ASSESSING DEATH ANXIETY IN EMPLOYEES IN A HOSPICE SETTING:
A CORRELATIONAL STUDY
by
Aaron Jonasen

A Thesis submitted in Partial
Fulfillment of the requirements for
The Master of Science in Counseling Degree

Thesis Chair: Brenda Rust O’Beirne, Ph.D.

THE UNIVERSITY OF WISCONSIN-WHITEWATER
July 23, 2012
The University of Wisconsin-Whitewater

Thesis Approved

Aaron Jonasen

Date: _______________________________

Committee Members: _______________________________

Brenda Rust O’Beirne, Ph.D.

_______________________________

Donald M. Norman, Ph.D.

_______________________________

Scott J. Peters, Ph.D.
Acknowledgements

I owe special thanks to my mom and dad, to my grandparents, to my aunt and cousins, to Stephanie, and to all of my friends who patiently talked to me about death whether they wanted to or not. You each continue to serve as constant reminders of how to live.

Thank you to UW-Whitewater, the School of Graduate Studies and members of the Counselor Education Department for your support throughout this project.

Thank you to Agrace HospiceCare for allowing me to conduct this research and to the employees who enthusiastically participated.

To the Grief Services Department at Agrace – You each made me feel like I was part of the team and taught me valuable lessons with your unique approaches. Thank you.

To Cheri Milton, my supervisor and mentor at Agrace - I could not have asked for a better role model for what it means to give someone the gift of compassionate presence. It only takes a moment with you to recognize that you genuinely believe in the work you do. This thesis was one of many doors I could not have opened without your support. Thank you so much for trusting me and for embodying what you teach.

To my committee members:

Scott - Before I took your class, I would not have believed someone could be so passionate about research that he would consistently forget to give his class a bathroom break during a two and a half hour lecture. Thank you for sharing your incredible knowledge and skill, for introducing in me a sense of humor and fascination for research, and for showing me its immense value and need.

Don – Our connection was immediate and it has only grown. Three and a half years ago you were the first faculty member I met when I stepped onto the Whitewater campus. From the opening moments of our conversation, you made me feel like I could accomplish anything, and I left your office beaming. If you had not shown such confidence in me, I can safely say I would not have found the confidence in myself to complete the program and this thesis.

Brenda – You have been extraordinarily instrumental in every leg of this journey. What a blessing to learn from you and with you in our group class, my internship and through this thesis. Even when spare time is at a minimum, you somehow make people feel like they have your full attention and like you will do whatever you can to help. The best part about this approach is the truth behind it – you are genuine in your words, your actions and your presence. You go beyond above and beyond. With grace and humor you share your wisdom and you live what you believe in. So, please know that the lessons you have taught me go beyond any words we have exchanged. In fact, I remember you once told me in my struggle to find words that sometimes words are over-rated. Indeed, how to adequately say thank you in this paragraph is a struggle. So I hope that my actions from here will serve as gratitude, because the impact you have had on my life will echo in how I serve others and how I live my life. And when I think of it this way, I do not see myself ever ceasing to say thank you.

Dedicated to my teachers who have gone to the next place, and whose memories and lessons will live beyond pages.

iii
Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title Page</td>
<td>i</td>
</tr>
<tr>
<td>Thesis Approval Page</td>
<td>ii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>iii</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>iv</td>
</tr>
<tr>
<td>Abstract Cover Page</td>
<td>v</td>
</tr>
<tr>
<td>Abstract</td>
<td>vi</td>
</tr>
<tr>
<td>Chapter 1 – Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Chapter 2 – Review of the Literature</td>
<td>4</td>
</tr>
<tr>
<td>Chapter 3 – Methods</td>
<td>27</td>
</tr>
<tr>
<td>Chapter 4 – Results</td>
<td>33</td>
</tr>
<tr>
<td>Chapter 5 – Discussion</td>
<td>37</td>
</tr>
<tr>
<td>References</td>
<td>45</td>
</tr>
<tr>
<td>Appendices</td>
<td>48</td>
</tr>
</tbody>
</table>

Appendix A – Revised Death Anxiety Scale (RDAS)
Appendix B – Consent Forms
Abstract of Thesis

Aaron Jonasen

Counselor Education

Assessing Death Anxiety in Employees in a Hospice Setting: A Correlational Study

July 23rd, 2012

Brenda Rust O’Beirne, Ph.D., Thesis Chair

The University of Wisconsin-Whitewater
To measure hospice employees’ perceptions of their own death, I implemented the Revised Death Anxiety Scale (RDAS) with a sample of 128 hospice employees. Participants were asked to include other information including age, gender, position and length of time employed in a hospice or palliative care setting. Results from the RDAS were correlated with length of time employed in a hospice or palliative care setting. Other variables and within group differences were considered including the correlation between RDAS scores and age, and the difference between correlations in RDAS scores in nurses and non-nurses. The goal of this study was to determine whether or not a relationship existed between death anxiety and the length of time employed in a hospice or palliative care setting. Results indicated there was a weak negative relationship between these two variables. There was also a weak negative relationship between age and RDAS scores. Lastly, there was not a statistically significant difference between RDAS scores and length of time employed in a hospice or palliative care setting for nurses. There was however a statistically significant negative correlation between these two variables for non-nurses ($p=.011$). Overall, RDAS scores were average when compared to scores from the original publication of the instrument (Thorson & Powell, 1992). When compared to a more recent study (Halliday & Boughton, 2008), scores in the present study were much lower. Research into death anxiety in hospice and palliative care settings should continue as the hospice movement is still in its infancy and offers a unique death experience. Ultimately, a better understanding of how employees experience their own mortality will allow hospices to better serve their patients and those significant in the patients’ lives.
Chapter One: Introduction

Death is the only certainty and arguably the greatest source of anxiety for humanity (Nyatanga, 2005). Death anxiety is an evolving concept that researchers have struggled in recent decades to narrow into a succinct definition (Lehto & Stein, 2009). Nyatanga and de Vocht (2006) attempted to move closer to agreement by differentiating between what is meant by “anxiety” and “fear”. They explained that while fear has a clear source for its cause, anxiety does not. Thus it is the lack of an object, in this case the unknown essence of what lies beyond death, that causes anxiety.

The lack of consensus over a definition for death anxiety should not overshadow the importance of continuing to study this concept. This is especially the case when attempting to gain a better understanding of how individuals who are exposed to death more frequently through their work confront their own mortality. A substantial amount of research into how nurses experience death anxiety has been conducted (Chen, Ben, Fortson, & Lewis, 2006; Cooper & Barnett, 2005). So far there has been some research into how other employees, such as funeral home directors, social workers and counselors experience death anxiety (Harrawood, White, & Benshoff, 2008; Kirchberg, Neimeyer, & James, 1991; Kirchberg, Neimeyer, & James, 1998; Simons & Park-Lee, 2009). However, little research exists into how hospice and palliative care workers confront their mortality. For the most part, hospice and palliative care workers have been neglected in the research on death anxiety. Consequently, research should continue into how those who surround themselves with death view their own death. Learning from these teachers will reap numerous benefits beyond the literature as death is one of the only givens to our
existence. Through a greater understanding of how their work influences them, we will better equip those who will accompany us on a journey we will all have to eventually take. In short, research of this nature should aim to increase the quality of care for those nearing end of life.

A general definition from the *Handbook of Nursing Diagnosis* (Carpenito-Moyet, 2008) was used for the purpose of this study. Here, death anxiety was defined as “the state in which an individual experiences apprehension, worry, or fear related to death and dying” (p. 39). For the sake of consistency, the term “hospice” will be used to include all palliative care settings. A hospice setting clearly provides a different death experience from that of a typical hospital. In hospitals there are likely attempts to save an individual’s life up until the end of life, and death is often viewed as a failure (Carr & Merriman, 1996). On the other hand, a hospice allows the individual to die as peacefully and painlessly as possible, without attempts to save his or her life. Additionally, the patient is given the freedom to establish his or her own end of life goals, rather than have those goals determined by a medical staff.

The hospice movement is still in its infancy and growing. Kubler-Ross (1969), one of the early advocates for dying a peaceful death, passionately believed death did not have to be frightening or painful. A better understanding of the death attitudes of individuals who make a peaceful death possible will benefit the hospice workers and those they serve. Additionally, how these individuals view their own mortality is an important step to take in the growing body of literature on death and dying.
Context for the Present Study

There were three key components considered in the literature review. First, the concept of death anxiety was defined. This included descriptions of attempts made to reach a consensus on a definition of death anxiety. Second, an analysis of the existing research on death anxiety in occupations with high death exposure such as nursing, counseling, social work and funeral directing was conducted. Finally, there was an exploration of the existing research on death anxiety in hospice and palliative care employees.

