.11</td>
<td>.77</td>
<td>-1.74</td>
</tr>
<tr>
<td>3.</td>
<td>1.76</td>
<td>3.31</td>
<td>.83</td>
<td>1.25</td>
<td>-4.21*</td>
</tr>
<tr>
<td>4.</td>
<td>2.88</td>
<td>3.69</td>
<td>1.41</td>
<td>1.19</td>
<td>-1.76</td>
</tr>
<tr>
<td>5.</td>
<td>2.88</td>
<td>3.94</td>
<td>1.17</td>
<td>.77</td>
<td>-3.04*</td>
</tr>
<tr>
<td>6.</td>
<td>3.23</td>
<td>3.69</td>
<td>1.03</td>
<td>1.35</td>
<td>-1.08</td>
</tr>
<tr>
<td>7.</td>
<td>3.18</td>
<td>3.75</td>
<td>.95</td>
<td>1.06</td>
<td>-1.63</td>
</tr>
<tr>
<td>8.</td>
<td>2.94</td>
<td>3.00</td>
<td>1.09</td>
<td>1.21</td>
<td>- .15</td>
</tr>
<tr>
<td>9.</td>
<td>3.00</td>
<td>4.06</td>
<td>1.37</td>
<td>1.80</td>
<td>-2.53*</td>
</tr>
<tr>
<td>10.</td>
<td>1.65</td>
<td>2.56</td>
<td>.78</td>
<td>1.26</td>
<td>-2.52*</td>
</tr>
<tr>
<td>11.</td>
<td>1.94</td>
<td>3.56</td>
<td>.75</td>
<td>1.03</td>
<td>-5.19*</td>
</tr>
<tr>
<td>12.</td>
<td>3.23</td>
<td>3.69</td>
<td>1.03</td>
<td>1.01</td>
<td>-1.28</td>
</tr>
<tr>
<td>13.</td>
<td>2.70</td>
<td>3.50</td>
<td>1.21</td>
<td>.97</td>
<td>-2.07</td>
</tr>
<tr>
<td>14.</td>
<td>1.41</td>
<td>2.81</td>
<td>.62</td>
<td>1.33</td>
<td>-3.92</td>
</tr>
<tr>
<td>15.</td>
<td>2.94</td>
<td>3.75</td>
<td>1.25</td>
<td>1.12</td>
<td>-1.95</td>
</tr>
</tbody>
</table>

* p < .05 (critical t value 2.02)
Hypothesis Five

For hypothesis five, that among those who complete six months employment, those who have low anxiety will make statements indicating that there have been enlarging or enriching changes in their lives, low scores were defined as less than the mean of 42.1.

This hypothesis was an attempt to determine if a distinction could be made between low scorers who made positive or negative responses. Following the conceptual framework, these individuals might have low anxiety scores because they were denying their anxiety and not making enlarging or enriching changes in their lives.

A content analysis was made of 15 subjects' responses to the question, "After being at the hospice for six months, how has the experience changed you or any part of your life?" The vast majority made responses judged to be enlarging or enriching, 10 out of 15. Of the two staff who scored below the mean and made statements judged to be not enriching or enlarging, one made a comment indicating "no change", and the other made one comment judged to reflect enriching changes, and one comment judged not to reflect such changed.

From this, it can be said that those with low scores can make non enriching statements, but no distinction can be made between those who might be using death denial and those who were not. A similar number of negative comments was made by high and low scorers. Positive comments tended to be made regardless of the score.

Although beyond the interest of this hypothesis, the following observations can be made. Two staff with scores very close to the mean
made a comment about negative changes or about no changes. A total of five such comments were made, three by staff with scores above the mean (43, 45, and 53). In addition, five of the eight high scoring staff made statements about enlarging or enriching changes.

Summary of all responses: Staff made a total of 32 discreet responses which were distributed among 14 categories of response (Table 3). The categories were: more search for meaning, less feeling of separateness, less fear of death, more appreciation of life, less fear of interpersonal risk, more able to be alone, more enjoyment helping people, valuing relationships more, being a happier, more contented person, having more friends, working better with patients and others, ideas that were reinforced, ideas that were changed, and indications of amounts of change.

In the category of ideas, three subcategories of responses were defined: "The hospice should deal with those dying of other diseases as well as cancer," "people should be helped to live fully until death," and "injustice pervade our society."

In the category of amounts of change upon which staff commented, three subcategories were defined. These were "lots of change with some comments about the nature of the changes," "lots of changes but not willing to say what they were," and "no changes."

