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THE EFFECT OF DEATH EDUCATION AND EXPERIENCE ON NURSING STUDENTS' RECONCILIATION WITH DEATH

BY

WENDY AUSTIN HURTIG

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF EDUCATION

IN

COUNSELLING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

(SPRING) (1986)

ISBN 0-315-30309-3

THE UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR ....Wendy.Austin.Hurtig.....

TITLE OF THESIS ...The.Effect.of.Death.Education.and.Experience on Nursing Students' Reconciliation with Death

DEGREE: .....Master.of.Education.....

YEAR THIS DEGREE GRANTED:.1986.....

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FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled The Effect of Death Education and Experience on Nursing Students' Reconciliation with Death submitted by Wendy Austin Hurtig in partial fulfilment of the requirements for the degree of Master of Education in Counselling Psychology.

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Supervisor

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Date .December 19, 1985.

Abstract

Nurse educators are exploring ways to allow students to become aware of their own death fears and concerns prior to confronting death in a nursing situation. This experimental study investigated the impact of didactic and experiential death education programs and personal death experience on nursing students' reconciliation with death. One hundred six first level diploma nursing students in a required psychology course were randomly assigned to a didactic, an experiential or a placebo death education treatment. Each program was presented as a one-day workshop : the didactic group received a series of lectures and films on death and the dying process; the experiential group, death awareness exercises and a dyadic encounter; the control group, a simulation game on independence in the aging adult. Seven days later, seventy-six subjects completed in full a death attitude measure - Klug's Confrontation-Integration of Death Scale (CIDS) - and answered an open-ended question regarding their experience with death. Subjects indicated their perceptions of the effect of the assigned program on their awareness of death anonymously via a workshop evaluation. Responses showed a majority of students believed themselves more aware of death following either type of program. Neither personal death experience nor death education treatment alone had a significant influence on CIDS scores. A significant interaction did occur between these variables in their influence on death confrontation scores. Inexperienced subjects treated with an experiential program had higher scores than experienced subjects; treatment of the

inexperienced with a didactic program resulted in scores similar to those of subjects in the control group. Conversely, experienced subjects treated with an experiential program had significantly lower death confrontation scores than similar subjects in both didactic and control groups. It was concluded that, while brief death education programs can promote death awareness in first level nursing students, an experiential program can be more effective than a didactic one in promoting death confrontation in those without experience with death. An experiential program can have a negative effect on the death confrontation of students who have experienced the death of a friend or relative, or who have had a personal encounter with death. The implications of these findings for nursing education are discussed. As seven days may be insufficient time to fully confront and integrate thoughts and feelings toward death, a longitudinal study is required to determine if death education can significantly influence reconciliation with death.

ACKNOWLEDGEMENTS

This thesis was partially funded by the Alberta Foundation for Nursing Research through a Student Research Bursary. I would like to express my appreciation for this assistance.

Thanks is extended also to Dr. Len Stewin, my thesis advisor, for his guidance and encouragement, and to the other committee members, Dr. Vern Nyberg and Dr. Elizabeth Davies. Their positive approach to this project was a great help.

Special thanks must go to the nursing students of the Royal Alexandra Hospital School of Nursing for their enthusiastic participation as subjects. May their energy and committment to nursing continue throughout their careers.

I express my gratitude as well to my parents, Phyllis and William Austin, for their loving support throughout all my endeavors.

Finally, I thank my husband, Rainer, my son, Mark and my daughter, Kara - their presence in my life served to lighten this task.

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I. Introduction to the Study

The present study was designed to investigate the effect of death education on nursing students' reconciliation with death. Didactic and experiential approaches to the topic were compared with a placebo treatment and the influence of personal death experience was examined. This initial chapter will elaborate on the purpose of this investigation, outline the research hypotheses, the assumptions, limitations and delimitations of the study and provide definitions of key terms. An overview of the organization of this thesis is provided.

Background

"You're on earth; there's no cure for that."

Samuel Beckett, Endgame

The fact of death is universal, but the face of death is variant (Lofland, 1978) - and death has changed for the members of contemporary western society. Until the onset of the present age, humans faced certain basic elements of life that shaped their experience of death. One element was obviously limited life expectancy. Few resources were available for dealing

with or controlling the forces of nature. Medical knowledge and its capabilities were limited and few people survived past the early maturity years. The entire life cycle took place within the context of the home and family. The average person was exposed to the sight of birth and of dead and dying persons. Life was precarious and death, very much a part of everyday life, was a visible aspect of the human experience. Today, death no longer fits into our way of life.

Our modern world is focused on the future - making the conception of no future intolerable (Feifel, 1977). Science and technology set the tone of modern life and are expected to provide a solution for all the difficulties besetting humankind. Technology has impacted, not only the human experience of life, but also that of death. This is the era of the Lazarus Syndrome: medical science can bring a person back to life (for a while, at least). With technology as the weapon, medicine seems preparing to conquer "the last enemy" (Harrington, 1969).

Death and the dying are now shunted to specialists (Kastenbaum & Aisenberg, 1972). The dying person has become the dying patient, and the hospital, the modern

setting for death. It is hospital staff, not family, who influence the social context within which one dies. These individuals who, in a sense, man the front lines in the battle with death, are in closest contact with the incurable and the dying, and are charged with their care. Though death has often become synonymous with failure for such care-givers, it is to them that the emotional burden of caring for the dying has fallen.

Health care professionals experience great difficulty coping with such a responsibility (Kastenbaum & Aisenberg, 1972). Key studies by Glaser and Strauss (1965; 1968), Kubler-Ross (1969) and Quint (1967) revealed the isolation of the person for whom medical science has no cure. Care-givers, rather than providing comfort and meaningful support, were found to maintain physical and social distance from the dying. Avoidance behaviors of physicians and nurses in contact with the terminally ill have been identified by health care leaders as a problem that must be resolved. The dying and the grieving require care from individuals who are prepared to help them meet their psychosocial needs as well as their physiological ones.

This study concerns the preparation of one group of health care professionals - nurses - in providing comprehensive care to the dying. Nurses have more constant contact with patients than any other group of hospital staff, and are more directly responsible for patients when care, not cure, is the goal. Nurses must play an important role if the context of dying within modern institutions is to be humanized.

Caring for those facing death is a difficult task (Garfield, 1977), and learning to interact comfortably and effectively with dying patients does not come easily. Talking about death in our society is taboo (Feifel, 1963). Along with the biological revolution has been a cultural one (Aries, 1974) - death is now an unsavory thing that happens to life, not a part of it. Death has become an invisible spectre, hidden and forbidden. Nurses come to the bedside of the dying person beset with the same cultural influences as the rest of our death-denying society. It is not surprising then, that they feel an inclination to maintain social distance between themselves and their dying patient. A nurse faces her own death-related fears in encounters

with the dying - fears that are augmented if the patient also represents professional failure.

Benoliel (1970), in an article concerning nurses' difficulties in talking to dying patients, suggests that the nurse comes to such interactions with little psychological preparation for death. They do enter the encounters with a socially learned value placed on emotional control - a control threatened by conversation that may precipitate sadness, fear or anger. Benoliel believes nurses need to recognize their own anger, fear and helplessness in order to learn to listen to the dying patient. Nurses must learn to confront personal reactions and feelings to death and dying before they can help others do the same. A survey published in Nursing '75 showed professional nurses worked more comfortably with the dying if they had experienced such an opportunity (Popoff, 1975).

This survey of over 15,000 nurses indicated that nurses' anxiety in caring for those facing death does seem strongly related to fear of their own death (p.18). Cumulative experience with death and the dying was not found to be a significant factor in dealing with such fear. It was also noted that a relationship

existed between satisfaction in caring for the dying and self-confidence in one's ability as a care-giver. Almost half of the nurses surveyed seldom or never experienced this satisfaction.

Stoller (1980) would agree that clinical experience itself does not provide a nurse with the necessary skills and insights to feel confident in working with the dying. In fact, she found the opposite: the uneasiness associated with interaction with dying persons was positively related to nursing experience. Her study had examined the impact of the work experience on nurses' anticipated respones to situations involving dying and death in a hospital setting. Price & Bergen (1977) in a study of death as a source of stress for nurses on a coronary care unit state (p.231): "The nurses in the group on which we are reporting drew our attention to the problem of experiencing a meaningful relationship to death as a source of acute inner conflict and stress." They concluded that nurses must make death meaningful for themselves if they are to experience their own role in an intensive care setting in a positive way.

Rankin (1983) states "To become aware of one's own perceptions, anxieties, and abilities to deal with grief and death is a necessary task of those professionals who dare to care for dying persons" (p.911). The question remains, however, as to how to assist nurses in fulfilling this task.

The Problem

If the accumulation of nursing experience cannot be expected to increase the nurse's ability to work comfortably and effectively with the terminally ill, then an educational intervention seems necessary. Quint (1967), in her study of the nurse and the dying patient, did conclude that a crucial place in which to initiate change in the care received by the dying was schools of nursing. She stressed that many nurses were inadequately prepared to deal constructively with death and dying in clinical encounters because their nursing education empahsized life-saving activities, professional control of self and the avoidance of failure.

A review of the literature indicates that nurse educators do recognize the need to prepare nurses to

work with the dying. However, some educators, like Wise (1974), have noted that, though teachers of nursing are now less fearful of the word "death", students are not gaining the experience they need to develop as people who can give better care to the dying. In a survey of nurses in seven specialities, Hoggart and Spilka (1970) found the majority felt ill-equipped by their education in dealing with terminality. Hopping (1977) believes the effectiveness of educational efforts that stressed the need for nurses to be more therapeutic in their approach to the dying have been more assumed than subjected to empirical testing. Fundamental questions remain : can educators increase a nurse's ability to work comfortably and effectively with the dying? Can education promote the nurse's awareness of her own attitudes toward death? Is there an optimal method for facilitating this type of learning process? Nurse educators are searching for ways through which the nurse can learn to cope with the spectre of death.

One means may be death education for nursing students. In the United States, death education programs have proliferated in colleges since 1970 in response to a new awareness of death-related issues

(Bugen, 1979). Such programs are directed to students outside the health care professions. Surprisingly, formally organized death education for nurses is still in the early stages of development. Thrush, Paulus and Thrush (1979) surveyed a random sample of 226 American nursing schools and found only 5% required a death and dying course. An additional 39.5% had an elective course available. In both elective and required courses the amount of credit hours of formal instruction averaged to 3 hours. The same technological advances that have changed the face of death in our society have placed heavy demands on the curricula guiding nursing education. There is minimal time available for preparing the nurse to care for the patient for whom there is no cure. It is essential, then, that this time be used well.

Empirical research is lacking in the evaluation of the impact of death education (Pine, 1977). Approaches to death education can be placed on a didactic-experiential continuum (Bugen, 1979), and though it is implied in the literature that teaching methods involving a personal, affective approach to the subject of death are more effective than those that

focus on giving information, there is little evidence to back such a claim (Durlack, 1978-79). Research is needed to determine the more effective method. As an experiential approach usually requires a higher teacher/student ratio than a didactic one, it is the more costly to implement. Evidence for the most optimal type of death education program would assist nurse educators to make informed curricula decisions.

Quint (1967) has implied that personal experience with death had a positive effect on one's ability cope with this sensitive nursing problem. She noted in her study that some nurse educators had learned to skillfully guide students in their care of the terminally ill - "usually through personal experiences with death" (p.244). Although professional experience with death has not been shown as a significant positive influence, personal experience may be an important factor. A review of the literature has indicated that no conclusive evidence as to this influence has been established. The impact of personal death experience on the effectiveness of a death education program needs also to be examined. It may prove a significant influence on the most powerful way to promote

reconciliation with death through a brief educational experience.

Purpose of the Study

This study was designed to investigate the effect of a short death education program on nursing students' reconciliation with death. It examined as well, whether an experiential approach to death education was more effective than a didactic approach. The experiential approach involved focusing on personal feelings and reactions to death; the didactic approach involved using a lecture format to provide information on death and dying. The effect of both approaches was compared to that of a placebo program presented to a control group.

The effect of personal death experience on a student's death attitude was also examined. In addition the impact of such experience on the effectiveness of either type of death education program was noted. In order to consider only personal death experience, professional experience was eliminated as a source of variance by using subjects in the first level of nursing education.

Reconciliation with death was measured using the Confrontation-Integration of Death Scale (CIOS), within a post-test only design. Information regarding subjects' personal death experiences was also collected on the CIDS form. A workshop evaluation was completed by subjects in the death education treatment groups, gathering information concerning the students' own perceptions of any change in their awareness of death.

Research Questions and Hypotheses

This study addressed the following questions:

1. Will a treatment of a brief death education program affect the death attitudes of the participants as measured in terms of reconciliation with death?

2. Will there be a difference in the reconciliation of death scores between subjects who receive an experiential death education program and subjects who received a didactic one?

3. Will there be a difference in the reconciliation of death scores between subjects who have had a personal experience with death and subjects who have not?

4. Will personal death experience impact the effectiveness of the death education programs as measured by reconciliation of death scores?

5. Will subjects receiving a brief death education program perceive an increased personal awareness of death?

On the basis of a review of the related research (as described in the next chapter) the following hypotheses were developed:

Hypothesis One. Stated in null form, this hypothesis was as follows:

Ho: There will be no significant difference in reconcilation with death scores between subjects who received a treatment of a death education program and subjects in a control group who received a placebo program.

In the event that this null hypothesis was rejected, an alternative hypothesis was formulated:

H1: Subjects receiving either death education program will have higher reconciliation with death scores than subjects in the control group who received a placebo program.

Hypothesis Two. Stated in null form, this hypothesis was as follows:

Ho: There will be no significant diffference in the reconciliation with death scores between subjects who received a didactic death education program and subjects treated with an experiential death education program.

An alternative hypothesis was formed in the event the null hypothesis was rejected:

H2: Subjects in the experiential program which addressed the personal reactions and feelings of the participants toward death will have higher reconciliation with death scores than the subjects in the didactic program where personal issues were not addressed.

Hypothesis Three. Stated in null form, this hypothesis was as follows:

Ho: There will not be a significant difference in the reconciliation with death scores between subjects who had a personal death experience and subjects who did not.

In the event that this null hypothesis be rejected, an alternative hypothesis was formed:

H3: Subjects with a personal death experience will have higher reconciliation with death scores than subjects who had no such experience.

Hypothesis Four. This null hypothesis was as follows:

Ho: Personal death experience will not influence the effect of a death education program on reconciliation with death scores. In other words, the main effects will be additive.

An alternative hypothesis was formulated in case this null hypothesis be rejected:

H4: An interaction between the type of program received and the personal death experience factor will occur. The main effects will not be additive.

Hypothesis Five. This null hypothesis was posited as:

Ho: Subjects will not perceive a change in their personal awareness of death following the treatment of a death education program.

The alternative hypothesis follows:

H5: Subjects will perceive an increased personal awareness of death following the treatment of a death education program.

Delimitations of the Study

This study is delimited to first year nursing students enrolled in a diploma program at the Royal Alexandra Hospital School of Nursing, Edmonton, Alberta, Canada.

Limitations of the Study

The limitations of this study are as follows:

1. The degree to which the death education programs were effectively conceived and presented.

2. The degree to which the subjects responded truthfully to the death attitude instrument.

3. The degree to which the subjects responded truthfully in the workshop evaluation.

Assumptions of the Study

The assumptions underlying this study are as follows:

- The individuals selected as program leaders meet the standards proposed for death educators (Leviton, 1977).

- The leaders of the death education programs were equally effective in their presentations.

- The influence of the workshop leaders was the same for each subject.

- The subjects complied to their agreement with the researcher and did not discuss their workshop experience with participants in another treatment group prior to the administration of the death attitude instrument.

- Subjects who had a personal experience with death answered the related question in the affirmative.

Definition of Terms

Reconciliation with death. The deliberate intellectual acknowledgement of the prospect of one's own inevitable death and the positive emotional assimilation of the consequences (Klug, 1976:32).

Death confrontation. The conscious contemplation of the inevitability of ones's own death.

Death integration. The positive emotional assimilation of the consequences of death confrontation.

Experiential death education program. A program focusing on personal death awareness through the use of death awareness exercises, music, drawing, and dyadic encounters between students.

Didactic death education program. A program using films and a lecture format to present such topics as the dying process, tasks of the dying, a developmental view of death, and death in our society.

Personal death experience. An experience with the dying process and/or the death of a friend or relative or a self-encounter with death.

Summary

A problem has been defined relating to the preparation of nurses in the care of the dying patient. Death education for nursing students is a potential solution if it can help nurses confront and positively integrate their own thoughts and feelings toward death. As time is at a premium in the nursing educational process, a brief, optimal program needs to be found. Personal death experience may impact the effectiveness of death education as an intervention, as well as influence death attitude. This chapter introduced the present study which compared the effect of two types of death education workshops with a placebo program presented to first level diploma nursing students.

Personal death experience was investigated as a source of variance.

The remainder of this document is divided into chapters presenting a review of the related research literature, an overview of the investigative procedures, the results of the study and a discussion of these results and findings. The appendexes contain a copy of the CIDS and outlines of both the didactic and experiential workshop programs.

II. Review of Related Literature

This chapter is a review of the literature related to the present study. It is divided into four major sections. The first section is an overview of the evolution of death education and the subsequent research. The second section examines death education as represented in the nursing curricula through a review of the nursing education research. The third section presents research focusing on the relationship between death attitudes and personal experience with death. The final section describes the theory and research related to death attitude measurement, culminating with the concept of death acceptance as a measured attitude.

Death Education

Background

The human orientation to death has changed. In the past, the entire life cycle took place within the context of home and family, and death was a visible aspect of that cycle. In our modern world, science and its offspring, technology, have impacted human existence to the extent that life expectancy has doubled and the average North American experiences a

death in the family only once in every twenty years (Dumont & Foss, 1972). Technology has also promoted the change in the setting of death from the private to the public domain - one dies in hospital, today, not at home. The average man has become insultated from the perception of death, and death and the dying have been shunted to technicians and specialists. In that sense, death has become invisible or unwitnessed in our society. In another sense, however, death has become ever-present. Telecommunications on a global scale now allow death due to wars, famine and natural disasters to be viewed from the average home. Technology has also given humankind the capacity to destroy the world and "Megadeath" is a reality. Such conflicting influences have had an impact on the human individual's orientation to death.

