

**DEALING WITH LOSS: A HOSPITAL INSERVICE**

**TRAINING PROGRAM**

**by**

**Loretta Wideen**

**B.A., Simon Fraser University, 1979**

**A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE**

**REQUIREMENTS FOR THE DEGREE OF**

**MASTER OF ARTS (EDUCATION)**

**in the Faculty**

**of**

**Education**

**© Loretta Wideen 1988**

**SIMON FRASER UNIVERSITY**

**November, 1988**


**All rights reserved. This thesis may not be reproduced in whole or in part, by photocopy or other means, without permission of the author**

APPROVAL

Name: Loretta Mae Wideen  
Degree: Master of Arts (Education)  
Title of Project: Dealing With Loss: A Hospital Inservice  
Training Program  
Examining Committee:  
Chair: Cornel M. Hamm

\_\_\_\_\_  
Selma Wassermann  
Senior Supervisor

\_\_\_\_\_  
James E. Marcia  
Professor

\_\_\_\_\_  
Dr. Anneliese M. Robens  
  
External Examiner

Date Approved Nov. 29, 1988

PARTIAL COPYRIGHT LICENSE

I hereby grant to Simon Fraser University the right to lend my thesis, project or extended essay (the title of which is shown below) to users of the Simon Fraser University Library, and to make partial or single copies only for such users or in response to a request from the library of any other university, or other educational institution, on its own behalf or for one of its users. I further agree that permission for multiple copying of this work for scholarly purposes may be granted by me or the Dean of Graduate Studies. It is understood that copying or publication of this work for financial gain shall not be allowed without my written permission.

Title of Thesis/Project/Extended Essay

---

Dealing With Loss: A Hospital Inservice Training Program

---

---

Author:

(signature)

Loretta Mae Wideen

---

(name)

Nov. 29, 1988

---

(date)

## Abstract

This study addressed the problem of inadequate attention to the emotional aspect of nursing care. The literature attributes this problem both to nurses' avoidance of dying patients and to their poor communication skills. Based on review of the death/dying literature including previous studies conducted to educate nurses regarding death/dying and training in communication skills, an inservice training program was developed for nurses. It sought to promote increased awareness of and sensitivity to patients' emotional distress when experiencing loss and to provide the nurses with communication skills to cope more effectively. The inservice training program was based on a phenomenological-fulfillment model and used an integrative approach recommended by Carkhuff with didactic, experiential and modeling components. The program, involving ten contact hours over a five-week period, was given to ten nurses and one occupational therapist from medical wards in an acute-care hospital.

In the quasi-experimental design used to evaluate the inservice training program, two null hypotheses were tested. One sought to determine attitudinal changes using a Death Attitude Questionnaire. The second examined written and audio-taped responses of subjects in a helper's role. Two independent, trained raters evaluated the responses according to Carkhuff's Index of Communication. A t-test was used to compare the pre- and post-training scores and the questionnaire items were correlated with the independent variables. A third hypothesis investigated the post-training changes observed in nursing care on the ward. Analysis of descriptive data included pre- and post-program samplings of nurses' charting and handovers, a post-program interview of the charge nurse, and a case study of one participant which involved pre- and post-program shadowing and interviews.

Results of the study showed no significant attitudinal change as measured by the Death Attitude Questionnaire. Significant improvements occurred on the measures for written and verbal responses of the participants indicating an increased ability to communicate empathically. Data from the work setting showed mixed results. Some

attitudinal and communication changes were observed and expressed when the investigator was present on the ward but these changes did not extend to nurses recordings of nursing care.

Several implications arose from the study: the necessity and appropriateness of this type of hospital inservice training and retraining for nursing staff to establish effective "helping relationships"; the possibility of varying approaches to meet the needs of different age groups, different shifts, different work settings; and the benefits of a team approach which encompasses all medical staff on each ward to promote emotional support and facilitate interpersonal communication.

Recommendations for further research include cross-sectional studies with nurses from different settings and different age groups, longitudinal case studies investigating long-term effects and retraining needs for effects maintenance, quasi-experimental research to investigate the impact of training all nursing staff from one ward, and an experimental research design to determine the effect of the charting format on nurses' attention towards emotional aspect of nursing care.

## Quotation

"He who has a why to live for  
can bear almost any how".

Nietzsche (Frankl, 1946: 121)

## Acknowledgements

For her enabling support of me in this research endeavor, special appreciation to my advisor Dr. Selma Wassermann. Her modeling of facilitative communication and editing expertise was a motivator and resource throughout the study.

Thanks are also extended to

Dr. Jim Marcia, for serving as a member of my committee,

Royal Columbian Hospital staff for participating in the study,

Ms Joanne Konnert, Director of Nursing, for facilitating the study within the hospital setting,

Marvin for listening,

Brian for reducing computer frustration

my family for enabling weekend gatherings in spite of my preoccupation,

my friends for balancing my life with other fun activities.

Appreciation is also expressed to

Universal Press Syndicate, Kansas City, for permission to reprint cartoons by Bill Watterson and Jim Unger,

## Table of Contents

APPROVAL.....	ii
ABSTRACT.....	iii
QUOTATION.....	v
ACKNOWLEDGEMENTS.....	vi
TABLE OF CONTENTS .....	vii
LIST OF TABLES AND FIGURES.....	x
CHAPTER I	
DEALING WITH LOSS: A HOSPITAL INSERVICE TRAINING PROGRAM.....	1
Introduction.....	1
Problem.....	1
Purpose of the study .....	3
Hypotheses under investigation.....	5
Limitations.....	6
Definition of terms.....	7
Conclusion.....	8
CHAPTER II	
LITERATURE REVIEW .....	9
Denial of death .....	9
Rationale for nurses learning about grieving .....	11



The signs and symptoms of patients' grieving .....	17
Rationale for teaching empathic communication skills .....	19
How have others approached the problem? .....	22
Conclusion.....	28

CHAPTER III

METHODOLOGY AND RESEARCH DESIGN.....	31
--------------------------------------	----

The development of the inservice training program.....	33
Implementation of the inservice program .....	40
The site.....	40
Participants .....	41
Therapist.....	42
Putting the inservice program into action.....	43
Research design .....	45
Procedure used to gather data for Hypothesis I.....	46
Discussion .....	46
Instrument.....	47
Procedures used to gather data for Hypothesis II .....	51
Discussion .....	51
Instruments .....	52
Rating procedure.....	54
Raters.....	55
Procedures used to gather data on Hypothesis III.....	56
Discussion .....	56
Charts and Handover reports.....	57
Interview of charge nurse. ....	59
Case Study. ....	59
Conclusion.....	62

CHAPTER IV

RESULTS AND DISCUSSION .....	64
------------------------------	----

Introduction.....	64
Results .....	64

Hypothesis I: There will be no significant difference between pre- and post- measures in the Death Attitude Questionnaire.....	64
Hypothesis II: There will be no significant difference between pre- and post- written and audio-taped responses of empathic communication.....	65
Hypothesis III: There will be attitudinal and communication changes after the inservice program which will be demonstrated in actual nursing care on the ward.....	67
Discussion of the Results.....	78
To determine if there was an attitudinal change towards death and dying.....	79
To determine if there was improved communication skills in coping with patients' emotional distress.....	82
To determine if this inservice program had an impact on actual nursing care.....	86
Conclusions.....	89
Implications.....	90
Recommendations for Further Research.....	92
APPENDICES.....	93
A. Hospital Inservice Program Plan.....	94
B. Exercise 1.....	98
C. A Guide for Gaining Knowledge in Caring for the Grieving Patient.....	99
D. Sample Situations.....	107
E. Introduction to Empathic Communication for Health Care Workers.....	112
F. A Special Inservice on Palliative Care for Nurses.....	121
G (i). Demographic Data.....	122
G (ii). Demographic Data Results.....	125
H. Consent Form.....	126
I. Death Attitude Questionnaire.....	127
J. Communication Questionnaire.....	132
BIBLIOGRAPHY.....	137

## List of Tables and Figures

Table I—Items in Death Attitude Questionnaire With High Correlation to Total Score.....	49
Table II—Attitude Items Which Have Higher Correlation to Independent Variables .....	50
Table III—"Helpee" Statements Related to Emotions of Grieving in Questionnaire.....	53
Table IV—A Comparison of Pre-and Post-Mean Scores on Death Attitude Questionnaire .....	65
Table V—Comparison of Group Mean And Modal Scores Pre- and Post-Inservice Training of Empathic Communication .....	67
Table VI—A comparison of nurses' charting of emotional aspect of nursing care.....	68
Table VII—A comparison of the handover reports pre- and post-inservice program.....	69
Table VIII—Pre- and post-inservice program shadowing time observations of nursing activities* .....	72
Figure 1—A comparison of time spent in nursing activities .....	72
Figure 2—A comparison of pre- and post-inservice program responses of nurse when giving nursing care to patients .....	73
Table IX—A Comparison of Pre- and Post-Means of Items in Death Attitude Questionnaire .....	80
Table X—A Comparison of Individual Mean Scores of Written, Audio-taped and Modal Responses Rated For Empathy .....	84
Table XI—Correlation of Mean Scores for Empathic Communication With Independent Variable Age .....	85
Table XII—A comparison of patients' status pre- and post-inservice program observations .....	89

## Chapter I

### Dealing With Loss: A Hospital Inservice Training Program

#### Introduction

Thanks largely to stories and reports in the media, we, as a population, are constantly made aware of man's mastery over life through artificial means. From respirators, pacemakers, prosthesis, organ transplants, including the heart, all the way to the beginning of life--to test-tube babies--the control of vital life functions are increasingly within our grasp. Due to continually improved scientific discoveries and their applications, nurses in hospital settings, confronted daily with acute and chronic illness, have their feelings of competence in controlling illness and death continually reinforced. However, this focus on "science aspects of healing" have led to increased de-emphasis in the psycho-social concomitants of patient care. This study is directed towards this deficiency.

#### Problem

It is true that through the work of such pioneers in thanatology as Kübler-Ross, increased attention has been given to the psychosociological aspects of treatment in the care of the dying, an area which up to recent times was ignored. Palliative care units aimed at caring for the terminally ill patient have been created throughout North America and considerable work has been undertaken to find ways to bring comfort to patients and their families. Despite these developments, there remains a lack of attention to the emotional needs of patients in the general hospitals. Health care workers generally acknowledge the need for more attention to the emotional care of patients, but there is minimal evidence of action being taken in this regard. One typical reason given by nurses is lack of time; but more significantly, reasons may include: 1) avoidance, for personal reasons, and 2) lack of knowledge of appropriate communication skills.

Considerable literature supports the need for better psycho-social patient care. For instance, research suggests that nurses tend to adopt a "professional detachment" as a protective mechanism that results in avoiding patients' expressions of emotional

distress (Appleyard, 1982; Caty, Tamlyn, 1984; Fleming, Brown, 1983; Hopping, 1977; Johnston, 1985). The end result is a mechanical approach which alienates and dehumanizes patient care (Appleyard, 1982; Iveson-Iveson, 1983; Keck, Walther, 1977).

The lack of knowledge in effective communication with patients is well documented (Kübler-Ross, 1975; Llewelyn, Fielding, 1983; Hopping, 1979; Keck, Walther, 1977; Vachon, 1978). Vachon, interviewed nurses who were in the process of developing a new palliative care hospital, and found that when the nurses were attempting to meet the patients' psychosocial needs they became increasingly aware of their inadequate coping skills (Vachon, 1978). In response to interview questions, the nurses stated that their main difficulties were responding adequately to the patients' *feelings* about their illness, prognosis, and death. There was ". . . a lack of knowledge and skill in interpersonal relationships and a lack of communication skills", which contributed to a feeling of impotence in giving adequate care (p. 368). Similarly, Kastenbaum (1972), in a hospital survey, found that when concerns were expressed by the patients, eighty-two percent of the health-care attendants responding to those patients, used avoiding, pacifying or denying statements.

The literature reviewed focuses on the emotional distress of death and dying and the subsequent loss experienced by not only the patient, but the patient's family, friends and possibly health care workers involved in the patient's care. From this, a theory of grieving has evolved which provides a model for understanding and dealing with loss. Although there is some disagreement, later studies agree that loss extends beyond that experienced from death to loss of parts of the body and losses experienced through major life changes such as social status, goals, roles and relationships, i.e. divorce (Bowly, 1973; Kübler-Ross, 1975; Schoenberg, Carr, Peretz, Kutscher, 1970; Solnit, Stark, 1961; Scarf, 1980).

"...Certain losses, at certain moments of our lives when we feel unready, unprotected, unconfident of our ability to cope with and transcend them, may be experienced as an emotional starvation, as annihilation, as death."  
(Scarf, 1980, p. 202).

