A STUDY OF ATTITUDES OF FRESHMEN AND SENIOR DIPLOMA NURSING STUDENTS TOWARD DEATH

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by

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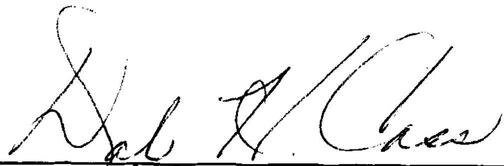

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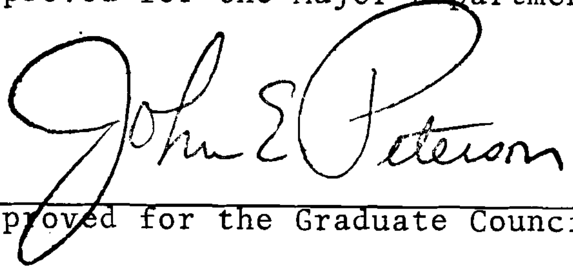

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TABLE OF CONTENTS

	Page
ACKNOWLEDGMENTS	iii
LIST OF TABLES	vi
Chapter	
1. THE PROBLEM, DEFINITIONS OF TERMS USED, AND LIMITATIONS OF THE STUDY	1
INTRODUCTION	1
THE PROBLEM	1
Statement of Problem	2
Statement of Hypothesis	2
Purpose of Study	2
DEFINITION OF TERMS	3
LIMITATIONS OF STUDY	3
2. REVIEW OF RELATED LITERATURE	5
FEAR OF DEATH	5
LACK OF PREPARATION	9
ATTITUDES TOWARD DEATH	12
REMEDIAL MEASURES	19
3. METHOD OF PROCEDURE	26
INTRODUCTION	26

Chapter Page

STUDY DESIGN 26

Questionnaire 26

Population Sample 27

Administration 29

Statistical Technique 29

4. ANALYSIS OF DATA 30

INTRODUCTION 30

ANALYSIS 30

5. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS 41

SUMMARY 41

CONCLUSIONS 42

RECOMMENDATIONS 44

BIBLIOGRAPHY 46

APPENDIX 49

LIST OF TABLES

Table		Page
1.	Classification of Freshmen Student Nurses According to Social Factors	28
2.	Classification of Senior Student Nurses According to Social Factors	29
3.	Attitudes Toward Psychological Influence Affecting Death	31
4.	Senior-Freshmen Comparison	32
5.	Attitudes Toward Knowledge of Terminal Illness	33
6.	Senior-Freshmen Comparison	33
7.	Attitudes Toward Autopsy	34
8.	Senior-Freshmen Comparison	35
9.	Attitudes Toward Suicide Prevention	36
10.	Senior-Freshmen Comparison	37
11.	Attitudes Toward Life Maintenance	37
12.	Senior-Freshmen Comparison	38
13.	Attitudes Toward Heart Transplants	39
14.	Senior-Freshmen Comparison	39

Chapter 1

THE PROBLEM, DEFINITIONS OF TERMS USED, AND LIMITATIONS OF THE STUDY

I. INTRODUCTION

Death is one of the most universal and inescapable fears of mankind. This fear provides the basic motivation of much human behavior, both normal and abnormal.

Folck and Nie have stated that American society today has little understanding of the process of death or its effect upon human behavior and, tragically, this applies to the professional nurse who is frequently exposed to the physical and emotional stress of death.[1]

Preparation of the nurse to cope with the problems and fears of the dying patient and his family should be one of the major goals of a nursing curriculum.

II. THE PROBLEM

In the preparation of a graduate nurse who can function effectively with the terminal patient and his

[1]M. M. Folck and P. J. Nie, "Nursing Students Learn to Face Death," *Nursing Outlook*, September, 1959, p. 510.

family, a nursing school must cope with the many psychological, social, and cultural factors associated with death.

Each individual nurse enters the school with preconceived attitudes, a development of the childhood socialization process, which influence the acceptance of nursing theory and clinical experience. Since the attitude toward death is largely based upon fear and is well developed by young adulthood, it is important that a nursing school identify preconceived attitudes of new students toward death and compare them with the attitudes of experienced students. This comparison could then serve the school as a tool for further course development, faculty in-service education, and curriculum evaluation in terminal care nursing.

Statement of the Problem

Is there a significant difference in the attitudes of freshmen and senior diploma nursing students toward death?

Statement of the Hypothesis

There is no significant difference in the attitudes of freshmen and senior diploma nursing students toward death.

Purpose of the Study

The purpose of this study was to discover any

differences in attitudes toward death between freshmen and senior diploma nursing students.

III. DEFINITION OF TERMS

To assure unity of thought, the following terms are defined.

Death. This is the permanent cessation of all vital functions of the body.

Thanatophobia. A morbid fear of death which is characterized by obsessions and compulsions which are designed to protect the individual.

Freshman. A student nurse in the first year of study in the diploma nursing program at Newman Hospital School of Nursing.

Senior. A student nurse in the third year of study in the diploma nursing program at Newman Hospital School of Nursing.

Questionnaire. Questions on death developed by Shneidman and others which were first published in *Psychology Today*.[2]

IV. LIMITATIONS OF STUDY

Limitations placed on this study included: The

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[2]E. Shneidman, E. Parker, and G. R. Funkhouser, "You and Death," *Psychology Today*, August, 1970, p. 67.

population was limited to freshmen and senior diploma nursing students attending Newman Hospital School of Nursing between May, 1972, and June, 1973. This is a biased population because of the homogeneity of the students in age, sex, geographic origin, religion, and stated motivation for entering nursing. There was no random sampling because of the small size of the population.

The questionnaire which was published in Psychology Today was biased, inasmuch as the population reflected was one of people with psychological interests. No reliability or validity statistics were available for the questionnaire and some questions were omitted in the reported information. Only the six items from the questionnaire deemed pertinent to nursing were used for this study.

Chapter 2

REVIEW OF RELATED LITERATURE

Death is inevitable and comes to everyone, yet so little is known about it that man can only fear it. This fear has been present down through the ages. It has been documented in religious beliefs, burial rites, language development, and social customs of ancient and modern man. Today, death has been termed a taboo subject by many social scientists in America.[1] Shneidman, however, disagreed. He termed the Western world today the most death-oriented since the "Days of the Black Plague in the fourteenth century."[2] His statement was based, in part, on the intense interest exhibited by college students at Harvard in his course on death.

I. FEAR OF DEATH

Wahl explored the fear of death by hypothesizing that man has been able to manipulate his environment so well through the use of his mind that he has ceased to fear hunger and many of the dangers of the past, but all this

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[1]Thomas Powers, "Learning to Die," Harper's, June, 1971, p. 72.

[2]Edwin S. Shneidman, "The Enemy," Psychology Today, August, 1970, p. 37.

scientific inquiry has not altered the state or inevitability of death. Man, therefore, resorts to magical thinking and irrationality to handle his fears and anxiety.[3]

Wahl documented the need for psychiatric study in a field which includes magical and delusional thinking as defense mechanisms and ultimately affects the emotional health of individuals and societies.[4]

The sources Wahl would use in the study of the fear of death include the individual, the field of psychopathology, dreams or the unconscious, and the child. He felt that the child was the best source, for thanatophobia can be found as early as at three years of age.

Thanatophobia appears contiguously with the ". . . development of concept formation and the formation of guilt, both of which greatly antedate the Oedipus formation."[5] It is associated with types of intrafamilial stress which include frustration, anxiety, rage, or a sense of parental loss.

The child's concept of death varies according to age. From one to four years of age, there is an inability to perceive cause and effect. The child is omnipotent, he controls his environment by his wishes; therefore, death is

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[3]C. W. Wahl, "The Fear of Death," <u>The Meaning of Death</u>, ed. Herman Feifel (New York: McGraw-Hill Book Co., 1959), p. 17.

[4]Ibid., p. 19.

