A STUDY OF NURSES' ATTITUDES AND ANXIETIES TOWARD DEATH AND DYING

by

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by

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has been approved

July 1972

Supervisory Committee

Dear, Graduate School
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Thanks also go to Ben and Tina, my husband and daughter, who gave me encouragement and help.
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ABSTRACT

The subject of death and dying are of growing concern to all nurses, particularly psychiatric nurses. This study was conducted to compare attitudes and anxieties about death between nurses who graduated from a two-year associate degree, or a four-year baccalaureate program in nursing.

The sample consisted of 510 registered nurses (65% return rate) who answered a mailed questionnaire. They graduated between the years 1967 through 1971 from Brigham Young University, Salt Lake City and Provo, Weber State College, Ogden, and the University of Utah, Salt Lake City. The respondents were also divided into subgroups according to work specialization and the extent to which the investigator perceived them to have had contact with critically ill and dying patients.

The questionnaire employed the semantic differential and included Emotionality and Evaluative Scales developed by Folta (1965), and an Anxiety Scale constructed by Forrest (1970). An analysis of variance was done to compare responses to the three scales for the two and four-year programs, and for the subgrouping of nurses' area of interest. Variables such as educational degree, years since graduation, years worked and experience with critically ill patients were intercorrelated with scores on the three scales.

There were no significant differences among the four schools on the scales. However, many variables were not controlled for which could have influenced this finding. It is of interest to note the
tendency for scores on all scales to be lower with more educational 
preparation, but the results did not reach statistical significance.

There were no significant differences among the nurses regarding 
years of total work experience and Evaluative and Anxiety Scores.

Recent graduates were no different in their attitudes toward 
death and dying than those nurses who had been graduated for longer 
than one year.

Significant negative correlations were found between total work 
experience and Emotionality, ($r = -.08, p < .05$) and between experience with 
critically ill patients and Anxiety ($r = -.07, p < .05$). Since neither the 
number of years since graduation, nor age significantly correlated 
with any of the scales, it was assumed that some nurses had prior work 
experiences before completing a degree program. Married nurses 
exhibited a significant tendency for higher scores on Anxiety than did 
single nurses.

There were no significant differences among the areas of interest 
and the Emotionality or Evaluative Scales. Significant variance 
($p < .05$) was found among the subgroups for the Anxiety Scale, 
indicating there were differences in the way various specialty groups 
viewed death and dying relative to the Anxiety Scale.

It had been hypothesized that nurses working in pediatrics 
would have the highest scores on the three scales. Nurses who listed 
pediatrics as their area of specialization ranked fourth highest on 
Anxiety, second on Emotionality, and seventh on Evaluative. Nurses 
in geriatrics and high risk nursery followed by those in teaching,
office nursing, school and research, ranked higher than the other groups on the Anxiety Scale. The group with the lowest mean Anxiety score was the emergency room nurses.

The criteria used for classifying nurses into a specialty subgroup were not considered valid for drawing meaningful conclusions. Suggestions are made as to how this might be more appropriately accomplished as well as for utilizing alternative statistical methods for analyzing the data.

The importance of including study of death and dying in nursing curricula is endorsed in a meaningful way, by the large percentage of nurses interested enough in the topic to respond to the questionnaire. While attitude measurement is difficult, ways need to be found to evaluate the impact of needed changes in nursing education. Further evaluation of the questionnaire and control for variables is of crucial importance for future studies of attitudes toward death.
CHAPTER I

INTRODUCTION

As man studies and investigates life, he is ultimately faced with having to look at the processes of death and dying. Freud (1938) described death as the return to an inorganic state. He stated that not only is death a "necessary outcome of life," and unavoidable; but that "in the unconscious every one of us is convinced of his own immortality," (Freud; 1936, p. 305).

Men's concern with aggression, war, destruction, and his ability to control or induce catastrophic events have paradoxically produced great advances in the ability of medical science to prolong life. More recently, there has been concern, not just with the preservation of life, but with preserving the quality of life, and preparing the dying individual and his family for separation and death.

Many nurses work with dying patients every day in situations such as assisting a potential transplant patient face the uncertainty of an available donor, helping a patient who has received a new kidney fight tissue rejection and/or infection, working with the young child dying of leukemia, or the aged person whose life is slowly ebbing, and the traumatic accidental death, or suicide. Not only is the nurse concerned with these individual deaths, she must also prepare for the possibility of a catastrophic event which could
leave many people dead, dying, or in critical condition. Moreover, nurses, as are all individuals, are aware of their own eventual death, as well as of the possible loss of loved ones.

Along with the increased interest in the subject of death has come the suggestion by several authors that we need to redefine the terminology commonly associated with death and dying (Shneidman, 1970; Vernon, 1970). These authors suggested that the definition of death needs to be expanded to correspond with the many parameters which are now included in the concept of death. Vernon (1970) discussed different kinds of death, such as social death, psychological death, and biological death. These processes, he stated, may or may not all occur simultaneously. Shneidman (1970) also made a distinction between death and dying. The former being the fact, and the latter being the process. He suggested that the term "cessation" be used instead of death, and defined it as that "which ends the potentiality of any (further) conscious experience," (Shneidman, 1970, p. 38).

Shneidman (1971) conducted a survey among readers of Psychology Today, from which he concluded that the American attitude toward death is one of ambivalence. Even though there seemed to be a need to talk about death, it was still considered to be a forbidden topic in our culture. Kubler-Ross (1969) found that although dying patients wanted to talk about death, hospital staff were either unable or unwilling to talk about it. Peisel (1959) and Christ (1965) also agreed that patients wanted to talk about their
feelings and thoughts associated with death. However, another researcher (Cappon, 1962), determined that those who were well were more willing to talk about dying than those who were ill. Thus the determining factor of willingness to talk about death was the relative health of the individual.

Attitudes toward death among nurses seemed an appropriate area for study, since persons in nursing are faced with death more frequently than the general population. Kasper (1959), in writing about the doctor and death, hypothesized that people who have high anxiety about death go into the healing professions, yet he found that people with conscious anxieties about death tended to stay away from medicine. He was unable to find any expressed fear of death in the life histories of physicians, and suggested that the doctor "takes his own fears, puts them as intellectual questions, and tries to answer them for other people," (Kasper, 1959, p. 263). Feifel (1965), in a pilot study, found that although physicians think less about death, they are more afraid of death than are their patients or other nonprofessionals. Feifel not only encountered resistance from the physicians participating in his study, but also found it was the physician who did not want to talk about death, not the patients.

Smelldman (1971), Feifel (1959), Greenberg (1965), and Vernon (1970), demonstrated that the sex of the individual makes a difference in attitude toward death. Generally, women seem to
think of death-related topics more than men. As an indication of this, Greenberg (1965) found that after one year there was a 50% turnover of nurses working in cancer research units, whereas there was only a 25% turnover of the nurses in the psychiatric and cardiac units in the same period of time. As might be expected, the patients on the cancer service, a research unit, had a higher death rate than patients in the psychiatric units. Even though the death rate on cardiac units is comparable to that on cancer units, the longer period of hospitalization of cancer patients and their concomitant disfiguration may be factors which influenced the high turnover rate of nurses on the cancer unit.

Both Greenberg (1965) and Chandler (1965) found that on units where many deaths occur there is lower staff morale and increased tension vented through anger and aggression.

In a study conducted by Livingston and Zimet (1965), the authors concluded that medical students who were interested in psychiatry were more anxious about death than those interested in surgery. Utilizing a questionnaire survey, Forrest (1970), demonstrated that although mean anxiety scores regarding death were higher for nurses working in public health nursing, psychiatric and supervisory nursing areas, there were no significant differences among the mean scores of all the nurses surveyed regardless of area of work specialization. She suggested the possibility that her small sample size and the criteria utilized to group the nurses may have biased the results.
The present investigator hypothesized that a larger sample and a more individual grouping of nurses, such as grouping according to area of interest and the amount and extent of contact nurses were likely to have with death and dying patients, would yield more valid data from which to determine nurses' attitudes toward death.