It was in the mid-fifties that the dramatic changes in attitudes toward death were first noted. In 1955 Geoffrey Gorer, a British antropologist, asserted that death had become an aversive and taboo topic in western civilization (Lifton, 1979). In 1956, Herman Feifel, an American, too noted that death had become an unsavory topic in modern society. He organized a session of the American Psychological Association

annual conference on the topic of death. Essays arising from presentations at that session formed the basis of his landmark book, The Meaning of Death. Although diverse disciplines and approaches were represented in the book, three themes were noted (Feifel, 1959, p.xvii):

-Death denial and avoidance characterize the American outlook, yet death must be faced for a full and meaningful existence. This has implications both for the individual and for society as a whole.

-A science-conscious culture, measuring all experience within the bounds of space and time, does not furnish individuals with the parameters necessary for understanding death.

-There exists a great need for systematic, controlled studies in this field.

Cicely Saunders (1959) began at about this time to write articles on the dying and their care. An American book by Mitford (1963), highly critical of the funeral industry, focused on another troubling aspect of the contemporary death system. Kubler-Ross's (1969) charismatic voice on the plight of the dying was heard as well. These examinations of current attitudes toward death stimulated academic interest in the topic.

Related research issues arose and attempts were made in academic circles to provide formal courses with death as the focus.

Development

The first regular death education course was offered by Robert Fulton at the University of Minnesota in 1963. The course was a multidisciplinary one and focused on a broad-range of related topics including the process of bereavement, care of the dying, death in everyday life and funeral practices (Pine, 1977). It set the tone for subsequent courses that slowly arose in academic institutions in the USA in the late 60's. In 1969 Fulton established a center for Death Education Research at the University of Minnesota. American interest in death education grew and reached its height of popularity in the seventies.

With the continued technological and biological revolution in the modern situation of dying, public interest in "death" grew. Bugen (1979) attributes the rapid growth of death education since 1970 to five factors (p.238):

- Consumer awarenesss of carcinogenic elements in food and the environment promotes an awareness of threats to health.

- Renewed interest on physical fitness and health is interacting with the ever-present interest in longevity.

- Media focus on death and related issues continues.

- Dramatic cases like the one of Karen Quinlan challenges the public's ability to face issues of modern dying and death.

- A new emphasis on patient advocacy demands accountability from the medical world.

The net effect of these societal factors will not necessarily increase the acceptance of death, but a confrontation is being promoted that may evolve toward such acceptance. Death education is an aspect of this confrontation.

A major step in the evolution of death education was the emergence of a regular means of communicating and exchanging ideas on death-related topics. Omega began as a newsletter in 1966, edited by Richard Kalish and Robert Kastenbaum, and grew into its present journal form three years later. Death Education, a second journal, specifically devoted to this topic, was begun in 1977 with Hannelore Wass as editor.

Death education has become available at the elementary and secondary levels in the United States. It is interesting to note that no parallel development has occurred in Canada. In Canada, Sweden, West Germany and Great Britain there has been no significant effort to develop death education in the public schools or university sectors (Leviton, 1977).

There are questions surrounding the formalization of education about death. One major question concerns the qualifications of the teachers. Leviton (1977) has proposed that death educators meet certain standards: The death educator must:

- Have come to terms with his/her own death feelings and be aware of their influence on the total personality.

- Be knowledgeable about the appropriate subject matter.

- Be able to use the language of death naturally, especially in the presence of the young.

- Be familiar with psycho-thanatological developmental events throughout life, and possess an understanding of the concomitant difficulties.

- Be cognizant of important social changes and their impact on the attitudes, practices, laws and institutions concerned with death.

Bugen (1979, p.248) adds two points to these:

- Be aware of his or her goals and potential emotional impact and select target audiences and methods of instruction accordingly.

- Identify local community resources and integrate them into the structure of the course.

Simpson (1979) warns that, while some death and dying courses are valuable and are undertaken by sensitive, talented teachers, some death awareness approaches involve a "happy death" movement promoted by "self-seeking exhibitionists" and "deathniks" (p.5). Kalish (1981) agrees and adds that people who are dying or bereaved are very vulnerable and can be victimized by exploitive persons promoting themselves as death educators or counselors. Such educators must therefore maintain a high standard of personal and professional ethics (p.291).

Another major question surrounds the objective of death education- is the goal to change death attitudes? Pine (1977) believes that such an intention is operative - death education is becoming a necessary

aspect of socialization. Although the thrust of particular courses is difficult to ascertain, death education in general has affected death attitudes - as evidenced by changes in concerns about the dying and increased humanistic treatment of the bereaved (p.76). This does not mean death education is implemented to transmit a particular perspective. Students need exposure to various approaches to the human problems involved in death and dying. Their concerns need to be addressed rather than one standard attitude toward death promoted.

Another legitimate question is whether death education is itself a form of death denial? Taking an academic approach to death can be a form of intellectualization - a defense mechanism through which painful, emotionally important impulses can be avoided by escape into intellectual concepts (Leigh, Pare & Marks, 1977; p.205). Death education can accentuate the very process it is suppose to overcome if it focuses entirely on providing factual information on death and related topics. It can be used as a shield rather than a opening to a new awareness.

Is there an optimal approach to death education? Bugen (1979) states that all death education efforts

can be profiled along a cognitive-affective dimension (p.249). At one extreme, only lecture and didactic presentations are used to impart knowledge. At the other, structured exercises are used to promote personal development for the participants. He believes that, as death and dying affect one's total self, both approaches are needed. The approach that is emphasized should depend on the goals of the program and on the target population. There is minimal evidence of what is optimal in a death education program. Durlak (1978-79,p.57) states that although 20,000 death education and training programs have been offered in the USA very few systematic investigations of their effectiveness have been made.

Research

An increasing need for studies investigating death education exists. Pine (1977) writes,

> Unfortunately, in the rush to educate, too many educators have avoided more extensive research, looking at hard data, and evaluating either the relevancy and accuracy of the theories in existence, or the impact of their courses. Clearly, death education has become popularized.

> However, it has not been analysed as to its utility, purpose or accomplishments (p.75).

A review of the death education research is presented here.

Descriptive studies. "Death educators have likened themselves to early explorers who merely describe new terrain." (Leviton, 1977; p.242). Though this approach to evaluating death education is changing, much of the research literature in this area is descriptive. Few well-controlled experimental studies have been completed. Following is a sample of the studies that primarily involve the description of a particular course.

Bloom (1975) described the goals and content of an undergraduate death education course that received favorable student evaluations. The eleven students enrolled in this experience were introduced to the subject matter through lectures, small group discussions and a variety of exercises, including the role play of family situations, a birth-death continuum and preparation of personal eulogies and epitaphs. Another undergraduate course was described by Leviton (1975) involving 300+ students. Involving primarily lectures on death and associated topics (eg.

bereavement) and a visit to a death-realted agency (eg. a cemetery), there was also opportunity for small-group discussion. Individual counselling was available. Comments of the students both before and after the course were used as the determiners of its effect. Ninty-one per cent reported that the course made some significant contribution in their ability to face personal death and feel more comfortable with their attitude toward death. Forty-nine per cent stated they felt better able to cope with the death of a significant other. About one third responded that the course enabled them to crystalize their thoughts about death, to verbalize, communicate and think about death consciously. Seven per cent found their frequency of thinking about death increased; three per cent found their fears of death exacerbated; one per cent found themselves depressed about death. During this experience at the University of Maryland, Leviton observed that students in death education evolve through stages similar to the stages the dying themselves evolve (Kubler-Ross, 1979). He labeled them shock, denial and disbelief, anger, depression and synthesis and hypothesized that the student of death

vicariously experiences the same emotions as the person facing personal death (p.190).

Rosenthal (1978) presented the course outline of a seminar for school counselors and teachers that aimed to increase the participants awareness of their own death attitudes and provide them with information about death, grief, and materials available for implementing death education in curricula. A didactic portion followed by extensive discussion, exercises and role-playing was the format of most of the eight three-hour sessions. Exercises included writing obituaries and sharing personal experiences. The participants seemed to benefit from the seminar. Evidence for this was cited in terms of results : one participant developed plans for a course on death in his high school; one reported a new-found ability to help a relative undergoing surgery, and others discussed death with their students in the ssroom.

Engel (1980-81) described a group dynamic approach to learning about grief. A film, What Happened to Pity was used to give information about grief and to evoke emotional responses in the student group. This film is a 1967 documentary on the impact on a Welsh mining town of the the death of 116 children and 28 adults

(resulting from the collapse of a coal tip). The personal reactions of the students to the portrayed situations were used to show how the various expressed reactions are a reflection of the many psychological and social devices people use to deal with the pain of grief and loss (p.47). The session described involved 80 participants, though 10-30 was seen as optimal. Engel believes this approach is more successful than traditional didactic approaches or group discussions of death, as few participants remain aloof and uninvolved.

Experimental studies. Some experimental studies have been undertaken. A review of such studies follows.

Bell (1975) utilized an experimental format to examine the influence of a college course on death and dying with only suggestive results. The experimental group (n=24) consisted of students pre-enrolled in the course, while the control group (n=50) was randomly chosen from the student population. The treatment consisted of an 18 week lecture course on the social aspects of death and dying, involving guest speakers from the medical, legal and religious communities. A pre- and post-test design utilizing the same likert-type instrument measured death attitudes. No attitudinal difference was found in the pre-test

measure - an important point, as the treatment group was self-selected - but significant differences were noted in the post-test in items constituting the cognitive dimension of death attitudes. Death education students entertained more frequent thoughts of death and appeared to manifest a greater amount of interest in death-realted discussions. No differences were found in relation to the affective items: both groups indicated approximately the same degree of fear in relation to death. Bell offered no evidence in support of the reliability and valrdity of his specially constructed measure.

Bugen (1980-81) assessed the self-reported coping capacity of college students who completed a death and dying seminar. The control group (n=30) was matched to the treatment group (n=24) in three areas: all students were self-selected into the experience, a wide range of academic backgrounds was represented and personal exposure to terminality was varied. The measure was the Coping with Death Scale, a likert-type response scale of 30 items. The treatment group experienced a fifteen unit death and dying seminar. This seminar consisted of both didactic and experiential components: the first half of a class session was devoted to presenting

didactic material; the second to structured exercises facilitating the exploration of attitudes and feelings. The control group experienced only two units of this death seminar. A pre- and post-test design was utilized. Results indicated that those completing the entire seminar showed significant changes in their ability to cope on 23 of the 30 items - changes not reported by the control group subjects. Bugen believes his results strongly suggest that death education can provide or enhance a variety of coping capacities in regard to death and dying.

Durlack (1978-79) compared experiential and didactic measures of death education. Finding that there existed no empirical data supporting some educators' claims that an emotional, personal approach to death is more effective than didactic presentations, he examined the impact of a death and dying workshop on individual's attitudes toward life and death. (As Durlack's study has a similar focus as the present research, it is described here in some depth.) A pre- and post-test design was used in collecting data from workshop participants (n=51) and a non-participant control group (n=19). The workshop group was divided into two experimental groups consisting of 19 subjects

from two didactically-oriented workshops and 32 subjects from three experientially-oriented programs. Four psychometric scales were used (in randomized order): Templar's Death Anxiety scale, Lester's Fear of Death Scale, Crumbaugh and Maholick's Purpose of Life Test and Marlowe-Crowne Social Desirability Scale. The workshops were part of a continuing education program at a large American medical center. They consisted of two four-hour sessions on consecutive days and were attended by 8 to 16 participants selected from a waiting list of a cross-section of hospital personnel. The primary difference between the programs was the methodology rather than the content. Both approaches dealt broadly with topics such as emotional reactions to grief and death and communication with the terminally ill. The didactic group used lecture and small-group discussion. The experiential group used role-playing and personalized death awareness and grief exercises to help the participants confront and examine feelings and reactions to death and grief.

Results were as follows:

- No significant difference was found between groups on the pre-test questionnaires. Social

desirability response parameters were a relatively unimportant influence on the questionnaire scores.

- The Purpose in Life Test was significantly and negatively correlated with both death scales (r >/-.36) This implies a relationship between "purpose in life" and death-related concerns. No changes appeared for any of the groups in purpose in life scores.

- The pattern of results differed on the two death scales. On the Templar scale the scores increased over time (ie. time of evaluation, pre and post) for all groups, but the experiential group demonstrated the smallest and the didactic group the greatest amount of change. On the Lester scale the didactic and control group scores increased from pre- to post-testing, while the experiential group scores declined. Durlak found these results to indicate that the experiential program decreased participant's fears and concerns about death while slightly heightening their anxieties about death. The didactic workshop had negative effects as greater fears and anxieties about death were reported at the end of the program. Controls showed slight negative changes over time.

Durlak acknowledged several experimental limitations : the results may not be replicated in a

situation where the group composition and workshop length are different; the program evaluation was confined to immediate, self-report measure of death attitudes and feelings and the problems of interpretation of findings of the two death attitude scales. Comparisons of the scales indicated that Lester's scale was more a measure of the conceptual meaning death holds for indviduals, including elements of fear, than a measure of death anxiety per se. Though there are limitations in experimental design and lack of strong, pervasive program effects in this study, Durlack noted it was more of an objective assessment of effects than was currently available from other programs.

Bohart and Bergland (1979) examined the effects of two behavioral treatments on college students who participated in counseling groups on death and dying. These investigators found prior studies in death anxiety reduction to lack an acceptable number of participants and to be weak in the control of experimental variables (p.387). Their subjects (n=104) were divided into three groups - an in vivo systematic desensitization group (n=35), a group to have the combination of systematic desensitization and symbolic

modeling (n=33), and a delayed-treatment control group (n=36). Treatment procedures were implemented in four two-hour once-a-week meetings. The in vivo systematic desensitization involved in vivo exposure to death-related topics - eg. filling out a mortuary form for themselves, visiting a mortuary, and a guided death fantasy experience. The second treatment was focused on vicarious experience and observation through the use of modeling - eg. viewing a model completing a mortuary form and discussing her reactions to the exercise, viewing a model touring a mortuary, and viewing a model participating in a guided death fantasy. Four dependent measures of the effectiveness of the treatments in lowering death anxiety were used: Templar's DAS (pre- and follow-up post-test), Collett-Lester Fear of Death Scale (immediate post-test), Bohart Anxiety Scale (pre- and immediate post-test) and the opportunity to view a videotaped autopsy (follow-up post-test). No significant differences were found between the treatment groups and control group as measured by either the immediate or the follow-up post-tests. The authors noted possible explanations of insignificant findings including insufficient time for integration (ie. not enough time was permitted prior to the

follow-up measure) and the nature of death anxiety (ie. so well established that change can only be effected through treatments over an extended period of time).

Wittmaier (1979-80) compared the attitudes toward death of fourteen students in a death education course to those of twenty students on its waiting list. A post-test only design was used to avoid the demand characteristics that pre-testing can create (p.272). The course followed primarily a discussion format but involved guest speakers and a tour of a funeral parlor. Two weeks after the course, a modified DAS and a semantic-differential scale that measured death in regard to evaluation, potency and activity were used as a post-tests. Students were also asked to estimate on a seven-point scale how they would feel talking with a dying person. The treatment group had greater death anxiety than the control group, but death had lower potency for them as measured by the semantic differential. There was no difference in self-ratings of comfort in talking to the dying. Wittmaier suggests his results may reflect more openess in revealing death anxiety on the part of the students with death education experience.

Whelan and Warren (1980-81) developed and evaluated a death awareness workshop. An encounter group format, coupled with structured exercises, reciprocal inhibition procedures, imagery and didactic instruction, was used in an attempt to parallel the experience of terminally ill patients and thus promote a level of death acceptance. The subjects were sixteen graduate counselling students who were randomly assigned to a treatment (n=8) or control group (n=8). Two pre-test measures were used: Templar's Death Anxiety Scale and a Death Attitude Questionnaire constructed for this study measuring cognitive attitudes toward death. The treatment death awareness workshop was a single 8-hour marathon session. Following, all subjects viewed the film, "Dying" and were instructed to write an essay concerning their reactions to the film. Post-testing with the death attitude measures took place both four days and eight weeks later. Results indicated that the participants in the workshop had significantly changed their cognitive attitudes toward death as measured by the Death Attitude Questionnaire. An emotional change was indicated by the emotional nature of the treatment groups' essays when compared to the non-emotional

essays of the control group. No lessening of anxiety, however, was noted at the first post-test. The follow-up test indicated the cognitive attitude change was maintained and that the treatment group had a significantly lower death anxiety. The researchers interpreted this to indicate that anxieties about death change gradually.

Knott and Prull (1976) studied the effect of a one semester course, "Death Education and Lethal Behavior". Thirty-five students registered in the course (treatment group) and thirty-five students on a waiting list (control group) composed the sample. A survey containing nine attitudinal, likert-scaled items was used as a pre- and post-test dependent measure. Though in an evaluation of the course's impact 96% of the students commented the subject matter and its presentation were positively received, a significant change in attitude was found only on one item. In comparison to the controls, the members of the experimental group showed a marked increase in thought about their own death. The authors noted two problems : articulation of course goals into measurable items and the time frame for evaluation (identifiable effects may not emerge for several months or years). No description

of the treatment phase (neither course content nor teaching methods) was provided.

Leviton & Fretz (1978-79) found some small differences in attitudes but with no discernible meaningful pattern in their research into the effect of death education. Using Collett and Lester's Fear of Death Scale (FDS) in a repeated measures design, they compared the responses of 17 students in a summer death education class to 17 comparable students in a sex education class. Students in the death education course did view death as more "approachable". A second study with 87 death education students was completed that used 87 introductory psychology students matched in sex and age as a control. The dependent measure was a packet of 125 items that included the FDS, demographic items and items related to attitude toward suicide, life and death. The results indicated a significant decrease in the fear of death and dying of others for the death education group, while the control group's fear in this respect increased.