It follows then, that most patients encountered within the hospital are experiencing an acute crisis of "loss", either through the imminence of death, or other crippling events, and could be grieving.

The primary role of nurses in a hospital is that of "helper". To function in this role implies the provision of knowledgeable physical care including dispensing of medication, application of specific treatments and informative monitoring of the illness presented. However, another important expectation of this role is the interpersonal aspect of care. This aspect is essential when dealing with the emotional loss experienced by patients in the hospital. However, as noted above, nurses have a tendency to avoid dealing with the emotional aspect of care. This avoidance results in distancing of the patient, which leads to isolation, feelings of abandonment, increased fears and loneliness (Fleming, Brown, 1983; McCaffery, 1984; Pierce, Carkhuff, Berenson, 1967). Llewelyn states that ". . . failure to manage psychological distress can prolong and magnify physical pain." (1983:30). Consequently, nurses' avoidance and lack of coping skills can affect patients' degree of suffering and length of recovery.

To summarize, it is clear that hospitalized patients experience loss with subsequent emotional distress. What's more, there is recognition that there are inadequacies in patient care in regard to this psychological suffering. The reasons for this are attributed to nurses' avoidance and lack of knowledge of coping skills. Thus, the educational problem is how to develop a hospital inservice training program for nurses to: decrease the problem of avoidance of patients' emotional distress; and to teach them communication skills to deal with the patients' emotional distress more effectively.

#### Purpose of the study

The words "palliative care" have become synonymous with hospice and/or care of patients terminally ill with cancer. The dictionary term "palliate" in respect to a disease,

means "... to relieve ... to reduce the severity of. . . affording relief, but not cure . . . to reduce the violence of. . .". Thus, the focus has been on quality of life using a pain-free approach in a therapeutic milieu of emotional, spiritual and especially, family-supportive care. One cannot deny the value and contributions made from this endeavor in the past three decades. However, one disadvantage is that it has tended to specialize the care of the dying, and designate those requiring this special treatment only to those patients suffering from cancer. One possible consequence of a specialized unit could be the tendency to relegate "dying" to palliative care specialists with a subsequent decline of care of the dying in other areas of the hospital.

When one realizes that at least fifty percent of the population die in hospitals, it becomes clear that a specialized approach towards one disease is highly inadequate. There are many patients with a variety of illnesses in a hospital who do not require invasive and/or technological interventions and may be dying. However, even though the nurses in the hospital may be confronted with dying patients they do not have access to the benefits of what is generally found in palliative care units; i.e. the psychosocial aspects of care, the peer support, and/or the institutional support in caring for the dying.

The hospice approach has provided a milieu which fulfills the helper role in a total sense of patient care -- physical, emotional and spiritual. However, many nurses in the general hospital do not have this training or experience. These nurses become trapped in a "responsibility vacuum" in which they are aware of increasingly refined approaches to caring for the dying but they lack the confidence, interpersonal skills or psychosocial setting necessary to fulfil their role expectations.

The purpose of this study was to develop, implement and evaluate a hospital inservice training program utilizing the knowledge gained in death education programs for palliative care but transcending this approach to all patients suffering from loss and possible grieving. The design is essentially a fulfillment, phenomenological model -- fulfillment model in the sense that nurses are seen as having the potential to achieve growth through personal awareness and acquired sensitivity of self and others; and

phenomenological in the sense that nurses will acquire communication skills that allow them to enter the perceptual world of the patients.

The inservice program developed for this study sought to address the stated problem in two ways. First, it included training to help nurses deal directly with patients' emotional needs, making the tendency for avoidance less likely. Second, it included training in empathic communication skills, thereby enabling nurses to deal more comfortably and effectively with the emotional aspect of care.

The objectives which follow from the above stated purpose are:

1. To assess the attitudes of the participants towards death and dying and nursing care of dying patients.
2. To assess the levels of empathic communication skills by using Carkhuff's Index of Communication on written and audio-tapes completed by the participants.
3. To provide the participants with a training program designed to increase awareness and sensitivity to patients' emotional needs related to loss, and to increase empathic communication skills.
4. To test statistically the effectiveness of the training program in changing the participants' attitudes towards death and dying.
5. To test statistically the effectiveness of the training program in increasing the participants' empathic communication skills.
6. To determine if the training program had any impact on the participants' nursing care in the hospital setting.

#### Hypotheses under investigation

For research purposes of the effectiveness of this hospital inservice training program, pre- and post-training data were collected and analyzed. The three hypotheses under investigation were two null hypotheses which were tested by statistical analysis and one hypothesis in which a descriptive analysis was done to measure changes related to the training program.



1. Hypothesis I: There will be no significant difference between pre- and post-measures in the Death Attitude Questionnaire.
2. Hypothesis II: There will be no significant difference between pre- and post-written and audio-taped responses of empathic communication.
3. Hypothesis III: There will be attitudinal and communication changes after the inservice program which will be demonstrated in actual nursing care on the ward.

### Limitations

Although it is possible to assume that this group of nurses could possibly represent other groups of nurses in similar hospital situations, the small sample size makes it impossible to generalize beyond what is found in the study. However, a small sample may nevertheless indicate patterns and trends that open up possibilities for further research.

This study extended over a five-week period. Because of the nurses' shift work and irregular days off from work, the problem of attrition may have affected the results.

In spite of the use of independent raters, the experiences, ability and bias of the investigator/therapist may affect the study.

This is a quasi-experimental study in which there is no control group to rule out any other hospital factors. A considerable portion of the study utilized a qualitative design in which the investigator made descriptive observations, interpreted data and attempted to find *verstehen*<sup>1</sup>.. Much of the analysis is subjective and therefore does not have any predictive value.

<sup>1</sup>"...the attempt to achieve a sense of the meaning that others give to their own situations through an interpretive understanding of their language, art, gestures and politics. To understand in this way further implies that one knows what another is experiencing by engaging in a recreation of those experiences in oneself. At its core, the essence of understanding is to put oneself in the place of the other--something which is possible if one possesses a degree of empathy with the other or has the disposition to recreate the experiences." (Smith,1983:12).

There is no assessment of long-term effects of this hospital inservice training program.

### Definition of terms

The following expressions are defined in terms of their meanings for the purpose of this study:

**Psychosociological aspects of nursing care:** This includes two aspects of nursing care necessary in the delivery of total nursing care to patients in the hospital. First, the psychological aspect deals with the emotional needs and feelings expressed, especially those regarding their illness, prognosis and/or death. Second, the sociological aspect involves the patients, patients' families and friends in which their feelings, concerns and interpersonal dynamics become part and parcel of the total care.

**Palliative care:** The nursing care designated for patients terminally ill. There is an acceptance by the patients and staff that this care will be non-invasive treatment with the goal of "caring" rather than "curing".

**Grieving process:** This term denotes the emotional distress experienced following a loss.

**Helper-helpee:** A therapeutic relationship in which the helper's intent is to facilitate growth and improved functioning in the helpee. This is inherent and necessary in the nurse-patient relationship for the patient's recovery (Anderson, 1980; Jourard, 1971; La Monica, Karshmer, 1978)

**Hospice:** A special unit or hospital in which there is a well-defined milieu and treatment for patients with terminal cancer.

**Hospital inservice training program:** This refers to the training program designed specifically for this study to promote awareness and knowledge of the emotional aspect of patient care and acquisition of interpersonal skills to cope more effectively with patients' emotional distress.

**Empathic Communication:** Communication in which the helper perceives the world as the helpee sees it and communicates this understanding to the helpee.

Carkhuff's Index of Communication: This instrument of measurement assesses the level of empathic communication in the written and audio-taped responses completed by the participants in the study. It is based on a five-point scale in which level 1 is the lowest level of empathy (Carkhuff, 1969)

### Conclusion

In this introductory chapter of the thesis, it has been posited that there are inadequacies in the psychosociological aspects of patient care which have been attributed to nurses' avoidance and lack of interpersonal skills. This study addressed this deficiency by developing and implementing a hospital inservice training program for training nurses to deal more effectively with the patients' emotional distress. For the statistical requirements of the study, three hypotheses were generated to determine the effectiveness of the inservice program in addressing the stated problem.

The second chapter is a literature review to establish the conceptual framework for the study. First, to better understand the tendency for nurses' avoidance of dying patients, a philosophical/psychological perspective on the denial of death which is so prevalent in our society is presented. This is followed by a look at the literature which supports the rationale for nurses learning about loss with subsequent grieving, and acquiring empathic communication skills. The literature review is completed with a description of previous studies dealing with nurses' avoidance and inadequate knowledge and skills to cope with patients' emotional distress.

The third chapter deals with the methodology and research design employed in the study. To deal with the procedural steps taken in the inservice training program, three areas are identified and described: development , implementation and evaluation.

The fourth chapter describes the results of the data analyses. This is followed by a discussion of the results and the subsequent conclusions, implications, and recommendations for further research.

## Chapter II

### Literature Review

Few, if any thoughts, ideas, choices, or problems occur in a vacuum. This chapter deals with some of the driving forces underlying the development of this study in examining the emotional aspect of nursing care. To illuminate these forces, the following questions are addressed: Why is there a denial of death? What is the rationale for nurses learning about grieving? How is grieving presented in the hospital? What is the rationale for teaching empathic communication to nurses? How have others approached this problem?

#### Denial of death

"...the idea of death, the fear of it, haunts the human animal like nothing else; it is a mainspring of human activity-activity designed largely to avoid the fatality of death, to overcome it by denying in some way that it is the final destiny for man...fear of death is indeed a universal in the human condition." (Becker, 1973: ix)

Robert Fulton, a sociology professor, found that through our social structure of nuclear families, segregation of the aging, deritualizing of mourning and isolation of the dying, we have achieved the "death of death itself" (Grollman, 1981: 37). Rollo May (1969) likens our repression of thought about death to the Victorian repression of sex. This denial of death is not new to our culture, although we have been more successful in hiding it from view. Feifel, using a multi-faceted approach to explore the meaning of death, found that "The idea of death has posed the eternal mystery, which is the core of our religious and philosophical systems of thought." (1959: xi).

Becker (1973) illuminates the existential paradox of mankind--the dualism of the symbolic unique self, which represents freedom of thought, imagination and infinite reach, and the body, which is deterministic, limits freedom and is doomed to decay. The mainspring of human activity is designed largely to *avoid/deny* the finiteness of the body--death. This dilemma creates a basic anxiety that even a child is aware of and thus a "lie" is established as a natural defense in self protection.

The existentialist, Kierkegaard, draws an analogy to the ejection of Adam and Eve from the Garden of Eden to indicate man's greatest anxiety. In this myth, when Adam eats of the fruit of the tree of knowledge, he attains self-consciousness and with this awareness, the *terror* of death. He believes that the child, because of this basic anxiety, unconsciously and automatically develops character defenses (Becker, 1973).

Freud introduced the concepts of repression, defenses and transference, with sexuality as the central core. Focusing on revealing man's creatureliness, he believed that these coping mechanisms formed man's human character as a means to create a safe environment without anxiety. Becker, who maintains that Freud, in his later years, was beginning to alter his initial assumption of sexuality, illustrated the importance of Freud's work but reinterpreted his findings from "repression of sexuality" to "repression of death". For example, he attributed the oedipal complex to the child wanting to conquer death by "becoming the father of himself, the creator and sustainer of his own life." (Becker, 1973: 36).

Jung agreed with the paradox of mankind. He stated that "We can conclude quite categorically that hypochondrias and phobias are focalizations of the terror of life and death by an animal who doesn't want to be one." (Becker, 1973: 227).

Maslow refers to the need for man to protect our ideal image through repression of death. But he also points out an irony of this repression of death which he calls the "Jonah Syndrome":

"...partly a justified fear of being torn apart, of losing control, of being shattered and disintegrated, even of being killed by the experience. And the result of this syndrome is what we would expect a weak organism to do: to cut back the full intensity of life". (Becker, 1973: 49).

Because of the anxiety reaction, the "fear of death" extends to a "fear of life". Thus, the negative aspect of being alive and having awareness of death is the need to repress this knowledge to relieve anxiety. However, the positive aspect of this knowledge is that without this awareness of death, life would not be so precious. Rollo May stated that "Love is not only enriched by our sense of mortality but constituted by it."

(1969: 101). He feels that only when we can confront death by opening ourselves to the negative as well as to the positive, can we have growth. Heidegger says "Death alone gives meaning and destiny to my human life." (Hunsinger, 1969:70). Jung, with his teleological view of life, states that "From the middle of life onward, only he remains vitally alive who is ready to die with life." (Feifel, 1959: 8).