The most frequent of the total 32 responses were the five responses in the category of "working better with patients and others." The next most frequent responses were in the category of being a happier, more contented person, and the category of having a greater
Table 3. Self Reported Life Changes

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Responses</th>
<th>Six Month Death Anxiety Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. More search for meaning</td>
<td>2</td>
<td>41, 44</td>
</tr>
<tr>
<td>2. Less feeling of separateness</td>
<td>2</td>
<td>41, 31</td>
</tr>
<tr>
<td>3. Less fear of death</td>
<td>2</td>
<td>41, 33</td>
</tr>
<tr>
<td>4. More appreciation of life</td>
<td>3</td>
<td>41, 46, 44</td>
</tr>
<tr>
<td>5. Less fear of interpersonal risk</td>
<td>1</td>
<td>44</td>
</tr>
<tr>
<td>6. More able to be alone</td>
<td>1</td>
<td>44</td>
</tr>
<tr>
<td>7. More enjoyment helping people</td>
<td>2</td>
<td>42, 33</td>
</tr>
<tr>
<td>8. Value relationships more</td>
<td>2</td>
<td>42, 42</td>
</tr>
<tr>
<td>9. Happier, more content, better person</td>
<td>3</td>
<td>31, 44, 47</td>
</tr>
<tr>
<td>10. Have more friends</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>11. Work better with patients and others</td>
<td>5</td>
<td>31, 41, 50, 44, 47</td>
</tr>
<tr>
<td>12. Ideas reinforced:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Hospice should be open to all,</td>
<td>1</td>
<td>32</td>
</tr>
<tr>
<td>not only those with cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. People should be helped to live</td>
<td>1</td>
<td>32</td>
</tr>
<tr>
<td>fully until death</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Injustice pervades society*</td>
<td>1</td>
<td>42</td>
</tr>
<tr>
<td>13. Ideas changed:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Dying can be beautiful</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>14. Amounts of change:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Lots of change (pain, worry, bad</td>
<td>1</td>
<td>45</td>
</tr>
<tr>
<td>dreams, decreased sleep)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Lots of change, but unwilling or</td>
<td>2</td>
<td>43, 52</td>
</tr>
<tr>
<td>unable to say*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. No change*</td>
<td>1</td>
<td>41</td>
</tr>
</tbody>
</table>

TOTAL NUMBER OF RESPONSES  32 (N=15)

*Indicates those responses not considered to be describing enlarging or enriching life changes
appreciation of life. The five responses that were judged to fall outside the enriching or enlarging range were the idea that "injustice pervades our society" had been reinforced, a report that "pain, worry, bad dreams and decreased sleep" characterized the changes perceived, two responses indicating changes had taken place but the respondent was unwilling or unable to describe them, and an indication that no changes had taken place. Five of the seven low scoring staff made statements indicating enlarging or enriching changes in their lives.

Responses relative to scores: Of the 32 responses, 27 were judged to be describing "enriching or enlarging responses" for purposes of hypothesis five. The Modified Templar Death Anxiety scores that were possible were 15-75, and the actual range of scores was 30-52. The mean of scores for all 15 subjects was 42.1.

Summary

Contrary to Hypothesis One, those who were employed at least three months had significantly lower death anxiety at the end of three months, when compared with their levels at employment. Contrary to Hypothesis Two, those nursing staff who were employed at least six months had no significant change in the amount of death anxiety during the interval from the third month to the sixth month.

Contrary to Hypothesis Three, there was no significant difference in death anxiety at the end of three months, between those who were employed at least six months, and those who resigned after three months employment. Consistent with Hypothesis Four, there was a significant difference in response to individual items on the Modified
Templar Death Anxiety Scale, between high and low scorers among the group who were employed at least six months.

In Hypothesis Five, those with low death anxiety scores tended to report enlarging or enriching changes in themselves or their lives as a result of their hospice experiences. Regardless of death anxiety scores, the majority of responses reported these kinds of changes, and subjects' responses indicated they seemed to feel themselves more fulfilled and competent interpersonally and as caregivers, were happier, more content and less fearful in their daily lives.
CHAPTER 5

DISCUSSION AND CONCLUSIONS

This section focuses on how the findings of this study relate to findings in other studies, to the theoretical framework of this study and how they relate to the research tool used. Directions for further study are discussed. In this study were examined changes in amount of death anxiety measured at intervals around an exposure to care of dying persons, and denial or acceptance of death as factors in death anxiety scores. Also examined was the discriminating character of individual test items when used in the hospice setting, as well as the life changes reported by subjects as a result of their hospice experience.