Bolan (1981) examined the effects of a short course (10 hours in 5 consecutive sessions) on attitude toward death and suicide acceptibility. One hundred adult subjects, located by media advertising, were

randomly assigned to either an experimental or a control group. The educational treatment touched broad areas of death education: attitudes toward death, the dying process, euthanasia and suicide, bereavement and grief, funeral customs, and death in art, literature and music. Using the Hardt Death Attitude Scale and the Hoelter Suicide Acceptibility Scale, subjects were post-tested after seven days. The control group was then treated with the death education course and all subjects retested. Results indicate that the death education was effective in positively changing death attitudes of both groups. After the course, both groups were able to see death as an acceptable thought but before the treatment the control group did not. The time span of 7 days between the post-tests of the experimental group did not alter the positive death attitude of that group. Death attitude and suicide acceptibility were not found to be related.

Summary of the research. Bugen (1979) does seem correct in his statement that death education programs can be placed on a didactic-experiential continuum. Of the fourteen studies reviewed, one was entirely experiential (Engel, 1980-81), three were primarily didactic (Bell, 1975; Bolan, 1981; Leviton, 1975), four

had an equal balance of didactic and experiential teaching methods,(Bloom, 1975; Bugen, 1980-81; Rosenthal, 1978; Whelan & Warren, 1980-81) and two compared approaches (Bohart & Bergland, 1979; Durlack, 1978-79;). The discussion format of one study (Wittmaier, 1979-80) could be placed midway on the didactic-experiential continuum. For three of the investigations, no description of the death education programs involved was provided in the report of their findings. An examination of the results of the studies indicates that no conclusions can be reached concerning the efficacy of a particular approach. One does not seem to be more effective than another. In fact, the two comparison studies had either no significant attitude change with either approach (Bohart & Bergland); or results that differed in relation to the death attitude measure used (Durlack, 1978-79). It may also be noted that no study examined the influence of an individual's personal experience with death on the outcome of any type of death education program.

The effectiveness of death education in general has yet to be established by the research. Though the descriptive studies all found that education was helpful in promoting an awareness of death (as measured

by course evaluations), those using more objective measures found less positive results. Some researchers noted either no discernible pattern of change in attitude (Leviton & Fretz, 1978-79) or a pattern that differed according to the scale used (Durlack, 1978-79). Others found only that a cognitive change had occurred -ie. students completing a death education program thought more frequently about death (Bell, 1975; Whelan & Warren, 1980-81; Knott & Prull, 1976). One researcher found death anxiety to be actually increased by a death education course (Wittmaier, 1979-80), while others found a decrease occurred if the anxiety was measured over time (Whelan and Warren, 1980-81). One well-controlled investigation (Bolan,1981) found positive changes in death attitude that were maintained over time. When self-rated coping capacity was measured rather than death attitude positive results were obtained. (Bugen,1980-81).

A fundamental concern facing each investigator has been how to measure the success of a particular program. It would appear that a basic problem with death education research is the wide variety of measurement tools used. The evaluative measures in the initial descriptive studies were either broad course

evaluations (Bloom, 1975; Leviton, 1975), or self-reported benefits arising from the experience (Rosenthal, 1978). One author (Engel, 1980-81) determined his program successful because the students did not appear aloof from the topic of death. The experimental programs used a variety of death attitude measures - evaluating death fear or death anxiety through use of different scales (though Templar's DAS and Collett and Lester's FDS were the ones most frequently used). Some studies (Bell, 1975; Whelan & Warren, 1980-81; Knott & Prull, 1976) used instruments specially constructed for their investigation - at times with no mention of their reliability or validity (Bell, 1975). One study measured coping with death rather than death attitude (Bugen, 1980-81). This variety in the dependent measures utilized has increased the difficulty of comparing results - a situation exemplified by Durlack's (1978-79) study in which change was indicated by one of the scales (FDS) but not the other (DAS). The investigation that used the broadest selection of dependent measures (Bohart and Bergland, 1979) found no significant changes with their treatment program. The development of appropriate

death attitude measurement for use in death education research is addressed later in this chapter.

The subjects in all experimental studies found were self-selected. The one exception may be Whelan and Warren's (1980-81) research - there is insufficient information provided to determine if self-selection occurred. Several of the studies used a self-selected control group (eg. from the course's waiting list) and, though external validity is still decreased, overcame the major difficulty with this type of selection. Three of the studies (Bell, 1975; Leviton & Fretz, 1978-79), however, used control subjects enrolled in other courses (eg. [illegible] education) and any influence on the selection process remained an influence on the dependent variable (Kerlinger, 1973;p.343).

In addition to the concerns involved when self-selected subjects are used, there is another problem with generalizing the results of these investigations. A pre- and post-test design was utilized in all except two of them (Bohart & Bergland, 1979; Bolan, 1981, Wittmaier, 1979-80). This design can be the source of an interaction effect between the sensitivity to the issues created by a pre-test, and the experimental manipulation. Since attitudes are

especially susceptible to sensitization by a pre-test (Kerlinger, 1973; p.337), its use may be a real threat to the external validity of these studies. This is an important consideration in educational research where the results are to be applied.

Summary

Death education is a response to the changes in the contemporary death system that have removed death from the individual's daily experience. Though courses have proliferated since the seventies, research has not yet established the effectiveness of education in helping individuals confront their personal attitudes toward death, nor have the most optimal approaches to teaching death education been established. Factors such as personal death experience have not been examined in terms of their impact on the effect of a death education program. A fundamental problem in this research areas seems to be finding an appropriate means to evaluate change. As well, the external validity of several of the studies can be questioned. This review of literature has indicated a need for further investigations into the efficacy of death education.

Death and Nursing Curricula

Quint (1967) in her classic study of the nurse and the dying patient concluded that a crucial place to initiate change in the care of the dying was the nursing school. She stressed that many nurses were inadequately prepared to deal with death and dying in clinical encounters because their nursing education emphasized life-saving activities, professional control of self and the avoidance of failure. It did seem that nursing education must evolve strategies to better prepare the nurse to care for the dying: in a survey of nurses in seven specialities, Hoggart and Spilka (1970) found the majority felt ill-equipped by their education in dealing with terminality.

Effective, organized ~~death~~ education for nurses, however, remains in an embryonic stage of development (Coyne,1977). While aware of the necessity to teach about dying, nurse educators are still exploring the best approach to take when including such education in the nursing curricula. Thrush, Paulus and Thrush (1979) surveyed a random sample of 226 American nursing schools and found only 5% required a death and dying course. An additional 39.5% had an elective course available. Relatively few students were enrolled in the

elective courses - an average of 15% of the class. In both elective and required courses the amount of credit hours of formal classroom instruction averaged to three hours (p.137). Most of the death education courses were relatively new, the majority being in existence for two to three years only.

Caty and Downe-Wamboldt (1983) took a look at death education in Canada. Forty-five medical and nursing schools were surveyed, with thirty-three responding. Of these schools only four nursing programs and two medical schools stated the topic of death and dying was not included in the curriculum. A large majority, twenty-seven schools, integrated the death and dying content into other courses. It was noted by the investigators that 37% of schools using an integrated approach did not specify the hours devoted to this topic, suggesting that content is not included in a systematic manner (p.37). Lecture format was frequently reported as a teaching strategy, with role playing reported infrequently. The authors of this survey recommended that evaluative research be encouraged to help determine the most appropriate time for and the most effective method of teaching this topic.

Nursing Research

Research has been completed that examined death education in the nursing curricula. Initially reports of changes in nurses' attitude toward death through education were descriptive and subjective. Nurse educators related their experiences in helping students to confront death and to provide care for the dying. Courses, their content, methods and assignments, were discussed. The effects of particular learning units were evaluated by authors through their own subjective observations and/or through self-reports of the students via course evaluations. A review such studies follows.

Folck and Nie (1959) described the material on the meaning of death and the management of grief that was incorporated into the curriculum of the Los Angeles School of Nursing. A multidisciplinary approach was used that included contributions from sociology, psychiatry, and theology. Student evaluations of the course mentioned the value of the series of lectures and requested further ones. The teachers found the learning impacted the clinical setting as the students seemed more at ease with dying patients and their families and seemed freer to discuss their own feelings

and behaviors. The authors stated their belief that such concepts in the curriculum were of great value in that nurses require preparation in confronting death, not only to protect themselves from undue trauma, but to provide adequate care to the dying patient and his family.

Drummond and Blumberg (1962) incorporated the topic of death into an adult health course in the senior year of a baccalaureate course for nurses, also at the Los Angeles School of Nursing. One two-hour period of the this course included a lecture and discussion of death. A written assignment directed students to describe an incident in their professional experience in which death had been a major aspect of the nursing care. The educators found the quality of work submitted to be considerably above that of the other papers produced for the course. One leitmotiv of the papers was that nurses, as individuals, must realize that they have personal views toward death that affect their capacity to care for patients (p.24).

Wagner (1964) described the method of teaching nursing students to work with the dying at the University of Kansas. A heavy reading list of both fiction and nonfiction was provided and followed by

discussions to help them analyse their own feelings and attitudes about death. It was believed such classroom discussions forced students to face up to death vicariously and to deal with their emotions prior to having actual experiences with patients. There was no systematic measurement of the effectiveness of this approach, but only two of the 64 student evaluations were negative - one stating the experience to be an inadequate one.

Junior nursing students at the University of Wyoming were introduced to death as a topic by a seminar (Watson, 1968). Role-playing and small group discussion were used to draw personal philosophies about death and the care of the dying. In collaboration with the seminar, an assignment was given : a written account of the student's personal death philosophy and a research topic related to death. In a second semester with some of the same students, a different, more structured approach was taken. A multidisciplinary panel consisting of a psychiatric social worker, a psychiatrist, an attorney, a physician, a Jewish rabbi, a Protestant minister and a Roman Catholic priest discussed questions about death and dying presented to them by the students who had completed a review of the

literature on death. Watson concludes that their are no definite answers as to how to present an uncomfortable topic like death, but that it should not be avoided in the field of nursing.

Robinson (1974) presented experiences encountered in teaching nursing students about death. As a teacher of a course focusing on developing relationships between health care workers and dying patients, she required her students to establish a relationship with a dying patient through weekly visits. During this fourteen week experience, the students kept records of the encounters, reviewed nursing literature related to dying, and prepared seminars on related topics. Robinson subjectively found that all the students had changed in some way by the end of the course. They no longer avoided awareness of the dying patient, nor shied away from relating to him. They were more spontaneous during interactions with their patients. The most successful students helped patients maintain open communication. "Best of all, the students learned not to fear." (p.652) This teacher maintains that, though didactic components are necessary in learning about death, the students must be free to report personal reactions to the experience.

Wise (1974) noted that, though nurse educators could now say the word "death", it was questionable whether students were gaining the experience they needed in order to develop as human beings who could give good care to the dying. She described a learning experience at the University of Texas School of Nursing intend to meet this educational deficiency. The experience occured in three phases. Phase one involved creating in the student the desire to study death by introducing music and readings on cultural responses to death and grieving. Phase two focused on identifying one's own response to death, by discussions stimulated by readings and films, and by completeing an attitudinal measure (not identified). Phase three provided learning about specific nursing interventions through role play and a simulation with a guest lecturer who assumes the role of a dying person. A questionnaire was administered to the students (number unidentified) between two and twenty-four months after this unit. Ninty per cent of the respondents (number unidentified) said that the learning experience had improved their care of the dying.

Some nursing studies did utilize more objective measurements of students' attitudes toward death in their evaluation, but these studies tended to investigate the effect of nursing education in general, rather than the effect of a particular program. The folowing is a review of two such investigations.

Lester,Getty and Kneisl (1974) compared death attitudes of 128 undergraduates, 66 graduate nursing students and 62 faculty at a New York state university school of nursing using the questionnaire,"Attitudes toward Death and Dying". These researchers examined whether fear of death and dying decreased with increased academic preparation and found that as a general trend this was so. Some exception was noted with the first-year graduate group. A second question posed was whether such fear was positively related to medical-surgical specialization rather than to other areas like community health or mental health - psychiatric nursing. No support was found for this hypothesis as there was no significant difference in mean scores according to area of clinical specialization.

Yeaworth, Kapp and Winget (1974) compared 108 freshmen and 69 seniors in a bacculaureate nursing

program in Cinncinnati. The seniors had completed a curriculum that provided experience in caring for dying patients, classes on loss, grief and death, and one-to-one counselling. In answering a questionnaire, "Questionnaire for Understanding the Dying Person and His Family", created for this project, the seniors had scores significantly different from the scores of the freshmen.They showed greater acceptance of feelings, more open communication and broader flexibility in their responses. It is important to note that significantly more of the seniors reported experiences with the death of a family member, but more freshman indicated having a friend who died. This difference in personal death experience may have influenced their scores. The investigators recognized also that verbal facility cannot be discounted as a factor in score differences and suggest a longitudinal study is needed to verify the findings.

Some nurse-researchers did investigate the effect of a particular program in the curriculum on the attitudes of the students toward death and dying. Three such studies were found.

Hopping (1977) examined whether a change in death attitude was associated with the senior clinical

course,"Nursing of the Adult Patient with Malignant Neoplastic Disease" at an American midwestern school of nursing. Twenty students in the course composed the study group with twenty randomly selected, non-enrolled students completing the control group. The subjects were pre- and post-tested (to avoid the Hawthorne effect, all 79 senior students were tested) using the questionnaire,"Death Attitude Indicator", designed by the investigator. The students in the study group showed overall a more positive attitude toward death as indicated by both pre- and post-tests. As these students were self-selected by their enrollment, it is possible their attitude influenced their decision to learn to care for the terminally ill. No change in attitude was found for either group. Hopping questioned whether the course ever addressed the personal attitudes of the participants.

Taylor (1979) did not find any signifcant effect occurring from a death and dying program for student nurses at a Texan Junior College. She used an pre- and post-test design to measure death anxiety of 60 student nurses divided into three treatment groups. An experimental group received fifteen hours of instruction concerning death and dying, an active

control group read On Death and Dying. (Kubler-Ross,1969), and a passive control goup received no experimental exposure to death and dying. The instruction on death and dying involved lectures and exercises presented to personalize the concepts of death and dying for the individuals taking part. Boyar's Fear of Death scale was used to measure death attitude. Taylor suggests that a post- post-test design may be more effective in determining change - ie. death anxiety may decrease over a period of time following the treatment of a death education program. This study differs from the others in that more rigorous experimental controls were applied.

Caty and Tamlyn (1984) found a two-day death education seminar to have provided third year bacculaureate nursing students with a more open flexible death attitude. Their program focused on promoting an awareness of personal feelings and attitudes toward death and an understanding of the nurse's role in caring for the dying through lectures, films and small and large group discussion. This study found a significant difference in the mean death attitude score, as measured by Winget's "Questionnaire for Understanding the Dying Person and His Family", of

nursing students who experienced the seminar and a control group of physiotherapy students who did not. The subjects were volunteers at the same Canadian university who were aware of the purpose of the study. Measurement occured prior to and 3 months and 14 months following treatment. As a significant difference was found between the experimental group and the control group at he time of pre-test. Adjusted mean scores were therefore used at the following analysis of mean scores, in an attempt to control for any confounding differences. There were no significant correlations between the mean scores and experience with the death of a family member, or experience with a dying patient, nor with intensity of religious belief. No significant difference was found between the treatment and the control groups three months after the seminar, but at the 14-month follow-up post-test such a difference was revealed. Death education treatment had a positive effect on death attitude. Prior to the seminar 73% of the treatment group had nursed a dying patient; at the time of final measurement, only 13% had no such clincal experience. By the final measurement 62% of the control subjects had worked with the dying; 53% had studied the topic of death and dying in a course. The

investigators note that measuring the students' attitudes a few days after the seminar might have given a better understanding of the influence of the seminar on death attitudes. Personal and professional experiences of the nursing students, as compared to that of the physiotherapy students, may have accounted for the final difference in death attitude. It may be that this study measured the positive effects of the overall nursing program on death attitudes of the students.

Further studies of the effect of a particular death education program have been completed but with registered nurses rather than students as the subjects.

Murray (1974) determined that a program of six one and a half hour sessions did decrease the anxiety level of its 30 nurse participants as measured by Templar's Death Anxiety Scale. This learning experience included films, discussions, lectures, and sensitivity exercises, and role-playing. The means obtained by the nurse subjects were 6.70 on a pre-test, 6.36 on a post-test given on completion of the program, and 5.63 on a post-test 4 weeks later. The follow-up post-test means are significantly lower than both other means. Murray suggests the interim following the course may

have given the nurses time to relfect upon their feelings and attitudes toward death. It should be questioned whether the re-testing factor influenced the results.

Laube (1977) also found a delayed positive effect of a two-day death education experience consisting of both lecture and small group discussion.The program focused on information regarding grief and the care of the dying, and discussion of the nurses' own attitudes toward death. This death and dying workshop lowered the death anxiety level of 44 nurses when measurement with the DAS occurred both at one month and three months following the experience. At the pre-test and post-test immediately following the workshop, the subjects scores had been consistent with that of the general population.

Ross (1978) questioned whether a professional's awareness of personal death concerns was helpful in the care of the dying. He found that using a fantasy of the subjects life and death and thus exploring personal death concerns increased the ability to respond more openly and to interact more congruently with dying patients' statements. His subjects were fifty-eight nurses active in the care of the terminally ill. This

research was conducted during a one-day inservice training seminar and used Dickstein's Death Concern Scale, the Thematic Apperception Test and seven videotaped dying patient statements as the dependent measures in a pre- and post-test design. The responses to the dying statements were rated independently by three judges as to a measure of openess or closedness in allowing the patient to discuss his concerns about death. Treatment was successful in moving a significant of the nurses toward more open responses. This research indicates that by having nurses face personal death concerns, there is a greater chance that they will relate in a helpful manner with the dying. Ross suggests that nursing programs may want to implement such methods into the curriculum.

