HOSPITAL NURSES' DEATH ANXIETY AND FREQUENCY OF CONTACT WITH DYING PATIENTS

by

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CHAPTER I

INTRODUCTION

Introduction to the Problem

Most deaths in the United States occur in hospitals. When the dying person enters the hospital, both the patient and his family relinquish considerable control over the patient's course of dying. To a large extent, the attitudes, behaviors, and anxieties of the staff determine the social context in which dying proceeds (Rosel, 1978-79; Blauner, 1966). The nursing staff are particularly important in shaping the experiences of the dying patients because they spend more time with them than other staff members. Also, nurses are most directly responsible for fulfilling patients' immediate needs (Shusterman & Sechrest, 1973).

The literature not only presents the needs of dying patients but also the needs of the staff who work with them (Vachon, 1978; Michaels, 1971). Accompanying the recent emergence of specialty hospital units with high death rates, there has been an increased recognition of the psychological stress and anxiety experienced by the nursing staff (Hay & Oken, 1972; Friel & Tehan, 1980; Vachon, 1978; Huckabay & Jagla, 1979; Holsclaw, 1965). Nurses report patient deaths as one of the major stressor in settings where there are high death rates (Gray-Toft, 1980; Huckabay & Jagla, 1979). Studies have shown that stressors such as patient deaths directly and indirectly affect the quality of nursing care provided patients (LeShan, 1969; Glaser & Strauss, 1969), which in turn affects the patients' medical condition (Meyer, 1962; Meyer & Mendelson, 1961; Revans, 1959). In addition, such

stress is thought to lead to staff burnout, job dissatisfaction, excessive turnover, difficulties in recruiting hospital nursing staff (Behling & Kosmo, 1971; Maslach, 1972; McMinn, 1979; Friel & Tehan, 1980; Gray-Toft, 1980), and staff conflicts (Campbell, 1980). In discussing these problems, several (Gow & Williams, 1977; Friel & Tehan, 1980; Gray-Toft, 1980; Campbell, 1980) highlight the need to understand more about the nurses who work in these stressful areas.

One factor which is frequently cited as contributing to the hospital staff's stress and uneasiness in caring for dying patients is their own death-related fears and anxieties (Kalish, 1966; VandenBerge, 1966; Campbell, 1980; Kubler-Ross, 1969). It has been suggested that the medical and nursing staff may view deaths as a reminder of their own mortality and contacts with dying patients as vicarious rehearsal for their own dying process or that of people close to them. VandenBerge (1966) attributes the difficulty medical personnel encounter in facing the dying and death of their patients directly to the staff's own unresolved death anxiety. Therefore, those providing care for dying patients are encouraged to recognize and resolve their own conflicts regarding death and dying. Just as dying persons must cope with their awareness of death, so must the nurses who are providing them care (Glaser & Strauss, 1965). Davis (1972) thinks the nurse's ability to recognize and resolve her own conflicts and anxieties regarding death and dying influence how well she functions.

This discussion, highlights the need to learn more about the death-related anxiety of nurses who work in areas with high death rates. This type of information about nurses could have implications for improving

patient care and increasing job satisfaction for the nursing staff. Theory-building which is all but nonexistent in this area could also be strengthened.

Statement of the Problem

In order to understand more fully the complexity of the interaction between nurses, dying patients and families, it is important to obtain information about nurses' own death-related anxieties. It is particularly important to understand the death-related anxieties of those nurses who interact frequently with dying patients and their families. The purpose of this study was to investigate the relationship between hospital nurses' death anxiety, as measured by a death anxiety scale, and the death rate (or frequency of contact with dying patients) on the specialty units where they work. The question asked by this study was: Do hospital nurses working on the specialty units where death rates are higher (or where contact with dying patients is more frequent) differ in the amount of death anxiety they demonstrate from nurses working in specialty units where the death rates are lower (or contact with dying patients is less frequent)?

Review of the Literature

The significance of death to man's existence has been one of the major focal points of philosophical and theological thought and writing for the past two thousand years. While death has always been a pervasive topic of discussion and concern in many fields of investigation, a qualitative difference is appearing in the approaches taken in more recent studies. Although many of these studies continue to be accompanied by vague theoretical conceptualization, to involve poor methodology, to yield

inconclusive results and suffer from the absence of an adequate measurement tool (Durlak, 1973), there appears to be an increase in scientific rigor in many current studies. Investigators in a variety of disciplines are beginning to collect systematic, empirical data. Much of this research activity has been focused on the assessment of attitudes toward death and specifically death anxiety (Schulz & Aderman, 1978-79).

Consistent with the focus of this study, the literature reviewed here will focus primarily on theory and studies investigating nurses' death anxiety. The concept of death anxiety and its measurement will be discussed followed by variables which may affect death anxiety: sex, age, religiosity, race, marital status, education, and contact with death. Of major interest will be the final section which deals with the frequency of contact with death as a variable affecting nurses' death anxiety. Studies of hospital nurses working in specialty units and high death rate areas will be reviewed.

The Concept of Death Anxiety and Its Measurement

Fear of death is a very individualistic reaction and its components are complex in nature. Though most research has viewed fear of death on a single continuum, Spilka (Vernon, 1970) attempted to understand the interrelationships of various components and dimensions of the concept. He viewed fear of death as embracing some of the following concepts: 1) fear of dying; 2) fear of death; 3) fear of the consequences of being dead, and 4) fear of the death or dying of others. Fear of death measures have been criticized for their failure to distinguish these components (Lester, 1967; Schultz, 1978). However, McDonald (1976) points out that these components may deal with the sources of fear,

rather than the general death fear apart from the sources. It is argued that individuals synthesize many of these dimensions into a general fear reaction to death (McDonald, 1976; Vernon, 1970) and that death anxiety may be dealt with as a generalized personality variable. This is the approach utilized in this paper. Recently the concept of "death anxiety" has been used extensively in the literature in place of "fear of death". Kalish (1963) initially utilized the concept in a factor analysis of death attitudes, encompassing fear of death under death anxiety.

Although some findings (Templer, 1970, 1972; Lucas, 1974; Templer, 1971; Rhudick & Dibner, 1961; McCarthy, 1980) indicate that death anxiety shares features with more general forms of anxiety, neurosis, and depression, it is also important to note that Templer (1970) reports data suggesting that death anxiety is a concept distinct from general anxiety. The intercorrelations among various death anxiety scales are consistently and significantly higher than their correlations with general anxiety (Schulz, 1978).

Both direct and indirect techniques have been used to assess death anxiety in a variety of populations and settings. Direct techniques include questionnaires, checklists, and rating scales, while indirect techniques include projective tests, the measurement of galvanic skin response, and reaction times during death-related work association tasks. Direct technique using rating scales is by far the most used despite criticisms of problems and limitations. The scales have been criticized for treating death anxiety as a unitary concept, lack of validation, and inability to discriminate between conscious and unconscious death

anxiety (Durlak, 1973; Kastenbaum & Costa, 1977; Schulz, 1978). At present there are six widely used death anxiety questionnaires (Boyar, 1964; Collett & Lester, 1969; Lester, 1967; Sarnoff & Corwin, 1959; Templer, 1970; Tolor & Reznikoff, 1967). Only Collett and Lester's (1969) Scale, which has not been validated, assumes death anxiety as a multidimensional concept. Only Boyar's (1964) Fear of Death Scale (FODS) and Templer's (1970) Death Anxiety Scale (DAS) have been validated.