Recognition of the meaning of life, even through suffering and dying, was exemplified in Frankl's experiences in a concentration camp where living appeared to be merely an existence of pain, suffering and indignities. He illustrated how one could transcend suffering and, through personal choice, find living meaningful.

It should be noted here, that even though this thanatological literature is reviewed from a psychological perspective, the ideas originate from the roots of psychology, philosophy. It was Socrates who said "...for is not philosophy the study of death?" (Kastenbaum, Aisinberg, 1972: 1). The literature is revealing in the examination of the fundamental question of "why." We deny death because we fear it and that fear is universal and has been seen in most cultures and in all ages. It has also been represented in many cultural manifestations, from art to religion. Because of fear, we see many attempts in our culture to allay the resulting anxiety, from our beliefs in immortality to our attention to sport heroes. "There have been a number of studies that indicate doctors choose medicine as a career because of an inordinate fear of death. And medicine is dedicated to defeating death." (Kübler-Ross, 1981; 12)

It is no wonder that in the field of medicine, there is a striving towards longevity and mastery of illness with a propensity to ignore/deny the perceived failures in this endeavor. Given such a history and such an ethos, it would seem logical that nurses would have a natural tendency to avoid/deny the dying patients' emotional distress.

#### Rationale for nurses learning about grieving

*"Affectus, qui passio est, desinit esse passio simulatque eius claram et distinctam formamus ideam. Emotion, which is suffering, ceases to be suffering as soon as we form a clear and precise picture of it."* (Frankl, 1946: 95)

The term grief is the emotional response to a significant loss, as presented by a patient and/or the patient's family. This emotional response to a loss is a process which can include definitive phases which are interpreted from different perspectives. For example, Freud saw the psychodynamics of grief as a means to withdraw the energy from the loved-objects. The energy directed towards a loved-object is termed "cathexis" and the withdrawal of that energy from the loved-object is "decathexis." The means to withdraw energy, termed hypercathexis, is seen as one of the initial phases in grieving, and is achieved by repetitively reviewing the painful events. This process is viewed as a natural and necessary process.

Furman described grieving similarly. She stated that there was a need to decathect the loved-object before one could wish to live and enjoy pleasures. Thus, hypercathexis was experienced through deep longing and pain when cathecting fond memories.

Parkes, who sees the grief process of realization internalizing the event, studied grieving widows and found a preoccupation of memories of the lost person. He concludes that "It seems that the human adult has the same need to go through the painful business of pining and searching if he is to 'unlearn' his attachment to a lost person." (Weiss, 1973: 66-67).

Peretz stated that "Grief, when expressed, usually involves a period of convalescences in which the ties to the object can gradually be withdrawn and energies reconstituted for the establishment of new ties." (Schoenberg, Carr, Peretz, Kutscher, Austin, 1970: 13). He found that often the basic defense of repression was used to protect one from such emotions of yearning, anguish, sorrow, anxiety. Other defenses often used were projection (blaming others), isolating emotion, rationalization, and avoidance of reminders.

Bowlby (1961) sees grieving as a biological adaptive function of promoting recovery of the lost-object, which was learned when a child experienced separation from the mother. He itemizes three phases of grief that occur; 1) focus on recovering loss--

weeping, anger, anxiety, grief, 2) disorganization--pain, despair, and 3) leading to a new state.

Kübler-Ross (1969) has identified five stages when grieving:

1. Denial and isolation. This stage functions as a buffer to allow time to adjust to the shocking news.
2. Anger. This anger can be displaced in all directions and projected outwards.
3. Bargaining. A tendency to try to bargain or "make a deal" with God if He will spare his/her life.
4. Depression. A feeling of deep loss, either a reaction to the initial loss or secondary when realizing impending losses.
5. Acceptance. This is the final stage, in which there is a feeling of peace when realizing that this is a reality that cannot be changed.

Vachon defined three stages in the process of grieving:

1. Shock, in which there is a dazed belief and denial.
2. Disorganization, in which there is a loss of patterns of conduct.
3. Turmoil, in which there is depression, anger, guilt, passively suicidal, feelings of despair.

"And then the despair,  
Oh God, the despair...  
It fills my entire being to the core.  
Until I lay flooded with wounds so open  
that I must fight to keep from  
drowning in my own blood."

by Linda Clark. (New Woman: June, 1984)

All agree that this is a time of extreme mental hurting and agony. One of the most painful feelings experienced by those grieving is that of loneliness (Sarf, 1980; Weiss, 1973). Becker states that "The most terrifying burden of the creature is to be isolated. . . ." (1973: 171). Loneliness is seen as a driving force which Bowlby and Parkes believe is an



evolutionary adaptive trait towards forming new attachments. "It is appropriate to avoid being alone as it is to avoid any of the other natural clues to potential danger." (p. 143)

It would be difficult to pin down one theory as exclusive but all identify the process of grieving as painful, personalized and unique with each individual. There are different versions of phases described but the general view of grieving, while varied has more similarities. There is a consensus that grieving is a natural, normal and necessary response to loss of a loved-object. From this, it seems clear that many patients and their families encountered within the hospital are coping with a loss and could quite conceivably be grieving.

Freud pointed out the necessity of going through the work of grieving before being able to be ready for a new relationship. Deutsch (1937) supported this in his research on the absence of manifestations of grief. Scarf (1980) said:

"This is true whether the bereavement has resulted from death itself, or from the death of a love-bond. Without taking into oneself the pain and the suffering, and without working through it, there is no emerging of the other side. The person who avoids the process -- thereby avoiding the suffering that accompanies it -- doesn't become psychologically ready, at liberty for a fresh try, a meaningful relationship." (p. 158)

To illustrate the consequences of not working through a loss is the following anecdote from personal experience:

The patient was a 61 year old woman, lying propped up on the stretcher with an oxygen mask over her nose. When approached she quickly removed her mask and began to disclose her thoughts/feelings with very little prompting. According to her, she had had a very close call with death the previous night. She began by saying that she had felt as if her sons had been taking her for granted lately which had brought her to the conclusion that she wasn't important to them any longer. After her cardiac distress the previous night with subsequent hospitalization, both sons had visited her and their concern and caring was obvious to her despite their difficulty in expressing it and her equal difficulty discussing it with them. Her pleasure in discovering this was obvious.

She shared her belief in reincarnation and her feelings about death. To her, death was a familiar friend and when it was time, she would be ready. She spoke of losing her father when she was 13 years old, her husband when her eldest son was 13 years old, and her second son

when her youngest son was approaching 13 years of age. Death was not a stranger in her life.

She discussed many items such as her funeral wishes, experiences with her family, her relationship with her in-laws, and then she suddenly began to reminisce about her childhood. She stated that she had hated her brother for years and it wasn't until the last five years that it suddenly dawned on her that he had also had problems as a child but they had just never shared their feelings at that time. Her anger began when her father died.

She said, "My dad and I were very close. As far as I was concerned, he was absolutely perfect and I guess I was his little girl and probably spoiled. We did everything together. He was ill for quite awhile and went to the hospital. One day I came home from school and knew that he was in the living room -- in a coffin. I just couldn't open that door. I knew that if I went in I would want to talk to him and he wouldn't be able to answer me." (Tears formed and began to slowly trickle down her cheeks.) "I sat down on the doorstep and my brother found me there. He sat down and asked me why I wasn't going in to see daddy. Then he said, "I'll bet it's because you feel guilty." Now I ask you, what does a child know about guilt? I hated him after that." (At this point her voice tone became very childlike with hurt and anger.)

What becomes apparent is the impact of this woman's loss as a child and the long-lasting effect on her relationship with her brother. This anecdote, which is one of many such anecdotes heard by nurses, supports the literature describing the trauma experienced by a child when a parent dies; the effect of nobody understanding how s/he feels and the necessity of assisting the child to work through her/his feelings (Furman, 1974; Knowles, Reeves, 1983). What's more, it supports the view that people would like to discuss their feelings and plans regarding dying (Feifel, 1959, Kübler-Ross, 1969, 1975, 1981).

It has been posited that the patients in the hospital are likely to be grieving due to the loss that they are experiencing. Also, the literature is clear about the necessity of working through this grief. Kübler-Ross offers an approach to recognizing and dealing with stages of grief with decorum and dignity for the patient. Schneidman and others, while not disagreeing that these stages are frequently seen, have found that everyone does not follow a lock-step series of stages but rather presents a wide variety of behavior, just as one sees a variety of behavior in living. The important message here is that the patients in the hospital frequently exhibit a variety of emotional and behavioral responses

of grieving and these are natural and normal as well as necessary for them to work through for a healthy future. Thus, it is important that nurses recognize and understand these responses so they may facilitate rather than impede the process of grieving.

When stressing the need for attention to the emotional reactions of the patients and their families, the nurses' responses often are: ". . . can't help it; we are here to deal with the medical care of these patients; we don't have time for that; we're too short-staffed; the most important part right now is to get the intravenous started." While it is true that there is not enough allowance made for the emotional treatment of patients, the primary reason is likely to be avoidance. Does this problem have any significance for the healthful care of patients and their families? Why should this be such a concern as long as the patients are receiving adequate physical care?

If one is to accept the theories of grieving presented earlier, it would appear that failure to work through the grieving process could result in a pathological disturbance which could affect one's health. Indeed, there have been many interesting studies done in which there is a high correlation between grief and subsequent illness, even mortality, especially with widows (Schoenberg et al, 1970). "It is believed that the emotional state is one of the conditions which allows the disease to appear." (p. 44) Hutschnecker found that a loss of a parent often resulted in a somatic crisis with a physical trauma (Feifel, 1959). Glick found that there was an increased risk of mental illness, especially depression, with widows. If depression is intense or persists for a long period, there is always the risk of suicide. Vachon, (1986) reported some possible consequences of death of a spouse as: illness, death (most often in males 55-70 years old), and suicide. When working with parental grief some of the consequences reported were: somatic problems, infertility, increased rate of miscarriage, psychiatric morbidity, marital breakdown, sexual problems and disturbed relationships with the other children.

The consequences of loss and subsequent grief are serious. It is true that most people successfully work through this painful time eventually. However, it would be difficult to determine the actual costs to the grieving individual and the family. If we can

recognize, understand and facilitate the grieving process in the hospital, it would be good preventive medicine.

To summarize, it has been acknowledged that with repression of the fear of death, the result has also been a fear of life. Kübler-Ross emphasizes that for growth, we must interpret dying as another phase of living with obligations and opportunities. To achieve growth in our care of patients, it is necessary to understand and treat the total patient — physical, emotional and mental. To approach the task of growth through care of patients, it is necessary to know and understand the concept of grief when experiencing loss, either through death or other significant losses seen in the hospital setting.

If the premises found in the literature are accepted, the following become issues for serious consideration in the training of nurses and in the effective delivery of health-care for hospital patients:

- a) Nurses are constantly being placed in the position of seeing patients suffer from a variety of losses and feel inadequate in dealing with the emotional aspects of this suffering.
- b) Nurses can learn to understand loss in more general terms by utilizing the knowledge gained in the area of death and dying.
- c) Through learning and applying the methods described in the death and dying literature, nurses can be more effective and find more satisfaction in caring for patients' suffering.

#### The signs and symptoms of patients' grieving

"There is nothing either good or bad, but thinking makes it so." Shakespeare: Hamlet II ii (Ellerbroek: 66)

As with the phases of grieving described above, there are a variety of descriptions of signs and symptoms of grieving seen in the hospital setting. For example, Schneidman (1980) described the response to a sudden death as a

"disaster syndrome'...combination of emotional dullness, unresponsiveness to outer stimulation and inhibition of activity...The individual who has just undergone disaster is apt to suffer from at least a transitory sense of worthlessness: his usual capacity for self-love becomes impaired." (p.160)

Glick, et al. (1974) noted that although knowledge of an impending death did not reduce actual grieving, the sudden unexpected death intensified the shock. In the hospital setting, we are essentially dealing with the acute crisis of loss, and as a result, are usually trying to cope with the first stages of grieving. Glick identifies the symptoms as disbelief, shock, crying, sadness, despairing, disorganization, fear of managing, collapse and considerable expression of anger towards others. When death is a sudden occurrence, there is a tendency to dwell obsessively on what happened and in a search for the cause. This observation coincides with Freud's theory of "hypercathexis".

Vachon (1978) found that in her experience, shock was the initial reaction with symptoms of disorganization, denial, desolate pining, guilt, anxiety and aggression. She also identified psychophysical signs, as described by Lindemann:

- 1) crying, often without warning or obvious reason.
- 2) sleep disturbance.
- 3) reduced energy level.
- 4) changes in appetite, weight.
- 5) somatic--aches, pains, fatigue, nervousness.

