A Study of the Differences in Responses of Students and Alumni of Two Types of Nurse-education Programs, to Questions Regarding Communication with Dying Patients

R. Cherie McClure

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A STUDY OF THE DIFFERENCES IN RESPONSES OF STUDENTS AND ALUMNI OF TWO TYPES OF NURSE-EDUCATION PROGRAMS, TO QUESTIONS REGARDING COMMUNICATION WITH DYING PATIENTS

By
R. Cherie McClure

A Thesis in Partial Fulfillment of the Requirements for the Degree Master of Science in the Field of Nursing

August, 1970
Each person whose signature appears below certifies that he has read this thesis and that in his opinion it is adequate, in scope and quality, as a thesis for the degree of Master of Science.

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CHAPTER I

INTRODUCTION TO THE STUDY

Death is a characteristic feature of all human existence; it is inevitable, for eventually we all must die. In spite of this stern reality, many have never faced it. People tend to ignore or deny the thought that one day they will cease to be a part of the living, dynamic world they know.1 "Facing death is difficult, and helping others face it is trying."2

Fear of death is a psychological aspect common to all cultures,3 but perhaps this is especially true of our twentieth-century American society. Thanks to mass communication media, the portrayal of death and violence are household commodities. Yet a personal experience with death and the dying process is not a part of the American scene. Many services formerly performed by families at the time of death now are purchased from special functionaries.4 According to Feifel, death and the dying process are taboos in our society; we just don't talk about

them in a personal sense. Because they remind one of death, even the elderly tend to be segregated and isolated from families.

Another device used for avoiding confrontation with death is seen in the substitution of euphemisms for the term. People are said to expire, to pass away, to be deceased, etc., but they are rarely said to die or to be dead.

Vanden Bergh put the problem succinctly when he quoted a famous French philosopher: "One cannot look directly at either the sun or death." More specifically, Eissler posed the question: "Which is really harder, to die or to witness death?"

The unknown quality of death renders both the dying and the witnessing of death excrutiatingly painful in prospect as in fact. Until death as it pertains to the self can be squarely and subjectively dealt with, death in another cannot be objectively and effectively ministered to. And such is the ministry especially devolving upon nurses—dealing effectively with the emotional and spiritual as well as the

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11Agilera, loc. cit.
physiological components of care of the terminally ill and dying pa-
tient.  

From the literature it is apparent that nursing has not complete-
ly solved this problem of how to properly and comfortably deal with dying
and death. According to Simmons and Henderson the ability of the aver-
age staff nurse to cope with the psychological needs of the dying patient
and his family is far from ideal. Quint and Strauss found "little evi-
dence that nursing personnel are prepared for 'professional conversation'
about death, or are comfortable with that conversation." "Too often . . .
her [the nurse's] acquaintance with death is an experience neglected in
every way by those who seek to guide her through an education primarily
concerned with illness and health, life and death." Davidson noted that "nurses do not usually talk about death and
above all would not talk about a patient's death with him."  

Definition of Terms

For the purpose of this study the following definition will apply:

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15 Jeanne C. Quint and Anselm Strauss, "Nursing Student Assign-


Therapeutic Communication: Interpersonal communication which creates an atmosphere of acceptance, understanding, respect and concern for another, invites another to talk about that which is causing him psychological discomfort, aids in the reduction and/or constructive redirection of anxiety.

II. THE PROBLEM

Assumptions

For the purpose of this study it was assumed that: (1) The person has within himself the potential for resolving his psychological problems.\(^{18}\) (2) In an atmosphere of acceptance, understanding and respect, this potential is released.\(^{19}\) (3) This release takes place when anxiety is reduced or constructively redirected through the use of skilled communication.\(^{20}\) (4) It is within the realm of possibility for nurses to respond to patients and their families in a way which will promote such communication.\(^{21}\)

Statement of the Problem

It has been noted in the literature that nurses are not prepared to cope effectively with the psychological needs of terminally ill and dying persons. The question then arises: Why is this so? Is it because


\(^{19}\)Ibid.


\(^{21}\)Ibid.
students of nursing are not given a sound theoretical foundation for therapeutic communication with this kind of patient? Are there differences between the way baccalaureate and associate degree students are prepared in this area?

Purpose

Situational questions dealing with communications with terminally ill and dying patients were used for the two-fold purpose: to determine if students and alumni of a baccalaureate and an associate degree nurse-education programs are prepared to cope with the psychological needs of terminally ill and dying patients and to determine whether there are differences in the ability of students and alumni from these two programs to cope with this type of nursing care situations.

Methodology

The exploratory method was used for this study. According to Selltiz, et al., this method is most appropriate in the study of social problems about which little knowledge is available.\textsuperscript{22}

A review of the literature was done. A ten-part questionnaire, after the Social Interaction Inventory by Methven and Schlotfeldt,\textsuperscript{23} was constructed. The questionnaire was tested by a pilot study; refinements were made. Data were obtained by means of a convenience sample from students of the associate degree and baccalaureate programs of Loma Linda University.


\textsuperscript{23}Methven, op. cit., p. 85.
University, and alumni of these two programs practicing nursing in the University Hospital.

With Methven and Schlotfeldt's type descriptions as a guide, response options on the questionnaire were classified as falling under five types, with values ranging from I, the most desirable, receiving five points, to V, the least desirable, receiving one point. This made it possible to construct a scoring key for assigning values to responses checked on the questionnaires. Mean scores were obtained, reported and interpreted. Weaknesses of design and study limitations were pointed out. Recommendations for further study were made.
Like the needs of all patients, those of the dying person can be summed up as the need for physical and psychological comfort. The main thrust of nursing care traditionally has been concern for the physical well-being of patients. Such is not the specific concern of this study, except to point out one salient fact. A person is a unity of body, mind and spirit; these various aspects are interrelated and interdependent. This fact is demonstrated in the effect anxiety has on the degree of pain sensation. It has been found that when the pain signal reaches the cerebral cortex, anxiety will tend to reinforce the signal. The result is more pain felt by the subject.

For the dying patient time is fast running out. In his final supreme emergency he experiences a reassessment of values; emphasis now must be on the quality and depth of experience. Since he has but little time it must be used economically. There is no time for extraneous

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material to enter the situation.\textsuperscript{28} Everything done for the patient at this time of crisis must focus on enabling him to make the most efficient use of time which remains for him.\textsuperscript{29} Physiological equilibrium is impossible now; psychological equilibrium is a must if he is to be helped to a peaceful death.\textsuperscript{30,31}

To become aware of one's own impending death is to be brought face to face with one's finiteness, a threat to his being. Such awareness produces anxiety.\textsuperscript{32}

For the dying person fear of the unknown wears many faces. There is the fear of isolation--of dying alone; fear of personal devaluation, fear of the loss of physical function or change of body-image. It might be fear of the loss of love objects and relationships, loss of identity, loss of awareness, the fear of nothingness, or all of these fears.\textsuperscript{33}


\textsuperscript{29}Paul G. Bauer, "Should the Patient be Told the Truth?" \textit{Nursing Outlook}, 8:672, Dec., 1960.


Fromm said that the awareness of human separation is a source of anxiety. He saw man's deepest need as "the need to overcome his separateness, to leave the prison of his aloneness."  

Sullivan set forth the principle that anxiety is communicated interpersonally; it is increased or decreased by the same mode. The dying person's anxiety and fears may be mitigated through communication with someone who is not afraid of his fears, someone who is able and willing to allow him to handle his anger and frustrations in his own context, someone who will allow him to choose what concepts will enter the interaction situation. It must be someone who will allow him to share his feelings and who will accept them as legitimate, someone who will treat him as a living, unique person as long as he is alive, someone who will not desert him, forcing him to spend his last days "alone on the brink of an abyss." 