Death anxiety in the nursing literature tends to be treated in a philosophical, theoretical, or anecdotal manner (Quint, 1967). Research on the death anxiety of nurses is still in its infancy (Hoggatt & Spilka, 1978-79). Particularly, little attention has been directed toward investigating the death anxiety of experienced working nurses. Most of the research which does exist is done with nursing students rather than with experienced nurses who confront terminal patients in the hospital situation (Golub & Reznikoff, 1971; Lester, Getty & Kneisl, 1974; Snyder, Gertler & Ferneau, 1973; Yeaworth, Kapp, & Wingert, 1974). Only a few studies have investigated the death anxiety of hospital nurses working in specialty units where there is frequent contact with dying patients and their families (Hoggatt & Spilka, 1978-79; Shusterman & Sechrest, 1973). There are problems interpreting the findings of these studies due to poorly designed methodology and low response rates.

Sex-Related Differences and Death Anxiety

Although several early studies yielded no sex-related differences in death anxiety (Christ, 1961; Rhudick & Dibner, 1961; Jeffers, Nichols, & Eisdorfer, 1961), more recent studies indicate that females

manifest higher death anxiety than males. Whenever researchers have found differences between the sexes, females at all ages have consistently shown higher death anxiety than males (McCarthy, 1980). Templer's (1970) Death Anxiety Scale has been administered to samples of apartment residents, hospital aides, psychiatric patients, ninth graders, and high school students and their parents (Templer, Ruff & Franks, 1971; Iammarino, 1975), and in all these groups females scored higher than males. This finding has been replicated by several other researchers (McDonald, 1976; Wass & Sisler, 1979; Chiappetta, et al., 1976; Thorson, 1977).

The author was unable to find any studies or articles in the literature that specifically discussed nurses' death anxiety as it relates to the nurses' gender. One study did investigate the care of dying patients by male and female nurses. In this survey of 15,430 nurses (Popoff, 1975), male nurses took care of dying patients just as frequently as female nurses but reported less likelihood of becoming angry, depressed, or discouraged by them.

Although theories of female psychology based on the castration complex, fear of maternal destructiveness (Rheingold, 1964; 1967) and women's greater susceptibility to depression (McCarthy, 1980) have been used to explain women's apparent higher death anxiety, others have argued that the differences are related to females' sex-roles and socialization (McDonald, 1976; Kalish & Reynolds, 1981). Since until the last seventy-five years, death was a potential accompanying each childbearing episode, death was a significant aspect of womens' biological reproductive role.

There have been findings regarding the sex-related differences of death anxiety which parallel sex-role characteristics. In Thematic Apperception Test (TAT) stories, males gave more themes of failure, frustration and violence; whereas, females gave more themes of mourning and loss (Swenson, 1961). There may be a cognitive and emotional component to death anxiety, with females viewing death in more emotional terms and males viewing death in more cognitive terms (Degner, 1974). Using a scale that measures death anxiety by measuring the cognitive distance subjects place between the concepts of "death" and "self", males tend to have higher death anxiety scores than females. However, when a more effective scale is used females show higher death anxiety than males (Krieger, Epsting & Leitner, 1974). One study suggested that males are relatively more defensive about death than females (Handal, 1969).

Contradictory findings and confusion surrounding this area have led most investigators to include controls for sex variables in research on death anxiety (McCarthy, 1980).

Age and Death Anxiety

Age is another variable mentioned in the literature as important in the study of death anxiety. Most of the death anxiety data have been collected from college students and the aged. Although investigations among the aged have been prolific, there are some pertinent data available for every age.

Using a retrospective technique with adults, Hall and Scott (Hall, 1922) attempted to assess death anxiety in children. They concluded that young children view death as characterized by specific objects and feelings associated with a specific death. A more informative study on

children's death anxiety was conducted by Nagy (1959) in which she described relatively discrete developmental phases of the understanding of death and suggested that the association between death and anxiety is established as early as three years of age when death is viewed as separation.

According to Rothstein (1967), death anxiety is relatively low throughout young adulthood and until the middle adult years. Relying on extensive interview data, he found that death anxiety peaks in the middle years, especially for males.

Several other research findings consistently indicate people over the age of 50 tended to express lower death anxiety than the young (Martin & Wrightsman, 1965; Swenson, 1961; Feifel, 1956). On the other hand, a study by Templer, Ruff, and Franks (1971) found no significant correlation between age and death anxiety scores. This discrepancy in findings remains unresolved and is further complicated by studies of elderly subjects' death anxiety at the unconscious level. Feifel and Branscomb (1973) found that elderly subjects who reported below-average overt death anxiety, exhibited unconscious death anxiety that was just as high as that of younger subjects. Similarly, Corey (1961) found older adults tend to show avoidance of death in projective tests.

Studies involving nurses (Shusterman & Sechrest, 1973; Gow & Williams, 1977) seem to correspond to the findings already mentioned. Older nurses express lower death anxiety than younger nurses. However, the findings from these studies are limited due to low subject response rates and other methodological problems. Also, studies involving nurses

support the conscious and unconscious death anxiety notion just discussed. Although older nurses report less death anxiety and deny that dying patients influenced specialty choice, they work in hospital areas where they will have a low likelihood of dealing with terminally ill patients (Hoggatt & Spilka, 1978-79; Popoff, 1975). There is a higher concentration of younger nurses in critical care areas where frequency of contact with death is greatest. There is a higher concentration of older nurses in administration (Popoff, 1975). Nurse administrators have expressed less death anxiety than staff nurses (Folta, 1965; Pearlman, Stotsky & Dominick, 1969). These findings may indicate that older nurses in particular may desire to avoid working with dying patients (Hoggatt & Spilka, 1978-79) and as other studies in the general population have speculated (Feifel & Branscomb, 1973; Corey, 1961) may express low death anxiety but may have high unconscious death anxiety. However, the notion of conscious and unconscious death anxiety remains unresolved and unsupported by research findings (Schulz, 1978). These findings may also indicate that younger nurses have more training in critical care techniques, more energy and quicker reaction time. Also, nurses right out of school are unable to get into administration; whereas, they are able to get into critical care.

Religiosity and Death Anxiety

At present there is no evidence to suggest that Jews, Protestants, Catholics, Buddhists, or any other participants in organized religion differ in the degree of death anxiety according to their particular religious affiliation (McCarthy, 1980; McDonald, 1976). However, research investigating the relationship of other religious variables and death anxiety is conflicting.

Several studies have found a positive relationship between death anxiety and intensity of religious devotion (Faunce & Fulton, 1958; Feifel, 1959; Stouffer, 1949). Other research indicates that there may be a negative relationship (Williams & Cole, 1968) or no significant relationship between the variables (Alexander & Adlerstein, 1959; Jeffers, Nichols, & Eisdorfer, 1961; Martin & Wrightsman, 1965; Swenson, 1961).

It is thought that possibly the disparate results of these earlier studies are attributable to different conceptualization of religiosity (Vernon, 1970; Schulz, 1978). Indicators of extrinsic religiosity (frequency of church attendance) might result in a positive relationship between religiosity and death anxiety, but religiosity measured in terms of fundamental intrinsic values might produce the reverse relationship (Schulz, 1978).