It is generally accepted that educational efforts should be directed toward preparing professional nurses capable of responding to the emotional needs of the terminally ill. Bowers, Jackson, Knight, and LeShan (1964) commented that many professionals are ill-equipped to care for the dying. Quint (1966) observed that many doctors and nurses make work choices that take them away from the dying. If a nurse is working in an area where dying occurs she develops defensive tactics in order to maintain her composure, as her great fear is that of losing control of herself in the dying situation. Quint identified some of the defensive tactics used by nurses to insulate themselves against the death of their patients. She listed the defenses most commonly used as selective listening, isolation of the patient, and, if isolation was not possible, using a verbal isolation by speaking infrequently with the patient. All these defenses served the purpose of cutting down involvement with dying patients. Glaser and Strauss (1965) stated that this defensive strategy is a developmental process, in that a nurse may gradually cut down her involvement with a patient as his condition deteriorates.
As more people are brought into the hospital to die, nurses will need some guidelines to assist them in coping with the dying patient (Quint & Strauss, 1964). Polck and Nie (1959) stressed the importance of helping students understand and cope with the experience of death. Often the study of death is not included in the student's curriculum, as the emphasis in nursing has been on saving lives. Since students tend to emulate what their instructors emphasize as being important, the dying patient is often given little attention.

In order for the nurse effectively to carry out her responsibilities to the dying patient, Polck and Nie (1959) suggested it would be helpful to incorporate the concepts of death and dying into the curriculum early in the student's experience. They concluded that their students were aided by this approach. The result was that the students, as well as the faculty, gained a deeper understanding of death, and felt freer to discuss it. It is still the practice, however, in many schools of nursing, to avoid the discussion of death.

As interest and concern in the subject of death and dying has increased, research and study into these formerly taboo topics has also increased. Hopefully this will assist in movement toward open discussion of these subjects, resulting in attitudinal change and finally leading to more humane care of the dying than apparently exists now.

An editorial in Nursing Outlook, "What Man Shall Live and Not See Death?" (1964), listed two responsibilities the nurse has toward
the dying person. The first is to give life preserving measures to
the patient as long as possible. The second responsibility is
toward those who love the patient, to reassure them, and in a sense
share the grief with them. The nurse's first commission, the
editorial emphasized, is simply to be available. Chandler (1965) also
advocated that the nurse should be consistently available to listen,
to be with the person in his silence or anger.

Increasing technological advances aid in the fight to keep
people alive who might have died a decade ago. Dialysis units, burn
care units, coronary care units, and improved treatment of chronic
illnesses, have been effective in prolonging life but also have
increased the probability that deaths will occur in hospitals. It
becomes increasingly important for nurses to be able to care for and
support the dying patient. Rothenberg (1961) recommended that good
psychological management in terminal cancer may alleviate suffering.
Chandler (1965) found that different processes of dying have different
behavioral effects upon any individual. Thus it seems reasonable
that nurses should learn how to handle their own responses toward
death and prepare themselves to be available to the dying patient.
In order to do this, further study, understanding, and clarification
of how nurses view death is needed. Studying the views of recent
graduates from schools of nursing should provide baseline information
against which to evaluate attitude changes of future graduates who
have been exposed to curriculum modifications. In addition, the
assessment information should be a useful indication of subject areas requiring stress in nursing education.

Folta (1965) conducted a study on the perception of death among nurses. She chose a religious, a research, and a secular hospital. She further divided the groups into administrative, staff, and licensed practical nurses, as well as attendents. She found that there were no significant differences in perception of death according to hospital or position within the hospital; however on an Anxiety Scale there was a positive relationship between anxiety and position within the hospital, although there were no significant differences among hospitals. Her study indicated that staff nurses had the highest degree of anxiety about death, followed by licensed practical nurses, administrative nurses, and attendents. This supported the idea of anxiety about death increasing with patient contact, although she did not consider the specialty area of work in her study. Staff nurses in this study were defined as those not employed as supervisors or head nurses.

Forrest (1970) surveyed a group of nurses and non-nurses in an attempt to validate Folta's findings. She hypothesized that those nurses who worked in areas where patients were more likely to have fatal or terminal illnesses would have more anxiety and emotionality concerning death than those who did not. Her results, on three scales used to measure anxiety about death, however, were in the reverse direction of her hypotheses, although the differences were
not significant. She did find that senior nursing students had a
tendency toward negative emotionality and evaluative attitudes
regarding death in comparison with new nurses, R.N.'s, and freshmen
nursing students. The differences among the groups on Emotionality
were significant at p = .05. She suggested the small and dispropor-
tionate size of the various subgroupings may have invalidated the
results, and also that the nurse's years of experience and length of
employment in a particular area of nursing, might be additional
variables which influenced the nurse's attitudes toward death.
Forrest (1970) suggested that another variable which may influence
the nurse's attitude toward death is her professional education. A
survey of the literature revealed no studies which investigated
attitudes toward death between nurses from baccalaureate and associate
degree programs.

It is assumed that nurses' attitudes toward death are affected
by a variety of factors including culture, feelings and experiences
with death, and the social value attributed to the patient. Glaser
and Strauss (1964), described aspects which influence the social
value placed on the loss of a patient. A very important factor was
the age of the patient. The death of a child, for instance, carried
a greater social loss than that of an aged person. Furthermore, the
age of the nurse, as well as her experience with death influenced her
attitudes. A rapid patient turnover buffered anxiety about death.
With either a slow patient turnover, or longterm patient stay, a
nurse had an opportunity to learn more about the patient, thus
becoming more involved with him, and increasing the perceived social loss resulting in greater anxiety over his death.

In summary, there is agreement that health services personnel, and nurses in particular, are often ill prepared to care for the dying patient. They often develop defensive and coping maneuvers which take them away from the patient. Some (Folta, 1965; & Greenberg, 1965) have concluded from their research findings that increasing contact with dying patients increases anxiety about death. Others have suggested (Livingston & Zimet, 1965) that persons choosing to work in areas removed from dying patients, such as in the field of psychiatry, may have more anxiety about death, while those who work in surgery for example, may be better defended against death, and thus express less overt anxiety. On the other hand, Forrest (1970) found that no significant differences existed among nurses in general or according to their area of work, in the way they viewed death. These findings indicate that further study and clarification of nurses' attitudes toward death seem appropriate.

Statement of the problem. The purpose of this study was to compare nurses' attitudes and anxieties toward death, looking particularly at the following variables: (1) different specialty areas of nursing; (2) type of preparation, associate or baccalaureate degree; and (3) time since graduation, utilizing graduates within a five-year period.
The investigator hypothesized that:

1. There will be no significant differences between nursing graduates of two or four year programs. Regardless of the program, a certain amount of anxiety will be experienced over a role shift from student to registered nurse. Expectations and responsibilities of a student are different from those of a registered nurse.

2. More recent graduates would demonstrate significantly greater Emotionality, Evaluative, and Anxiety scores than nurses who had been working longer than one year.

3. Nurses who indicated a specialty in nursing services such as intensive care units (ICU), operating rooms (OR), and emergency rooms (ER) would show significantly less Anxiety, Emotionality, and Evaluative scores concerning death than nurses employed in caring for patients in a ward or general nursing situation. It was assumed that the significant variable would be not only contact with dying patients but the duration of the contact.

4. The greatest Anxiety, Emotionality and Evaluative scores would occur among nurses who work in pediatric units.
CHAPTER II

METHOD

Description of the Sample. The study sample consisted of registered nurses who graduated during the years 1967 through 1971 from two Associate Degree programs and two Baccalaureate Degree programs. The associate degree nurses were graduated from Brigham Young University, Salt Lake City, Utah, and Weber State College, Ogden, Utah. The baccalaureate degree nurses graduated from Brigham Young University, Provo, Utah, and the University of Utah, Salt Lake City, Utah. These nurses worked in a variety of settings: obstetrics, medicine, surgery, intensive care units, emergency room, pediatrics, psychiatry, public health, teaching, as well as a few who were unemployed at the time of the study.

The mean age of the combined sample was 26.69 years with an age range of 20 to 60 years. The data are presented in Table 1.