[5]Ibid., p. 21.

reversible, a mere banishment. This omnipotence gradually modifies as gratification is withheld; but, this sense of omnipotence is very important in the psychosocial development of the adult, for the feelings of security and adequacy are dependent upon it. Omnipotence develops only in the loved, secure child and is not found in a child from a nonsuccorent environment.[6]

This omnipotent concept allows the average adult to handle the anxiety of death with the equanimity attributed by Wahl to the psalmist David. "A thousand shall fall at thy right hand and ten thousand at thy left, but it shall not come nigh thee."[7] It can also act to produce guilt for the child, for as his sense of time develops, death becomes nonreversible and he must take responsibility for his magical, destructive thoughts. He becomes frightened for his ambivalently loved persons and self and resorts to magical words, rites, and spells. An example is the obsessive blessing of persons in a thanatophobic child's prayers.[8]

In addition to the above concept, the child will

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[6]C. W. Wahl, "The Fear of Death," The Meaning of Death, ed. Herman Feifel (New York: McGraw-Hill Book Co., 1959), p. 22.

[7]Ibid., p. 23.

[8]Ibid., p. 24.

view parental death or separation as a deliberate abandonment for which he was responsible.[9]

Hinton disagreed slightly with Wahl as to the age when anxiety and fear of death begins for a child. From five years to nine years of age most children develop their concept of death, ". . . as a person or some pale, perhaps frightening, figure."[10]

Kubler-Ross agreed closely with Wahl on the mechanisms of the unconscious, that to the unconscious, death is never possible in regard to oneself. It is always caused, ". . . it is inconceivable to die of a natural cause or of old age. Therefore, death in itself, is associated with a bad act, . . . something that calls for retribution and punishment."[11]

Secondly, the unconscious does not distinguish between a wish and a deed. People still believe in the Law of Talion (to think a thing is to do that thing: to do a thing is to ensure an equal and similar punishment to the self)."[12]

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[9]Ibid., p. 25.

[10]John Hinton, Dying, (Baltimore: Penguin Books, 1967), p. 22.

[11]Elizabeth Kubler-Ross, On Death and Dying, (New York: MacMillan Company, 1969), p. 3.

[12]Wahl, op. cit., p. 24.

This law is the basis of many death customs, the ashes smeared on the body, torn clothing, and the veil. It is an attempt at self-punishment to reduce the guilt felt by the bereaved, for the guilt contains anger, the child's reaction to abandonment.

To Kubler-Ross, the emotions caused by death have not changed during time's passage. "What has changed is our way of coping and dealing with death and dying, and our dying patients."[13]

She decried the practices of denial of death which have evolved; of making the dead look merely asleep, of preventing children from visiting dying relatives in the hospitals, and of the debates which center on whether to tell the patient the truth. Death, to her, has become more mechanized, dehumanized, "More gruesome."[14] ". . . the patient is suffering more--not physically, perhaps, but emotionally. And his needs have not changed over the centuries, only our ability to gratify them."[15]

II. LACK OF PREPARATION

Quint stated that the young people of today are exposed to the paradox of increased violence and death from

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[13]Kubler-Ross, op. cit., p. 4.

[14]Ibid., p. 7.

[15]Ibid., p. 9.

television and movies, but lack the opportunity to actually participate in the preparation for death at home and the mourning rituals which were common to society fifty years ago.

> Close personal encounters with dying are no longer commonplace during the growing-up process. Unlike those who entered medicine and nursing at the turn of the century, young people entering these fields today have little personal experience with death. Yet they have chosen occupations which carry a direct responsibility for protecting the populace from death for as long as possible.[16]

A six-year research program begun in 1961, financed by the National Institute of Health, Nursing Research Branch, and titled, "Hospital Personnel, Nursing Care and Dying Patients," has given much insight on the interaction of the dying patient and the hospital staff. It has especially described decisions and emotional problems of nurses confronted with working with the dying.[17] The study provided material for four books on death by the research team of Glaser, Strauss, and Quint.

The research team's interviews with newly graduated nurses indicated that preparation for care of the dying in nursing schools, varied from no or little experience, up through multiple, prolonged contact, sometimes highly traumatic. There was little advance planning by the school and

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[16] Jeanne C. Quint, *The Nurse and the Dying Patient*, (New York: MacMillan Co., 1967), p. 2.

[17] Ibid., p. 3.

more time was spent teaching items for which nurses are held morally and legally accountable. Very little time was spent preparing the nurse for interaction with the dying patient and his family.[18]

Wagner, in her discussion of the lack of preparation of nursing students to cope with death, cited a book published in 1908. One brief paragraph pertained to the care of the dying and dead. ". . . the nurse should first notify the physician if he happens to be not present. Then she should gently lead the family from the room in order to cleanse the body and put the room in order."[19] Wagner felt that the nursing profession had done little since that time to expand the concepts and skills related to nursing and care of the dying.

To document the lack of emphasis the nursing profession placed on terminal nursing care prior to the last few years, the *American Journal of Nursing*, the official publication of the nursing profession, was surveyed for articles on death from the years 1947 to 1970. From January, 1947, to December, 1959, there appeared five articles, one excerpt, one book review, and two comments on the

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[18]Jeanne Quint and Anselm Strauss, "Nursing Students, Assignments, and Dying Patients," *Nursing Outlook*, January, 1964, p. 24.

[19]Bernice Wagner, "Teaching Students to Work with the Dying," *American Journal of Nursing*, November, 1964, p. 128.

subject of death. The next five years produced eight articles and one abstract. However, from 1966 through 1970, there appeared eighteen articles, two abstracts, six book reviews, one comment, and one code on transplantation.

III. ATTITUDES TOWARD DEATH

In planning a major curriculum change for terminal nursing care, a factor for consideration should be the attitudes toward death of the nursing student and what variance there might be from the nursing professional.

Folta explored the attitudes of nursing personnel through the use of three attitude scales; perception, anxiety, and religion. Four hundred twenty-six nursing personnel in three different types of hospitals were tested, but no significant differences were found in the perception of death between hospitals or positions within the hospitals.

"Adjectives appeared to suggest that death was perceived by at least one-half of the study population as a natural and even positive phenomenon."[20]

Analysis of the religious scale placed eighty-nine persons toward the sacred end of the continuum, one hundred eleven persons at midpoint, and two hundred five

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[20]Jeannette Folta, "The Perception of Death," Nursing Research, Summer, 1965, p. 232.

persons toward the secular end of the continuum. Again, there were no significant differences between hospitals or position.

The anxiety scale registered a fairly high degree of anxiety about death for the greatest proportion of the population. There was a significant chi-square relationship ($p < .01$) between the level of anxiety and the nursing position.[21]

The staff nurse position showed the greatest percentage of high anxiety, followed closely by the licensed practical nurse position. Administrative positions were followed percentage-wise by the attendant position which showed the lowest percentage of high anxiety.

Position	Percentage
Administrative nurse	31.2
Staff nurse	49.4
Practical nurse	38.5
Attendant	25.5[22]

Folta explained the high anxiety rate for the staff nurse and the practical nurse as due to the close patient contact. This explanation would not be true for the attendant position, however, for this position frequently has the highest patient-contact hours. Perhaps the stress of responsibility for the patient would weight the anxiety level more than the patient-contact hours.

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[21]Ibid., p. 235.

[22]Ibid.

The high degree of anxiety within the population was explained by Folta as 1) a human characteristic toward death, and 2) individuals with a great deal of anxiety about death tend to go into the "healing professions."[23]

Kasper stated his belief about the high anxiety of the "healing profession":

> It is somehow an improbable notion that a doctor should die. . . . The challenge, 'Physician, heal thyself,' is also a hint at what is possible for a physician. Here we glimpse part of the psychological motivation of the doctor to cure himself, to live forever.[24]

Feifel agreed: ". . . some physicians often reject the dying patient because he reactivates or arouses his own fears about dying . . ."[25]

Folta's data showed that most nursing personnel view death as "A peaceful, controlled, predictable, and common phenomenon. A natural termination of the life process,"[26] but with a high degree of anxiety manifested. These apparent contradictory findings were explained as:

> The semantic factors are measuring death--the abstract concept, while the anxiety scale is measuring death--the personal threat, and the sacred-secular

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[23]Ibid.