Speaking of such communication Wygant observed that it provides a relationship for sharing the patient's fears. Sharing a fear with an empathic listener may bring no solution or removal, or even a logical

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explanation for its existence. But somehow the sharing tends to reduce
the intensity of the fear.\textsuperscript{39}

The deep need of the dying person for relationship is graphically
illustrated in these poignant lines from a dying girl:

Don't run away. . . wait. . . all I want is to know that
there will be someone to hold my hand when I need it. I
am afraid. Death is new to me. . . I've never died before.\textsuperscript{40}

These references to needs of the dying patient seem to bear out ob-
servations of Rogers and others. They noted that, given the proper cli-
mate of concern, acceptance, understanding, and warm human involvement, a
person is free to draw on his own potential for meeting his emotional
needs.\textsuperscript{41-44} Without doing violence to the intent of the sources, we might
restate the overall emotional and spiritual (or simply the psychological)
needs of the dying person thus: what is needed is a climate which will
enable the dying person to rally his own intellectual and emotional forces
in such a way as to help him obtain emotional and spiritual security in
the face of approaching death.

\textsuperscript{39}Wygant, \textit{loc. cit.}

\textsuperscript{40}Anonymous, "Death in the First Person," \textit{AJN}, 70:236, Feb., 1970.

\textsuperscript{41}Carl R. Rogers and Rosalind F. Dymond, (eds.), \textit{Psychotherapy

\textsuperscript{42}Hildegard Peplau, \textit{Interpersonal Relations in Nursing}. (New York:
G. P. Putnam's Sons), 1952.

\textsuperscript{43}Charlotte Towle, \textit{The Learner in Education for the Professions},

\textsuperscript{44}E. H. Porter, \textit{An Introduction to Therapeutic Counseling}, (Cam-
II. THE NURSE'S ROLE

Wangensteen declared the patient himself to be the most important person in an illness. While no one will disagree with this view, one recognizes the astuteness of Agilera's statement: "Basic to the process of dying are the attitudes of the persons involved in the situation." In hospitals nurses are involved in the dying process of many persons. In view of the importance of the nurse's attitudes and the philosophies which shape those attitudes, study was first given to some pre-requisites to adequate emotional-spiritual care of the dying. Following these considerations, attention was given to the nurse's unique role in the care of the dying, and some factors which might contribute to a nursing failure in filling the role.

A Firm Philosophy On Death

"What man is he that liveth and shall not see death?" asked the Psalmist. Agilera affirmed, "To all who are living, death is certain. This universal phenomenon has ominous presence, both in its realism and its inescapability."

According to Jackson, perhaps on no other subject is the human mind compelled to delve below the surface of ordinary knowledge as in

47 Psalm 89:48.
48 Agilera, op. cit., p. 277.
the building of a philosophy of death and dying adequate for its needs. This is not accomplished by a small or partial view of life.  

Kierkegaard observed that the development of a person consists in his active interpretation of himself in the light of his inevitable death.  

In the words of another, life is a time for development of character, in view of an eternity beyond the grave.  

Laney agreed with the spirit of this view when he said that life's true significance lies in its "unrepeatable, thus utterly morally serious character." Rahner saw the awareness of death as coloring all of life's decisions and giving them moral seriousness. He referred to this central awareness of death as the "axiological presence" of death, which persists throughout one's whole life.  

It could therefore be said with Jaspers that: "Learning how to die is actually the condition for the good life. To learn to live and to learn how to die are one and the same thing." It is, then, as

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Laney said, the anticipation of death that gives one a deepened sense of time's unique preciousness.  

Armiger was specific concerning the context in which one must deal with the axiological presence of death. "The path of acceptance of death as an integral part of life, as self-fulfillment in the highest sense, must be approached through Christ."  

The concept of "dying with Christ" and thereby simply relinquishing the hold on life, puts to rout the sentiment that death is a defeat. Actually, as suggested by Laney, it becomes the basis for a victorious self-possession no longer shaken by thoughts of death. Thus seen, death is not the end of life; it is its beginning.  

Self-Awareness  

Much has been written on the dichotomy of telling or not telling a person he has a terminal illness. Wolff inferred that to engage in such a dichotomy is to beg the question. When one's own anxieties and fears about death are resolved, then, and only then, can meaningful communication take place. Then the nurse can recognize the real issue

55 Laney, op. cit., 235.


57 Laney, op. cit., p. 239.


of the dichotomy to be: "Am I ready and willing to be with him [the patient] on his last mile, accepting his feelings, be they ever so different from my own, and respecting his wish to be told or to be spared?"61 In other words, an honest self-appraisal is indicated here.

In the same turn of mind, Oken declared that awareness of one's attitude is the first step in a treatment of cancer patients. "Our personalities, feelings and attitudes play a major role in determining the manner in which we communicate with... patients."62 Wahl agreed with this philosophy. He said: "There is merit... in seeing ourselves, as well as life, clearly and wholly."63

Francis and Munjas and others also saw self-awareness as a prime requisite to the helping person's function as a consistently effective healing force. This is true because therapeutic use of the self in allaying or redirecting another's anxiety demands complete psychological focus. Such a focus is impossible in a context of one's own anxieties, biases and inhibiting emotions.64-66

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If self awareness can be reached regarding the certainty of eventual personal death, and if one can come to grips with such an actuality, Laney and others felt this would help one overcome his natural revulsion for death. This in turn would help make this person available to another at his time of dying. This is a duty and obligation of nurses. 67-71

Only when the nurse is freed from fear so that it is possible to accept and respond to the patient's need will it truly be said, 72 "The faithful hand of the living does not desert the hand of the dying." 73

Creating the Therapeutic Climate

Goethe is credited with having said, "If we take people as they are, we make them worse. If we treat them as if they were what they ought to be, we help them to become what they are capable of becoming." 74 Rogers wrote of the growth possibilities made available to persons

72 Wolff, loc. cit.
through a climate of acceptance and understanding.\textsuperscript{75} He is able to come to self-awareness, making psychological healing possible.\textsuperscript{76}

Vanden Bergh wrote of communication within such an environment providing treatment which prepares the person to meet death undefeated and in full human dignity. Such treatment provides relief from loneliness, fear and depression. It promotes the maintenance of security, self-confidence and dignity.\textsuperscript{77}

\textbf{Listening: a chief component of therapeutic communication.} It is important for effective, ongoing assessment.\textsuperscript{78} Agilera summarized the assessment process as listening, reflecting and gathering data. She emphasized that it is not introjecting one's own feelings, values and judgments. These "could distort the meaning of the event both to the individual and to the nurse."\textsuperscript{79}

The dying person needs to talk; he wants to talk when he has a listening and understanding audience.\textsuperscript{80} For the nurse to respond verbally is often to meet her own need, not that of the patient. Therapeutic listening will catch clues to the patient's anxiety in expressions of anger, somatic complaints, dissatisfaction, demands for attention,

\begin{itemize}
\item \textsuperscript{75} Carl R. Rogers, \textit{Counseling and Psychotherapy}, (Boston: Houghton Mifflin Company, 1942).
\item \textsuperscript{76} Francis & Munjas, \textit{op. cit.}, p. 73.
\item \textsuperscript{78} Lucile Lewis, "This I Believe About the Nursing Process," \textit{Nursing Outlook}, 16:26, May, 1968.
\item \textsuperscript{80} Francis and Munjas, \textit{op. cit.}, p. 51.
\end{itemize}
withdrawal, suspicion, etc. Clues may also indicate that the patient wants to talk—but not about death. These also must be picked up.

Suhrie said: "The critical listener habitually and unconsciously observes, questions, differentiates, mentally synchronizes the behavior she observes, and then interprets the entire situation in preparation to planning and acting." She also spoke of effective listening as being done with the total being—communication by keeping silent. Thus it is seen that therapeutic listening is a complex behavior involving interaction of all the sensory elements. It includes posture, gestures, even facial expressions. Such listening encourages the patient to continue talking. This is a case, as suggested by Saunders, of which it could truly be said: "In quietness and confidence shall be your strength."

Again, Vanden Bergh wrote of listening with open and uncluttered minds—to learn and not to prove.