The Questionnaire. In an attempt to measure attitudes and anxieties of nurses regarding death and dying, a questionnaire utilizing the semantic differential was given to 510 nurses. Green (1954) originally suggested that attitudes can be measured and given a numerical rating. Osgood (1957) developed the semantic differential as a means for measuring attitudes.
<table>
<thead>
<tr>
<th>Groups</th>
<th>N</th>
<th>Age Range</th>
<th>Mean Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>I  Brigham Young University 2-year program</td>
<td>148</td>
<td>20 to 60</td>
<td>28.29</td>
</tr>
<tr>
<td>II Weber State College 2-year program</td>
<td>123</td>
<td>20 to 50</td>
<td>25.86</td>
</tr>
<tr>
<td>III Brigham Young University 4-year program</td>
<td>141</td>
<td>21 to 34</td>
<td>25.60</td>
</tr>
<tr>
<td>IV University of Utah 4-year program</td>
<td>98</td>
<td>22 to 49</td>
<td>26.85</td>
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<tr>
<td>Combined Group</td>
<td>510</td>
<td>20 to 60</td>
<td>26.69</td>
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A composite questionnaire was constructed by this researcher using parts of Folta's and Forrest's questionnaires. This can be found in Appendix A. Section I consisted of the scales of Emotionality and Evaluative, which were derived from the Folta (1965) semantic differential items. It consisted of a semantic differential scale of 14 items, with a 7-point scoring range for each item on the Emotionality and Evaluative Scales.

**Emotionality.** Refers to Folta's scale composed of opposite adjectives such as "graceful"--"awkward" (see Appendix A) designed to identify the degree of positive or negative emotional attitudes toward death. The greater the score the more negative the emotional attitude toward death. Scores could range from a high of 42 to a low of 6. It included the first six items in Section I of the questionnaire (see Appendix B).

**Evaluative.** Refers to Folta's scale composed of opposite adjectives, such as "sweet"--"bitter" (see Appendix A) designed to identify the degree of positive or negative evaluative attitudes toward death. The greater the score the more negative the attitude toward death. The scores could range from a high of 56 to a low of 8. The scale included the last eight items in Section I of the questionnaire (see Appendix B).

**Anxiety.** Section II was an Anxiety Scale, constructed by Forrest (1970) for which Folta's Anxiety Scale was utilized as a guide. It consisted of an Anxiety Scale of ten items, used to measure the extent to which the subject agreed or disagreed with statements.
concerning the anticipation of death, whether it be his own or someone else's. On this scale, the greater the score the greater the anxiety and more negative the attitudes concerning death. Scores could range from a high of 70 to a low of 10 (See Appendices A and B).

Background information from the respondents was obtained which aided in making certain the subjects met the criteria, as well as to facilitate assigning nurses to the appropriate subgroups based on area of nursing practice and the school from which the nurse was graduated. The questionnaire used by Forrest was considered too lengthy for mailing, and this was one reason for shortening it.

The questionnaire numbers one through four, nine through eleven, and thirteen through fifteen were taken from the Forrest questionnaire. Two questions were added by the investigator (see Appendix B, numbers nine and ten). The investigator modified the questions eleven through thirteen so that the respondents had a choice of answers. This facilitated data grouping for these particular questions.

Collection of Data. Names and Addresses of graduates from previously mentioned programs were obtained. These names were checked against the Utah State Nurses' roster. A four paged questionnaire was sent to each graduate for whom an address could be established, with a cover letter attached (see Appendix B), along with a stamped, self-addressed return envelope and a 3 x 4 card. The letter asked for participation in the study and gave instructions for answering the questionnaire. The questionnaire itself had been
coded to match each person to whom a questionnaire was sent. The
3 x 4 card was utilized for the nurse's address, to be returned with
the questionnaire if a copy of the abstract of the thesis was
desired. It was hoped this would be an incentive for returning the
questionnaire.

There were 935 graduates listed in the original lists obtained
from the schools. Of these, 96 were returned with no forwarding
address available, and a search for address changes was not fruitful.
Of the 839 remaining questionnaires, 535 were returned (523 from
women, 12 from men), giving a return rate of 65%. Of these, 510
questionnaires were used; the twenty-five not used were incomplete.

**Analysis of Data.** The Emotionality, Evaluative, and Anxiety
Scale scores for each respondent were totaled by adding the indicated
numbers for each item on the 7-point-scale questions, to conform with
Forrest's study. The low scores showed positive attitudes and low
anxiety, and high scores showed negative attitudes and high anxiety.
The first five items in the Anxiety Scale were transposed, following
Forrest, in order to conform to scale direction. The individual
scores for the scales were then totaled.

Analysis of variance was computed to determine any significant
differences among any subgroup mean scores on the Emotionality,
Evaluative, and Anxiety Scales.

The investigator used the following groupings: year of
graduation, type of program from which the subject graduated, as
well as the major area of interest and specialty.
The subgroupings were determined by how the individual nurse answered the question concerning major area of interest and specialty. The subgroup categories were designed to cluster nurses according to the degree and extent to which they were thought to have contact with death and dying patients. The categories were not necessarily mutually exclusive since nurses involved in teaching, research, or public health, might also have contact with patients in geriatrics, pediatrics, intensive care, and other specialty areas.

The major areas of interest and specialties were grouped into the following categories:

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CHAPTER III
RESULTS

Replies were received from 535 respondents, of which 510 were used.

Hypothesis 1. It was hypothesized that there would be no significant differences in attitudes toward death as scored on the questionnaire between the two and four year graduates. Means, standard deviations, and rank orders for the four programs represented are presented in Table 2. The analysis of variance showed that there were no significant differences on any of the scales among the groups.

The mean scores indicated that the University of Utah graduates, with a mean score of 24.09, scored higher on Emotionality than graduates from the other schools. Graduates from the Brigham Young University, two-year program, scored the lowest, with a mean score of 22.14. On the Evaluative Scale, the University of Utah graduates scored highest, with a mean score of 28.5. Graduates from the Brigham Young University, four-year program scored the lowest, with a mean of 26.42. Weber College graduates scored the highest on the Anxiety Scale, with a mean score of 33.08, while the Brigham Young University, two-year program graduates scored lowest with a score of 30.42. The University of Utah scored second on the Anxiety Scale, with a mean score of 31.65. Of all the scales the variability as represented by ± the standard deviation was highest for all programs on the Anxiety Scale.
### Table 2

Rank Order of Programs, Means and Standard Deviations on Emotionality, Evaluative and Anxiety Scales

<table>
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<tr>
<th>School</th>
<th>Emotionality Scores</th>
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<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Standard Deviation</td>
<td></td>
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<tr>
<td>University of Utah</td>
<td>24.09</td>
<td>± 6.58</td>
<td></td>
</tr>
<tr>
<td>Weber State College</td>
<td>22.63</td>
<td>± 5.73</td>
<td></td>
</tr>
<tr>
<td>Brigham Young University</td>
<td>22.28</td>
<td>± 5.68</td>
<td></td>
</tr>
<tr>
<td>4-year program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brigham Young University</td>
<td>22.14</td>
<td>± 5.87</td>
<td></td>
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<tr>
<td>2-year program</td>
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<tr>
<th>School</th>
<th>Evaluative Scores</th>
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<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Standard Deviation</td>
</tr>
<tr>
<td>University of Utah</td>
<td>28.50</td>
<td>± 7.33</td>
</tr>
<tr>
<td>Brigham Young University</td>
<td>27.37</td>
<td>± 8.15</td>
</tr>
<tr>
<td>2-year program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weber State College</td>
<td>26.69</td>
<td>± 8.04</td>
</tr>
<tr>
<td>2-year program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brigham Young University</td>
<td>26.42</td>
<td>± 6.78</td>
</tr>
<tr>
<td>4-year program</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School</th>
<th>Anxiety Scores</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Standard Deviation</td>
</tr>
<tr>
<td>Weber State College</td>
<td>33.03</td>
<td>± 8.42</td>
</tr>
<tr>
<td>2-year program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University of Utah</td>
<td>31.65</td>
<td>± 8.00</td>
</tr>
<tr>
<td>Brigham Young University</td>
<td>31.32</td>
<td>± 8.48</td>
</tr>
<tr>
<td>4-year program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brigham Young University</td>
<td>30.42</td>
<td>± 8.33</td>
</tr>
<tr>
<td>2-year program</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
When a correlation of numbers of years in a nursing program was done with scores on each of the 3 scales, a slight negative correlation was found as can be seen in Table 3. The coefficients of correlation are Emotionality (-.01), Evaluative (-.02), and Anxiety (-.05). This suggests that there is a tendency for graduates of baccalaureate programs to have more positive attitudes toward death than two-year graduates, but the differences did not reach statistical significance.