Belief in afterlife has been suggested as an intervening variable reducing death anxiety for highly religious people. Jeffers et al., (1961) found that individuals with strong religious commitments were more likely to believe in afterlife and also showed less fear of death than less religiously committed persons. Osarchuck and Tatz (1973) found that for subjects scoring high on a Belief in Afterlife Scale, a death-threatening slide show induced still greater belief in an afterlife. In general, the link between belief in afterlife and religiosity has been well demonstrated (McCarthy, 1980).

An extensive nursing survey (Popoff, 1975) indicates the typical nurse is Protestant and moderately religious. However, there appear to be no findings in the literature relating religiosity or belief in after-

life to nurses' death anxiety.

Race, Marital Status and Death Anxiety

No significant correlations have been found for race and death anxiety (Pandey, 1974; Pandey & Templer, 1972).

As far as nurses' marital status is concerned, Popoff (1975) found that nurses who have never been married report that they are much more likely to feel uncomfortable and anxious when a patient brings up the topic of death; whereas nurses who are divorced and widowed report they are the least likely to feel uncomfortable. Nothing is mentioned regarding the currently married. These findings may be related more to the ages of the nurses than their marital status. Since older people report lower death anxiety than younger people, and older nurses are more likely to be widowed or divorced and younger nurses are more likely to be unmarried, it may be their ages rather than marital status that accounts for this difference. Also, it may be that either widowhood or divorce as an event which involves loss is correlated with some features of death anxiety.

Educational Intervention and Death Anxiety

Attempts to verify the success of decreasing death anxiety through intervention, in the form of nursing curricula and college courses, have met with mixed success. No studies were found that attempted to relate the level of nursing education to death anxiety. It seems that nurses nearing graduation accept death more than students earlier in their training (Yeaworth, Kapp, & Winget, 1974). Their death anxiety is lower (Lester, Getty, & Kneisl, 1974), and thoughts of death are less frequent (Snyder, Gertler, & Ferneau, 1973).

Schulz (1978) points out that although several specific death education programs have been evaluated, only one caused a significant reduction in death anxiety. Murray (1974) found that nurses' death anxiety scores were significantly reduced after a six week course. Most researchers attribute the changes in death anxiety to the nursing curriculum ignoring alternative explanations such as contact with patients. Schulz (1978) suggests that since courses for college students did not change death anxiety significantly (Bell, 1975; Leviton, 1973; Wittmaier, 1975), it is possible that the practical work of the nursing students may have interacted with the program to produce less death anxiety. However, some evidence suggests that death experience may lead to an increase in death anxiety (Feifel et al., 1967; Lester et al., 1974; Denton & Wisenbaker, 1977).

Lester et al. (1974) noted that increased education through a course in a classroom setting was related to a decreased fear of death in the nurses; however, the investigators recorded exceptions to the finding when the educational course included a clinical involvement in which nurses experienced contact with the death and dying of patients. This finding led Lester to suggest that increased experience with death may be related to increased death anxiety.

Contact with Death and Nurses' Death Anxiety

Glaser and Strauss (1968) state that different hospital units are characterized by different mortality rates and different "sentimental order", or patterning of mood, which allow the nurses to organize their work activities and emotional reactions around the "normal" rate of patient deaths. Popoff (1975) found the nurses who worked in units

where there were low death rates were more likely to become discouraged and depressed when a patient died. Also they were less certain of their ability to provide technical care and manage the psychological needs of terminally ill patients than nurses who worked in units where there were high death rates. Although death rates on the units has been mentioned as an important factor in nurses' behavior (Glaser & Strauss, 1968), little attention has been directed at nursing specialties, their death rates and nurses' death anxiety (Campbell, 1980).

Three studies were reviewed that involved experienced working nurses. In the first by Shusterman and Sechrest (1973), a death anxiety questionnaire tapping six conceptually distinct aspects of attitudes toward death was developed from the work of previous investigators and administered to 188 hospital nurses. Older nurses expressed less anxiety about death of others and more acceptance of conventional medical procedures for managing the dying patient. No aspect of death anxiety was related to death rate on the unit in which the nurse worked. However, there are problems in interpreting the findings of this study. Approximately 50% of the questionnaires were not returned. The investigators attributed the low response rate to lack of support for the study from the hospital's administration and to the dependence upon mail return of the questionnaires. Another problem with the study is that although reference is made to the fact that the unit on which a nurse works may affect her death anxiety, the units examined are not specified nor are the size of the samples of each unit indicated. Also, the investigators point to the psychometric limitations of their questionnaire as a critical impediment to the interpretation of

their findings. The questionnaire lacked internal consistency and validity.

The work reported by Popoff (1975) constitutes a major addition to the literature. The sample of 15,430 nurses responded to a questionnaire asking about demographic information and their attitudes toward death and dying. Although the study did not specifically measure death anxiety, some of the results are useful to the present study. The survey found that the most frequent contact with dying patients occurred in ICU/CCU, Emergency, Med.-Surg., and geriatrics in that order. The least frequent contact with dying patients occurred in Ob/Gyn, psychiatry and pediatrics. Psychiatric nurses appeared to be the most uncomfortable in dealing with terminally ill patients. Popoff (1975) speculated about whether this was the reason these nurses choose to work in an area where death seldom enters the scene. However, his study does not address this question.

Hoggatt and Spilka (1978-79) studied five nursing specialties: Ob/Gyn, ICU, Peds., Ortho-Neuro, and Med.-Surg. They gave their questionnaire to 207 RNs of whom 88% responded. They did find some variations among the nursing specialties on the different items in their questionnaire. Similar to Popoff (1975), they found that nurses in Intensive Care were significantly younger and had higher likelihood of encountering dying patients than those in Obstetrics-Gynecology, Pediatrics and Medical-Surgical services. Although they found a tendency on the part of all the nurses they studied to deny the use of extreme measures to maintain life, this inclination was strongest for those in Pediatrics, Orthopedics-Neurology and Medical-Surgical. When nurses were confronted with the choice of sitting with a dying patient

or a post-operative one requiring much attention, the nurses in Pediatrics, Medical-Surgical and Obstetrics-Gynecology seemed most willing to sit with the terminal person while those in Intensive Care and Orthopedic-Neurology seemed less desirous of such duty. The variations they found may be the result of other potential correlates such as age and experience rather than nurses' attitudes and specialties. No analysis was performed taking these possibilities into account. The study investigated nurses' attitudes using a twenty item death-related questionnaire which they developed. No validity was established in the questionnaire. Although the study did not measure nurses' death anxiety, some of the results of the comparison of the specialties is useful for this present study.

Popoff (1975) questioned if there was a relationship with nurses' attitudes about death and their choice of where they worked in the hospital. There are a few studies dealing with the relation of death anxiety and selection of clinical specialties but these studies only involve students (Livingston & Zimet, 1965; Lester, Getty & Kneisl, 1974).

Findings involving medical students lends empirical support to the idea that selection of specialty is related to death anxiety. Livingston and Zimet (1965) reasoned that medical students with less death anxiety would function comfortably in specialties where death is relatively common (eg., surgery); whereas, students who had high levels of death anxiety would choose specialties where death is uncommon (eg., psychiatry). The results supported their hypothesis: psychiatry-oriented students showed higher death anxiety than students oriented toward surgery. This

was true regardless of the year of training. This finding seemed to indicate that medical students decide on a specialty upon entering medical school and that this decision is in part determined by their level of death anxiety. However, a study of student nurses (Lester, Getty, & Kneisl, 1974) found no relationship between death anxiety and specialty choice.