[24]August Kasper, "The Doctor and Death," The Meaning of Death, p. 260.

[25]Feifel, The Meaning of Death, p. 122.

[26]Folta, op. cit., p. 235.

> scale is measuring death--a metaphysical phenomenon registering either the end or the beginning.[27]

Patrylow correlated the relationship of attitudes toward death and dominant values of one hundred forty-seven senior associate degree nurses in an eastern metropolitan area in her study. Studies by Smith[28] and Redden and Scales[29] show nurses almost always have dominant religious and social values; therefore, Patrylow hypothesized that:

> Those with dominance of person-oriented values (religious and/or social) have more positive attitudes toward caring for the dying than do those with nonperson-oriented values (theoretical, economic, aesthetic, and/or political)."[30]

She used the Allport, Vernon, and Lindzey, "Study of Values" to determine dominant values while a scale was constructed, "Attitudes Toward Caring for the Dying," to measure the attitudes toward death. A personal data sheet gave information on religious affiliation, education, and previous experience in working with the dying.

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[27]Ibid.

[28]Jeanne Smith, "Personality Structure in Beginning Nursing Students: A Factor Analytic Study," _Nursing Research_, Spring, 1968, p. 143.

[29]J. W. Redden and E. E. Scales, "Nursing Education and Personality Characteristics," _Nursing Research_, Fall, 1961, p. 217.

[30]Sarah Patrylow, "The Relation of the Dominant Values of Senior Associate Degree Nursing Students to Their Attitudes Toward Caring for the Dying," New York University (Microfilms Co. microfilm copy).

The hypothesis which was accepted as correct for the conclusions showed:

> 1. Individuals who show dominance of person-oriented values have more positive attitudes toward caring for the dying than do those with dominance of nonperson-oriented values.
> 2. Among the nursing students in the sample the mean scores of values from most dominant to least dominant were: social, religious, aesthetic, theoretical, political, and economic.
> 3. Those that state their religious preference as Catholic have more positive attitudes toward caring for the dying than do those who stated other religious preferences.
> 4. Those who give clear answers to questions about their experience with death have more positive attitudes toward caring for the dying than do those who give no answer or an unclear answer.[31]

Another finding of interest was a shift from dominant religious values to dominant social values in the population. Explanations for this shift of attitude were that the self-sacrificing service image of the nurse may have changed or that religion in our culture is "assuming a more social form."[32]

Golub and Reznikoff's study compared the attitudes toward death of eighty-two graduate nurses and seventy associate degree and diploma nursing students from the New York, New Jersey metropolitan area to support the hypothesis that the nurse's professional education and experience influence attitudes toward death.[33]

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[31]Ibid., p. 102. [32]Ibid., p. 84.

[33]Sharon Golub and Marvin Reznikoff, "Attitudes Toward Death," Nursing Research, November-December, 1971, p. 503.

The questionnaire, prepared by Shneidman, Parker and Funkhouser[34] which appeared in Psychology Today, was used to sample childhood experiences, attitudes toward funeral rites, suicide, medical treatment of the dying, and concepts concerning death as religion, philosophy, fears, and expectations of one's own death. Only six items which the authors considered pertinent to nursing experience and practice were used.

Using a χ^2 comparison of graduate and student answers on psychological factors affecting death, there was a significant difference beyond the ($\rho < .05$). Graduates were much more positive in their belief of the influence of psychological factors influencing death.

Responses toward being told of a terminal illness were very similar between the students and graduates, but the graduates were much more positive toward having an autopsy done than the students who indicated they didn't care either way. Both groups favored suicide prevention but the students were more positive that there should be no exceptions to suicide prevention. Efforts to maintain life through reasonable care and effort were afforded positive attitudes by both groups, but there was a significant difference ($\rho < .01$) between students who favored "All possible

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[34]Shneidman, Parker, and Funkhouser, op. cit., p. 67.

effort" and graduates who were more likely to favor "Reasonable efforts." There was marked similarity between the groups on the attitudes toward heart transplants.

The graduate group responses were further categorized according to age, nursing specialty, experience and education. It was felt that psychiatric principles and further education were factors which would influence the differences between students, graduates, and the graduate nurse with over twenty years of experience.

The uniformity of attitudes of students and graduates toward knowledge of terminal illness was consistent with the studies of Kubler-Ross,[35] and Quint.[36] The differences in attitudes toward autopsy were thought to be due to peer professional pressure. It was speculated that the students' attitudes toward suicide prevention would change after having psychiatric nursing experience.

The students' attitude toward preservation of life was thought to reflect the general value system of American society or to be a defensive response while the graduates' attitude was thought to reflect concern for the moral and ethical considerations of the question.

Since the attitudes toward heart transplantation

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[35]Kubler-Ross, op. cit., p. 25.

[36]Quint, op. cit., p. 171.

were very similar, they were thought to be an accepted cultural attitude for an altruistic group.

The surprise finding of the study was the lack of difference among the nursing specialty groups. The amount of contact with the dying patient was not a major determining factor of attitude. It was thought that attitude change was the result of the identification process with the role model, the professional nurse.[37]

IV. REMEDIAL MEASURES

In 1959, Folck and Nie appear to have been leaders in discussing how to help student nurses cope with problems associated with death. At the University of California at Los Angeles School of Nursing, the course on death was placed in the maternal-child nursing course. Four hours were devoted to this subject; a two hour panel discussion involved a Jewish rabbi, a Catholic priest, a Protestant minister, and two sociologists. They helped the students see how people react to death according to individual philosophy, religious beliefs, cultural patterns and social mores. A psychiatrist spent one hour explaining the dynamics of human behavior when confronted with death, and the final hour was a summation by the nurse faculty member.[38]

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[37]Golub and Reznikoff, op. cit., p. 508.

[38]Folck and Nie, op. cit., p. 510.

Wagner reported on the efforts of the University of Kansas in teaching terminal care. Their program was based on five assumptions: (1) since most people die in a hospital, the student should be able to meet their needs; (2) the nurse must learn to identify and cope with the extreme emotions generated by death; (3) feelings of unpleasantness and fear ease as the student becomes better prepared; (4) insight and skills develop through prolonged but intermittent contact with terminal nursing care; and (5) skills develop most fully when the student takes responsibility for her own learning.[39]

Initially, an exploration of the literature was conducted by each student. After presentation of each paper, classroom discussion was held. These discussions were spaced in order to make the students more comfortable. Questions discussed included: (1) the charge that the American concept of death is immature; (2) effects of cultural conditioning on acceptance of death; (3) a child's concept of death; (4) how to help parents cope with a dying child; (5) how to detect subtle pleas for help from the patient and family; (6) what the physical and interpersonal environment may mean to a patient and family; (7) euthanasia and use of extreme measures; and (8) nonverbal communication with the

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[39]Wagner, op. cit., p. 129.

terminally ill. The discussions were deemed the most helpful to the students.[40]

Only two students out of sixty-four responded negatively to the course of study when the evaluation was finished. Clinical evaluation of the students through faculty observation varied from satisfaction to admiration of the nursing care.[41]

Watson, in her work with junior students of the University of Wyoming, introduced death content during the medical-surgical-pediatric nursing, an integrated course.

The students were asked to write their personal philosophy and to conduct library research on one of the following topics:

1. Cultural patterns of reaction to death.
2. Sociological approach to death.
3. Religious beliefs about death.
    a. Catholic
    b. Judaic
    c. Protestant
    d. Other
4. Children's attitudes toward death of self.
5. Children's interpretations and response to death of others.
6. Literary representation of death.
    a. Socrates
    b. Dante
    c. Tolstoi
    d. Others
7. Legal implications in death.