Table 3

Coeficients of Correlations Between Emotionality, Evaluative, and Anxiety Scales, and Background Items for the Combined Groups

<table>
<thead>
<tr>
<th></th>
<th>Emotionality</th>
<th>Evaluative</th>
<th>Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.04</td>
<td>.06</td>
<td>-.01</td>
</tr>
<tr>
<td>Marital Status</td>
<td>.02</td>
<td>.04</td>
<td>.10**</td>
</tr>
<tr>
<td>Educational Degree</td>
<td>-.01</td>
<td>-.02</td>
<td>-.05</td>
</tr>
<tr>
<td>Years Since Graduation</td>
<td>-.06</td>
<td>.01</td>
<td>.03</td>
</tr>
<tr>
<td>Years Worked Since Graduation</td>
<td>-.04</td>
<td>.05</td>
<td>.04</td>
</tr>
<tr>
<td>Total Work Experience</td>
<td>-.08**</td>
<td>.02</td>
<td>.02</td>
</tr>
<tr>
<td>Experience with the Critically Ill</td>
<td>-.06</td>
<td>-.01</td>
<td>-.07**</td>
</tr>
<tr>
<td>Experience with a Recent Death</td>
<td>-.02</td>
<td>.03</td>
<td>-.02</td>
</tr>
</tbody>
</table>

* p < .05 A correlation of .066 was required to reach the .05 level of probability.

** p < .01 A correlation of .093 was required to reach the .01 level of probability.

Hypothesis 2. It was hypothesized that the more recent graduates would demonstrate significantly greater Emotionality, Evaluative and Anxiety scores than nurses who had been working longer
than one year. Table 4 shows the number of people responding to the questionnaire who graduated each year between 1967 and 1971.

Table 4
Number of Subjects Who Responded According to Year Since Graduation

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1967</td>
<td>74</td>
</tr>
<tr>
<td>1968</td>
<td>101</td>
</tr>
<tr>
<td>1969</td>
<td>95</td>
</tr>
<tr>
<td>1970</td>
<td>123</td>
</tr>
<tr>
<td>1971</td>
<td>117</td>
</tr>
<tr>
<td>Total</td>
<td>510</td>
</tr>
</tbody>
</table>

Table 3 shows that there were no significant correlations between years since graduation and the Emotionality, Evaluative, and anxiety Scales. A negative correlation of \(-0.06\) was demonstrated on Emotionality. As years since graduation increased, the Emotionality scores tended to decrease.

The number of years worked since graduation was negatively correlated with Emotionality and had a coefficient of \(-0.04\). However, a significant \((p < 0.05)\) negative coefficient correlation of \(-0.08\) between total work experience and Emotionality was found. (Total work experience could have included work experience prior to
becoming a registered nurse in addition to graduation from more than one nursing program such as obtaining a baccalaureate degree in nursing after attending a 3-year school.) The results thus indicated that the longer a nurse had worked the less Emotionality was shown regarding death.

Additional general results are shown in Table 3. As age increased, Emotionality and Anxiety tended to decrease, as shown by the correlations of -.04 and -.01 respectively. On all scales, as a greater educational degree was obtained, scores on the Emotionality, Evaluative and Anxiety Scales tended to decrease (-.01, -.02, -.05 respectively). As experience with the critically ill increased, Emotionality and Evaluative correlations decreased (-.06 and -.01), with a significant (p < .05) decrease in Anxiety of -.07.

Experience with a recent death showed negative correlations of -.02 on both Emotionality and Anxiety.

A significant positive correlation of 0.10 (p < .01) was indicated between marital status and Anxiety.

In summary, with increasing age, years since graduation, years of work experience and higher educational degree, there was a slight tendency for Emotionality to decrease. Anxiety scores also had a tendency to decrease with age.

Hypothesis 3. It was hypothesized that the nurses who worked in specialty areas of intensive care, operating room, and emergency room would demonstrate significantly less Anxiety, Evaluative, and Emotionality scores than nurses working on a general floor situation.
The mean scores and standard deviations of the Emotionality, Evaluative, and Anxiety Scales were compared according to area of interest and specialty, using an analysis of variance. Table 5 presents these results including the rank order of where each subgroup scored on the scales in relation to the other subgroups. Significant variance was found only on the Anxiety Scale. Analysis of variance indicated that only on the Anxiety Scale was there a significant difference between specialty groups. By using an analysis of variance it is not possible to identify specific group differences.

The rank orders indicated that the mean scores for some subgroups, such as Group 7 (ICU, OR, Anesthesiology, RR), Group 8 (ER), Group 6, (Medicine, Surgery, General Floor) tended to fall into similar positions on all the scales. Emergency room nurses tended to be toward the lower end of the rank order positions, particularly for the Anxiety (10th) and the Emotionality (9th) Scales.

On the Emotionality Scale, psychiatric nurses scored highest (23.62 mean score), followed by pediatrics and/or neurology (23.56), then public health nurses, visiting nurses, and rehabilitation nurses (23.46 mean score), while those either not working or not specifying a specialty area showed the lowest mean score of 20.54. The highest standard deviation of ± 8.01 was indicated by those not working or indicating no specialty, followed by psychiatric nurses, ± 7.55. The lowest standard deviation, ± 3.32, was indicated by the nurses in teaching, research, and school nursing. There were, as
Table 5

N, Mean, Standard Deviations, Rank Order, Analysis of Variance, F-Ratio and Significance of Nurses According to Work Experience on Scales of Emotionality, Evaluative, and Anxiety

<table>
<thead>
<tr>
<th>Groups</th>
<th>N</th>
<th>Emotionality</th>
<th>Evaluative</th>
<th>Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Rank Order</td>
<td>S.D.</td>
<td>Mean</td>
</tr>
<tr>
<td>0 - Not working, no specialty listed</td>
<td>11</td>
<td>20.54</td>
<td>10</td>
<td>8.01</td>
</tr>
<tr>
<td>1 - Teaching, office school, camp, research, student health service</td>
<td>10</td>
<td>22.40</td>
<td>6</td>
<td>3.32</td>
</tr>
<tr>
<td>2 - Public health, rehabilitation, visiting nurses</td>
<td>13</td>
<td>23.46</td>
<td>3</td>
<td>6.07</td>
</tr>
<tr>
<td>3 - Psychiatric</td>
<td>35</td>
<td>23.62</td>
<td>1</td>
<td>7.55</td>
</tr>
<tr>
<td>4 - Obstetrics</td>
<td>103</td>
<td>22.86</td>
<td>4</td>
<td>5.51</td>
</tr>
<tr>
<td>5 - Pediatrics and/or neurology</td>
<td>62</td>
<td>23.56</td>
<td>2</td>
<td>5.66</td>
</tr>
<tr>
<td>6 - Medicine, Surgery, general floor</td>
<td>165</td>
<td>22.38</td>
<td>7</td>
<td>5.70</td>
</tr>
<tr>
<td>7 - ICU, OR, Anes. recovery room</td>
<td>93</td>
<td>22.29</td>
<td>8</td>
<td>6.46</td>
</tr>
<tr>
<td>8 - Emergency room</td>
<td>8</td>
<td>21.75</td>
<td>9</td>
<td>3.79</td>
</tr>
<tr>
<td>9 - Geriatrics, high risk nursery</td>
<td>10</td>
<td>22.5</td>
<td>5</td>
<td>4.75</td>
</tr>
</tbody>
</table>

Analysis of Variance

- F-Ratio: 0.548 (NS)
- F-Ratio: 0.315 (NS)
- F-Ratio: 2.00 (p < .05)
can be seen in Table 5, no significant differences between these specialty groups on the Emotionality Scale, or all groups were more alike than different in Emotionality.