Respecting and preserving human dignity. The nurse's goal here should be to promote comfort by helping the patient maintain intact his sense of identity. Strict honesty is the inalienable right of the dying

81 Ibid., p. 78.
85 Isaiah 30:15.
86 Vanden Bergh, op. cit., p. 72
person. Day was adamant in this regard. "There is no place for deceit—although this may be a tempting escape at times." Sperry used Scripture to describe the proper attitude: "Speaking the truth in love."

It is the patient's right and privilege to know the truth. It is also his right not to know if he so chooses. One has no right to force himself upon another in such a private area. To do so would be to show disrespect for the privacy and personal integrity of another. Leave the initiative to the patient.

Therapeutic use of self in this respect demands careful reading of cues and then making the appropriate decision in light of them. Perhaps as a rule of thumb, one will always be safe following Finesinger's formula: "We need not tell the whole truth, but whatever we say should be truthful." Rennecker's study bore this out. He reported that all the cancer patients with whom he talked admitted relief when they had someone willing to talk openly with them about their illness.

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91 Francis and Munjas, op. cit., p. 31.


Another means of preserving dignity and self-esteem in the dying person is that of doing all one can to "enable him to live until he dies," rather than making him the victim of "premortem dying." He should continue to be consulted as one whose opinions are valued. Granting him the autonomy to make choices and decisions does much to enhance his self-esteem.  

Sharing his loneliness. For the person who is dying there is an inescapable and undisguisable loneliness. Fromm spoke of man's need to leave the prison of his aloneness. Ross saw the dying hospitalized patient as being alone in a crowd, surrounded by people doing things for and to him, but not with him as a distinct human being. Tillich sensed separation from life (aloneness) most acutely in a situation such as described by Ross as "surrounded by noise and talk." For the dying person the loneliness of death is a constant burden.

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94Saunders, op. cit.
96Francis and Munjas, op. cit., p. 50.
100Francis and Munjas, loc. cit.
Impending death envisages one's loss of status and identity.\textsuperscript{101} This in turn engenders shame,\textsuperscript{102} which is seen by Lynd as an isolating factor. This is conceivable since shameful subjects demand denial, or at best, concealment. Sharing of one's shame reduces the need for concealment, thus relieving the burden of isolation and aloneness.\textsuperscript{103}

The dying person's autonomy must be honored and maintained. Wygant pointed out, however, the value of simply letting him know that he need not be alone in his trial. The helping person does this by demonstrating that though he senses the fear and the hurt of dying he is not afraid of them. He is able to accept the hurting one without being devastated by his expression of the hurt.\textsuperscript{104} In the warmth of such a relationship the dying person is helped to overcome his separateness. Such help is seen by Fromm as man's greatest need.\textsuperscript{105} In this security the dying one is enabled to validate over and over his own sense of worth and value.\textsuperscript{106}

As Francis and Munjas said, no one can share in another's death---this is something he must pass through alone. Yet one can share in the

\begin{footnotesize}
\begin{enumerate}
\item Marilyn Folk and Phyllis J. Nie, "Nursing Students Learn to Face Death," \textit{Nursing Outlook}, 7:510, September, 1959.
\item Wygant, op. cit., p. 576.
\item Fromm, \textit{loc. cit.}
\item Wygant, \textit{loc. cit.}
\end{enumerate}
\end{footnotesize}
dying. This is a privilege. More--on the part of the nurse, this shar-
ing is a professional responsibility. 107, 108

Giving Spiritual Care: Preparation for a Peaceful Death. Piep-
gras' view was to the effect that giving spiritual care is an integral
aspect of promoting psychological comfort for the dying patient. It is
also the most sadly neglected--perhaps a faithful reflection of a materia-
listic age. One may discuss religion, but to admit personal spiritual
concern is to risk the fanatic's label. From mere tenders of patients'
somatic symptoms and promoters of physical well-being, nurses have ad-
vanced to guardians and healers of the emotional aspect of patients as
well. This is good, but it is not enough. Man is a complex unity. Just
as his being has intellectual, emotional and physical components, it also
has a spiritual component. Man is a dynamic unity; all his component as-
pects are interdependent. They all must be supported. 109

As Francis pointed out, perfect care for a patient's physical and
emotional needs will not suffice to calm his fears if he feels spiritual-
ly unprepared to die. 110 Some people give no thought to life's true
meaning or their God-man relationship until they are in a "full-blown
crisis." 111 No mere human relationship can supply the need for spiritual
balm. Though good and commendable, referring such a patient to his

107 Francis and Munjas, loc. cit.
108 Harry R. Custer, "Nursing Care of the Dying," Hospital Progress,
109 Ruth Piepgras, "The Other Dimension: Spiritual Care," AJN
110 Gloria M. Francis, "Cancer: the Emotional Component," AJN
111 Piepgras, op. cit., p. 2613.
minister or the chaplain is not sufficient. One unaccustomed to things of a spiritual nature often needs preparation before he can be receptive to pastoral care. He may need to learn that to experience, even to express spiritual longings is acceptable—not a sign of weakness. 112 Of all who attended him, the nurse is the nearest and the most constant. 113 Her major role here must be that of catalyst. Tension and uncertainty from unfamiliarity with spiritual things on the nurse's part will close the door. 114 Faith in God is made infinitely easier by faith in someone whose kindness and constancy make him feel safe. Happy the nurse who, through familiarity with spiritual values, can be relaxed and confident in laying a solid foundation for spiritual care. 115

Miller cited the patient's need to come to grips with his faith and thus gain a sense of comfort and peace. This he saw as one reason for helping him face the realities of his situation. 116

There are times when even believers question the reason for suffering and death. They may become confused and tempted to despair. In such times it is not another's philosophy which the dying person needs for comfort. He needs an understanding and a listening ear to which he can express his doubts and confusion. This is no time for working through his questions and doubts; he needs a sounding board for frightening

112 Ibid.
114 Piepgras, loc. cit.
115 Saunders, loc. cit.
thoughts. "Ignoring his grief or dulling his sensibilities will not solve his problems." This is the cowardly route--let nurses not be guilty! 117

Eissler termed the state of being ready to die "orthonasia". It is defined: "Dying with ease or in harmony, without remorse or fear, a cherished goal throughout the ages." 118 In the same spirit the Hendersons pointed out the error of always seeing death as a cruel foe. If one is prepared, death is actually a friend. The healing professions help people into the world; they have the obligation and privilege to help them go. 119

A person loses his fear when he finds himself in a climate of safety and concern. In this climate he is allowed to come to his own awareness in his own time, in his own way. He is prepared to die courageously and peacefully. This is a "good end." 120

Morgan saw this phase of the nursing role as supporting and sustaining the spirit in its battle. Even though the body may be doomed to defeat, the spiritual self may be victorious. 121 For the believer this is true. Armiger explained it this way. For one "prepared to die,"

117 Piepgras, loc. cit.


120 Saunders, loc. cit.

death means the end of the death experience. Therefore acceptance of
death is self-fulfillment for him.\textsuperscript{122}

From the foregoing paragraphs one may infer the nurse's role to
be one exclusively of giving. Are there no rewards for so difficult a
role? If so, are they actually worth the price the nurse must pay?
Francis and Munjas felt that tending a dying person can add a dimension
to the nurse's understanding of human experience available nowhere
else.\textsuperscript{123} Saunders assured us that this larger ministry is its own re-
ward. To those providing it is bequeathed a unique heritage--a philo-
sophy which removes the "sting of Death." They are helped to see death
for what it can be: life's fulfillment,\textsuperscript{124} "the threshold of eter-
nity."\textsuperscript{125}

III. NURSES' FAILURE TO FILL THE ROLE
Due to Unresolved Fear and Some Moral Implications

Why is death so extremely unacceptable and why is the very thought
that one day one might die so painful that every effort is made to deny
the fact? Glaser and Strauss saw in this tendency a moral attitude.\textsuperscript{125}
To indulge in such a denial is to perpetuate an old-age delusion foisted

\textsuperscript{122}St. Bernadette Armiger, "Reprise and Dialogue," \textit{Nursing

\textsuperscript{123}Francis and Munjas, \textit{op. cit.} pp. 49, 50.