Feifel attributed many of the symptoms to anxiety, a negative emotional state. "Death fears can dissemble in insomnia, overconsideration for one's family, fears of loss, the depressed mood,...diverse psychosomatic disturbances." (Kastenbaum, 1972: 52)

While these symptoms are described when dying is the focus of loss, they are not exclusive to death. Schoenberg recognized similar symptoms before surgery. "The most awesome sense of loss is experienced by patients undergoing cardiac surgery." (1970: 136) He also referred to the "phantom limb" of the amputee where grieving occurs. Kastenbaum (1972) found that the debilitated athlete ". . . may perceive one or more of his part-selves as wholly dead." (p. 122).

In a hospital setting, a patient frequently experiences the loss of freedom. The literature describes the extreme dependency felt by a hospitalized patient and the subsequent feeling of loss of control. "This climate of dependence on staff and on the institution drains the patient's sense of uniqueness and of human worth." (Schoenberg et al.,1970:22) This loss of independence is often felt to be more painful than the illness itself. With any loss of part of self without control, there is often a recognition and threat of the future worsening. It would be safe to say that most losses carry the threat of a future loss, which would account for the increased anxiety and fear frequently seen in patients.

Therefore, one can deduce from the above that in the hospital, the first phase of grief is shock with the predominate symptoms of denial, disorganization, anxiety, depressed mood and likelihood of psychophysiological changes. There would appear to be a panoply of human feelings and emotions expressed that are likely signs and symptoms of grieving. When noting the variation, Schneiderman (1980) stated that "oncology recapitulates ontology" in that "...each individual tends to die as he or she has lived, especially as he or she has previously reacted in periods of threat, stress, failure, challenge, shock and loss." (p. 110)

#### Rationale for teaching empathic communication skills

There is no time now for the game  
Of mutual pretense.  
To act as if I'm still the same  
Quite simply makes no sense.

Observe me here, the worn remains  
Of what I used to be.  
This weary mass of aches and pains  
Is plain for all to see.

But still it loves and wants to share  
Its feelings with its friends.  
So listen now and show some care  
Before my sweet life ends.

by Lewis R. Aiken

Should we learn methods to cope more adequately with the emotional anguish experienced in the hospital? The literature is clear that this is not only possible but desirable in health-care settings.

"Actually, my findings indicate that patients want very much to talk about their feelings and thoughts about death but feel that we, the living, close off the awareness for their accomplishing this. (Feifel, 1959: 123)

It is important for the nurses to recognize and understand the messages from the mind and body of the patient and to be aware of the vulnerability of the patient due to the state of shock and feeling of dependency described above. To achieve maximum psychological comfort, the patients need to retain some sense of autonomy in the decisions remaining to them. However, many patients have difficulty expressing their emotional reactions, may be unaware or deny their feelings, and invalidate underlying feelings of vulnerability, for example, by masking their fear with anger.

From the literature some communication *musts* for all health-care givers have been activated: (Kübler-Ross, 1969, 1975, 1981; Schoenberg, et al., 1970; Feifel, 1959; Glick et al., 1974; Grollman, 1967)

1. Recognize the patients' state of shock. Orient them to place and situation frequently with an attempt to fortify reality rather than deny it. Frequent clarification may be necessary.
2. Recognize the need for repetitive review of events and be prepared to answer the same question many times. It is important to realize that occurrences at this time will be played over and over in the patient's mind.
3. Encourage verbalization of feelings. Let them choose their attitude even if there is considerable anger directed towards the nurses.
4. Be truthful. Discuss facts with the emphasis on an area of their gaining control.
5. Reassure them:
  - give support in accepting the illness
  - let them know they will be taken care of by the nurses.

—let them know that what they are feeling is not only normal but "okay."

—let them know they are not alone and offer to "help in the fight."

6. Offer hope. Do not give up on the patient but be willing to share information, feelings and concerns with the patient and family, giving them the opportunity to make decisions and plan some goals, however small, for the future.

"Those who know how close the connection is between the state of mind of a man--his courage and hope, or lack of them--and the state of immunity of his body will understand that the sudden loss of hope and courage can have a deadly effect." (Frankl, 1946: 96-97)

7. Silence is also an important facet of communication--the willingness to listen and just "be there."

The nurses need to communicate their willingness to listen in order to have the patients share in the decisions regarding the illness. They need to recognize that grieving is a personal and unique experience. There are no "right" or "wrong" reactions and feelings must be acknowledged as messages to be listened to, understood and dealt with in an open, honest factual communication. This is a reciprocal process of caring, respect and dignity which requires awareness and supportive empathic communication from the nurse.

However, it has been established that nurses have a low level of empathy (Anderson, 1980; La Monica, Karshmer, 1978). In fact, in a study comparing a number of occupational and professional groups, a sample of nurses scored second lowest on a measure of empathy (Truax, Wittmer, Wargo, 1974). Similar results were found by La Monica et al. (1976) when measuring the level of empathy in nurses involved in a human-relations-modeled staff development program. The mean score was 1.47 using Carkhuff's Index of Communication (1969). This score indicates that nurses' responses are midpoint between 1.0 which represents irrelevant or hurtful responses and 2.0 which represents responses that only partially communicate an awareness of the surface



feelings of the helpee (Carkhuff, 1969). This is well below the minimally facilitative level of 3.0 which is considered necessary for enhancing growth in a helping relationship.

Thus, the training of empathic communication skills is essential for nurses to be effective as helpers in the nurse-patient relationship. Carkhuff's Index of Communication (1977) offers a skills acquisition model with which to teach empathic communication. This model is based on the Rogerian concept that the attitude of the helper promotes a feeling of acceptance, trust, being understood and independence in the helpee which allows the helpee to discover himself and the capacity to use the relationship for growth (Rogers, 1961). Carkhuff states that "Helping is a process leading to new behavior for the person being developed" (1980: 11). He describes responsiveness as a basic dimension of human development and helping, which involves empathy and communicating that experience to the person by responding to the content and feelings expressed by the helpee. It is this action of exploration and understanding that leads to action towards new behavior, thus, a crisis becomes an opportunity for growth and development.

The empathic mode described by Carkhuff provides the key to a therapeutic relationship in that it is a non-judgmental, respectful approach which says to the patient that 1) I am hearing you, 2) I understand what you are saying, and 3) I am interested in your perspective, your opinion and your wishes. Thus, this mode of communication, even at the minimally facilitative level: allows the patients to maintain a feeling of autonomy and self-respect; encourages verbalization of feelings; reassures them that these feelings are okay and are supported; establishes an open line for facilitating an understanding of self and his/her illness and provides an opportunity for the patients to develop new actions. In other words, if this mode of communication is established, it would fulfill the communication *musts* described above.

#### How have others approached the problem?

The response to the problem of avoidance and inadequate knowledge and skills to cope with emotional distress has resulted in various studies described below.

### Avoidance.

"Perceiving an event as pleasant or unpleasant is, again, a matter of choice of the individual, and although related to the event is not determined by the event."  
(Ellerbroek, 67)

When describing the concept of avoidance the implicit assumption adopted by researchers is that it is related to attitudes. The nurses' negative attitude towards death and dying results in verbal and non-verbal behaviors which inhibits communication of emotional concerns (Hopping, 1977). Nurses' attitudes towards death are influenced by family attitudes, personal experiences with family or friends and personal experiences caring for a dying patient (Coty, Tamlyn, 1984; Milton, 1984; Mullins, Merrian, 1983; Shruck, Swanson, 1981). There is a need for nurses to understand their own feelings/attitudes regarding death and the death process itself, before they can give understanding and empathic care to the patients (Appleyard, 1982; Hopping, 1977; Llewelyn, Fielding, 1983; Keck, Walther, 1972; Stowers, 1983).

From these premises, death education courses were developed that included opportunities for self-exploration and ventilation of feelings regarding death, general knowledge of the process of dying, and strategies for coping with dying patients and their families. These education courses were taught to groups consisting of nursing students (Coty, Tamlyn, 1984; Coolbeth, Sullivan, 1984; Hopping, 1977), and nurses in extended care homes (Fleming, Brown, 1983; Mullins, Merrian, 1983). The courses used a didactic and experiential approach, utilizing such techniques as role-playing situations and group discussions.<sup>2</sup> Pre and post-questionnaires were given to ascertain the effectiveness of changing the attitudes of the nurses towards death. Those finding a significant increase in positive attitudes (Coty, Tamlyn, 1984; Coolbeth, Sullivan, 1984) supported the theory of Shruck and Swanson that there was an increase in positive

<sup>2</sup>The didactic approach emphasizes the knowledge base and techniques to be taught while the experiential approach stresses awareness of one's own feelings and learning from one's own experience (Payne et al, 1972).

attitude with experience and death education. Lev (1986) found that experience alone did not affect attitude. Hopping (1977) found no significant increase in positive attitude.

There were mixed results regarding whether the training increased or decreased the nurses' anxiety regarding death (Lev, 1986; Mullins, Merrian, 1983; Milton, 1984). Denton and Wisenbaker (1977) reported that experience with death was inversely related to death anxiety among the nurses they studied. In one study observing nurses giving nursing care to dying and non-dying patients, Keck and Walther (1977) found that nurses did not spend less physical time with dying patients but less time attending to the emotional needs of dying patients indicating an obvious discomfort. This noted uneasiness in nurses caring for dying patients was the impetus for a study by Stoller (1980). In her analysis of a questionnaire given to 32 nurses, she found that the nurses' uneasiness associated with interaction with dying patients increased with experience. She posited that one reason could be ". . . a task structure which enables the RN to minimize social contact with the dying and therefore does not motivate her to acquire strategies for handling death-related conversations" (p. 38).

No research was found that linked more positive attitudes towards death to actual patient care. In other words, we do not know from the above research if death education courses have any impact on reducing the nurses' tendency to avoid the dying patients in a hospital. It was noted that after one death education course, there was a change in the nurses' charting, indicating some transfer of awareness to the work situation (Fleming, Brown; 1983). However, the charting only changed in the subjective reporting and did not affect the nurses' planning for the patient.

Thus, the evidence linking attitude to nursing care of the dying remains inconclusive. It should be noted here that the actual education programs were seldom described which makes comparisons difficult. What's more, due to the difficulty of developing a valid measurement of attitudes, the measurement scales utilized may not have been adequate.

### Lack of appropriate communication skills.

When describing appropriate communication skills the implicit assumption is that the primary ingredient for a nurse-patient relationship is empathy (Carkhuff, 1969; La Monica, Karshmer, 1978; Kalish, 1973).

"Empathy is the ability to enter into the life of another person, to accurately perceive his current feelings and their meanings...When communicated it forms the basis for a helping relationship between nurse and patient."  
(Kalish, 1973: 1548)

If empathy is not present in a helping relationship, rather than enhancing growth, it can be destructive to it (La Monica et al., 1976; Vachon, 1980).

Training in communication skills using empathy has been well defined and validated in various research studies with a variety of groups such as undergraduate students (Berenson, Carkhuff, Myrus, 1966; Collingwood, 1969; Foulds, 1969; Payne, Weiss, Kapp, 1972), parents of adolescents (Guzetta, 1976), parents of emotionally disturbed children (Carkhuff, 1970), nurses (La Monica, 1976, 1978), nursing instructors (Anderson, 1980) and psychiatric in-patients (Pierce, Drasgow, 1967; Truax et al., 1971). These training programs effectively increased interpersonal communication at the significant level.

Guzetta's study documented the effectiveness of a structured training program for 45 parents of adolescents to respond empathically to their children. The parents were divided randomly into three experimental and one control group in which all but the control group received the six-hour training program. Using Carkhuff's Empathy five-point scale (1969), the treatment groups showed significantly more empathy than the control group.

In the nursing context, La Monica et al. (1976) reported the effectiveness of a staff development program to increase nurses' abilities to perceive and respond with empathy. This experimental design involved three groups; 1) the experimental group receiving the program, 2) the control group for effectiveness, and 3) a control group for test-retest variability. Using Carkhuff's Index of Communication (1969) as the instrument

to assess the effectiveness of the staff development program, the experimental group made significant gains in empathic communication after 11 hours of training. Their responses did not achieve a 3.0 level, the minimally facilitative level. However, it is clear that a systematic approach to training groups in empathic communication skills is effective.

In the nursing-teaching context, Anderson (1980) empirically investigated the effectiveness of a 20-hour interpersonal skills training program implemented for nurse educators using Carkhuff's Index of Communication (1969). The results of the study indicated a significant increase in facilitative functioning of the experimental group compared to the control group.