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[40]Ibid., p. 130.

[41]Ibid., p. 131.

8. Your definition of life--when does it cease, and how will it be defined in the future."[42]

Class discussion of the research and a soliloquy on the inner world of a newly bereaved person were conducted. The students were then divided into small discussion groups for twenty minutes according to the topic each student had researched. Each group was to identify and plan for providing nursing care to a terminally ill patient. Much discussion, role-playing, and exchange of ideas took place.

The second semester, a review of literature was again carried out and personal questions on death were submitted by the students. A panel consisting of a psychiatric social worker, a psychiatrist, an attorney, a physician, a Jewish rabbi, a Protestant minister, and a Catholic priest discussed topics which included: (1) the reasons for hostility from the bereaved; (2) reasons for refusal to view body; (3) question of whether it is a "sin" to wish death for a lingering, painful, dying patient; (4) religious viewpoint on telling the patient the truth; (5) whether people know they are dying; (6) is there a way to openly talk about death to the dying; (7) the difficulty of accepting a child's death in this culture as opposed to others; (8) question of responsibility of securing spiritual aid without the family's permission; (9) guidelines for accepting

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[42]M. Watson, "Death--A Necessary Concern for Nurses," <u>Nursing Outlook</u>, February, 1968, p. 47.

one's own death; and (10) the right to life of "vegetables."

The questions, for the most part, were unanswerable except in an individual's own frame of reference, but did show the feeling, fear, and concern of the students about death.[43]

Quint and Strauss identified the factors in a school of nursing which affect a student's attitude and performance of nursing care for a terminally ill patient.[44]

Instructors are influential because they determine a student's assignment; however, they are often unaware of the secondary effects resulting from assignments. The instructor will usually try to fulfill a course objective such as the performance of a procedure and will overlook the interaction of student and patient or the identification of interpersonal problems. The assignment system influences when and how a student meets a terminal patient.

The rotation pattern of a school involves how a student progresses through the theoretical and clinical courses in a school. The variance of time in one particular locale will influence the amount of experience a student will receive in giving terminal nursing care, as the various

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[43]Ibid., p. 48.

[44]Quint and Strauss, op. cit., p. 20.

clinical areas work with the problems of death in varying proportions. A rotation plan can, therefore, either protect a student from dying patients or expose her to prolonged contact.

A rotation change results in new faculty with different expectations of the student. Continuity for the student is lost. Another difficulty is planning a terminal nursing care assignment which gives the student needed learning and yet protects her from a "nightmare" experience.[45]

For death to be a traumatic experience for the student, eleven factors must be present in varying amounts or combinations: (1) a personal sense of inadequacy, immobilization, or negligence, (self-concern); (2) an assignment for which she was not ready, (instructor blame); (3) personal involvement with patient and family, (prolonged contact); (4) involvement with the patient's story, (his high social value); (5) disillusionment with medical and nursing practices; (6) personal association with the patient; (7) an unforgettable sight, a horrible way of dying; (8) an unexpected event; (9) a dislike for the patient; (10) direct accusation of negligence; and (11) a sense of having been left alone.[46]

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[45]Ibid., p. 24.

[46]Ibid., p. 27.

The last factors identified were the need for faculty preparation and change in curriculum focus. The faculty must foresee the problems which a student will encounter and initiate support before help is needed. Consistent supervision and guidance must be made available to instructors who counsel and work with students and terminally ill patients.

Finally, curriculum objectives must be changed to emphasize the care of the terminally ill patient as a major nursing task in order to benefit and protect the nursing students.[47]

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[47] Ibid.

Chapter 3

METHOD OF PROCEDURE

I. INTRODUCTION

Information included within this chapter consists of published facts on the questionnaire, population sample, personal information on each class, administration procedure, method of analysis, and statistical tests used.

II. STUDY DESIGN

Questionnaire

The questionnaire, "You and Death," designed by Shneidman in conjunction with Parker and Funkhouser of Stanford University, was used to elicit attitudes toward death.[1] This questionnaire is a modification of a prior questionnaire developed at Harvard under Shneidman's direction and was designed to obtain information about childhood experiences and attitudes toward death, factors such as books or religions which have shaped attitudes, and personal feelings toward death, funerals, autopsies, suicide, euthanasia, and afterlife. Self-evaluation of physical and

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[1]Shneidman, Parker, and Funkhouser, op. cit., p. 67.

mental health, religious and political viewpoints, and an estimation of longevity were elicited. Personal information such as race, sex, age, geographical origin, socioeconomic level, marital status, and occupation were also asked.

Over 30,000 readers of Psychology Today responded to the questionnaire and a composite profile was made from their answers. The typical respondent was a "20 to 24 year old, single Caucasian, ("somewhat religious") Protestant, politically independent ("somewhat liberal") female." She was a college graduate, earned between $10,000 and $15,000 a year, lived in the Midwest, and came from a small family (one sibling). She was in "very good" (but not "excellent") physical and mental health, and she indicated that there was little probability of committing suicide.[2]

Population Sample

The sample for this study was four classes of student nurses attending Newman Hospital School of Nursing between May 1, 1972, and June 17, 1973. These four classes were comprised of two senior classes containing forty-one females and two males, and two freshmen classes of fifty-three females and five males. There was no random sampling because of the small total population.

The majority of the freshmen student nurse respon-

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[2]Edwin Shneidman, "You and Death," Psychology Today, June, 1971, p. 44.

dents had a personal profile very similar to the Psychology Today's composite profile, while the majority of the graduating seniors varied from the profile by being more moderate politically and lower socioeconomically. The two males in this class were Vietnam veterans, one with front-line receiving hospital experience. This would be a relevant factor affecting attitudes toward death which was not asked for in the questionnaire.

Table 1

Classification of Freshmen Student Nurses According to Social Factors

Age	Sex	Religion	Marital Status	Origin	Socioeconomic Level*
16-20 48	F-53	P.-44	S.-52	Midwest-56	Under $5,000 5
21-25 9	M- 5	C.-10	M.- 5	N. Eng.- 1	$5,000-10,000 27
26-30 1		O.- 4	D.- 1	West - 1	$10,000-15,000 14
					$15,000-25,000 6
					$25,000-50,000 3

*There was not always 100% response to the questionnaire.

Table 2

Classification of Senior Student Nurses According to Social Factors

Age		Sex	Religion	Marital Status	Origin	Socioeconomic Level	
21-25	39	F-41	P.-34	S.-37	Midwest-42	Under $5,000	5
26-30	3	M- 2	C.- 9	M.-13	S. West- 1	$5,000-10,000	18
31-35	0			R.- 1		$10,000-15,000	15
36-40	0			D.- 2		$15,000-25,000	4
41-45	1					$25,000-50,000	1

Administration

Each freshmen class was administered the questionnaire at the completion of six hours of theory on terminal nursing care. The questionnaire was administered to the senior classes during their final two weeks in the school.

Each subject was asked to indicate the class and date of administration, but was not to place a name anywhere on the questionnaire, thus guaranteeing the anonymity of the respondent.

Statistical Technique

Correlation of the scores of freshmen and the scores of seniors was done by a Chi-square ($p < .05$) analysis. The level of significance used was at the ($p < .05$) level. Degrees of freedom varied from two to three depending on the size of the cell contents.

Chapter 4

ANALYSIS OF DATA

I. INTRODUCTION

This chapter contains the statistical analysis of the study and an interpretation of the study's results. The results are also compared to pertinent studies by Quint, and Golub and Reznikoff.

II. ANALYSIS

Each class of student nurses was compared on their response to six items on the questionnaire which had been picked by Golub and Reznikoff as "particularly relevant to nursing experience and practice."[1]

Enough statistical evidence was found between the freshmen's and seniors' attitudes toward death to pronounce the null hypothesis invalid. A difference in attitude does exist between the beginning and graduating student. Further research, however, would be necessary to determine how factors such as nursing theory, clinical experience, acceptance of a role model, and peer pressure contribute to this change.