On the Evaluative Scale, those not working had the highest mean score (28.9), and those in teaching, research, etc., had the lowest mean score (25.4). Those nurses indicating they were not working or had no specialty also showed the greatest variability, standard deviation ± 9.87, with those in teaching showing the least variability, standard deviation ± 6.45. There were no significant differences between specialty groups on this scale.

On the Anxiety Scale nurses who were working in geriatrics or high risk nurseries had the highest mean scores (35.90), followed by those in teaching, school nursing, camp nursing, etc. (35.10). The lowest scores were demonstrated by nurses working in the emergency room (24.00). The greatest variability was indicated by the geriatrics group, standard deviation ± 10.55, followed by those in teaching, school nursing and camp nursing, standard deviation ± 9.64, and those not working, standard deviation ± 9.45. The emergency room nurses had the lowest variability, standard deviation ± 4.47.

There was a significant difference (p < .05) on this scale which indicated that the Anxiety scores of the various specialty groups were more different than alike.

Hypothesis 4. It was hypothesized that the highest Emotionality, Evaluative, and Anxiety scores would occur among nurses working in pediatric settings. This hypothesis was not supported. The highest
mean scores occurred in Group 9 (Geriatrics and high risk nursery), 35.9, followed by Group 1 (teaching, office, school nursing, etc.), 35.1. Pediatric nurses ranked fourth highest on the Anxiety Scale.
CHAPTER IV
DISCUSSION

The subject of death has justifiably become a topic of concern and a source of study for many professionals from diverse disciplinary persuasions. Investigation into how various population subgroups view the subjects of death and dying has been increasing over at least the past fifteen years. The investigator was interested in this topic because of her own experiences of caring for dying patients, and of recognizing the individual differences of others in their reactions to death. These differences ran from anger, expressed by a nurse when the intravenous solution for a dying child did not drip properly, to a stunned, pale face of a relative when given the news of the death of a loved one.

Stressful periods of life are of concern to psychiatric nurses, as crisis intervention has often prevented maladaptive resolution of crises. The death of an individual involves or can precipitate an extremely stressful period for care givers as well as relatives. Therefore, the nature of nurses' attitudes and anxieties regarding death and dying was considered an area of appropriate research.

Hypothesis 1. The investigator hypothesized that there would be no significant differences between two or four year graduates in attitudes toward death. The findings of this study supported this hypothesis to the extent that the analysis of variance demonstrated
no significant difference between the two and four year graduates on the three questionnaire scales utilized to measure attitudes.

Many factors which were not controlled for in the study may have influenced this finding. No attempt was made to determine the nature of the content on death and dying given in each of the schools involved. Recent curriculum changes would not be reflected in the results of this study. It is also important to note that the type of clinical, practicum experiences offered in each program may vary significantly. For example, the University of Utah graduates had the highest mean scores on two of the three scales and ranked second on the Anxiety scale. Students from the University of Utah have much of their clinical experiences at the University Medical Center, where patients with complex and often critical problems are referred and treated; whereas, students from Brigham Young University generally have more community based learning experiences. The possible significance of religious influences and age at the time of graduation cannot be overlooked, but were not explored in this study. Educational differences, other than baccalaureate or associate degree, such as advanced preparation (7 nurses had master's degrees) or post graduate study were also not considered.

Forrest's (1970) study comparing attitudes of nurses and non-nurse business women, indicated that nurses tended to have attitudes toward death not significantly different from non-nurse women except in terms of the Evaluative scale. The questionnaire itself was not
designed to pick up either differences in educational preparation, or to evaluate clinical performance. Since there was a tendency for the scores on all three scales to be lower as educational degree increased, there may be significant differences which could be determined if the factors discussed above were taken into consideration.

Another way to have looked at the data would have been to determine the number of baccalaureate and associate degree nurses working in each specialty area. Differences may exist if more baccalaureate than associate degree nurses work in, for example, intensive care units.

Hypothesis 2. It was hypothesized that recent graduates (less than one year of experience) would demonstrate significantly greater Emotionality, Evaluative, and Anxiety scores than nurses who had been working longer than one year. No significant correlations on this variable were demonstrated by this study, thus the hypothesis was not supported. Rather than the length of time since graduation, marital status seemed to have more influence on the degree of Anxiety. Those nurses who were married demonstrated significantly higher Anxiety scores than nurses who were not married (see Table 3). A possible explanation for this finding might be that married nurses may have formed closer attachments to individual persons and therefore may more closely identify with the grieving family unit than single nurses.
However, on the Emotionality Scale, some interesting trends were found. Table 3 shows negative correlations on Emotionality between years since graduation (-0.06) and years worked since graduation (-0.04). This indicated a tendency for nurses who had been out of school and working for longer periods to demonstrate less Emotionality regarding death than nurses who have been out of school for shorter periods of time. A significant negative correlation of -0.08 (p =< 0.05) was found between total work experience and Emotionality. This indicated that some older nurses may have returned to school to obtain a degree, or that total work experience had included work experience other than nursing. Since a new graduate (there were 117) was considered anyone who graduated in 1971, regardless of age or previous work experience as an R.N. or L.P.N., better criteria or definition of "new graduate" would be appropriate for a future study.

Asking for the educational background of each respondent would give additional data for determining previous diploma or licensed practical nurses returning to school for a degree, or for determining nurses who might have advanced preparation beyond the associate or baccalaureate degree.

Hypothesis 3. It was hypothesized that nurses who indicated a specialty in nursing services such as intensive care units, operating rooms, and emergency rooms would show significantly less Anxiety, Evaluative, and Emotionality scores concerning death than nurses employed in caring for patients in ward or general nursing situations.
This hypothesis was supported on the Anxiety Scale. There were no significant differences in either the Emotionality or Evaluative Scales among the nurses according to their specialty area of practice. Significant differences (p = <.05) among the means according to specialty area were found on the Anxiety Scale. Emergency room nurses (Group 8) demonstrated the lowest mean Anxiety scores, followed by those nurses who worked in teaching, office, and school nursing (Group 1). The nurses in intensive care units, operating room, recovery room, or anesthesiology (Group 7) demonstrated anxiety scores similar to the scores of nurses working in medicine, surgery, general floor duty (Group 6).

The results given in Table 3 indicated that as duration of work with the critically ill increased, Anxiety significantly decreased, (p = <.05). No information was ascertained to determine whether associate degree or baccalaureate graduates had more contact with critically ill patients. Several factors may account for these results. Perhaps experience with critically ill patients increases the likelihood of defensive operations occurring or of there being a greater acceptance of death on the part of the nurse. There were no significant correlations demonstrated on questions nine to thirteen which may suggest defensive operations operating.

The explanation supported by the findings of Glaser and Strauss (1964), which seems meaningful, is that nurses who work in emergency rooms are able to transfer patients to other areas of the hospital, thus limiting their contact with dying people. Another reason for the differences might be that nurses in emergency rooms work in a very
task and crisis oriented environment, thus cutting down patient involvement.

Although the nurses in intensive care situations demonstrated scores more closely in line with nurses working on a general floor, the mean Anxiety scores were lower than those of the floor nurses. In intensive care situations nurses learn ways of handling the dying person, such as utilizing the necessity of being heavily involved in a task oriented environment as a means of avoiding more personal concern for the patient. Thus, the nurse's concern with the technical aspects of maintaining life may serve as a defense or protection against involvement with the patient as an individual. Patients generally stay for longer periods of time on wards than in intensive care units, particularly terminally ill patients, affording nurses opportunities for greater contact with both patients and their relatives.