Changes in Amount of Death Anxiety

Death anxiety among the nursing caregivers was found to decrease significantly at the end of three months of hospice experience, but did not change significantly between the third month and the sixth month. In addition, the death anxiety scores at three months were not significantly different between the group who resigned after three months, and the group who continued to six months employment.

These findings differ from those previously reported in the literature. While Murray (1974) and Lester et al. (1974) had found that there was no significant difference in death anxiety after
clinical involvement with dying persons, Denton and Wisenbaker (1977) reported that experienced nurses had more anxiety than nurses who had little experience in seeing an actual death. Harper (1977) had observed that social workers in a setting with intensive exposure to large numbers of dying persons subjectively reported a rise in anxiety about death at the end of six months and then a decrease in that anxiety at the end of one year.

In the present study the largest number of resignations occurred before the third month of hospice work (16 of 22). This suggests the value of further studies focusing on that time period. Studies might evaluate the role of education and supportive individual and group counseling which are focused on the phenomenon of death anxiety and possible outcomes for the individual of changes in the amount of death anxiety experienced.

Changes in the Nature of Death Anxiety

While Swenson and Fulton (1965) assumed that death acceptance was the only opposite of death anxiety, Paris and Goodstein (1966), Weisman and Hackett (1961), Nogas et al. (1974), Kelly (1955) and Kreiger et al. (1974) found indications that low death anxiety might reflect either death acceptance or death denial. Ray and Najman (1974) suggest that there is a continuum of those who block conscious awareness of death, those who fear death with awareness, and those who have conscious awareness of death with minimal anxiety. Durlak (1973) found that those who accept death may think about it as often as those who are quite threatened by it. No previous findings exist, from
studies done in settings with the intense exposure to death and dying that occurs in hospices.

The current findings provide no indications of the role of death denial or death acceptance, in low death anxiety among subjects at any point in their employment. Hypothesis Five was an attempt to see if a correlation exists between low death anxiety scores and the presence of reported enriching or enlarging changes in the subject's lives. In the conceptual framework, an outcome of death acceptance is more meaningful, richer existence.

The study showed no relationship between these kinds of changes and low levels of death anxiety. The great majority of all subjects who had completed six months employment did, however, report enlarging or enriching experiences. One conclusion to be drawn is that nursing caregivers in a hospice setting cannot operate for six months with denial as a defense mechanism against death anxiety. It may be that acceptance of personal mortality with a resultant lowering of death anxiety is necessary to continued functioning in this role. During the six months of the study 94 patients died at the hospice, in a setting where the average daily patient census was 18.

Seeing progressive metabolic wasting and witnessing changes in bodily appearance and functioning, and being with patients during and following their deaths, are daily facts of life for nursing caregivers in this hospice setting. Nursing staff care for patients, families and those significant to them, who are experiencing anticipatory grief with varying degrees of intellectual openness and emotional intensity. The
nursing role involves being available to patients and families who wish to explore their anticipation of separation and loss, and nurses may participate with patients and families as they seek to give structure to their cognitive expectations of death and existence beyond death.

Nursing staff may participate with patient and family in planning and arranging funeral or other services. They may attend these services to meet their own needs and to support those bereaved. They may attend and participate in monthly memorial services at the hospice, for all patients who died the previous month. They sit with patients and families in the hours preceding death, care for the body after death and assist with moving of the physical remains to the mortuary. It seems that those who keep anxiety low by using denial of death could not function effectively for six months, and so were not among the group tested at the end of that time. Since there was no death anxiety testing of nursing staff at the time of their resignations, there were no data to show whether some staff had low anxiety scores at employment due to denial and experienced increased death anxiety when confronted with dying patients, which then led to their resignation. Replication of this study, obtaining death anxiety scores of staff at the time of their resignation, would be helpful in examining the role of acceptance and denial in changes that occur in death anxiety.
Relationship of Data to Conceptual Framework

Western society has traditionally adopted a dualistic value system in which life and death cannot exist together and so life becomes the central value affirmation, death the ultimate value negation. This focus on living and fear of its supposed opposite, death, is in contrast to those Eastern philosophies which stress that the totality of human existence includes both life and death. The Tibetan Book of the Dead (Evans-Wentz 1960), for example, not only teaches about death and describes how to achieve certain goals during the time immediately surrounding the death itself, but serves as a practical instruction for living as well.

The conceptual framework for this study is the existential position that life and death are a continuum rather than a dichotomy, and that incorporating an acceptance of personal mortality into one's idea of life leads to a more meaningful existence. Anxiety about death is seen as motivating if kept to manageable levels, because energy can be directed into worthwhile changes in daily existence. Denial of personal mortality is another option, particularly if anxiety is at an unmanageable level.