\textsuperscript{124}Saunders, \textit{op. cit.} p. 75.

\textsuperscript{125}Grace Russo Pierce and Raymond J. Pierzchalski, "Everyone

\textsuperscript{126}Barney G. Glaser and Anselm Strauss, \textit{Awareness of Dying},
off on humanity from antiquity, according to one fundamental Protestant interpretation. 127

At the very incipience of the race the divine warning was to the effect that the seeds of destruction were intrinsic to disobedience of moral law. "Thou shalt surely die," 128 was the admonition. Counter to this solemn pronouncement was the bold denial: "Ye shall not surely die." 129 Intervening ages have done little if anything more than reinforce the delusion without altering man's mortality.

There appears to be a consensus in the literature agreeing with Feifel who saw the prevailing attitude of rejecting the dying person as a reflection of personal fear of death. 130 So intolerable is the fact of death to the individual, so great the anxiety it engenders that our society tends to shroud its approach in secrecy. 131 Even the dying person is often denied the truth. In an attempt to relieve our own anxiety by diversion, denial, or evasion, these persons may be isolated in their need to face their reality. 132


128 Genesis 2:17.

129 Ibid. 3:4.


Nurses are prone either to adopt a cheerful attitude all the time or to withdraw from the moribund person. Such untherapeutic behavior results from fear and the need to deny the approach of death. But the unfortunate result of using denial to deal with death is for the dying patient to feel abandoned or rejected in his hour of greatest need. Abandonment or desertion was seen by Henderson and Henderson to be the plight which perhaps the dying fears above all others.

Baker and Sorensen enumerated many of the undesirable behaviors resulting from nurses' unresolved fears of death. Whichever form of behavior may be used, the same effect is accomplished: communication is deferred or broken. The patient is left to wrestle alone with the problem of his own fears. This is what Ross speaks of as being alone in a crowd. It is to escape facing one's own mortality that we tend to avoid becoming personally involved with dying patients.

Nurses who fail to meet spiritual needs of dying patients may experience guilt and helplessness. This may be because they feel there is nothing they can do. Expertise in rendering physical and emotional help does not substitute for spiritual care when the need arises. No earthly

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135 Henderson and Henderson, loc. cit.


relationship can fully fill the void or heal the ache of feeling estranged from one's God. If the nurse has no firm spiritual conviction of her own, she is not likely to be on very intimate terms with God. When this is true it is not easy to introduce the seeking one to Him.\textsuperscript{138}

CHAPTER III

METHODOLOGY

The purpose of this chapter is to describe the method, the instrument and the procedures used in the study.

I. THE RESEARCH METHOD AND THE INSTRUMENT

Method of Research

The exploratory method was chosen for this study. The decision to use this method was based on the recommendation of Selltiz, et al. They observed that few tried and proven methods have been worked out which provide clear guidance for empirical research in the area of social relations.139

A questionnaire was employed for collection of data. This tool was preferred above the interview for several reasons pointed out by Selltiz. First, it insures a degree of uniformity from one measurement situation to another. Second, respondents are likely to respond more freely due to increased confidence provided by anonymity. A third advantage is that of economy in expenditure of time and funds. This economy lends itself to another advantage--it facilitates increased sample size.140

Selection of the Instrument

Literature revealed few instruments designed to objectively and uniformly evaluate one's theoretical background for creating an atmosphere

140 Ibid., pp. 239, 240.
which would leave the patient free to move toward a solution of his problem. The technique developed by Heil and Cavaglieri, in which recordings were used for creating the situation and the student's response was taped, seemed to have merit for this purpose. However, it also has the decided disadvantages of being time-consuming and expensive. Also the responses are difficult to score.  

Bernstein and associates developed a tool for evaluation of the effectiveness of a teaching experiment. This test, modified and adapted from Porter, has two characteristics which tend to limit its usefulness in most situations. It was prepared for use with male patients in Veteran Administration hospitals and also the responses were not derived from empirical investigations of nursing situations.

The Social Interaction Inventory developed by Methven and Schlotfeldt immediately appeared promising as a guide. This scale allows one to construct an interaction measurement tool in which responses can be uniformly classified according to specific types, thus facilitating analysis. Criteria call for (1) the use of situations which are typical only of those encountered by students of nursing in patient care and (2) the use of verbal responses which appear logical and appropriate to nurses engaged in direct nursing care to patients. The careful researching, testing, refinement and retesting which went into the preparation of this


tool by its authors further recommended it for use as a guide for the con-
struction of an instrument for this study.\textsuperscript{143} The decision was made to
develop the instrument in this context.

Development of the Research Instrument

It was noted that, as Becker pointed out, social data are not sus-
ceptible to experimental manipulation; the investigator's only recourse
is to construct types of social organization or conduct. Such constructs
must be built within the framework of conclusions reached by specialists
in the given field. These constructed types are not self-validating;
they must be drawn from facts and then continually thrown back upon those
facts in order to insure soundness of generalization.\textsuperscript{144}

With this precautionary note in mind, development of the instrument
proceeded in this manner. The researcher, with the cooperation of a nurse-
educator in a baccalaureate program, who had educational preparation be-
yond the masters level in psychiatric nursing, constructed the question-
aire to meet the criteria of the Social Interaction Inventory mentioned
above. The instrument consisted of ten statements representing stress-
producing situations related to communication with terminally ill persons.
These situations were drawn from the researcher's experience and resembled
those frequently encountered in the care of persons with terminal illnesses.

\textsuperscript{143} Dolores Methven and Rozella M. Schlotfeldt, "The Social

\textsuperscript{144} Howard Becker, "Constructive Typology in the Social Sciences," \textit{American Sociological Review}, 5:40-55, February, 1940.
The questionnaire was then used in two different ways. The first elicited a subjective response to each of the ten situations. This questionnaire was termed Questionnaire A (see Appendix 1). Each subject was to write a one-sentence response indicating his projected verbalization for each situation.

The second use was as Questionnaire B. (see Appendix 4). This contained the identical ten situations found in Questionnaire A, but had one notable difference. Guided by Methven and Schlotfeldt's type descriptions, one option was prepared to represent each of the five types. The subject was to choose the option which he believed represented the most theoretically desirable response.

To insure credibility for the study, Questionnaire B was then submitted to a panel of five experts. This panel was composed of two psychiatric nurse educators in a baccalaureate program with masters' degrees, and three professors in behavioral sciences with doctoral degrees. All these persons were prepared by virtue of experience and education to understand and interpret the nuances of interpersonal communication.

Each panel member was asked to classify independently all responses according to the type specifications (see Appendix 5).

Type I responses, assigned the value of five points each, were to be considered the most desirable. Type V, assigned one point each, would be the least desirable. A scoring key, based on the resulting type classification, was then devised (see Appendix 6).

\[145\] Methven and Schlotfeldt, op. cit. p. 85.
Complete step-by-step directions attached to the front of Questionnaire A (see Appendix 4) instructed the respondent not to open the questionnaire until he had completed the reading of all eight steps and carried out the directions in the order in which they were given. These indicated that no name was necessary, that the criteria (listed at bottom of page) which fitted him be checked off, that he respond with one simple sentence for each situation, indicating the first thing he felt he would do or say were he in that situation, that he strive for honest subjectivity in his response, and that he return his questionnaire immediately upon completing it. He was now ready to begin. Instructions for Questionnaire B were identical in all but one respect. Instead of writing the response, one response option for each situation was to be indicated by a circle around the letter before it. (see Appendix 5).

Pilot Study

Step 1. The researcher met with a class of senior baccalaureate students, explained that she was conducting a thesis study as a requirement for her master's degree and at this point was in need of five senior students of nursing for a pilot study. There were five who volunteered to participate. At the prearranged time and place four of these volunteers met with the researcher and were each given a copy of Questionnaire A with instructions attached. The group worked quietly as the researcher sat at the rear of the classroom.