Hypothesis 4. It was hypothesized that the highest Anxiety, Evaluative and Emotionality scores would occur among nurses who worked in pediatrics. No significant differences between the Emotionality and Evaluative scores were found among the specialty groups. Anxiety scores, however, were high among nurses in the pediatric group, a mean of 32.33, the fourth highest. The highest mean Anxiety scores occurred among nurses who worked in geriatrics and the high risk nursery. This might be attributed to higher death rates in geriatrics and the high risk nursery areas. Another factor
contributing to these differences would be greater involvement with patients and families because of long term care and the seriousness of the illnesses of the patients in these units.

A disproportionate number of nurses listed geriatrics (N = 9) and high risk nursery (N = 1) as their areas of specialization, as compared with pediatrics and/or neurology (N = 62). Such an imbalance in the groups may account for the differences among the groups. Combining pediatrics and/or neurology as a subgroup, was arbitrary and would not constitute an adequate reflection of the amount of experiences nurses actually had with dying patients, particularly with children who were terminally ill. It was unclear from the statements made by some nurses (Group 6) whether they worked just with children or with adult neurology patients.

Moreover, the Anxiety scores ranged from 15 to 52 in the geriatric group, with the ages of the respondents ranging from 20 to 60 years. The 60 year old nurse had the score of 15, whereas the 22 year old nurse had the 52 score. On the other hand, a 20 year old nurse had a score of 40. The highest possible score was 70. The person who gave high risk nursery as her area of interest had a score of 46, and was 35 years old. Thus, age did not seem to have a direct effect on the scores in these subgroups.

Limitations of the Study. The validity of the study can be looked at in terms of the objectivity of the semantic differential test. Osgood (1957) stated that objectivity will lie with the observer rather than the observed, since only the responses of the
observed are being reported. However, how the observer interprets the results affects the objectivity. In the case of this study, the groupings according to school were probably more objective than the groupings according to area of interest and specialty. The sub-grouping in the specialty areas needs to be re-examined. For example, this investigator combined some groups and not others into the 10 areas of work and interest categories. The groupings were made according to the extent to which the investigator perceived the nurse to have contact with death and dying patients and whether the contact would be of short-term or a long-term duration. In some cases a nurse listed, for example, "pediatrics and neurology." A better categorization might have been achieved if the respondents had been asked to give more specific information on their present position, work experience, post-graduate educational level, and an estimate of their contact with death and dying patients, since years of work experience did not seem to be related to anxiety, but contact with critically ill patients did. No significant correlations were demonstrated on questions nine to thirteen, which dealt specifically with contact with dying or dead people.

The number in each specialty group varied greatly, even though there were no significant differences regarding the emotionality and Evaluative scores. For example in pediatrics, further breakdown into general floor duty or high risk nursery could have been requested on the questionnaire, thus making the results more meaningful.
Limitations of the semantic differential have particular significance for this study. Table 6 shows the lowest, neutral, or midpoint, and the highest individual scores possible for the three scales.

### Table 6

**Lowest, Neutral or Midpoint, and Highest Individual Scores Possible for the Three Scales**

<table>
<thead>
<tr>
<th></th>
<th>Emotionality</th>
<th>Evaluative</th>
<th>Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Neutral</td>
<td>24</td>
<td>32</td>
<td>40</td>
</tr>
<tr>
<td>Highest</td>
<td>42</td>
<td>56</td>
<td>70</td>
</tr>
</tbody>
</table>

When considering a group of scores on the semantic differential there is a tendency for the mean scores to fall near the neutral or mid-point; yet, the individual respondents checked the more extreme responses. For example, one respondent may have scored 6 on Emotionality, another 42, giving a mean of 24. Therefore, the mean scores may not necessarily be a valid reflection of the overall scores for either the population or for a single individual.

The results of this study indicated that the nurses tended to score within the neutral range regarding their attitudes toward death and dying, but more in the positive direction than in the negative. When looking at individual responses, the scores did not indicate that death was being viewed as a neutral process. Individual scores,
especially those in the extreme ranges, were pulled toward the neutral range in the process of taking means.

Using percentages is suggested as an alternative way to report the data. Percentages of those nurses scoring in the high-negative, neutral, and low-positive ranges would have given more information about the individual responses on each scale.

Several respondents commented that the instructions were not clear. Questions were raised as to whose death they should be imagining when they were responding, a child, an elderly person, a member of their own family, or their own. Some expressed opinions that each death is different, and hence, it could be assumed responses would have been different if the questions had been more specific. Therefore, it appears that to generalize on such a topic may result in invalid conclusions. Another approach might have been to look at the questionnaire in terms of nursing care and nurses’ attitudes toward patients who are critically ill or dying.

Two differing opinions were frequently expressed by respondents in the "comments" section of the questionnaire. One opinion was that of being glad to participate in the study, and the suggestion that more on the dying person needs to be covered in the nursing curriculum. The other opinion was that in research about people valid information cannot be obtained from questionnaires, as the topic is personal and subjective. These opinions suggested that nurses do think the subject is important, yet some nurses may continue to think of death and dying as taboo topics.
A difficulty encountered in the design of the study was the necessity of mailing questionnaires. This method of gathering information was chosen because it was time saving and also allowed participation of nurses outside the immediate vicinity. Several nurses responded from out of state as far away as New Jersey and Hawaii. There is no way of knowing how long each respondent took to answer the questionnaire, nor if each respondent conferred with someone else before answering the questions. In addition, only those who were more than likely interested in the study, returned the questionnaire. In general a very low response can be expected from questionnaires which have to be mailed. However, 65% of these questionnaires were returned which indicates a better than average return.

The results of Forrest's questionnaire survey of registered nurses and the investigator's combined group results are shown in Table 7.

Table 7

Results of Forrest's Questionnaire Survey of Registered Nurses and the Investigator's Combined Group Results

<table>
<thead>
<tr>
<th></th>
<th>Forrest's R.N.'s</th>
<th>Investigator's Combined Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>52</td>
<td>510</td>
</tr>
<tr>
<td>Age Range</td>
<td>26 to 63</td>
<td>20 to 60</td>
</tr>
<tr>
<td>Mean Age</td>
<td>44.68</td>
<td>26.69</td>
</tr>
<tr>
<td>Emotionality Mean</td>
<td>21.71</td>
<td>22.67</td>
</tr>
<tr>
<td>Evaluative Mean</td>
<td>25.23</td>
<td>27.16</td>
</tr>
<tr>
<td>Anxiety Mean</td>
<td>32.64</td>
<td>31.54</td>
</tr>
</tbody>
</table>
In both studies mean scores of slightly more positive than neutral attitudes and anxieties toward death and dying were found. This may support what both Quint (1966) and Folta (1965) suggested, that those who chose nursing as a career had in some way handled their anxieties and feelings regarding death. Kasper (1959) stated that people who chose a medical career tended to be anxious about death, but were able to conceal it from consciousness. This is not necessarily a contradiction, since concealing the anxiety from consciousness would be one way of handling it. A variety of coping mechanisms may be used to deal with anxiety toward death. Some nurses who have anxieties concerning death may choose areas of teaching, research, or office nursing in order to handle their anxiety by avoidance of areas where death may frequently occur. Another mechanism would be for a nurse to work in an area where she is more likely to encounter death with her anxiety increasing at first and then beginning to drop with increasing experience, and as coping and defensive mechanisms are utilized.

The investigator reached the following conclusions from this study:

Nurses, regardless of whether they graduated within the past five years from a four-year baccalaureate program or a two-year associate degree program, or had varying years of experience, expressed similar attitudes and anxieties toward death and dying.

Nurses in emergency room, intensive care situations, and public health, demonstrated lower anxiety toward death and dying than nurses
in other areas. As educational degree and experience with the critically ill increased, the scores on all three scales decreased. Anxiety scores were significantly higher among married nurses than among single nurses or those no longer married.

Although the mean scores of Forrest's study and the present one appear similar, statistical computation would be needed before any assumptions or comparisons could be made. Green (1954) stated, since attitudes are dynamic and changing, they are very difficult to measure. The difficulty expressed by many nurses in generalizing attitudes toward death further supported this. The nurses may also have been commenting on their own difficulty in dealing with the subjects of death and dying.

The reliability of the study lies primarily in the total number of respondents, 510. Cohen (1969) as well as others, says that as the number of respondents increases, the reliability of the results increases.

