

AN ABSTRACT OF THE THESIS OF

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The purpose of this study was to determine if adding a specialized instructional section on death and dying to ongoing curriculum would affect attitudes of student nurses toward death and dying. Subjects were 30 first-year nursing students enrolled in the Associate Degree Nursing Program at Linn-Benton Community College, Albany, Oregon. Two instruments in the form of validated questionnaires were utilized. Hopping's Death Attitude Indicator and Templer's Death Anxiety Scale were used to ascertain the negative to positive attitudes of the students toward death and dying. A pretest was given and the students were randomly divided into an experimental and a control group. The treatment consisting of five hours of course content related to death and dying, was administered to the experimental group followed by a post-test which was administered to both groups. After this, the students were assigned to clinical experience in extended care facilities. At the end of the quarter, Post-test II was administered.

Descriptive statistics were used to analyze the sample and

inferential statistics were used to interpret the data and to answer the research question posed. The Student's t -test with pooled error was used for comparison of the experimental and control groups on the pretest and two post-tests. The paired t -test was used to compare the mean difference of the control and experimental groups separately.

All study hypotheses were retained except one. The rejected hypothesis showed that there was a difference in the mean difference between Post-test I and Post-test II scores in Templer's Death Anxiety Scale in the control group. Clinical experience tended to increase negative attitudes toward death and dying except in the experimental group which had received the specialized instructional section. Thus, a specialized curriculum may be helpful in preventing the development of negative attitudes. It is recommended that this study be replicated using larger samples, and that curricula related to death and dying be incorporated in all areas of nursing education.

ATTITUDES TOWARD DEATH AND DYING AMONG STUDENT NURSES
AS AFFECTED BY A SPECIALIZED CURRICULUM

by

Taffy L. Johnson

A THESIS

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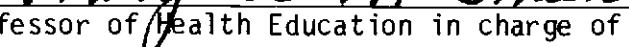
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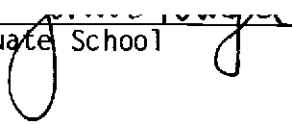
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PRAYER FOR HEALERS

LORD,

Make me an instrument of your health:
where there is sickness,
let me bring cure;
where there is injury,
aid;
where there is suffering,
ease;
where there is sadness,
comfort;
where there is despair,
hope;
where there is death,
acceptance and peace.

GRANT that I may not:
so much seek to be justified,
as to console;
to be obeyed,
as to understand;
to be honored,
as to love
for it is in giving ourselves
that we heal,
it is in listening
that we comfort,
and in dying
that we are born to eternal life.

Prayer of St. Francis

(modified by Charles C. Wise)

TABLE OF CONTENTS

	<u>Page</u>
I. INTRODUCTION	1
Statement of the Problem	2
Purpose of the Study	3
Definition of Terms	3
Summary	4
II. REVIEW OF LITERATURE	5
Demands on the Student Nurse	5
Attitudes Toward Death	6
Mount, Jones, and Patterson	7
Mullins and Merriam	7
Coolbeth and Sullivan	8
Tamlyn and Caty	9
Milton	9
Nursing Education Programs Related to Death	10
Further Research Needed	12
Nursing Curriculum Related to Death	13
Needs of the Student Nurse	13
Needs of the Dying Patient	14
Needs of Family Members	17
Role of the Student Nurse	18
Summary	21
III. METHODS AND PROCEDURES	22
Subjects	22
Instruments	23
Hopping's Death Attitude Indicator	23
Templer's Death Anxiety Scale	24
Descriptive Data Questionnaire	25
Treatment	26
Development of the Specilized Curriculum	26
Study Design	27
Hypotheses	28
Treatment of Data	29
Summary	30
IV. ANALYSIS OF DATA	31
Demographic Data	31
Statistical Analysis	32
Findings Related to the Hypotheses	34
Hypothesis One	34
Hypothesis Two	34
Hypothesis Three	34
Hypothesis Four	34
Hypothesis Five	34
Hypothesis Six	36

	<u>Page</u>
Hypothesis Seven	36
Hypothesis Eight	36
Hypothesis Nine	36
Hypothesis Ten	36
Hypothesis Eleven	38
Hypothesis Twelve	38
Hypothesis Thirteen	38
Hypothesis Fourteen	38
Hypothesis Fifteen	38
Hypothesis Sixteen	39
Hypothesis Seventeen	39
Hypothesis Eighteen	39
Summary	40
V. SUMMARY, IMPLICATIONS, AND RECOMMENDATIONS	41
Summary	41
Implications	42
Recommendations	43
BIBLIOGRAPHY	45
APPENDICES	
Appendix A. Instruments	49
Hopping's DAI	50
Templer's DAS	55
Appendix B. Specialized Curriculum	56
Appendix C. Validation of Course Content	64
Panel of Content Experts	71
Participating Community Colleges	72
Suggestions of Content Experts	73
Appendix D. Letter of Request to Conduct Study	74
Letters of Permission	77
Student Consent Form	80
Appendix E. Student Demographic Data	81

LIST OF FIGURES

Figures	<u>Page</u>
1. Graphic Study Design	28
2. Demographic Data (Sample Group)	33

LIST OF TABLES

Table	<u>Page</u>
I. Control and experimental groups: Mean Scores, Standard Deviation, t value and 2-tail probability.	35
II. Pre- and post-tests: Mean Scores, Standard Deviation, t value and 2-tail probability.	37

ATTITUDES TOWARD DEATH AND DYING AMONG STUDENT NURSES AS AFFECTED BY A SPECIALIZED CURRICULUM

CHAPTER I

INTRODUCTION

Of all human experience, death is the most mysterious, the most threatening, and the most tantalizing. It is the ultimate cruelty. It is the essence of relief. It is universally feared, sometimes actively sought (Shneidman, 1973). Freud speaks of death as the "goal of life." Peter Pan calls it "an awfully big adventure," and Socrates distinguishes it as "the greatest of human blessings."

Death and dying are a part of living. It has always been so; it will always be. No modern technology, no matter how sophisticated, has discovered a way to do more than prolong the time of death. Consequently, it is advisable to investigate ways to improve the process of dealing with death.

Nurses are exposed to death and dying far more than the average individual. In western countries, two-thirds of the population die in hospitals; therefore nurses by way of propinquity find themselves involved in the dying and grieving process (Channon, 1984). Student nurses are often faced with a dying patient, a distraught family, or a seemingly endless array of life-supporting equipment. They are expected to carry out the physical care of the dying patient while giving emotional support to the family. According to Birch (1979),

during these crises it is imperative that nursing students have the ability to cope with their own anxieties and fears concerning death.

Although the process of dealing with death is of critical importance the curricula in schools of nursing often contain an appalling lack of subject matter in the area of death and dying (Birch, 1979; Milton, 1984; Quint, 1977). Quint suggests that the students may be left to struggle through as best they can with minimal support from instructors who often feel as inept as the student.

Yeaworth, et al. (1974) found that important shifts in attitude (toward death and dying) resulted from nursing education. In their opinion, more research should be done to determine which educational designs and length of course contribute to improved attitudes towards the dying and their families.

Four areas of nursing education need to be addressed. These are 1) needs of dying patients, 2) needs of student nurses, 3) needs of family members, 4) active role of the student nurse (Backer, 1982; Hurley, 1984; Kalish, 1985; Kübler-Ross, 1969; Schrock & Swanson, 1981; Stephenson, 1985; Quint, 1973). These studies form the core of a small body of literature which deals with the importance of developing carefully designed content on death and dying to be added to the curricula for student nurses.

Statement of the Problem

It's not the patient's illness or dying that produces the upset, but the insanity of those around him who deny reality.

-LeShan

The literature consistently suggests that many nurses are poorly equipped to deal with the affective elements with which they are frequently confronted in their care of dying patients. In spite of the identified need for content in dealing with death and dying in the nursing curriculum, the curriculum is often lacking, or poorly delineated. More explicitly, the literature is not clear as to whether curriculum specifically directed at the four categories of need (page 2) will produce positive changes.

Purpose of the Study

The purpose of this study was to determine if a specialized instructional section on death and dying added to the ongoing curriculum would effect changes in attitudes of student nurses toward death and dying. The research question posed was as follows. Will a specialized curriculum regarding death and dying change student nurses' attitudes toward death and dying?

Definition of Terms

To facilitate better understanding of this research study, the following terms are defined:

(1) Attitude - precursors of behavior which represent predispositions to act in specific ways toward a person, situation, or event; represents conscious or unconscious views developed through cumulative experience.

(2) Curriculum - a particular course of study. In this research

also defined as five hours of specialized content dealing with death and dying.

(3) Death - the cessation of life (Stedman's Medical Dictionary, 1972).

(4) Dying - approaching death; ceasing to live.

(5) Student nurse - future nurse. In this research also defined as freshmen students enrolled in the Associate Degree Nursing Program at Linn-Benton Community College, Albany, Oregon.

Summary

Many nurses are poorly equipped to deal with affective elements concerning death and dying. The literature suggests that these elements can be changed through nursing education. Four general threads run through the literature common to nursing education and death and dying.

This chapter discusses the problem, need for the study and purpose of the study. A definition of terms used in this study was provided. Chapter II contains a review of the limited literature related to this investigation.

CHAPTER II

REVIEW OF LITERATURE

The human mind is as little capable to
contemplate death as the eye is able to
look at the sun.

-LaRochefoucauld

This chapter reviews literature pertinent to attitudes toward death and dying. With increased emphasis on technology today, it is easy to lose sight of the fact that student nurses must learn, together with giving skillful care of physical needs, how to deal with the human spirit. As Backer, et al. (1982) suggest, the things of the spirit are difficult to measure and the meaning of life and death is not readily transposed into a scientific model.

Demands on the Student Nurse

John Birch (1979) stated that there are powerful pressures on the student nurse. The work is highly demanding with profound and often unpredictable stresses. Although some level of anxiety is an effective motivator and an essential part of life and living, Birch found that the anxiety measured in subjects in his sample was capable of producing ineffective functioning and frank morbidity. Birch believed that the level of stress sustained by student nurses was totally unacceptable and that the factors causing anxiety were directly related to the curriculum. Similarly, Quint (1967) long recognized for her work concerning the nurse and the dying patient

declared that student nurses who came from the relatively protected life of middle-class America were thrown into a world overflowing with emotionally disturbing sights and events. The shock of encountering death, especially sudden death and death of the young, could produce far-reaching consequences, according to her. She found that students were disturbed by situations which brought about feelings of helplessness and these may have caused a resulting depression and anger. Lack of religious belief and practice is an additional factor that must be considered since many of these student nurses may have little if any belief in God and no faith to sustain them during some of the more shattering experiences they will face (Luckman, 1979). Kalish (1985) agreed by stating that stress was exacerbated by the lack of a system of meaningful, cohesive religious beliefs.