The training format in the above research studies combined a didactic, modeling and experiential approach with a variety of techniques, including role-playing. Guzzetta (1976) also adopted Goldstein's structured learning approach<sup>3</sup> which included social reinforcement. In an experimental design using four groups to compare three learning components--didactic, modeling and experiential--in a training program for college students, Payne et al. (1972) found the didactic-modeling combined approach most effective in a brief empathy training program. This concurs with the findings of Carkhuff and Truax (1965), who found that the integrated approach was basic to an effective training program.

Generally, there were pre and post-assessments of written, audio-taped and/or role-played responses to "helpee-stimulus" statements. These statements were based on situations which could occur in a "helper-helpee" dyad, wherein the subjects were asked to place themselves in the "helper" role and either write or tape their best helping response to a "helpee" statement of a problem, concern or feeling. These responses were rated by raters using Carkhuff's Empathy Scale, in which high empathy is rated 5 on a 0-5 scale. This scale has established validity and reliability (Carkhuff, 1969, 94-99)

<sup>3</sup>Goldstein's structured learning training combines the techniques of modeling, role-playing and social reinforcement. The social reinforcement is not included in the didactic and experiential approach used in the other studies.

The length of training in the above research studies varied from six to twenty hours over a one to ten week period. Collingwood (1971) studied the efficacy of training interpersonal communication skills to large groups and found that ten hours was effective in increasing empathic communication. Another consideration for training programs of communication skills is the long-term effect. Collingwood (1971) investigated the retention and retraining of interpersonal skills after a ten-hour training program. There was a significant drop in levels of functioning after a five-month period but the levels of functioning were restored to the training program level after a brief retraining program.

Research literature indicates that the trainer's level of functioning has an impact on the success/failure of a training program in providing constructive growth for the trainees. In a summary of sixteen studies of lay and professional training programs assessing the trainer's level of functioning in relation to the trainee's level of functioning, it was found that the trainees converged in the direction of their trainers (Carkhuff, 1969). Additional support for this finding was found in a later study comparing the differential effects of high and low functioning counselors upon counselors-in-training (Pierce et al., 1967). The trainees of the high level functioning counselor demonstrated greater gain. This is a key factor when planning a training program to increase interpersonal skills.

There is general consensus regarding the effectiveness of training groups to increase empathic communication if an integrative approach is used and the trainer models a high functioning level of interpersonal skills. However, the transfer of these skills to actual situations has not been established. Guzetta (1976) considered this problem in her research with parents of adolescents. She adopted Goldstein's principle of "identical elements"<sup>4</sup> by including the parents' children in one of the experimental groups. She found ". . . no evidence that the experimental manipulation designed to increase transfer did, in fact, result in higher levels of empathy. . . ." (p. 452). She

<sup>4</sup>"identical elements" is a principle which states that the greater the similarity between situations, the greater the transfer of the learned skill to that situation.

suggested that one possibility could be that the situations role-played were not truly representative of their normal interactions. In another study to determine if there were actual changes in personality and interpersonal functioning it was found that there was significant improvement in general indicating personality changes. However, "the significant others" did not perceive any changes on empathy and concreteness (Martin, Carkhuff, 1968: 110). Thus, no conclusions can be made regarding the transfer of the newly acquired skills to other situations without more research.

In summary, the literature reviewed indicates that an important facet of patient care is missing due to nurses' avoidance and lack of appropriate communication skills. There have been attempts through education courses to change nurses' attitudes towards death and dying, as well as training programs to improve empathic communication. Generally, increased empathic communication skills resulted but attitudinal changes were inconclusive. There were mixed results regarding increased/decreased anxiety towards death with the resulting proposition that increased anxiety may actually increase awareness and empathy.

The literature indicates that empathy is an essential skill for nurses to facilitate healthy nurse-patient relationships. It has also been demonstrated that empathic skills can be taught to homogeneous groups. However, there was no evidence to indicate that these training programs have had an impact on the actual setting. We are left with two important questions when considering a program for training nurses. Do attitudinal changes result in less avoidance of the patients' emotional distress? Are the learned empathic communication skills transferred to patient care?

### Conclusion

Within the hospital setting there is a focus on "science" and the implicit belief of mastery over life through artificial means. This focus has contributed to the neglect of the psychosociological aspect of patient care with subsequent increased suffering. Nurses' neglect of patients' emotional distress is attributed to: avoidance due to personal

experiences and attitudes; lack of awareness and knowledge of the emotional impact of loss; and lack of adequate coping skills to deal with this emotional aspect of care.

This chapter was motivated by a search for some underlying principles which promote understanding of this deficit in nursing care but also, to serve as a foundation on which to develop, implement and evaluate a hospital inservice program directed towards the problem.

To examine the question of why there is avoidance/denial of death, a philosophical/psychological overview was made revealing that man's denial of death is a universal fear. This appears especially true in medical personnel who are constantly fighting death. There is some thought that, by seeing it happen to others, we are able to deny or distance death for ourselves. "The very act of struggling against loss, pain, disability and ultimately death enhances feelings of power and security." (Schoenberg et al., 1970: 27)

The review of the "rationale for nurses learning about grieving" and "the signs and symptoms of patients' grieving" illustrated the need for nurses to come to terms with death, and to have knowledge of the symptoms of grieving in the hospital before they can effectively help dying patients (Furman, 1974; Kübler-Ross, 1978, Rogers, 1958).

The "rationale for teaching empathic communication" illuminated the necessity of acquiring empathic communication skills as a coping response to the patients' emotional needs when suffering from loss. Carkhuff's integrative model of empathic communication was illustrated as an appropriate means for training nurses these skills.

In "how others approached this problem," other research studies were reviewed which dealt with avoidance of dying patients and inadequate communication coping skills. Death education programs and empathic communication training programs were reviewed to determine their effectiveness in addressing these problems. The findings were indicative of some positive, but mixed results in changing attitudes towards death and an improvement in communication skills, but the impact of these programs on the actual setting remains unanswered. At the present writing, the combination of these two



specific approaches has not been offered as an inservice program to practicing nurses in an acute care hospital.

In Chapter III, the methodology and research design of the study includes a description of the development and implementation of a combined death education and empathic communications training program and the evaluation procedures used to determine any changes and impact on the hospital setting.

## Chapter III

### Methodology and Research Design

The purpose of this study was to develop, implement and evaluate an inservice training program for nurses to deal with the emotional aspects of loss experienced by patients in an acute care hospital. This chapter describes the procedural components of this study under three sections: a) the development of the inservice training program; b) the implementation of the inservice training program; c) the research design utilized for evaluation of the inservice training program. However, before dealing with these sections, the underlying aims, assumptions, beliefs and evaluation concerns of the inservice training program are summarized.

The aim of this study was to develop, implement and evaluate a hospital inservice training program to promote: 1) facilitation of self-awareness of attitudes towards death and dying; 2) knowledge of emotional impact of loss on patients and families; and 3) development of empathic communication skills as a coping strategy. The expectations were that the effectiveness of this inservice program would be evidenced by:

- 1) changed nurses' attitudes regarding emotional needs/care of the patient,
- 2) improved functioning of the nurses in empathic communication, and
- 3) impact on the hospital ward in which the nurses work.

An implicit expectation was that this inservice program would enable nurses to feel more comfortable and confident dealing with the patients' emotional distress. These feelings should not only enhance the delivery of total nursing care to the patients-- physical, mental and emotional--but contribute to greater satisfaction for nurses.

#### Underlying assumptions.

1. A concept of health and well-being for the patients includes physical, mental and emotional health.
2. Patients in a hospital setting experience emotional distress due to loss and/or crisis.

3. Emotional care of patients, which has been neglected, must be given a central place in health care.
4. The psychological state of mind is linked to physical recovery.
5. Nurses must have knowledge and understanding of loss and its subsequent emotional impact on patients.
6. Nurses' attitudes and beliefs have an impact on their ability to deliver adequate emotional care to patients.
7. Nurses require empathic communication skills to cope with the emotional aspect of nursing care.

Underlying philosophical beliefs.

1. Patients in the hospital have the right to receive total health care— physical, mental and emotional.
2. A sense of autonomy, independence and dignity is necessary for emotional health.
3. Patients have a right to be informed about and participate in their own decisions regarding care.
4. Nurses are potentially capable of establishing a therapeutic helping role in which they can enable the patients to achieve emotional as well as physical health.

Evaluation of this inservice training program addressed three areas of concern.

1. Will this inservice training program have an impact on nurses' attitudes towards caring for patients who experience emotional distress from loss?
2. Will this inservice training program improve the communication skills necessary to cope with the patients' emotional distress?
3. Will nurses' increased awareness and knowledge of patients' emotional distress as related to loss and their acquisition of communication skills be transferred to the actual nursing care of patients in the hospital?

Keeping these underlying assumptions, aims, beliefs, and evaluation concerns in mind, the remainder of this chapter describes the procedural components of the study, beginning with the first section, the development of the inservice training program.

#### The development of the inservice training program

The purpose of this inservice training program was twofold: 1) to promote the nurses' awareness and sensitivity to patients' emotional distress due to loss, and 2) to teach the nurses' empathic communication skills to cope with this emotional aspect of nursing care. A phenomenological/fulfillment model was chosen for the training program to enable the nurses to establish a helping relationship in which there is trust, genuineness and the ability to see the world as the patients see it (Rogers, 1958, 1961); to focus this nurse-patient helping relationship on the patients' emotional distress due to loss; to provide the understanding and communication skills to enable the patients to clarify their feelings, perceptions, information, and thus, make more knowledgeable and constructive decisions regarding self-care.

The key ingredient to understanding helpes and communicating that understanding to them is Empathy (Brammer, 1973; Carkhuff, 1961; Kalish, 1973; LaMonica, 1976; Truax, Carkhuff, 1967). It is the helper's ability to enter the world of the helpee and communicate that awareness and understanding to the helpee that allows the helpee to feel less isolated with the problem (Carkhuff, Berenson, 1967). However, it was previously noted that nurses have a low level of empathy (Anderson, 1980; La Monica, 1976; ). For this training program, Carkhuff's skills acquisition model of empathic communication (Carkhuff, 1969; Carkhuff, 1973; Carkhuff, Berenson, Pierce, 1973) was chosen to meet this deficiency. The model is based on a non-judgmental, respectful, genuine mode of empathic communication with clear, progressive step-by-step gradations for learning, understanding and teaching others.

Carkhuff's systematic training method of interpersonal skills uses the didactic, experiential and modeling approaches. When comparative studies were done, this integrative approach was found to be the most effective in increasing interpersonal skills

(Carkhuff, 1969; Carkhuff, Berenson, 1967; Collingwood, 1972; Gazda et al., 1975, 1977). The variety of training components used in this training program is described below.

The didactic component is based on the assumption that information and techniques need to be taught for learning to occur. Carkhuff stated:

". . . the high level trainer has the responsibility for teaching the trainee in a structured and didactic fashion the components of his fine discrimination and communication, both inter- and intrapersonal." (1969: 200).

According to this principle, a structured plan was prepared and implemented for carrying out the twofold purpose of the training program (Appendix A) : to learn about patients' emotional distress due to loss, and to learn how to communicate empathically. Written guides and group discussions were the instructional strategies used in these two areas.

The experiential component, an essential component in a training program (Carkhuff, 1969; Carkhuff, Berenson, 1967), is based on the assumptions that learning is best if one is involved personally and that knowledge has to be self-discovered to be meaningful (Rogers, 1961). To meet these conditions, dyad discussions and role-playing techniques were used to give the participants the opportunity to experience the effects of and practice the conditions of the empathic communication skills being taught. Special attention was given to how these conditions were applicable to the helper-helpee relationship in nursing care.

The modeling technique has been found to be effective in learning new skills (Truax, 1964; Carkhuff, Bierman, 1970; Pierce, Drasgow, 1969; Guzzetta, 1976). It is the responsibility of the trainer to model the characteristics and skills of high levels of interpersonal functioning — empathy, respect, genuineness (Carkhuff, 1969). Thus, the trainer practiced a high level of empathic communication during the training sessions, especially during group discussions. Another modeling technique used was videotaped role-playing of "helper-helpee" situations with a focus on empathic communication. This technique was based on the assumption that the videotape could function as an

illustrative approach to teach empathic communication but also as a facilitative approach to promote awareness and meaningful understanding through the examination and discussion of the modeling examples.

### Group.

The inservice training program was designed for a group size of 12-20 people. Since group participation and sharing was an important learning component in the acquisition of self-awareness, sensitivity and knowledge regarding loss and empathic communication, it was felt that that would be difficult to achieve with larger numbers, unless they were divided into sections with individual leaders.