Step 2. Upon completion of Questionnaire A, the students turned them in. The same subjects were then given Questionnaire B and asked to follow the written instructions.
Resulting raw data obtained from Step 1 were then submitted to the panel of experts for independent type classification of all responses. Data from Step 2 were assigned values based on the scoring key. Examination of the panel's work on typing of the raw data revealed wide differences of opinion as to type classification of responses (see Appendix 7). Three out of ten responses of Subject A, five of Subject B, four of Subject C and three of Subject D received agreement from three out of the four judges (one member's classified data was returned too late for use). Obviously this posed a dilemma.

At this point the investigator sought counsel from an expert in statistics. Although it was evident that a deletion of Step 1 would alter final results, the tremendous expenditure of time and effort on the part of the panel which would be necessary to type the raw data from the complete sample of subjects appeared disproportionate in view of the lack of agreement achieved. The decision was made to delete this step. Questionnaire B, therefore produced the only results considered in the study.

The Population

For the sake of convenience, it was decided to use students and alumni of a Seventh-day Adventist University to comprise the population.

Criteria for the Sample

Also for the sake of convenience, the sample was to be drawn from four breakdowns of the population according to the following criteria.

Group I
1. Senior, baccalaureate nursing program, Loma Linda University
2. Not over twenty-five years of age
3. Exposed a minimum of ten years in the general American culture
Group II
1. Sophomore, associate degree nursing program, Loma Linda University.
2. Not over twenty-five years of age.
3. Exposed a minimum of ten years to general American culture

Group III
1. Alumnus of baccalaureate or associate degree nursing program, Loma Linda University.
2. Practicing staff nurse at the University Hospital
3. Exposed a minimum of ten years to general American culture

Group IV: The Control
1. Non-nursing undergraduate student, College of Arts and Sciences, Loma Linda University.
2. Not over twenty-five years of age
3. Exposed a minimum of ten years to general American culture

Permission to Conduct the Study

Petition to conduct the study was made to the Committee on Human Experimentation. A sample of both questionnaires with instructions was attached to the petition. Permission was promptly granted.

Letters were written to (1) the Academic Dean, Loma Linda University, (2) the Dean, School of Nursing, the University, (3) the Chairman, Department of Nursing, School of Arts and Sciences, the University, and (4) the Director of Nursing Services, the University Hospital. These letters were
for the purpose of introducing the study and requesting cooperation in obtaining data. A self-addressed card was enclosed with each letter for reply via campus mail.

Selection of the Sample

Group I was selected in the following manner. The researcher obtained permission from the women's residence hall dean to recruit volunteers for the study following an evening convocation in the residence chapel. Permission was granted and approximately twenty senior nursing students remained following the convocation to participate in the study. Data were obtained from this group in the same manner as described in the pilot study. The remaining 12 subjects volunteered in a similar manner and remained following a class in the hospital building.

Group II selection was in this manner. The request for volunteers was made to the group at the time of a class gathering in the residence hall on the campus of White Memorial Hospital, Los Angeles. This represented considerable inconvenience for the researcher in time and travel. Because this was true, the group was simply asked by the director to participate in the study by responding to the questionnaires. The request was acceded to by the whole group. There were twenty-four in this group.

Group III was selected at random from the personnel files in the Nursing Office. They were approached individually in the hospital during the researcher's regular tour of duty, mostly days or evenings, and asked to participate during a rest break during the shift. Out of the thirty questionnaires distributed in this manner, there were seventeen returned, divided almost equally between the baccalaureate and the associate degree.
alumni. Completed questionnaires were returned to the researcher via the pneumatic tube system.

Group IV. For this group the researcher went to the campus of the College of Arts and Sciences, Loma Linda University, at the time of morning classes. At the close of two classes she approached individuals returning to the residence hall and requested volunteers for the study. A total of twenty-one questionnaires were completed in this way on the one morning as the researcher waited.
CHAPTER IV

DATA DESCRIPTION, ANALYSIS AND RESULTS

This chapter will deal with the description of the data gathered, their treatment, the analysis and results obtained.

I. DESCRIPTION OF THE DATA

Data consisted of responses to the ten situations on the questionnaires, each representing one choice out of the five options. Out of a total of ninety-four, there were thirty-two for Group I, twenty-four for Group II, seventeen for Group III, and twenty-one for Group IV.

II. ANALYSIS AND RESULTS

Values were assigned to the responses, based on the scoring key (see Appendix 8). The questionnaires were scored and results tabulated, as indicated in Table I.

An analysis of variance for testing whether the means are equal was done. The results of this analysis are shown in Table II. It will be seen that the F ratio of 66.4 far exceeds the critical value of 2.70. \( P < .001 \). This would indicate that the difference among the means are highly significant. It does not reveal, however, where the variance is to be found. For this information we must go to Table III.

Multiple comparisons of the means were then made for the purpose of comparing the means of the four sample groups among themselves. This is illustrated in Table III.
## TABLE I

**DISTRIBUTION OF THE DATA**

**RAW DATA SHOWING TOTAL SCORES FOR EACH SUBJECT**

<table>
<thead>
<tr>
<th>Subjects</th>
<th>B.S.</th>
<th>A.D.</th>
<th>Staff</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>49*</td>
<td>40</td>
<td>45</td>
<td>40</td>
</tr>
<tr>
<td>2.</td>
<td>50</td>
<td>35</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>3.</td>
<td>50</td>
<td>29</td>
<td>40</td>
<td>28</td>
</tr>
<tr>
<td>4.</td>
<td>47</td>
<td>49</td>
<td>45</td>
<td>28</td>
</tr>
<tr>
<td>5.</td>
<td>45</td>
<td>41</td>
<td>42</td>
<td>28</td>
</tr>
<tr>
<td>6.</td>
<td>50</td>
<td>43</td>
<td>39</td>
<td>28</td>
</tr>
<tr>
<td>7.</td>
<td>50</td>
<td>42</td>
<td>43</td>
<td>24</td>
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<td>8.</td>
<td>44</td>
<td>48</td>
<td>47</td>
<td>36</td>
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<td>9.</td>
<td>35</td>
<td>46</td>
<td>50</td>
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<tr>
<td>10.</td>
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<td>44</td>
<td>46</td>
<td>26</td>
</tr>
<tr>
<td>11.</td>
<td>43</td>
<td>40</td>
<td>45</td>
<td>28</td>
</tr>
<tr>
<td>12.</td>
<td>41</td>
<td>48</td>
<td>48</td>
<td>31</td>
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<tr>
<td>13.</td>
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<td>49</td>
<td>41</td>
<td>36</td>
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<td>44</td>
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<td>16.</td>
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<td>50</td>
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<td>17.</td>
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<td>18.</td>
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<td></td>
<td></td>
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<tr>
<td>31.</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Totals**  1544  1022  755  611

\[ \bar{x} = 45.47 \quad 42.58 \quad 44.4 \quad 29.10 \]

*50 = highest possible score*
TABLE II

ANALYSIS OF VARIANCE FOR TESTING WHETHER
THE MEANS OF THE FOUR GROUPS ARE EQUAL

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Square</th>
<th>F Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Among Means</td>
<td>3871.98</td>
<td>3</td>
<td>1290.66</td>
<td>F = 66.4*</td>
</tr>
<tr>
<td>Among Groups</td>
<td>1751.72</td>
<td>90</td>
<td>19.50</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5623.71</td>
<td>93</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*P < .001 F .95(3.90) = 2.70 Critical Value

Referring to Table III, it is noted that confidence limits 2.89 ± 3.43) indicate no significant difference when B.S. student mean scores were compared with those of the A.D. students. Since it is not significant, the difference is not stated.

Comparing the combined means for the two groups of students with that of the staff nurses indicates no significance.