Summary

Early studies of death education in the nursing curricula were descriptive and measured the effect of a program on the attitude of nursing students by subjective evaluation. All of these initial studies that were reviewed reported positive results (Drummond and Blumberg, 1962; Folck and Nie, 1959; Robinson, 1974; Wagner, 1964; Watson, 1968; Wise, 1974). A common recommendation by the authors of these studies was to

provide students with the opportunity to examine their personal views and reactions to death and dying. Various strategies were used in the programs described: journals, essays on personal philosophy, role-playing, and discussion groups. Ross's (1978) study confirmed that it is helpful for nurses to address personal death concerns.

The research reviewed has indicated that death anxiety decreases with further nursing education (Lester et al, 1974; Yeaworth et al, 1974). Some studies found no change in death attitude occurred following specific programs related to death and dying (Hopping, 1977; Taylor, 1979). Studies that used some longitudinal measurement, however, did find a delayed positive effect (Caty and Tamblyn, 1984; Laube, 1977; Murray, 1974). Death attitudes may change gradually and thus no change may be found if measured only immediately after the treatment of a death education program.

The research into the effect of death education for nurses has evolved from a descriptive to an experimental phase. The few experimental studies completed that have investigated nurses' death education, however, do have problems with methodology:

self-selected subjects (Caty and Tamblyn, 1984; Hopping, 1977), no control group, (Laube, 1977; Murray, 1974), or a control group other than nurses (Caty and Tamblyn, 1984). A control group seems an especially important aspect to the design structure when the change is measured over time. Events occurring in the interim may be confounding the results achieved. The before-after designs utilized in the majority of the experimental investigations reviewed (Caty and Tamblyn, 1984; Hopping, 1977; Laube, 1977; Murray, 1974; Taylor, 1979) have a troublesome aspect because of the possible sensitizing effect of the pre-test. As discussed in the section reviewing general death education research, this can affect the external validity of the experiment. A major difficulty in deriving conclusions from research in this area remains - a broad variety of death attitude measures were used, from measures of death anxiety and death fear to a measure of the understanding of the dying person and his family. Despite such difficulties, nursing research indicates that brief death education programs can be effective. The next section of this literature review examines the research that relates death attitude with personal experience with death.

Death Attitudes and Experience with Death

In her book, The Nurse and the Dying Patient (1967), Jeanne Quint examined nursing students' encounters with dying patients in the course of their education. She found that their nurse teachers' efforts to teach the nursing care of the dying patient were greatly influenced by their prior personal experience with death (p.55). The nurse teachers who could openly talk to students about this type of care were those who had come to terms with their own death concerns. This had been achieved commonly through an experience with the death of a family member or for some, through a positive encounter with a critically ill patient. Many of the instructors were found to be unable to teach about the care of the dying patients in an effective matter because they hadn't learned to cope with death and dying - in fact, they were "anxious about these matters" (p.56).

Quint's finding would suggest that those with more death experience would have less death anxiety or a more positive attitude toward death. Research into the effect of experience with death on the death attitude of the individual, however, has not confirmed this. Schultz (1978), in a critical review of the death

anxiety research, noted that, in spite of many attempts, no study had shown that contact with death or with high-risk situations influences death anxiety in either a positive or a negative fashion. (p.36) His review included studies with parachute jumpers and widows.

Nursing Research

Research studies involving nurses' attitudes toward death have been completed which examined the effect of death experience. The definition of such experience varied from the death of a relative, death of a friend, a personal near-death encounter to experience with dying patients. The results of some of these studies will be presented here.

Pearlman, Stotsky, and Dominick (1969) investigated the attitudes toward death among nursing home personnel. The 68 volunteer subjects in this study were nurses working in a nursing home or a hospital and nursing students. Divided on the basis of training, subjects underwent a semi-structured interview. The questions asked were of four general types: personal, religious, familial, and professional. It was found that those subjects with more experience with death (personal and professional) compared with those with

less experience felt uneasy discussing death with dying patients. Those less experienced were less defensive about talking with the dying. They were also less likely to favor the inclusion of the clergy in nursing education on the management of dying patients and recommended courses and seminars on care ofthe dying rather over actual experience with dying patients for nursing students.

Shusterman and Sechrest (1973) measured the attitudes toward death of 188 registered nurses in a general hospital setting using a death anxiety questionnaire. There was no relationship to any aspect of the nurses' death anxiety and death experience measured by the patient death rate on their unit. Age was a significant factor, however, and the investigators found that, for nurses, as age and experience increase, anxiety about the death of others decreases and satisfaction toward the traditional approach to the care of the dying increases. (This traditional approach involved beliefs that dying patients should be isolated from other patients, that nurses should not tell a physician their opinion of the psychological needs of the dying patient, and that

dying patients should not be told their true prognosis (p.424).

One of the most comprehensive surveys of nurses' attitudes toward death and working with the dying patient involved a sample of 15,430 nurses and nursing students (Popoff, 1975, p.16). It was accomplished by asking subscribers to Nursing 75 to complete and return a 70-item questionnaire, "Death and Dying". This study found that, in relation to one's own fear of death, little difference existed between those with frequent contact with dying patients and those with little contact. Popoff suggests that coming to terms with one's own death is not necessarily the result of cumulative experience with death and dying (p.17).

It is interesting to note that the nurse respondents to this survey indicated that 47% of them seldom or never experienced fullment and satisfaction in caring for the terminally ill. A majority of these nurses (72%) were only slightly confident or not at all confident of their ability to manage the psychological needs of the dying. Of the nurses who were very confident in their ability to give such care, 74% reported having experienced satisfaction and fullfillment at least occasionally. Popoff states " the

nurses' anxiety appears to be strongly related to fear of one's own death" (p.18). The survey indicated that about one-half of the respondents felt that they had come to terms with their own death, one-third, only in part, and one-eighth of the sample wrote that they had not yet done so.

Denton and Wisenbaker (1977) examined the relationship between death experience and death anxiety among nurses and nursing students by examining data collected in a broader research study at Eastern Kentucky University. The 76 subjects were enrolled in a course in the sociology of medicine. Three different dimensions of death experience were examined: the death of a close friend or relative (DE1), the actual experience of seeing a violent death (DE2), and a subjective death experience (DE3). Death anxiety was measured by Templer's DAS. It was found that there was no correlation between death anxiety and the death of a close friend or relative. The results, however, also indicated that death anxiety and death experience as measured by DE2 and DE3 were inversely related. This study indicates that the concept of death experience is multidimensional - with the relation to death anxiety varying with the type of experience that has occurred.

Increased exposure to death and dying alone does not lower a nurse's death anxiety.

In examining the effect of nursing experience in general on death attitudes, Golub & Reznikoff (1971) compared the attitudes of 81 graduates with those of 71 first-year nursing students. Schneidman's 57-item multiple-choice questionnaire, "You and Death" was used. The graduate nurses were identified as to clinical specialty. Graduates, regardless of years of experience or nursing specialty, were found to have different attitudes toward death and suicide than the students. Years of professional experience were not a significant factor. These researchers believe that it is in the early years of nursing experience death attitudes are influenced - most probably during the student years.

Stoller (1980) also examined, using a questionnaire, the impact of nursing experience in general on nurses' responses to situations involving death and dying in the hospital. The subjects were 44 registered nurses (RNs) and 18 licensed practical nurses (LPNs) on duty in a 450 bed hospital within a 24-hour period. The RNs had a mean of 11.5 years experience and the LPNs, a mean of 5.5 years. She found

the RNs did not increase their ability to cope with dying or death as they accumulated clinical experience. In fact, the uneasiness associated with interaction with the dying increased (p.37). Unlike the RNs, the LPNs did appear to gain coping mechanisms as they gained experience. In discussing her findings, Stoller suggested that the hospital task structure enables social contacts between the RNs and the dying to be minimized. An accumulation of negative experiences with dying patients or of loss experiences associated with affective involvement with the patient and his family were given as possible sources of the RNs' uneasiness.

Hopping's (1977) study of the effects of a program on nursing students' death attitude, also tested the hypothesis that there would be a difference at the time of pretesting with the questionnaire, "Death Attitude Indicator", between respondents who had experienced the death of a family member and those who had not. It was found those experiencing such a death did have significantly lower scores. Experiencing the death of a patient, friend or acquaintance had no apparent association with the scores.

Like Hopping(1977), Caty and Tamblyn (1984), in addition to looking at the effects of education on

death attitudes, examined the relationship between death attitude and two death experience variables: death of a family member and experience with a dying patient. No significant correlation was found between either death experience variable and the dependent measure of death attitude, the "Questionnaire for Understanding the Dying Person and His Family".

Summary

A review of the related lrature has indicated that there is no substantial data to suggest that experience with death has a positive influence on death attitude. The opposite was found to be true by some studies : death anxiety and/or difficulties in approaching the dying seem to increase with nursing experience (Lester, 1974; Pearlman et al, 1969; Stoller, 1980) Other studies indicated that nursing experience with dying patients has no significant effect, either positive or negative, on nurses' attitude toward death (Caty and Tamblyn, 1984; Golub and Reznikoff, 1971; Popoff, 1975; Schusterman and Sechrest, 1973). Death of a friend or family member was not found to be a signifcant factor (Caty and Tamblyn, 1983; Denton and Wisenbaker, 1977), except by Hopping (1977) who found death of a family member to be

associated with less positve death attitude while death of a friend had no effect. One study, though, using a multidimensional assessment of death experience, found viewing a violent death and a subjective death experience to be both inversely related to death anxiety (Denton and Wisenbaker, 1977). This would suggest future research needs to consider the conditions under which death experience and death attitude are related. Until such research is completed, one must agree with Schultz (1978) that no relationship between death experience and death attitude has been established.

It would seem that the important factor for Quint's nurse teachers may have been that they had confronted and reconciled their thoughts and feelings toward death - having a experienced the death of a friend or relative or accumulating experience nursing the dying would not seem to be sufficient.

As the research has indicated that death experience is multidimensional, the present study will narrow its examination of death experience by eliminating as a variable, the effect of death experience associated with the nursing role. This is achieved by selecting first level nursing students as

subjects - ie. students without clinical nursing experience. The focus will be upon personal death experience in terms of a family member, friend or self.

The following section contains an overview of the research related to death attitude measurement. The death education research, both in general and as related to nursing curricula, has indicated a lack of systematic use of death attitude measures. A major purpose of this study was to determine if a death education intervention can facilitate nursing students in gaining a greater awareness of their own death concerns in a positive way. It was important to find the appropriate measuring tool.

Death Attitude Measurement

Death Attitude Research

As many as fifty-two factors have been investigated in relation to death attitude (Klug, 1975). In a review of empirical studies, Pollack (1979) found many conflicting, contradictory and even paradoxical conclusions. He resolved that death attitude is a complex construct that interrelates in a variety of ways that are not completely understood with many demographic and personality factors (p.114). Directly contradictory evidence in the relationship of

death attitudes and such variables as sex, age and religion have been found (Chandler, 1980)., Durlack and Kass (1981-82), in an article concerning the clarification of death attitude measurement, comment: "The growing body of death research is perhaps best characterized by its inconsistent findings."(p.129). It is a complicated, confusing, area of research.

Janz (1983) identified the following problems as frequently associated with death attitude research (p.32):

- Poor definition and operationalization of death attitude constructs. Death fear, anxiety , concern, acceptance are mistakenly used interchangeably.

- The dimensionality of death attitude may determine its relationship to other variables. Death attitude may be perceived as unidimensional (death anxiety, fear) or multidimensional (death concern, reconciliation with death).

- The depth of analysis may determine research findings. Conscious (self-report; interview) or unconscious (physiological; projective) measures may determine different findings.

- The type of sample used will frequently determine the direction of the research results.

Variables such as age, occupation, and religion can impact the attitudes demonstrated.

In regards to the contradictions of this research, Dumont and Foss (1972) noted that, after a survey of the major problems involving general methodological shoddiness, investigator bias, deficiencies in questionning techniques and projective devi[illegible] overinterpretation of data and conceptual [illegible], one must be surprised that there exists as muc[illegible]ement as there does in this field.

Death Attitude Measures

A major dilemma facing the researcher wanting to measure attitude change through death education is ho[illegible] to effectively operationalize and measure an individual's attitude toward death (Kurlychek, 1978). Chandler (1980), in an extensive review of death attitude research, found that this attitude has been operationalized in terms of (1) death fear (2) death anxiety (3) death concern (4) death acceptance and (5) reconciliation with death. A review of death attitude research follows in order to provide the reader with some understanding of the evolving issues related to death attitude measurement. Chandler's (1980) division of death attitude research will be utilized.

Death Fear. Kastenbaum & Aisenberg (1972) theorized that death fear can involve fear of extinction, fear of afterlife and fear of the event of dying. In distinquishing death fear from death anxiety, Liburd (1980) suggests that death fear possesses direction and objectification, while death anxiety is a vague apprehension without either characteristic. In spite of a recognizable difference in the concepts of death fear and death anxiety, they are used as interchangeable concepts in much of the research (Janz, 1983; Shultz, 1978).

One of the earliest measurements of death attitude was initiated by Sarnoff and Corwin (1959) when they sought to examine the relationship between fear of death and castration anxiety. The five-item Sarnoff and Corwin Fear of Death Scale was used in a test of the hypothesis that individuals with severe castration anxiety should show more fear of death after being exposed to sexually arousing stimuli than individuals with less castration anxiety. The hypothesis was confirmed in a study of 56 male undergraduates. In this early, psychoanalytically-orientated attempt to construct a measure, fear of death is conceived as arising secondary to castration anxiety.

Lester (1967) developed a twenty-one item questionnaire with items assigned weighted values to reflect different amounts of death fear in a study of suicidal patients. Collett and Lester (1969) developed a thirty-eight item questionnaire in research differentiating between types of death fear : fear of death, fear of the process of dying, fear of death of self and fear of death of others. From this research they concluded that there is a need to treat death fear as other than a single component concept. The broad spectrum of this measure differentiated it from other scales. Durlak (1972) examined the scales of Sarnoff and Corwin, Lester, and others by Tolor and Boyar. He noted as a primary concern that measures should be based on a clearly defined fear of death and definitons of related events such as terminal illness. He would find that the four measures reviewed as measuring personal fear of death, rather than indefinite or free-floating anxiety.

Death Anxiety

Kastenbaum and Aisenberg (1972) define distinctive death anxiety as being a diffuse, very unpleasant experiential state as well as an emotional response to one's own extinction, annihilation, obilteration or

ceasing to be. They note that death anxiety and non-death anxiety are frequently indistinguishable.

A death anxiety measure, a forced-choice multiple response questionnaire, was developed by Dickstein and Blatt (1966). Its intention was to measure manifest anxiety associated with preoccupation with death. The picture arrangement portion of the Weschler Adult Intelligence Scale was added to assess concern with future events. The authors noted from research with this scale that individuals who openly approached the subject of death tended to be independent personalities (Dickstein & Blatt, 1966, p. 16).

Templer (1970) developed the Death Anxiety Scale (DAS) in an effort to measure a broader range of death attitudes. This fifteen-item scale is a questionnaire in which the respondents decide whether or not a particular statement is true or false. Templar validated his scale both with psychiatric patients in a state mental hospital and with college students. Patients verbalizing death anxiety concern had significantly higher DAS scores than control patients. The validity of two of Templer's basic premises has been questioned by other researchers: first, that death anxiety is a unitary measure accurately relfecting

attitude toward death (Shultz, 1978); second, that death anxiety is an inverse measure of death acceptance (Dickstein, 1972; Klug, 1976).

Death Concern. Dickstein (1972) conceptualized and operationalized death concern as the degree to which individuals consciously contemplate death and the level to which they negatively valued it. This expanded the concept of death anxiety to include, not only the affective component, but a cognitive dimension as well. The Dickstein Death Concern Scale, consisting of thirty items, was developed in a study with one hundred fifty-one female college students. Death concern was found to exist as a concept distinct and separate from general anxiety.

Death Acceptance. Ray and Najam (1974) questioned Templer's assumption that death anxiety is inversely related to death acceptance. Examining both the DAS and Sarnoff and Corwin Fear of Death Scale, they found a preponderance of death anxiety items with the remaining items focusing on denying the fear of death. No test item measured positive attitudes toward death. They emphasized that it would be possible to confuse highly maladaptive with highly adaptive respondents since responses are conceptualized only in terms of admitting

death anxiety or fear or denying them. Therefore, a new questionnaire was devloped, adding seven death acceptance items to fifteen items selected from Templer's and and five from Sarnoff and Corwin's scales. Tested with two hundred and six college students, only a low negative correlation was found between death acceptance and death fear and death anxiety (r=-.263 and r=-.242, respectively). The findings support the validity of death acceptance as a separate construct, and suggest assumptions that it is the categorical opposite of death fear or anxiety are incorrect.

Hardt (1979) has developed a death attitude measuring device. Using multiple regression analysis of his results, he concluded that variables of sex, socio-economic level attendence at religious functions and a death experience of a recent nature did not have an substantial effect on a subject's attitude toward death acceptance. Hardt implies from his research that accepting death and personal death are indicative of mental hygiene, and that his instrument could be utilized to identify a pathological fear of death.

Another scale has been developed to measure death acceptance and is consistent with the thesis that an

individual can exhibit a degree of death fear and still simultaneously maintain a sense of acceptance of death. Kurlychek (1978-79) developed a Death Acceptance Scale, created according to standard semantic differential attitude scaling procedures, uses seven biploar adjectives loading high on the evaluative dimension (eg. useful-useless, negative,positive) to anchor each end of a seven-point response scale. Any death-related concept can be inserted by the investigator into the scale.

Death fear, death anxiety and death concern research did not seem to distinquish among individuals who denied negative feelings toward death and those who had confronted and accepted death. Death acceptance represented a more promising construct for exploring death attitudes. Klug's conception of death acceptance, reconciliation with death, is used in this study and, therefore, will be reviewed in detail.