Attitudes Toward Death

The attitudes toward death are imperceptibly formed from early childhood through adulthood (Backer, 1982). Kübler-Ross in her extensive work with dying patients recognized that attitudes of the caregivers were fundamental to the total network of relationships. The care of the dying was not a skill that could be turned off and on, but was implicit in the needs of the patient and subject to the social-psychological perspectives of the nurse. Yet attitudes are changeable. Yeaworth (1974) found that nursing education could bring about important shifts in attitude. Five specific research studies regarding the attitudes of student nurses toward death and dying were identified in the literature. A brief review of each follows.

Mount, Jones, and Patterson, 1974

This study endeavored to analyze attitudes in a general hospital toward death and dying. More nurses responded than any other group of caregivers in the hospital (which included attending staff, residents, interns, patients, social workers and clergy). An interesting result noted in this study of attitudes in a teaching hospital was that the patients were the only group of which the majority felt that their emotional needs were "usually" or "always" met. Patients should surely be more aware of defects in having needs met than the medical staff. In another curious finding, four percent of the attending staff thought that their profession was "always" aware of patient's emotional needs, whereas seventeen percent felt that they themselves were "always" aware. "I don't have a problem, but everyone else does." Patients assessed nurses as the group most highly aware of their needs. Only the nurses assessed their awareness of the patient's emotional needs as being similar to their profession as a whole. This study recommended that death education be encouraged at all levels starting in childhood, to help correct the feeling of inadequacy in "knowing what to say" and the guilt accompanying failure to cure the patient.

Mullins and Merriam, 1983

An experimental study of the impact of a short-term training program on death is reported by Mullins and Merriam. They felt it

was important to assess the nurse's information about, and attitudes toward, death and dying. They stated that the treatment given the dying patient by the nurse was determined by the way the nurse perceived the act of dying-- whether it was painful, a blessing, etc. Their hypothesis that nurses receiving death instruction should experience significantly less death anxiety as evidenced by the Facts on Death Instrument was supported. There were significant cognitive gains among recipients of the course. Oddly, the scores on Templer's Death Anxiety Scale showed more anxiety after completing the death training program. This was not necessarily a negative finding according to the authors since if nurses were stimulated by the increase in anxiety about death to spend more time considering their own demise they might also be stimulated to greater empathy with those about them who are facing death. In realizing that simply hearing information about death has heightened their own anxiety, they may more fully understand the feelings of those persons to whom they are ministering. Hopefully, the nurses will transfer the anxiety they experienced into a constructive energy outlet stimulating greater patient understanding.

Coolbeth and Sullivan, 1984

This study was conducted to evaluate the effectiveness of the educational program of the University of Connecticut in producing more positive attitudes in nursing students toward death and dying. A positive attitude was defined as a score of greater than fifty-one on the Death Attitude Questionnaire (adapted from Hopping's Death

Attitude Indicator) reflecting the abilities to discuss death, understand dying patients and care for them, and a personal philosophy encompassing death. Recognizing the need for student nurses to be able to deal with their own emotions and attitudes toward death in order to effectively care for dying patients, the nursing curriculum offered segments of death education in the form of lectures, faculty panel discussions, small group seminars and reading assignments from current literature on the subject.

The authors concluded that exposure to death coupled with education produced the most positive attitudinal changes. This study did not show an inverse relationship between experience and attitudes.

Tamlyn and Caty, 1984

Tamlyn and Caty pointed out the need for more research to determine which educational design would be the most effective in improving attitudes among nurses toward death and dying. The results of adding a two-day seminar (with a free day in between) were positive. The difference between the mean scores of measurement before and after the seminar as measured by "Questionnaire for Understanding the Dying Person and His Family" developed by Yeaworth, Kapp, and Winget was statistically significant. Students identified positive factors as being the off-campus setting, faculty sharing, and discussion on spiritual issues.

Milton, 1984

Milton stated that the attitudes of nurses toward caring for

dying patients may be considered strong indicators of their clinical behavior. Her rationale for conducting this study was to identify specific concerns about nursing dying patients in order to modify the nursing curriculum to deal with these concerns. The concern which nursing educators have about societal attitudes toward death brought into the nursing programs by students was reaffirmed by this study. Seventy-eight percent of the students reported they were from families who discussed death with discomfiture, as taboo, or not at all. Family attitudes accompany the student into the nursing program. This re-emphasized Kübler-Ross' contention that nurses must take a hard look at their own attitudes toward death and dying before they will be able to care for the dying without undue anxiety.

Nursing Education Programs Related to Death

Nurses, especially neophytes, need information early in their training on dealing with the dying patient. Currently, curricula may include brief courses (often in the sophomore or senior year) or may incorporate education on death and dying into other units such as oncology or mental health. Yeaworth (1974) found that important shifts in attitude result from nursing education.

Nash, Connors, and Gemperle (1977) recommend the saturation technique such as an intensive workshop experience. They conducted a twelve hour program using interviews and collecting descriptive data from personnel who worked with the terminally ill finding that a positive impact resulted with the participants.

The study conducted by Mullins and Merriam (1983) shows that some students are actually more afraid of death and have a lower perception of purpose in life after receiving death education. Other studies (Denton and Wisenbaker, 1977; Stoller, 1980) show an inverse relationship between experience and attitudes, with the nursing students with the most experience having the most negative attitudes. An experimental study of the impact of a short-term training program on death on nursing home nurses shows that a positive attitude among nursing personnel can be facilitated through instructional sessions. Murray's findings (1974) seem to indicate that a combination of educational units and practical experience produces the most positive attitudinal changes (Coolbeth and Sullivan, 1984).

The study conducted by Coolbeth and Sullivan (1984) shows that the University of Connecticut provides a curriculum which enhances positive changes in attitudes toward death and dying. In this study improvement in attitude was shown to be the result of academic exposure. The University of Connecticut curriculum consists of lectures, panel discussions by faculty, small group seminars, and reading assignments from current literature. The faculty is available for one-to-one counseling and the students have practical experience as part of their clinical requirement. This study recommends that the attitudes of freshman nursing students be measured instead of sophomores, the authors believing that it would be more balanced by increasing the number of students with no previous experience with death.

A study carried out by Jinadu (1982) seemed to show that the general nursing student educational preparation did not make any significant positive contribution to attitudes toward dying patients in the hospital. In fact, reverting to Birch's study, " . . no more than 50% of the students believed they had been prepared to understand and deal with the patient's emotional response to dying; the role of denial in the dying patient; the process of the patient's separation or disengagement from others; the dying patient's grief; the family's anticipatory grief and mourning; and the nurse's emotional reaction to the patient."

Jinadu submits that there is a pressing need for a nursing curriculum which will provide basic theoretical knowledge about social, cultural, and psychological aspects of death and dying plus guided clinical experiences in caring for dying patients.

Further Research Needed

Based on the current literature it is difficult to draw conclusions about the effectiveness of the student's exposure to death and dying (Backer, 1982). Research is indicated to continue to develop nursing education that will be relevant to patients, students, and faculty.

Quint (1967) maintains that it is of critical importance to educate those in the health professions who care for dying patients. Tamlyn and Caty (1984) advocate a replication of their study with the inclusion of a control group for the purpose of better understanding the contribution of professional socialization to the development of

death attitudes. They also feel that more study is needed to ascertain the effect of different educational designs on attitudinal change, and what is the optimal course length.

Nursing Curriculum Related to Death

Needs of the Student Nurse

Nurses confront several conflicts in terms of personal and professional identity. It is possible for the nurse to use so much energy in resolving his/her own conflicting emotions that not enough is left to focus on the dying patient's needs. Who cares for the caregiver? (Grollman, 1981)

Nurses who are attentive and nurturing to patients have to pay the penalty of becoming close to the patient and therefore grieving when that relationship ends. Kalish (1985) and Backer (1982) point out that nurses involved with a terminal patient may need extra time off or a lighter patient load. Fatigue is a common reaction to bereavement (Lerea & Limauro, 1982). They need the encouragement of peer support, receiving "strokes" and the opportunity to ventilate feelings. According to Backer et al. (1982), the amount of support and supervision that faculty, students and graduate nurses need in order to provide appropriate, humanistic care to dying patients is a major factor influencing positive attitude change.

Hopping (1977) and Kalish (1985) have identified some of the defenses commonly used by nurses: avoiding patients; being very brisk and efficient when doing physical care; only speaking when the

patient speaks; avoiding conversation; and/or only talking about neutral subjects which are comfortable for the nurse.

Needs of the Dying Patient

Nurses are trained to meet the needs of patients. This involves integrating the academic, the philosophic and the practical aspects of those needs. The patient's needs include the personal and emotional issues, especially those involved in "caring" relationships (Kalish, 1985).

Maslow's hierarchy of needs is applied to the dying patient by Kalish. This system assumes that the basic needs must be at least partially satisfied before the person can become interested in the next higher level. These five categories of needs are physiological, safety and security, love and belonging, esteem and self-esteem, and self-actualization. The needs of the dying patient are the same as those of the living.

The greatest physiological need for the dying patient is freedom from pain. Pain, coupled with the knowledge of impending death, makes a heavier load to carry. The other physiological needs (food, water, air, sleep, etc.) are the same as for non-terminal individuals even though they may have to be met in different ways (Kalish, 1985).

In regard to security and safety, the dying person appears to have two major sources of insecurity--lack of trust in the caretakers, and fear of abandonment. The patient needs to have faith in the physician, nurses, and significant others, (not necessarily that

they will cure the incurable, but that they will guide the suffering persons safely through the dying process as long as they are under their care). The fear of abandonment leaves them feeling lonely, isolated, and vulnerable. This is a fear nurses must keep in mind so they will work to reassure the patients that they will not be abandoned.

Kalish (1985) stated that one is never too sick or too near death to need love. Love comes from many places and family, close friends, physician, nurse, or other health workers can express the true concern and caring which mean so much.

Kalish also maintained that as the patient approaches death self-esteem suffers. Self-esteem depends on many things, including control of self, ability to do necessary tasks well, autonomy and independence. It is in this area that reminiscing is helpful and enriching. The dying person can focus on times that were deeply satisfying. Anticipation of the future may seem futile and enjoyment of the present dubious, but considerable pleasure can be derived from recalling the past. No longer can the dying patients make the contributions they once did, and they gradually become incapacitated, helpless and dependent, losing the ability to make decisions and control their own lives. Sometimes the awareness of impending loss is even more painful than recalling of past losses.

Only the dying know how to live (Kalish, 1985). Because a person is dying does not mean that development stops. Zinker and Fink (1966) did a study describing the personal growth of a dying woman who was the focus of intensive research. They concluded that

the impending end of life may be the impetus for resolving problems, establishing closer relationships, and even becoming more productive. However, they found that as the woman's breathing became more difficult and physical strength diminished, she needed more energy to satisfy physiological needs and had less left to satisfy esteem or self-actualization.