Summary

"Death anxiety" as used in the research literature can be defined as "a general fear reaction to death". Attempts have been made to measure it by both direct and indirect techniques. These different measuring tools as well as differing conceptualizations of death anxiety have resulted in conflicting results in the literature.

Numerous variables including age, sex, religiosity, race, marital status, education and contact with death, have been thought to influence death anxiety. However, few clear and consistent patterns have emerged.

There are only a few studies of working nurses and death anxiety (Shusterman & Sechrest, 1973; Hoggatt & Spilka, 1978-79; Popoff, 1975). The two studies on working nurses' death anxiety and death rates on specialty units (Hoggatt & Spilka, 1978-79; Shusterman & Sechrest, 1973) have methodological problems and report conflicting findings. Studies on the relation of the selection of clinical specialty and the degree of death anxiety are limited; those that have been done involve only students (medical and nursing) and the findings are conflicting (Lester, Getty, & Kneisl, 1974; Livingston & Zimet, 1965).

Conceptual Framework

A framework for understanding nurses' responses to dying patients includes concepts dealing with death anxiety, death as a stressor, and nurses' coping responses.

Death Anxiety

Death anxiety has been viewed from or explained by both psychoanalytic theory and existential theory. In early psychoanalytic theory, death anxiety was described as a derivative of castration anxiety (Freud, 1953, 1960). The more recent, broader conceptualization of death anxiety as the loss of self and a derivative of separation anxiety (Bowlby, 1968) may be more appropriate for nursing. Separation is one of the most significant and universal meanings of death whether we are focusing upon the anticipated loss of a loved person, the absence and emptiness experienced since the person actually died, or whether we are anticipating our own death (Kastenbaum, 1977).

Campbell (1980) has focused also on nurses' death anxiety as it may relate to the concept of death wishes from a psychoanalytic point of view. He discussed the concept of fearing in death what we have imagined for those whose death we have wished. Death evokes anger and feelings of rejection and abandonment while at the same time producing feelings of guilt and anxiety because of a sense of responsibility - in effect, making nurses both the victim and victimizer. He relates this sense of responsibility to a child's blurring of thought and action and sense of infantile omnipotence that pervades responses to death. Campbell (1980) points out it is interesting to speculate to what extent the sense of responsibility for the death of a patient has

its origins in irrational past connections with conscious and unconscious death wishes.

Death anxiety has also been viewed from an existential perspective. "Man is the only creature who must live with the constant awareness of the possibility and inevitability of nonbeing" (Coleman, 1972, p. 71). Unless an individual chooses suicide, she or he must live with the fact that death will come at some unknown time and place. According to existentialist thinkers (Becker, 1973; Meyer, 1975, May, 1950, 1953), it is this awareness of inevitable death that leads to existential anxiety - a deep concern over the meaning of life. This concern manifests itself through questions about whether one is leading a fulfilling and authentic life. Viewed from the existential perspective, the idea of nothingness can arouse anxiety so general that it influences our entire lives.

Although writers have conceptualized death anxiety using different approaches such as psychoanalytic and existential, most agree that human beings are anxious about death and this anxiety directly or indirectly motivates much of their behavior. These ideas suggest that death anxiety as it relates to nursing behavior is complex and for each individual nurse is related to specific death fears as well as the more universal notion that death anxiety is rooted in the meaning of life.

Death as a Stressor

Nurses have recognized the death of patients as anxiety-producing and stressful (Campbell, 1980; Huckabay & Jagla, 1979). ICU nurses have ranked the death of a patient as one of the most stressful situations in their work environment (Huckabay & Jagla, 1979). However, in

another study it was interesting to note that nurses identified heavy lifting as a major source of stress in the CCU (Cassem & Hackett, 1972). It has been suggested that this finding can be explained as a collective denial of psychological stress or a concrete metaphor for other burdens that must be borne (Campbell, 1980). Although no descriptive studies have been done which describe with validity and reliability the stressors commonly experienced by hospice nurses (Friel & Tehan, 1980), the literature suggests patients' deaths are the major stressor in this setting (Gray-Toft, 1980; Vachon, 1978).

One reason given for the stress nurses experience when patients die is the paradox of being those who deal most with death and yet being those whose work is primarily directed toward the preservation of life (with the exception of hospice nursing). Caught in this dilemma in recovery-oriented hospitals, nurses may feel a sense of failure and stress when a patient dies (Blauner, 1966; Benoliel, 1972, 1979).

Another reason given for nurses' stress in caring for dying patients is the nurses' own death-related fears and anxieties (Kalish, 1966; VandenBerge, 1966; Weisman, 1972). It has been suggested that the nursing staff may view patient deaths as a reminder of their own mortality and contacts with dying patients as vicarious rehearsal for their own dying process or that of people close to them (VandenBerge, 1966; Campbell, 1980, Hay & Oken, 1972).

Nurses' Coping Responses

The classic "Fight or Flight" concept gives a framework in which to view nurses' coping responses to dying patients. Walter Cannon, (1920, 1939), a noted physiologist, first spotlighted the biologic

significance of intense threatening emotional stimuli and gave us the now classic phrase "Fight or Flight" as a way of describing the bodily changes that accompany intense emotions.

Just as there is a physiological mechanism to handle anxiety, Branch (1968) suggests a mental mechanism - symbolic "Fight or Flight". He points out just as the body mobilizes for possible emergency action, the mind automatically moves either to eliminate what has been termed a "major source of human discomfort" or to escape (Laughlin, 1956).

The "fight" aspect fits with the notion that people entering the health care professions and choosing to work with dying patients do so because of much more death anxiety than the average person. Their's is a "fight" response; a desire for mastery over death (Vachon, 1978; Feifel, 1963). Through self-selecting processes these individuals with high death anxiety may be more likely to go into the health care professions (Jenkins, 1955; Lippincott, 1969; Pearlman, Stotsky, Dominick, 1969; Livingston & Zimet, 1965; Feifel, 1963). Another aspect of the "fight" response may be the attempt to get control over the stressor. According to Lefcourt (1974) the degree of control the individual feels he has over a situation is inversely related to how stressful he perceives the circumstances to be. High technology and procedures in high death rate areas of a hospital may give the care giver a sense of control (Campbell, 1980; Blauner, 1966). Another means of gaining control may be increasing one's knowledge about the stressor, death. Janis (1958) maintains that knowledge about the stressor reduces the severity of the stress reaction.

It is suggested that the general response of nurses to dying patients is one of "flight" - avoidance. Nurses maintain both physical and social distance from dying patients through such behaviors as closing dying patients' doors, taking longer to answer their call lights (LeShan, 1969), heavily sedating them (Glaser & Strauss, 1968) and remaining detached from them through nursing routines, rituals and procedures (Stoller, 1980-81; Quint, 1967).

Statement of the Hypothesis

Based on the above, the writer has arrived at the following hypothesis:

> There will be a significant difference between the level of death anxiety of nurses working in high death-rate units and the level of death anxiety of nurses working in low-death rate units.

Operational Definitions

Death Anxiety

A general fear reaction to death dealt with as a generalized personality variable (McDonald, 1976) as measured by Templer's (1970) Death Anxiety Scale (DAS).

