Thesis
LB
2322
.A9x
T-535

RELATIONSHIP OF NURSING WORK EXPERIENCE TO MULTIDIMENSIONAL MEASURES OF DEATH ANXIETY

YI-CHUEN CHEN

Relationship of Nursing Work Experience to Multidimensional Measures of Death Anxiety

A Thesis

Presented for the

Master of Science

Degree

Austin Peay State University

Yi-Chuen Chen

May, 1998

STATEMENT OF PERMISSION TO USE

In presenting this thesis in partial fulfillment of the requirement for a Master's degree at Austin Peay State University, I agree that the library shall make it available to borrowers under rules of the library. Brief quotations from this thesis are allowable without special permission, provided that accurate acknowledgment of the source is made.

Permission for extensive quotation from or reproduction of this thesis may be granted by my major professor, or in her absence, by the Head of Interlibrary Services when, in the opinion of either, the proposed use of the material is for scholarly purposes. Any copying or use of the material in this thesis for financial gain shall not be allowed without my written permission.

Signature Yi Chuen Chen

Date April 3, 1998

To the Graduate and Research Council:

I am submitting herewith a thesis written by Yi-Chuen Chen entitled "Relationship of Nursing Work Experience to Multidimensional Measures of Death Anxiety." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts, with a major in Clinical Psychology, Clinical Concentration.

Jean G Lewis

Dr. Jean Lewis, Major Professor

We have read this thesis
and recommend its acceptance:

Accepted for the Graduate and
Research Council:

Dean of the Graduate School

DEDICATION

This thesis is dedicated to my parents

Mr. Che Chen and Mrs. Lien-Tao Wu Chen

who have given me the confidence to succeed.

ACKNOWLEDGMENTS

I would like to thank my major professor, Dr. Jean Lewis for her endless patience and guidance. I would also like to thank the other members of my committee, Dr. Anthony Golden and Dr. Stuart Bonnington for their assistance. I would especially like to thank my parents, Mr. Che Chen and Mrs. Lien-Tao Wu Chen, for supporting me and helping to make my dream to study Psychology in the U. S. come true. Dr. Joseph Maloney, Dr. Carol Kominski, Dr. Samuel Fung, Dr. Charles Grah, and Dr. Robert Neimeyer have also been a great source of encouragement and assistance. Finally, I would like to thank my friends for always providing support when I needed it: Dana Burnham, Liz Ivey, Julie Brash, Judy Barton, Candy Lai, and Fenella Chu.

ABSTRACT

This research investigated the relationship of death anxiety and working experience among a group of 49 inexperienced nursing students, a group of 53 experienced nursing students, and a group of 50 college students who had majors which were not likely to result in close encounters with death or the dying. The Multidimensional Fear of Death Scale (MFODS) was used to measure death anxiety. Results were consistent with previous research which indicated that the control group had significantly lower levels of death anxiety on the Fear of the Unknown subscale when compared to inexperienced nursing students and experienced nursing students. The results of this study also found that experienced nursing students had significantly higher levels of death anxiety on the Fear of Dying subscale when compared to the control group and the inexperienced nursing students group.

TABLE OF CONTENTS

CHAPTER

PAGE

I. INTRODUCTION. 1

II. REVIEW of LITERATURE 1

Gender 1
Age 2
Religiosity 2
Personal Death Experience 3
Social Desirability 4
Methods of Measuring Death Anxiety 4
Health Care Professionals 7
Health Care Staff 8
Medical Students 9
Nursing Students 11
Purpose of the Study 12

2. METHODS 14

Participants 14
Procedure 14
Instruments 15

3. RESULTS 17

Overview of Analyses 17
Descriptive Statistics and Social Desirability for Three Groups 17
Analyses of Covariance on Death Orientation Measures 18

4. DISCUSSION 25

LIST OF REFERENCES 28

APPENDIXES 34

A. Informed Consent Statement 35
B. Letter of Permission to Use HMFODS 37
C. Letter of Permimssion to Use MCSDS 37
D. Letter of Permission to Use Human Subjects 38
E. Hoelter's Multidimensional Fear of Death Scale (HMFODS). 44
F. Marlowe-Crowne Social Desirability Scale (MCSDS) 47
G. Demographics Questionnaire 49

LIST OF TABLES

TABLE PAGE

1. Demographic Characteristics and Social Desirability of Experienced Nursing Students, Inexperienced Nursing Students, and Control Group 19

2. Adjusted Means and F Results for Experienced Nursing Students, Inexperienced Nursing Students, and Control Group on Death Orientation Measures 23

3. The Post Hoc Test of Fear of Dying by using Tukey HSD 24

4. The Post Hoc Test of Fear of the Unknown by using Tukey HSD 24

CHAPTER 1

Introduction

In the last few decades, violent crimes and incurable diseases have become more apparent causes of death in our society. Although violent crimes, and incurable diseases are not new to our society, our awareness of such events has been increased by exposure from the mass media. The high visibility of death has led to individuals no longer viewing death as an event that only occurs to the elderly. For example, in 1992 riots broke out in Los Angeles and resulted in over 50 deaths because of the failure to indict a Los Angeles policemen involved in beating motorist Rodney King. NBA star Earvin "Magic" Johnson announced in late 1991 that he had tested positive for the human immunodeficiency virus (HIV), a typically fatal disease.

These cases brought the topic of death into the living rooms and coffee shops frequented by children, adolescents, and adults throughout the United States and beyond (Leming & Dickinson, 1994). Terror, anxiety, and panic are common responses, when facing the dying process and death itself. Bohart and Bergland (1979) argued that fear of death has led to psychological impairment such as depression, posttraumatic stress disorder, or anxiety for many individuals. Because these disorders are very costly to our society and to the individuals' quality of life, there has been an increasing interest in conducting research on factors that lead to death anxiety.

Review of Literature

Gender

There are several variables shown to affect levels of death anxiety. Gender is one of these variables. Studies which have investigated the relationship between death anxiety

and gender have provided different results. For example, Dattel and Neimeyer (1990), Levin (1990), and Iammarino (1975) reported that females were more death anxious than males. Johnson (1990) indicated that for male rehabilitation counselors were more death anxious than females, but the difference was nonsignificant. Robbins (1989) suggested that individual sex-role stereotypes could help account for gender differences on death anxiety. The more "feminine" individuals were reported to be the more death anxiety they showed. However, Eggerman and Dustin (1985) found that there were no significant differences in death anxiety on the Threat Index Scale for different genders of medical students and family physicians.

Age

Some studies have found an effect of age on death anxiety. In a hospice volunteer study, Amenta (1984) suggested that age may be a confounding factor for her finding that persisters were lower in death anxiety and higher in purpose in life. Eggerman and Dustin (1985), Johnson (1980), and Nelson (1979) reported that age was negatively correlated with death anxiety. However, Gesser, Wong, and Reker (1987) found death anxiety was high in the young (18 to 26 years old), highest in middle adulthood (35 to 50 years old), and lowest in the elderly (60 and over 60 years old).

Religiosity

Studies concerning death anxiety and religiosity have resulted in contradictory conclusions. Downey (1984) found no significant relationship between death anxiety and religiosity among a group of middle-aged men. Templer and Dotson (1970) reported no significant relationship between death anxiety and religiosity for college students. In

contrast to the college students, Templer (1972) found a significant negative relationship between death anxiety and religious convictions in a survey of very religiously involved persons. Nelson and Cantrell (1980) reported that high religiosity seemed to attenuate death anxiety, but moderate religiosity seemed to induce death anxiety. Thorson (1991) indicated that people over thirty years old tended to have significantly lower death anxiety with higher religiosity. However, a study by Richardson, Berman, and Piwowarski (1983) showed that the strength of the relationship between religiosity and concerns about death declined with age for people 21 years age or older.