Perhaps the best ones to ask about the needs of the dying are dying persons themselves. In one study, sixty terminally ill cancer patients were asked what their needs were. They mentioned that they needed help with (1) financial problems which arose frequently from reduced income and high medical costs; (2) illness-related matters such as concern about pain, loss of energy and strength, trouble with medical procedures and tests and confinements to home and hospital; (3) changes in social and sexual relationships; (4) difficulties at the hospital including erratic attention from the nurses, impersonal treatment, and inadequate information about their condition; and (5) handling emotional problems, including depression, anxiety, suicidal ideation, and hostility (Koenig, 1968). Though this list was compiled nearly twenty years ago it is still applicable. The financial problems are surely as bad today as they were then, and patients probably don't get any more attention from nurses, (probably less, as so much of the nurse's time is now taken up with technology and documentation). Also, it is regrettably still true that patients are not given enough information on changes in their social and sexual relationships.

An example of what the dying really want as described by Kalish (1985) is found in the success of the hospice program. Hospice maintains self-help groups, holds workshops and seminars, provides books and articles and conversation with other people about their concerns.

Needs of Family Members

According to Utley and Rasie (1984), more attention must be given to the needs of the family members. In their study, health care professionals appeared to concentrate more on individual patients than on family and friends when death occurred and the survivors were expected to regroup on their own. Family members who love the patient normally have a deep feeling of emptiness and helplessness. If they are directly involved in the planning and care of the patient it helps them cope with the powerlessness. Families tend to feel that they have failed the dying patient due to the inevitable outcome.

Grollman (1981) mentions two things in the hospital that he did not find helpful while his small daughter was dying. These were lack of privacy for the grieving family, and game playing-"You look so much better today!"

When the patient dies, supportive care ends. The needs of the family may be just beginning. The family should be allowed as much time as they need. An empathetic, caring nurse can often give more comfort than the physician (Kübler- Ross, 1974).

Grollman (1981) found that guilt feelings could be the most devastating, the most unreasonable, and the hardest with which to

deal. Guilt was experienced for not having done enough, for not calling the doctor sooner, and often for the sense of relief that came when the long process was over.

While nurses usually see only the immediate grief of the family members, there are helpful actions they can take. Grollman (1981) recommended helping them choose what to remember of the past, along with how to cherish the joys of the present, and how to plan a future to which they can look forward. Experiencing a loved one's terminal illness is an exhausting process, but the anticipatory grief tends to shorten the period of grief after death has occurred (Kübler- Ross, 1974).

Role of the Student Nurse

We speak derisively of "Job's comforters" but Job's friends did two things right. They came and they listened (Kushner, 1981). Realizing that a major fear of the dying person is the fear of abandonment (Kalish, 1985), a primary function of the nurse is simply to be there.

Frihofer and Felton (1976) conducted a study which identified the nursing behaviors which spouses, relatives and close friends considered the most supportive and comforting. Following are listed the four most desired behaviors and the four least desired behaviors of family members and others.

In order of ranking, the most desirable are as follows: Keep the patient well groomed; allow the patient to do as much as

possible for himself; give the pain medication as often as needed; keep the patient physically comfortable. Strangely, the least desired were as follows: Encourage them to cry; hold their hand; cry with them; remind them that the patient's suffering will be over soon. These findings do not agree with the literature on thanatology (Backer. 1982).

Kalish (1985) recommended honesty with the dying patient. He quoted Chaplain Walter Johnson, a Presbyterian clergyman serving in a hospital near San Francisco, as putting this into an equation.

Truth minus love = brutality.

Love minus truth = sentimentality.

Truth plus love = healing relationship.

It is important to be able to trust the caretaker, and this precludes dishonesty of any type. The whole brutal truth need not always be told.

Worden (1982) outlines four tasks which must be accomplished during the grieving process. The person must 1) accept the reality of the loss, 2) accept that grief is painful, 3) adjust to a new environment without the person, and 4) withdraw emotional energy and reinvest in new relationships.

Kalish (1985) applies Elisabeth Kübler-Ross' five stages of dying to the process of grieving as well. Nurses must be aware of these stages while realizing that all people do not progress systematically from one stage to another; some people do not go through all stages, and some get "stuck" in one stage.

Denial may be an important means of coping (Kalish, 1985). A common misconception is that people flow from one stage of grief to the next in chronological order. Nurses must be aware that if the patient is comfortable in the stage of denial, he needs the freedom to stay there without disapproval (Kübler-Ross, 1974). There is healthy denial and adaptive denial which is beneficial to the patient (Kalish, 1985).

Elisabeth Kübler-Ross has many pertinent and helpful suggestions for the nurse, among which are the following. It is cruel not to let the patient believe in miracles or to tear down their defenses. If you don't believe, perhaps the patient will convince you. Do not approach patients on the subject of death. They will bring it up when they are ready to discuss it. If they want to talk about pain, talk about pain with them. Speaking of it may render it less powerful. Always help the one who needs it the most. Allow the family and significant others as much time as they need. Allow a glimpse of hope. Remember that the dying live more intensely. Don't deny the concerns of the dying.

The role of the nurse is to provide comfort, reduce pain, offer companionship. It often is valuable to the patient to reminisce over past life and accomplishments (Kalish, 1985). "Listen! Listen! Listen!" (Kollar, 1982, Kübler-Ross, 1975, p 84). Specific techniques may include sitting down with the patient, touching the hand, communicating warmth and sincerity, offering assistance, but demanding no instant intimacy (Kalish, 1985).

All too often we treat the dying person as if already dead (Wilcox and Sutton, 1977). Since one does not know the point at which the sense of hearing is lost, sensitive nurses talk to comatose patients.

There are two roles that can be played by the caregiver. That of a "mechanic" who helps the person die, or that of a "gardener" who helps the person live in whatever time is left (Kalish, 1985).

Summary

Although there are differences of opinion, the current literature seems to identify lack of preparation of nursing students in the area of death and dying. Negative attitudes are formed early in their clinical experience, but education can offset these and contribute to the development of positive attitudes toward the dying patient as well as towards their own mortality. More study is needed to develop a curriculum that will increase communication and coping skills and thus change attitudes in a positive direction.

CHAPTER III

METHODS AND PROCEDURES

This study was designed to determine if a specialized curriculum presented to freshman student nurses is conducive to the development of more positive attitudes toward death and dying. Thus, the central question of this research study is whether a specialized curriculum regarding death and dying will change attitudes of student nurses toward death and dying. The methods and procedures used to answer the research question are discussed in this chapter. These include subject selection, instrumentation, research treatment, hypotheses under examination, and data treatment.

Subjects

Subjects involved in this study were all freshman nursing students enrolled in the Associate Degree Nursing Program at Linn-Benton Community College, Albany, Oregon. In this respect, subjects were a census. Freshmen were chosen because of a recommendation by Coolbeth and Sullivan (1984) that it is preferable to select a group that has had little or no previous experience with dying patients. This research was conducted during fall term in order that the Pre-test could be administered, the treatment applied, and Post-test I given before the students were assigned to care for patients in the clinical setting.

All subjects were divided into one of two groups - controls or experimentals. To ensure randomness, students signed up at registration for either the "Monday" group or the "Tuesday" group. The "Monday" group was then chosen as the experimental group. Students who volunteered to change into the experimental group were not permitted to do so. Participation was encouraged but was voluntary.

Instruments

Two instruments in the form of validated questionnaires were utilized. Hopping's Death Attitude Indicator and Templer's Death Anxiety Scale were used to ascertain the negative to positive attitudes of the students toward death and dying. Hopping's Death Attitude Indicator was scored from four to zero with four indicating the most positive response and two considered neutral. Some items are reverse scored to prevent students from perceiving a pattern in marking the continuum. Conversely, Templer's Death Anxiety Scale was scored from one to 15 with 15 being the most negative response. Since the tests were evaluated independently this did not affect the results.

Hopping's Death Attitude Indicator

Considering that attitudes cannot be measured, only inferred, Hopping developed the Death Attitude Indicator to indicate attitudes by looking at life experience factors, personal beliefs, opinions, behaviors and feelings. Part I contains 24 items concerning beliefs, feelings, and personal opinions related to death and dying. In order

to avoid affronting the respondent, the test items were arranged with opinions and beliefs first, then behaviors, and finally feelings. A five-point graphic rating scale was provided which defined a continuum in terms of equal intervals. This prevents the respondent from feeling hemmed in by specific responses and allows many shades of response. An absolute measure is felt to be unnecessary and the participants total item scores are distributed along a continuum. Part II of Hopping's instrument concerns life experiences which cannot be changed by planned educational experiences.

Prior to usage, the instrument was extensively revised and the format changed from multiple choice to a bipolar graphic rating scale. Hopping's Death Attitude Indicator has a pre-and post-test validity of 0.68 (Hopping, 1977).

Templer's Death Anxiety Scale

The Death Anxiety Scale (DAS) was developed by Templer to reflect a wider range of life experiences than Boyar's Fear of Death Scale (FODS). Forty items were devised on a rational basis and the face validity rated by seven judges. The direction of the question to indicate greater death anxiety was specified by Templer and the judges rated each item from one to five on this basis: 1) irrelevant to death anxiety, 2) slightly associated with death anxiety, 3) moderately associated with death anxiety, 4) considerably associated with death anxiety, and 5) very greatly associated with death anxiety. The average rating for each item was calculated and the

nine items that received a value below 3.0 were discarded. The remaining 31 items were embedded in 200 filler items, the last 200 items of the Minnesota Multiphasic Personality Inventory. It was considered worthwhile to determine the relationship of the DAS to personality variables as measured by the MMPI scales.

Internal consistency was determined by item-total score point biserial correlation coefficients for three independent groups of subjects. Construct validity was established by two separate projects, one involving psychiatric patients in a state mental hospital and the second utilizing college students. Presumably high death anxiety psychiatric patients were found to have significantly higher DAS scores than control patients, and DAS scores were correlated significantly with Boyar's FODS, with another death anxiety questionnaire, and with a sequential word association task. Fifteen questions constituted the final DAS. There was a high correlation between the DAS and the FODS; however the uniqueness of the DAS as a measure of death anxiety was not established at that time (Templer, 1972).

Descriptive Data Questionnaire

A brief questionnaire designed to elicit descriptive data was also utilized. This questionnaire was developed by the researcher. In addition to routine questions of age, race, sex, marital status etc. this instrument included questions concerning childhood conceptions of death, personal involvement with death, and the meaning of death to the student. These questionnaires are found in Appendix A.

Treatment

The randomly selected experimental group was provided with five hours of specialized curriculum regarding death and dying. All other instructional factors for the experimental and control groups were equal.

To reduce the possibility of contamination, the experimental group was instructed to refrain from discussing the curriculum content with the control group until the research study was completed.