Purpose of the Study

As noted earlier, numerous studies have examined death anxiety in settings with high death exposure. Few studies however, have focused specifically on a hospice employee’s experience. Hospice facilities provide a unique death experience, different from most hospitals and nursing homes. Whereas the focus in a hospital is typically to save a life, the focus in a hospice facility is to allow the individual to die comfortably and peacefully. Studying death anxiety in hospice employees is a new venture. Given the distinct experience provided to the patient by the hospice employee, the purpose of this study was to implement the Revised Death Anxiety Scale (RDAS) (Neimeyer, 1994) to gain a better understanding of how the hospice employee’s work impacts the personal experience of his or her own mortality.

Research Question

What is the relationship between death anxiety and length of time employed in a hospice or palliative care setting?
Chapter Two: Review of the Literature

An examination of the literature revealed that “death anxiety” remains an evolving concept (Lehto & Stein, 2009). Yet while authors and researchers debate the specific meaning of the term, research should continue into how awareness and attitudes toward mortality change alongside variables such as age, gender, position and length of time employed in a hospice setting. This is especially true when examining individuals who have a much greater exposure to death than the average person because of the nature of their work. While death anxiety has been examined extensively in nursing and to some extent in other fields, it has been all but neglected in hospices. Overall, a hospice provides a much different death experience than hospitals and nursing homes. Therefore, this literature review addressed three areas related to death anxiety. The first section addressed the defining features of death anxiety, including the debate over the meaning of this concept. The second section focused on studies that have examined death exposure in various settings, including nursing, counseling, social work and funeral directing. Finally, the third section discussed the existing research on death anxiety in hospice settings.

Death Anxiety

While the body of literature on death and dying continues to grow, many existential concepts remain difficult to study and define. Death anxiety is no exception to this challenge. Currently, there is a lack of consensus among researchers and philosophers as they attempt to reach an agreed upon definition.

To begin his exploration of death anxiety, Nyatanga (2005) wondered if the fear of death itself is even a rational fear. In his commentary, Nyatanga wondered why people
should fear something they have not experienced. He went on to propose that perhaps people fear death because it interferes with the potential for more life and therefore the realization of life goals. So, while it may seem irrational for people to fear something that they have not experienced, the fact is that anxiety over death exists. Not only does it exist according to Nyatanga, it is a concept that is definable and can be quantified.

Nyatanga and de Vocht (2006) asserted that there is no consensus on what death anxiety is. In their article, numerous examples of how death anxiety has been defined were presented. These examples were drawn from individual existential philosophers such as Heidegger and Kierkegaard, along with perspectives from broader frameworks such as psychoanalytical, reductionist and sociocultural theories. According to the authors, all of these attempts fall short of clearly stating what death anxiety is. Thus, the purpose of this article was to move closer to an inclusive and consensual definition of death anxiety. The authors hoped to accomplish this by differentiating between the human experiences of anxiety and fear.

The difference between anxiety and fear, according to the authors, is that fear has a clear source (Nyatanga & de Vocht, 2006). That is to say, there is a specific object that produces the feeling of fear. Anxiety on the other hand, lacks a visible source. Therefore, it is the feeling of insecurity in light of a nonexistent object that produces anxiety.

In their conclusion, Nyatanga & de Vocht (2006) pointed out that fear and anxiety have often been used interchangeably in the literature on death and dying. They also offered their own definition of death anxiety as “an unpleasant emotion of multidimensional concerns that is of an existential origin provoked on contemplation of
death of self or others” (p. 413). The purpose of their proposed definition was to create a springboard toward synchronization among the varying perspectives. Agreement on a definition would allow future researchers to clearly determine and understand what they are researching, along with ensuring that future educators teach the same definition as their colleagues.

Other researchers have made significant contributions to the working definition of death anxiety. For example, Lehto and Stein (2009) reviewed the literature on death anxiety between the years 1980-2007. The purpose of their study was to advance the field of nursing by “identifying important defining attributes, antecedents, and consequences of the concepts and to provide a synopsis of this work for nursing utilization and practice” (p. 24). Their review of the literature, while conducted from a nursing perspective, contributed significantly to the working definition of death anxiety.

The authors relied mainly on journal articles, using the term “death anxiety” to search the databases DINAHL, EMB Review, Health and Wellness Resource Center, UM-Medsearch, psychINFO and PubMed between 1980 and August 2007 (Lehto & Stein, 2009). They retrieved and reviewed 89 articles that met the inclusion criteria. Each article was coded and summarized independently. Themes were identified through data units including words and sentences that would answer questions such as: “What are the specific attributes of death anxiety?” and “How is death anxiety measured?” Finally, the articles were grouped together according to common characteristics.

The authors identified six attributes of death anxiety: emotional, cognitive, experiential, developmental, sociocultural shaping and source of motivation (Lehto &
Stein, 2009). First, emotion was found to play a key role since death anxiety is often grounded in negative emotions. Next, a cognitive component to death anxiety was established to discuss how the awareness of death is incorporated in the ability to anticipate the future. Then, the experiential attribute was developed to highlight the self-regulation processes that defend against death anxiety. These processes included boundaries from death awareness, such as self-esteem and positive affect. The developmental attribute was then established to highlight the variances in death anxiety across the lifespan. Additionally, the developmental attribute emphasized the correlation between age and anxiety. Next, sociocultural shaping was established as an attribute to explain the protective buffer that culture serves in assuaging death awareness. Here, Lehto and Stein posited that cultural beliefs and values serve to reduce death anxiety. Finally, source of motivation was established to highlight the vehicles through which a fundamentally denied death is expressed. This expression often takes the form of creative efforts to symbolically overcome death. Along with the six defining attributes, Lehto and Stein identified antecedents that increased death awareness. These reminders of personal mortality were placed into three categories: stressful environments, diagnosis of a life-threatening illness and experiences with death and dying.

Several areas for discussion developed from the data analysis and the establishment of six defining attributes and three categories of influential antecedents (Lehto & Stein, 2009). First, the authors commented on the evolution of the measurement of death anxiety. They noted that self-report measures have been used in most studies. For example, Templer’s (1970) 15-item Death Anxiety Scale (DAS) was the most
frequently used instrument in assessing death anxiety. Next, the authors discussed the progression towards a definition of death anxiety (Lehto & Stein, 2009). They determined that while death anxiety and fear of death are often used as interchangeable concepts, fear and anxiety are distinct components. Further, these notions coexist within the human awareness of death and the individual’s attempts to manage this awareness.

The authors concluded that while the results of these concept analyses are significant, particularly in light of the broad amount of research on death anxiety, there has been little integration of the literature (Lehto & Stein, 2009). Accordingly, clinical implications included the importance of nurses assessing their own death anxiety, and examining how unresolved death anxiety may impede their ability to provide adequate care for patients facing death, pain and suffering. While the foundation of this article was from a nursing perspective, the authors recognized that their conclusions and the concept of death anxiety reach far beyond the field of nursing. This lends support for the present study, as a variety of positions and experiences exist in an effective hospice facility.

Death anxiety is clearly an evolving concept. Therefore, to advance the concept, the authors recommended qualitative measures of death anxiety to capture the individual experience (Lehto & Stein, 2009). The authors also recommended examining death anxiety and self-esteem alongside age, gender, culture, personal experience and nursing background. Finally, Lehto and Stein recommended the implementation of interventions that would reduce the maladaptive consequences of death anxiety.

The literature reviewed in this section emphasized the fact that there is plenty of work to be done in the field of death anxiety. Not only does the concept itself lack
consensus in a definition, the application of this concept in research has been limited.
Efforts should continue to reach an agreed upon definition. This includes differentiating
between the meanings of “anxiety” and “fear”, which will help to narrow how death
anxiety is presented in the research and taught in the classroom. Additionally, looking for
trends and themes in death anxiety research will also lead towards an enhanced and
accepted definition. While work towards a consensus continues, research into how
humans experience death anxiety should continue as well. Previous research has been
limited by a lack of diversity in samples and extensive study of death anxiety has been
restricted to a handful of settings. The current study sought to expand on these settings.

As noted previously, a general definition from the Handbook of Nursing
Diagnosis (Carpenito-Moyet, 2008) was used in the present study. Here, death anxiety is
defined as “the state in which an individual experiences apprehension, worry, or fear
related to death and dying” (p. 39), and the term “hospice” was used to include all
palliative care settings.