Reconciliation with Death

Klug (1976) made a substansive review of the existing death attitude literature with an emphasis placed on formulations of death acceptance. Klug reviewed theoretical articles by Feifel, Dumont & Foss, McKissack, and Paskow. He found support for a two

component formulation of death acceptance in their work.

Feifel. Feifel (1959) used the terms confrontation and integration of death in his examination of death attitudes, but did not clearly define them.

Dumont & Foss. Dumont and Foss (1972) described "attitudinal death acceptance" as a concept allowing for degrees of denial, fear and concern to co-exist with acceptance. This type of acceptance was conceived as evolving from more than an acknowledgement of the inevitability of death: it required an individual to utilize both his intellectual and emotional capacities.

McKissack. McKissack (1974) proposed that an individual's acceptance of death occurs in a variety of forms or levels. The first level, involving only a cognitive approach, would involve the intellectual acknowledgement of death as a fact and a condition of life. The second level would concern the acknowledgement of fear, anxiety, and depression which result from thinking about death. McKissack's third level would be reached when personal feelings about death combine with the cognitive acknowledgement of death to create a form of personal death acceptance.

Paskow. Paskow's (1974) writng emphasized that death acceptance does not mean unconditional, passive acceptance with no fear or anxiety involved. He stressed it is not a concrete objective to be obtained or maintained without effort from the individual. He, as well, described death acceptance as a process with both intellectual and emotional dimenssions. His terms were "confrontation" for the intellectual component and "emotionally apprehending death" (p.57) for the emotional component of death acceptance.

Klug recognized a need to develop a construct of death acceptance with a theoretical base, clearly defined terms and a research instrument from which direct inferences could be made. He formulated a new model, a dualistic concept of death acceptance, termed "reconciliation with death". Reconciliation with death was defined as "The deliberate intellectual acknowledgement of the prospects of one's own inevitable death and the positive emotional assimilation of the consequences." (Klug, 1976, p.32). The first of the two components of reconciliation with death is death confrontation : one cognitively confronts the inevitablity of one's own death. The second component, death integration, involves accepting

and integratating one's personal feelings about death that arise as a consequence of death confrontation. Klug viewed both components as essential to death acceptance, as both intellectual and affective acceptance must be present for an individual to be reconciled with death.

CIDS. Klug (1976) then developed the CIDS with items constructed to reflect his two-dimensional formulation of reconciliation with death. He used this scale to investigate the hypothesis that high self-actualizing individuals would tend to confront and integrate thoughts and feelings of death and dying at a significantly higher level than low self-actualizing individuals. Using 245 church-attending Roman Catholics as subjects, Klug found his hypothesis confirmed.

Summary

In summary, a review of the literature pertaining to death attitude measurement revealed that investigators have tended to define death attitude in negative terms involving fear, anxiety, denial and concern rather than positive terms such as acceptance of death. Death fear, death anxiety and death concern research has been unable to distinquish between those who harbor yet deny a fear of death and those who

exhibit a degree of death fear and yet maintain a sense of acceptance of death. Reconciliation with death differs from other formulations in that it seeks to make direct inferences about an individual's efforts to confront and integrate thoughts and feelings about death. It is a potentially more sensitive approach to assessing an individual's personal death attitude as feelings of denial or anxiety are not automatically excluded (Chandler, 1980). When measuring death attitudes following an educational intervention in which personal anxieties may be aroused, this is an especially important attribute of the measure to be utilized. As this investigation was designed to measure if death education can facilitate nursing students in gaining an awareness of their thoughts and feelings concerning death in a positive way, Klug's CIDS was selected as the most appropriate dependent measure.

Chapter Summary

Chapter two reviewed research literature which indicated that, though conclusive data was not yet available on the effectiveness of death education, it could be a potential solution for enabling nursing students to confront their own death concerns. Nursing researchers maintain that it is helpful for nurses to

address personal thoughts and feelings toward death. It would seem that attitudes toward dying patients are probably formed in a nurse's student years,- indicating the nursing school as an appropriate place to set a death education program. No relationship between death experience and death attitude has been established, but the research suggests death experience is multidimensional. The present study examined the relationship between death attitude and personal death experience. Professional experience was eliminated as a variable.

Death anxiety seems to decrease with further nursing education in general, but no change has been found immediately following specific death education programs in the curricula. Change, however, has been found when death attitude was measured over time following a death education intervention. In this respect, the present investigation may be somewhat limited as longitudinal measurement was not feasible. No conclusive evidence was available as to the most optimal approach to teaching about death, though most courses could be placed along a didactic-experiential continuum.

One major difficulty in deriving any common denominators from research in this area has been the wide variety of death attitude concepts and measures used by investigators. Death acceptance was found to be the most appropriate concept for this study - as the study examined the effect of educational interventions in promoting an awareness of death and personal death concerns in a posftive way. Klug's CIDS was reviewed as a measure of death acceptance and selected as the dependent measure of this study.

This literature review has indicated a need for well-controlled studies investigating optimal approaches to death education for nursing students. The investigative procedures utilized in the present study are outlined in the following chapter.

III. The Investigative Procedures

This chapter is an overview of the investigative procedures that comprise this experimental study. Information is provided in regard to the subjects, the measurements, and the design of the study. As well, a step-by-step execution plan is presented in order to ensure the possibility of replication. The seven phases of the study are outlined: the formulation of the death education programs, the introduction of the workshop experience to the students, the workshop day, the workshop evaluation, the administration of the CIDS, the death education experience for the control group and the data analysis.

Subjects

A first-year class of 106 nursing students comprised the sample. Their hospital-based school, the Royal Alexandra Hospital School of Nursing, is located in Edmonton, Alberta - a major urban center in western Canada. The school has a 28-month program leading to a diploma in nursing. Subjects' ages ranged from 17 to 42 years, with a mean age of 22.9 years. Of the 106 students, four students were males.

Self-selection of subjects was controlled by incorporating the programs comprising the treatment levels of this study into the adult development section of a required psychology course. Seven nursing service personnel were also enrolled in the course: their data were omitted.

The subjects were in the first level of their program - ie. they had as yet no clinical experince as nursing students. This enabled experience with dying patients to be controlled as a variable. As well, their nursing education had not encompassed material on bereavement, loss and grief, nor the care of the dying patient.

Randomly assigned to one of three treament groups, 32 of a possible 36 subjects attended the placebo program provided to the control group. Thirty-five of a possible 35 subjects attended the didactic program; 31 of a possible 35 attended the experiential session. Five subjects left their assigned group at some time during the treatment sessions: one from the control group due to illness, four from the didactic group (three for medical or chiropractic appointments; one to write an examination in another course). Their data were omitted.

By chance, at the subsequent class in which data were collected, 27 students from each group attended whose data could be utilized - ie. subjects who had attended their entire treatment session. (This may be an indication of the effectiveness of the random assignment.) Of these 81 students, five did not fully complete the instrument measuring their reconcilation with death: one from the control group; four from the experiential group. Their data were omitted. Therefore, n=27 in the didactic group; n=23 in the experiential group; and n=26 in the control group.

The drop-off may not have been random. It is possible that some factor arising from the treatment influenced a student's non-appearance at the data-collecting phase of this research. Another influential factor may have been that the class in whch death attitudes were measured immediately followed an exam-time break period - ie. some students took an additional day off. All the "drop-offs" were female.

The Instruments

Reconciliation with death was measured by Klug's (1976) Confrontation-Integration of Death Scale (CIDS). The CIDS is a likert-type response option

questionnaire that measures the two components of the reconciliation with death construct, death confrontation and death integration. Previously elaborated in Chapter II, these factors are defined as conscious contemplation of the inevitability of one's own death (death confrontation) and the positive emotional assimilation of the consequences of such a confrontation (death integration).

Score range of the CIDS is 0-72. There are 18 items. The death confrontation factor is measured in 8 items: questions 1,6,8,9,11,12,14, and 17 on the CIDS. The score range on this 8 item scale is 0-32. These items attempt to assess an indiviual's willingness to reflect on death and discuss death, even amidst feelings of fear, concern and anxiety. The death integration factor is measured in 10 items: questions 2,3,4,5,7,10,13,15,16, and 18 on the CIDS. The score range on this 10 item scale is 0-40. These items attempt to assess the extent to which an individual has assimilated thoughts and feelings about the prospect of death in such a way that life is more meaningful. On both of these scales, a high score indicates that a subject possesses a greater degree of the factor being assessed than would be indicated by a lower score.

CIDS Validity

Research (Klug, 1976) has indicated that the CIDS demonstrates a positive correlation (r=+.33) between death confrontation and death integration and a negative correlation with death anxiety as measured by Templar's Death Anxiety Scale (DAS). Correlation between confrontation and DAS was -.36; correlation between integration and DAS was -.22. The direction of these correlations is as predicted by Klug's reconciliation with death construct. The CIDS shows a low positive relationship between thinking about death and integrating feelings about death in a positive, life-enhancing manner - as would be expected with two components that were not independent. A low negative relationship is exhibited between such confrontation and integration and death anxiety. This low negative correlation (rather than a high negative one) is in keeping with Klug's contention that a certain level of death anxiety is not incompatible with death reconciliation but rather may be a dimension of it. This research provides some support, then, for the validity of the reconciliation with death concept and its measurement through the use of the CIDS.

CIDS Reliability

The CIDS has undergone some reliability checking (Klug,1976). Test-retest reliability coefficients of .59 for the confrontation items and .55 for the integration items, after a lapse of 5 weeks were obtained for a group of 42 female nursing students. Kuder-Richardson Twenty Coefficients of .81 for the confrontation items and .85 for the integration items were obtained for a sample of 178 subjects. In a sample of 221 subjects, Kuder-Richardson Twenty Coefficients of .78 for the confrontation items and .85 for the integration items were obtained.

CIDS Scoring and Administration

No time limit was set for subjects completing the CIDS. The items were hand-scored using a four category likert-type response option: strongly agree, agree, disagree, strongly disagree. Seven of the eight confrontation questions (1,6,8,9,12,14,17) were scored in the direction of four to one. Question 11 was scored in the direction of one to four. The ten questions designed to measure death integration (2,3,4,5,10,13,15,16,18) were all scored in the direction of one to four.

Data were gathered with the CIDS concerning personal death experience: subjects were asked to volunteer information concerning any personal death experience, be it with a relative, a friend, a stranger, or a personal brush with death.

Workshop Evaluation

A workshop evaluation form was completed by the students in the experiential and didactic program groups.

This form contained 6 items :

1.How comfortable or uncomfortable were you in the first hour? Circle one: very comfortable, comfortable, uneasy, moderately uncomfortable, very uncomfortable.

2.How comfortable or uncomfortable were you in the last hour? Circle one: very comfortable, comfortable, uneasy, moderately uncomfortable, very uncomfortable.

3.The part of the workshop that you liked best was...

4.The part of the workshop that you liked least was...

5.Did you become more aware of death? If yes, was this awareness helpful, not helpful, or of no effect at all? Please explain.

6.Do you have any comments, ideas or constructive criticisms to add?

Descriptive data concerning the participants' reactions to the death education programs were gathered anonymously through this questionnaire.

In summary, the major instrument used to measure the subjects' reconciliation with death was the Confrontation-Integration of Death Scale. Data regarding the students' personal evaluation of the death education programs' effects on their awareness of death were gathered via an open-ended questionnaire. Information regarding the subjects' personal death experience was collected.

Design of the Study

This experimental study involved the random assignment of subjects to two experimental groups and a control group. Using a post-test paradigm, the independent variable manipulated was attendence at a short program of death education. There were three levels of the independent variable: an experiential approach, focusing on personal reactions and feelings toward death; a didactic approach, focusing on providing information on death and the dying process; and a placebo approach provided to the control group. The dependent variable, reconciliation with death, was measured by the CIDS, a likert-type response option

questionnaire. Descriptive data were gathered concerning the subjects impressions of the death education programs and their personal death experience.

Study Procedure

There were seven phases to this study. In phase one the death education programs were formulated and the workshops leaders selected and prepared. In phase two the workshops were introduced to the students who were randomly assigned to one of three treatment groups. In phase three the one-day workshops were presented. Phase four involved the completion of a workshop evaluation that asked the participants of death education programs for their anonymous opinions of their program. In phase five the CIDS was administered during a regular psychology class period that occured 7 days following phases two and three. Phase six involved the presentation of a brief death education program to the students that comprised the control group. Data analysis comprised the seventh and final phase. Following is a description of the specific aspects of each phase of this study.

Phase One: Formulation of the Death Education Programs

The researcher designed and outlined the objectives and content of the three programs that

constituted the treatment levels of this study. Detailed course outlines may be found in the appendixes: a general description will be given here.

The Didactic Program. A format of lectures, films and group discussion was used to present such topics as the dying process, tasks of the dying, a developmental view of death and death in our society.

The Experiential Program. A personal focus was taken, using death awareness exercises, music, drawing and dyadic encounters between students.

The Placebo Program. A program consisting of a simulation game, "Brookside Manor" that deals with independence in the aging adult, and lectures from the psychology course were presented. The students in the other two groups received these lectures later, while the control group attended two death education seminars (phase six).

The researcher selected and hired five workshop leaders to present the death education programs. These individuals all had graduate-level preparation in educational psychology, specializing in counselling. All but one were involved in research relating to terminal illness, death or bereavement. That one individual had preparation and skills in group

counselling that were required by the experiential program. Two of the leaders were nurses as well as counsellors: each death education program had one leader who was a nurse.

In an attempt to minimize any effect of researcher bias on the outcome of the study, the researcher, a nurse, was involved only in the program presention to the control group. There were two leaders of the control group program, the other being the professor of the required psychology course in which the subjects of this study were enrolled. The didactic program had two leaders, as well. The format of the experiential program required a higher leader/participant ratio and three leaders were involved with this group.

The program leaders met in separate groups with the researcher to plan and to discuss the specific details of the workshop presentations. They were provided detailed course outlines and reference materials, as well as any audio-visual aids that were used. At a later date, the leaders met within their groups and without the researcher to rehearse the workshop day.

Phase Two: Introduction of the Workshop to the Students

During a regular psychology class, one week prior to the treatment of this study, students were informed that a lab or workshop would take place in conjunction with the adult development section of the course. This section focuses on such topics as mid-life developmental tasks, aging and death. They were also informed t an aspect of the one-day workshop would be a research project on nursing education- a graduate student project being partially funded by an Alberta Foundation of Nursing Research Bursary.

Students were told that they had been assigned at random to one of three groups, and that a posted class list would announce their group number and the place of their workshop. They agreed not to discuss any part of their workshop day with participants in another group until formally notified that they could do so. (This was particularly stressed and restated again during the workshops at their onset, conclusion and prior to lunch break.) Students were told the project would be concluded in the class one week following the workshops, and that the researcher would discuss the project with them at that time.

The workshop experience would not be a graded component of the psychology course. Random assignment of subjects to groups was accomplished using a numbered class list and a random numbers table.

Phase Three: The Workshop Day

The three levels of the treatment in this study, the workshops, took place simultaneously at the Royal Alexandra Hospital School of Nursing on Monday, November 26, 1984. The workshop programs ran from 8:00 h. to 1500 h. with a one-hour break for lunch. The didactic program was held in a classroom; the experiential program was held in the school auditorium and the placebo program was held in a classroom and a seminar room. The auditorium was not an ideal setting for the experiential approach: it was too large and bare to facilitate a warm, sharing atmosphere. It was the only space available, however, that could accommodate this group and its exercises.

Phase Four: Workshop Evaluations

At the conclusion of the workshop, subjects in the didactic and experiential groups completed the workshop evaluation form, anonymously except for group membership. These were completed without a time-limit and submitted to the workshop leaders.

Phase Five: Administration of the CIDS

The CIDS was administered to all students attending the regular psychology class, seven days following the workshop programs. It was necessary to find a method to indicate students who were from nursing service, or who did not attend the workshops, or who had left the workshops for such reasons as a medical appointment, in order that their data be omitted from the study. It was also essential to know to which treatment level the student belonged. The method utilized involved placing the students' names on a detachable label to the front of the instruments. The instruments were then coded with the workshop group number, and information concerning attendence and level of experience (ie. graduate or student nurse). The students were given the instruments with their name on them and the directions to detach their name-label on completion of the questionnaires.

Phase Six: Death Education for the Control Group

As the researcher believed that a valuable education program had been offered to the subjects in the other treatment groups, a death education program was made available to the control group. This is in keeping with the ethics involved in educational

research. The program for the control group was a seminar presentation in format, involving group discussion, music and some lecture.

The researcher presented the program to these students during the two class periods following the administration of the CIDS. (The other students were receiving lectures given to the control group on the workshop day.) Because the psychology course was near completion, this program had to be presented at this time. It was not possible to allow a period of time to elapse and to have a remeasurement of the subjects' death attitudes before the control group received a death education program. This is regretable as such a remeasurement may have indicated a change over time in reconcilation with death scores.

Phase Seven: Data Analysis

CIDS. A two-way analysis of variance was completed with the CIDS scores for death confrontation and death integration with treatment group and personal deat experience as the variables. This analysis was a test of hypotheses one through four.

Two assumptions underlying the use of an analysis of variance model follow:

Assumption 1: ...the distributions of the variables from which the samples are drawn are normal.

Assumption 2: ...the variances in the populations from which the samples are drawn are normal. This is known as homogenity of variance.

One advantage of the analysis of variance model is that reasonable departures from the assumptions of normality and homogenity may occur without seriously affecting the validity of the inferences drawn from the data (Ferguson, 1981;p.245-246).

Workshop Evaluation Analysis. The students' responses to the open-ended questionnaire that comprised the workshop evaluation form were compiled. Percentages were calculated to determine if the majority of the participants of each program believed that the workshop had increased their awareness of death. Comfort levels were assessed as to increasing or decreasing from the onset to the completion of the programs.The remaining information available through the evaluations was descriptive.