Personal death experiences

Another variable that affects the levels of death anxiety for an individual is personal death experience. Hoelter and Hoelter (1980) reported that there was a positive correlation between exposure to the dying process and the levels of death anxiety. Denton and Wisenbaker (1977) asserted the multidimensionality of the death experience. They indicated that the death experience consisted of three dimensions: (1) the death of a close friend or relative (DE1), (2) the actual experience of seeing a violent death (DE2), and (3) a personal subjective immediacy of death for the respondent (DE3). Denton and Wisenbaker (1977) found that DE2 and DE3 had an inverse relationship with death anxiety when controlling age and work experience and that DE1 was not correlated with death anxiety. In this study, work experience was assessed by determining whether a respondent was a nurse or a nursing student. Nurses were judged to have more death-related work experience and nursing students were judged have less death-related work experience. In contrast, Hoelter and Hoelter (1980) and Franke and Durlak (1990)

suggested that an individual's relationship with persons who were dying or deceased played an important role in death anxiety.

Social desirability

Social desirability set is defined as respondents modifying their answers to what they believe to be a socially approved response. This is another factor that affects death anxiety results. Several studies have been conducted to study the relationship between attitudes toward death and social desirability. Dickstein (1975) reported that death concern was negatively related to social desirability. Dickstein (1978) found that the Death Concern Scale, the Templer Death Anxiety Scale, and the Tolor and Reznikoff Death Anxiety Scale showed significant negative correlations with social desirability. Only the Fear of Death and Dying Scale did not show any correlation with social desirability. Levin (1990) indicated that there was a significant negative relationship between scores on the Templer Death Anxiety Scale and scores on the Marlowe-Crowne Social Desirability Scale. Martin (1982) extracted five factors from the Death Anxiety Scale by using a principal-axes factor analysis and examined the relationships between the five factors and social desirability. Martin (1982) found that only one factor, "death anxiety denial," had a significantly negative relationship with social desirability. In contrast, Krieger, Epting, and Hays (1979) and Templer (1970) found no relationship between death anxiety and social desirability.

Methods of measuring death anxiety

Neimeyer (1995) described two methods to measure death anxiety. One was to measure indirect levels of death anxiety by using projective instruments or experimental

tasks. An example of a projective instrument is Murray's Thematic Apperception Test (TAT) in which a participant is asked to tell a story after seeing an ambiguous stimuli. The participant's response is assumed to indirectly reveal his/her death anxiety. In experimental tasks, participants are presented both death-related words and neutral words and are asked to identify the color of ink in which they are printed. Death anxiety is measured by calculating the number of errors made, the time required to react, or the degree of physiological arousal shown in responding to the death words as opposed to the neutral words. The projective instruments and the experimental methods have largely been abandoned in the last decade because of their uncertain reliability and validity. The other method used to measure death anxiety has been to measure it directly by using interviews and questionnaires. The Threat Index (TI) is one of the interview methods. By assessing respondents' tendencies to define their own identities as living beings and their own death, the more splits found between their own identities as living beings and their death, the more threatened the respondent was assumed to feel.

Neimeyer (1995) reported that questionnaires have increasingly been used in death anxiety research. Over 95 percent of the published studies on death anxiety to date used questionnaires. It is crucial to consider precisely what these instruments measure. The Death Anxiety Scale (DAS) is composed of fifteen short true or false statement items which together measure a single construct, i.e., general death anxiety. The DAS developed by Templer in 1970 has become the most popularly used instrument to measure death anxiety, i.e., over 60 percent of the studies on death anxiety which have been published have utilized the DAS. Templer (1994) and Templer (1970) indicated that

simplicity, good reliability, good internal consistency, stability, and concurrent validity were the reason for the scale's popularity. However, Levin (1990) reported that the DAS was measuring more than a single dimension of death anxiety. Further, a number of studies using factor analysis tended to support this statement (e.g., Durlak, 1982; Durlak & Kass, 1981; Warren & Chopra, 1978). It is reasonable that two groups who have similar death anxiety scores as measured by this scale would not clearly warrant that they had the same types of death anxiety. For example, two groups might obtain the same mean score on the DAS, but one might obtain higher scores on one dimension, whereas the latter might obtain higher scores on the other dimension. Thus, it is likely that all of the studies that have used the questionnaires measuring general death anxiety may not get consistent results because each questionnaire may be measuring different dimensions of death anxiety.

Neimeyer (1995) stated that multidimensional approaches to studying death anxiety have been developed such as the Collett-Lester Fear of Death Scale (CL) and the Hoelter Multidimensional Fear of Death Scale (MFODS). The CL consists of 36 items which were written to assess four conceptually distinct dimensions of death fear. They are Death of Self, Death of Others, Dying of Self, and Dying of Others. Neimeyer (1995) indicated that although the CL is a unique multidimensional questionnaire in wide use (it appears in 18 percent of all published studies in the past 10 years), it has low reliability as indicated by test-retest correlations for various subscales. Thus, the reliability of the CL needs to be improved. Durlak and Kass (1981) reported that the CL did not differentiate and measure the four separate dimensions of fear of death effectively. This raised the

possibility that the empirical factor structure of the CL deviated from theoretical expectations. Thus, the developers of the CL need to resolve its empirical dimensionality.

As a comparatively new scale, the MFODS has not been widely used in death anxiety research. It has been used in only 4 percent of the literature published since 1977 (Neimeyer, 1995). The MFODS consists of 42 items which were written to measure eight distinct dimensions of death anxiety. They are Fear of the Dying Process, Fear of the Dead, Fear of Being Destroyed, Fear for Significant Other, Fear of the Unknown, Fear of Conscious, Fear for the Body after Death, and Fear of Premature Death. Long (1985), Walkey (1982), and Hoelter (1979) indicated that these eight dimensions had acceptable levels of internal consistency (average .75) when the participants were from various cultures. However, to date no published study has examined its test-retest reliability.

Health care professionals

Health care professionals often deal with dying persons and death. Interacting with the dying or death may cause the health care professionals to think about their own death. This frequent interaction may increase their death anxiety. However, their reactions to the dying and death may strongly influence patients. For example, some health care professionals may deal with their death anxiety by avoiding dying patients. This avoidance makes the dying patients feel lonely and isolated as they die. Shady, Brodsky, and Staley (1979) indicated that avoidance of death might be a strong underlying factor in death anxiety as measured by Templer's Death Anxiety Scale. The researchers thought that the student-nurse volunteers' willingness to continue to do volunteer work in hospitals was affected adversely by their early hospital experiences.

Similarly, Sundin, Gaines, and Knapp (1979) suggested that the attitudes toward the dying and death, as measured by the Collett-Lester Fear Scale, was a factor influencing students' choice of medical or dental school. In addition, Field and Howells (1988) indicated that final-year British medical students with higher fear of death, as assessed by the Fear of Death (FOD) scale, were more likely to report difficulty in discussing prognoses with dying patients and to experience minor psychological problems. Thus, it is very important to examine the death anxiety of health care professionals, because death anxiety may affect the mental health of health care professionals and may impair their relationship and the quality of care given to dying patients.