Death Anxiety in Settings other than a Hospice

There are certain work environments that provide employees with greater death
exposure simply through the nature of the work. This is especially true for nurses, who
are clearly more likely to be exposed to death and dying. Cooper and Barnett (2005)
pointed out that while death anxiety has been found in nursing professionals, research has
neglected to identify influential factors and determine when death anxiety begins.

Cooper and Barnett (2005) confirmed in their qualitative study of 38 first year
nursing students that these students indeed expressed high levels of death anxiety in
caring for dying patients. They analyzed reflective diaries written by beginning nursing students and carried out two focus groups. The researchers proposed that death anxiety may result from the large amount of emotional energy invested in the care for the dying patient. Additionally, beginning nurses may not be prepared for the emotional bond with the dying patient and the accompanying stress of seeing the patient suffer and die.

Chen, Ben, Fortson and Lewis (2006) sought to further shed light on how death anxiety developed in nursing students. The purpose of their study was to examine if death anxiety in nursing professionals developed early in their nursing career while they were still students, and whether or not social desirability impacted responses. The Multidimensional Fear of Death Scale (MFODS) was used to assess death anxiety.

Participants in this study were first year undergraduate nursing students, final year undergraduate nursing students and undergraduate students enrolled in non-medical related courses at a southeastern regional university (Chen, Ben, Fortson, & Lewis, 2006). Participants were approached and recruited at the beginning of classes. A total of 152 students participated in the study. Fifty-three of the participants were experienced nursing students, 49 were inexperienced nursing students and 50 were non-nursing students. Nurses who were considered to be experienced had been part of an internship, practicum or field placement that exposed them to death-related situations. Participants were between the ages of 18 and 40 ($M=23.6$, $SD=6.3$), and 80% were female while 77% were Caucasian.

Participants were given the MFODS to assess death anxiety (Chen, Ben, Fortson, & Lewis, 2006). The MFODS uses a five-point Likert scale that ranges from one
(strongly disagree) to five (strongly agree). There are eight factors on the MFODS: (a) fear of the dying process, (b) fear of the dead, (c) fear of being destroyed, (d) fear for significant others, (e) fear of the unknown, (f) fear of conscious death, (g) fear for the body after death and (h) fear of premature death. Participants were also given the Marlowe-Crowne Social Desirability Scale (MCSDS). The MCSDS consists of 33 true-false questions. The questions are designed to assess the tendency to alter self-presentation toward social desirability. Numerous dependent variables were measured in the study, including age, gender, ethnicity, religiosity, seeing a violent death, being in a situation with imminent personal death, death of someone close, seeing a person die and the total score on the MCSDS. The independent variable was death anxiety.

The MFODS and the MCSDS were taken back-to-back during the first 10 to 15 minutes of class in a typical classroom setting (Chen, Ben, Fortson, & Lewis, 2006). Participation was voluntary and no compensation for participation was given. After consent was given, the MFODS and MCSDS were taken. Of the 173 students approached, 169 agreed to participate. Additionally, 17 of the surveys were thrown out because of previous work experience in settings with high death exposure. This resulted in a sample of 152 undergraduate students.

After the surveys were collected, eight one-way analyses of covariance (ANCOVAs) were conducted to determine whether or not there were significant group differences in the MFODS factors (Chen, Ben, Fortson, & Lewis, 2006). Significant group differences were shown on two MFODS factors: fear of the dying process and fear of the unknown. Here, follow-up tests revealed experienced nursing students had greater
fear of the dying process than inexperienced nurses, and greater fear of the unknown than non-nursing students. The results indicated that for the remaining six subscales, there was no statistical difference between the three groups.

There were several limitations to this study (Chen, Ben, Fortson, & Lewis, 2006). First, the sample size was small, which limited the strength of the analyses. Another limitation was the method in which participants were selected. The study used convenience sampling and therefore lacked the advantage of random sampling and assignment. Convenience sampling makes it difficult to generalize the results to the entire population and may also add participant bias to a study. Another limitation was the cross-sectional nature of the study. This limited the ability to examine the development of death anxiety, something which would be possible through a longitudinal study. Finally, the fourth limitation identified was the lack of attention to other variables that may influence death anxiety, such as coping style, prior psychopathology, physical health and exposure to traumatic events.

Several conclusions were made regarding how overall death anxiety and the MFODS factors vary among nursing students (Chen, Ben, Fortson, & Lewis, 2006). Most notably, because first and last year nursing students demonstrated slightly lower scores on the fear of the unknown factor than non-nursing students, this suggests that nursing students’ fear of the unknown exists early in training and perhaps even elevates with experience. The authors suggested future studies implement a longitudinal design and incorporate different types of nursing students and professionals. The authors advised that future studies continue to examine the impact of death anxiety in other populations. The
present study sought to expand on the previous articles. Since approximately half of the sample surveyed consisted of nurses, it made sense to examine how nursing experience with death was related to death anxiety.

Like the nursing student, the beginning counselor’s death attitudes are worth mentioning to better understand how and when death anxiety appears. A critical component of a hospice is its grief services department, which consists mainly of grief counselors. Beginning counselors as a whole, while not typically provided with extensive training in death and grief, will most certainly confront situations involving death and grief at some point in their careers (Kirchberg, Neimeyer, & James, 1998). Additionally, these situations could be among the most urgent a counselor faces in his or her career. Yet there continues to be little research into how death and grief impacts the mental health counselor.

Kirchberg and Neimeyer (1991) paved the way in studying how counselors react to issues involving death and grief. In their initial study, they tested the assumption that client issues involving death and dying placed high, strenuous demands on the mental health professional. By surveying 81 beginning counselors, the authors discovered that these counselors were indeed uncomfortable with scenarios involving death and loss. Further, client issues involving death and dying were the most anxiety provoking for beginning counselors.

After establishing that death and loss can indeed provoke anxiety for beginning counselors, Kirchberg, Neimeyer and James (1998) looked to expand on these findings. The purpose of this study was to replicate the previous findings and to include a
behavioral measure in the design of the study.

The study took place at the University of Memphis (Kirchberg, Neimeyer, & James, 1998). There were 58 practicum students nearly finished with their master’s degree in counseling who participated in the study. Of these subjects, 51 were women and seven were men. Of the females, 44 were Caucasian and seven were African American. Of the seven men, five were Caucasian and two were African American. The average age of participants was 34.9 years with a range of 22 to 56 years.

The researchers used the MFODS (Kirchberg, Neimeyer, & James, 1998). Participants were also given the Threat Index (TI). In this instrument, a “threat” is defined as the awareness an individual has of whether or not an event would threaten his or her core identity. Lastly, the researchers designed a counselor response form which assessed the counseling students’ comfort levels with each scenario. The counselor was asked to provide a written response to the client and the response was assessed for empathy.

The researchers created eight videotaped counseling scenarios for the study (Kirchberg, Neimeyer, & James, 1998). Actors depicted situations involving death and dying in four of the videos, while the other four counseling scenarios were not related to death. Additionally, two separate tapes for each scenario were created to control for the possible influence of the actor. To control for race and gender, actors consisted of two African American men, two African American women, two Caucasian men and two Caucasian women. The researchers controlled for two other possible factors that may have influenced the responses including the possibility that exposure to a death attitudes
scale before viewing the scenarios could influence responses, and that the prospect of
viewing an actor in these scenarios could influence the intended effect of the scenarios.
Participants were randomly assigned to four groups to control for these two factors.

Two of the four groups began the study by completing a demographic information
form, the MFODS and the TI (Kirchberg, Neimeyer, & James, 1998). Then, one of these
two groups viewed version A of the eight tapes, while the other group viewed version B.
After viewing each scenario, participants completed the counselor response form. The
counselor response form was designed to rate a respondent’s comfort level with each
scenario from one (very uncomfortable) to nine (very comfortable). Additionally,
respondents were asked to give a written response to each videotaped client which would
be measured for empathic understanding. The other two groups were first exposed to
either version A or version B of the videotapes, and then completed the demographic
information form, the MFODS and the TI. Like the other two groups, they recorded their
comfort level and a written response to the client.

Results indicated that counseling students reported a significantly high level of
discomfort in responding to the death-related scenarios (Kirchberg, Neimeyer, & James,
1998). Further, the overall score on the MFODS was predictive of discomfort, while the
TI was not. Next, the examination of individual empathy responses revealed that the
mean scores in each of the scenarios were significantly different from each other.
Additionally, participants showed slightly more empathy in responding to the death-
related scenarios than the non-death-related scenarios. This study reinforced previous
findings that beginning counselors demonstrated greater discomfort in death-related
scenarios than in scenarios that were not death-related (Kirchberg, Neimeyer, & James, 1998).