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[1]Golub and Reznikoff, op. cit., p. 504.

The graduate nurse intragroup comparison of Golub and Reznikoff showed no significant variations on any of the six items studied when compared by nursing specialty, nursing experience and education, or age. Therefore, they hypothesized that "nurses appear to acquire common attitudes early in their professional experience and these may remain comparatively stable throughout their nursing careers."[2]

The belief that psychological factors influence death was explored on the first item. Four options offered a continuum from strong belief to doubt for the respondent.

Table 3

Attitudes Toward Psychological Influence Affecting Death

Options	Freshmen	Seniors*
1. Strongly believe	41.47%	30.23%
2. Tend to believe	37.92%	46.51%
3. Undecided	13.79%	18.60%
4. Doubt	6.89%	2.32%

*One senior answer missing.

Comparison between the freshmen and senior groups showed the majority of freshmen (41.51%) strongly believe in psychological influences affecting death while the seniors by a larger majority (46.51%) tend to believe in

[2]Ibid., p. 508.

psychological influences affecting death. This is not a statistically significant finding at the .05 level of probability, but it is a very puzzling result. Freshmen students have not had psychiatric nursing experience and would not be expected to have developed more positive attitudes toward psychological influences than the seniors. This finding was in opposition to Golub and Reznikoff's result which showed the graduate much more positive than the beginning student.[3]

One probable factor affecting the senior students' attitudes toward psychological influences could be the rapid faculty turnover in the theoretical instruction of psychiatric nursing in the past two years.

Table 4

Senior-Freshmen Comparison

Sources of Comparison	χ^2	df.
Between groups	5.5629*	3

* is not significant at the .05 level ($\rho < .05$)

The second item questioned the personal wish to learn of one's own terminal illness from the physician.

[3]Ibid., p. 504.

Table 5

Attitudes Toward Knowledge of Terminal Illness

Options	Freshmen	Seniors
1. Yes	72.41%	86.04%
2. No	5.17%	0.00%
3. Depends on circumstances	22.41%	13.72%

Both groups agreed that they would want to know of a personal terminal illness which fully agreed with Golub and Reznikoff's findings.[4]

Quint, however, observed:

> The general practice of not being very open with the patient about his own death is a cultural phenomenon reflecting a wish to deny the reality of death. As a consequence, the patient's right to shape his own way of living--and dying--has sometimes been assumed by others. Allowing dying patients more opportunities to participate openly in their own dying is a serious and difficult problem, one for which nurses, doctors, and laymen in this society have not been well prepared.[5]

Table 6

Senior-Freshmen Comparison

Source of Comparison	χ^2	df.
Between groups	8.4322*	2

* is significant at the .05 level ($p < .05$)

[4]Ibid., p. 505.

[5]Quint, op. cit., p. 246.

The seniors' attitudes toward terminal illness could be judged as more mature and realistic, perhaps reflecting nursing experience with the long term terminally ill.

Item three questioned the attitudes of the students toward autopsy. The options offered a continuum from approval to strong disapproval. Quint stated that the attitude "difference often depends on the actions of the pathologist and the other person in attendance, and the kind of atmosphere they create."[6]

A factor influencing the attitudes toward autopsy of the students is the actual attendance of an autopsy. No freshmen had attended an autopsy while all seniors had attended at least one.

Table 7

Attitudes Toward Autopsy

Option	Freshmen	Seniors
1. Approve	31.03%	46.51%
2. Indifferent	51.70%	23.25%
3. Disapprove	13.79%	23.25%
4. Strongly disapprove	3.44%	6.97%

The comparison between freshmen and seniors showed

[6]Ibid., p. 129.

highly significant differences, even beyond the ($p < .001$) level.

Table 8

Senior-Freshmen Comparison

Sources of Comparison	χ^2	df.
Between groups	17.5027*	3

* is significant at the .05 level ($p < .05$)

These findings agree with Golub and Reznikoff's results. They theorized that the positive attitude was learned from association with the health team, especially the medical profession which advocates autopsy for scientific advances. The authors felt that the students who indicated indifference as an attitude would change as the process of identification with the model nurse role was completed.[7]

The majority of the freshmen, if studied at the senior level, should then show a much more positive attitude toward autopsy.

Prevention of suicide, "in all cases," was more strongly advocated by the freshmen than by the seniors, although the large majority of both classes favored suicide prevention.

[7]Golub, p. 505.

Golub and Reznikoff found that more students than graduates favored the "in no case" option and that this attitude persisted even in age-group comparisons.[8]

Table 9

Attitudes Toward Suicide Prevention

Options	Freshmen	Seniors
1. In every case	68.96%	60.46%
2. In all but a few	10.34%	23.25%
3. In some, yes, in others, no	17.24%	13.72%
4. In no case	3.45%	2.32%

The Newman nursing students agreed in attitude toward suicide prevention more closely with the graduates of Golub's study than with the students. Factors such as nursing education, experience, and age showed no statistical significance for Golub;[9] however, a statistical significance existed between the Newman freshmen and seniors.

Further insight on this difference might have resulted from the analysis of the items on conservatism-liberalism and religious affiliation, for Golub and Reznikoff viewed suicide prevention as a reflection of cultural and religious attitudes of American society.[10]

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[8]Ibid.

[9]Ibid.

[10]Ibid., p. 507.

Table 10

Senior-Freshmen Comparison

Source of Comparison	χ^2	df.
Between groups	6.1413*	3

* is significant at the .05 level ($\rho < .05$)

The attitudes toward life maintenance efforts showed a marked statistical difference existing between the freshmen and seniors, above the ($\rho < .001$) level.

Table 11

Attitudes Toward Life Maintenance Efforts

Options	Freshmen	Seniors
1. All possible efforts	6.89%	0.00%
2. Reasonable efforts for individual	63.79%	81.39%
3. Natural death after reasonable care	20.68%	18.60%
4. No effort for senile	6.89%	0.00%

The response to "all possible efforts" was thought by Golub and Reznikoff to reflect the general value system of American society or to serve as a defense mechanism. Other responses were thought to reflect nursing experience

and acceptance of the "inevitability of death." ". . . responses involved in prolonging or not prolonging life."[11]

Table 12

Senior-Freshmen Comparison

Source of Comparison	χ^2	df.
Between groups	16.0097*	3

* is significant at the .05 level ($\rho < .05$)

In speaking of the development of nurse identity, Quint observed:

> Idealistically, the medical and nursing professions prolong life. And this is what the public's image is. This is what our self-image is. But when you see sickness every day, and you see relatives who are suffering prolonged agony watching a member of their family go downhill, stay downhill. Financially unable to afford care, emotionally drained, you realize that death can be a blessing--not only to the person who is the patient but to those around him that love him.[12]

The very significant difference, beyond the ($\rho < .001$) level of significance, between the freshmen and seniors would be explained as the result of nursing experience and acceptance of the role model.

The question of willingness to donate your heart for a transplant received similar replies from the freshmen

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[11]Ibid.

[12]Quint, p. 167.

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Table 12

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Between groups	16.0097*	3

* is significant at the .05 level ($\rho < .05$)

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[11]Ibid.

[12]Quint, p. 167.

and seniors. There was no significant difference between them although the seniors should have had greater knowledge of the research results on heart transplants.

Table 13

Attitudes Toward Heart Transplants

Options	Freshmen	Seniors
1. Yes, to anyone	86.20%	74.41%
2. Yes, but only to a relative	1.72%	4.65%
3. Strong feeling against	1.72%	6.97%
4. No	10.34%	13.72%

Golub and Reznikoff stated that the affirmative answers probably reflected a culturally learned attitude and would reflect the altruistic beliefs of a service oriented group.[13]

Table 14

Senior-Freshmen Comparison

Source of Comparison	χ^2	df.
Between groups	5.8595*	3

* is not significant at the .05 level ($\rho < .05$)

[13] Golub and Reznikoff, p. 507.