Development of the Specialized Curriculum

As previously discussed in Chapter I, the literature is not specific regarding death and dying in nursing curricula. However, the literature does suggest four common elements for inclusion in a curriculum. With these in mind, a five-hour curriculum was developed. (See Appendix B). Content of the five-hour specialized curriculum used as the treatment was validated by three means.

(1) Similar course content on death and dying reported in the literature related to nursing (Chodil and Dulaney, 1984; Cowles and Swain, 1978; Mullins and Merriam, 1983; Tamlyn and Caty, 1984; Wallace, Bakke, Hubbard and Pendergrass, 1984).

(2) Course objectives on death and dying from all responding Community Colleges with Associate Degree or Licensed Practical Nurse Schools of Nursing in the State of Oregon.

(3) Panel of content experts from various disciplines within

the nursing profession which are associated with death and dying. (See Appendix C).

Study Design

The pre-test was given to the entire freshman group of nursing students before they knew if they were controls or experimentals. At this time a card with a number from a random numbers table was issued to each student. The students then wrote their names on the card and the number on the test. Cards were collected by a student, put in a manilla envelope and given to a secretary who secured them.

The randomly selected experimental group was provided five hours of specialized curriculum regarding death and dying. Outline of curriculum content appears in Appendix D.

Upon completion of this curriculum Post-test #1 was administered. A student gave the cards from the manilla envelope to the students whose names had been placed on them before. Again the cards were collected by a student and returned to the secretary to be secured.

After Post-test #1, the students began their clinical experience in four selected extended care facilities. Attempts were made to assign as many students as possible from both the experimental group and the control group to dying patients. At the end of the quarter, Post-test #2 was administered in the same manner as the pre-test and Post-test #1.

The study design is presented graphically in figure 1 below.

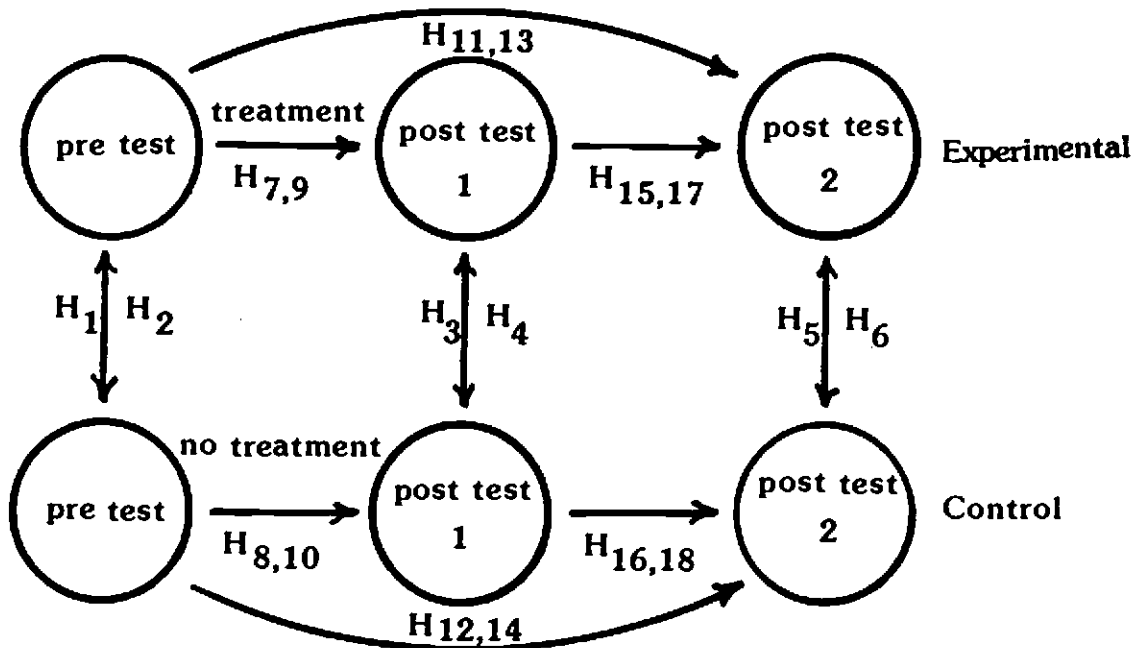


Figure 1

Graphic Study Design

Hypotheses

H₁ There is no difference between the experimental group and the control group's pre-test total mean scores of Hopping's Death Attitude Indicator.

H₂ There is no difference between the experimental group and the control group's pre-test total mean scores of Templer's Death Anxiety Scale.

H₃ There is no difference between the experimental group and the control group's Post-test #1 total mean scores of Hopping's Death Attitude Indicator.

H₄ There is no difference between the experimental group and the

control group's Post-test #1 total mean scores of Templer's Death Anxiety Scale.

H₅ There is no difference between the experimental group and the control group's Post-test #2 total mean scores of Hopping's Death Attitude Indicator.

H₆ There is no difference between the experimental group and the control group's Post-test #2 total mean scores of Templer's Death Anxiety Scale.

H₇₋₁₀ There is no difference in the mean difference between pre-test scores and Post-test #1 scores in the experimental and control groups.

H₁₁₋₁₄ There is no difference in the mean difference between Post-test #1 scores and Post-test #2 scores in the experimental and control groups.

H₁₅₋₁₈ There is no difference in the mean difference between pre-test scores and Post-test #2 scores in the experimental and control groups.

Treatment of Data

Descriptive statistics were used to analyze the sample while inferential statistics were used to interpret the data and answer the research question posed.

The questionnaires were scored by the researcher without knowing the name of the student, or whether the participant was in the experimental group or the control group. The questionnaires were scored

according to the key provided with them and the scores were put on computer cards for statistical analysis. The student's t -test with pooled error was used for group means to test hypothesis H_1 through H_6 . The paired t -test was used to test hypothesis H through H_{18} .

Summary

This chapter discussed the methods and procedures which were developed to answer the research question posed. Subjects involved consisted of a census group of freshman nursing students who were randomly divided into control and experimental groups. A specialized five-hour treatment was provided for the experimental group. Both groups were given the pre- and post-tests. The scores were tabulated and put on computer cards for statistical analysis.

CHAPTER IV

ANALYSIS OF DATA

This study was conducted for the purpose of investigating the effects of an added specialized curriculum on the attitudes of student nurses toward death and dying. The first section of this chapter will deal with demographic data of the participants. The second section will present the statistical findings.

Demographic Data

Thirty-eight students were enrolled for fall quarter in the freshman class of an Associate Degree Nursing Program at Linn-Benton Community College, Albany, Oregon. Thirty-seven students participated in the pretest, and were randomly divided into an experimental group and a control group. Fifteen members of the experimental group came voluntarily to receive the specialized curriculum on death and dying. Two did not participate for personal reasons. Several dropped from school during the first weeks and 2 did not correctly complete the questionnaires. This left 15 in the control group and 15 in the experimental group.

Fourteen percent of each group were male and 86% female with an age range of 19 to 44. Forty percent of the class were single, 33% married and 27% divorced. Thirty-six percent had no children and the remaining students had from one to five children.

All students in the freshman class were Caucasian which is not surprising in this nearly all-white, middle-class milieu. Fifty-seven percent were from towns with a population of 10,000 to 50,000. Twenty-seven percent were from below 10,000 population and 16% from above 50,000. Religious faith was deemed strong by 23%, medium by 53%, and weak by 13%. Ten percent stated that they had no religious faith. Concerning previous experience in nursing and/or related areas, 63% reported yes, 33% stated no, and 3% had no answer. However, nearly all (87%) stated that they had had previous experience with death. (See Figure 2) Eighty percent were willing to have a body organ transplanted to anyone. Three percent were willing to donate only to a relative and 17% said "No." Thirty-seven percent approved of an autopsy on themselves, 13% disapproved, 7% were strongly against it and 40% didn't care.

Statistical Analysis

A pooled t test was used to contrast the differences between the means of the experimental and control groups' pretest scores on Hopping's Death Attitude Indicator and Templer's Death Anxiety Scale. The data were interval and normal distribution was assumed. The null hypotheses were tested at the .05 level of significance.

The differences were contrasted between the pretest and Post-test I mean scores of the experimental and control groups, and the Post-test I and Post-test II mean scores of the experimental and control groups. The level of confidence was set at 95% with fourteen

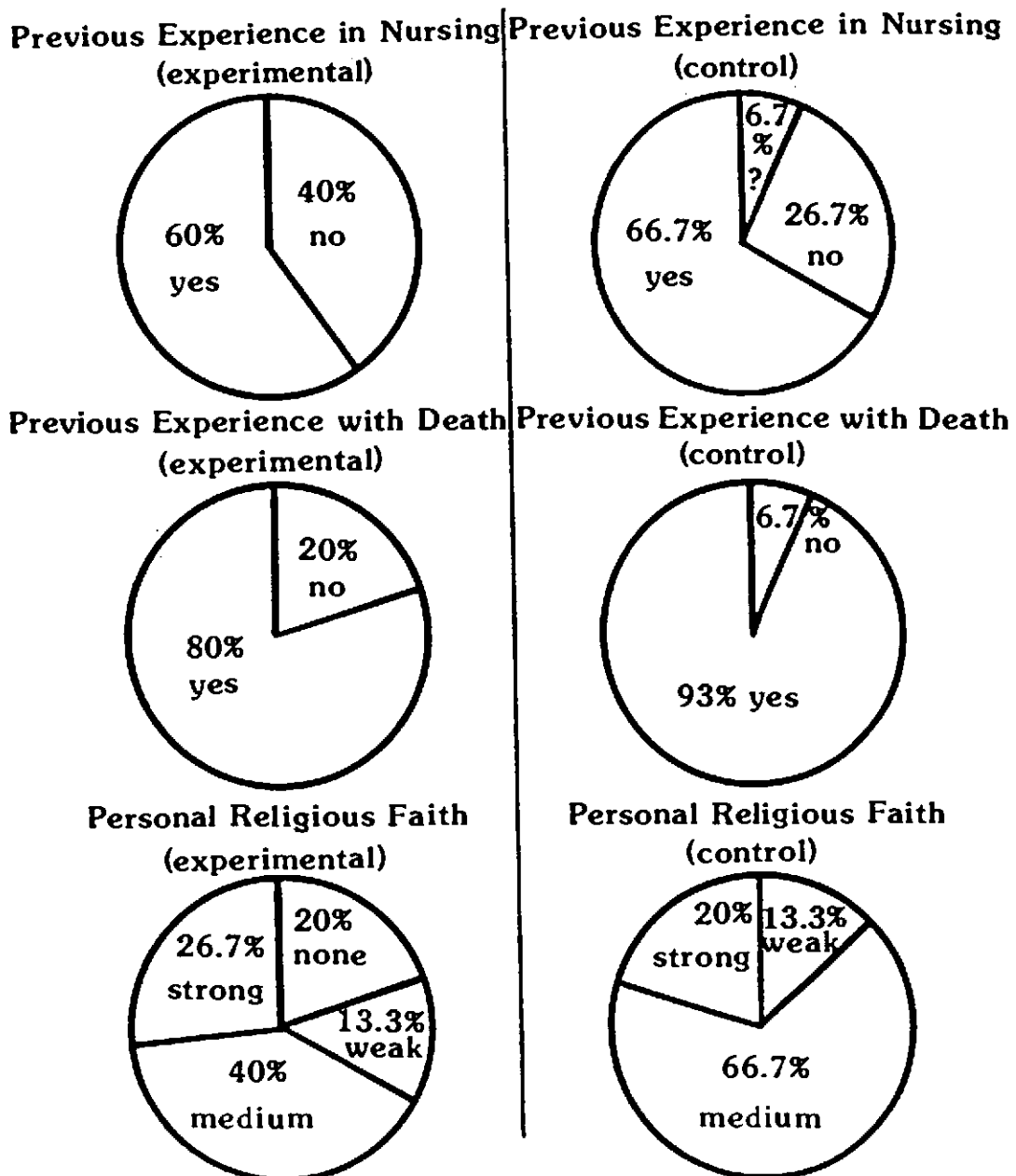


Figure 2. Demographic Data (Sample Group)

degrees of freedom. The Student's t was used to determine the critical value of t .