Social workers are another population worth mentioning because of their potential for death exposure. Similar to the previous articles reviewed, it is helpful to assess for death anxiety early in the social worker’s career. By doing so, researchers add to the body of literature on when and how death anxiety develops, along with what influences the care workers comfort level when working with end-of-life issues.

Simons and Park-Lee (2009) surveyed 272 bachelor’s and master’s level social work students from the United States and Canada. Death anxiety was assessed using the Templer Death Anxiety Scale, which was included as part of a larger survey. Given the broad scope of this study, the researchers proposed numerous hypotheses related to death anxiety, experiences with death and comfort with death. The hypotheses most relevant to this literature review and the research questions posed in this study were: 1. Students with previous experience in gerontological social work would express greater comfort working with clients nearing end of life and 2. Students who had completed or expressed a desire to complete a field placement in a hospice setting would express greater comfort working with clients nearing end of life.

The researchers discovered that students who had completed or expressed a desire to complete a field placement in a hospice setting reported a higher level of comfort providing end-of-life care (Simons & Park-Lee, 2009). However, there was not a significant association between prior gerontological social work experience and comfort providing end-of-life care. Limitations noted in this study were that respondents were
mostly Caucasian females. Another limitation was that the researchers used convenience sampling by targeting students who had previously expressed interest in aging.

Continuing the examination of occupations with high death exposure, funeral directors offer another population of interest for researchers to study. In particular, funeral directors who attend funerals and participate in embalming procedures are subjected to a high degree of exposure to death. There are many variables that could be considered in examining death anxiety experienced by a funeral director. Like the studies in nursing, counseling and social work, this field offers yet another window into how high death exposure is related to death anxiety.

Harrawood, White, and Benshoff (2008) surveyed a national sample of United States funeral directors. The purpose of this study was to expand on previous research on death anxiety by surveying a large sample of funeral directors. Further, researchers investigated the relationship between death anxiety and death exposure, age and gender. The funeral directors were given the MFODS to measure death anxiety.

The sample included funeral directors from across the United States (Harrawood, White, & Benshoff, 2008). Funeral homes were contacted randomly from The National Yellow Book of Funeral Directors. Of the 21,000 funeral homes listed alphabetically, every 21st funeral home was used in the sample. A random number table was used to choose the first funeral home contacted. The resulting sample was 243 funeral directors from 42 states which included 193 men, 47 women and three who did not identify their gender.

The survey packet mailed to funeral homes included a cover page about the
researcher, a letter explaining the purpose of the study, a demographic questionnaire and the MFODS (Harrawood, White, & Benshoff, 2008). Initially, 1000 packets were mailed, 63 were returned as undeliverable and 243 of the packets were completed and returned resulting in a 26% response rate.

Death exposure was assessed based on two measures: the number of funerals attended per year and the number of embalmings performed per year (Harrawood, White, & Benshoff, 2008). Death exposure, age and gender were the dependent variables in the study and were correlated with the total score and subscale scores on the MFODS as the independent variables.

Through a correlational analysis, researchers discovered there were negative correlations with some of the measures of death anxiety and death exposure (Harrawood, White, & Benshoff, 2008). First, men revealed a significant negative correlation between funerals attended per year and death anxiety when compared to women. Second, while there was not a significant correlation for number of embalmings performed and death anxiety, the subscale factor fear of premature death showed a significant negative correlation for women with number of embalmings performed per year. Next, researchers discovered a significant negative correlation between age and death anxiety. Additionally, they found women displayed a stronger negative correlation than men between age and death anxiety. Overall, women reported slightly higher death anxiety levels than men. However, there was not a statistically significant difference between these scores.

Several conclusions were made based on this study (Harrawood, White, &
Benshoff, 2008). First, not only does a funeral allow family and friends the opportunity to grieve, it causes everyone involved, including the funeral director, to confront his or her own mortality. The authors explained that exposure to death and funeral rituals allow individuals to better accept their own mortality. Since longer employment naturally indicates greater death exposure, this was an especially important conclusion to consider as the present study sought to determine whether or not a relationship existed between death anxiety and length of time employed in a hospice. Another conclusion noted was that death anxiety did not positively correlate with the number of reported embalming cases. This was a curious discovery according to the researchers because people might assume that the handling of a dead body would be a traumatic experience, thereby heightening death anxiety. However, the researchers theorized that funeral directors may feel they are providing a vital service to the dead and their families and that this feeling of service overrides other feelings that would typically heighten death anxiety.

There were a few limitations to note in this study (Harrawood, White, & Benshoff, 2008). First, there were considerably fewer women in the sample than men. A second limitation was the fact that the men in the sample were much older than the women. Finally, there was a lack of diversity in the sample in terms of ethnicity since 92% of the sample identified as being Caucasian.

The authors concluded their article with several recommendations (Harrawood, White, & Benshoff, 2008). First, they recommended a qualitative look at funeral directors’ death attitudes. By doing so, this could reveal trends which contribute to what constitutes a healthy view of death. The researchers also recommended examining the
funeral ceremony itself to determine if certain components or rituals contribute to the view of death. Further, it was recommended that future studies focus on using a more diverse sample, particularly one with more women and one which is more ethnically diverse. Finally, the researchers recommended that death anxiety be explored in other occupations with high death exposure. The present study took this advice into consideration by attempting to include a variety of occupations within the hospice setting.

In concluding this section, it is clear that the literature on death anxiety in professionals with heightened death exposure is still in its infancy. Furthermore, a large portion of this research has taken place in the field of nursing. While this research has made valuable contributions to the understanding of death exposure and its relationship to death anxiety, there are reasons a concerted effort to differentiate between the numerous fields that focus on death and dying should continue. For instance, a funeral home director clearly has a very different experience with death than an emergency room nurse. Moreover, it was evident in the articles evaluated in this literature review that different samples yielded unique results when it came to death anxiety. Yet the common connection between these professions remains, and this is their potential exposure to death and grief.

As a result of these conclusions, factors involved in a death experience should be identified and studied. Additionally, the best teachers for what contributes to a healthy view on death will continue to be those who surround themselves with death on a daily basis. The present study contributed to the growing body of literature on death anxiety by examining a population that has for the most part been neglected in the research. Hospice
employees provide a unique death experience for the dying. On the surface, there is a serene environment which strives to provide a peaceful and painless experience for the dying and their friends and families. This study sought to understand how the increasingly popular hospice approach to death is personally impacting the professionals who make this experience possible. Ideally, this enhanced awareness will result in a higher level of care offered to those nearing end of life.

**Death Anxiety in Hospice Settings**

The literature on death anxiety in hospice settings remains sparse. However, there has been some research into how high death exposure in this work environment influences the hospice employee’s level of death anxiety.

Payne, Dean and Kalus (1998) compared death anxiety in hospice nurses to death anxiety in emergency nurses. The sample consisted of 43 nurses, which included 23 hospice nurses and 20 emergency nurses. The average age of hospice nurses was 37 and the average age of emergency nurses was 33. The researchers used the Death Attitude Profile-Revised (DAP-R). The 32 item DAP-R consists of five subscales: fear of death, death avoidance, neutral acceptance, approach acceptance and escape acceptance. Participants rated questions using a seven-point Likert scale ranging from strongly disagree to strongly agree. Researchers included an additional questionnaire with the DAP-R. This questionnaire asked participants why they chose to work in their specialty of hospice or emergency nursing, how many years they had worked in that specialty and any other qualifications they had. Additionally, a six question semi-structured interview was used to gain information on how the participant had dealt with previous situations
involving the death of a patient.

Results from the DAP-R were compared between the hospice and emergency nurses (Payne, Dean, & Kalus, 1998). Here, researchers discovered that emergency nurses had a greater fear of death and were less accepting of death than hospice nurses. The authors hypothesized that a hospice nurse’s skill and confidence in providing quality care to a dying patient may have contributed to the lower level of death anxiety. The interviewer also performed a content analysis with the responses to the additional questionnaire. An interesting result of this analysis was that of the 20 emergency nurses surveyed, only 10 could recall a situation which they had a patient who they “cared for particularly well” (p. 701). Of these 10, only two described care which was given directly to the patient. The other eight described care they had provided to the family of the patient. On the other hand, only three of the 23 hospice nurses interviewed could not recall a situation in which they had cared for a patient particularly well. The present study attempted to expand on Payne, Dean and Kalus’s discovery that hospice nurses were more accepting of death than emergency nurses by examining more closely how a hospice employee views his or her own mortality.