Golub and Reznikoff's description of an altruistic service group would fit the diploma nursing students, because eighty-four percent of the group had expressed a desire to help someone as the motivation for entering nursing.

Chapter 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

SUMMARY

The student nurse's problems of providing competent and empathetic nursing care to the terminally ill patient without the task becoming an overwhelming emotional burden has not always been recognized or relieved by nursing education personnel. Therefore, the general aim of this study was to help improve the nursing care of the terminally ill patient by providing specific information to schools of nursing on differences in student nurses' attitudes toward death.

Four classes of student nurses, two freshmen and two senior classes comprising 101 students, were administered the questionnaire, "You and Death," during the thirteen months between May, 1972, and June, 1973.

A survey of the literature revealed that recognition of the students' difficulties with terminal nursing was a comparatively new area for research. One other study by Golub and Reznikoff[1] reported on results of the questionnaire with student nurses.

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[1]Golub and Reznikoff, loc. cit.

Six items on the questionnaire which were pertinent to nursing were used in assessing the students' attitudes toward death. The attitudes of the senior class were contrasted with the freshmen by chi-square computation and conclusions were made as to the probable factors influencing each attitude.

CONCLUSIONS

Conclusions based on the data obtained include the following.

1. Belief that psychological factors influence death was similar in each class. This was a puzzling result because the freshmen had not experienced the ten week psychiatric rotation at the time of testing. Factors which had probably negatively influenced the seniors' attitudes included rapid faculty change with the resulting loss of continuity and stability in that affiliation experience.

2. The wish to know of one's own personal terminal illness was statistically significant. The seniors' attitudes were thought to reflect their experience with the terminally ill and were considered to be more mature and realistic than those of the freshmen.

3. Attitudes of the seniors toward autopsy were markedly different and much more positive than were those of the freshmen. Factors influencing this difference were

the actual attendance at a postmortem examination by the seniors and the acceptance of the health team's concept of an autopsy as scientific and a learning experience.

4. Prevention of suicide exhibited a statistical difference between the freshmen and seniors, but factors which might account for the difference as religious affiliation or liberal-conservatism would need to be the subjects of further research.

5. The attitude toward life maintenance efforts exhibited another very marked contrast between the seniors and freshmen. Experience in caring for the long term and chronically ill patient usually alters the most zealous of efforts and tempers it to sometimes accept death as release for the patient.

6. The willingness to donate one's heart for transplantation received similar replies and was not statistically significant. This attitude was thought to be representative of an altruistic group.

7. The seniors exhibited attitudes similar to Golub and Reznikoff's survey of graduate nurses.[2] This would illustrate the acceptance of professionally oriented attitudes based on nursing education and experience.

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[2]Ibid.

RECOMMENDATIONS

To aid the school in their stated goal of producing a graduate who will ". . . possess knowledge, skills, and attitudes essential for good nursing care,"[3] the following methods of facilitating the education of a student nurse in terminal nursing care are presented for consideration.

1. Introduction of the student earlier in the program to nursing in an elderly or long term clinical unit or nursing home. This would allow the student to master the simple procedural skills while observing the normal physical developments of aging and the psychological consequences of social isolation and loss of self-image associated with age.

Death in this setting is more frequently seen as natural and the fulfillment of a long life and should, therefore, be less traumatizing to the inexperienced student.

2. Provisions of a home visit to a terminally ill patient would acquaint the student with the attitudes, life roles, and customs of the patient and his family. The scope of problems in giving nursing care in the home and the adjustments which must be made in family life to cope

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[3] <u>Bulletin</u>, Newman Hospital School of Nursing (Emporia, 1973), p. 6.

with a terminally ill family member are frequently unknown to the hospital-based student.

3. An inservice program for all faculty personnel would emphasize the factors identified as influencing the students' attitude and performance in terminal nursing care. These factors include continuity of learning objectives and evaluative tools, and reassurance from the clinical instructor by providing the instructor's physical presence for support and encouraging the student to discuss her feelings and thoughts about terminal nursing care.

4. Development of evaluative forms for terminal nursing care for each level of student which would state the learning objective. This form could then serve as a checklist of personal progress for the student and as a final evaluation tool for the instructor.

5. The faculty member responsible for instruction of terminal nursing care should make a careful analysis of her attitudes and actions during instruction, for the influence of the role model makes lasting impressions.

BIBLIOGRAPHY

BIBLIOGRAPHY

A. BOOKS

Bowers, Margaretta K., and others. Counseling the Dying. New York: Thomas Nelson and Sons, 1964.

Engelhart, Max D. Methods of Educational Research. Chicago: Rand McNally and Co., 1972.

Feifel, Herman (ed.). The Meaning of Death. New York: McGraw-Hill Book Co., 1959.

Fulton, Robert. Death and Identity. New York: John Wiley and Sons, Inc., 1965.

Glaser, Barney, and Anselm L. Strauss. Awareness of Death. Chicago: Aldine Publishing Co., 1966.

________. Time for Dying. Chicago: Aldine Publishing Co., 1967.

Hinton, John. Dying. Baltimore: Penguin Books Inc., 1967.

Kubler-Ross, Elizabeth. On Death and Dying. New York: MacMillan Co., 1969.

Newman Hospital School of Nursing. Bulletin. Emporia: [n.n.], 1973.

Patrylow, Sarah S. The Relation of the Dominant Values of Senior Associate Degree Nursing Students to Their Attitudes Toward Caring for the Dying. New York: University of New York, 1970. Copy available at University Microfilms.

Quint, Jeanne C. The Nurse and Dying Patient. New York: MacMillan Co., 1967.

BIBLIOGRAPHY

B. PERIODICALS

Folck, M. M., and P. J. Nie. "Nursing Students Learn to Face Death," Nursing Outlook, 7:510, July, 1959.

Folta, Jeanette R. "The Perception of Death," Nursing Research, 14:232, Summer, 1965.

Golub, Sharon, and Marvin Reznikoff. "Attitudes Toward Death," Nursing Research, 20:503, November-December, 1971.

Powers, Thomas. "Learning to Die," Harper's, 242:1453, June, 1971.

Quint, Jeanne, and Anselm L. Strauss. "Nursing Students, Assignments, and Dying Patients," Nursing Outlook, 12:24, January, 1964.

Redden, J. W., and E. E. Scales. "Nursing Education and Personality Characteristics," Nursing Research, 10:217, Fall, 1961.

Shneidman, Edwin S. "The Enemy," Psychology Today, 4:37, August, 1970.

________. "You and Death," Psychology Today, 5:43, June, 1971.

________, Edwin Parker, and G. Ray Funkhouser. "You and Death," Psychology Today, 4:67, August, 1970.

Smith, Jeanne E. "Personality Structure in Beginning Nursing Students: A Factor Analytic Study," Nursing Research, 17:143, March-April, 1968.

Wagner, Bernice. "Teaching Students to Work with the Dying," American Journal of Nursing, 64:128, November, 1964.

Watson, M. Jean. "Death--A Necessary Concern for Nurses," Nursing Outlook, 16:47, February, 1968.

APPENDIX

PSYCHOLOGY TODAY QUESTIONNAIRE

YOU AND DEATH

1. Who died in your first personal involvement with death?

   A. Grandparent or great-grandparent.
   B. Parent.
   C. Brother or sister.
   D. Other family member.
   E. Friend or acquaintance.
   F. Stranger.
   G. Public figure.
   H. Animal.

2. To the best of your memory, at what age were you first aware of death?

   A. Under three.
   B. Three to five.
   C. Five to ten.
   D. Ten or older.

3. When you were a child, how was death talked about in your family?

   A. Openly.
   B. With some sense of discomfort.
   C. Only when necessary and then with an attempt to exclude the children.
   D. As though it were a taboo subject.
   E. Never recall any discussion.