This chapter has summarized the investigative procedures involved in this study. The subjects comprising the sample have been described, the dependent measures reviewed, and the research design

presented. A step-by-step execution plan has been outlined in regard to the seven phases of this investigation. The results of the study are presented in the next chapter.

IV. The Results of the Investigation

This chapter presents an analysis of the data obtained from the post-test only design of this study. It consists of two major sections. The first section describes the results of a statistical analysis of the CIDS scores comparing the two levels of the nominal variable, personal death experience, and the three levels of treatment of a death education program. The second section consists of a review of the experimental subjects' evaluation of their workshop experience, including their perceptions of the effect of the death education program on their personal awareness of death.

Results of the Statistical Analysis of the Data

A two-way analysis of variance was computed for the CIDS scores comparing the two levels of the nominal variable, personal experience with death, and the three levels of treatment. This comparison was completed in two steps:

- an examination of death confrontation scores (Table 1)

- an examination of death integration scores (Table 2).

The level of significance was set at p = .05. This analysis was a test of hypotheses one through four.

In the analysis of variance, an unweighted main effects solution was utilized -ie. without the assumption of additivity. This is a commonly used method for adjusting data for unequal numbers in the subclasses (Ferguson, 1981; p.267). The cell sizes for this experiment are to be found in Table 3. The results of this analysis of variance follows.

Analysis of the relationship between reconcilation with death and treatment of a death education program

First hypothesis. Stated in null form, this hypothesis was as follows:

Ho: There will be no significant difference in reconcilation with death scores between subjects who received a treatment of a death education program and subjects in a control group who received a placebo program.

Table 1

Mean Death Confrontation Scores as a Function of Death Education and Personal Experience with Death

	Personal Death Experience		
Death Education	Experienced	Inexperienced	
Experiential	23.000	26.500	24.750
Didactic	24.364	22.400	23.282
Control	24.381	22.000	23.190
	23.915	23.633	

Table 2

Mean Death Integration Scores as a Function of Death Education and Personal Experience with Death

	Personal Death Experience		
Death Education	Experienced	Inexperienced	
Experiential	27.176	30.167	28.672
Didactic	28.955	28.000	28.477
Control	30.048	28.200	29.124
	28.726	28.788	

Table 3

Distribution of Nursing Student Subjects by Treatment Group and Personal Experience with Death

Treatment Group	Personal Death Experience	
	Experienced	Inexperienced
Experiential	17	6
Didactic	22	5
Control	21	5

In the event that this null hypothesis was rejected, an alternative hypothesis was formulated:

H1: Subjects receiving either death education program will have higher CIDS scores than subjects in the control group who received a placebo program.

The null hypothesis was accepted. The treatment of a death education program was not found to be a significant source of variance in the scores. The F-Ratio for the death confrontation scores (Table 4) was 1.176 with $p>.05$. The F-ratio for the death integration scores (Table 5) was .109 with $p>.05$.

Second hypothesis. Stated in null form, this hypothesis was as follows:

Ho: There will be no significant diffference in the reconciliation with death scores between subjects who received a didactic death education program and subjects treated with an experiential death education program.

An alternative hypothesis was formed in the event the null hypothesis was rejected:

Table 4

Analysis of Variance for Death Confrontation Scores

Source	Sum of Squares	D.F.	Mean Squares	F Ratio	Prob.
Rows (Treatment)	0.2489E +02	2	12.443	1.176	0.315
Columns (Experience)	0.9844E +00	1	0.984	0.093	0.761
Interaction	0.9257E +02	2	46.285	4.374*	0.016
Error	0.7408E +03	70	10.582		
Total	0.8592E +03	75	11.456		

* Denotes F significant at a critical level of p = .05

Table 5

Analysis of Variance for Death Integration Scores

Source	Sum of Squares	D.F.	Mean Squares	F Ratio	Prob.
Rows (Treatment)	0.3590E +01	2	1.795	0.109	0.897
Columns (Experience)	0.5078E -01	1	0.051	0.003	0.956
Interaction	0.5685E +02	2	28.426	1.724	0.186
Error	0.1154E +04	70	16.486		
Total	0.1215E +04	75	16.193		

H2: Subjects in the experiential program which addressed the personal reactions and feelings of the participants toward death will have higher reconciliation with death scores than the subjects in the didactic program where personal issues were not addressed.

The null hypothesis was retained, as neither death education program by itself was a significant source of variance in the scores.

Analysis of the relationship between reconciliation with death and a personal death experience.

Third hypothesis. Stated in null form, this hypothesis was as follows:

Ho: There will not be a significant difference in the reconciliation with death scores between subjects who had a personal death experience and subjects who did not.

In the event that this null hypothesis be rejected, an alternative hypothesis was formed:

H3: Subjects with a personal death experience will have higher reconciliation with death scores than subjects who had no such experience.

The null hypothesis was retained. Personal experience with death alone was not a significant source of variance in the CIDS scores. The F-Ratio for death confrontation scores (Table 4) was .093 with $p>.05$; for death integration scores (Table 5), $F=.003$ with $p>.05$.

Analysis of an interaction effect between treatment of a death education program and personal death experience.

Fourth hypothesis. This null hypothesis was as follows:

Ho: Personal death experience will not influence the effect of a death education program on reconciliation with death scores. In other words, the main effects are additive.

An alternative hypothesis was formulated in case this null hypothesis was rejected:

H4: An interaction between the type of program received and the personal death experience factor will occur. The main effects will not be additive.

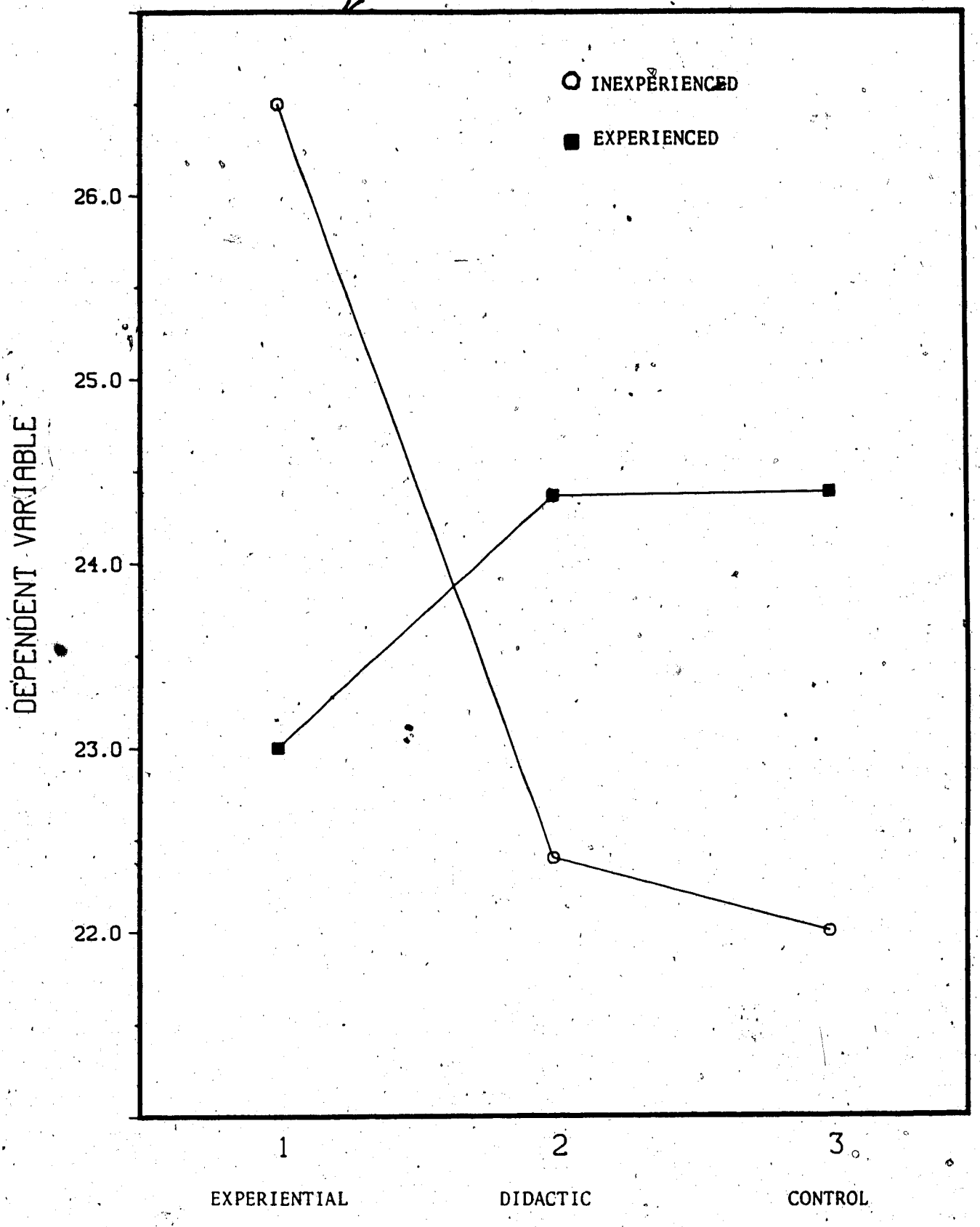
A significant interaction was found for the death confrontation scores and the null hypothesis was rejected. As Table 4 indicates, with the

death confrontation scores, a F-Ratio of 4.374 with a probability of p=.016 (ie.p<.05) was obtained. This demonstrates an interaction between the main effects of this study.

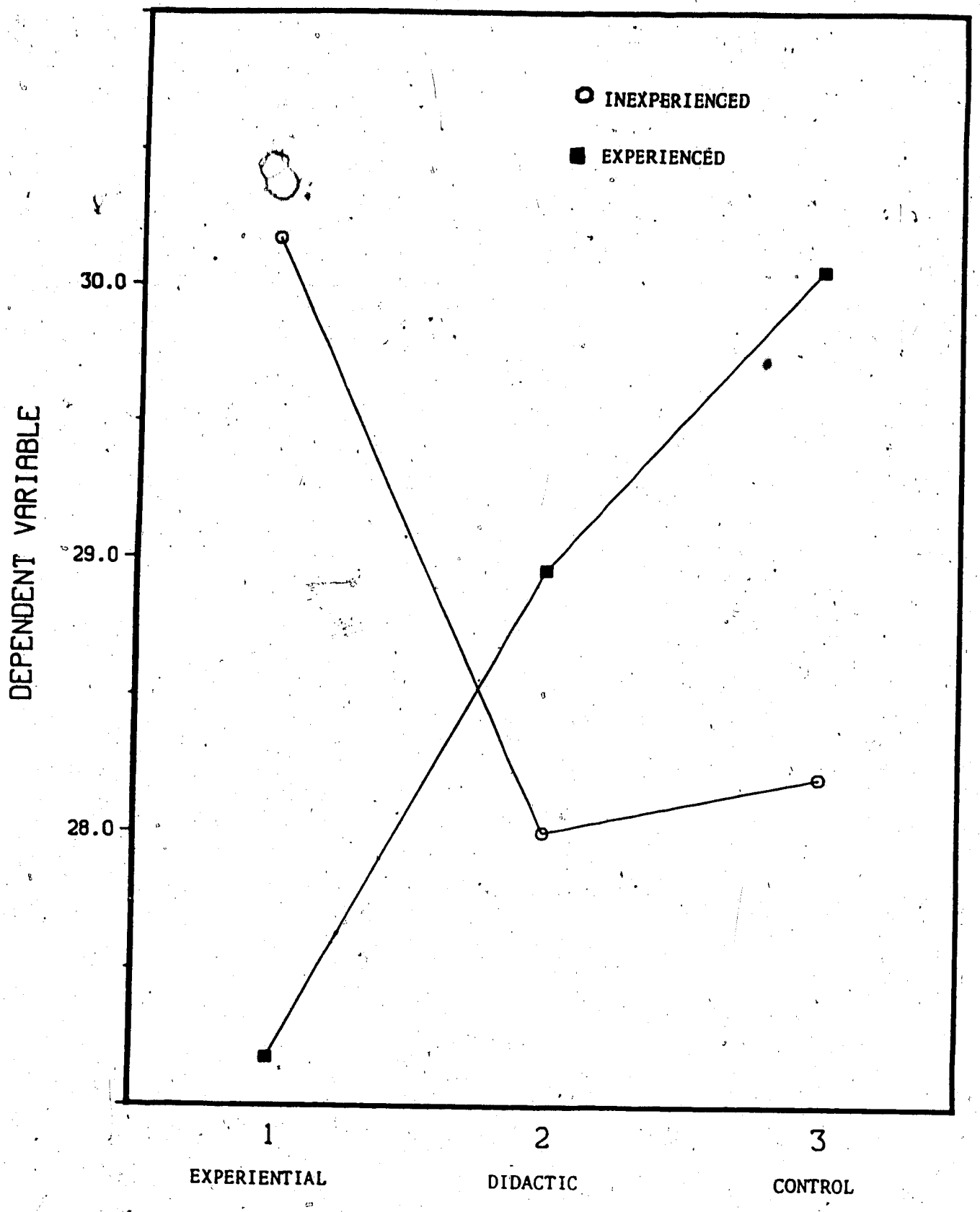
Cell means were plotted and it was found that the interaction was disordinal (Graph 1). Analysis indicated that while neither type of treatment nor personal death experience had an effect by themselves, an interaction between these two variables had a significant effect on the dependent variable, death confrontation. Subjects in the experiential group who stated they had no personal death experience had significantly higher death confrontation scores than subjects who had such an experience. Conversely, subjects with no experience in the both the didactic and the control groups had lower scores than those with experience. Subjects with experience in the experiential group had lower confrontation scores tha such subjects in either the didactic or the control groups.

The confrontation of death component measures subjects' conscious contemplation of their own inevitable death. Higher scores on this part of

PROFILE OF MEANS: DEATH CONFRONTATION



PROFILE OF MEANS: DEATH INTEGRATION



the CIDS indicate a greater willingness to refect on and discuss death, eventhough feelings of concern, fear and anxiety may be present. The results of this study indicate that individuals with no personal death experience can be better helped to contemplate death through an experiential approach. Individuals with a personal death experience seem to find this approach does not facilitate a confrontation of their personal death concerns - rather, the experiential approach to death education has a negative effect on their willingness to think about death. This disordinal interaction relative to treatment group suggests different treatment for different subjects and will be discussed in Chapter Five.

There was not a similar significant interaction effect found with the death integration scores. Noted in Table 5, the F-Ratio for these scores was 1.724 with a probability of $p=.186$ (ie. $p>.05$). The graph of these scores (Graph 2) indicates a somewhat similar trend existed, but such a trend was not statistically significant. This similarity is to be expected as the integration of death component is the positive

emotional assimilation of the consequences of previous death confrontation.

Experimental Subjects' Evaluation of the Death Education Experience

A workshop evaluation was completed anonymously by the subjects in both death education programs at the end of the workshop day. The evaluation form consisted of six items (See Chapter 3). All participants completed the form, including the nursing personnel involved in the class but not the study, and those subjects who were later deleted from the study due to incompletion of the death attitude questionnaire. From the didactic group, 32 workshop evaluations were received; from the experiential group, 31 evaluations.

Increased Awareness of Death

The fifth hypothesis, stated in null form, was that subjects would not perceive a change in their personal awareness of death following the treatment of a death education program. The alternative hypothesis was as follows:

H3: Subjects will perceive an increased personal awareness of death following the treatment of a death education program.

The null hypothesis was rejected. When participants were asked this question " Did you become more aware of death? If you did was it helpful, not helpful, or of no effect at all? Please explain.", 65% answered that they were more aware of death following the workshops. The results are detailed below, according to treatment group.

Didactic Group. In this group 68.8% of the participants felt they became more aware of death through the workshop. A typical comment was "I better understand what it is like to be faced with the knowledge that you are going to die." The workshop seemed to have promoted a more personal awareness for some students: "Maybe I'm more aware of my own death - I've always considered someone else's and not my own." and "I feel I was aware of the issues (experienced death of mother and mother-in-law) but perhaps it just help to put the emotions of myself and other family members together." This awareness was recognized as

helpful, with such statements being made as "It was helpful to make me think of death more as a natural part of, or end to someone's lifetime rather than just an abstract not considered." and "Made me aware of my need to examine further my feelings so I can help deal with other people in that situation."

In this group 28.1% of the participants did not feel they became more aware of death as a result of the workshop. Most of these students stated that this was because they have been previously aware of death -eg. two students stated, "I have thought about death for some time." One individual added, "I have had experience with death already and had to deal with it, but it brought up feelings and ways which I had dealt with the experience and made me think whether it was good or not. One student, however, blamed the teaching approach: "Lecture format isn't condusive to becoming aware.". One participant (3.1%) indicated that more time was needed, "I will endeavor to rehash the material presented today and try to make some personal sense out of it.".

Experiential Group. The majority of the participants (61.3%) in this group stated they believed that they were more aware of death following the workshop experience. Few stated whether such awareness was helpful or not, but added comments such as "I got to really understand the viewpoints of others and other outlooks. It helps to know others feel the same." This particular student also noted the workshop made her aware of " my own emotion of the loss of my father and sister." As with participants in the didactic group, death became more a personal concern:

"I have always been aware of death but not of my own. It made me think about plans that I should make to prepare myself and my family for my or their death."

"Realized I've been worried about death of others, haven't taken time, strength to consider my own."

"I have been aware of death as my mother died of cancer when I was 11 yrs. old. It has been helpful though in being aware of my own death."

Students with previous experience with death found dealing with past concerns helpful:"I have had

past experiences with people close to me that have died and this workshop brought up some feelings that I have put away. I don't feel this is bad - in fact, it made me see the importance of telling others how you feel whether it's before they go away or before you die." Some students felt they needed more time : " Yes, I think I have (more awareness) but I need some time to try and understand it better."