In their conclusion, the researchers recommended exercising caution in interpreting the results. Specifically, they pointed out that while the sample itself was demographically very similar and that the death rates in the two settings were nearly identical, the structure of the settings themselves were very different. Therefore, environmental factors may have had a stronger influence than the personal characteristics of the nurses themselves. For that reason, researchers recommended future studies take a
qualitative approach to better understand factors that may have influenced the emergency and hospice nurses’ responses. Lastly, the small sample size was the most notable limitation to this study.

A much larger sample of 355 inpatient and outpatient oncology nurses in a cancer center in New York was utilized by Lange, Thom and Kline (2008). The purpose of the study was to assess the nurses’ views towards caring for dying patients and examine any relationships between death attitudes and demographic data, including gender, age and previous experience working with dying patients. Researchers used the Frommelt Attitude Toward Care of the Dying (FAT-COD) Scale and the DAP-R (Lange, Thom, & Kline, 2008). The FAT-COD Scale is a 30 item scale which uses a five-point Likert scale ranging from strongly disagree to strongly agree. This instrument was used to assess participants’ attitudes toward caring for dying patients. The DAP-R was used to assess participants’ death attitudes.

There were significant findings in this study which were relevant to the present study. First, the number of years working as a nurse positively correlated with the attitude toward caring for cancer patients (Lange, Thom, & Kline, 2008). In other words, more experienced nurses were more likely to view death from an optimistic point of view. Furthermore, the authors noted that the findings in this study confirmed the findings of a previous study in which Dunn, Otten and Stephens (2005) discovered that nurses who had more contact with dying patients had more positive attitudes toward death. The present study expanded on these discoveries by examining how experience with death correlated with the view towards one’s own death.
In another examination of hospice nurses’ attitudes on death, Halliday and Boughton (2008) used the RDAS to assess death anxiety levels in hospice nurses. They also surveyed three additional groups of participants from the general population and organized the results by age range. The purpose of this study was to establish the moderating effect of death exposure on death anxiety. The researchers hypothesized that hospice nurses would report lower death anxiety on the RDAS than the general population. Additionally, researchers hypothesized that the participants from the general population who reported infrequent death experience would report lower death anxiety on the RDAS than participants from the general population who reported having no death experience. Other hypotheses included that women would report higher death anxiety than men and older individuals would report lower death anxiety than younger individuals.

The sample consisted of 160 participants (Halliday & Boughton, 2008). In addition to completing the RDAS, participants were asked to indicate their age, gender, level of death experience and occupation or previous occupation if retired. The participants were then divided into four groups with 40 participants in each group. These groups were comprised of hospice nurses, individuals age 16 to 25, 26 to 49 and 50 and older.

Results indicated that women scored statistically significant higher scores than men on the RDAS (Halliday & Boughton, 2008). According to the authors, this was a finding consistent with past research. While not statistically significant, adults in the 50 and older group scored higher on the RDAS than individuals in the two younger groups.
This finding was inconsistent with the hypothesis and did not support previous findings. Finally, based on the mean scores of the RDAS, hospice nurses scored significantly lower than women from all three age groups. Therefore, the authors concluded that experience with death in fact moderates death anxiety. RDAS scores in Halliday and Boughton’s (2008) study were compared to the RDAS scores in the present study.

**Conclusion**

Death anxiety is a developing concept and attempts to reach an agreed-upon definition should continue. Differentiating between the meanings of “fear” and “anxiety” for example will allow researchers to better understand what it is they are studying. As a result, when death anxiety is presented to students there will be consistency in its definition for researchers and educators alike. Meanwhile, efforts should continue to expand on the existing body of literature on death anxiety and its presence in employees who work in settings with high death exposure. While the majority of research on death anxiety has centered on nursing, more attention should be paid to hospice employees in general. Hospice employees provide a unique death experience for the patient and the patient’s friends and family. Additionally, the patient is given more choice than he or she would typically have in a hospital, and the focus is on allowing the patient to die comfortably and with dignity.

Hospices provide a valuable service and the hospice movement is growing. The majority of the U.S. public wants to ensure hospices remain available so that the patient’s wishes are honored (Kastenbaum, 2003). To make this possible, death education must continue and for that reason, research of this nature must continue as well. Ultimately, all
parties involved in the end of a life will benefit from a better understanding of how a hospice employee’s work influences his or her death anxiety. If it is determined that hospice employees have low death anxiety, future studies may seek to understand why this is. On the contrary, if it is determined hospice employees are experiencing high levels of death anxiety, action may be taken by hospice facilities to enhance employee well-being. In either case, by taking care of the hospice employee, a higher level of care will be provided to the patient and the patient’s friends and family.
Chapter Three: Methods

The research question “What is the relationship between death anxiety and length of time employed in a hospice or palliative care setting?” was addressed in this study. This was a quantitative study which used a single instrument, the Revised Death Anxiety Scale (RDAS), to assess for death anxiety. At the conclusion of the survey, I asked participants to indicate their age, gender, current position and length of time employed in a hospice or palliative care setting. First, I considered the correlation between the two variables identified in the research question. Then, I considered the correlation between RDAS scores and age. Finally, I looked at within group differences between nurses and non-nurses. Results of this study will be submitted to academic journals to be considered for publication. They will also be shared with the hospice in which the study took place.

Setting

This study took place at a hospice in southern Wisconsin. There were a total of 544 employees when the research was conducted. This included 481 females and 63 males. The mean age of male employees was 43 years while the mean age of female employees was 45 years. Finally, the staff averaged 3.82 years of employment at the time of the study. The RDAS was administered to employees individually throughout the building and to larger groups in meetings held in various locations throughout the building.

Participants

I used convenience sampling for my study. There were a couple of reasons I chose to use convenience sampling. First, I happened to be interning in the grief services
department at this particular hospice. Therefore, I had access to numerous groups and individuals. I was given permission by the human resources department and the Grief Services Manager to attend meetings and to approach employees individually regarding the study. This site and the access I had to it allowed me to fill a gap in the literature by directly studying the hospice employee’s experience. I worked alone on data collection, survey scoring and data analysis. Finally, this research took place with limited resources other than a modest research grant from the University of Wisconsin-Whitewater School of Graduate Studies.

I attempted to survey a diverse sample within the setting by attending various meetings and approaching participants individually. The initial intended sample was 150. The final sample was 128. This consisted of 65 nurses, 22 administrative staff, 17 social workers, nine grief counselors, six chaplains, five supervisors/managers, three doctors and one pharmacist. There were 22 surveys that had to be thrown out because participants did not indicate their length of time employed in a hospice or palliative care setting. Of the 128 participants, 118 were female and 10 were male.

**Instrument**

The Revised Death Anxiety Scale (RDAS) was used to assess for death anxiety (Neimeyer, 1994) (Appendix A). Neimeyer noted in the *Death Anxiety Handbook* that researchers have permission to use the RDAS provided they cite this book as the source. The RDAS consists of 25 statements in which respondents are asked to agree or disagree with each statement based on a five-point Likert scale. At the conclusion of the survey, I asked participants to indicate their age, gender, current position and length of time
employed in a hospice or palliative care setting. This information was collected so that a correlational analysis could be conducted between each of the variables and RDAS scores in the data analysis.

**Validity and reliability.** From 1977 to 1990, Thorson and Powell (1992) conducted numerous studies in the development and eventual publication of the RDAS. By including responses from their previous studies, the final sample used to determine validity and reliability included a total of 346 individuals ranging in age from 18 to 88. The result was a mean score of 43.6 ($SD=23.4$). The authors determined the Cronbach alpha of reliability to be .83 in their final analysis of the data. Thorson and Powell (1992) concluded that the RDAS achieved acceptable levels of reliability in its use among large, diverse samples. Further, they acknowledged that future researchers may consider using other instruments that account for the multiple dimensions and complexity of death anxiety. However, the RDAS was recommended for its convenient administration to larger samples. Thus, given the large sample size and the fact that I would be handing out surveys, scoring the surveys and analyzing the data myself, I chose to measure death anxiety using the RDAS over other scales presented in the Death Anxiety Handbook (Neimeyer, 1994).

**Procedures**

Data collection took place in April and May 2012. I handed out most of the surveys and informed consent forms (Appendix B) at the beginning of meetings. These meetings were interdisciplinary team meetings and were made up of nurses, administrative staff, social workers, grief counselors, chaplains, supervisors/managers,
doctors and pharmacists. I handed out approximately 25 surveys individually. Lastly, I did not handle any of the data until all of the surveys and informed consent forms had been submitted to the Grief Services Manager.