Health care staff

A large body of research on death anxiety for health care professionals has been conducted by psychologists, social scientists, and medical professionals. Depaola, Neimeyer, Lupfer, and Fiedler (1992) reported that participants in a control group had higher levels of death anxiety on two dimensions as measured by the MFODS (Fear of the Dead and Fear of Significant Others Dying) and had lower levels of death anxiety on one dimension (Fear of the Unknown), when compared to nursing home personnel. Depaola, Neimeyer, and Ross (1994) demonstrated that when nursing professionals (i.e., registered nurses and licensed practical nurses) were compared to nursing assistants, the former had lower levels of death threat and anxiety as measured by the Threat Index (TI) and the Multidimensional Fear of Death Scale (MFODS) and more positive attitudes toward the elderly as measured by the Personal Anxiety toward Aging subscale of the

Aging Opinion Survey. In contrast to nursing professionals, nursing assistants had higher levels of death anxiety on four dimensions of death anxiety. They were "Fear of the Dead," "Fear of the Unknown," "Fear of Consciousness when Dead," and "Fear for Body after Death."

Neimeyer and Neimeyer (1984) examined the death anxiety of suicide interventionists and its relation to skill in responding to suicidal clients. They found that the suicide interventionists had lower death anxiety than the general population. However, there was no linear or curvilinear relationship between death anxiety and suicide counseling skill.

Pepitone-Arreola-Rockwell (1981) examined the levels of death anxiety as assessed by Templer's Death Anxiety Scale (DAS) for four occupational groups, i.e., psychiatrists, psychologists, suicidologists, and funeral directors. Pepitone-Arreola-Rockwell (1981) found that psychologists showed the highest levels of death anxiety followed by suicidologists, psychiatrists, and funeral directors. However, Viney, Walker, Lilley, Tooth, Bell, and Nagy (1994) reported that the palliative care staff had more death anxiety than the burn and neonatal staff or the mature age staff. The palliative care staff also had less shame and diffuse anxiety.

Medical students

Field and Howells (1985) showed that different types of worry were associated with death and the dying as measured by an open-ended questionnaire designed by the experimenters for a group of third-year medical students. There were few worries about "Being Dead Oneself." "One's Own Dying Process" was related mainly to worries about

pain. "The Death of Close Others" was associated with worries about the breaking of relationships. For "Interacting with A Dying Patient," the difficulty in communicating with them was the main worry. Sundin, Ganines, and Knapp (1979), using the Collett-Lester Fear Scale, found that dental students were more fearful of the death of others and somewhat more fearful of their own dying than were medical students. However, Howells and Field (1982) indicated that medical students were not significantly different from other students in their fear of death as measured by a Fear of Death Questionnaire Scale (FODS). The scale measures three separate concepts: (1) the thought of dying yourself, (2) the thought of being dead yourself, and (3) the thought of someone close to you dying. Both groups were most fearful of the death of someone close to them, somewhat less fearful of dying themselves, and least fearful of being dead themselves.

Some research has been conducted to examine whether increased medical experience changes attitudes toward death and the dying. Howells and Field (1986) demonstrated that clinically experienced medical students were not significantly different from clinically inexperienced students in their fear of death as measured by a fear-of-death questionnaire consisting of four separate concepts. The concepts were: (a) the thought of dying yourself, (b) the thought of being dead yourself, (c) the thought of someone close to you dying, and (d) the thought of talking with a dying patient about his/her condition during clinical work. In addition, Field and Howells (1988) indicated that there was no significant change in the fear of death (FOD) scale for medical students in their first and final years. In this study, all the final-year medical students had had some direct clinical experience with dying patients, i.e., 70 percent of them had contact with 10

or more dying patients.

Powell, Thorson, Kara, and Uhl (1990) found that there was no significant change in death anxiety scores, as assessed by the DAS, from the time medical students entered medical school until they graduated, but both those entering and those graduating had lower scores on the DAS than control groups.

Nursing students

There was some research conducted to determine if there would be a change in attitude toward death and the dying from nursing education. Lester, Getty, and Kneisl (1974) indicated that fear of death and dying as measured by the Collett-Lester Scale decreased with increased nursing education. In contrast, Denton and Wisenbaker (1977) showed that experienced nursing students (registered nurses) had higher death anxiety as measured by Templer's Death Anxiety Scale (DAS) than nursing students with little or no experience (baccalaureate nursing students). However, Hopping (1977) indicated that there was no pretest-posttest change in attitudes toward death and the dying for 40 senior nursing students. Attitudes toward death and the dying were measured by the Death Attitude Indicator designed by the experimenter.

Golub and Reznikoff (1971) showed that graduates in different nursing specialties (medicine-surgery, public health, psychiatry, administration, education, and school nursing) and with years of nursing experience had different attitudes toward death and the dying than first-year nursing students. The researchers suggested that the influence of nursing experience in forming attitudes toward death and the dying most likely happened during the early nursing career (student years). Their attitudes were assessed by the

multiple choice questionnaire designed by Edwin Shneidman of the Center for Advanced Study in the Behavioral Sciences in conjunction with Edwin Parker and G. Ray Funkhouser of Stanford University which appeared in Psychology Today (Shneidman, 1970). There were no significant differences by later nursing specialty or years of nursing experience.

Purpose of the study

Although many studies have been conducted dealing with death anxiety in health care professionals, few have been conducted using multidimensional measures. The purpose of this study was to assess whether or not there would be a difference in attitudes toward death and the dying as a function of length of nursing experience and whether nursing students with or without nursing experience would have different death anxiety scores from the general population. The multidimensional measure for death anxiety was the MFODS. Three groups of undergraduate students were recruited for this study. They were nursing students with no experience, i.e., first-year nursing students; experienced nursing students, i.e., final-year nursing students; and general undergraduate students.

The secondary interest of this study was to assess the relationship between death anxiety and social desirability and to measure the extent to which responses on the MFODS were influenced by the response set of social desirability. Health care professionals have markedly more death-confrontation experience because they have a greater likelihood of being exposed to dying and death events. However, health care professionals are often encouraged by their institutional peer groups to respond to death related events with composure, self-control and competent efficiency. Health care

professionals who do not maintain such group standards may be thought by their co-workers to be of weak character.

Based on overlapping results of the studies of Depaola, Neimeyer, and Ross (1994) and Depaola, Neimeyer, Lupfer, and Fiedler (1992), this current study predicted that experienced nursing students would have higher levels of death anxiety on the "Fear of the Unknown" dimension as measured by the MFODS, when compared to general undergraduate students. No prediction was made about differences in death anxiety dimensions between inexperienced nursing students and general undergraduate students, nor about differences in dimensions between inexperienced nursing students and experienced nursing students, since this investigator could not find any published literature to support a particular position.

When compared with the past research, this study had several advantages. Since one dimensional death anxiety scales generally combine all items together, it might be expected that these items would cancel each other out. The first advantage was that by using a multidimensional measure of death anxiety, this study provided more specific and detailed information about what dimensions of death anxiety were being affected by varying amount of nursing experience of the nursing students. The second advantage was that by controlling confounding variables such as gender, age, and social desirability, this study clarified what dimensions of death anxiety were really affected by nursing experience for nursing students. The third advantage was that the results of this research provided more specific information that might be helpful to persons designing death education programs for nursing students.

CHAPTER 2

Method

Participants

A total of 152 participants, aged 18 to 40, were recruited for this study. Seventeen participants with previous volunteer work experience or regular employment in a health field related to high death exposure such as an emergency medical technician were excluded from this study. Participants fitted one of three categories: (1) experienced nursing students, (2) inexperienced nursing students, and (3) a control group. The experienced nursing students were recruited from final-year nursing students who had at least one-year nursing experience at Austin Peay State University in Clarksville, Tennessee. The inexperienced nursing students were recruited from first-year nursing students at the same institution. The control group were recruited from the undergraduate students who were not majoring in a medically related field.

Procedure

All participants were provided with an Informed Consent Form (see Appendix A) to determine their willingness to participate. After indicating their willingness, all participants were asked to complete the Demographic Form, the Hoelter Multidimensional Fear of Death Scale (MFODS), and the Marlowe-Crowne Social Desirability Scale (MCSDS). Testing occurred in a standard classroom setting at the University. The order of presentation of the questionnaires was the same for all three groups of participants.