Findings Related to the Hypotheses

Hypothesis One: There is no difference in the mean Hopping's Death Attitude Indicator of the experimental and control groups at the time of the pretest. As presented in Table I, the t value for the difference between the mean scores was .02 and the p value was .988. The null hypothesis was retained.

Hypothesis Two: There is no difference in the mean Templer's Death Anxiety Scale of the experimental and control groups at the time of the pretest. The results presented in Table I show the t value was $-.86$ and the p value was .395. The null hypothesis was retained.

Hypothesis Three: There is no difference in the mean Hopping's Death Attitude Indicator of the experimental and control groups at the time of the first post-test. As presented in Table I, the t value was $-.17$ and the p value was .868. The null hypothesis was retained.

Hypothesis Four: There is no difference in the mean Templer's Death Anxiety Scale of the experimental and control groups at the time of the first post-test. The results presented in Table I show the t value to be $-.34$ and the p value was .736. The null hypothesis was retained.

Hypothesis Five: There is no difference in the mean Hopping's Death Attitude Indicator of the experimental and control groups at

Table I.

Control and Experimental Groups: Mean Scores,
Standard Deviation, t value and 2-tail Probability

<u>Source of Mean</u>	<u>Mean</u>	<u>Standard Deviation</u>	<u>t Value</u>	<u>-2 Tail Probability</u>	<u>Decision</u>
<u>Total Score</u>					
<u>Experimental</u>					
<u>Hopping</u>	686.6667	53.173			
<u>Hopping I</u>	684.0000	54.648	.21	.835	Not Significant (NS)
<u>Control</u>					
<u>Hopping</u>	686.3333	65.314			
<u>Hopping I</u>	688.0000	74.157	-.16	.875	NS
<u>Experimental</u>					
<u>Hopping</u>	686.6667	53.173			
<u>Hopping II</u>	691.6667	38.390	-.41	.690	NS
<u>Control</u>					
<u>Hopping</u>	686.3333	65.314			
<u>Hopping II</u>	671.0000	62.883	1.05	.312	NS
<u>Experimental</u>					
<u>Hopping I</u>	684.0000	54.648			
<u>Hopping II</u>	691.6667	38.390	-.77	.455	NS
<u>Control</u>					
<u>Hopping I</u>	688.0000	74.157			
<u>Hopping II</u>	671.0000	62.883	1.06	.308	NS
<u>Experimental</u>					
<u>Templer</u>	6.0000	2.619			
<u>Templer I</u>	6.3000	2.590	.32	.595	NS
<u>Control</u>					
<u>Templer</u>	6.8667	2.869			
<u>Templer I</u>	6.6667	3.266	.32	.756	NS
<u>Experimental</u>					
<u>Templer</u>	6.0000	2.619			
<u>Templer II</u>	6.5333	2.356	-.85	.407	NS
<u>Control</u>					
<u>Templer</u>	6.8667	2.869			
<u>Templer II</u>	7.5667	3.520	-1.36	.196	NS
<u>Experimental</u>					
<u>Templer I</u>	6.3000	2.590			
<u>Templer II</u>	6.5333	2.356	-.50	.584	NS
<u>Control</u>					
<u>Templer I</u>	6.6667	3.266			
<u>Templer II</u>	7.5667	3.520	-2.20	.045	Significant

the time of the second post-test. As presented in Table I, the t value was 1.09 and the p value was .287. The null hypothesis was retained.

Hypothesis Six: There is no difference in the mean Templer's Death Anxiety Scale of the experimental and control groups at the time of the second post-test. The results presented in Table I show that the t value was -.94 and the p value was .353. The null hypothesis was retained.

Hypothesis Seven: There is no difference in the mean difference between pretest scores and Post-test #1 scores on Hopping's Death Attitude Indicator in the experimental group. As presented in Table II, the t value for the test means was .21 and the p value was .835. The null hypothesis was retained.

Hypothesis Eight: There is no difference in the mean difference between pretest scores and Post-test #1 scores on Hopping's Death Attitude Indicator in the control group. The results presented in Table II show that the t value was -.16 and the p value was .875. The null hypothesis was retained.

Hypothesis Nine: There is no difference in the mean difference between pretest scores and Post-test #1 scores on Templer's Death Anxiety Scale in the experimental group. As presented in Table I, the t value was -.54 and the p value was .595. The null hypothesis was retained.

Hypothesis Ten: There is no difference in the mean difference between pretest scores and Post-test #1 scores on Templer's Death

Table II.

Pre- and Post-tests: Mean Scores, Standard Deviation,
t Value and 2-tail Probability

<u>Source of Mean</u>	<u>Mean</u>	<u>Standard Deviation</u>	<u>t Value</u>	<u>2 Tail Probability</u>	<u>Decision</u>
<u>Total Score</u>					
Pre-Test					
<u>Hopping</u>					
<u>Experimental</u>	686.6667	53.173			
<u>Control</u>	686.3333	65.314	.02	.988	Not Signi- nificant (NS)
<u>Templer</u>					
<u>Experimental</u>	6.0000	2.619			
<u>Control</u>	6.8667	2.869	-.86	.395	NS
Post-Test I					
<u>Hopping I</u>					
<u>Experimental</u>	684.0000	54.648			
<u>Control</u>	688.0000	74.157	-.17	.868	NS
<u>Templer I</u>					
<u>Experimental</u>	6.3000	2.590			
<u>Control</u>	6.6667	3.266	-.34	.736	NS
Post-Test II					
<u>Hopping II</u>					
<u>Experimental</u>	691.6667	38.390			
<u>Control</u>	671.0000	62.883	1.09	.287	NS
<u>Templer II</u>					
<u>Experimental</u>	6.5333	.608			
<u>Control</u>	7.5667	.909	-.94	.353	NS

Anxiety Scale in the control group. The results presented in Table II show that the t value was .32 and the p value was .756. The null hypothesis was retained.

Hypothesis Eleven: There is no difference in the mean difference between pretest scores and Post-test #2 scores on Hopping's Death Attitude Indicator in the experimental group. As presented in Table II, the t value was -.41 and the p value was .690. The null hypothesis was retained.

Hypothesis Twelve: There is no difference in the mean difference between pretest scores and Post-test #2 scores on Hopping's Death Attitude Indicator in the control group. The results presented in Table II show that the t value was 1.05 and the p value was .312. The null hypothesis was retained.

Hypothesis Thirteen: There is no difference in the mean difference between pretest scores and Post-test #2 scores on Templer's Death Anxiety Scale in the experimental group. The results presented in Table II show that the t value was -.85 and the p value .407. The null hypothesis was retained.

Hypothesis Fourteen: There is no difference in the mean difference between pretest scores and Post-test #2 scores on Templer's Death Anxiety Scale in the control group. As presented in Table II, the t value was -1.36 and the p value was 1.96. The null hypothesis was retained.

Hypothesis Fifteen: There is no difference in the mean difference between Post-test #1 scores and Post-test #2 scores on Hopping's Death Attitude Indicator in the experimental group. The results

presented in Table II show that the t value was determined to be $-.77$ and the p value was $.455$. The null hypothesis was retained.

Hypothesis Sixteen: There is no difference in the mean difference between Post-test #1 scores and Post-test #2 scores on Hopping's Death Attitude Indicator in the control group. As presented in Table II, the t value was 1.06 and the p value $.308$. The null hypothesis was retained.

Hypothesis Seventeen: There is no difference in the mean difference between Post-test #1 scores and Post-test #2 scores on Templer's Death Anxiety Scale in the experimental group. The results presented in Table II show that the t value was $-.56$ and the p value $.594$. The null hypothesis was retained.

Hypothesis Eighteen: There is no difference in the mean difference between Post-test #1 scores and Post-test #2 scores on Templer's Death Anxiety Scale in the control group. As presented in Table II, the t value was 2.20 and the p value was $.045$. The null hypothesis was rejected.

There was a significant difference in the mean difference between the Post-test #1 scores and the Post-test #2 scores on Templer's Death Anxiety Scale in the control group as shown in Hypothesis Eighteen. During the time interval between the first and second post-tests, all freshman students had clinical experience in various extended care facilities. There was no significant difference in the mean difference between the Post-test #1 scores and the Post-test #2 scores on Hopping's Death Attitude Indicator.

Summary

The demographic data were analyzed in reference to the 38 students initially taking part in this study. The statistical analysis of the data from Hopping's Death Attitude Indicator and Templer's Death Anxiety Scale was performed for the 30 participants who completed the study.

The Student's t test was utilized in testing the eighteen hypotheses. Hypotheses One through Seventeen were retained and Hypothesis Eighteen was rejected.

CHAPTER V

SUMMARY, IMPLICATIONS, AND RECOMMENDATIONS

This study was implemented to ascertain if student nurses' attitudes toward death and dying could be influenced in a positive direction by adding a specialized curriculum. A freshmen group of 30 associate degree nursing students was randomly divided into an experimental and a control group. A pretest utilizing Hopping's Death Attitude Indicator and Templer's Death Anxiety Scale was administered to the entire group. A brief questionnaire developed by the researcher was used to elicit descriptive data.

The treatment, consisting of five hours of specialized curriculum, was administered to the experimental group over the first three weeks of school and a post-test given to the entire group using the same instruments as used for the pretest. After the students completed their clinical experience in extended care facilities the tests were readministered as Post-test II. The researcher scored all tests before knowing which were experimentals and which were controls.

The Student's t -test with pooled error was used for comparison of the experimental and control groups on the pretest and two post-tests. The paired t -test was used to compare the mean difference of the control and experimental groups separately.