I administered all of the surveys. To ensure anonymity in meetings, I left the room before participants began completing the surveys. I left two large manila envelopes in the room and asked one of the participants to be responsible for delivering the envelopes to the Grief Services Manager following the meeting. One envelope was labeled “Completed Informed Consent Forms” and the other was labeled “Completed Surveys”. The individual responsible for the envelopes delivered them to the Grief Services Manager following the meeting. The completed informed consent forms and surveys were kept in the Grief Services Manager’s office until data collection was complete. In cases when I approached individual employees, I provided them with two envelopes which they were asked to seal and give to the Grief Services Manager at their earliest convenience. These envelopes were labeled “Completed Informed Consent Form” and “Completed Survey”.

When I approached potential participants either in a group or individually, I stated, “I am doing research for my thesis for my master’s degree. I am interested in learning more about how the work you do here relates to your views toward your own death. I was wondering if you would be willing to fill out a brief survey. It should not take you more than ten minutes to complete. You do not have to take the survey if you don’t want to. These three forms have more information. The top consent form is for you to read and sign if you agree to participate in the study. The second is a copy of the
consent form for you to keep for your records. It is identical to the copy you are being asked to sign, except that it does not include a section for your signature. The third form is the survey.” I then handed the potential participants the informed consent forms and surveys and left the room.

**Additional Ethical Considerations.** Permission to recruit participants was obtained from the human resources department and the Grief Services Manager at the hospice in which the study took place. I personally recruited all of the participants without the use of phone or email. Further, no recruiting materials were used in this process. Permission to conduct this study was also granted by the University of Wisconsin-Whitewater Internal Review Board for the Protection of Human Subjects.

The RDAS includes 25 questions that caused participants to consider aspects of their own death, including life circumstances that could lead to death. In the case that participants felt disturbed by the questions, they were provided with information on how to receive assistance. The informed consent form directed them to contact the Grief Services Manager for resources and support if needed.

**Data Analysis**

As the primary researcher, I scored all of the surveys and entered each participant’s RDAS score, age, gender and length of time employed in a hospice or palliative care setting into a spreadsheet. First, I computed the mean and standard deviation of the RDAS scores and length of time employed in a hospice or palliative care setting. Then, I conducted a correlational analysis to determine whether or not a statistically significant relationship existed between RDAS scores and length of time
employed in a hospice or palliative care setting. I also conducted a correlational analysis to determine whether or not there was a statistically significant relationship between RDAS scores and age.

I also looked for within group differences in RDAS scores. Specifically, since slightly over half of the sample was comprised of nurses, I wanted to see if there was a statistically significant difference in the correlation between the two groups in the RDAS score and length of time employed in a hospice or palliative care setting. This portion of the data analysis included a $t$-test to determine whether to reject or fail to reject the null hypothesis. Finally, I compared the mean RDAS scores in my study to Thorson and Powell’s (1992) original study. I also compared the scores in my study to a more recent study which implemented the RDAS in palliative nurses and a sample from the general population (Halliday & Boughton, 2008).
Chapter Four: Results

The research question “What is the relationship between death anxiety and length of time employed in a hospice or palliative care setting?” was addressed in this study. The Revised Death Anxiety Scale (RDAS), with a possible score ranging from zero (no death anxiety) to one hundred (highest level of death anxiety), was used to assess death anxiety. At the conclusion of the survey, participants were asked to provide their age, gender, position and length of time employed in a hospice or palliative care setting. The correlation between RDAS score and length of time employed in a hospice or palliative care setting, the correlation between RDAS score and age, and the difference between nurses and non-nurses in RDAS score and length of time employed in a hospice or palliative care setting were considered.

The mean score on the RDAS for all respondents was 40.94 ($SD = 13.33$) and the mean length of time employed in a hospice or palliative care setting was 5.03 years ($SD = 4.68$). Scores on the RDAS ranged from 12 to 84 and length of time employed in a hospice or palliative care setting ranged from two months to 35 years. The relationship between the two variables was slightly negative ($r= -.22$). However, because the relationship was not statistically significant there was a failure to reject the null hypothesis. Results from the surveys are presented in Table 1.
Table 1.

*Mean Scores on the RDAS for Employees in the Hospice Setting*

<table>
<thead>
<tr>
<th>Position</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>65</td>
<td>42.14</td>
<td>21.13</td>
</tr>
<tr>
<td>Administrative Staff</td>
<td>22</td>
<td>43.36</td>
<td>15.66</td>
</tr>
<tr>
<td>Social Workers</td>
<td>17</td>
<td>38.47</td>
<td>11.00</td>
</tr>
<tr>
<td>Grief Counselors</td>
<td>9</td>
<td>36.44</td>
<td>13.74</td>
</tr>
<tr>
<td>Chaplains</td>
<td>6</td>
<td>35.67</td>
<td>5.50</td>
</tr>
<tr>
<td>Supervisors/Managers</td>
<td>5</td>
<td>46.60</td>
<td>10.40</td>
</tr>
<tr>
<td>Doctors</td>
<td>3</td>
<td>27.33</td>
<td>8.18</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1</td>
<td>41.00</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The mean age of participants was 43 years and participants ranged in age from 21 to 68 years. There was a slightly negative ($r=-.17$) relationship between age and RDAS scores. Additionally, this negative correlation was not statistically significant ($p=.05$). Therefore there was a failure to reject the null hypothesis. The correlation between age and RDAS scores is displayed in the figure below. Please note that this scatter plot includes 127 participants from the sample since one participant did not indicate his or her age.
Since approximately half of the sample (n=65) was comprised of nurses and the other half (n=63) consisted of “non-nurses” (social workers, administrative staff, grief counselors, chaplains, supervisors/managers, doctors and pharmacists), these two groups were compared in the data analysis as well. On the RDAS, nurses had a mean score of 42.14 while non-nurses had a mean score of 39.70. Both groups showed a negative correlation when comparing RDAS scores with length of time employed in a hospice or palliative care setting. However, there was a large difference between the levels of correlation. Nurses had a -.07 correlation while non-nurses displayed a -.32 correlation when the length of time employed in a hospice or palliative care setting was compared to their RDAS scores. Additionally, the negative correlation for non-nurses was statistically significant (p=.011). Therefore, there was a failure to reject the null hypothesis that there would not be a statistically significant relationship between RDAS scores and length of time employed in a hospice or palliative care setting.

A t-test was also conducted between the RDAS scores achieved by nurses and
non-nurses ($p=.30$). Based on the results of the t-test, there was a failure to reject the null hypothesis. In other words, the t-test confirmed that there was not a significant difference between nurses’ and non-nurses’ RDAS scores.
Chapter Five: Discussion

The hospice movement and death education are new and growing endeavors. The first modern hospice, Hospice Inc. based in Connecticut, began offering home services in 1974 and a residential unit in 1978 (Howarth & Leaman, 2001). Death education did not enter the U.S. classroom until the 1960s and early 1970s (Caine, 2010). It was at this time that Robert Kastenbaum, a pioneer in death studies, became distressed that students in fields ranging from social services to medicine were not being taught about death. Kastenbaum referred to the clients and patients these students were being trained to work with as “hypothetical people” who did not grow old or die. As a result of his dismay, Kastenbaum founded the first death education course in the United States.

Because hospices and death education remain new to the western world, much of the success of the hospice movement, including its benefits and its shortcomings, has yet to be determined. Research into factors that assist someone in dying a peaceful death and specific components of dying such as death anxiety will shed light on how we can better serve those on a journey we must all take at some point in our lives. For the most part, research in death anxiety has been restricted to nurses working in hospitals in emergency rooms or oncology units. The impact of death on counselors, social workers and funeral directors has been moderately covered in the research. However, how hospice and palliative care employees view their own mortality remains a newer venture within this already young field.

The purpose of this quantitative study was to determine if a correlation existed between death anxiety and length of time employed in a hospice or palliative care setting.
I attempted to create a diverse sample since researchers have recommended examining death anxiety in a wide variety of professionals who work with the dying, the dead and their loved ones (Chen, Ben, Fortson, & Lewis, 2006; Harrawood, White, & Benshoff, 2008). Death anxiety was assessed in a hospice in southern Wisconsin using the Revised Death Anxiety Scale (RDAS) (Neimeyer, 1994). In addition to completing the RDAS, participants were also asked to indicate their age, gender and current position. Age and RDAS scores were also considered in a correlational analysis. Lastly, differences in correlations and levels of statistical significance between nurses and non-nurses were examined. Overall, the intent of this study was to fill a gap in the research on death anxiety and on death and dying, and to provide a foundation for future research.