Although there are economical advantages in training a group as opposed to a few participants, this medium was chosen because the learning of interpersonal skills is enhanced by the group itself; there is interaction among the members, dialogue between the group and trainer, and knowledge gained from group members through discussion. Carkhuff and Bierman (1970: 157) speak to the functional aspect of the group medium for learning with the following propositions:

- a) the core of functioning or dysfunctioning (health or psychopathology) is interpersonal;
- b) the core of the helping process (learning or relearning) is interpersonal;
- c) group processes are the preferred mode of learning interpersonal functioning;
- d) systematic group training in interpersonal functioning is the preferred mode of learning interpersonal processes.

The effectiveness of systematic training programs for increasing interpersonal skills with a variety of groups has already been documented. (Chapter II: 24-26)

### Length of time.

A consideration when planning a communication skills training program is the relationship between the length of the program to the resulting success/failure in achieving the expected goals. Although some studies indicate the necessity of 15-30

hours of training (Pierce, Drasgow, 1969; Pierce et al., 1967), Collingwood found that ". . . a large number of trainees were trained en masse and in only ten hours." (1969: 462). Although more hours might have been preferable, ten hours was allotted for this training program because of logistical and practical factors related to attrition, research and nurses' commitment.

Many hospital educational programs are given in a one to two day workshop mode. This is more convenient to arrange due to the difficulty of nurses' regular attendance because of shift-work and irregular free days. However, an intervaled approach was chosen since it was assumed to be more effective to use a schedule that allows time for the nurses to learn and assimilate new ideas, practice them in the group, have opportunity to apply them in their clinical work, and then share their experiences/findings with the group. Thus, the inservice program was implemented in five two-hour weekly sessions in March, 1988.

#### The inservice training program schedule.

The schedule, found in Appendix A, illustrates the objectives of each session and instructional strategies carried out each day. The sequence of the sessions<sup>5</sup> follows a deliberate design. The five sessions of the inservice program were divided into two sections to fulfill the two purposes of the inservice program: 1) death education and 2) empathic communication skills training. Each section began with a special focus on nurses' self-awareness of their attitudes towards death and their communication techniques. This awareness was taken as an "a priori" condition to their appreciation and acquisition of new knowledge and practice towards change.

The first section, consisting of two sessions, was devoted to 1) encouraging awareness and acceptance of feelings and attitudes regarding death and dying and 2) expanding nurses' knowledge base regarding the patients' emotional needs due to loss.

<sup>5</sup> "Session" corresponds to the "Day" indicated in the inservice schedule (Appendix A).

The second section included the latter three sessions and was devoted to a training program in empathic communication skills to deal with the emotional aspect of nursing care. Research has shown that those best prepared to assist others were those who could discriminate, communicate and respond at high levels of functioning (Carkhuff, 1969). Due to the limited time available for training in empathic communication, the training concentrated on the *responding* dimension of this skill.

Each session began with a different relaxation exercise. There are four reasons for including this aspect of training (Davis, 1982; Nicassio et al., 1974; Walker, 1975). First, it allows time for a transition from the hectic activities prior to entering the group and thus, enhances concentration. Second, it promotes awareness of the effectiveness of such a technique to reduce stress. Third, it creates a more relaxed and open atmosphere. Fourth, it teaches five different relaxation techniques that can also be used with patients who suffer emotional and physical distress.

The instructional strategies used in the five sessions (Appendix A) are described further. In the first session, the exercise (Appendix B) was specifically designed to sensitize trainees to their feelings and attitudes regarding death and dying. This was posited as an essential process before one can help others (Kübler-Ross, 1979; Rogers, 1961).

In the second session, to provide information on death and dying and a framework for shaping the trainees' ideas and responses, a study guide was developed, distributed and used as a focus for group discussion. This "Guide for Gaining Knowledge on Caring for the Grieving Patient" (Appendix C) was designed: 1) to provide an opportunity for trainees to think about, write and discuss their feelings and attitudes about death and dying, 2) to identify the psychosocial issues involved in nursing care of the dying by sharing knowledge and experiences in group discussions, 3) to give trainees an opportunity to become aware and sensitive to their own values, attitudes, and experiences when coping with the patients' emotional needs, and 4) to identify the nurses' role in care of the dying patient and his or her family.



It should be noted here that because of the gravity of the topic and the anxieties that were anticipated in the discussions, a sense of humor and flexible approach were felt to be important factors when dealing with the varied experiences of the group. Humor was not only used in the written material but cartoons were used as examples for discussion. In the discussion groups, the topics were frequently chosen by the participants and directed by their concerns rather than imposed by the trainer/investigator.

In concurrence with the assumption that self-awareness was an essential part of the process of change, the third session focused on self-awareness of communication styles used when dealing with the patients' problems. In an experiential approach using role-playing, the trainees formed dyads and took turns being the "helper." Sample situations (Appendix D) were typed on cards for use if trainees did not wish to create their own situation. These sample situations are common types of statements which nurses frequently hear in their daily routine at work and are designed, according to Goldstein's "identical elements," to represent different concerns or feelings--anger, fear, loneliness, blame--that a patient, family member or nurse could be experiencing in the hospital setting.

For session four, an "Introduction to Empathic Communication" (Appendix E) was developed and distributed as a guide to provide written information to be learned and shared in discussion; to serve as a model for practice; and to be used as a reference for discussing and evaluating the video presentation. This guide was based on Carkhuff's Index of Communication in which empathy has two main components: *perceiving* or "tuning in" to the words and behavior of the other; and *responding* by communicating to the other that "I am with you" (Carkhuff, 1969). Scale I (Appendix E) shows that low levels of empathy, especially level one, are viewed as subtractive--irrelevant, hurtful, critical, mechanical, denial of feelings--in that they do not attend to the patient's ideas or expressions of feelings. Level two is ineffective as there is only partial awareness and often distortion of the patient's surface feelings. Level three is the minimally facilitative

level in which the therapist's responses are interchangeable because they demonstrate awareness of both content and feeling expressed by the patient. The higher Levels four and five are described as additive as they not only demonstrate awareness but expand on the ideas and feelings expressed.

Session four was designed to promote knowledge of empathic communication. The above guide was one of the instructional components. Another component, a video role-playing demonstration made during this inservice training program demonstrated two examples of ineffective communication followed by an example of empathic communication. The purpose of the videotape presentation was to serve as a modeling example for learning and as a stimulant for discussion.<sup>6</sup>

The plan for session five included a review of the videotape presentation so that the trainees could compare the therapist's responses to the levels of communication in the "Introduction to empathic communication." Time was allotted for the participants to practice empathic communication in dyad role-playing situations and to complete the post-questionnaires required for the study.

Thus, the inclusion of didactic, experiential and modeling techniques essential for effective training (Carkhuff, 1969) is evident in the above description of the instructional components used in this inservice program. To enhance bridging the gap between the training program and on-the-job practice, the trainees were encouraged to practice empathic communication with the patients and each other and to share their experiences with the group.

<sup>6</sup>The guide and videotape modeling are directed towards the achievement of Level three only, the interchangeable level. Although considered a minimum level, this level is seen as the safest level for nurses who are inexperienced in this aspect of care. It enables them to give respect and autonomy to the patient. Thus, the importance of just reflecting the content and feelings expressed by a patient are stressed in this training program. The non-verbal aspects were briefly explored, for example the importance of the language and tone of voice being congruent with the patient. A stereotyped version often reported is the situation in which a nurse bounces into a sick person's room and gaily states, "And don't we look great today!"

Although this was described as a ten-hour inservice program, it should be acknowledged that a portion of this time was devoted to completing the pre- and post-measures described later in this chapter. While not precisely part of training, the measures nevertheless are seen as functional in the learning process chosen for the inservice program as they also promoted awareness of feelings, attitudes and weaknesses, as well as offered opportunities to think about and practice therapeutic communication.

### Implementation of the inservice program

#### The site

The hospital chosen for the study is a 588 bed acute-care hospital in British Columbia. It was chosen for two reasons. The first was convenience since the investigator was a full-time employee there so arrangements and attendance were easily accommodated. Also, as an employee and privy to employee confidentiality, consent was readily granted for access to the wards and medical charts. The second reason was that it fulfilled the research requirements of being an acute-care general hospital.

By chance, there was another factor which may have affected the appropriateness of giving the inservice program in this hospital. Despite considerable protests from hospital staff and the community, the palliative care unit was closed for economic reasons six months prior to the implementation of the program. This resulted in the placement of terminally-ill patients, previously cared for in the special unit, to the general areas of the hospital, primarily the medical wards. Thus, there was acute awareness of added stress and need for the provision of assistance to these wards. When approval was sought from the Director of Nursing for the inservice program, she not only granted permission but arranged for the investigator to meet with the medical cluster (charge nurses from five medical wards) with recommendations that the time required for this inservice program be arranged for any nurses wishing to attend.

## Participants

The participants consisted of eleven Registered Nurses, nine from acute medical wards and two from an extended care ward<sup>7</sup> and one occupational therapist from the extended care ward. All volunteered to attend the inservice program. As expected, attrition was a problem. One of the nurses quit on the third session; one nurse missed two sessions due to surgery and one missed the final session which was important in regard to collecting data. Thus, the actual data collection was carried out for only nine participants. Due to illness, working the night shift or inability to leave the ward, four out of the nine participants missed one of the five sessions.

The participants were given a demographic questionnaire (Appendix G) to complete. From the responses (refer to Appendix G (ii)), it was found that all of the nurses were graduates of diploma nursing programs and the occupational therapist had a university degree. The ages ranged from twenty-five years old, to four over forty years of age. One participant had previously attended a death education course and two had taken an interpersonal skills training program as part of their nurses' training. Clinical experience ranged from two nurses in the one-three year range to four who had more than ten years experience. All participants had provided nursing care to more than ten terminally-ill patients and had recent experience with dying patients. Generally speaking, these participants constituted a mature group of nurses who were not strangers to care of the dying. In fact, during the course of the inservice training sessions, most participants were actively involved with care of terminally-ill patients.

In accordance with research protocol and requirements of the Simon Fraser University Research Ethics Review Committee, each participant signed a Consent Form (Appendix H) and was given a Simon Fraser University "Subject Feedback Form"

<sup>7</sup>Extended care ward in this hospital consists of patients who are functionally unable to care for themselves and are requiring basic physical care but not "acute" hospital care. Most are on a waiting list for nursing home accommodations for patients requiring total care.

following the inservice program. At the outset, they were informed that this inservice training program was a research project; their participation was voluntary and they could withdraw if they wished without affecting their hospital status; all data collected would be coded and used for research purposes only; anonymity would be ensured; and the results of the study would be published and available to read at a later date.

### Therapist

It has been suggested that the level of functioning of the therapist has a relationship to the efficacy of the training (Foulds, 1969; Friel, Kratochvil, 1968; Martin, Carkhuff, 1968; Pierce et al., 1967). For example, research by Pierce et al. indicated that the counselors functioning at the highest level elicited the greatest gain. Since the issue of the level of trainer functioning is critical, the investigator's qualifications should be noted. The investigator's background is quite eclectic, both in education and experience. The education background includes a nurse's three year diploma training program, a Baccalaureate in Arts degree with a major in psychology and the required course work completed for a Master's degree with the Faculty of Education, Simon Fraser University. Graduate courses included statistics, curriculum development and more important for the training of empathic communication, a teacher-student interactions course which focused on Carkhuff's Index of Communications. This course involved learning, practicing and self-and trainer-assessment of interpersonal skills.

Clinical experience consisted of more than ten years experience in acute care hospitals, which included obstetrics, medical and surgical nursing care. In all these areas, responsibility for the nursing care of dying patients and working with grieving families was experienced. There has also been eleven years experience in psychiatric units which included care of the chronic and acute mentally-ill patients. In the latter eight years, the focus of treatment has been on assessment, utilizing a multi-disciplinary team approach. There has also been two years experience as a Psychiatric Clinician in a Psychiatric Day Program. This program consisted primarily of group therapy which ranged from unstructured, exploratory and psychotherapeutic groups to structured groups which

involved teaching with a focus on communication skills and stress management.

Interpersonal skills are foremost and central to effective psychiatric nursing.

#### Putting the inservice program into action

To arrange for implementation of the inservice program, the investigator met with the medical cluster to explain the plan. A consensus was achieved for the most favorable time to conduct it and arrangements were made to post a description of the inservice program (Appendix F) on each ward. One of the charge nurses was feeling particularly stressed that day due to a sudden death on the ward and the subsequent frustration of coping with avoidance and inexperience, as well as with the patient's family. Recognition of the need for this type of inservice program was demonstrated in the attention given to posting the notice and informing staff, with the resulting greater participation (6 out of 11 participants) from this ward. Because of this response, this ward was chosen to collect data for the evaluation of impact to be described later.