Instruments

The Demographic Form, designed by the experimenter, was a general information sheet on which the participants provided sociodemographic information such as gender, age, ethnic status, and personal death experiences (see Appendix B).

The Multidimensional Fear of Death Scale (MFODS) developed by Hoelter in 1979 consists of 42 items divided into eight distinct dimensions. Walkey (1982) and Holter (1979) reported alpha coefficients of the eight dimensions as follows: Fear of the Dying Process (.80), Fear of the Dead (.72), Fear of Being Destroyed (.81), Fear for Significant Other (.76), Fear of the Unknown (.73), Fear of Conscious (.65), Fear for the Body after Death (.82), and Fear of Premature Death (.72). The mean internal consistency for the various subscales is .75 (see Appendix C).

The Marlowe-Crowne Social Desirability Scale (MCSDS) developed by Marlowe and Crowne in 1960 is used to indicate the extent to which an individual may distort his/her responses in order to present himself/herself in a socially approved direction. The MCSDS consists of thirty-three statements which are answered in a true-false format. Crowne and Marlowe (1960) reported that MCSDS had a good internal consistency coefficient (.88). In addition, the MCSDS had a significant correlation (.35) with the Edwards Social Desirability Scale (SDS) whose items were drawn from various questions on the Minnesota Multiphasic Personality Inventory (MMPI). The correlations found between the Edwards SDS and the MMPI scales were higher than that found between the MCSDS and the MMPI. Further, the items of the Edwards SDS and the MMPI are more

"pathological" in content than the MCSDS. Because the items of the MCSDS are not pathological in content, correlations show MCSDS only partially overlaps the Edwards SDS and MMPI for measuring Social Desirability (see Appendix D).

CHAPTER 3

Results

Overview of analyses

Demographic characteristics and social desirability scores for experienced nursing students, inexperienced nursing students, and the control group were examined. Subsequently, a multivariate analysis of covariance (MANCOVA) was conducted on all death orientation measures comparing the three groups. Next, univariate analyses of covariance (ANCOVAs) were examined for each significant finding on death anxiety measures, the social desirability measure, and any demographic variables which exhibited significant differences among the three groups.

Descriptive statistics and social desirability for three groups

Table 1 presents means and standard deviations for each demographic variable and social desirability scores for experienced nursing students, inexperienced nursing students, and the control group. Despite efforts to recruit comparable samples, preliminary analyses indicated that the vast majority of participants had personal death experiences, i.e., a death in their family, of a close friend, or of a close relatives within the past year or two year. In particular, the majority of participants in the control group had significantly higher levels of personal death experience when compared to inexperienced nursing students and experienced nursing students. The preliminary analyses also showed the experienced nursing student sample included older students than the inexperienced nursing student sample and the control sample. These demographic variables which had significant differences among the three groups may have added variability to the measure

of death anxiety in this study. These demographic variables were controlled in subsequent analyses using appropriate covariance techniques.

Analyses of covariance on death orientation measures

A multivariate analysis of covariance (MANCOVA) was conducted on all death orientation measures comparing the three groups. The MANCOVA for the death orientation scores revealed a significant main effect for all death orientation measures (Wilk's $\lambda = .27$), $F(8, 140) = 47.41$, $p < .001$. Subsequently, univariate analyses of covariance (ANCOVAs) were examined for each measure. Age and personal death experience, i.e., a death in your family, of a close friend, or of a close relative, were used as covariates. Table 2 presents the adjusted group means, F results, and significance levels for each death orientation measure. The results indicated that significant differences did emerge on two of the eight subscales of the MFODS. They were the Fear of Dying subscale and the Fear of the Unknown subscale. The predicted values from removing the variability in the Fear of Dying and the Fear of the Unknown due to the covariates (age and personal death experiences) were used for the Post Hoc test. Table 3 presents the Post Hoc test for the Fear of Dying subscale. The results indicated that experienced nursing students ($M = 23.81$) had significantly higher apprehension regarding the Fear of Dying when compared to inexperienced nursing students ($M = 21.80$) and the control group ($M = 22.16$). Table 4 shows the Post Hoc test for the Fear of the Unknown subscale. The results revealed that the control group ($M = 8.62$) had significanlty less apprehension regarding the Fear of the Unknown when compared to inexperienced nursing students ($M = 10.49$) and experienced nursing students ($M = 10.70$).

Table 1

Demographic Characteristics and Social Desirability of Experienced Nursing Students, Inexperienced Nursing Students, and Control Group.

Characteristics	Experienced nursing students (n= 50)	Inexperienced nursing students (n = 49)	Control group (n = 53)	Test	P
Age	26.5	21.5	22.7	F = 10.25	.000
Gender					
Male	11 (21%)	5 (10%)	14 (28%)	$\chi^2 = 5.00$	.082
Female	42 (79%)	44 (90%)	36 (72%)		
Ethnicity					
African American	6 (11%)	8 (16%)	10 (20%)	$\chi^2 = 5.98$	.650
Asian or Pacific Islander	0 (0%)	1 (2%)	1 (2%)		
White Non-Hispanic	42 (79%)	37 (76%)	38 (76%)		
American Indian or Alaskan	3 (6%)	1 (2%)	0 (0%)		
Other	2 (4%)	2 (4%)	1 (2%)		

Table 1

Demographic Characteristics and Social Desirability of Experienced Nursing Students, Inexperienced Nursing Students, and Control Group.

Characteristics	Experienced nursing students (n= 50)	Inexperienced nursing students (n = 49)	Control group (n = 53)	Test	P
Religiosity					
Strong	30 (60%)	26 (65%)	33 (73%)	$\chi^2 = 3.41$	.492
Moderate	18 (36%)	12 (30%)	12 (27%)		
Weak	2 (4%)	2 (5%)	0 (0%)		
Personal death experience (a death in your family, of a close friend, or of a close relative)					
3 = Within the past year to two years	21 (40%)	30 (61%)	36 (72%)	$\chi^2 = 14.76$	.005
2 = Within the past three to five years	16 (30%)	12 (25%)	11 (22%)	F = 7.983	.001

Table 1

Demographic Characteristics and Social Desirability of Experienced Nursing Students, Inexperienced Nursing Students, and Control Group.

Experienced nursing students	Inexperienced nursing students	Control group		
Characteristics	(n= 50)	(n = 49)	(n = 53)	Test	P
1 = More than five years	16 (30%)	7 (14%)	3 (6%)		
Personal death experience					
(have seen a violent death)					
Yes	9 (20%)	5 (16%)	1(4%)	$\chi^2 = 3.122$	.210
No	36 (80%)	26 (84%)	23 (96%)		
Personal death experience (have					
been seriously thought you were					
going to die)					
Never	24 (45%)	18 (37%)	27 (54%)	$\chi^2 = 6.684$	.351
Rarely	26 (49%)	26 (53%)	17 (34%)		

Table 1

Demographic Characteristics and Social Desirability of Experienced Nursing Students, Inexperienced Nursing Students, and Control Group.

Characteristics	Experienced nursing students (n= 50)	Inexperienced nursing students (n = 49)	Control group (n = 53)	Test	P
Occasionally	3 (6%)	5 (10%)	5 (10%)		
Frequently	0 (0%)	0 (0%)	1 (2%)		
Social Desirability					
Scale score	15.43	15.61	15.94	F = 0.122	.885

*p < .05. **p < .01.