Results indicated a weak, negative correlation between RDAS scores and length of time employed in a hospice or palliative care setting. Additionally, mean scores on the RDAS varied within the groups surveyed. For instance, although only three doctors were included in the study, their mean score was only 27.33 ($SD=8.18$). This was an extremely low score, especially when compared to nurses and administrative staff, the two largest groups in the study. Nurses ($n=65$) had a mean score of 41.14 ($SD=21.13$) and administrative staff ($n=22$) had a mean score of 43.36 ($SD=15.66$). One theory when comparing the scores between doctors and nurses might be that doctors spend less time with patients and therefore have less death anxiety than nurses who are more hands-on. This would not however, be consistent with other findings (Halliday & Boughton, 2008; Harrawood, White, & Benshoff, 2008). It would also not explain why administrative staff, who likely spend less time with patients than doctors and nurses, scored slightly
higher than nurses. In fact, administrative staff scored the highest in the study second
only to supervisors and managers.

Perhaps hospice employees simply have a lower fear of death than the general
population. It has been 20 years since the original publication of the RDAS (Thorson &
Powell, 1992). Thus, while the scores from the present study reflect low average to below
average levels of death anxiety when compared to the samples used by Thorson and
Powell, more recent studies should be used when comparing death anxiety scores.
Therefore, when compared to a more recent study which implemented the RDAS in
palliative nurses and in the general population (Halliday & Boughton, 2008), the hospice
employees in the present study reported considerably lower death anxiety. Halliday and
Boughton discovered the mean score for palliative nurses on the RDAS to be 60.35
(\(SD=11.16\)) and 73.4 (\(SD=12.32\)) in the general population. On the other hand, nurses in
the present study obtained a mean score of 42.14 (\(SD=13.13\)). All of the hospice
employees surveyed in the study had a mean score of 40.94 (\(SD=13.33\)). In fact, of the
128 total employees surveyed in this study, only 10 scored higher than 60. This means
that only 10 scored higher than the mean score for palliative nurses in Halliday and
Boughton’s study.

It could also then be argued that hospice employees in this particular setting have
lower death anxiety than employees in other hospices. One reason for this may be the
hospice in this study provides an environment that keeps anxiety in its employees at bay.
This could be accomplished through the employee training programs, ongoing efforts to
promote employee well-being and other general aesthetic factors that put the employee at
ease. For instance, all new employees are required to attend a one week training which covers extensively the hospice experience. Also, there are activities organized both on and off site for employees. These activities recently included yoga once a week, a minor league baseball game and free tickets to the opera. Finally, the physical appearance of the hospice facility is maintained to a high standard. A fountain with a memorial brick walk greets visitors as they enter, and numerous trees, plants and flowers surround the building. The inside is decorated with memorial quilts and weavings, local art, and live plants and flowers. As Payne, Dean and Kalus (1998) noted in their study, the structure of a setting could have prominent influence on employees’ attitudes and feelings.

The second conclusion noted in the results was the weak but non-statistically significant correlation between RDAS scores and age ($p=.05$). It should be noted how close this negative correlation was to being statistically significant. Often in research an alpha level less than .05 is considered to be statistically significant. A negative correlation between death anxiety and age is consistent with previous studies (Harrawood, White, & Benshoff, 2008; Russac, Gatliiff, Reece, & Spottswood, 2007).

The third and final analysis of the data compared nurses to non-nurses in their correlation between RDAS scores and length of time employed in a hospice or palliative care setting. While the $t$-test did not reveal a statistically significant difference between the two groups, there was a large gap in the statistical significance of the correlations between the two variables. Nurses had a weak and statistically insignificant correlation of -.07 when their length of time employed in a hospice or palliative care setting was compared to their RDAS scores. Non-nurses on the other hand, displayed a much greater
and statistically significant correlation of -.32.

There are several reasons why non-nurses may have demonstrated a statistically significant negative correlation between RDAS score and length of time employed in a hospice or palliative care setting while nurses did not. First, nurses are more likely to be exposed to death regardless of work environment. Therefore, unless it is his or her first job, a nurse beginning employment in a hospice has likely confronted death in a previous job. A non-nurse such as a social worker or grief counselor beginning employment in a hospice setting may be coming from an environment in which death was virtually a non-factor. For example, while this individual may have dealt with the occasional grieving client, he or she likely did not view death as a persistent part of the work day as a nurse typically would. Also, nurses may be more adequately prepared for life and death situations in their training. Besides other medical professionals such as doctors, non-nurses likely have not received extensive education in death and dying. Thus, it could be argued that even without previous work experience, nurses are better prepared for death. Therefore the nature of previous work and the training content may play a factor in nurses experiencing lower levels of death anxiety throughout the span of their career. Non-nurses on the other hand, may not have the luxury of such preparation either through their previous work experience or their education. Thus when beginning work in a hospice, a non-nurse may experience heightened death anxiety. As time goes on however, and as this study may indicate, death anxiety tapers with death experience.

Limitations

There were a few limitations to note in this study. First, there was the lack of a
control group. Without a control group, I could not compare the RDAS scores from the participants in the study to the general population. Another limitation was the lack of a diverse sample. The majority of the participants were female and approximately half of the participants were nurses. The next limitation to note was the fact that I used convenience sampling in a single hospice in which I was already working as an intern. Convenience sampling makes it difficult to generalize the results to the entire population. Further, my relationship with employees as an intern may have influenced their responses. Finally, the simplicity of the RDAS itself was a limitation. Indeed the RDAS is a brief, easy-to-score instrument which offers the convenience of administration to larger samples. However, even Thorson and Powell (1992) suggested other instruments may better account for the multidimensional nature of death and individual perceptions toward death.

**Recommendations for Future Research**

There are numerous recommendations for future research. First, a control group from the general population could be used. This would allow researchers to compare death anxiety scores of hospice employees to scores from the general population. Second, a more diverse, representative population could be sampled. This might be accomplished by including more than one hospice facility in the study, more males in the study and an adequate representation from each of the positions within a hospice. Third, a different instrument could be used to account for individual perceptions and the various aspects of death that one might fear. This instrument could be the MFODS, which was used in many of the studies mentioned in the literature review. Finally, qualitative and longitudinal
studies may shed light on why people fear or do not fear death. Researchers could inquire why people chose to work in a hospice, and a study of this nature would be a natural follow-up to this research and to other research. For example, Simons and Park-Lee (2009) determined in a sample of social workers that the desire to work in a hospice setting resulted in a higher level of comfort in providing end-of-life care. A logical follow-up question to such a discovery would be why these particular individuals chose to work in a hospice in the first place.

Since the present study resulted in much lower RDAS scores than another recent study (Halliday & Boughton, 2008), a qualitative study at the hospice in which this study took place might be a beneficial next step. A study of this nature could include follow-up questions and interviews that may reveal why death anxiety scores were so low. Perhaps like the funeral directors in Harrawood, White and Benshoff’s (2008) study, the feeling that they are providing a vital service to the dying, the dead and their families overrides any feelings of anxiety for the hospice employee. Additionally, a longitudinal study could better address the research question and shed light on whether or not a relationship exists between death anxiety and length of time employed in a hospice or palliative care setting. Finally, a longitudinal study may uncover specific experiences that correlate positively or negatively with death anxiety.

**Conclusion**

Whether or not and how often we choose to confront our mortality is a personal decision. We may choose to ignore death until it is too late, living out our lives in a busy, distracted stupor as if tomorrow is always a certainty. Or, we may as Martin Luther
suggested, live in constant awareness of death with the taste of it on our lips (Becker, 1973). Perhaps there is a middle ground somewhere. Regardless, there are two certainties to this life. First, there is the certainty that we will all die. Second, there is the certainty in the uncertainty of how or when we will die (Rinpoche, 2002). Bearing this in mind, there has recently been a new way to die peacefully recognized in our western world. This is thanks to the growing hospice movement. With its increased acceptance as a comfortable exit from this earth, we have the benefit of learning precious lessons from the dying and those surrounding their deathbed. As Kubler-Ross (1967) reminded us, “Those who have the strength and the love to sit with a dying patient in the silence that goes beyond words will know that this moment is neither frightening nor painful” (p. 276). We should therefore continue to study and to learn from these teachers so that we may face our own death not as a failure but as the final triumph of having lived a fulfilling and meaningful life. After all, by boldly asking ourselves how to die a better death, we may discover we are actually teaching each other how to live better lives.
References


United States funeral directors and its relationship with death exposure, age, and sex. *Omega, 58*(2), 129-146.