4. Which of the following best describes your childhood conceptions of death?

   A. Heaven-and-hell concept.
   B. After-life.
   C. Death as sleep.
   D. Cessation of all physical and mental activity.
   E. Mysterious and unknowable.
   F. Something other than the above.
   G. No conception.
   H. Can't remember.

5. Which of the following most influenced your present attitudes toward death?

   A. Death of someone close.
   B. Specific reading.
   C. Religious upbringing.
   D. Introspection and meditation.
   E. Ritual (e.g., funerals).
   F. TV, radio or motion pictures.
   G. Longevity of my family.
   H. My health or physical condition.
   I. Other (specify): ________________.

6. Which of the following books or authors have had the most effect on your attitude toward death?

   A. The Bible.
   B. Camus.
   C. Hesse.
   D. Agee.
   E. Shakespeare.
   F. Mann.
   G. No books or authors.
   H. Other (specify): ________________.

7. How much of a role has religion played in the development of your attitude toward death?

   A. A very significant role.
   B. A rather significant role.
   C. Somewhat influential, but not a major role.
   D. A relatively minor role.
   E. No role at all.

8. To what extent do you believe in a life after death?

   A. Strongly believe in it.
   B. Tend to believe in it.
   C. Uncertain.
   D. Tend to doubt it.
   E. Convinced it does not exist.

9. Regardless of your belief about life after death, what is your wish about it?

   A. I strongly wish there were a life after death.
   B. I am indifferent as to whether there is a life after death.
   C. I definitely prefer that there not be a life after death.

10. To what extent do you believe in reincarnation?

    A. Strongly believe in it.
    B. Tend to believe in it.
    C. Uncertain.
    D. Tend to doubt it.
    E. Convinced it cannot occur.

11. How often do you think about your own death?

    A. Very frequently (at least once a day).
    B. Frequently.
    C. Occasionally.
    D. Rarely (no more than once a year).
    E. Very rarely or never.

12. If you could choose, when would you die?

    A. In youth.
    B. In the middle prime of life.
    C. Just after the prime of life.
    D. In old age.

13. When do you believe that, in fact, you will die?

    A. In youth.
    B. In the middle prime of life.
    C. Just after the prime of life.
    D. In old age.

14. Has there been a time in your life when you wanted to die?

    A. Yes, mainly because of great physical pain.
    B. Yes, mainly because of great emotional upset.
    C. Yes, mainly to escape an intolerable social or interpersonal situation.
    D. Yes, mainly because of great embarrassment.
    E. Yes, for a reason other than above.
    F. No.

15. What aspect of your own death is the most distasteful to you?

    A. I could no longer have any experiences.
    B. I am afraid of what might happen to my body after death.
    C. I am uncertain as to what might happen to me if there is a life after death.
    D. I could no longer provide for my dependents.

E. It could cause grief to my relatives and friends.
F. All my plans and projects would come to an end.
G. The process of dying might be painful.
H. Other (specify):_______________.

16. How do you feel today?

A. On top of the world.
B. Wonderful.
C. Cheerful.
D. On the whole, all right.
E. About like the average person.
F. Just fair.
G. Kind of low.
H. Down and out.
I. Wish I were dead.

17. How do you rate your present physical health?

A. Excellent.
B. Very good.
C. Moderately good.
D. Moderately poor.
E. Extremely bad.

18. How do you rate your present mental health?

A. Excellent.
B. Very good.
C. Moderately good.
D. Moderately poor.
E. Extremely bad.

19. Based on your present feelings, what is the probability of your taking your own life in the near future?

A. Extremely high (I feel very much like killing myself).
B. Moderately high.
C. Between high and low.
D. Moderately low.
E. Extremely low (very improbable that I would kill myself).

20. In your opinion, at what age are people most afraid of death?

    A. Up to 12 years.
    B. Thirteen to 19 years.
    C. Twenty to 29 years.
    D. Thirty to 39 years.
    E. Forty to 49 years.
    F. Fifty to 59 years.
    G. Sixty to 69 years.
    H. Seventy years and over.

21. What is your belief about the causes of most deaths?

    A. Most deaths result directly from the conscious efforts by the persons who die.
    B. Most deaths have strong components of conscious or unconscious participation by the persons who die (in their habits and use, misuse, nonuse or abuse of drugs, alcohol, medicine, etc.).
    C. Most deaths just happen; they are caused by events over which individuals have no control.
    D. Other (specify):______________.

22. To what extent do you believe that psychological factors can influence (or even cause) death?

    A. I firmly believe that they can.
    B. I tend to believe that they can.
    C. I am undecided or don't know.
    D. I doubt that they can.

23. When you think of your own death (or when circumstances make you realize your own mortality), how do you feel?

    A. Fearful.
    B. Discouraged.
    C. Depressed.
    D. Purposeless.
    E. Resolved, in relation to life.
    F. Pleasure, in being alive.
    G. Other (specify):______________.

24. What is your present orientation to your own death?

    A. Death-seeker.
    B. Death-hastener.
    C. Death-accepter.
    D. Death-welcomer.
    E. Death-postponer.
    F. Death-fearer.

25. How often have you been in a situation in which you seriously thought you might die?

    A. Many times.
    B. Several times.
    C. Once or twice.
    D. Never.

26. To what extent are you interested in having your image survive after your own death through your children, books, good works, etc.?

    A. Very interested.
    B. Moderately interested.
    C. Somewhat interested.
    D. Not very interested.
    E. Totally uninterested.

27. For whom or what might you be willing to sacrifice your life?

    A. For a loved one.
    B. For an idea or a moral principle.
    C. In combat or a grave emergency where a life could be saved.
    D. Not for any reason.

28. If you had a choice, what kind of death would you prefer?

    A. Tragic, violent death.
    B. Sudden but not violent death.
    C. Quiet, dignified death.
    D. Death in line of duty.
    E. Death after a great achievement.
    F. Suicide.
    G. Homicidal victim.
    H. There is no "appropriate" kind of death.
    I. Other (specify):_______________.

29. Have your attitudes toward death ever been affected by narcotic or hallucinogenic drugs?

    A. Yes.
    B. I have taken drugs but my attitudes toward death have never been affected by them.
    C. I have never taken drugs.

30. If it were possible, would you want to know the exact date on which you are going to die?

    A. Yes.
    B. No.

31. If your physician knew that you had a terminal disease and a limited time to live, would you want him to tell you?

    A. Yes.
    B. No.
    C. It would depend on the circumstances.

32. If you were told that you had a terminal disease and a limited time to live, how would you want to spend your time until you died?

    A. I would make a marked change in my life-style; satisfy hedonistic needs (travel, sex, drugs, other experiences).
    B. I would become more withdrawn; reading, contemplating or praying.
    C. I would shift from my own needs to a concern for others (family, friends).
    D. I would attempt to complete projects; tie up loose ends.
    E. I would make little or no change in my life-style.
    F. I would try to do one very important thing.
    G. I might consider committing suicide.
    H. I would do none of these.

33. How do you feel about having an autopsy done on your body?

    A. Approve.
    B. Don't care one way or the other.
    C. Disapprove.
    D. Strongly disapprove.

34. To what extent has the possibility of massive human destruction by nuclear war influenced your present attitudes toward death or life?

    A. Enormously.
    B. To a fairly large extent.
    C. Moderately.
    D. Somewhat.
    E. Very little.
    F. Not at all.

35. Which of the following has influenced your present attitudes toward your own death the most?

    A. Pollution of the environment.
    B. Domestic violence.
    C. Television.
    D. Wars.
    E. The possibility of nuclear war.
    F. Poverty.
    G. Existential philosophy.
    H. Changes in health conditions and mortality statistics.
    I. Other (specify):_______________.

36. How often have you seriously contemplated committing suicide?

    A. Very often.
    B. Only once in a while.
    C. Very rarely.
    D. Never.

37. Have you ever actually attempted suicide?

    A. Yes, with an actual very high probability of death.
    B. Yes, with an actual moderate probability of death.
    C. Yes, with an actual low probability of death.
    D. No.