The attempt to follow the inservice plan (Appendix A) as described was generally successful except for the third session. This session started late, two participants were absent and three came rushing in from their wards, one of them talking animatedly about the pressure due to lack of time allowed for another inservice program. When the participants were asked to do the Communication Questionnaire (Appendix I), the non-verbal messages were very apparent. Some slouched in their chairs; there were many sighs and groans; a few tapped their pencils; there was frequent shifting of legs and staring out the window. It took much longer than expected to accomplish this task. Along with this, there were the usual avoidance behaviors expressed verbally when people first meet this type of task. For example, "It's hard to write it;" "I know it would be easy if they were saying it;" "I run across this every day and it's easy to reply when you are there." Suddenly, one of the nurses jumped up, handed in her unfinished questionnaire and

left.<sup>8</sup> It was difficult to assess what was happening. Were the questions too difficult? Was the training program too demanding? Were they tired? Were they angry? Was it the ability of the investigator/trainer?

After the trainees completed and discussed the questionnaire, the trainer began preparation for role-playing dyads. At this point the non-verbal messages became even more obvious and a hypothesis was generated that these behaviours were due to "resistiveness." A decision was made to forego the agenda and use some empathic listening to clarify the situation. This would both uncover the difficulty as well as model the techniques being advocated in the training program. In response to the observation that "there seemed to be something bothering them," one of the nurses stated in a loud, somewhat defiant tone-of-voice, "We need some answers." She began with "What do we do when. . ." questions in relation to patients dying, to which the group provided the answers through discussion and sharing of ideas. What surfaced as most problematic for them was two major changes on their ward at this time. They were suddenly having to deal with palliative care patients and the difficulties that care entailed in learning and accepting the "pain-free" medication regime.<sup>9</sup> But to compound this stressful situation, they were suddenly faced with having to learn how to care for patients with tracheotomies who were going to be moved from the intensive care units to their ward. Although some had previous experience with this specialized care, they were being introduced to a new type of equipment called a tracheotomy-cuff, which would require a few hours of

<sup>8</sup>The nurse quit the inservice at this time. In an interview the following week, she stated that she was unable to continue due to too many commitments at that time. She also stated that she was uncomfortable with the experiential style of the course, preferring the didactic approach.

<sup>9</sup>Pain-free regime is a special medication regime for pain usually associated with cancer, in which the medication (usually morphine mixture) is titrated and given regularly in doses large enough to alleviate pain. Not only does this method require careful monitoring until a therapeutic level is reached but psychologically, it is difficult for many nurses to accept as: 1) the amount of morphine can reach much higher levels than routinely given; 2) morphine is a narcotic which is usually given on a p.r.n. (whenever necessary) basis; and 3) nurses tend to fear creating and perpetuating drug addiction so are reluctant to give a narcotic unless the pain is obvious.

instruction and supervision. From this added load of work and responsibilities, a variety of feelings were expressed: anger as they already felt overworked; fear of the new equipment; resentment because they felt pressured trying to accommodate this extra instruction; frustration that "nobody" cared about their stress; and concern that the work situation was bordering on being unsafe. Once their feelings and concerns were vented, the training program agenda continued with no re-occurrence of the above resistiveness.<sup>10</sup> However, it did cut substantially into the time allotted for them to become involved with their own practice in empathic communication skills.

### Research design

The purpose of this study was to develop, implement and evaluate an inservice training program for hospital nurses to cope with the emotional aspect of loss. The first two sections of this chapter described the process of developing and implementing the inservice program. This third section deals with the process of evaluation. This includes a description of the measures utilized to determine if the outcomes in the three defined areas of interest--effect on nurses' attitudes, improved communication skills and impact on actual nursing care--were, in fact, realized. For the determination of outcomes, three hypotheses were tested in this study:

1. Hypothesis I: There will be no significant difference between pre- and post-measures in the Death Attitude Questionnaire.
2. Hypothesis II: There will be no significant difference between pre- and post-written and audio-taped responses of empathic communication.

<sup>10</sup>Deductions from this discussion and experience were: 1) Unspoken and hidden feelings can have an impact on learning and concentration. 2) Attending and responding with empathic communication is an effective tool in "clearing the air" when leading a group. 3) One cannot underestimate the impact of a "change" in creating emotional distress. 4) The fact that the palliative care unit had *ever existed* increased the nurses' feelings of inadequacy as they could not replicate the esteemed palliative nursing care on their unit. 5) The "resistiveness" was not necessarily directed towards this inservice program but there was a general feeling of frustration, overwork and fatigue. Thus, expecting them to "do" something became an added burden at this time.



3. Hypothesis III: There will be attitudinal and communication changes after the inservice program which will be demonstrated in actual nursing care on the ward.

In the first two, rejection of the null hypotheses was determined at the .05 level using a two-tailed test of "significance". In the third hypothesis, a qualitative description of identified changes pre- and post-training program was done. The results of the testing of these three hypotheses are described in Chapter IV.

#### Procedure used to gather data for Hypothesis I

#### Discussion

Inquiry into attitude is based on the assumption that fears, values, beliefs, preferences and prejudices of nurses can shape their expectations about others and thus, affect their nursing care of the patients. The expectation in this study was that the inservice training would have an effect on the nurses' beliefs, attitudes, and feelings when caring for dying patients. This effect would result in increased understanding of patients' emotional distress and subsequently less avoidance when dealing with this aspect of nursing care.

When measuring attitudes it becomes necessary to try to infer the attitude from a variety of responses that are seemingly related. This implies that the responses reflect the attitude and thus, provide validity. The search for obtaining a previously tested Death Attitude Questionnaire was unsuccessful, and therefore required the development of one which borrowed some ideas and questions from three other studies (Beck, Weissman, 1974; Coolbeth, Sullivan, 1984; Hoppings, 1977). In Coolbeth's study, he identifies questions which are directed towards a person's opinions, feelings and beliefs regarding death and dying. Hopping uses a similar approach but organizes the questions in a sequence beginning with opinions and ending with feelings so as to reduce the possibility of the respondent being affronted or "hemmed in" (p. 445). Both examples use a Likert model based on the assumption that attitudes are best measured on a

continuum with the middle value being neutral. Beck & Weissman illuminated the impact of hopelessness on health recovery: the assumption is made that nurses' attitude of hopelessness could have an effect on their nursing care of the dying.

#### Instrument

In developing an attitude questionnaire for this inservice program, the goal was to measure the participants' personal philosophy (opinions, beliefs, and feelings towards death and dying); their ability to discuss these feelings with patients and others; their understanding of the patients' emotional distress; their ability to care for dying patients and their attitude of hope. For this questionnaire, some items were borrowed and/or modified from the above three studies; some items were developed by the investigator. It was inferred that these chosen items reflected the personal philosophy described above.

The developed death attitude questionnaire consisted of 39 items using a Likert 5-point bipolar-graphic rating scale with the highest score (5) indicating a positive attitude, the lowest score (1) indicating a negative attitude and (3) indicating a neutral attitude. There was no specific sequence to the questions but some items were reverse-ordered in a random manner so the participant could not discern a pattern in marking the continuum.

To determine internal consistency, this questionnaire was field-tested with thirty nurses and student nurses. To ascertain if the language used would be interpreted as intended, the respondents were asked to report any items that were unclear to them. Using SPSS<sup>11</sup>, an item analyses was done, which found the questionnaire items to have a .79 reliability. After inspection of the questionnaire, some of the items that showed no variance were dropped. Following discussion with the respondents, some of the items that were unclear were deleted; some modifications were made in the inversion order of

<sup>11</sup>SPSS—Statistical Package for the Social Sciences.

items; and six new questions were added. This resulted in a 36-item Death Attitude Questionnaire which was used for the study (refer to Appendix I). (The asterisks by the item numbers indicate those items reverse-ordered). Another test for reliability was done, using 22 nurses and the reliability score was .77, an adequate result for a group measure.

Additional information about the final instrument is provided in Table I. The items which correlated more highly with the total score are listed and are assumed to be indicative of the attitude being measured. Table I illustrates the items which were found to have a correlation coefficient greater than .40 and their probability value.

These thirteen items are the strongest discriminators of attitude in the questionnaire and as such, are useful for further development and/or replication of a death attitude questionnaire in future research. It is noted that two of the items of higher correlation, twelve and seventeen, are related to hope, an attitude that Beck & Weissman maintain has impact on care of dying patients.

TABLE I

ITEMS IN DEATH ATTITUDE QUESTIONNAIRE WITH HIGH CORRELATION TO TOTAL SCORE

<u>Items</u>	<u>N</u>	<u>Correl a-tion</u>	<u>p- Value</u>
11. All possible efforts should be made to keep a terminal patient alive?	22	.43	.04
12. There is no reason in trying to get what I want because I probably won't get it.	22	.72	.00
15. I would feel very uncomfortable if I entered the room of a terminally ill patient and found him/her in tears.	22	.44	.03
16. Even if a patient knows s/he is dying I would feel uncomfortable discussing his/her impending death.	22	.46	.03
17. One can always find something to look forward to.	22	.63	.00
19. Discussion with the dying about their feelings/fears should only be done by people trained for this.	22	.55	.00
20. I cannot become involved with the emotional care of the patient as it takes too much time.	22	.43	.04
21. Families must be involved in discussions and decisions regarding the terminal patients care.	22	.54	.00
22. I feel uncomfortable riding the elevator when there is a patient being transferred to the morgue.	22	.50	.01

<u>Items Cont.</u>	<u>N</u>	<u>Correl a-tion</u>	<u>p Value</u>
23. When I answer the call light of a patient who is critically ill, I am often concerned that s/he might die when I am in the room.	22	.63	.00
24. After the death of a patient it should be discussed with the other patients in the room.	22	.63	.00
25. I would rather take care of a comatose who is terminally ill than one who is conscious and aware of impending death.	22	.47	.02
33. Do you believe emotions should be expressed (1) or controlled (5)?	22	.57	.00

For further interpretation of the items used, a correlation was also done of each item with the independent variables in the demographic questionnaire (Appendix G). Table II illustrates the attitude items which indicated a high correlation to the demographic data, using a p value at the .05 level of significance.

**TABLE II**

**ATTITUDE ITEMS WHICH HAVE HIGHER CORRELATION TO INDEPENDENT VARIABLES**

<u>Demographic Items (Appendix G)</u>	<u>Death Attitude Items</u>			
2. Age	1	25	34	19
5. Previous training re: death/dying	3	30		
6. Previous communication skills training	8	1		
7. Communication course	8	9*	23*	
8. Years of clinical experience	11*	19*		
11. Recent death of a close person	11			

\* p value of .01

Although the small sample size precludes any generalizability, this information could be useful for further research. For example, item 11, "All possible efforts should be made to keep a terminal patient alive", correlates highly with two control variables: over ten years clinical experience and no recent experience with death of a close person. Since item 11 is inversely ordered, this indicates that those participants with the most clinical experience and no recent personal experience strongly disagree with the statement. Another example, item 8, "The patient should be told right away if he is terminally ill" correlates highly with those participants who have taken a communication course (demographic items 6 and 7). One could suggest that their agreement with these statements indicates increased confidence communicating in this situation.

The Death Attitude Questionnaire was completed by the participants in pre- and post-sittings. Using SPSS, a matched t-test was done for the statistical purposes of testing the first null hypothesis, using a two-tailed test at the .05 level of significance.

Hypothesis I: There will be no significant difference between the pre and post-measures in the Death Attitude Questionnaire.

The results of the t-test are described in Chapter IV.

#### Procedures used to gather data for Hypothesis II

#### Discussion

When patients experience loss, a psychodynamic concomitant of that loss is the repression of feelings. When such emotional distress is repressed, it is frequently expressed in other behaviors, described as defenses, such as: projection--blaming others; isolating emotion--aloof, withdrawn; displacement--anger towards others or objects; rationalizing; and avoidance or denial of the distressed feeling (Becker, 1973; Deutsch, 1937; Scarf, 1980). The key to understanding and unlocking these repressed feelings is through communication (Aiken, 1985; Furman, 1974; Gonda, Ruark, 1984; Kübler-Ross, 1975; Schoenberg et al., 1970).

The expectation of the training program in empathic communication, was that by attending to the thoughts, ideas and feelings expressed in the training examples, the participants would develop the skill to truly hear what the patient is saying and to communicate to the patient that s/he has been heard. Previous studies suggest that this communication of empathy enables patients to explore and accept their feelings of loss and thus, be free to gain greater understanding of the emotional aspects of that loss, resulting in enhancing dignity, autonomy and ability to make decisions.