Subjects who stated they did not believe they were more aware of death totaled 29.0%. Many felt they were already aware of death through personal experience as indicated by such comments as: "I have encountered death within my family, so the workshop did not have too much of an effect on me." and "I didn't become more aware. I've already had several experiences with death. They were all very close and I have found my own way to deal with it." One student, however, suggested the opposite. She wrote, "Because I have never had to deal with death, it was hard to imagine." Two students (6.5%) answered neither yes or no to the question of gaining awareness: they stated it was difficult to say. Their comments:

"I don't know if I learned anything that would help me help a client's family deal with his death."

"Because I have not had any experience with death and so it is hard to express any opinion or feelings toward it except the ones that I have about my own death."

One student (3.2%) did not answer this question.

Information was collected as to the levels of comfort experienced before and after the workshops and as to the best and least liked aspects of both workshop experiences. The information obtained is summarized here, according to treatment group.

Comfort Levels

Items one and two addressed the comfort level of the participants in the first and the last hour. Students were asked to assess their own level of comfort at these times using a scale ranging from very uncomfortable to very comfortable. "Comfort" was not defined, thus the responses relate to the individual student's interpretation of this term.

Didactic Group. The majority of the students (90.6%) perceived themselves as comfortable or

better in the first hour of the workshop. By the last hour, 25% of the students described themselves as uneasy or to some degree uncomfortable. No change in comfort level from the first to the last hour was reported by 59.4% of the participants. Perceiving their level of comfort to have increased by the last hour were 15.6%, while 8% stated they felt less comfortable.

Experiential Group. A smaller majority of students (51.8%) in this program perceived themselves as comfortable or better in the first hour of the workshop. However, by the last hour, a similar percentage (22.6%) described themselves as uneasy or to some degree uncomfortable. No change in comfort level was reported by 35.5% of the participants. Perceiving their level of comfort to have increased by the last workshop hour were 41.9%, while 25.8% stated they felt less comfortable.

Favorite Aspects of the Programs

Participants were asked through an open-ended question, to indicate the part of the workshop that they liked the best. Many respondents listed more than one aspect of the program.

Didactic Group. The use of visual aids and films was mentioned by many students. In some cases particular films were listed - for instance, "Jocelyn", was listed by 14 of the 32 respondents. Seven students liked best the research and discussion regarding children's view of death. Two students found examples of people coping with death was an important aspect of the program. Two others felt relating the death and dying process to nursing was their favorite part of the workshop. One listed the discussion on the importance of talking about death.

Experiential Group. The majority of this group found sharing experiences and feelings with others to be the most liked part of the program. Thirteen listed the dyadic encounter experience in particular, while eight listed the guided fantasy exercise. Two students mentioned the eu[illegible]y as their favorite part; two listed the music used to facilitate the program. Two of the participants wrote that their favorite aspect of the workshop was the opportunity to think about their own death - previously, they said, they h[illegible] thought only of others dying.

Least Preferred Aspects of the Programs

The workshop participants were also asked, through an open-ended question, to state what part of the workshop they liked the least.

Didactic Group. Many students mentioned "just listening" as the aspect of the program that they liked the least. Too much theory, too many studies, too much to handle in one day were mentioned. The lecture on the history of death was indicated by 4 students. Two participants found the sound quality of one film to be a problem. Not enough breaks was mentioned by two others. One student stated she liked "searching our own ideas and feelings about death" the least. Four participants said that there was no aspect of the program that they did not like.

Experiential Group. Nine students listed both the tombstone and eulogy exercise as the least liked aspect of this program, while 7 others listed the tombstone exercise alone and 1, the eulogy exercise. Comments like "perhaps I wasn't ready to deal with it", " It made me feel uncomfortable -like I was setting myself up to die tomorrow", " talk about morbid!" and "I felt very

uncomfortable with these" accompanied the listing of these particular exercises. Three students noted the guided fantasy; two students said drawing death. One stated she felt pushed to share feelings and another found sharing feelings with others who she didn't know was difficult. One wrote that the lack of information about death was the least favorite part. One stated the openness of the gymnasium environment was not congruent with the topic.

Additional Comments

Participants were asked to contribute any comments, ideas or constructive criticisms?

Didactic Group. Several students just commented on the workshop as being "good" or "interesting". Several others noted that it was too long and that an afternoon break was needed. One comment was "too much for one day - it would have been beneficial if perhaps it was approached in a few sessions". Two students thought the workshop should have looked at how nurses have to communicate with dying individuals. One felt that if the workshop had been given after the class had clinical experience with dying patients, that it

may have been more effective. Many students, however, identified a need for more discussion and group involvement to deal with their ideas and feelings toward death. One participant put it this way: "I think there would have been a wealth of thoughts, ideas, concerns from within the group if there had been more chance for group discussion and participation. Nevertheless, it was a wothwhile day providing things to think about."

Experiential Group. As with the evaluations of the didactic approach, comments were made in relation to the workshop being a "good experience". One comment was, "Overall the workshop was exceptionally done. It was a very pleasant day eventhough the subject was death I was very impressed with the three ladies who oversaw the workshop." A comment was made by one student to the effect that the workshop would have more significance if it came after the class had clinical experience. The majority of comments, however, addressed a need for concrete information on how to react to the dying and bereaved. These ranged from one student's comment, "As student nurses I think we should focus on ~~other~~ people's

deaths - I thought drawing your own tombstone was very morbid and unnatural.", to others' request for a second workshop on dealing with the client and family facing death. The comments suggested that students have identified a great need for nurses to learn to care for the dying. They want help in gaining such knowledge. One student ended a request for a discussion on how to help the terminally ill with "I know myself that right now I don't know how to cope with it."

Some students wanted such expertise without first facing personal death concerns -eg."Deal more with how we as nurses can help patients and families facing death instead of placing so much stress on our personal dealing with death.". Other participants recognized that, though knowledge is needed concerning working with the dying, "you must come to terms with (your) own feelings before you can deal with patients and others". One participant evaluated the workshop this way:"I had hopes of getting a handle on sympathy - some 'how to's'. I guess I came looking for answers, but I'm leaving with more questions. Personally very relevant."

Summary of Results

In summary, the independent variables in this study, personal death experience and treatment group, did not produce independently a significant variation in the dependent variables, death confrontation and death integration. A significant interaction was found to occur, however, between personal death experience and treatment with a death education program in the effect on death confrontation scores. The experiential approach had a positive effect on the death confrontation of subjects with no personal experience with death. Such subjects had higher death confrontation scores than others if in the experiential treatment group but lower scores if in either the didactic or control group. The experiential approach, however, had a negative effect on the death confrontation scores of experienced subjects who had higher scores if receiving either a didactic or a placebo treatment. Though a similar trend appeared in the death integration scores, a statiscally significant interaction was not found.

The students themeselves did perceive the death education programs as increasing their awareness of death. In the didactic program, 68.8% stated they were more aware of death following the workshop, as did 61.3% of the experiential workshop participants - an overall total of 65% of the participants. Those who did not believe themselves to be more aware tended to state their previous level of awareness as the reason - ie. because of personal experience, they had already achieved a level of death awareness. The overall tone of the workshop evaluations of both groups indicated that the death education programs were perceived as positive, worthwhile experiences by the majority of the participants.

In approaching this learning experience, more students in the experiential program were uneasy or uncomfortable at the start of their workshop than those in the didactic program: 25% as compared to 9.4%. This may indicate that an experiential approach is perceived as more threatening than a didactic one. By the end of the workshop day, however, a similar percentage of both groups rated themselves as uneasy or to some

degree uncomfortable: 22.6% and 25% respectively. The comments on the workshop evaluation suggest that some of the didactic program participants found the day to be a long one. The amount of material covered and the lack of overt student participation seem to have been factors.

The best liked aspects of the didactic program were the films employed and the presentation of "Children's View of Death". The least liked aspects were the "just listening" role of the participants and the amount of material presented. The sharing of thoughts and feelings with others in the group was noted as the favorite part of the experiential program. The exercises, "Tombstone" and "Eulogy", which direct the participant's focus to his own inevitable death, were noted most often as the least favorite part of the workshop.

The participants in the didactic group expressed a need for more group involvement and an opportunity to discuss their thoughts and feelings toward death. Participants in the experiential group wanted more concrete information on how to react to the dying and the bereaved. Overall, the

students demonstrated a great interest in the topic and a recognition of the nurse's responsibility to care for the dying patient and his family. Several students indicated that they wanted expertise in caring for the terminally ill but were uneasy in addressing personal death concerns. Others recognized that self-awareness in regard to death concerns was the first step in learning to help others. It was also noted that some students found they would need time to assess the overall effect of this death education experience.

Chapter IV has presented the results of this experimental study. These results are discussed in the final chapter and recommendations for future research investigations are made.

V. Conclusions and Implications

This study was designed to investigate the impact of two types of death education programs and that of personal death experience, on the death attitudes of first level diploma nursing students. As society continues to shunt the care of the dying to specialists, the death attitudes of nurses (the prime care-givers) assume a great importance. It is these health care workers who influence the context of modern dying. Nurse educators are exploring ways to promote positive attitudes toward death and dying among nurses.

Such attitude formation must begin in the early stages of a nurse's education - before clinical contact with the dying patient occurs. Negative experiences in caring for the terminally ill affect a nurse's ability and willingness to provide holistic care for the dying. Education for nurses that allows them to become aware of their own death fears and concerns prior to confronting death in a nursing situation may decrease the incidence of such negative experiences - both for the nurse and the patient.

To date, most nursing research in this area has examined the effect of nursing education in general on the death attitude of students. Few controlled studies

have been completed that investigate the effect of a particular type of death education program. It is vital, however, that the limited time available in nursing curricula for preparation for terminal care be used well. This investigation's intent was to determine the optimal type of brief death education program for nursing students.

Death education has fostered more positive attitudes and coping skills in the lay population. These programs have provided a basis for developing death education programs for nursing students. The educational approach used in such courses can be placed somewhere along a didactic-experiential continuum. This study, therefore, compared the two polarities (a didactic approach and an experiential one) through a one-day workshop experience. Though research has not been conclusive in determining if personal death experience is a significant indicator of death attitude, the present investigation examined if death experience - with a friend, a family member, or a personal brush with death - impacted a student nurse's death attitude or the effectiveness of a death education program. Reconciliation with death was the death attitude construct measured in this study. It is

the confrontation and positive integration of personal thoughts and feelings toward death.

Discussion of Findings

An experimental investigation was designed to answer five questions:

1. Will a treatment of a brief death education program affect the death attitudes of the participants as measured in terms of reconciliation with death?

2. Will there be a difference in the reconciliation of death scores between subjects who receive an experiential death education program and subjects who received a didactic one?

3. Will there be a difference in the reconciliation of death scores between subjects who have had a personal experience with death and subjects who have not?

4. Will personal death experience impact the effectiveness of the death education programs as measured by reconciliation of death scores?

5 Will subjects receiving a brief death education program perceive an increased personal awareness of death?

Hypothesis One

The first hypothesis, stated in null form, was designed to assess if brief death education programs could promote the confrontation and integration of thoughts and feelings concerning death. As the death education programs that comprised the treatment phase of this study did not exert a significant influence on the dependent measure used (the CIDS), the null hypothesis was accepted.

Subjects may have had insufficient time to fully confront and integrate their thoughts and feelings concerning death. As one participant stated, " Yes, I think I have (more awareness) but I need some time to try and understand it better." The seven days between the treatment and post-test may not have given such students enough time. Though Bolan (1981) found a positive change in death attitude seven days following a death education treatment, other investigators have found this attitude change only when measurement occured many weeks following the educational intervention (Whelan & Warren, 1980-81; Caty & Tamblyn, 1984; Murray, 1974; Laube, 1974). The programs may have stimulated students to examine their own attitudes toward death ("I guess I came looking for answers, but

I'm leaving with more questions. Personally very relevant."), but they may have required a "gestation period" before new, more accepting attitudes emerged. The identifiable effects of death education may not emerge for several years (Knott & Prull, 1976).

It is important to recognize, however, the difficulties involved with measuring attitudes over time when assessing the impact of a particular program. During the intervening time between treatment and measurement, other factors may exert a significant influence on the attitude variable in question. For instance, in Caty & Tamlyn's (1984) investigation, students in the treatment and control groups had various and different experiences with dying patients ad/or with death-related topics in their curricula between the death education program and the post-test measures.

It is also possible that a one-day workshop format is insufficient for promoting reconciliation with death. Bohart & Bergland (1979), in obtaining similar results, suggested that more than brief learning interventions are needed due to the nature of death anxiety. Several programs that found some success with an hour allottment similar to that used in this study

were presented over a prolonged period of time - eg. 6 one and a half hour sessions (Bolan, 1981; Durlack, 1978-79; Murray, 1974). Change, however, has been found after other one-day marathon sessions (Ross, 1978; Whelan & Warren, 1980-81).

Hypothesis Two

In order to determine if an experiential teaching approach to death education, using death awareness exercises, music and a dyadic encounter was more effective than a didactic one, using lectures and films, a second hypothesis was developed. It was accepted in null form, as neither approach was found to be a significant main effect.

In examining the students' evaluation of the workshop programs, it can be seen that some students in the experiential program expressed a desire for information concerning death and dying. (eg. one student said the lack of information about death was the part of the program liked the least). In the didactic program, on the other hand, there were students who thought opportunities to discuss personal feelings and concerns would have improved the program, eg."I think there would have been a wealth of thoughts, ideas, concerns from within the group if there had been

more chance for group discussion and participation. Nevertheless, it was a wrthwhile day providing things to think about." It may be that the most effective approach is one midway on the experiential-didactic continuum -ie. providing information on death and dying, but also providing the opportunity for confronting and discussing personal death concerns. Bugen (1979) believes that death education must approach the individual on both the cognitive and affective level as - "Death, dying, life and living all affect our total selves" (p.240).

An experiential approach to death education can be the more threatening at first: only 51.8% of students in this treatment group felt comfortable or better in the first hour of the workshop, compared with 91.6% in the didactic group. By the last hour, however, the comfort levels of the two groups were similar. Even within a didactic framework, considering personal attitudes can be difficult - one student in the didactic group stated the least liked aspect of that program was "searching our own ideas and feelings about death". Durlack (1978-79) has found an experiential approach heightened death anxieties, though it lowered fears and concerns about death.

Hypothesis Three

A hypothesis was posited concerning the effect of personal death experience on death acceptance as measured by the CIDS. This hypothesis was stated in null form and accepted, as personal death experience itself was not found to be a significant source of variance. Though Hopping (1977) found the death of a relative to decrease death attitude scores, this finding concurs with most research. Experience with the death of a relative, close friend or patient has not been found to affect death attitude scores. Denton & Walker (1977) using a multidimensional conception of death experience, did note that a subjective death experience and the viewing of a violent death were inversely related to death anxiety. Though death experience in the present study was narrowed to exclude experience with dying patients, a more sensitive measuring of personal death experience may have found a variation in the effect of levels of personal death experience on the CIDS scores.

Hypothesis Four

The fourth hypothesis was posited to assess the influence of personal death experience on the effectiveness of death education programs. The null

form of this hypothesis was rejected, as analysis of the death confrontation scores of the CIDS indicated that the main effects were not additive - rather, a disordinal interaction occurred. Inexperienced subjects when treated with an experiential death education program had significantly higher scores than experienced subjects. Treatment of inexperienced subjects with a didactic progrm resulted in scores similar to those of subjects treated with a placebo program. Conversely, experienced subjects treated with an experiential program had significantly lower death confrontation scores than similar subjects in both the didactic and control groups. The graph of death integration scores indicated a similar interaction, but not at a statistically significant level.

Death confrontation refers to the conscious contemplation of the subject's own inevitable death. It would seem that an experiential approach focusing on personal awareness of death concerns can promote death confrontation for individuals who have not experienced the death of a friend or relative, nor had a brush with death themselves. The music and death encounter exercises such as the guided life-death fantasy may make death seem more real for them at a subjective

level. Students' comments would substantiate this: "Before I always took life for granted. This made me realize that I could go at any time." "I knew death was always there, but I found out some of my feelings toward death itself." " Realized I've been worried about the death of others, haven't taken time, strength to consider my own."

The personal, affective approach with experienced persons, however, had a negative effect on their willingness to think about death. One explanation may be that this personal focus touches the grief and sadness remaining from the past experiences in too intensive a manner. The individual may resist confronting these strong feelings and reactions in an educational setting. One student in the experiential group did state that she found it difficult to share feelings about death within the group.

Another explanation may be that feelings and emotions from unresolved grieving surfaced during the death awareness exercises and impacted the death confrontation scores. For example one confrontation item on the CIDS reads "After discussing the subject of death, I feel depressed." Agreeing with this statement would lower an individual's score. It could be that

subjects' in the experiential program addressed emotions relating to the loss of significant others or a brush with death and did feel sad or depressed. The didactic approach to death education, not addressing these personal feelings, would not have produced this type of reaction.

Arousing such a reaction is not necessarily negative. Students with death experience did find that the experiential workskhop had value - as one student said, "I have had past experiences with people close to me that have died and this workshop brought up some feelings that I have put away. I don't feel this is bad - in fact, it made me see the importance of telling others how you feel whether it's before they go away or before you die."

Hypothesis Five

The final hypothesis of this study was designed to determine if the participants in the death education workshops believed that the programs made them more aware of death. The hypothesis in null form was rejected as the majority in both the experiential and didactic programs indicated that they were more aware of death at the completion of the workshop day. The death education programs, then, can be considered

successful as facilitators of a nursing student's conscious awareness of death.

Though overall the workshop evaluations indicated that most students appreciated the opportunity to discuss death and think about their own reactions to it, there were students who were reluctant to become more aware of personal death concerns. This seems exemplified by the student who commented, "As student nurses I think we should focus on other people's deaths ...". This student did not recognize that before a nurse can give appropriate care to those facing death, she must first come to terms with her own perceptions and anxieties. Corr (1978), in commenting on a nursing student who approached death education only in terms of a care-giver, stated, "... it should be fundamental that one must confront and achieve some modus vivendi with one's own thoughts and feelings about death and dying before one can systematically help others in this area." (p.450). Not recognizing this point is self-defeating. Nurse educators need to help students recognize the importance of self-awareness in fulfilling the care-giver role.