Low Death Anxiety

A score from 0-4 on Templer's DAS.

Moderate Death Anxiety

A score from 5-7 on Templer's DAS.

High Death Anxiety

A score from 8-15 on Templer's DAS.

Death Rates on the Hospital Units

The number of deaths at Providence Hospital per year in the nursing units divided by the number of patient days per year in the units based on monthly records for 1981.

High Death Rate Units

The four units at Providence Hospital with the high death rates for 1981: .009-.004 deaths per patient day. They consist of ICU (.009), Hospice (.006), CCU (.005), and Oncology, (.004).

Low Death Rate Units

The four units at Providence Hospital with low death rates for 1981: .0003-0.0 deaths per patient day. They consist of Rehab. (.0003), Orthopedics (.0001), Urology (.00009) and Gynecology (0.0).

CHAPTER II

METHODS

Design

This study used an ex post facto correlational design. Ex post facto correlational studies are considered very important (Polit & Hungler, 1978) because experimentation is often unfeasible or impractical in many research situations. Correlational research is generally an efficient and useful method of collecting a large amount of data in a relatively short period of time. Ex post facto correlational studies are typically strong in terms of their realism. As Polit and Hungler (1978) point out, ex post facto correlational studies tend to lack the artificiality that frequently accompanies laboratory experiments, their results are more likely to be generalizable to other realistic settings.

On the other hand, Polit and Hungler (1978) point out the weaknesses of ex post facto correlational studies. The primary weakness is that the researcher lacks experimental control, both in terms of inability to manipulate the independent variable and inability to randomly assign subjects to treatment groups. Because of this lack of control, ex post facto correlational studies are more likely to run the risk of erroneous interpretation of results than experimental studies. In interpreting the results of ex post facto correlational studies, it is important to consider that correlation, an index of the extent to which two variables are interrelated, does not demonstrate causal relationship. The ex post facto correlational design does not demonstrate cause and effect.

Therefore, in this study, the terms independent and dependent variables are not used to imply a condition of causality; but rather,

as they are frequently used, to suggest directionality of influence (Polit & Hungler, 1978). For purposes of this study, the direction of influence will run from death-rate on units to death anxiety. Death anxiety will be conceptualized as the dependent variable and death-rates on the unit as the independent variable.

Although in this study there were no manipulation of variables nor randomization, there were attempts to control extraneous variables. Because previous research had supported a relationship between death anxiety and gender (McCarthy, 1980; Templer, Ruff, & Franks, 1971; Iammarino, 1975; McDonald, 1976; Wass & Sisler, 1979; Chiappetta, et al., 1976; & Thorson, 1977) this variable was controlled by having only female nurses participate in the study. Further control was maintained by limiting the study to registered nurses. Also, because findings indicate a difference between the level of death anxiety of staff nurses and nurse administrators (Folta, 1965; Pearlman, Stotsky & Dominick, 1969), this study was limited to staff nurses.

Constancy of conditions was controlled by having all the subjects from the same hospital and having the written information and questionnaires distributed and collected in a similar manner on the hospital units.

Subjects and Setting

Subjects consisted of 99 registered nurses in eight specialty units of Providence Hospital, a 400-bed Catholic-affiliated, general hospital located in Portland, Oregon. The criteria to participate in the study were that the subjects must be females and function as staff registered nurses in one of the designated units. One hundred and

twenty full and part-time employed nurses meeting this criteria were contacted and 83% (99) responded.

Eight hospital units were included in this study. The following numbers participated from each unit: ICU (13), Hospice (8), CCU (17), Oncology (24), Rehabilitation (5), Orthopedics (11), Urology (12), and Gynecology (11). These eight units were selected for the study based on death rate calculations for 1981.

The death rates on all of the hospital's nineteen units were calculated based on monthly records for 1981 (see Appendix A). The number of deaths per year in the units were divided by the number of patient days. Based on these calculations the high death rate units were: ICU, Hospice, CCU and Oncology (62). The low death rate units were: Rehabilitation, Orthopedics, Urology, and Gynecology (37). When selecting units with low death rates, Pediatrics, although it had no deaths in 1981, was eliminated because in 1982 it had been merged with a medical unit. Also, the two mental health units which had no deaths in 1981 were eliminated from the study because of their differences from the other nursing units: they were not involved in the same level of physical nursing care and were not staffed under nursing administration.

Instruments

Background Questionnaire

Nurses were given a ten-item background questionnaire (see Appendix B) asking their age, years of experience in the specialty in which they were presently working, years of experience in nursing, race/ethnic group, marital status, education, religious preference, and if they had

experienced the death of a significant other within the last year. The questionnaire included a self-rating question regarding religiosity. Nurses were asked to rate how religious they considered themselves on a scale of 1-5 with 1 being non-religious and 5 being very religious. Also, there was a question asking nurses if their choice to work on a unit would be influenced more likely, less likely, or not affected by the fact that a particular unit had dying patients.

Templer's Death Anxiety Scale (DAS)

The instrument used in measuring death anxiety (see Appendix C) was Templer's (1970) Death Anxiety Scale (DAS). The scale consists of 15 true-false items that were selected from a pool of 40 items on the basis of internal consistency and ratings of judges. A high score on this scale represents high death anxiety. A test-retest reliability coefficient of .83 with a three-week interval has been reported (Templer, 1970). The Kuder-Richardson reliability coefficient reported by Templer (1970) was .76 demonstrating reasonable internal consistency. The scale was also shown in the same study (Templer, 1970) to be unrelated to agreement response set and social desirability. Templer (1970) also reported that presumable high death anxiety psychiatric patients were found to have significantly higher Death Anxiety Scale (DAS) scores than control patients. College students who scored high on the DAS (Templer, 1970) reported more emotion word associations to death. Scores on the DAS have, in addition, been shown to be significantly related to such variables as scores on the MMPI Depression scale (Templer, 1971), GSR to death-related words and Byrne's Repression-Sensitization Scale (Templer, 1971), neuroticism and number of cigarettes smoked (Templer, 1972), and femininity (Templer, Lester & Ruff, 1974).

Templer's DAS is thought to represent the best validated currently available measure of death anxiety and to reflect a wider range of life experiences than other fear of death measures (Aronow, Rauchway, Peller, & DeVito, 198-81). Templer (1970) has reported on the construct validation for the DAS and on the value of the scale for providing information about death anxiety. The normal range of total DAS scores is from 4.5 to 7.0 with standard deviations of 3.0. Possible responses on the scale range from 0 to 15.

Lonetto, Fleming, and Mercer (1979) performed a factor analysis of the DAS. Results indicated that there was more commonality than uniqueness in the factor patterns of the groups analyzed. Four common death anxiety patterns were classified as follows: (a) cognitive-affective concerns (items 1 & 5 on the DAS scale); (b) concerns about physical alterations (items 4 & 14); (c) concern about the passage of time (items 8 & 12); and (d) concern about stressor and pain (items 6, 9, 11, & 13).

Procedure

Steps were taken to inform, to obtain consent, and to protect the privacy of the nurses who participated in the study. Permission was obtained from the hospital to request the registered nurses in the designated units to participate. The researcher met with the head nurses of each of the eight units to solicit their support and cooperation. The head nurses requested that they be allowed to distribute the questionnaire on their respective units. This was mutually agreed upon.