38. Whom have you known who has committed suicide?

    A. Member of immediate family.
    B. Other family member.
    C. Close friend.
    D. Acquaintance.
    E. No one.
    F. Other (specify):_______________.

39. How do you estimate your lifetime probability of committing suicide?

    A. I plan to do it some day.
    B. I hope that I do not, but I am afraid that I might.
    C. In certain circumstances, I might very well do it.
    D. I doubt that I would do it in any circumstance.
    E. I am sure that I would never do it.

40. Suppose that you were to commit suicide, what reason would most motivate you to do it?

    A. To get even or hurt someone.
    B. Fear of insanity.
    C. Physical illness or pain.
    D. Failure or disgrace.
    E. Loneliness or abandonment.
    F. Death or loss of a loved one.
    G. Family strife.
    H. Atomic war.
    I. Other (specify):_______________.

41. Suppose you were to commit suicide, what method would you be most likely to use?

    A. Barbiturates or pills.
    B. Gunshot.
    C. Hanging.
    D. Drowning.
    E. Jumping.
    F. Cutting or stabbing.
    G. Carbon monoxide.
    H. Other (specify):_______________.

42. Suppose you were ever to commit suicide, would you leave a suicide note?

    A. Yes.
    B. No.

43. To what extent do you believe that suicide should be prevented?

    A. In every case.
    B. In all but a few cases.
    C. In some cases, yes; in others, no.
    D. In no case; if a person wants to commit suicide, society has no right to stop him.

44. What efforts do you believe ought to be made to keep a seriously ill person alive?

    A. All possible effort: transplantations, kidney dialysis, etc.
    B. Efforts that are reasonable for that person's age, physical condition, mental condition, and pain.
    C. After reasonable care has been given, a person ought to be permitted to die a natural death.
    D. A senile person should not be kept alive by elaborate artificial means.

45. If or when you are married, would you prefer to outlive your spouse?

    A. Yes; I would prefer to die second and outlive my spouse.
    B. No; I would rather die first and have my spouse outlive me.
    C. Undecided or don't know.

46. What is your primary reason for the answer which you gave for the question above?

    A. To spare my spouse loneliness.
    B. To avoid loneliness for myself.
    C. To spare my spouse grief.
    D. To avoid grief for myself.
    E. Because the surviving spouse could cope better with grief or loneliness.
    F. To live as long as possible.
    G. None of the above.
    H. Other (specify):_______________.

47. How important do you believe mourning and grief rituals (such as wakes and funerals) are for the survivors?

    A. Extremely important.
    B. Somewhat important.
    C. Undecided or don't know.
    D. Not very important.
    E. Not important at all.

48. If it were entirely up to you, how would you like to have your body disposed of after you have died?

    A. Burial.
    B. Cremation.
    C. Donation to medical school or science.
    D. I am indifferent.

49. Would you be willing to donate your heart for transplantation (after you die)?

    A. Yes, to anyone.
    B. Yes, but only to a relative or a friend.
    C. I have a strong feeling against it.
    D. No.

50. What kind of a funeral would you prefer?

A. Formal, as large as possible.
B. Small, relatives and close friends only.
C. Whatever my survivors want.
D. None.

51. How do you feel about "lying in state" in an open casket at your funeral?

A. Approve.
B. Don't care one way or the other.
C. Disapprove.
D. Strongly disapprove.

52. What is your opinion about the costs of funerals in the U. S. today?

A. Very much overpriced.
B. No one has to pay for what he doesn't want.
C. In terms of costs and services rendered, prices are not unreasonable.

53. In your opinion, what would be a reasonable price for a funeral?

A. Under $300.
B. From $300 to $600.
C. From $600 to $900.
D. From $900 to $1,500.
E. More than $1,500.

54. What are your thoughts about leaving a will?

A. I have already made one.
B. I have not made a will, but intend to do so some day.
C. I am uncertain or undecided.
D. I probably will not make one.
E. I definitely won't leave a will.

55. To what extent do you believe in life insurance to benefit your survivors?

A. Strongly believe in it; have insurance.
B. Tend to believe in it; have or plan to get insurance.
C. Undecided.
D. Tend not to believe in it.
E. Definitely do not believe in it; do not have and do not plan to get insurance.

56. Assuming that there has been an increase in the amount of concern with death in the U. S. in the last 25 or 50 years, to what principally do you attribute this change?

    A. Wars.
    B. Domestic violence.
    C. Pollution of the environment.
    D. Atomic and nuclear bombs.
    E. Existential philosophy.
    F. The drug culture.

57. What is your sex?

    A. Male.
    B. Female.

58. What is your age?

    A. Under 20.
    B. From 20 to 24.
    C. From 25 to 29.
    D. From 30 to 34.
    E. From 35 to 39.
    F. From 40 to 49.
    G. From 50 to 59.
    H. From 60 to 64.
    I. Sixty-five or over.

59. How many brothers and sisters do you have?

    A. One.
    B. Two.
    C. Three.
    D. Four.
    E. Five.
    F. Six or more.
    G. None; I was an only child.

60. To what racial group do you belong?

    A. Caucasian.
    B. Negro.
    C. Oriental.
    D. Other.

61. What is your marital status?

    A. Single.
    B. Married once.
    C. Remarried.
    D. Separated.
    E. Divorced.
    F. Living with someone.
    G. Widow.
    H. Widower.

62. What is your religious background?

    A. Protestant.
    B. Roman Catholic.
    C. Jewish.
    D. Other.

63. How religious do you consider yourself to be?

    A. Very religious.
    B. Somewhat religious.
    C. Slightly religious.
    D. Not at all religious.
    E. Antireligious.

64. What is your political preference?

    A. Republican.
    B. Independent.
    C. Democratic.
    D. Other.

65. Would you describe your political views?

    A. Very liberal.
    B. Somewhat liberal.
    C. Moderate.
    D. Somewhat conservative.
    E. Very conservative.

66. What is your level of education?

    A. Grade school.
    B. High-school graduate.
    C. Some college.
    D. College graduate.
    E. Some graduate school.
    F. Master's degree.
    G. Ph.D., M.D. or other advanced degree.

67. What is the approximate annual income of your family?

    A. Less than $5,000.
    B. From $5,000 to $10,000.
    C. From $10,000 to $15,000.
    D. From $15,000 to $25,000.
    E. From $25,000 to $50,000.
    F. More than $50,000.

68. What area of the country would you call your home?

    A. West.
    B. Southwest and mountain states.
    C. Midwest.
    D. South.
    E. New England.
    F. Middle Atlantic.
    G. Other than U. S.

69. What is the population of the city or community you live in?

    A. Under 10,000.
    B. From 10,000 to 50,000.
    C. From 50,000 to 100,000.
    D. From 100,000 to 500,000.
    E. From 500,000 to 1,000,000.
    F. Over 1,000,000.

70. What are your present living arrangements?

    A. With my family.
    B. In a dormitory, shared dwelling or apartment with others.
    C. Living alone (in room, apartment or house).

71. What is your present occupation?

    A. Student.
    B. Elementary or H. S. teacher.
    C. Housewife.
    D. White-collar, clerical or sales.
    E. Technician, craftsman, etc.
    F. College professor or instructor.
    G. Business manager or executive.
    H. Unemployed.
    I. Other.

72. Do you work professionally as one of the following?

    A. Physician.
    B. Psychologist.
    C. Guidance counselor.
    D. Social worker.
    E. Lawyer.
    F. Engineer or scientist.
    G. Clergyman.
    H. None of the above.

73. If you have completed one or more of the previous Psychology Today questionnaires on
    Cities,
    Law,
    Drugs, or
    Sex,
    please indicate which ones: ______________.

74. What effect has this questionnaire had on you?

    A. It has made me somewhat anxious or upset.
    B. It has made me think about my own death.
    C. It has reminded me how fragile and precious life is.
    D. No effect at all.
    E. Other effects (specify): ______________.