On the other hand, it was interesting to note that a comparison of B.S. students and the control group (16.37 ± 3.57) was highly significant.
### TABLE III

**MULTIPLE COMPARISONS**
***AMONG MEANS OF THE FOUR SAMPLE GROUPS***

<table>
<thead>
<tr>
<th>B.S.</th>
<th>A.D.</th>
<th>STAFF</th>
<th>CONTROL</th>
<th>CONFIDENCE LIMITS (At the .05 Confidence Level)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$\bar{x}_1$</td>
<td>$\bar{x}_2$</td>
<td>$\bar{x}_3$</td>
<td>$\bar{x}_4$</td>
<td>$2.89 \pm 3.43$</td>
</tr>
<tr>
<td>$\bar{x}_1$ - $\bar{x}_2$</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$\bar{x}_1$ + $\bar{x}_2$ - $\bar{x}_3$</td>
<td></td>
<td></td>
<td></td>
<td>$0.38 \pm 3.26$</td>
</tr>
<tr>
<td>$\bar{x}_1$ - $\bar{x}_4$</td>
<td></td>
<td></td>
<td></td>
<td>$16.37 \pm 3.57$</td>
</tr>
<tr>
<td>$\bar{x}_2$ - $\bar{x}_4$</td>
<td></td>
<td></td>
<td></td>
<td>$13.48 \pm 3.80$</td>
</tr>
<tr>
<td>$\bar{x}_3$ - $\bar{x}_4$</td>
<td></td>
<td></td>
<td></td>
<td>$14.31 \pm 4.14$</td>
</tr>
</tbody>
</table>

The same was true to a somewhat lesser degree when the A.D. group was compared with the control (13.48 ± 3.80). Comparison of the staff group with the control indicated greater significance than that of the A.D. group, but less than that of the B.S. group (14.31 ± 4.14).

Summarizing information of Table III, there was no significant difference between student and staff nurse groups; there was significant difference between the control and each of the student groups when they were compared separately.

III. INTERPRETATION

Results indicate that there are differences in the way baccalaureate, associate degree students and alumni of these programs respond to questions related to communications with dying patients, but the differences are not significant. Results also answered the question of whether nurse education is preparing theoretically, students to cope with psychological care of dying patients. This was shown to be true when the nurse groups were compared with the control group.

Of interest to nurse educators are the following facts:

1. The combined mean for the two student groups was 44.025 as compared with 44.410 for the staff nurses.

2. A breakdown of the staff group into B.S. and A.D. alumni showed that the mean for the B.S. nurses was 47.00; for the A.D. nurses it was 44.00.

3. The B.S. alumni mean was 47.00 as compared to the B.S. student mean of 45.47.

4. The mean for the A.D. alumni was 44.00 as compared with the A.D. student mean of 42.58.
IV. DISCUSSION

Careful review of the analysis and results of this study suggested a number of questions to the researcher.

Why is there such a significant difference between the control group and the nurse groups? Does this indicate that subject matter covered by nursing curricula is the only influencing factor causing nurses to score much higher than the non-nursing control group? Or could it be that a greater degree of maturation occurs in individuals when there is concurrent application of principles during the theory-learning period, as is the case in nurse education?

Is it possible, on the other hand, that the person who goes into nursing is naturally more likely to be the nurturing type and more interested in another's psychological needs?

Because of the last mentioned possibility, would the use of students beginning their clinical experience in each of the two programs have influenced the results of the study?

V. LIMITING FACTORS

There were various limiting factors easily recognized by the researcher after completion of the study. Among these were:

1. There were insufficient controls over data collection. Limitations due to lack of availability of student subjects and accessibility of advisory assistance imposed by the scholastic calendar rendered proper controls extremely difficult if not impossible. Had data been collected earlier in the semester, it is very possible that all the data from each group could have been obtained collectively at one sitting. This would
have eliminated the lack of uniformity in the degree of voluntary participation on the part of all the subjects. It was felt that, in the instances when the subjects remained after a class or other assembly to participate in the study, it was probably the better students who tended to volunteer. If this was true, it would tend to bias the results.

2. The introduction of an additional variable in the form of non-nursing students to act as the control sample. This would be a limiting factor in a specific sense if it is true that the type of person who aspires to becoming a nurse is more the nurturing type than the average non-nursing student.

3. Weakness of the design for obtaining data in the form of subjective raw data. The researcher felt that the design should have contained provision whereby it could be ascertained whether the nurses tended to score as high as they did on the optional responses simply because they had developed the sophistication to recognize the best answers. It was for this reason that the original design called for using the questionnaire, first for subjective responses and then for choosing a response option. The task of classifying by types so many subjective responses promised to be such a formidable one for the panel, that in view of the lack of consensus, it was abandoned as impractical under the circumstances.

In retrospect the researcher felt that if situations requiring subjective responses had been limited to one, or two at the most, the task of type classification would have been relatively simple. Values could then have been assigned and mean scores obtained for the various groups, thus hopefully balancing out the possibility of scoring high because of ability to recognize the best response.
4. Weakness of design for the classification and assignment of values by the panel. In retrospect the researcher felt that this procedure would have been more impartial had the questionnaire situations and response options been presented to the panel differently. If each response option and the appropriate situation had been given them without regard to any sequential order (or scrambled), this would have allowed greater freedom of choice to the panel members in their classification of the responses.

5. Size of the sample. In order to make any generalization of findings, a larger sampling needs to be done.

VI. RECOMMENDATIONS FOR FURTHER STUDY

As the result of the experience, the researcher would recommend further study of this problem, but with these differences of approach:

1. Stricter controls over collection of data by insuring that subjects for participation were obtained under uniform circumstances, preferably at the same time and place for any one group, with an exact duplication of circumstances for all groups. This would call for specific criteria for selecting the samples and obtaining the data.

2. Use of beginning clinical students as controls.

3. Provision in the design for only one or two situations requiring subjective responses, and insuring that these responses consist of one simple sentence. This would make provision for the collection of raw data, which in the researcher's opinion would enhance the value of the study.

4. Investigation into the reason why practicing nurses tended to score higher than finishing students.
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BIBLIOGRAPHY

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APPENDICES
APPENDIX 1

QUESTIONNAIRE

1. You have been assigned four patients requiring treatments, and have been told that one of them—a woman with terminal cancer and who knows her diagnosis—makes frequent demands for service. She never seems quite pleased, whatever the response to her requests. This patient has already summoned you four times this morning with the following successive pleas: "Will you give me the other pillow?" "My water is too far for me to reach without danger of spilling it—would you please hand me a drink?" "This extra pillow is too much—please take it away." "If the drapes were drawn, maybe I could take a nap." Now her light goes on for the fifth time. You enter the room; she begs tearfully, "Won't you get some fresh water? Why do I always have to ask for everything I need? Nobody wants to take care of me. . . ."

2. You are a home care nurse making a pre-discharge visit on a sixty-five-year-old lady following a colon resection for advanced metastatic cancer. She knows she has but a few months to live, but she insists on retaining her independence in her small apartment where she lives alone just as long as possible. You ask about her friends or relatives who may be dropping in on her from time to time. Her response is: Well I guess it doesn't do much good to think of who my visitors used to be. Since I can no longer get around and do things for people they're not going to come to see me—or, if they do, it will be just because they feel sorry for me.

3. You prepare to suction a robust-appearing high school boy who has acute leukemia complicated by pneumonia. His mother has just left a large bunch of gladiolas in a vase. You see sweat rolling from the patient's forehead—his face is flushed. He screams at you, "Get out of here! I hate you nurses—always pester a guy with something. Can't you let me die in peace?"

4. A twenty-five-year-old wife has been admitted for biopsy and possible bilateral mastectomy. She has known for some time she had suspicious lumps, first in one breast and then in the other. She is crying when you enter her room to prep her. When you ask what is the matter, she sobs, "What's the use? I hope I die on the operating table tomorrow!"
5. As you enter the room of a male patient who is to have radical neck surgery tomorrow, you greet him: "How are you this morning?" His irritable reply is, "Who cares? You're the sixth person who has asked me that same question this morning!"