It was apparent from the workshop evaluations that nursing students want to prepare to care for the dying

patient. Some recognized death awareness as only the first step and requested a second workshop focusing on the terminally ill. A second workshop was not in the mandate of this study, but the students will receive guidance in working with the terminally ill when they begin clinical practice.

Conclusions

The conclusions that can be derived from this study are that:

1. brief death education programs can promote personal death awareness in first level nursing students.

2. an experiential program can be more effective than a didactic approach in helping nursing students without a personal death experience to confront their thoughts and feelings concerning death.

3. an experiential program can have a negative effect on the death confrontation of nursing students who have experienced the death of a friend or relative, or who have had a subjective encounter with death.

Implications

A brief death education program does promote greater awareness of death for nursing students and,

therefore, seems a worthwhile addition to the nursing curricula. "If we can reduce the cultural norm that prescribes the avoidance of thinking about death, we may ultimately provide more useful care to the dying (Thrush et al, 1979; p.139)." First level students were found to be actively interested in preparing to give holistic care to the dying: introducing such concepts at the first level of nursing education (prior to clinical practice) seems not only realistic but necessary. Facing personal death concerns before confronting death in the form of a terminally ill patient may help nurses better fulfill their role as care-givers. Some students may need help in recognizing the importance of such self-awareness.

A productive teaching strategy would be to divide death education classes into groups according to personal death experience. The inexperienced group could begin learning about death through experiential methods that include death awareness exercises - making death a more apparent reality. As this affective approach does not appear helpful for experienced students, a more cognitive, didactic approach could be used with this group. These students could begin to confront their thoughts and feelings concerning death

in a less intensive way - at least initially. Dealing with unresolved thoughts and feelings toward death that arise from past bereavements is not necessarily a negative process - in fact, it seems a vital one. Some students may be identified who need individual help with this process.

Using an experience basis for program assignment may also facilitate the dynamics within the learning group. Students may be more able and willing to share their ideas and reactions toward death when all members of the group have a common experience level. As well, this division can allow for a more effective use of teaching time. An experiential approach - which requires a higher teacher/student ratio - would be used only for those students who would benefit from it. In this study the inexperienced/experienced ratio was 8/30. If is representative of other nursing class ratios, then only approximately one-quarter of the class would be involved in the experiential program.

Promoting greater awareness of death is only the first step in preparing nurses to care for the dying. Nursing students want and need information concerning death, the dying process, loss and grief, and other issues related to terminal illness. However, before

such information can become truly meaningful, a nursing student must be helped to explore her own feelings about life and illness, dying and death (Mandel, 1981).

Recommendations for Further Research

1. A longitudinal study is needed. Examining reconciliation with death scores over time would allow an investigator to see if:

- the death confrontation scores of experienced subjects in the experiential group would improve over time.

- death integration scores would follow the trend indicated in this study to a statistically significant level.

- the treatment of a death education program is a significant main effect on death acceptance.

2. Further investigation is needed to indicate the relationship of death experience and reconciliation with death. A more sensitive, multidimensional measurement of personal death experience needs to be utilized.

3. A replication of this study that includes an additional type of death education program - one midway on the didactic-experiential continuum- would provide further insight into the most optimal program.

4. A replication of this study in which the brief death education treatments are given over several sessions rather than one marathon session is needed. This may prove to be a more effective manner of presentation.
5. A replication of this study using baccalaureate students as subjects is needed.
6. More consistency is needed in the death attitude constructs used by death education researchers. Reconciliation with death (as measured by the CIDS) was the construct used in this study and it would appear to be an appropriate tool for future study.
7. A study is required to examine the influence of clinical experience with death on CIDS scores.
8. A clinical study is needed to determine if students with higher CIDS scores are better able to give holistic care to the dying.

There are inherent difficulties with doing both longitudinal and clinical research, but the problems seem worth surmounting if nurses can be better prepared to care for the dying.

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APPENDIX A

CONFRONTATION-INTEGRATION OF DEATH SCALE

(CIDS)

INSTRUCTIONS TO SUBJECTS

This is a death attitude questionnaire. It will take about twenty minutes to complete. It consists of a variety of statements concerning attitudes toward death, and some general background information which is standard on a research questionnaire.

All but two of these questions can be answered by simply making a checkmark with a pen or pencil. If you are not sure of an answer please give your honest opinion or make an estimate. We are not interested in right or wrong answer. We want to know what you think and how you feel. Please give your own personal reactions, not the reactions you think are expected. First impressions are usually best is such matters. Please work as rapidly as you can.

Thank you again for your co-operation.

1. I avoid discussing death when the occasion presents itself.

Strongly Disagree	Disagree	Agree	Strongly Agree

2. I enjoy life more as a result of facing the fact of life.

Strongly Disagree	Disagree	Agree	Strongly Agree

3. Remembering the dead makes me thankful for life.

Strongly Disagree	Disagree	Agree	Strongly Agree

4. An occasional visit to the cemetary is a healthy practice.

Strongly Disagree	Disagree	Agree	Strongly Agree

5. Recognizing the fact of my inevitable death helps me grow as a person.

Strongly Disagree	Disagree	Agree	Strongly Agree

6. I make a conscious effort to avoid dwelling on thoughts of death.

Strongly Disagree	Disagree	Agree	Strongly Agree

. Accepting death helps me be more responsible for my life.

Strongly Disagree	Disagree	Agree	Strongly Agree

. If possible, I avoid friends who are grieving over the loss of someone.

Strongly Disagree	Disagree	Agree	Strongly Agree

. After discussing the subject of death I feel depressed.

Strongly Disagree	Disagree	Agree	Strongly Agree

0. My life has more meaning because I accept the fact of my own death.

Strongly Disagree	Disagree	Agree	Strongly Agree

1. I am willing to discuss death with a dying friend.

Strongly Disagree	Disagree	Agree	Strongly Agree

2. It is morbid to deliberately think about my inevitable death.

Strongly Disagree	Disagree	Agree	Strongly Agree

13. I feel more free when I accept the fact of my death.

Strongly Disagree	Disagree	Agree	Strongly Agree

14. I tend to deny the fact of my inevitable death.

Strongly Disagree	Disagree	Agree	Strongly Agree

15. The sooner I accept the reality of my death the sooner I can start living.

Strongly Disagree	Disagree	Agree	Strongly Agree

16. The more I find meaning in death the more I find meaning in life.

Strongly Disagree	Disagree	Agree	Strongly Agree

17. I really prefer not to think about death.

Strongly Disagree	Disagree	Agree	Strongly Agree

18. The more fully I accept death the more fully I respond to life.

Strongly Disagree	Disagree	Agree	Strongly Agree

YOU HAVE NOW COMPLETED THE DEATH ATTITUDE QUESTIONNAIRE. IT WOULD BE HELPFUL IF YOU PROVIDED THE FOLLOWING BASIC INFORMATION.

19. Age:

20. Sex: (1) Female (2) Male

21. Marital Status:

(1) Married (2) Single (3)Divorced/Separated (4) Widowed

22. Level of Education completed to date:

(1) High school graduate (2) Some university (please specify) (3) Other training

PLEASE USE THE ATTACHED SHEET OF PAPER TO ADD ANY COMMENTS YOU MAY HAVE WITH RESPECT TO QUESTION #23 AND QUESTION #24.

23. Would you please describe any personal experience you have had with death, be it with a relative, friend, stranger, or perhaps a personal brush with death.

24. If you have any additional comments you wish to make about your attitude towards death (thoughts or feelings), please feel free to add them at this time.

APPENDIX B

Death : The Missing Season

The Didactic Program

This workshop provides the student nurse participants with an overview of death and dying as conceptualized by our society. It involves a didactic approach using lectures, films and discussion with the aim of promoting awareness of attitudes and values toward death. The workshop leaders should not only be knowledgeable in the death-related topics presented, but have an understanding of their own attitudes and death concerns. As participants may be unprepared for their reaction to a death awareness learning experience, an agreement should be reached with students that no individual quits the program without first informing a workshop leader.

Outline of the Workshop

Time : Seven hours (90 minutes for Lunch and Breaks included)

Workshop Objectives:

To desensitize the participants to death-oriented language.

To explore the current attitudes and values toward death in our society.

To promote interest in confronting one's own conceptualization of death.

Teaching Aids:

Films: "What Man Shall Live and Not See Death"
"Why me?"
"Jocelyn"

Film projector

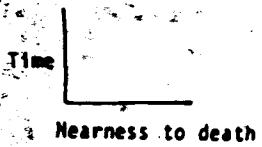
Overhead projector

Transparencies

Death-related quotations on blackboard

OBJECTIVES	CONTENT	TIME	LEARNING ACTIVITY
To introduce the theme of the workshop and the leaders.	I. Introduction to the Workshop	30 min.	Lecture/Discussion
	A. Introduction of leaders and overview of workshop day.		
	B. Death as a taboo-topic.		Transparency: Euphemisms for "dead
	C. Why talk about death? (Feifel, 1963)		Examples of everyday language showing unconscious awareness of death
			Discussion: How comfortable are the participants with death as a topic?
			Parable: "The Horse on the Dining Table" (Kalish, 1980).
To explore the evolution of our current beliefs and values toward death. To examine the future directions of such beliefs.	II. Death and Dying: Past, Present, and Future.	90 min.	Lecture
	A. Death attitudes as a reflection of culture.		
	B. The Past		
	1) Earliest stages of human development		
	2) Ancient Eygptians		
	3) Ancient Greeks		
	4) Hebrews		
	5) Early Christianity		
	6) Middle Ages		

OBJECTIVES	CONTENT	TIME	LEARNING ACTIVITY
	7) 15th and 16th Century		
	8) 19th Century		
	C. The Present		
	1) Modern View of Death		
	2) Modern Death Encounter		Discussion: What is your image of a typical death in our times?
	a) Institutionalization of death		
	b) Secularization of death		
	3) A Modern Death Issue: How is death defined?		Transparency: A Living Will.
	a) Somatic death (UN definition)		
	b) Cardiac death		
	c) Brain death		
	d) Clinical death		
	e) Biological death		
	D. The Future		
	-The immortalist proposition (Harrington,1969).		Discussion: Current interventions into death: eg. "Baby Fae"
	E. Summary		Film: "What Man Has Lived and Not Seen Death?" (Color,57 minutes)

OBJECTIVES	CONTENT	TIME	LEARNING ACTIVITY
To examine the death concepts of children and adolescents.	III. A Developmental View of Death A. Children's View of Death 1) Denial of death in relation to children 2) A Historical review of children's literature 3) Research on the [illegible] view of death 4) The Terminally ill child 5) Talking to children about death B. Adolescents' View of Death	60 min.	Lecture Quotes from children about death
To describe the process of human dying.	IV. The Death Process A. The Dying Trajectory (Glaser & Strauss, 1968) B. Death Awareness (Glaser & Strauss 1965) 1) When does dying begin? 2) Ways of learning one is dying 3) Awareness contexts -closed -suspicion -mutual pretense -open	60 min.	Lecture Graph: 

OBJECTIVES	CONTENT	TIME	LEARNING ACTIVITY
	C. Stages of Dying (Kubler-Ross, 1969)		Film: "Why Me?" (Color, animated cartoon, 9.5 minutes)
	1) Denial and isolation		
	2) Anger		
	3) Bargaining		
	4) Depression		
	5) Acceptance		
To identify the main tasks of the dying person.	V. Tasks of the Dying -completing unfinished business -dealing with medical-care needs -allocating time and energy resources -arranging for what happens after death -coping with loss -encountering the mysteries of death	60 min.	Film: "Jocelyn" (Color, 28 minutes) Handout: Brochure from a Funeral and Memorial Society
To identify if there are any positive aspects of death.	VI. The Value of Death A. "Death destroys a man; the idea of death saves him" (E.M. Forster). B. Styles of Dying (Living) -"Eat, Drink and be Merry for ..." -"Do not go gently into that good night" - For everything there is a season -Come now, greatest of feasts -Others C. Sanskrit Proverb; "Look to this Day"	30 min.	Discussion

Death : The Missing Season

The Experiential Program

This workshop provides the student nurse participants with an opportunity to explore their own mortality and to learn to talk about death with a degree of comfort. It involves an experiential approach using music, a dyadic encounter and death awareness exercises to promote a focus on personal feelings and reactions to death. The workshop leaders should be individuals who have dealt with their own death-related concerns and who are aware of the influence of such feelings on the total personality (Bugen,1979). As participa[redacted] may be unprepared for their reaction to a death awareness learning experience, an agreement should be reached with students that no individual quits the program without first informing a workshop leader. Students need to be advised that the thoughts and feelings shared within the workshop are "privileged information".

Outline of the Workshop

Time: Seven hours (90 minutes for Lunch and Breaks included)

Workshop Objectives:

To desensitize participants to death-related discussion

To stimulate the examination of thoughts and feelings toward death.

To encourage participants to compare and contrast their attitudes and values relating to death with those of other group members.

Teaching Aids:

Dyadic Exercise booklet

Felt pens, paper, masking tape

Tape player and music tapes

Mats or pillows

OBJECTIVES	CONTENT	TIME	LEARNING ACTIVITY
To introduce the theme of the workshop and the leaders.	I. Introduction to the Workshop A. Introduction of leaders and overview of workshop day. B. Theme: "Death, the missing season"	15 min.	Music: "Turn, Turn, Turn" (The Byrds -based on Ecclesiastes 3:1-8 "For everything there is a season, and a time to every purpose under heaven: a time to be born and a time to die..".
To establish a relaxed open atmosphere.	II. Warm-Up Exercise	15 min.	The Robot or similar movement exercise: Participants are asked to stand and assume the position of a robot: Arms across chest; body stiff, eyes closed. As robots they can only follow the directions of the voice they hear. Directions require them to gradually become alive, move about, interact. Usually promotes laughter and a sense of being alive (Weiner, 1975).
To enable the participants to engage in death-related discussion. To assist them in examining personal feelings toward life and death.	III. Dyadic Exercise: Talking about Life and Death A. Booklet outline : individual pages read: 1) Complete one statement at a time. Share and discuss your response with your partner before continuing to the next statement.	90 min.	Process: Participants divided into dyads. Directed to proceed through booklet at comfortable pace. Leaders available to facilitate. Paper, crayons, felt pens available for drawing death.

OBJECTIVES	CONTENT	TIME	LEARNING ACTIVITY
	2) Right now I feel ...		
	3) I am happiest when ...		
	4) The most important part of my life...		
	5) I love ...		
	6) My greatest ambition is ...		
	7) My most pleasant memory is ...		
	8) In the past ...		
	9) Life in general is ...		
	10) I feel great when ...		
	11) Stop. Consider your responses. Summarize them to your partner. Give feedback to one another. Continue.		
	12) I am afraid of ...		
	13) What really makes me feel anxious is ...		
	14) Death is		
	15) What frightens me most about death is ...		
	16) A dead body makes me feel ...		
	17) Being buried is ...		

OBJECTIVES	CONTENT	TIME	LEARNING ACTIVITY
	18) Cementaries are ... 19) Most depressing of all is ... 20) I could accept death if ... 21) Right now I'm feeling ... 22) Stop. Think: Am I being honest? What am I learning about myself? About my partner? 23) After death comes ... 24) Belief in a soul is ... 25) Reincarnation is ... 26) Heaven is ... 27) I think living forever would be ... 28) Stop and consider how you feel about this exercise. Have you learned anything about yourself or your partner? 29) Draw a picture of death. Show it to your partner only when you have finished it. Discuss the differences between your pictures. Are they similar in any way? B. Group discussion - small group		Dyads are place in one of three groups. A facilitator (leader) promotes a discussion of reactions to the exercise.

OBJECTIVES	CONTENT	TIME	LEARNING ACTIVITY
To stimulate the conceptualization of one's own mortality in a non-threatening way: To promote the sharing of the individual differences in concepts of an "appropriate death".	VI. A Life and Death Fantasy - a guided life review and appropriate death fantasy exercise - small group discussion - ensemble discussion	90 min.	Process: Using mats or pillows, participants make themselves as comfortable as possible. Directed to close eyes and shut out external distractions. Music (eg. Zamfir's pan flute music is played 10 minutes before Guided Fantasy directions begin. One leader guides the group through a life review and a fantasy of one's own future "appropriate" death. Participants are given 15-20 minutes to develop this fantasy. Discuss, in groups of four, the paradox of imagining one's own death. Discuss: The differences in the typical modern death and the type of death imagined by the group members.
To provide closure to the workshop experience in a positive way.	VII. Closure -A "Parable on Life" by La Monica is read. -participants are asked to share their reactions to the death awareness learning experience. - Leaders summarize the "day". - Famous "exit lines" can be presented.	30 min.	Reference: LaMonica, E. (1979). "A Parable on Life". Nurse Educato November-December, 25. Music: "Leaves That A[illegible] Green" (Simon & Garfunkel) "Stairway to Heaven" (Led Zeppelin)

OBJECTIVES	CONTENT	TIME	LEARNING ACTIVITY
	-ensemble		One individual is selected in each group to present a synopsis of the reactions to the entire ensemble.
	C. Closure		Facilitators summarize the experience. Personal reflection time is provided. Music: "And When I Die" (Blood, Sweat & Tears)
To promote awareness of personal mortality.	IV. Tombstone	30 min.	Process: Each person creates his/her own tombstone, including a suitable inscription. Completed tombstones are taped to wall - creating a cemetary. Participants can visit the cemetary and view others' tombstones.
	A. Creating a tombstone.		
	B. Ensemble discussion		A discussion of the participants' reaction to this exercise takes place
	V. Obituary (Weiner, 1975)	60 min.	Each participant is invited to write a personal obituary: a. as it might be sometime in the future. b. as it would be today: achievements survivors and the essence of themselves as a person should be included.
	A. Writing a personal obituary		
	B. Discussion -small group -ensemble		
	C. Closure		Leaders summarized the experience. Music: "Mother and Child Reunion" (Paul Simon)