All study hypotheses were retained except one. The rejected hypothesis showed that for the control group there was indeed a

difference in the mean difference between Post-test I and Post-test II scores from Templer's Death Anxiety Scale.

Implications

There was no significant difference in any of the test scores from Hopping's Death Attitude Indicator which may indicate that this instrument is not as sensitive as Templer's Death Anxiety Scale. Both instruments, although dealing with death, deal with two different constructs of the death concept.

In this study, the control group's attitudes toward death and dying became more negative during the clinical experience in extended care facilities. This is not surprising since experience with death tends to increase one's death anxiety. The experimental group did not show the same evidence of becoming more negative.

One may conclude from this study that a specialized curriculum for student nurses may be helpful in preventing attitudes from becoming more negative. The control group showed a more negative response after clinical experience. However, the experimental group may have gained confidence and a degree of comfort from the curriculum which included what the role of the nurse encompassed when dealing with death and dying, and how to deal with the needs of the patient (including special needs of children and family) as well as their own needs.

Recommendations

Although modern education is not capable of preparing student nurses for many of the experiences which they will meet in the course of their careers, it is felt that education about death and dying is essential. It is also felt that such education can contribute to positive attitudes toward death and dying by providing nurses with actual ways to cope with fear of death that will be beneficial for the caregiver and for the patient. This responsibility should be assumed by those individuals who conduct educational research or who work specifically with nursing education.

The following research recommendations are made:

1. This study should be replicated in several schools of nursing.
2. A similar study should be designed utilizing a larger sample.
3. Content and teaching strategies aimed at increasing positive attitudes toward death and dying should be incorporated in the early stages of nursing education.
4. Continuing content on dealing with death and dying should be incorporated into each specific area of the curricula (Oncology, Pediatrics, Neurosurgery, etc.).
5. A study should be designed to explore relationships between attitudes toward death and dying and experience with death.
6. A study should be designed to explore the relationship between attitudes toward death and dying and differing age

groups (infants, children, adolescents, adults, the aged).

7. A study should be designed to explore the relationship between attitudes toward death and dying and differing situations involving death (chronic disease, sudden death, accidental death, etc.).
8. A study regarding attitudes should be designed which incorporates a didactic approach and field components such as the effect of close contact with the dying, participation in support groups, etc.

The following recommendations regarding the implementation of curricula concerning death and dying in nursing education are made:

1. A specialized curriculum should be incorporated in nursing education.
2. The approach for development of this curriculum should be many faceted.
3. Every nursing faculty should have at least one qualified instructor who can comfortably address the issue of death and dying and thus provide appropriate curriculum.
4. Issues of death and dying should be incorporated early in the program and should continue in each level and in different units of the nursing curriculum.

Curriculum related to issues of death and dying may be of great benefit to nursing students, patients and their families. It is imperative that this area be addressed by researchers and educators who are concerned with nursing education.

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APPENDICES

APPENDIX A
INSTRUMENTS

DEATH ATTITUDE INDICATOR (DAI)

Part I

INSTRUCTIONS: Please place an X on the line following each question at the slash mark which best indicates where along the continuum your opinion, feeling, or belief lies. There are no right or wrong answers--your current opinions, feelings, and beliefs are being sought. Please make sure you answer every question, unless instructed not to do so.

1. What does death represent to you.

/-----/-----/-----/-----/
 Immobility and loss of control A change in the state of existence

2. How do you see death?

/-----/-----/-----/-----/
 Never appropriate Natural end of life

3. How do you believe your own death will occur?

/-----/-----/-----/-----/
 Accident Old age

4. Do you have a personal philosophy which includes clear conceptions about both life and death?

/-----/-----/-----/-----/
 No Yes

5. Do you believe there is a higher power of some kind (i.e., God) functioning in the universe?

/-----/-----/-----/-----/
 No Yes

6. Should children be allowed to visit and/or be with a dying person?

/-----/-----/-----/-----/
 No Yes

7. Should children attend funerals?

/ / / / /
No Yes

8. When speaking about a person who has died, what term do you usually use?

/ / / / /
Died or Other, i.e.,
dead passed away,
deceased, ex-
pired, etc.

9. If you had to choose a friend from the following, from which group would you choose?

/ / / / /
Cancer victim A Jew
Terminal child A Black
Terminal elder A Mexican-
American

10. Do you believe emotions should be

/ / / / /
Expressed? Controlled?

11. How often do you talk about death with others?

/ / / / /
Frequently Never

12. Would you introduce the topic of death into a social conversation?

/ / / / /
No Yes

13. Do you believe a dying person wants to talk about his approaching death?

/ / / / /
No Yes

14. Do you believe it is ever justified to label a person as dying, or terminal?

/ / / / /
No Yes

15. Would you volunteer to be with a dying patient?

/ / / / /
No Yes

Part II

INSTRUCTIONS: Please circle the answer that applies to you.

1. Have you ever been with a dying person at or near the time of his death?
 - a. Yes
 - b. No
2. If you answer yes to the above, into which category(s) did this individual(s) fit?
 - a. Immediate family
 - b. Other relative
 - c. Close friend
 - d. Acquaintance
 - e. Stranger
 - f. Patient
3. Have you ever attended a funeral?
 - a. Yes
 - b. No
4. If you answered yes to the above, approximately how many? _____
5. To which one of the following categories do you belong?
 - a. Member of a nuclear family. (Husband, wife, possibly children.)
 - b. Member of an extended family. (More than 2 generations living together.)
 - c. Self-supporting and living alone.
6. Which one of the following doctrines prevail in the culture to which you belong?
 - a. Sacred
 - b. Secular
 - c. Don't know
7. To which age group do you belong?
 - a. 20-25 years
 - b. 26-30 years
 - c. 31-35 years
 - d. 36-40 years
 - e. 41-45 years
 - f. 46 and over
8. Does any particular experience come to your mind that has had a definite impact on how you feel about death in general?
 - a. Yes
 - b. No
9. If you answered yes to the above, please explain.

DEATH ATTITUDE INDICATOR (DAI)--SCORING KEY

Part I

For items number 1, 2, 3, 4, 5, 6, 7, 12, 13, 14, 15, 17, 22

the extreme left slash mark = 0
the next slash mark = 1
the middle slash mark = 2
the next slash mark = 3
the extreme right slash mark = 4

To accommodate those respondents who respond between slash marks, 0.5 is added to the next lower slash mark score.

For items numbered 8, 9, 10, 11, 16, 18, 19, 20, 21, 23, 24

the extreme left slash mark = 4
the next slash mark = 3
the middle slash mark = 2
the next slash mark = 1
the extreme right slash mark = 0

Part II

These items are not scored. This information is to be compared with the total score of Part I to ascertain if any correlations exist.

TEMPLER'S DEATH ANXIETY SCALE

Please mark T after statements you feel are true and F after statements that you feel are false.

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

APPENDIX B

SPECIALIZED CURRICULUM CONTENT

OUTLINE OF COURSE CONTENT

OBJECTIVES

General Objective: To determine the effect of added specialized content on death and dying to the ongoing curriculum on the attitudes of student nurses on death and dying.

Class I

Needs of Dying Patient

Objective: To make student nurses aware of the specific needs of the terminally ill and/or dying patient.

The student nurse will be able to-

- a) demonstrate awareness of dying person's special needs by active sharing in class discussion.
- b) identify nursing interventions for spiritual problems.
- c) identify four fears a dying person might experience.
- d) correctly identify a variety of community agencies which can assist the dying person.
- e) describe the concept of hospice care.
- f) identify realistic hopes nurses can offer dying patients.

Class II

Needs of Student Nurses

Objective: To delineate emotional and psychosocial needs of the student nurse relating to care of the terminally ill and/or dying patient.

The student nurse will be able to-

- a) discuss own personal attitudes toward death and dying.
- b) develop personal values and attitudes toward death and dying.
- c) foster acceptance of death as part of life.

Class III

Needs of Family Members

Objective: To make student nurses aware of the specific needs of the relatives and significant others in relation to dying patients.

The student nurse will be able to-

- a) list the stages of guilt.
- b) list three areas of supportive care.
- c) list three phases of care in which the family can participate.

Class IV

Role of Student Nurses

Objective: To identify and clarify the role of the student nurse in caring for terminally ill and/or dying patients.

The student nurse will be able to-

- a) make three comforting "safe" statements to the patient and/or significant others.
- b) list four important areas of physical care.
- c) list three appropriate resources for patient and/or family.

Class V

Special Needs of Dying Children

Objective: To identify for student nurses the special needs of the terminally ill child.

The student nurse will be able to-

- a) list three ways to comply with educational needs of child.
- b) list three emotional side effects
- c) list three physical side effects.
- d) identify two ways to assist family communicate with child, each other, caregivers, and siblings.

Course Content on Death and Dying

Class I (50 minutes)

Needs of Dying Patient

	<u>Time</u>	<u>Strategy</u>
I. Maslow's hierarchy of needs applied to dying	15 minutes	lecture
A. Physiological needs		
B. Safety and security needs		
C. Love and belonging needs		
D. Esteem and self-esteem needs		
E. Self-actualization needs		
(Kalish, 1985)		
II. Freedom from pain	10 minutes	lecture
A. Physical		
1. Medication		
2. Potentiates		
B. Emotional		
1. Loneliness		
2. Anticipation of pain		
3. Unfinished business		
a. need to reminisce		
4. Spiritual needs		
(Kalish, 1985)		
III. Dealing with fears	15 minutes	lecture
A. Fear of abandonment		class participation
B. Fear of unknown		
C. Fear of loss		
1. loss of self esteem; dependence		
2. loss of social relationships; love		
3. loss of control		
(Kalish, 1985)		
IV. Resources/Referrals	10 minutes	lecture
A. Hospice		question/answer period
1. the concept		
2. where available		
B. Support groups		
1. Community Health programs		
2. Church-based programs		
3. Institutionally based programs		
(Kalish, 1985)		

Class II (50 minutes)

Needs of Student Nurses

- | | | | |
|------|--|------------|------------------------|
| I. | Current Concepts | 10 minutes | lecture |
| | A. Death and Dying in Today's Culture | | |
| | B. Changes in Attitudes | | |
| II. | Personal feelings and conflicts about death and dying. | | questionnaire |
| | A. Normal anxieties and fears | 15 minutes | small group discussion |
| | B. Understanding and dealing with feelings
(Hopping, 1977) | | |
| III. | Specific needs relative to death and dying while
on clinical rotation | 10 minutes | class participation |
| | A. Need for faculty support | | lecture |
| | B. Need for faculty support | | |
| | C. Need for graduate nurse support | | |
| | D. Need for family/significant other support | | |
| | E. Need for communication among physician/nurse/patient/family
(Backer, 1982) | | |
| IV. | Fulfilling personal/professional needs | 15 minutes | lecture |
| | A. Avocation | | question/answer period |
| | B. Professional growth | | |
| | C. Emotional stress | | |
| | 1. family concerns | | |
| | 2. health problems | | |
| | 3. financial pressures | | |
| | (Kalish, 1984) | | |