6. A fifty-five-year-old patient had a gastric resection for cancer three days ago. You are caring for him when he says to you: "A man I worked with had this operation five years ago and he lived only a few months. At that rate, I don't have long left."

7. A patient asks you if he has cancer and you refer him to his doctor. The patient retorts angrily: "You people are all alike. You refuse to commit yourself on anything; a patient never gets a real answer. It's always the same: 'I can't tell you,' or 'Ask your doctor' whenever I ask about my condition. Don't patients have a right to get an answer from someone? The doctor is always in a hurry, so he doesn't stop to tell me anything; he just runs off to see his other patients. Why won't someone tell me something?"

8. For several days you have been caring for a patient with cancer which has metastacised throughout the abdomen and invaded the spinal cord. In your previous contacts, the patient has appeared optimistic about hospitalization and treatment, and even though confined to bed now, has shown continued enthusiasm for many activities. You have enjoyed all the chatting and joking, and found this assignment a pleasant one. This morning you enter the room with the breakfast tray; the patient appears subdued and discouraged, and finally says to you: "Each day I seem to be getting more helpless; more pain; no appetite, and haven't been out of bed for two weeks--I'm getting worse instead of better! Do you think I'm going to die?"

9. As you are preparing one evening to give care to a patient with advanced Hodgkins disease and who is obviously dying, he seems troubled. He comments: "My pastor was here yesterday; he's a busy man but he still finds time to visit the hospital twice a week. It was very easy to pray when he was here and I felt much better, but now I'm finding it hard to get the same feeling of peace when I pray alone."
10. Suppose you, a student nurse, are the patient. You have leukemia and you suspect from your symptoms that you have little time to live, though no one has hinted of such a possibility to you. Your nurse has told you she would like to give your bedtime care when her other duties are out of the way so there will be more time for you without fear of interruption. She comes in and there is plenty of time for a good long back rub and a chat. You say to her, "I don't think I'm getting any better." Which response do you honestly feel would make you most comfortable?"
APPENDIX 2

QUESTIONNAIRE

1. You have been assigned four patients requiring treatments, and have been told that one of them--a woman with terminal cancer and who knows her diagnosis--makes frequent demands for service. She never seems quite pleased, whatever the response to her requests. This patient has already summoned you four times this morning with the following successive pleas: "Will you give me the other pillow?" "My water is too far for me to reach without danger of spilling it--would you please hand me a drink?" "This extra pillow is too much--please take it away." "If the drapes were drawn, maybe I could take a nap." Now her light goes on for the fifth time. You enter the room; she begs tearfully, "Won't you get some fresh water? Why do I always have to ask for everything I need? Nobody wants to take care of me. . . ."

   a. With four patients to care for, I've kept pretty busy this morning.
   b. Of course, I'll be glad to get you some fresh water right away. I'm sorry you had to ask for it.
   c. Did you receive fresh water when the other patients did?
   d. You would find people more helpful if you would try to cooperate a little too.
   e. When you are uncomfortable and you can't get the things you need, it isn't surprising you get the feeling nobody cares.

2. You are a home care nurse making a pre-discharge visit on a sixty-five-year-old lady following a colon resection for advanced metastatic cancer. She knows she has but a few months to live, but she insists upon retaining her independence in her small apartment where she lives alone just as long as possible. You ask about her friends or relatives who may be dropping in on her from time to time. Her response is: "Well I guess it doesn't do much good to think of who my visitors used to be. Since I can no longer get around and do things for people they're not going to come to see me--or if they do, it will be just because they feel sorry for me.

   a. You like being with people don't you? And right now you're not sure how folks will feel about your having cancer.
   b. Don't worry, I'm sure your family and friends won't forsake you now.
c. You won't get anywhere by giving up that way. A situation like yours demands real courage.

d. Now let's see if we can find out why you think people would come around only because they feel sorry for you.

3. You prepare to suction a robust-appearing high school boy of seventeen who has acute leukemia of the rapid type complicated by pneumonia. His mother has just left a large bunch of lovely gladiolas in a vase. You see sweat rolling from the patient's forehead--his face is flushed. He screams at you, "Get out of here! I hate you nurses--always pestering a guy with something. Can't you let me die in peace?"

   a. Do you know why I need to suction you?
   b. What a gorgeous bouquet of glads! Who sent them?
   c. Sorry fellow, I know it is unpleasant.
   d. I don't like to punish you this way, but I must in order to help you get over your pneumonia.
   e. You're angry with me because you feel helpless; I don't blame you!

4. A twenty-five-year-old wife has been admitted for biopsy and possible bilateral mastectomy. She has known for some time she had suspicious lumps, first in one breast and then in the other. She is crying when you enter her room to prep her. When you ask what is the matter, she sobs, "What's the use? I hope I die on the operating table tomorrow!"

   a. When did you first notice the lump?
   b. You have so much to live for--your whole life is still before you!
   c. This can happen to anybody. You must try to accept it as God's will.
   d. Right now the future looks pretty dark because you're afraid you have cancer.
   e. I'm terribly sorry you feel so bad--try not to cry--we'll do all we can for you.

5. As you enter the room of a male patient who is to have radical neck surgery tomorrow, you greet him: "How are you this morning?" His irritable reply is, "Who cares? You're the sixth person who has asked me that same question this morning!"
6. A fifty-year-old patient had a gastric resection for cancer three days ago. You are caring for him when he says to you: "A man I worked with had this operation five years ago and he lived only a few months. At that rate, I don't have long left in this world."

a. Comparing operations is always a mistake; chances are you and your friend had different conditions.

b. That's interesting; were your friend's symptoms the same as yours?

c. It's natural to make comparisons and recalling your friend's illness makes you wonder how much of his experience applies to you.

d. That may have been true in your friend's case, but there has been great medical advance in five years. Buck up and put up a fight!

e. You have a fine surgeon with much experience. You may be sure he did a good job of your operation.

7. A patient asks you if he has cancer and you refer him to his doctor. The patient retorts angrily: "You people are all alike. You refuse to commit yourself on anything; a patient never gets a real answer. It's always the same: 'I can't tell you,' or 'Ask your doctor' whenever I ask about my condition. Don't patients have a right to get an answer from someone? The doctor is always in a hurry, so he doesn't stop to tell me anything; he just runs off to see his other patients. Why won't someone tell me something?"

a. There are some questions we nurses are not supposed to answer; why not write out your questions so you'll remember to ask when he comes next time?

b. You think it's about time that someone gave real attention to you and your questions.

c. How much do you believe a patient should be told about his condition?"
60

d. I wonder whether you really have tried to ask your doctor questions. I notice he always seems to have plenty of time to talk to other patients.

e. Doctors do appear busy, but I'm sure you'll have a chance to talk to your doctor the next time he comes in.

8. For several days you have been caring for a patient with cancer which has metastasised throughout the abdomen and invaded the spinal cord. In your previous contacts, the patient has appeared optimistic about hospitalization and treatment, and even though confined to bed now, has shown continued enthusiasm for many activities. You have enjoyed all the chatting and joking, and found this assignment a pleasant one. This morning you enter the room with the breakfast tray; the patient appears subdued and discouraged, and finally says to you: "Each day I seem to be getting more helpless; more pain; no appetite, and haven't been out of bed for two weeks--I'm getting worse instead of better! Do you think I'm going to die?"

a. You are worried, aren't you? I don't blame you.

b. I'm sorry you're worried. You always feel worse when you worry.

c. You really shouldn't be talking like that.

d. How long have you been wondering about this?

e. We are doing everything possible for you.