Appendix A

Revised Death Anxiety Scale (Thorson & Powell)

For each item, circle Strongly Agree, Agree, Neutral, Disagree, or Strongly Disagree:

1. I fear dying a painful death.
   Strongly Agree                Agree                Neutral                Disagree               Strongly Disagree

2. Not knowing what the next world is like troubles me.
   Strongly Agree                Agree                Neutral                Disagree               Strongly Disagree

3. The idea of never thinking again after I die frightens me.
   Strongly Agree                Agree                Neutral                Disagree               Strongly Disagree

4. I am not at all anxious about what happens to the body after burial.
   Strongly Agree                Agree                Neutral                Disagree               Strongly Disagree

5. Coffins make me anxious.
   Strongly Agree                Agree                Neutral                Disagree               Strongly Disagree

6. I hate to think about losing control over my affairs after I am gone.
   Strongly Agree                Agree                Neutral                Disagree               Strongly Disagree

7. Being totally immobile after death bothers me.
   Strongly Agree                Agree                Neutral                Disagree               Strongly Disagree

8. I dread to think about having an operation.
   Strongly Agree                Agree                Neutral                Disagree               Strongly Disagree

9. The subject of life after death troubles me greatly.
   Strongly Agree                Agree                Neutral                Disagree               Strongly Disagree

10. I am not afraid of a long, slow dying.
    Strongly Agree                Agree                Neutral                Disagree               Strongly Disagree

11. I do not mind the idea of being shut into a coffin when I die.
    Strongly Agree                Agree                Neutral                Disagree               Strongly Disagree
12. I hate the idea that I will be helpless after I die.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

13. I am not at all concerned over whether or not there is an afterlife.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

14. Never feeling anything again after I die upsets me.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

15. The pain involved in dying frightens me.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

16. I am looking forward to new life after I die.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

17. I am not worried about ever being helpless.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

18. I am troubled by the thought that my body will decompose in the grave.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

19. The feeling that I will be missing out on so much after I die disturbs me.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

20. I am worried about what happens to us after we die.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

21. I am not at all concerned with being in control of things.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

22. The total isolation of death is frightening to me.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

23. I am not particularly afraid of getting cancer.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

24. I will leave careful instructions about how things should be done after I am gone.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>
25. What happens to my body after I die does not bother me.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

Your Age: _____  Gender: _____
Length of time employed in a hospice or palliative care setting: _____ Years _____ Months
Current Position (check one):

- [ ] Social Worker
- [ ] RN
- [ ] CNA
- [ ] LPN
- [ ] NP
- [ ] Pharmacist
- [ ] Doctor
- [ ] Chaplain
- [ ] Grief Counselor
- [ ] Administrative
- [ ] Facilities
- [ ] Food Service
- [ ] Supervisor/Manager
- [ ] Volunteer Coordinator
- [ ] Other (please specify)
Appendix B

Consent for Participation in Research
Assessing Death Anxiety in Individuals Working in a Hospice Setting
Researchers: Aaron Jonasen and Brenda Rust O’Beirne, Ph.D.

This document outlines research being conducted by Aaron Jonasen for his Master’s Thesis as part of earning his MS in Counseling from the University of Wisconsin-Whitewater. Please read this document carefully and ask any questions before signing below.

Background
The purpose of this study is to assess your level of death anxiety. The researchers are interested in understanding how employees of a hospice or palliative care setting view their own mortality.

Elements of the Study
The Revised Death Anxiety Scale (RDAS) is a 25 question survey in which you will be asked to agree or disagree with each statement based on a five-point Likert scale. The survey should take no longer than 10 minutes to complete. If you have been provided with manila envelopes labeled “Completed Surveys” and “Completed Informed Consent Forms,” please place your signed informed consent form and completed survey in the appropriate envelope. If you have been given two letter-sized envelopes labeled “Completed Survey” and “Completed Informed Consent Form,” please give both sealed envelopes to Cheri Milton, Grief Services Manager at your earliest convenience and no later than May 4th, 2012.

Risks
The survey includes 25 questions that will cause you to consider aspects of your own death, including life circumstances that could lead to your death. If these thoughts make you uncomfortable, please consider not taking the survey. If you feel troubled after taking the survey, please contact Cheri Milton at 276-4660 for a follow-up consultation. Arrangements will be made to ensure you receive adequate support.

Participation
You may choose not to take this survey. There will be no repercussions for not participating.

Benefits
There are ways in which you may benefit from this study. First, by considering your own death, you may discover a greater urgency to live a healthier and more meaningful life. You may also benefit by being reminded of the valuable service you provide at Agrace HospiceCare. Finally, Agrace HospiceCare as a whole may benefit by understanding how work in a hospice setting relates to attitudes towards an employee’s own death.
Confidentiality
Every effort will be made to maintain your confidentiality. The only identifiable information you will be asked to give is your age, gender, position, and length of time employed in a hospice or palliative care setting. Surveys will be gathered in a large manila envelope which Cheri Milton will keep in her possession. The contents of the envelope will not be analyzed by the researchers until all surveys have been collected.

Contacts and Questions
If you have questions regarding this study, please contact:

Aaron Jonasen
Phone: 414-530-5438 Email: JonasenAM01@uww.edu

Brenda O’Beirne
Winther Hall #6047
UW-Whitewater
800 West Main Street
Whitewater, WI 53190
Office Phone: (262) 472-1452 Email: obeirneb@uww.edu

Additional questions or concerns may be directed to:

Denise Ehlen
Director of Office of Research and Sponsored Programs
800 West Main Street
Whitewater, WI 53190
Phone: 262-472-5212 Email: ehlend@uww.edu

Statement of consent
I have read the above information and consent to participate in the study.

Name (Print)__________________________________________________________________

Signature_____________________________________________Date______________

Signature of Investigator___________________________________________Date______________

Please sign and date this form and place it in the provided envelope. You have also received an additional form attached to this form. The second form is provided for you to keep for your records. It is identical to the form you are signing, except it does not include a section for you to sign or this disclaimer at the bottom.
Consent for Participation in Research
Assessing Death Anxiety in Individuals Working in a Hospice Setting
Researchers: Aaron Jonasen and Brenda Rust O’Beirne, Ph.D.

This document outlines research being conducted by Aaron Jonasen for his Master’s Thesis as part of earning his MS in Counseling from the University of Wisconsin-Whitewater. Please read this document carefully and ask any questions before signing below.

Background
The purpose of this study is to assess your level of death anxiety. The researchers are interested in understanding how employees of a hospice or palliative care setting view their own mortality.

Elements of the Study
The Revised Death Anxiety Scale (RDAS) is a 25 question survey in which you will be asked to agree or disagree with each statement based on a five-point Likert scale. The survey should take no longer than 10 minutes to complete. If you have been provided with manila envelopes labeled “Completed Surveys” and “Completed Informed Consent Forms,” please place your signed informed consent form and completed survey in the appropriate envelope. If you have been given two letter-sized envelopes labeled “Completed Survey” and “Completed Informed Consent Form,” please give both sealed envelopes to Cheri Milton, Grief Services Manager at your earliest convenience and no later than May 4th, 2012.

Risks
The survey includes 25 questions that will cause you to consider aspects of your own death, including life circumstances that could lead to your death. If these thoughts make you uncomfortable, please consider not taking the survey. If you feel troubled after taking the survey, please contact Cheri Milton at 276-4660 for a follow-up consultation. Arrangements will be made to ensure you receive adequate support.

Participation
You may choose not to take this survey. There will be no repercussions for not participating.

Benefits
There are ways in which you may benefit from this study. First, by considering your own death, you may discover a greater urgency to live a healthier and more meaningful life. You may also benefit by being reminded of the valuable service you provide at Agrace HospiceCare. Finally, Agrace HospiceCare as a whole may benefit by understanding how work in a hospice setting relates to attitudes towards an employee’s own death.
Confidentiality
Every effort will be made to maintain your confidentiality. The only identifiable information you will be asked to give is your age, gender, position, and length of time employed in a hospice or palliative care setting. Surveys will be gathered in a large manila envelope which Cheri Milton will keep in her possession. The contents of the envelope will not be analyzed by the researchers until all surveys have been collected.

Contacts and Questions
If you have questions regarding this study, please contact:

Aaron Jonasen
Phone: 414-530-5438 Email: JonasenAM01@uww.edu

Brenda O’Beirne
Winther Hall #6047
UW-Whitewater
800 West Main Street
Whitewater, WI 53190
Office Phone: (262) 472-1452 Email: obeirneb@uww.edu

Additional questions or concerns may be directed to:

Denise Ehlen
Director of Office of Research and Sponsored Programs
800 West Main Street
Whitewater, WI 53190
Phone: 262-472-5212 Email: ehlend@uww.edu