Table 2

Adjusted Means and F Results for Experienced Nursing Students, Inexperienced Nursing Students, and Control Group on Death Orientation Measures

Characteristics	Experienced nursing students (n= 50)	Inexperienced nursing students (n = 49)	control group (n = 53)	F	P
MFODS					
F1 Fear of Dying	24.34	21.58	21.81	3.32	.039
F2 Fear of the Death	16.01	17.98	18.37	2.51	.085
F3 Fear of Being Destroyed	12.78	13.17	13.59	0.54	.585
F4 Fear for Significant Others	24.22	24.08	23.55	0.45	.641
F5 Fear of the Unknown	10.92	10.52	8.35	5.14	.007
F6 Fear of Consciousness When Dead	13.87	14.98	13.90	1.04	.355
F7 Fear for Body After Death	14.93	15.74	13.90	2.26	.108
F8 Fear of Premature Death	12.29	13.37	13.28	1.04	.355

*$p < .05$. ** $p < .01$.

Table 3

The Post Hoc Test of Fear of Dying by using Tukey HSD

	Mean differences	P
Experienced nursing students (M = 23.81) vs. Inexperienced nursing students (M = 21.80)	2.01	.000
Inexperienced nursing students (M = 21.80) vs. control group (M = 22.16)	-0.36	.127
Experienced nursing students (M = 23.81) vs. Control group (M = 22.16)	1.65	.000

*p < .05. **p < .01.

Table 4

The Post Hoc Test of Fear of the Unknown by using Tukey HSD

	Mean differences	P
Experienced nursing students (M = 10.70) vs. Inexperienced nursing students (M = 10.49)	0.21	.505
Inexperienced nursing students (M = 10.49) vs. Control group (M = 8.62)	1.87	.000
Experienced nursing students (M = 10.70) vs. Control group (M = 8.62)	2.08	.000

*p < .05. **p < .01.

CHAPTER 4

Discussion

Based on overlapping results of the studies of Depaola, Neimeyer, and Ross (1994) and Depaola, Neimeyer, Lupfer, and Fiedler (1992), this current study predicted that experienced nursing students would have higher levels of death anxiety on the "Fear of the Unknown" dimension as measured by the MFODS, when compared to general undergraduate students. No prediction was made about differences in death anxiety dimensions between inexperienced nursing students and general undergraduate students, nor about differences in dimensions between inexperienced nursing students and experienced nursing students, since this investigator could not find any published literature to support particular position.

The results of this study indicated that there were no differences in the Fear of the Dead subscale, the Fear of Being Destroyed subscale, the Fear for Significant Others subscale, the Fear of Consciousness When Dead subscale, the Fear for Body after Death subscale, and the Fear of Premature Death subscale when compared to the three groups. The results of this study found that the experienced nursing students and inexperienced nursing students had significantly higher levels of death anxiety on the Fear of the Unknown subscale when compared to the control group. This is consistent with previous research. One possible interpretation for this finding is that previous self-selection for death acceptance in pursuing their major and greater exposure to death and dying have caused them to think about the ambiguity of death and the ultimate question of existence. The lack of an explanation for the uncertainty of death and a sense of losing control may

cause their greater death anxiety. This interpretation is supported by the research of Depaola, Neimeyer, Lupfer, and Fiedler (1992) who reported that nursing home personnel showed more death fear on the fear of the unknown when compared to a control group.

Regarding the Fear of Dying subscale, Depaola, Neimeyer, Lupfer, and Fiedler (1992) reported that there were no differences in the fear of dying between nursing home personnel (registered nurses, licensed practical nurses, and nurse aides) when compared to a control group. One possible interpretation for these findings is that nursing home personnel may become depersonalized to death and its impact on survivors. By thinking of patients as objects rather than people, nursing home personnel acclimate to death as a consequence of their employment. In contrast to the study of Depaola, Neimeyer, Lupfer, and Fiedler (1992), the results of this current study found that experienced nursing students had significantly higher levels of death anxiety on the Fear of Dying subscale when compared to the control group and inexperienced nursing students group. One possible explanation for these findings is that experienced nursing students may not have had as much nursing experience as nursing home personnel. Watching patients' struggle with the dying process may have a great impact on experienced nursing students and require more experience and time to become depersonalized to the dying process. Moreover, before choosing their major, nursing students believed that they could handle confrontations with death and dying. However, without nursing experiences, inexperienced nursing students may underestimate their attitudes toward patients' death and dying. This may be the reason that inexperienced nursing students have lower levels of death anxiety on the Fear of Dying when compared to experienced nursing students.

Nursing students may have adequate technical training, but they may lack training with the emotional demands of their job. Nursing students may use depersonalization as a defense mechanism to cope with their different dimensions of death anxiety except in the case of the fear of the unknown dimension. A long period of emotional exhaustion and depersonalization can lead to a decreased sense of self-efficacy and possible depression (Lee & Ashforth, 1990). Thus, it may be very important to help nursing students experience a healthy balance of sensitivity to patients and dedication to the field. The results of this study may provide some insight into how to design more effective programs for nursing students. Programs emphasizing death education may help nursing students cope with anxiety, uncertainty, and depression related with death and dying.

Replication of the present research with different health care professionals would be beneficial. Comparing nursing students or nursing professionals who work with different categories of patients might provide more specific information about attitudes toward death and dying due to a variety of nursing experiences. A longitudinal design incorporating different types of nursing students and nursing professionals may show more accurate differences in their attitudes toward death and dying as a function of length of nursing experiences.

LIST OF REFERENCES

References

Amenta, M. M. (1984). Death anxiety, purpose in life and duration of service in hospice volunteers. Psychological Reports, 54, 979-984.

Bohart, J. B. & Bergland, B. W. (1979). The impact of death and dying counseling groups on death anxiety in college students. Death Education, 2, 381-391.

Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. Journal of Consulting Psychology, 24, 349-354.

Dattel, A. R., & Neimeyer, R. A. (1990). Sex differences in death anxiety: Testing the emotional expressiveness hypothesis. Death Studies, 14, 1-11.

Denton, J. A., & Wisenbaker, V. B. (1977). Death experience and death anxiety among nurses and nursing students. Nursing Research, 26, 61-64.

Depaola, S. J., Neimeyer, R. A., Luper, M. B., & Fiedler, J. (1992). Death concern and attitudes toward the elderly in nursing home personnel. Death Studies, 16, 537-555.

Depaola, S. J., Neimeyer, R. A., & Ross, S. K. (1994). Death concern and attitudes toward the elderly in nursing home personnel as a function of training. Omega, 29, 231-248.

Dickstein, L. S. (1975). Self-report and fantasy correlates of death concern. Psychological Reports, 37, 147-158.

Dickstein, L. S. (1978). Attitudes toward death, anxiety, and social desirability. Omega, 8, 369-378.

Downey, A. M. (1984). Relationship of religiosity to death anxiety in middle aged males. Psychological Reports, 54, 811-822.

Durlak, J. A. (1982). Using the Templer scale to assess "death anxiety": A cautionary note. Psychological Reports, 50, 1257-1258.

Durlak, J. A., & Kass, R. A. (1981). Clarifying the measurement of death attitudes: A factor analytic evaluation of fifteen self-report death scales. Omega, 12, 129-141.

Eggerman, S., & Dustin, D. (1985). Death orientation and communication with the terminally ill. Omega, 16, 255-265.

Field, D., & Howells, K. (1985). Medical students' self-reported worries about aspects of death and dying. Death Studies, 10, 147-154.

Field, D., & Howells, K. (1988). Dealing with dying patients: Differences and strategies in final-year medical students. Death Studies, 12, 9-20.

Franke, K. J., & Durlak, J. A. (1990). Impact of life factors upon attitudes toward death. Omega, 21, 41-49.