Conflict over denial or acceptance of death tends to occur when death becomes a conscious experience through exposure to dying persons.

This study showed that there was significant reduction in death anxiety at the end of the third month of employment, and little change between the third and sixth month, among those staff who
remained at the hospice for those time periods. Those staff who continued in their hospice work for at least six months reported a significant incidence of reportedly enriching or enlarging changes, after being at hospice.

The role of acceptance and denial in amount of death anxiety was not defined in this study, and no data are available showing the amount of death anxiety experienced at the time of resignation, by subjects who resigned during the study.

Counseling, particularly peer counseling, might be utilized to keep death anxiety at a manageable level, particularly during the first three months. Those who have experienced positive life changes as a result of their hospice experience might serve as models as they share their early struggles as well as later positive outcomes, with newer staff. New staff exploring values and philosophic constructs of life and death might benefit from hearing alternatives discussed.

Studies which explore the process of achieving meaningful life changes might be used to indicate structures that could benefit nursing staff. Koestenbaum's (1974) "pain test" discriminates between eight types of philosophically related pain -- physical pain, tragedy, depression, anxiety, guilt, meaninglessness, loneliness and frustration, and indicates which type of pain might be the best place to begin creating a more meaningful life.
Relationship of Findings to Research Tool

Among subjects who were employed at least six months there were found to be significant differences between high and low scores in their responses to individual test items. This may indicate that those items are particularly good discriminators as test items. A replication of this part of the study might show more about whether this tool is applicable as a measure of death anxiety in hospice work. Used in conjunction with a revised scoring system, a more appropriate research tool for hospice work might be devised.

The results of Hypothesis Four indicated a significant difference in eight of 15 Templar Death Anxiety Scale items, between those with high anxiety scores and those with low anxiety scores.

The data were analyzed using the traditional scoring method for death anxiety. However, a clinical supervisor at the hospice was given a copy of the Templar Death Anxiety Scale, and asked to score it "true" or "false" on the basis of how she felt an experienced and effective hospice nurse might respond. This scoring revealed a difference between Templar's scoring system and that of the supervisor. The individual test items that Templar thought positive or negative indicators of death anxiety were viewed differently, in eight of the 15 items (items 2, 4, 5, 6, 7, 9, 12 and 13). This difference suggests a possibility for further study, which would rescore the outcomes using a revised scoring system.
APPENDIX A

MODIFIED TEMPLAR DEATH ANXIETY SCALE

Directions:

Below you will find a series of statements expressing feelings about death and dying which you may have experienced or thought about. After each statement there is a set of possible responses as follows:

Strongly Disagree 1 2 3 4 5
Disagree 2 3 4 5
Neutral 3 4 5
Agree 4 5
Strongly Agree 5

You are asked to read each of the following statements and then to circle the response which best represents your immediate reaction to the opinion expressed. Respond to each opinion as a whole. If you have reservations about some part of a statement, circle the response which most clearly approximates your general feeling.

1. I am very much afraid to die. 1 2 3 4 5
2. The thought of death seldom enters my mind. 1 2 3 4 5
3. It doesn't make me nervous when people talk about death. 1 2 3 4 5
4. I dread to think about having to have an operation. 1 2 3 4 5
5. I am not at all afraid to die. 1 2 3 4 5
6. I am not particularly afraid of getting cancer. 1 2 3 4 5
7. The thought of death never bothers me. 1 2 3 4 5
8. I am often distressed by the way time flies so very rapidly. 1 2 3 4 5
9. I fear dying a painful death. 1 2 3 4 5
10. The subject of life after death troubles me greatly. 1 2 3 4 5
11. I am really scared of having a heart attack. 1 2 3 4 5
12. I often think about how short life really is. 1 2 3 4 5
13. I shudder when I hear people talking about World War III. 1 2 3 4 5
14. The sight of a dead body is horrifying to me. 1 2 3 4 5
15. I feel that the future holds nothing for me to fear. 1 2 3 4 5

NAME:

DATE:
APPENDIX B

SCORING KEY FOR TEMPLAR DEATH ANXIETY SCALE

<table>
<thead>
<tr>
<th>Key</th>
<th>Content</th>
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<tbody>
<tr>
<td>T</td>
<td>1. I am very much afraid to die.</td>
</tr>
<tr>
<td>F</td>
<td>2. The thought of death seldom enters my mind.</td>
</tr>
<tr>
<td>F</td>
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</tr>
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