The head nurses distributed the questionnaires to nurses on all three shifts who met the criteria for the study: 1) they must be female and 2) they must function at the staff level. The nurses individually

completed the questionnaires sealing them in envelopes and returning them to a collection site on their particular unit. After a two week period, the investigator collected all of the sealed questionnaires.

Each nurse meeting the criteria of the study was given an introductory letter (see Appendix D), asked to participate, and the return of a completed questionnaire constituted consent. Nurses were informed in the letter that while the hospital allowed them to participate in the study, in no way did the hospital require it. It was explained that the hospital would not be informed as to who participated or completed the questionnaires. Also, the nurses were informed that the study had been designed to protect their privacy and that their anonymity would be preserved. Their names would not appear anywhere on the questionnaire.

Analysis of Data

A non-parametric statistic, Chi-square, was used for analysis to determine if the distribution of death anxiety scores was different for nurses working in high or low death-rate units. The hypothesis to be tested was that there would be a difference in the levels of death anxiety of nurses working in high death rate units and the levels of death anxiety of nurses working in low death-rate units. In applying the Chi-square test (see Table 1), the nurses were classified into two categories: nurses in high death rate units and nurses in low death rate units. Their death anxiety scores were classified into three levels: low (0-4), moderate (5-7), and high (8-12). This breakdown of the DAS scores is the same as that used by McDonald (1976).

Most of the demographic data obtained was used to describe the sample.

CHAPTER III

RESULTS

Characteristics of the Sample

All of the respondents were female, staff registered nurses. The mean age was 32.8 with a range from 20 to 63 years old. The average number of years of nursing experience was 10.4 with a maximum of 40 years. The average (mean) respondent was white, married, educated at the diploma level, Protestant, and rated herself moderately religious, had not experienced the death of a close family member or friend within the last year, and expressed that the presence of dying patients would influence her so that she would be less likely to take a job on a unit where there were dying patients.

Findings Relative to the Research Question

A significant relationship was found between death rates on the units and nurses' level of death anxiety (see Table 1). The Chi-square value of $\chi^2=9.17$ with 2 df is significant at the .01 level. As seen in Table 1, a curvilinear relationship is indicated by the percentages with findings indicating that nurses in low-death rate units expressed higher death anxiety than nurses in high-death rate units.

Additional Analysis

Additional analysis was done using Pearson product-moment coefficients to assess the possibility that in addition to death rates on the units, the level of death anxiety varied with other potential correlates such as age, years of nursing experience, religiosity, education, death of a significant other, and nurses' choice of

TABLE 1

Chi-square for Relationship Between Nursing Units (low and high death rate) and Death Anxiety

	Low Death-rate units (N 37)		High Death-rate units (N 62)	
	N	(%)	N	(%)
Death Anxiety				
Low (0-4)	10	(27.0)	13	(21.0)
Medium (5-7)	8	(21.6)	32	(51.6)
High (8-12)	19	(51.4)	17	(27.4)
Total	37	(100.0)	62	(100.0)

$\chi^2 = 9.17^*$

* Significant at .01 level

where they worked being influenced by the presence of dying patients. The Pearson Correlation Coefficients are presented in Table 2.

Using the Pearson r, DAS and Death rates were found to have non-significant correlation (-.15); whereas, using the Chi-square test a significant relationship was found. Other variables that showed no significant correlations using the Pearson r test were education and the nurse's choice of where she works as being influenced by the presence of dying patients.

The Pearson r test did produce some significant correlations among the variables. As one might expect, age appears to have had a significant (.001) positive correlation with the number of years of experience in nursing (.93). Also, there is a significant (.005) negative correlation between age and death rates or the probability of encountering dying patients (-.26). Note: Because years of nursing experience is so highly correlated with age (.93), both variables have similar patterns of correlation with other variables. Thus, years of nursing experience is negatively correlated (-.32) with death rates). Religiosity was found to be significantly (.008) related to DAS (-.24). The death of a close family member or friend was found to be statistically related (.002) to the unit where the nurse worked (.29). Nurses who worked in high death rate units expressed that they had experienced the death of a close family member or friend more frequently than nurses who worked in low death rate units.

TABLE 2

Pearson Correlation Coefficients

	Templer DAS	Death Rate	Age	Years in Nursing	Education	Religiosity	Sig. Death	Choice
Templer DAS	--	-.15 (99)[a]	-.11 (93)	-.13 (97)	.02 (98)	-.24** (97)	-.12 (98)	-.07 (98)
Death Rate		--	-.26** (93)	-.32*** (97)	.06 (98)	.13 (97)	.29*** (98)	-.06 (98)
Age			--	.93*** (92)	-.02 (93)	.05 (92)	-.16 (93)	.08 (93)
Years in Nursing				--	-.05 (97)	.04 (96)	-.11 (97)	.03 (97)
Education					--	.05 (97)	.06 (98)	.12 (98)
Religiosity						--	-.05 (97)	-.02 (97)
Significant Death							--	.03 (98)
Choice								--

[a] Numbers in parenthesis indicate the number of cases.

* Significant at .05 level
** Significant at .01 level
*** Significant at .001 level

CHAPTER IV

DISCUSSION

Characteristics of the Sample

The characteristics of the sample in this study were similar to those of Popoff's (1975) large sample of over 15,000 nurses: white, married, Protestant, educated at the diploma level, and considered themselves moderately religious. However, the average age was younger (26 years old) than the average age in this study (32.8). Also, in Shusterman and Sechrest's study (1973) the nurses were younger (27.1) than the present study. However, Hoggatt and Spilka's (1978-79) sample with an average age of 32.1 is similar to the present study's average age of 32.8

Findings Relative to the Research Question

The hypothesis of this study that there would be a significant difference between the level of death anxiety of nurses working in high death rate units and the level of death anxiety of nurses working in low-death rate units was supported by the Chi-square test. The Chi-square test indicated a significant relationship between death rates on the units and nurses' level of death anxiety with findings indicating that nurses in low-death rate units expressed higher death anxiety than nurses in high death rate units.

These findings differed from previous studies. Shusterman and Sechrest (1973) found no relationship between death anxiety and the units on which nurses worked. The finding that nurses in low-death rate units expressed higher levels of death anxiety than nurses in high-death rate units contrasts with the numerous articles in the literature

identifying death anxiety as a major problem or stressor in the high death rate units (Campbell, 1980; Friel & Tehan, 1980; Gray-Toft, 1980; Huckabay & Jagla, 1979).

The finding that nurses in low-death rate areas expressed higher death anxiety than nurses in high death rate units is similar to Livingston and Zimet's (1965) finding that medical students with higher levels of death anxiety choose specialties where death is uncommon lending support to the idea of self-selection of specialty related to death anxiety.

The finding of this present study may be explainable on the basis of self-selection. Nurses with higher levels of death anxiety may have chosen to work on units where there are low death rates. This notion fits with the avoidance or "flight" response which is mentioned in the literature (Quint, 1967; LeShan, 1969; Glaser & Strauss, 1968) as the general response of nurses to dying patients.

Another possibility for the finding could be the element of desensitization whereby those working frequently with death become desensitized to death thus scoring lower on the DAS. This possibility fits with the "fight" response of gaining control over the stressor, death. One means of gaining control may be by increasing one's knowledge about death which according to Janis (1965) reduces the severity of the stress reaction. Thus we could expect those nurses in high death rate units to have learned more about death reducing their anxiety and leading to desensitization and lower levels of death anxiety than nurses who work in low-death rate units.