Gesser, G., Wong, P. T. P., & Reker, G. T. (1987). Death attitudes across the life-span: The development and validation of the death attitude profile (DAP). Omega, 18, 113-128.

Golub, S., & Reznikoff, M. (1971). Attitudes toward death. Nursing Research, 20, 503-508.

Hoelter, J. W. (1979). Multidimensional treatment of fear of death. Journal of Consulting and Clinical psychology, 47, 996-999.

Hoelter, J. W., & Hoelter, J. A. (1980). On the interrelationships among exposure to death and dying, fear of death and anxiety. Omega, 11, 241-254.

Hoping, B. L. (1977). Nursing students' attitudes toward death. Nursing Research, 26, 443-447.

Howells, K., & Field, D. (1982). Fear of death and dying among medical students. Social Science and Medicine, 16, 1421-1424.

Howells, K., & Field, D. (1986). Fear of death and dying in medical students: effects of clinical experience. Medical Education, 20, 502-506.

Iammarino, N. K. (1975). Relationship between death anxiety and demographic variables. Psychological Reports, 37, 262.

Johnson, J. C. (1980). Death anxiety of rehabilitation counselors and clients. Psychological Reports, 46, 325-326.

Krieger, S. R., Epting, F. R., & Hays, C. H. (1979). Validity and Reliability of provided constructs in assessing death threat. Omega, 10, 87-95.

Lee, R. T., & Ashforth, B. E. (1990). On the meaning of Mashlach's three dimensions of burnout. Journal of Applied Psychology, 75, 743-747.

Leming, M. R., & Dickinson, G. E. (Eds.). (1994). Understanding Dying, Death, & Bereavement (3rd ed.). Fort Worth: Harcourt Brace College.

Lester, D., Getty, C., & Kneisl, C. R. (1974). Attitudes of nursing students and nursing faculty toward death. Nursing Research, 23, 50-53.

Levin, R. (1990). A reexamination of the dimensionality of death anxiety. Omega, 20, 341-349.

Long, D. D. (1985). A cross-cultural examination of fears of death among Saudi Arabians. Omega, 16, 43-50.

Martin, T. O. (1982-83). Death anxiety and social desirability among nurses. Omega, 13, 51-58.

Neimeyer, R. A. (1995). Death Anxiety. In H. Wass, F. M. Berardo, & R. A. Neimeyer (Eds.), Dying: Facing the facts (pp. 97-136). Washington: Hemisphere Publishing Corporation.

Neimeyer, R. A., & Neimeyer, G. J. (1984). Death anxiety and counseling skill in the suicide interventionist. Suicide and Life-Threatening Behavior, 14, 126-131.

Nelson, L. D. (1979). Structural conduciveness, personality characteristics and death anxiety. Omega, 10, 123-133.

Nelson, L. D. & Cantrell, C. H. (1980). Religiosity and death anxiety: a multi-dimensional analysis. Review of Religious Research, 21, 148-157.

Pepitone-Arreola-Rockwell, F. (1981). Death anxiety: Comparison of psychiatrists, psychologists, suicidologists, and funeral directors. Psychological Reports, 49, 979-982.

Powell, F. C., Thorson, J. A., & Uhl, H. S. (1990). Current problems and resolutions. The Journal of Psychology, 124, 339-342.

Richardson, V., Berman, S., & Piwowarski, M. (1983). Projective assessment of the relationships between the salience of death, religion, and age among adults in America. The Journal of General Psychology, 109, 149-156.

Robbins, R. A. (1989). Gender and sex-role stereotypes in scales of death concern. Death Studies, 13, 579-591.

Shady, G., Brodsky, M., & Staley, D. (1979). Validation of the

multidimensionality of death anxiety as supported by differences between volunteers and nonvolunteers. Psychological Reports, 45, 255-258.

Shneidman, E. S. (1970). Death questionnaire. Psychology Today, 4, 67-72.

Sundin, R. H., Gaines, W. G., & Knapp, WM. B. (1979). Attitudes of dental and medical students toward death and dying. Omega, 10, 77-86.

Templer, D. I. (1970). The construction and validation of a death anxiety scale. The Journal of General Psychology, 82, 165-177.

Templer, D. I. (1972). Death anxiety in religiously very involved persons. Psychological Reports, 31, 361-362.

Templer, D. I. (1994). Templer death anxiety scale. In J. Fischer & K. corcoran (Eds.), Measurement for clinical practice (pp. 656-657). New York: Free Press.

Templer, D. I. & Dotson, E. (1970). Religious correlates of death anxiety. Psychological Reports, 26, 895-897.

Thorson, J. A. (1991). Afterlife constructs, death anxiety, and life reviewing: The importance of religion as a moderating variable. Journal of Psychology and Theology, 19, 278-284.

Viney, L. L., Walker, B. M., Lilley, B., Tooth, B., Bell, P., & Nagy, S. (1994). The quality of life of palliative care staff: A personal construct approach. Omega, 28, 201-217.Warren, W. G., & Chopra, P. N. (1978). Some reliability and validity considerations on Australian data from the Death Anxiety Scale. Omega, 9, 293-299.

Walkey, F. W. (1982). The multidimensional fear of death scale: An independent analysis. Journal of Consulting and Clinical Psychology, 50, 466-467.

APPENDICES

Appendix A

Participants

You are about to participate in a study investigating your thoughts about death. *Please read the following material carefully.* It describes the purpose of the study, the procedures to be used, risks and benefits of your participation, and what will happen to the information that is collected from you.

1. The purpose of the study:
The purpose of the study is to investigate your thoughts about death.

2. The procedure to be used:
You will be asked to complete the Demographic Form (which asks you to indicate your gender, ethnicity, and religion) and a number of assessment instruments to investigate your thoughts about death. Testing will occur in a standard classroom setting at Austin Peay State University.

3. Risks and benefits of participation:
You may have a sense of sadness and loss after you complete the assessment instruments. This may be especially true if you have experienced the recent loss of someone close to you. After you complete all assessment instruments you will be given information about the counseling center in the APSU Student Department Center. If you would like to have counseling sessions, you can contact them at (615) 648-6242.

There are no direct benefits to you other than perhaps a sense of satisfaction from having participated and knowledge of what is like to participate in psychology research.

4. What will happen to the information collected:
Only the principle investigator and her faculty sponsors will have access to the data obtained from you. The data obtained from you will be coded by an arbitrary subject number and entered into a computer for analysis. The data from you will be used for purposes of research and scientific publication only. In any such use of the information, all identities will be carefully protected. The identities of participants will not be revealed in any published or oral presentation of the results of the study. Information will be made public in the form of summaries which make it impossible to tell who the participants were.

If you would like a summary of the findings of this study, you may contact:

Yi-Chuen Chen
P. O. Box 7388
Austin Peay State University
Clarksville, TN 37044
(931) 551-3519
email: YC4625@apsu01.apsu.edu

If you would also like a record of your data, you can obtain it from Yi-Chuen Chen as well. To obtain your data, it is necessary that you keep a record of your subject number.

Thank you for your participation.

****

Informed Consent Statement

Please read the statements below. They describe your rights and responsibilities as a participant in this research project.

1. I agree to participate in the present study being conducted by a graduate student under the supervision of Dr. Jean G. Lewis, Dr. Anthony Golden, and Dr. Stuart Bonnington in the Department of Psychology at Austin Peay Sate University.

2. I have been informed in writing of the procedures to be followed as well as the risks and benefits to me for participating. I have been given an opportunity to ask questions about my participation.

3. I understand that only Yi-Chuen Chen and her faculty sponsors will have access to my data. My data will be used only for purpose of analysis.

4. I understand that I may terminate my participation at any time without penalty or prejudice and that I may have all data obtained from me destroyed.