The semantic differential does have the capability for eliciting varied responses, but the results as statistically handled for this study indicated that nurses had neutral attitudes toward death. This did not appear to represent the nurses' attitudes toward death as individuals, since the results did not show how many, or what percentage of nurses regarded death negatively, neutrally, or positively. Kerlinger (1964) suggested that one difficulty in utilizing the semantic differential lies in an appropriate and relevant analysis.
The following suggestions are given for any future studies and/or work in the area of death and dying.

Hospitals could look into possible ways of reducing tension in nursing areas where there is more likely to be contact with dying patients. Faculty in schools of nursing need to recognize areas which elicit anxiety among students, and develop ways of helping students to expand their awareness and sensitivity to the emotional needs of the dying patient and his family. Explore possible ways of teaching students to cope with death and the dying patient in an attempt to see if coverage of this subject would in fact be helpful.

A further study could possibly be done, comparing a group before and after formal presentations on the dying process, in an effort to determine whether attitudes would differ after such an exposure. Some variables to consider in determining care of the dying patient might be length of time spent with the patient, and frequency of interactions with the family and patient.

Some method of coding the data so that neutral scores on each scale would be the same would give uniform meaning to looking at the scores on the three scales.

A revision of the questionnaire itself would be most helpful. The instructions could be made more specific to determine the nurses' attitudes toward dying patients.

While the subjects of death and the dying process remain relatively unexplored, they are of crucial interest to all nurses and particularly to psychiatric nurses. Not only are psychiatric
nurses in positions to alleviate the suffering of patients and assist families to deal with their conflicts and limitations, they can also apply their knowledge and skills toward helping other nursing personnel relate with dying patients in more open and interpersonally sensitive ways. Grief, loss, separation, pain, and death are meaningful human processes about which continuing research and study are needed in order to prevent needless suffering and the waste of potentially constructive nursing resources. Psychiatric nurses justifiably should be leaders in the pursuit of more knowledge into these emotionally-laden areas of death and dying, and of defining more effective means for utilizing the understandings thus gained. We must learn what attitudes work toward increasing interpersonal perceptiveness, and work toward incorporating these into nursing education programs.
REFERENCES


What man shall live and not see death? *Nursing Outlook*, 1964, 12, 23.
APPENDIX A

QUESTIONNAIRE ON THE ATTITUDES AND ANXIETIES TOWARDS DYING AND DEATH

USED BY FORREST (1970)

The following questionnaire investigates some of the reactions which people have towards dying and death. Even though most people have had experiences relating to death, very little research of this nature has been done. Your help will be greatly appreciated. You are not asked to provide your name, so that you may feel free to indicate the answer or answers to each question which most accurately reflects your personal feelings.

Dying is defined as approaching death. Death is defined as the end of life; the total and permanent cessation of all the vital functions of life.

SECTION I

INSTRUCTIONS: The following is a list of words describing death. On a scale from 1 to 7 indicate how you feel about death by circling the number corresponding to your general reaction.

| Graceful  | 1 2 3 4 5 6 7 | Awkward  |
| Peaceful  | 1 2 3 4 5 6 7 | Fearful   |
| Rational  | 1 2 3 4 5 6 7 | Emotional |
| Pleasant  | 1 2 3 4 5 6 7 | Gruesome  |
| Lenient   | 1 2 3 4 5 6 7 | Severe    |
| Friendly  | 1 2 3 4 5 6 7 | Hostile   |
| Sweet     | 1 2 3 4 5 6 7 | Bitter    |
| Hopeful   | 1 2 3 4 5 6 7 | Hopeless  |
| Fair      | 1 2 3 4 5 6 7 | Unfair    |
| Beautiful | 1 2 3 4 5 6 7 | Ugly      |
INSTRUCTIONS: On a scale from 1 to 7 indicate whether you agree or disagree. Please circle the number corresponding to your reaction to the statement.

1. I find it difficult and become upset when visiting a person who is dying.
   Agreed      1 2 3 4 5 6 7   Disagreed

2. If possible I would prefer to avoid contact with someone who is dying.
   Agreed      1 2 3 4 5 6 7   Disagreed

3. If possible I would prefer to avoid contact with someone who has a close relative or friend who is near death.
   Agreed      1 2 3 4 5 6 7   Disagreed

4. I frequently think of my own death.
   Agreed      1 2 3 4 5 6 7   Disagreed

5. I am afraid of dying.
   Agreed      1 2 3 4 5 6 7   Disagreed

6. If I contracted a fatal illness, I would want to be told that I would most likely die.
   Agreed      1 2 3 4 5 6 7   Disagreed
7. I feel adequately prepared to face my own death even if it should come today.

Agreed 1 2 3 4 5 6 7 Disagreed

8. I feel adequately prepared to face the death of a loved one.

Agreed 1 2 3 4 5 6 7 Disagreed

9. I would be willing to have a post mortem examination if deemed advisable.

Agreed 1 2 3 4 5 6 7 Disagreed

10. I would be willing to will my eyes to an eye bank or donate my heart or kidneys, etc., to someone else who might have a vital need for such an organ, at the time of my death.

Agreed 1 2 3 4 5 6 7 Disagreed

SECTION III

INSTRUCTIONS: Each of the following questions is self-explanatory.

1. Rank the following situations as to which would make you feel most anxious and which least anxious. Place the number "1" in the blank preceding the item arousing the most anxiety; number "2" for the next, etc., up to number "4" for the least.

The situation in which the person is not aware of his impending death although everyone else is.

The situation in which the person suspects that you know and tries to confirm his suspicion.

The situation in which you and the person know he is dying, but each pretends the other does not know.

The situation in which both you and the person realize he is dying and you both are relatively open in your interactions.
2. Indicate the relative importance of the following fears you may have concerning death, by placing number "1" in the blank preceding the item you fear most; number "2" for the next, etc., up to "6" for the least.

_____ I could no longer have any experiences.
_____ I am uncertain as to what might happen to me if there is a life after death.
_____ I could no longer care for my dependents.
_____ My death would cause grief to my relatives and friends.
_____ All my plans and projects would come to an end.
_____ The process of dying might be painful.

3. Indicate which of the following deaths in general would upset you most by placing a number "1" by the item you feel would upset you most and number on up to "5" for least.

_____ Death of a newborn infant
_____ Death of a child
_____ Death of a teenager or young adult
_____ Death of an adult in his prime (who may have children)
_____ Death of an elderly person

SECTION IV

INSTRUCTIONS: Choose the one best response that most accurately reflects your personal feelings.

1. In which of the following situations do you experience the greatest grief?

_____ Awaiting an impending death
_____ When first notified of a death
_____ During the funeral service in a chapel or church
_____ At the graveside service
_____ After burial whenever reminded of the person

2. If you've ever experienced losing a loved one in a hospital, how did you feel?

_____ Never had this experience
_____ Felt comforted by the doctors and nurses
_____ Felt avoided and received little support from the doctor and nurses
3. If an individual is dying and is beyond any available medical aid, is it more desirable to remove the person to a hospital or other institution, rather than have him remain at home to die?