Another explanation for the findings could be that there may be other potential correlates in addition to death rates on the units which

operate to vary the level of death anxiety. For this reason, additional analysis was performed.

Additional Analysis

When the Pearson Correlation Coefficients were performed to assess potential correlates of death anxiety, it was interesting to note that DAS and death rates which had been significantly related using the Chi-square test were non-significant (-.15) using the Pearson r, a linear correlation coefficient. This discrepancy is probably because of the curilinear nature of the Chi-square findings.

The finding that older, more experienced nurses worked in areas where there was low likelihood of encountering dying patients and that younger, less experienced nurses worked in areas where there was high likelihood of encountering dying patients is consistent with other findings in the literature (Hoggatt & Spilka, 1978-79; Popoff, 1975). Hoggatt and Spilka (1978-79) offered an explanation other than self-selection for this finding. They point out that nurses usually request to work on a certain unit; however, if there are no openings, they may get their second desire or be placed where there is need. Older nurses are likely to have been around a hospital longer and therefore possess a greater chance of obtaining the unit they want. Intensive Care, which may involve a great deal of hard work in an atmosphere with a high likelihood of death, would, in all probability, be left over for the younger nurses, while their older counterparts obtain the more favored units which deal with children or relatively healthy persons. Another explanation may be that older nurses are not working in areas of high likelihood of encountering dying patients because these areas are largely

critical care areas. Critical care, as a more recent development, may not have been included in older nurses' training and education. Younger nurses with more recent education would be more likely to have the expertise and skills necessary to function in the rapidly expanding technical field of Critical Care.

Although the study found significant correlations between age and death rates and, as we might expect, age and years of nursing experience, no significant correlation between age and death anxiety was found.

As might be expected, those rating themselves more religious expressed less death anxiety. This may be because of a belief in an afterlife which has been linked to religiosity (McCarthy, 1980) and has been suggested as an intervening variable reducing death anxiety for highly religious people (Jeffers et al., 1961).

The death within the last year of a close family member or friend was found to be statistically related to the death rate on the unit where the nurse worked. Nurses on high death rate units expressed loss of a significant other more frequently than nurses on units with low death rates. One might expect just the opposite since the nurses on the low death rates are older. It may be that the nurses on high death rate units such as Hospice and Oncology where patients possibly stay for long periods of time, considered their patients close friends. Also, this finding could suggest the possibility of self-selection processes whereby nurses who had experienced recent loss of a significant friend or family member chose to work with dying patients possibly as a means of resolving their own personal grief. Finally, in discussing this finding it may be important to keep in mind that statistical significance

should not be given the interpretation of "important" or "meaningful". Instead a significant level means that the obtained results are unlikely to have been due to chance at the specified level of probability (Polit & Hungler, 1978).

Implications for Nursing Practice

Areas in which findings of this study might be relevant to nursing were presented in the Introductory Section of Chapter I. It was speculated that findings might contribute to more effective nursing care for dying patients and their families. Implications arising from the support given to the relationship of death rates on units and nurses' death anxiety could be beneficial to staff nurses, nurse administrators, and nurse educators.

Nurse administrators could utilize the findings of this study when hiring nurses to work in specialty areas of the hospital. The findings could be helpful in placing nurses in areas of the hospital where they may be more comfortable or better suited. This could result in less absenteeism, turnover, burnout, and staff conflicts. Also, nurses working in areas of the hospital where they are more comfortable or better suited, may experience greater job satisfaction and psychological and physical well-being.

Nurse educators may find there is a desensitizing process operating for nurses in high death rate units. It would be helpful to know if this process does operate, and if so, what factors facilitate it. Nurse educators may then be better equipped to offer classes and experiences to prepare nurses who work with dying patients and their families.

The findings of the study may have particular implications for nurses who work on low death rate units. When a death does occur on

these units where nurses expressed higher levels of death anxiety, it may be necessary for the staff to receive extra support from each other, other health-care professionals, and nurse administrators.

CHAPTER V

SUMMARY, LIMITATIONS AND RECOMMENDATIONS

The summary and limitations associated with this study are presented in this chapter. Recommendations for future research conclude the chapter.

Summary

This correlational study focuses on hospital nurses' death-related anxieties. Nurses' death-related anxieties are important because they affect the nursing care of dying patients and their families. In addition, nurses' death anxiety is thought to lead to psychological stress which may produce burnout, job dissatisfaction, excessive turnover, and staff conflicts.

The purpose of this study was to examine if death rates on the nursing units was related to nurses' death anxiety. A convenience sample of 99 hospital staff nurses comprised the study population. Nurses' death anxiety was measured by Templer's (1970) Death Anxiety Scale. In addition, data were collected regarding the nurses' age, years of experience in the specialty in which they were presently working, years of experience in nursing, race/ethnic group, marital status, education, religious preference, religiosity, and if they had experienced the death of a close friend or family member within the last year. Also, nurses were asked if their choice to work on a unit would be influenced by the fact that a particular unit had dying patients.

There was a significant correlation between death rates on the unit and nurses' death anxiety. Nurses on low death rate units expressed higher levels of death anxiety than nurses on high death rate units.

Further examination of the data revealed that older, more experienced nurses worked in areas of the hospital where there was a low likelihood of encountering dying patients. Nurses rating themselves more religious expressed less death anxiety. Nurses on high death rate units expressed loss of a close friend or family member within the last year more frequently than nurses on low death rate units.

Finally, no statistically significant relationships were found between nurses' death anxiety and age, education, or choice of where nurses work being influenced by the presence of dying patients.

Limitations

A major problem in working with the topic of "death anxiety" is the discrepant way it has been conceptualized: unidimensional, multidimensional, conscious, and unconscious. This discrepancy of conceptualization of death anxiety has led to much confusion and limitations in its measurement.

Although Templer's DAS is thought to represent the best validated currently available measure of death anxiety and to reflect a wider range of life experiences than other fear of death measures (Aronow, Rauchway, Peller & DeVito, 1980-81), it is still limited in that it represents death anxiety more as a unitary concept (Schulz, 1978). Also, Templer's DAS measures only overt, conscious death anxiety. Because no indirect techniques were used in this study, the issue of conscious and unconscious death anxiety remains an untangled discrepancy limiting the study.

The DAS as a questionnaire is also limited because of the use of dichotomous items. Polit and Hungler (1978) point out that the type of

question which requires the respondent to make a choice between two alternatives is considered most appropriate for gathering factual information but may be problematic when seeking information that is less clear cut such as the information sought in this study.

The DAS questions may have problems of interpretation for nursing situations. For instance, the ICU or Hospice nurse may have difficulty interpreting "the thought of death seldom enters my mind" (DAS, Question #2). This may be interpreted by the nurse to mean thought of her own death or thought of the patients' deaths. For a nurse who works with death and dying every day, of course the thought of death will enter her mind.

Another limitation is that as a correlational study, the data presented are limited in that they offer no causal explanations for why nurses' level of death anxiety differs significantly with the death rates on the units where they work. Also, the study offers no data to demonstrate the functional or behavioral consequences of nurses' death anxiety.

Recommendations

The data from the present study could possibly be analyzed further in relationship to the four common death anxiety patterns of Templer's DAS as classified by Lonetto, Fleming and Mercer (1979). It might be helpful to replicate the study using not only Templer's DAS but also a multidimensional tool. Also, the study could be replicated in different settings.