5. I realized that by signing this form, I willingly consent to participate in this study. I also acknowledge that I have been given a copy of this consent form to keep.

_____	_____	_____
Name (please print)	Signature	Date

AUSTIN PEAY
STATE UNIVERSITY

Psychology Department
P.O. Box 4537
Clarksville, TN 37044

Phone: (615) 648-7233
FAX: (615) 648-6267

April 28, 1997

Ms. Julie Krempa
Baywood Publishing Co., Inc.
P.O. Box 337
Amityville, NY 11701

Dear Ms. Krempa:

I am a graduate student at Austin Peay State University in Clarksville, Tennessee. I am writing to request permission to use Hoelter's Multidimensional Fear of Death Scale (MFODS) in my Master's Thesis.

Thank you for your time and any assistance that you can provide will be greatly appreciated.

Sincerely,

Yi-Chuen Chen

Yi-Chuen Chen
P.O. Box 7388
Austin Peay State University
Clarksville, TN 37044
(615) 648-7315 or (615) 551-3519
APSU Fax # (615) 648-7614

baywood
PUBLISHING COMPANY, INCORPORATED
26 Austin Avenue • P.O. Box 337 • Amityville, New York 11701 • (516) 691-1270 • Fax (516) 691-1770
e-mail: baywood@baywood.com • web site: http://baywood.com

May 1, 1997

Yi-Chuen Chen
P.O. Box 7388
Austin Peay State University
Clarksville, TN 37044

Dear Yi-Chuen Chen:

We are pleased to grant you permission to use Hoelter's Multidimensional Fear of Death Scale (MFODS) in your Master's Thesis.

Please note the credit line should be cited properly giving full credit to the Journal, Author (as well as to the Series, Editor, or Translator, if any), and the Baywood Publishing Co., Inc. as Publisher.

If I may be of any further assistance, please let me know.

Sincerely,

Julie Krempa

Julie Krempa
Permissions Department

JK:jk
Enc.

AUSTIN PEAY
STATE UNIVERSITY

Psychology Department
P.O. Box 4537
Clarksville, TN 37044

Phone: (615) 648-7233
FAX: (615) 648-6267

May 14, 1997

J. Gayle Beck, Ph. D.
Department of Psychology, University of Houston
4800 Calhoun Street
Houston, Texas 77204-5341

Dear Ms. Beck:

I am a graduate student at Austin Peay State University in Clarksville, Tennessee. I am working on my thesis. I have tried to contact Dr. Douglas P. Crowne and Dr. David Marlowe at the institutions that were printed in the Journal of Consulting Psychology, Vol. 24(4), 1960 (pages 349-354) in order to request permission to use the Crowne-Marlowe Social Desirability Scale (CMSD) in my Master's Thesis. However, the information that was provided on page 394 is no longer correct.

I read your article recently and found that you used the Crowne-Marlowe Social Desirability Scale (CMSD) in the Journal of Sex Research, Vol.28(3), 1991 (pages 443-456). Could you give me some suggestions on how to request permission to use the Crowne-Marlowe Social Desirability Scale (CMSD) in my thesis?

Thank you for your time and any assistance that you can provide will be greatly appreciated.

Sincerely,

Yi-Chuen Chen

Yi-Chuen Chen
P.O. Box 7388
Austin Peay State University
Clarksville, TN 37044
(615) 648-7315 or (615) 551-3519
APSU Fax # (615) 648-7614
AFTER MAY 23rd, PLEASE SEND TO:
Austin Peay State University
Psychology Department
Attention: Dr. Jean Lewis
P. O. Box 4537
Clarksville, TN 37044
FAX: (615) 648-6267

It is my understanding that this instrument is now in the public domain —

J Beck

Appendix D

AUSTIN PEAY STATE UNIVERSITY

TITLE: Relationship of nursing work experience to multidimensioanl measures of death anxiety

FUNDING SOURCE: Principle investigator

PRINCIPLE INVESTIGATOR: Yi-Chuen Chen DEPARTMENT: Psychology

SPONSOR: Dr. Jean Lewis, Dr. Anthony Golden, and Dr. Stuart Bonnington

1. A brief description or outline of my research procedures as they relate to the use of human subjects:

Although many studies have been conducted dealing with death anxiety in health care professionals, few have been conducted using multidimensional approaches. The purpose of this study is to assess whether or not there will be a difference in attitudes toward death and the dying as a function of length of nursing experience and whether nursing students with or without nursing experience will have different death anxiety scores from the general population. The multidimensional measure for death anxiety will be the MFODS.

In addition, health care professionals have markedly more death-confrontation experience because they have greater likelihood to be exposed to dying and death events. However, health care professionals are often encouraged by their institutional peer groups to respond to death related events with composure, self-control and competent efficiency. Health care professionals who do not maintain such group standards may be thought by their co-workers to be weak characters. Thus, the secondary interest of this study is to assess the relationship between death anxiety and social desirability and to measure the extent to which responses on the MFODS are influenced by the response set of social desirability.

A total of one hundred and fifty participants, aged eighteen to forty, will be recruited for this study. Participants will fit one of three categories: (1) experienced nursing students, (2) inexperienced nursing students, and (3) control group. The experienced nursing students will be recruited from final-year nursing students who have at least one-year nursing experience at Austin Peay State University in Clarksville, Tennessee. The inexperienced nursing students will be recruited from first-year nursing students at Austin Peay State University in Clarksville, Tennessee. The control group will be recruited from the undergraduate students who are not majoring in a medically related field at Austin Peay State University in Clarksville, Tennessee.

All participants will be provided with an informed consent form to determine their willingness to participate in this study. After indicating their willingness, all participants

will be asked to complete the Demographic Form, the Hoelter Multidimensional Fear of Death Scale (MFODS), and the Marlowe-Crowne Social Desirability Scale (MCSDS). Testing will occur in a standard classroom setting at Austin Peay State University. The order of presentation of the questionnaires is the same for all three groups of participants.

2. Risks of psychic, legal, physical, or social harm to the participants:

The participants may have a sense of sadness and loss after they complete the assessment instruments. This may be especially true if the participants have experienced the recent loss of someone close to them. After the participants complete all assessment instruments they will be given information about the counseling center in the APSU Student Development Center. If the participants would like to have counseling sessions, they can contact them at (615) 648-6246.

3. Benefits to the participants:

There are no direct benefits to the participants other than perhaps a sense of satisfaction from having participated and knowledge of what is like to participate in psychology research.

4. Informed consent:

Informed consent will be obtained from all subjects or their legally authorized representative.

5. The confidentiality of all subjects will be maintained and all participants are protected from the future potentially harmful use of the data collected in this investigation in the following ways:

Only the principle investigator and her faculty sponsors will have access to the data obtained from all participants. The data obtained from all participants will be coded by an arbitrary subject number and entered into a computer for analysis. The data from all participants will be used for purposes of research and scientific publication only. In any such use of the information, all identities will be carefully protected. The identities of participants will not be revealed in any published or oral presentation of the results of the study. Information will be made public in the form of summaries which make it impossible to tell who the participants were.

If the participants would like a summary of the findings of this study, they can contact:

Yi-Chuen Chen
P. O. Box 7388
Austin Peay State University
Clarksville, TN 37044
(931) 551-3519
email: yc4625@apsu01.apsu.edu

If they would also like a record of their data, the participants can obtain them from Yi-Chuen Chen as well. To obtain their data, it is necessary that the participants keep a record of their subject number.

6. The data to be collected do not relate to illegal activities.

I have read the Austin Peay Sate University Policies and Procedures on Human Research and agree to abide by them. I also agree to report to the Human Research Review Committee any significant and relevant changes in procedures and instruments as they related to subjects.