9. As you are preparing one evening to give care to a patient with advanced Hodgkins disease and who is obviously dying, he seems troubled. He comments: "My pastor was here yesterday; he is a busy man, but still finds time to visit the hospital twice a week. It was very easy to pray when he was here and I felt much better, but now I'm finding it hard to get the same feeling of peace when I pray alone."

a. To what church do you belong?

b. You've been having quite a few visitors, haven't you? That should cheer you up.

c. We try to meet the spiritual needs of our patients. Would you like me to put your name on the chaplain's list?

d. Would it help to talk to someone more often?

e. You will probably feel more relaxed after your back rub. Probably prayer will come more easily then.
10. Suppose you, a student nurse, are the patient. You have leukemia and you suspect from your symptoms that you have little time to live, though no one has hinted of such a possibility to you. Your nurse has told you she would like to give your bedtime care when her other duties are out of the way so there will be more time for you without fear of interruption. She comes in and there is plenty of time for a good long back rub and a chat. You say to her, "I don't think I'm getting any better." Which response do you honestly feel would make you most comfortable?

   a. What makes you think so?

   b. You mustn't get discouraged. We can go just so far to help you; beyond that it's up to you--you have to put up a good fight.

   c. You're afraid you're worse. It's understandable that you are concerned. Maybe you would feel less frightened if you could talk to someone about it.

   d. I guess it's natural for you to get discouraged sometimes, but I don't think you're worse.

   e. You are depressed because you know you need to get back to school. I'm sure you're safe in your doctor's hands. A good back rub will help you sleep and you'll feel better tomorrow.
APPENDIX 3

TYPE DESCRIPTIONS FOR CLASSIFICATION OF RESPONSES*

Type I: A reply which indicates the nurse's awareness that the person involved is experiencing an unmet need or a problem, and conveys a concern to understand the nature of his difficulty. It encourages verbalization, and conveys a willingness to listen. It seeks to promote reduction of stress experienced by the patient (or family members) and stimulates him to use his own resources in solving his problem.

Type II: A reply which indicates the nurse's awareness that the person involved is experiencing a problem and conveys sympathy and reassurance based upon explicit content of the conversation, exclusive of the real nature of the problem. It seeks to promote the person's well-being by accepting his feelings and by creating superficial reassurance, but does not encourage verbalization of his real problem nor stimulate him to use his own resources in its resolution.

Type III: A reply which indicates the nurse's awareness that the person involved is experiencing a problem and conveys an intent to investigate the problem. It seeks to promote discussion but inquires into tangential aspects of the problem and overlooks cues to identify its real nature. It seeks to promote the person's well-being by acquiring further information but because of the nature of the inquiry, does not promote resolution of the problem.

Type IV: A reply which indicates the nurse's awareness that a need is being expressed by the person involved, but conveys a lack of intent to promote verbalization of his problem. Instead, it seeks to explain, justify, or defend the nurse's point of view or those with whom she identifies—or to give advice. It denies opportunities to consider the position of the person with whom she is interacting and offers rational responses which tend to avoid exploration of his problem.

Type V: A reply which indicates the nurse's awareness that a need is being expressed by the person involved and conveys rejection or denunciation of the need. It seeks to change the subject or to
show disapproval of his point of view. It focuses on relief of the nurse's stress and/or allows for verbalization of the nurse's disapproval of the person with whom she is interacting, and thus denies to him an opportunity to explore his problem and to use his own resources in its resolution.

APPENDIX 4
INSTRUCTIONS TO QUESTIONNAIRE RESPONDENTS

Dear Respondent:

Please read the following instructions carefully and proceed as instructed.

1. Do not turn this page until you are instructed to do so.

2. Names of respondents are not of significance to this study; do not sign.

3. Please check off the information requested below--do it now.

4. There are ten nursing situations presented on the questionnaire. Please read each one carefully and indicate your response, when you are told to begin.

5. Responses should consist of one concise sentence representing the first thing you would say or do under the given circumstances, or which you customarily feel most comfortable doing or saying.

6. Please note carefully
   a. This is not a test of nursing theory.
   b. It is an endeavor to assess nurses' feelings and practice in given area.
   c. Please strive for honest subjectivity in your responses.

7. Return the questionnaire when instructed to do so.

8. Now you are ready to turn the page and complete the questionnaire.

INFORMATION

Please check the appropriate box in each case.

1. I am: ( ) a student in baccalaureate program, LLU.
   ( ) a student in associate degree program, LLU.
   ( ) a student in pre-nursing program, LLU.
   ( ) a staff nurse (RN), alumnus of LLU, baccalaureate program.
   ( ) a staff nurse (RN), alumnus of LLU, associate degree program.
   ( ) a non-nursing student of LLU.

2. My age is: ( ) under twenty-five years.
   ( ) over twenty-five years.

3. Years I have been exposed to general American culture: ( ) less than ten.
   ( ) ten or over.

APPENDIX 5
INSTRUCTIONS TO QUESTIONNAIRE RESPONDENTS, No. 2

Dear Respondent:

As you did in the case of the first questionnaire, please read all instructions carefully and proceed as instructed.

1. Do not turn this page until instructed to do so.
2. Names of respondents are not significant to this study; do not sign.
3. Please check off the information requested below--do it now.
4. In this questionnaire you may draw freely on your knowledge of therapeutic communication theory.
5. Five response options are given you for each of ten situations in this questionnaire.
6. Circle the one response which you feel to be most theoretically correct.
7. You are now ready to turn the page and begin. Please do so.

INFORMATION

Please check the appropriate box in each case.

1. I am: ( ) a student in baccalaureate program, LLU.
   ( ) a student in associate degree program, LLU.
   ( ) a student in pre-nursing program, LLU.
   ( ) a staff nurse (RN) alumnus of LLU, baccalaureate program.
   ( ) a staff nurse (RN) alumnus of LLU, associate degree program.
   ( ) a non-nursing student of LLU.

2. My age is: ( ) under twenty-five years.
   ( ) over twenty-five years.

3. Years I have been exposed to general American culture: ( ) less than ten.
   ( ) ten or over

APPENDIX 6  
CLASSIFICATION OF RESPONSES AND VALUES ASSIGNED BY PANEL EXPERTS  
FROM PILOT STUDY  
QUESTIONNAIRE B

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*Response options were typed I - V by "Social Interaction Inventory" (Methven & Schlotfeldt)  
**Values were assigned by panel beginning with I = 5, decreasing inversely to V = 1.
APPENDIX 7

CLASSIFICATION, BY PANEL EXPERTS,* OF SUBJECTIVE RESPONSES OF PILOT STUDY QUESTIONNAIRE A

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* Four out of the original panel of five replied

** No opinion
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LOMA LINDA UNIVERSITY

Graduate School

A STUDY OF THE DIFFERENCES IN RESPONSES OF STUDENTS AND ALUMNI
OF TWO TYPES OF NURSE-EDUCATION PROGRAMS, TO QUESTIONS
REGARDING COMMUNICATION WITH DYING PATIENTS

By
R. Cherie McClure

An Abstract of a Thesis
in Partial Fulfillment of the
Requirements for the Degree Master of
Science in the Field of Nursing

August, 1970
ABSTRACT

The study concerned a comparison of responses made by students and alumni from two types of nurse-education programs, to questions regarding communications with dying patients. This was for the purpose of answering two questions: Are students of nursing given adequate preparation for coping with the psychological needs of dying patients? Are there significant differences in the way nurses from baccalaureate and associate degree programs cope with these needs? In an effort to obtain answers to these questions, a ten-part situational questionnaire was developed. It was assumed that some clue to a subject's ability to cope effectively in emotionally stressful situations encountered in care of dying persons would be indicated by the degree to which she tended to choose the most desirable response options to such situations on the questionnaire. The questionnaire was administered to finishing students and alumni of a baccalaureate and an associate degree program within the same university and university hospital. Data were collected according to the design. Computation and analysis of data revealed that there were no significant trends toward differences in the performance of students and practicing alumni of the two programs. The tendency for practicing nurses to score somewhat higher than the students, though of no statistical significance, was nevertheless of interest. Highly significant differences in mean scores of all the nurse groups from that of the non-nursing control group, appear to indicate significantly effective preparation by both types of programs in the area under consideration. Design weaknesses and limiting factors were pointed out; these, and the small sample size, render any generalization of findings unfeasible. Recommendations for further study were made.