Class III (50 minutes)

Needs of Family Members

I. Supportive Care	10 minutes	lecture
A. Listening		
B. Honesty		
C. Privacy		
(Kushner, 1981)		
II. Planning and Care of Patient	5 minutes	lecture
A. Including family in planning		
B. Allow participation in care		
C. Anticipate physical changes		
D. Family councils with nursing/medical staff/community services		
E. Respite care		
(Kubler-Ross, 1974)		
III. Dealing with Stages of Grieving	10 minutes	lecture
A. Dealing with guilt		
1. for not having done enough		
2. for past personal conflicts		
3. for sense of relief when death finally comes		
B. Permit denial and anger		
C. Allow glimpse of hope		
D. Allow as much time as needed		
E. Give freedom of expression		
F. Nurse's response to grief		
(Grollman, 1981; Kubler-Ross, 1977)		
IV. Practical Preparations	5 minutes	lecture
A. Discussion of funeral arrangements		
B. Getting affairs in order		
V. Review of Resources/Referrals	20 minutes	film (<u>Day by Day</u>)
(see Class II)		question/answer period

Class IV (50 minutes)

Role of Student Nurses

I. Support of the Dying A. Be there! B. Make no demands C. Listen! D. Permit patient to express feelings <u>or</u> maintain privacy (Kushner, 1981)	15 minutes	lecture
II. Support Family Members (Class III) (Kushner, 1981; Kubler-Ross, 1974, 1977)	5 minutes	lecture
III. Physical Care A. Encourage self-help B. Control pain C. Nutrition D. Comfortable; well groomed E. Encourage communication (don't force it!) (Backer, 1982)	10 minutes	lecture
IV. Handling Vital Information A. Communicating with physician B. Bad news: when does nurse step in?	5 minutes	lecture
V. Provide Patient with Resources for Help (listed in Class II)	5 minutes	lecture
VI. "Gardener versus Mechanic" concept ("Mechanic" helps the person die, "Gardener" helps person live in whatever time is left) (Kalish, 1984)	10 minutes	lecture group discussion question/answer period

Class V (50 minutes)

Special Needs of Dying Children

- | | | |
|---|------------|------------------------|
| I. Impact on the Child | 15 minutes | lecture |
| A. Emotional side effects | | |
| 1. play therapy | | |
| B. Physical side effects | | |
| C. Educational concerns | | |
| 1. activities for child at home and in hospital | | |
| 2. hospital school-teacher | | |
| (Wallace, et.al. 1984) | | |
| II. Impact on the Family | 20 minutes | lecture |
| A. Special needs of siblings | | question/answer period |
| B. Parent's communication and relationship | | |
| C. Support sources | | |
| (Wallace, et.al. 1984) | | |
| III. Impact on the Caregivers | 15 minutes | lecture |
| A. Handling grief | | |
| B. Psychosocial concerns | | |
| (Wallace, et.al. 1984) | | |

APPENDIX C

VALIDATION OF COURSE CONTENT

PANEL OF CONTENT EXPERTS

PARTICIPATING COMMUNITY COLLEGES

SUGGESTIONS OF CONTENT EXPERTS

Course Content on Death and Dying

Class I (50 minutes)

Needs of Dying Patient

- I. Maslow's hierarchy of needs applied to dying
 - A. Physiological needs
 - B. Safety and security needs
 - C. Love and belonging needs
 - D. Esteem and self-esteem needs
 - E. Self-actualization needs
- II. Freedom from pain
 - A. Physical
 1. Medication
 2. Potentiates
 - B. Emotional
 1. Loneliness
 2. Anticipation of pain
 3. Unfinished business
 - a. need to reminisce
 4. Spiritual needs
- III. Dealing with fears
 - A. Fear of abandonment
 - B. Fear of unknown
 - C. Fear of loss
 1. loss of self esteem; dependence
 2. loss of social relationships; love
 3. loss of control
- IV. Resources/Referrals
 - A. Hospice
 1. the concept
 2. where available
 - B. Support groups
 1. Community Health programs
 2. Church-based programs
 3. Institutionally based programs

Panel	Comm.College	Literature
A-G	1-3, 7-10, 12-14.	Kalish
A-G	1-3, 7-10, 12-14.	Cowles & Swain Wallace et al.
A-G	1-3, 7-10, 12-14.	Tamlyn & Caty Cowles & Swain
A-G	1-3, 7-10, 12-14.	Wallace et al. Tamlyn & Caty

Class II (50 minutes)

Needs of Student Nurses

- I. Current Concepts
 - A. Death and Dying in Today's Culture
 - B. Changes in Attitudes
- II. Personal feelings and conflicts about death and dying.
 - A. Normal anxieties and fears
 - B. Understanding and dealing with feelings
- III. Specific needs relative to death and dying while on clinical rotation
 - A. Need for faculty support
 - B. Need for faculty support
 - C. Need for graduate nurse support
 - D. Need for family/significant other support
 - E. Need for communication among physician/nurse/patient/family
- IV. Fulfilling personal/professional needs
 - A. Avocation
 - B. Professional growth
 - C. Emotional stress
 - 1. family concerns
 - 2. health problems
 - 3. financial pressures

Panel	Comm. College	Literature
A-G	1-3, 7-10, 12-14.	Wallace et al. Mullins & Merrian
A-G	1-3, 7-10, 12-14.	Hopping Chodil & Dulaney Mullins & Merrian
A-G	1-3, 7-10, 12-14.	Backer Chodil & Dulaney Mullins & Merriam
A-G	1-3, 7-10, 12-14.	Kalish Mullins & Merriam Chodil & Dulaney

Class III (50 minutes)

Needs of Family Members

- I. Supportive Care
 - A. Listening
 - B. Honesty
 - C. Privacy

- II. Planning and Care of Patient
 - A. Including family in planning
 - B. Allow participation in care
 - C. Anticipate physical changes
 - D. Family councils with nursing/medical staff/community services
 - E. Respite care

- III. Dealing with Stages of Grieving
 - A. Dealing with guilt
 1. for not having done enough
 2. for past personal conflicts
 3. for sense of relief when death finally comes
 - B. Permit denial and anger
 - C. Allow glimpse of hope
 - D. Allow as much time as needed
 - E. Give freedom of expression
 - F. Nurse's response to grief

- IV. Practical Preparations
 - A. Discussion of funeral arrangements
 - B. Getting affairs in order

- V. Review of Resources/Referrals
(see Class II)

Panel	Comm. College	Literature
A-G	1-3, 7-10, 12-14.	Kushner Cowles & Swain
A-G	1-3, 7-10, 12-14.	Kübler-Ross Wallace et al.
A-G	1-3, 7-10, 12-14.	Grollman Cowles & Swain Chodil & Dulaney Wallace et al.
A-G	1-3, 7-10, 12-14.	Kalish Backer
A-G	1-3, 7-10, 12-14.	Tamlyn & Caty Wallace et al.

Class IV (50 minutes)

Role of Student Nurses

- I. Support of the Dying
 - A. Be there!
 - B. Make no demands
 - C. Listen!
 - D. Permit patient to express feelings or maintain privacy
- II. Support Family Members
(Class III)
- III. Physical Care
 - A. Encourage self-help
 - B. Control pain
 - C. Nutrition
 - D. Comfortable; well groomed
 - E. Encourage communication (don't force it!)
- IV. Handling Vital Information
 - A. Communicating with physician
 - B. Bad news: when does nurse step in?
- V. Provide Patient with Resources for Help
(listed in Class II)
- VI. "Gardener versus Mechanic" concept
("Mechanic" helps the person die,
"Gardener" helps person live in whatever time is left)

Panel	Comm. College	Literature
A-G	1-3, 7-10, 12-14.	Kushner Cowles & Swain
A-G	1-3, 7-10, 12-14.	Kushner Wallace
A-G	1-3, 7-10, 12-14.	Backer Chodil & Dulaney
A-G	1-3, 7-10, 12-14.	Mullins & Merrih Kalish
A-G	1-3, 7-10, 12-14.	Kalish Wallace
A-G	1-3, 7-10, 12-14.	Kalish

Class V (50 minutes)

Special Needs of Dying Children

- I. Impact on the Child
 - A. Emotional side effects
 - 1. play therapy
 - B. Physical side effects
 - C. Educational concerns
 - 1. activities for child at home and in hospital
 - 2. hospital school-teacher

- II. Impact on the Family
 - A. Special needs of siblings
 - B. Parent's communication and relationship
 - C. Support sources

- III. Impact on the Caregivers
 - A. Handling grief
 - B. Psychosocial concerns

Panel	Comm. College	Literature
A-G	1-3, 7-10, 12-14.	Mullins & Merriam Wallace
A-G	1-3, 7-10, 12-14.	Chodil & Dulaney Wallace
A-G	1-3, 7-10, 12-14.	Chodil & Dulaney Wallace

Key: Letters A through G: Panel of Content Experts (page 68)
 Numbers 1 through 14: Community Colleges in Oregon (page 69)

Validation of Course Content

Course content was validated in three ways:

- I. Panel of content experts from various disciplines within the nursing profession which are associated with death and dying. (List of panel in Appendix C)
- II. Similar course content on death and dying reported in the literature (Mullins & Merriam, 1983; Wallace, Bakke, Hubbard & Pendergrass, 1984; Tamlyn & Caty, 1984; Cowles & Swain, 1978; Chodil & Dulaney, 1984).
- III. Course objectives on death and dying from all responding community colleges with Associate Degree or LPN Schools of Nursing in the State of Oregon. (Listed in Appendix C)

Panel of Content Experts

- A. Polly Adkins RN; Director of Nursing, Villa Cascade Extended Care Facility. Lebanon, Oregon.
- B. Phyllis Commeree RN, MS; Director of Nursing Service, Lebanon Community Hospital, Lebanon Oregon.
- C. Helen McGovern RN; Director of Nursing, Mennonite Home, Albany, Oregon.
- D. Jeannie Osterman RN; Certified Emergency Nurse, EMT Clinical Coordinator, Linn-Benton Community College, Albany, Oregon.
- E. Jacqueline L. Paulson RN, MA; Oncology Nurse Clinician; Nursing Instructor, Linn-Benton Community College, Albany, Oregon.
- F. Evon Hull Wilson RN, MS; Co-ordinator of Nursing Programs, Linn-Benton Community College, Albany, Oregon.
- G. Sandra Wright RN; Head Nurse, Critical Care Unit, Lebanon Community Hospital, Lebanon, Oregon.