Signature Yi Chuen Chen

Student research directed by faculty should be co-signed by faculty supervisor.

Signature Dean G Lewis

RESEARCH INVOLVING HUMAN SUBJECTS

PROJECT NUMBER 98015
DATE October 22, 1997

Title of Proposal: Relationship of nursing work experience to multidimensional measures of death anxiety
Principal Investigator: Yi-Chuen Chen
Faculty Sponsor (if student): Dr. Jean Lewis

Action of the Human Research Review Committee:

☒ A. Approved as described. Researcher is responsible for obtaining approval from the Committee prior to introducing any changes in protocol; for keeping signed consent statements for the duration of the project and for three years thereafter; and for informing the Committee of any unexpected physical or psychological effects on subjects.

☐ B. Approved with recommendations as follows (Researcher may revise the project in accordance with the recommendations and communicate in writing the changes which have been made; discuss the action with the committee, or withdraw the proposal):

☐ C. Proposal deferred for additional evidence as follows (further action is contingent on the investigator supplying the committee with appropriate information):

☐ D. Proposal not approved for the following reasons (Researcher may revise the project or discuss the action with the Committee):

Reviewed by: Chairman, Human Research Review Committee

Signature

Membership, Human Research Review Committee

Signature

Copies to: Investigator
File with Proposal

PPM FORM 2:002:b

APSU/AA/AA/5124 (11-80)

Appendix E

HMFODS

Directions: Please read each statement and decide which of the five answers best describes how you feel. Place the numeral of your answer in the blank space provided.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

___ 1. I am afraid of dying very slowly.

___ 2. I am afraid of dying in a fire.

___ 3. I am afraid of experiencing a great deal of pain when I die.

___ 4. I am afraid of dying of cancer.

___ 5. I have a fear of suffocating (or drowning).

___ 6. I have a fear of dying violently.

___ 7. I dread visiting a funeral home.

___ 8. Touching a corpse would not bother me.

___ 9. Discovering a dead body would be a horrifying experience.

___ 10. I would be afraid to walk through a graveyard, alone, at night.

___ 11. It would bother me to remove a dead animal from the road.

___ 12. I am afraid of things which have died.

___ 13. I would like to donate my body to science.

___ 14. I do not want medical students using my body for practice after I die.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

___ 15. I do not like the thought of being cremated.

___ 16. I do not want to donate my eyes after I die.

___ 17. I have a fear of people in my family dying.

___ 18. If the people I am very close to were to suddenly die, I would suffer for a long time.

___ 19. If I would die tomorrow, my family would be upset for a long time.

___ 20. Since everyone dies, I won't be too upset when my friends die.

___ 21. I sometimes get upset when acquaintances die.

___ 22. If I died, my friends would be upset for a long time.

___ 23. I am afraid that there is no afterlife.

___ 24. I am not afraid of meeting my creator.

___ 25. I am afraid that death is the end of one's existence.

___ 26. I am afraid that there may not be a supreme being.

___ 27. No one can say, for sure, what will happen after death.

___ 28. There are probably many people pronounced dead that are really still alive.

___ 29. I am afraid of being buried alive.

___ 30. People should have autopsies to insure that they are dead.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

___ 31. It scares me to think I may be conscious while lying in a morgue.

___ 32. I hope more than one doctor examines me before I am pronounced dead.

___ 33. I am afraid of my body being disfigured when I die.

___ 34. I dread the thought of my body being embalmed some day.

___ 35. The thought of my body never being found after I die scares me.

___ 36. It doesn't matter whether I am buried in a wooden box or a steel vault.

___ 37. The thought of being locked in a coffin after I die scares me.

___ 38. The thought of my body decaying after I die scares me.

___ 39. I have a fear of not accomplishing my goals in life before dying.

___ 40. I am afraid I will not live long enough to enjoy my retirement.

___ 41. I am afraid I will not have time to experience everything I want to.

___ 42. I am afraid I may never see my children grow up.

Appendix F

MCSDS

Listed below are a number of statements concerning personal attitudes and traits. Please read each item and decide whether the statement is *true* or *false* as it pertains to you personally.

___ 1. Before voting I thoroughly investigate the qualifications of all the candidates.

___ 2. I never hesitate to go out of my way to help someone in trouble.

___ 3. It is sometimes hard for me to go on with my work if I am not encouraged.

___ 4. I have never intensely disliked anyone.

___ 5. On occasion I have had doubts about my ability to succeed in life.

___ 6. I sometimes feel resentful when I don't get my way.

___ 7. I am always careful about my manner of dress.

___ 8. My table manners at home are as good as when I eat out in a restaurant.

___ 9. If I could get into a movie without paying and be sure I was not seen I would probably do it.

___ 10. On a few occasions, I have given up doing something because I thought too little of my ability.

___ 11. I like to gossip at times.

___ 12. There have been times when I felt like rebelling against people in authority even though I knew they were right.

___ 13. No matter who I'm talking to, I'm always a good listener.

___ 14. I can remember "playing sick" to get out of something.

___ 15. There have been occasions when I took advantage of someone.

___ 16. I'm always willing to admit it when I make a mistake.

___ 17. I always try to practice what I preach.

___ 18. I don't find it particularly difficult to get along with loud mouthed, obnoxious people.

___ 19. I sometimes try to get even rather than forgive and forget.

___ 20. When I don't know something I don't at all mind admitting it.

___ 21. I am always courteous, even to people who are disagreeable.

___ 22. At times I have really insisted on having things my own way.

___ 23. There have been occasions when I felt like smashing things.

___ 24. I would never think of letting someone else be punished for my wrong doings.

___ 25. I never resent being asked to return a favor.

___ 26. I have never been irked when people expressed ideas very different from my own.

___ 27. I never make a long trip without checking the safety of my car.

___ 28. There have been times when I was quite jealous of the good fortune of others.

___ 29. I have almost never felt the urge to tell someone off.

___ 30. I am sometimes irritated by people who ask favors of me.

___ 31. I have never felt that I was punished without cause.

___ 32. I sometimes think when people have a misfortune they only got what they deserved.

___ 33. I have never deliberately said something that hurt someone's feelings.

Appendix G

Demographic Information

Please complete following:

___ Age

_____ College Major

___ Gender: 1 - Female
2 - Male

___ Class: 1 - Freshman
2 - Sophomore
3 - Junior
4 - Senior
5 - Other _____

___ Ethnicity: 1 - African American
2 - Asian or Pacific Islander
3 - White Non-Hispanic
4 - Hispanic
5 - American Indian or Alaskan
6 - Other

___ Have you had previous volunteer work experience or regular employment in a health related field? (For example, a hospital volunteer or an emergency medical technician)

1 - Yes _____ (please specify the job you did)
2 - No

___ If yes, did you have direct care of patients?

3 - Yes
4 - No

___ Are you currently doing your nursing internship?

1 - Yes
2 - No

___ Religion: 1 - Christian Denomination _____ (please specify)

2 - Jewish

3 - Muslim

4 - Buddhist

5 - No religion

6 - Other _____

Religiosity

___ If you checked one of the Religion Categories (for example, Christian, Jewish, Muslin, or Buddhist) how strong is your attachment to that belief system?

1 - Strong

2 - Moderate

3 - Weak

Personal death experience

___ How recently have you experienced a death in your family, of a close friend, or of a close relative?

1 - Within the past year to two years

2 - Within the past three to five years

3 - More than five years

___ Have you ever seen a person die?

1 - No

2 - Yes

___ If yes, have you seen a violent death?

3 - No

4 - Yes

___ How often have you been in a situation in which you seriously thought you were going to die?

1 - Never

2 - Rarely

3 - Occasionally

4 - Frequently