It might prove productive in untangling the discrepancy between conscious and unconscious death anxiety to use an indirect technique of

measurement along with the direct technique of Templer's DAS.

Since in this study religiosity appeared to be related to nurses' death anxiety, it may be beneficial to pursue study of this relationship.

Finally, studies of nurses' death anxiety that relate to functional or behavioral consequences are needed.

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APPENDIX A

CALCULATION OF PROVIDENCE HOSPITAL'S DEATH RATES FOR 1981

Calculation of Providence Hospital's Death Rates for 1981

Units		Deaths	Patient Days	Deaths/Patient Days
ICU		27	2973	.009
Hospice	3H	11	1834	.006
CCU		14	2785	.005
Oncology,	3A	29	7537	.004
	4K	18	9968	.002
	2K	7	4684	.001
	4G	12	8293	.001
	2G	11	8483	.001
	2R	8	6610	.001
	3R	6	6435	.0009
	5G	7	8945	.0007
	3G	5	9021	.0005
Rehabilitation,	3L	2	6096	.0003
Orthopedics,	5R	1	9675	.0001
Urology,	5K	1	10549	.00009
Gynecology,	4R	0	4500	0.0
Mental Health,	4L	0	4702	0.0
Mental Health,	5L	0	4981	0.0
Pediatrics,	6L	0	3249	0.0

APPENDIX B

BACKGROUND QUESTIONNAIRE

Background Questionnaire

PLEASE FILL IN THE BLANKS:

Age_____

Years of experience in _____

Years of experience in nursing _____

RACE/ETHNIC GROUP (Circle one)

1. White
2. Black or Negro
3. Spanish Surnamed
4. American Indian
5. Japanese
6. Chinese
7. Other (specify)_____

MARITAL STATUS (Circle one):

1. Single
2. Married
3. Widowed
4. Divorced/separated

HIGHEST LEVEL OF EDUCATION COMPLETED (Circle one):

1. Associate degree
2. Diploma
3. Baccalaureate in nursing
4. Baccalaureate in other field (specify) _____
5. Master's in nursing
6. Master's in other field (specify) _____
7. Doctorate (specify _____

RELIGIOUS PREFERENCE (Circle one):

1. Catholic
2. Protestant
3. Jewish
4. None
5. Other (specify)_____

ON A RATING SCALE OF 1 TO 5, PLEASE CIRCLE HOW RELIGIOUS YOU CONSIDER YOURSELF:

Non-religious				Very religious
1	2	3	4	5

HAS A CLOSE FAMILY MEMBER OF FRIEND DIED WITHIN THE LAST YEAR? (Circle one):

1. Yes
2. No

IF YOU HAD THE OPPORTUNITY TO WORK ON A UNIT WITH DYING PATIENTS, WOULD THE PRESENCE OF DYING PATIENTS: (Circle one)

1. Influence you more likely to take the job?
2. Influence you less likely to take the job?
3. Not affect your decision?

APPENDIX C

TEMPLER'S DAS, SCORING KEY, AND LETTER OF PERMISSION

Templer's DAS

DIRECTIONS: Please answer the 15 questions. If a statement is true or mostly true as applied to you, circle "T". If a statement is false or mostly false as applied to you, circle "F".

T F 1. I am very much afraid to die.

T F 2. The thought of death seldom enters my mind.

T F 3. It doesn't make me nervous when people talk about death.

T F 4. I dread to think about having to have an operation.

T F 5. I am not at all afraid to die.

T F 6. I am not particularly afraid of getting cancer.

T F 7. The thought of death never bothers me.

T F 8. I am often distressed by the way time flies so very rapidly.

T F 9. I fear dying a painful death.

T F 10. The subject of life after death troubles me greatly.

T F 11. I am really scared of having a heart attack.

T F 12. I often think about how short life really is.

T F 13. I shudder when I hear people talking about a World War III.

T F 14. The sight of a dead body is horrifying to me.

T F 15. I feel that the future holds nothing for me to fear.

DAS Scoring Key

Key	Content
T	I am very much afraid to die.
F	The thought of death seldom enters my mind.
F	It doesn't make me nervous when people talk about death.
T	I dread to think about having to have an operation.
F	I am not at all afraid to die.
F	I am not particularly afraid of getting cancer.
F	The thought of death never bothers me.
T	I am often distressed by the way times flies so very rapidly.
T	I fear dying a painful death.
T	The subject of life after death troubles me greatly.
T	I am really scared of having a heart attack.
T	I often think about how short life really is.
T	I shudder when I hear people talking about a World War III.
T	The sight of a dead body is horrifying to me.
F	I feel that the future holds nothing for me to fear.

APPENDIX D

NURSES' INTRODUCTORY LETTER

OF EXCELLENCE
9 73
FRESNO

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

Dear Judy Zorsuck:

Thank you for your ~~letter~~ call of 2-25-82. 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,

[redacted]

Donald I. Templer, Ph.D.

DIT/rs

OREGON HEALTH SCIENCES UNIVERSITY

Dear Nurse,

You are invited to participate in a nursing research study titled "Nurses' Death Anxiety and Choice of Specialty" by Judith Gorsuch, R.N., B.A. working under the supervision of Marie Scott-Brown, R.N., Ph.D. The investigation aims at finding out about nurses' attitudes on death and dying.

Your participation involves completing a 5-10 minute self-administered questionnaire on death and dying.

In order for you to feel comfortable in answering these questions, the study has been designed to protect your privacy. Your anonymity will be preserved. Your name will not appear anywhere on the questionnaire. After completing the questionnaire, you will seal it in an envelope and return it to the researcher.

Although Providence Hospital has agreed to allow you to participate in this study, the hospital will not be informed as to who participates or completes the questionnaires. You may refuse to participate or withdraw from this study at any time without affecting your employment at Providence Hospital. Likewise, you may refuse to participate or withdraw from this study at any time without affecting your relationship with, or treatment at, the Oregon Health Sciences University.

While you may not benefit directly from participation in this study, others may be helped by the results of this study. The results will be made available to you through your hospital's nursing administration.

I am available to answer any questions and can be reached at 625-7031 should any questions arise.

Sincerely,

[redacted]

ABSTRACT

AN ABSTRACT OF THE THESIS OF

Judith A. Gorsuch

For the MASTER OF NURSING

Title: HOSPITAL NURSES' DEATH ANXIETY AND FREQUENCY OF CONTACT WITH DYING PATIENTS.

APPROVED: _____

Marie Scott-Brown, R.N., Ph.D., Thesis Advisor

The purpose of this correlational study was to investigate the relationship between death rates on units and nurses' death anxiety. The study focused on hospital nurses who worked in high and low death rate units.

The selection criteria for this investigation yielded a sample of 99 subjects, 62 nurses in high death rate units and 37 nurses in low death rate units. The setting was a general hospital in Portland, Oregon. Data was collected through the administration of Templer's (1970) Death Anxiety Scale and demographic data was collected through a background questionnaire. Data were analyzed using Chi-square and Pearson r.

Findings indicated a relationship between death rates on the units and nurses' level of death anxiety. Nurses on low death rate units were more experienced, older, and expressed higher levels of death anxiety. Nurses on high death rate units more frequently experienced a significant death within the last year. Nurses who rated themselves more religious expressed less death anxiety.