Participating Community Colleges

Oregon Council Associate Degree Nursing Programs

1. *Blue Mountain Community College, Pendleton, Oregon
2. *Central Oregon Community College, Bend, Oregon
3. *Chemeketa Community College, Salem, Oregon
4. Clatsop Community College, Astoria, Oregon
5. Clackamas Community College, Oregon City, Oregon
6. Lane Community College, Eugene, Oregon
7. *Linn-Benton Community College, Albany, Oregon
8. *Mt. Hood Community College, Gresham, Oregon
9. *Portland Community College, Portland, Oregon
10. **Rogue Community College, Grants Pass, Oregon
11. Southern Oregon State College, Ashland, Oregon
12. *Southwestern Oregon Community College, Coos Bay, Oregon
13. *Treasure Valley Community College, Ontario, Oregon
14. *Umpqua Community College, Roseburg, Oregon

*Responding schools

**Offers LPN program only

Suggestions by
Panel of Content Experts

- Polly Adkins: Exploring living wills
*Death with dignity (no code situations)
- Phyllis Commere: *Family and significant other support for the student nurse
*Financial fears
*Spiritual needs (Yin and Yang)
*Respite care for family
- Helen McGovern: *Spiritual needs
*Permit anger
*Support of families faced with decision to remove life support.
- Jeannie Osterman: *Understanding feelings (anxiety is normal)
- Jackie Paulson: *The need to make meaning of his/her life (reminisce)
*Special attention to the grieving child
*Anticipating physical changes prior to death
- Evon Wilson: *Give class on Needs of Dying Patient before Needs of Student Nurse.
(Easier to identify patient's needs before thinking of their own)
*Fear of abandoning own responsibilities
- Sandy Wright: *Knowledge of grief process and stages of grief
*Deal with feelings about own death
*Lessen pain but still allow patient to be alert enough to finish business
*Spiritual needs (contact resources, clergyman etc.)
*Determine if they can cope with information (what/what not to share)
*Allow child time to verbalize
play therapy, resource people, support group
*Include siblings of dying child

*Included in final teaching plan

APPENDIX D

LETTER OF REQUEST TO CONDUCT STUDY

LETTERS OF PERMISSION

STUDENT CONSENT FORM

LETTER OF REQUEST TO CONDUCT STUDY

September 15, 1985

Evon Wilson, RN, MS
Coordinator of Nursing Programs
Linn-Benton Community College
Albany, Oregon 97374

Dear Evon:

As a doctoral candidate at Oregon State University in the field of Education, I hereby seek permission to conduct a research study using the freshmen nursing students as subjects. There will be no risks involved to the student or to the institution, and all information will be kept strictly confidential.

The purpose of this study is to determine if the addition of a specialized content concerning death and dying will make a difference in the attitudes of student nurses. I request permission to use approximately one-half of the students as the experimental group (Group A) and approximately one-half of the students as the control group (Group B). For Group A, this will involve an estimated six and one-half additional hours of time. One and one-half hours for instructions, questions, and filling out questionnaires, and five hours for lecture.

I understand that the student is free to refuse to participate or to withdraw from participation in this study at any time without affecting his/her relationship with the faculty or the School of Nursing.

I will be happy to share the results of this study with you.

Sincerely,

Taffy Johnson

LETTER OF REQUEST TO CONDUCT STUDY

September 24, 1985

Jon Carnahan
Vice-president for Instruction
Linn-Benton Community College
Albany, Oregon 97321

Dear Mr. Carnahan:

As a doctoral candidate at Oregon State University in the field of education, I hereby seek permission to conduct a research study using freshmen nursing students as subjects. There will be no risks involved to the student or to the institution, and all information will be kept strictly confidential.

The purpose of this study is to determine if the addition of a specialized content concerning death and dying will make a difference in the attitudes of student nurses. I request permission to use approximately one-half of the students as the experimental group and approximately one-half of the students as the control group. This will involve a total of six and one-half hours of additional time for the experimental group; five hours of lecture, questions, and discussion, and one and one-half hours for filling out questionnaires.

I understand that the student is free to refuse to participate or to withdraw from participation in the study at any time without affecting his/her relationship with the faculty or school of nursing.

I will be happy to share the results of this study with you.

Sincerely,

Taffy Johnson



LINN-BENTON
COMMUNITY
COLLEGE

77

September 16, 1985

Taffy Johnson
38383 Hungry Hill Drive
Scio, OR 97374

Dear Taffy:

Taffy Johnson has my permission to conduct her research study involving Freshmen Associate Degree Nursing Students. This project will take place during Fall Quarter 1985-86.

Good luck on your upcoming project.

Sincerely,

(
Evon Wilson, Coordinator
Nursing Programs

EW/ph



THE UNIVERSITY OF KANSAS

School of Nursing
College of Health Sciences
39th and Rainbow Blvd., Kansas City, Kansas 66103
(913) 588-1601

September 12, 1985

Taffy Johnson, M.S., R.N.
38383 Hungry Hill Drive
Scio, Oregon 97374

Dear Taffy,

I am enclosing a copy of my Death Attitude Indicator, its scoring key, and a critique of the tool for your use in your doctoral study. My permission for your use of this tool is also given.

Good luck in your scholarly endeavors.

Sincerely,

Betty Hopping, Ed.D., R.N.
Associate Professor and Coordinator
BSN Completion Program for RNs



California School of Professional Psychology - Fresno
 1350 M Street • Fresno, California 93721 • 209/486-8420
 Founded by The California State Psychological Association

Dear _____

Thank you for your letter of 11-4-85.
 You most certainly have my permission to use my Death Anxiety Scale (DAS). Since it is not on the commercial market, there is no payment for its use. Enclosed find a DAS form that I have used since 1970, and a couple of articles pertaining to DAS construction, validation, items, scoring, administration, and norm like information. One point is scored for each item answered in the keyed high death anxiety direction, so that a DAS score could be as low as 0 and as high as 15. A Likert format for the DAS is described by McMordie in Psychological Reports, 1979, 44, 975-980.

Feel free to contact me for additional information or advice, including help in preparation of a manuscript for a journal article if your findings are sufficiently interesting.

Sincerely, _____

Donald I. Templer, Ph.D.

DIT/rs

STUDENT CONSENT

I, _____ agree to serve as a subject in the investigation into the effectiveness of the additional specialized content related to death and dying added to the curriculum of beginning freshmen nursing students.

This research will be done by Taffy Johnson, RN, in partial fulfillment of the requirements for a doctorate in education from Oregon State University and will entail approximately six hours of my time in addition to the regular curriculum.

The information obtained will be kept confidential. My name or personal identification will not appear on the records and anonymity is assured. I understand that the scores on the tests will be seen only by the researcher and an assistant, and will not be available to the classroom (or clinical) instructors.

I understand that I am free to refuse to participate or to withdraw from participation in the study at any time without affecting my relationship with or treatment by Linn-Benton Community College School of Nursing.

I have read the above, and agree to participate.

Date _____ Name _____

APPENDIX E

STUDENT DEMOGRAPHIC DATA

Student Demographic Data

Please check the appropriate space;

Sex: Female _____ Male _____

Single _____ Married _____ Divorced _____ Widowed _____

Place in family: _____ (i,e, first, second, etc.)

Age: _____ Birthdate _____ No. of children _____

Size of home town: Less than 10,000. _____
10,000-50,000 _____
over 50,000 _____

Race: Caucasian _____ Asian _____ American Indian _____ Hispanic _____
Black _____

Religious faith: strong? _____ medium? _____ weak? _____ none? _____

Previous experience in nursing or related field? (Specify area and timespent)

Other occupation outside nursing? _____

Any previous experience with death of family member or close friend? _____

Means of Support; Self _____ Parents _____ Spouse _____ Other _____

Please circle as many responses as you need to answer completely.

1. Who died in your first personal involvement with death?
 - a. grandparent or greatgrandparent
 - b. parent
 - c. brother or sister
 - d. other family member
 - e. friend or acquaintance
 - f. stranger
 - g. public figure
 - h. animal
2. To the best of your memory, at what age were you first aware of death?
 - a. under three
 - b. three to five
 - c. five to ten
 - d. ten or older
3. When you were a child, how was death talked about in your family?
 - a. openly
 - b. with some sense of discomfort
 - c. only when necessary and then with an attempt to exclude the children.
 - d. as though it were a taboo subject.
 - e. never recall any discussion.
4. Which of the following best describes your childhood conceptions of death?
 - a. heaven-and-hell concept
 - b. after-life
 - c. death as sleep
 - d. cessation of all physical and mental activity.
 - e. mysterious and unknowable
 - f. something other than the above.
 - g. no conception
 - h. can't remember
5. Do you believe in life after death?
 - a. strongly believe in it.
 - b. tend to believe in it.
 - c. uncertain
 - d. tend to doubt it
 - e. convinced it does not exist
6. If you could choose, when would you die?
 - a. in youth
 - b. in middle prime of life
 - c. just after the prime of life
 - d. in old age
7. What does death mean to you?
 - a. the end: the final process of life
 - b. the beginning of a life after death; a transition, a new beginning
 - c. a joining of the spirit with a universal cosmic consciousness
 - d. a kind of endless sleep; rest and peace
 - e. termination of life but with survival of the spirit
 - f. don't know
 - g. other (specify) _____

8. To what extent do you believe that psychological factors can influence or even cause death?
 - a. I firmly believe that they can
 - b. I tend to believe that they can
 - c. I am undecided or don't know
 - d. I doubt that they can
9. If you had a choice, what kind of death would you prefer?
 - a. tragic, violent death
 - b. sudden but not violent death
 - c. quiet, dignified death
 - d. death in line of duty
 - e. death after a great achievement
 - f. suicide
 - g. homicidal victim
 - h. there is no "appropriate" kind of death
 - i. other (specify) _____
10. If you were told that you had a terminal disease and a limited time to live, how would you want to spend your time until you died?
 - a. I would make a marked change in my life-style.
 - b. I would become more withdrawn; reading, contemplating or praying
 - c. I would shift from my own needs to a concern for others
 - d. I would attempt to complete projects; tie up loose ends
 - e. I would make little or no change in my life-style
 - f. I would try to do one very important thing
 - g. I might consider suicide
 - h. I would do none of these
11. In your opinion, what would be a reasonable price for a funeral?
 - a. under \$300
 - b. from \$300 to \$600
 - c. from \$600 to \$900
 - d. from \$900 to \$1500
 - e. more than \$1500
12. How do you feel about having an autopsy done on your body?
 - a. approve
 - b. disapprove
 - c. strongly disapprove
 - d. don't care one way or other
13. Would you be willing to have a body organ removed for transplantation after you die?
 - a. yes, to anyone
 - b. yes, but only to a relative or friend
 - c. I have a strong feeling against it
 - d. No

14. Have you seen a movie in the last year which has made an impression on you about death? Yes _____ No _____
If yes; what was it's title? _____

15. Have you read a book in the last year which has made an impression on you about death? Yes _____ No _____
If yes, what was it's title? _____

16. Have you seen a television program in the last year which has made an impression on you about death? Yes _____ No _____
If yes, what was the name of the program? _____