- Yes, this is the best course
- No, death should be at home, if at all possible
- Undecided

4. Do you approve of mercy killing in cases of extreme suffering?

- Yes definitely
- No definitely
- In some cases

5. In regard to mercy killing, with which one of the following situations do you agree or approve?

- If requested by patient himself even if lethal agent self administered
- If requested by patient and if lethal agent were administered by someone other than patient such as the physician
- Only if patient to stage of no recovery and the family and physician agree
- Strongly against mercy killing of any form

6. If you met someone who had a loved one die since your last encounter with this person would you

- Mention the death
- Wait for them to mention the death
- Prefer that no mention of the death be made by either party
- Never considered this situation before, and do not feel prepared to answer one way or the other

7. How would you prefer to be treated if you were mourning?

- Be left alone with my own thoughts
- Be left with only a few people I feel closest to
- Prefer to receive expressions of sympathy from a large number of my acquaintances
- Undecided
8. Is the question of a life after death important to you?
   _____ Yes considerably
   _____ Yes at times
   _____ Sometimes
   _____ Very rarely
   _____ Never

9. Do you believe there is a life after death?
   _____ Yes, I believe strongly—feel convinced
   _____ Yes, I think so
   _____ I'm not sure one way or the other
   _____ No, I have doubts
   _____ No, I feel convinced one doesn't exist

10. If you could, would you prefer to know positively if there is or is not a life after death, or would you prefer to have it left as a matter of faith?
    _____ Know positively
    _____ Left to faith or belief
    _____ Undecided
    _____ Doesn't matter

11. If you knew positively that there were no life after death in store for you, do you think that your manner of living in the present life would be changed?
    _____ Very slight if any change
    _____ Slight change
    _____ Considerable change
    _____ Extensive change

12. Which of the following best describes your general reaction when you think most seriously about God?
    _____ Strong fear
    _____ Moderate fear
    _____ Slight fear
    _____ No fear

13. Have your religious experiences in general served to increase or to decrease fear toward your own death?
    _____ Increase fear
    _____ Decrease fear
    _____ No influence
14. Do you feel that religious observance by the living can somehow benefit the state of those already dead?
   _____ Yes
   _____ No
   _____ Don't know

15. Do you have a strong wish to live after death?
   _____ Yes
   _____ No
   _____ Undecided

16. Have funeral arrangements for those now living been discussed in your family?
   _____ Yes
   _____ No
   _____ Don't know

17. If a relative of yours were dying would you approve or disapprove of the doctor maintaining life by all scientific means available even if there were no hope left in saving the person's life?
   _____ Approve
   _____ Disapprove

SECTION IV

BACKGROUND INFORMATION

1. Sex

2. Age

3. Married
   Single
   Divorced
   Separated
   Widowed

4. Religious affiliation
5. Religion plays a: (check one below)
   Great part in my life___________
   Moderate part_________________ 
   Minimal part__________________

6. Number of children, if any________

7. Number of children lost through death (List whether a son or daughter and age at time of death)

8. How would you describe your health history:
   ______ Excellent
   ______ Generally Good
   ______ Average
   ______ Poor

9. Occupation_________________ Years of experience___________

10. Highest educational degree you hold________________________
    If you are a registered nurse list the type of program or programs from which you graduated____________________________
    If you are a registered nurse also list your major area of interest and specialty in nursing__________________________

11. Have you ever cared for critically ill persons either in a hospital or at home?
    ______ Many times
    ______ A few times
    ______ Never

12. Did you lose an important person in you life while growing up, such as a parent? If so, give the relationship and your age at the time__________________________

13. Have you recently experienced the death of a relative, friend, or loved one? (Please comment):
14. Give the approximate number of times you have actually seen a dead body before preparation by a mortician and after as in a funeral home.

15. Give the approximate number of people you have seen who could be classified as dying and the number of deaths you have witnessed.

16. In your past experiences, at what age do you recall having the greatest fear of death?

- 1 to 3 years of age
- 4 to 6
- 7 to 10
- 11 to 13
- 14 to 16
- 17 to 21
- 22 to 30
- 31 to 40
- 41 to 50
- 51 to 60
- Over 60

Fears of death not specific to any age, have remained unchanged

No fears of death can be recalled

Any comments

Permission to use portions of this questionnaire was given by Dr. Jeannette R. Folta, Department of Psychiatry, College of Medicine, University of Vermont, and Mrs. JoAnn F. Forrest, San Antonio, Texas.
APPENDIX B

LETTER AND QUESTIONNAIRE USED

BY THE INVESTIGATOR

2235 East 21st South
Salt Lake City, Utah 84109
October, 1971

Dear

Nurses have always been concerned with providing the best possible care for the dying patient. Most of us consider this to be one of our most difficult tasks. I am studying attitudes of nurses toward death and dying as part of my graduate work in nursing at the University of Utah. The study should have implications for curriculum change and for in-service programs for nurses. Your assistance is needed and will be greatly appreciated.

Enclosed is a short questionnaire along with a stamped, self-addressed envelope. Please fill out the questionnaire and return it to me as soon as possible, preferably within 48 hours. Your first impression is the most valuable response and the questionnaire can be completed easily in ten minutes.

Also enclosed is a 3x4 card. If you would like a copy of the abstract containing the results of this study upon completion, please write your name and address on the card, and include it when returning the questionnaire.

Thank you for your help and participation.

Yours truly

Mary N. Seegmiller, R.N.

Encl.
QUESTIONNAIRE ON DEATH
FROM THE NURSE'S STANDPOINT

The following questionnaire investigates some of the reactions which people have towards dying and death. Even though most people have had experiences relating to death, very little research of this nature has been done. Your help will be greatly appreciated. You are asked to indicate the answer or answers to each question which most accurately reflects your personal feelings.

Dying is defined as approaching death. Death is defined as the end of life; the total and permanent cessation of all the vital functions of life.

SECTION I

INSTRUCTIONS: The following is a list of words describing death. On a scale from 1 to 7 indicate how you feel about death by circling the number corresponding to your general reaction.

Graceful 1 2 3 4 5 6 7 Awkward
Peaceful 1 2 3 4 5 6 7 Fearful
Rational 1 2 3 4 5 6 7 Emotional
Pleasant 1 2 3 4 5 6 7 Gruesome
Lenient 1 2 3 4 5 6 7 Severe
Friendly 1 2 3 4 5 6 7 Hostile
Sweet 1 2 3 4 5 6 7 Bitter
Hopeful 1 2 3 4 5 6 7 Hopeless
Fair 1 2 3 4 5 6 7 Unfair
Beautiful 1 2 3 4 5 6 7 Ugly
Non-cruel 1 2 3 4 5 6 7 Cruel
SECTION II

INSTRUCTION: On a scale from 1 to 7 indicate whether you agree or disagree. Please circle the number corresponding to your reaction to the statement.

1. I find it difficult and become upset when visiting a person who is dying.
   Agree 1 2 3 4 5 6 7 Disagree

2. If possible I would prefer to avoid contact with someone who is dying.
   Agree 1 2 3 4 5 6 7 Disagree

3. If possible I would prefer to avoid contact with someone who has a close relative or friend who is near death.
   Agree 1 2 3 4 5 6 7 Disagree

4. I frequently think of my own death.
   Agree 1 2 3 4 5 6 7 Disagree

5. I am afraid of dying.
   Agree 1 2 3 4 5 6 7 Disagree

6. If I contracted a fatal illness, I would want to be told that I would most likely die.
   Agree 1 2 3 4 5 6 7 Disagree

7. I feel adequately prepared to face my own death, even if it should come today.
   Agree 1 2 3 4 5 6 7 Disagree

8. I feel adequately prepared to face the death of a loved one.
   Agree 1 2 3 4 5 6 7 Disagree
9. I would be willing to have a post mortem examination if deemed advisable.
   Agree 1 2 3 4 5 6 7 Disagree

10. I would be willing to will my eyes to an eye bank or donate my heart or kidneys, etc., to someone else who might have a vital need for such an organ, at the time of my death.
   Agree 1 2 3 4 5 6 7 Disagree

SECTION III
BACKGROUND INFORMATION

1. Sex

2. Age

3. Single
   Married
   Separated
   Divorced
   Widowed

4. Religious affiliation

5. Occupation. Years of Experience

6. Highest educational degree you hold
   Year of graduation
   List your major area of interest and specialty in nursing

7. Have you ever cared for critically ill persons either in a hospital or at home?
   Many times
   A few times
   Never

8. Have you recently experienced the death of a relative, friend, or loved one? (Please comment)

9. How long have you worked in your present area of nursing?

10. What area did you work in prior to the present one?
   How long?
11. Give the approximate number of times you have actually seen a dead body before preparation by a mortician.

0 1-5 6-10 11 or more

Give the approximate number of times you have actually seen a dead body after preparation as in a funeral home.

0 1-5 6-10 11 or more

12. Give the approximate number of people you have seen who could be classified as dying.

0 1-5 6-10 11 or more

13. Give the approximate number of deaths you have witnessed.

0 1-5 6-10 11 or more

Any comments:
VITA

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