### Instruments

Two measures were used to gather data on Hypothesis II, a written questionnaire and audio-taped recordings.

#### Written questionnaire.

The written questionnaire was based on Carkhuff's Index of Communication. It consists of "helpee" statements in which a problem is expressed and in which "helper" responses showing empathic concern must be formulated. The method of writing "helpee-stimulus" responses was found to have validity as an index of a helper's level of functioning in a helping role by Greenberg (Anderson, 1980: 68). Carkhuff (1969) established that the index is a reliable indicator of high and low-level communicators. This index has been used in many training programs for a variety of populations and has been discussed extensively in Chapter II.

The Communication Questionnaire developed to gather data on trainees' level of communication skills is found in Appendix J. It consists of fourteen "helpee" statements which were designed to represent feelings and content often revealed in hospital situations. These statements are a deliberate attempt to utilize the same concept of identical elements described earlier (p. 26). Table III lists four emotions related to grieving (fear, anger, depression and blame) and the related statements which could be symptomatic of these emotions. Added to this are two statements which test the nurse's ability to respond empathically, in a non-judgmental manner, when there could be perceived personal criticism.

**TABLE III**

**"HELPEE" STATEMENTS RELATED TO EMOTIONS OF GRIEVING IN QUESTIONNAIRE**

<u>Emotions of grieving</u>	<u>Related "helpee" statements (Appendix J)</u>		
Fear	Excerpt 1	Excerpt 5	Excerpt 12
Anger	Excerpt 2	Excerpt 7	Excerpt 13
Depression	Excerpt 3	Excerpt 8	Excerpt 10
Blame	Excerpt 4	Excerpt 9	Excerpt 14
<hr/>			
Testing empathy	Excerpt 6	Excerpt 11	

The participants were given this questionnaire prior to the beginning of training in empathic communication skills (Session three). They were instructed to formulate a response to each of the "helpee" statements as though they were the helper in these situations and write it in the space provided. As previously noted, the participants appeared to struggle with this task. Because this measure took longer than anticipated and some of the statements were not completed, the post-measure was shortened by eliminating the uncompleted ones. Deleted from the post-version were excerpts 1, 3, 9, 13, 14, leaving nine "helpee" statements which were used for pre-post-training statistical analysis.

**Audio-taped measures.**

For this study, it was felt that both written and audio-taped measures should be used. Then, those who have problems with writing responses are given the opportunity to use an alternative medium. Although simulating role interactions is frequently described as too artificial to be applicable to real situations, participants quickly forget they are "pretending" and begin to manifest strong emotional responses. In addition, this technique offers an opportunity for practice of a skill promoting learning that can be transferred to actual situations.



Carkhuff (1969) advocates the use of a taping technique to obtain samples of a person's counseling competency. He states that the excerpts assessed should contain at a minimum one "helpee-helper-helpee" interaction.

In pre- and post-empathic communication training, the participants were divided into dyads and instructed to role-play "helping" situations, taking turns being the "helper" and to tape themselves. This measure was unstructured in that 1) they could choose their role situation from personal experience or use one of the sample situations created for the program (see Appendix D); 2) they were given enough time to expand the situation as they chose; and 3) they could respond as they chose.

One limitation to be noted in this procedure was the factor of pre-treatment inequality. For example, choice of partners was constrained by convenience and availability; the capability of partners was not accounted for; and there might have been compatibility problems between partners from previous experiences.

#### Rating procedure

This section describes the rating procedure used in this study to investigate Hypothesis II.

Hypothesis II. There will be no significant difference between pre and post-written and audio-taped responses of empathic communication.

#### The scales.

To assess the effectiveness of the training of communication skills, the pre- and post-written and audio-taped responses were rated using the Carkhuff's Empathy Scale. Validity and reliability of this scale has been established in previous studies (Anderson, 1980; Guzzetta, 1976; La Monica, 1976, 1978; Kalish, 1973; Pierce et al., 1967). The scale for empathy is a five-point equal interval scale in which a rating of 1.0 is low and a 5.0 is high. Level three, the facilitative interchangeable level is the expectation level for this training since that represents the minimum level of effective helping responses.

### Rating of the measures.

Prior to the rating, the participants' written responses to the nine communication items were coded with randomized numbers. To ensure anonymity, each excerpt was separated from the questionnaire and typed onto nine different sheets under the nine different items. Thus, each sheet contained all the participants' responses to one of the items. The pre- and post-responses were randomly distributed on each sheet so the raters would not know if the response was pre- or post-data. In the margin, the rater noted the communication score for each item. The score for each participant was obtained by totalling their score and dividing by the nine items for the mean score to be used for pre-post comparisons.

Similarly, the audio-taped recordings were also coded with randomized numbers and randomly organized so that the raters were unsure of which excerpts were pre- or post-data. These tapes were rated in the same manner as the written items. The scores for each participant's pre- and post-recording were totalled and divided by the number of responses given for a mean score to be used statistically in the study. Carkhuff (1969) stated that ". . . because of the inability of the scales to assess many aspects of the helpee-helper interaction the modal level of helper functioning may be the most appropriate statistic" (p. 232). For this reason a modal comparison is also used in the statistical analysis.

### **Raters**

The raters were two independent raters who had been taught Carkhuff's Index of Communication in a graduate class and who are especially interested in the area. Prior to the rating, they met to discuss the rating procedure and share their interpretation of the levels. They rated all written and audio-taped responses independently. The interrater reliability was calculated using the Pearson's product-moment coefficient of correlation and was .98 on the pre- and .98 on the post-written responses; .98 on the pre- and .97 on the post-taped recordings. The average of the raters' scores for each index was used

for the statistical purposes of evaluation. A t-test was done for pre-post-training comparisons of the means and these results are shown in Chapter IV.

### Procedures used to gather data on Hypothesis III

#### Discussion

Guzetta (1976) states "one of the central problems in both education and counseling, however, is how to maintain behaviors and extend them to new settings once they have been taught." (p. 449) This assertion has serious implications because even if skills can be learned in a training program, we do not know if they are applied to the situations for which they are intended. In an attempt to delineate this factor, Guzetta applied Goldstein's "identical elements" to one of the four groups of parents being trained to communicate empathically with their children (1976). In this group she included the parents' children in the training but found no evidence that this experimental manipulation increased transfer or a higher level of empathy than in the other two experimental groups. In another study to determine if there were actual changes in personality and interpersonal functioning it was found that there was significant improvement in general, but the "significant others" did not perceive any changes on empathy and concreteness in the participants (Martin, Carkhuff, 1968). Thus, from the literature reviewed, no conclusions can be made regarding the transfer of newly acquired skills to "real life" situations.

There is consensus that empathy is an essential skill for nurses to facilitate healthy nurse-patient relationships (Chapter II). However, it is still unclear if the methods chosen to teach this skill have an impact on actual nursing care in the hospital. To gather data on the transfer of training skills to actual hospital practice, one ward was chosen. Six of the twenty-six nurses employed on this ward were enrolled in the inservice program. This representation of staff from one area was considered to have the potential of showing some indications of transfer of new skills to the work situation. To assess this issue of transfer to the ward, three approaches were utilized: 1) charts and handover

reports; 2) interview of charge nurse and 3) a case study. These data were collected and analyzed to investigate the third hypothesis.

Hypothesis III: There will be attitudinal and communication changes after the inservice program which will be demonstrated in actual nursing care on the ward.

#### Charts and Handover reports.

A chart is assembled for each patient in the hospital which consists of all the medical reports pertinent to that patient during hospitalization. A legal document of the hospital, the chart is an index of the total care being given to the patient. It is the responsibility of the nurse to write all observations and treatments given to the patient in a section referred to as Nurses' Notes. As such, the necessity of this documentation requires a considerable portion of the nurses' time in performing this task. The format of the nurses' charting varies. Sometimes it is a summation of the care given to the patient each shift; sometimes a sequential description of events as they occur during the day is reported; sometimes the patients' medical condition at that time is described. Generally speaking, the focus on the medical ward is the physical aspect of care; descriptions of treatments given and results, invasive treatments such as intravenous therapy, various diagnostic tests performed, respiratory and circulation monitoring, repositioning of the patient, ambulation levels and elimination problems. There is very little mention of the thoughts, feelings and/or concerns of the patient.

Handover is a term used to designate the report on patients' status that is given from one shift of nurses to the next shift. All pertinent information regarding the patients' treatments is reported at this time to ensure continuity of care. The handovers are audio-taped on each shift by a designated nurse, referred to as the team leader, who gathers and organizes the information from the nurses giving care to the patients. The advantage of using charts and handovers is that they offer an unobtrusive index of the nurses' concerns when delivering nursing care. The disadvantage encountered within the scope of this study was that the charts of all participants of the inservice program could not be

analyzed. Similarly, the handovers would not necessarily contain reports made by the participants.

The purpose of examining the charts and handovers was to determine if they reflected any change in attitudes or nursing care following the inservice program. Specific change in attitude would be indicated by increased attention towards the emotional needs of the patients.

The investigator, who has 20 years of experience in charting and handover procedures and had access to the confidential information contained in the charts, conducted this investigation. In an attempt to control the possible bias of the investigator, objective criteria were established a priori the data collection. It has been established that the purpose of the training program was to promote an awareness, sensitivity and ability to discern and not avoid the emotionality factor attendant to hospitalization. Thus, the criteria used to determine if there were any changes in nursing attention to the emotional aspect of care were written or verbal references made to: the emotional state of a patient; reasons given for the defined emotion; emotional needs of a patient; measures to alleviate a patient's emotional distress or pain; and family visiting or family concerns.

The contents of the Nurses' Notes in twenty-two charts were analyzed. They were not chosen at random but represented the patients under the care of the nurse who participated in the case study. This decision was made as many nurses on the ward were not attending the inservice program and subsequently, could not reflect the impact of the inservice program. By chance, in all of the charts used, there were some nurses' notes written by other participants in the inservice program. The contents of the previous 48 hours of charting were analyzed for criteria described above. The observations of the "emotional aspect of care" were recorded and totalled for pre-and post-inservice program comparison.

In the week prior to and after completion of the inservice program, four handover tapes were analyzed. As previously mentioned, it was impossible to ensure that these tapes would be recorded by a participant of the inservice program. Thus, only two out of

eight handovers were taped by a participant. Pre- and post-inservice training, the investigator visited the ward and listened to one dayshift (0730-1930) handover, and three nightshift (1930-0730) handovers were obtained through the charge nurse. The observations related to the above criteria of "emotional aspect of care" were recorded and totalled for pre-and post-inservice program comparison. The results of the charting and handover reports are illustrated in Chapter IV.

#### Interview of charge nurse.

The charge nurse's support for this training program has been reported above. Although she was aware of the basic principles of the inservice training, she was not informed of any details of the research design itself, such as the criteria for observation on her ward. She willingly agreed to an interview following the inservice program.

The purpose of the interview was to ascertain if she had noted any changes in attitudes or behavior of nurses who participated in the inservice program; if she felt that the inservice training had improved the nurses' delivery of nursing care of the dying, and if she had noted any changes in the ward dynamics since the inservice program, even though only five of her twenty-six nurses were actually attending.

The interview was done ten days after completion of the inservice program, in her office. It was recorded and later typed. The contents of the typed copy were identified and reduced to analysis of the three cited criteria: changes in nurses' behavior; changes in ward dynamics; and changes in nursing care of the dying.

#### Case Study.

Initially, the plan was to include case studies of two nurses working in the clinical setting. However, due to the unexpected illness of one of the trainees, she was unable to give the time required in the preparation of the second case.

The choice of a nurse for a case-study was random in the sense that she was the only nurse on duty the day the investigator visited the ward to see how many would be attending the inservice program. She agreed to participate and arrangements were made

to meet four days prior to the inservice program and eight days following completion. Convenience determined the choice of time. First, the evening shift was chosen because the ward was quieter with less external interruptions of her nursing care and because it provided the longest continuous period of nurse-patient contact. Second, the choice was limited to a time when she was working and the investigator was free.

Two approaches were undertaken for the case study--shadowing and interviewing. The purpose was to ascertain if there were any notable changes in behaviors, feelings and/or actions regarding nursing care of the patients.

#### Shadowing.

This is a process in which the nurse is followed as she performs nursing duties. The hours chosen were 1900-2200, a period in which some of her responsibilities consist of listening to the handover report, planning the agenda of nursing care with her assistant (L.P.N.)<sup>12</sup>, preparing the medications and, with her assistant, giving the required treatments and settling the patients for the night. To ensure privacy for the patients, the investigator remained outside the curtained area when physical care was being given.

It was difficult to know which procedure to use when conducting the observations. Keck and Walther (1977) used a stopwatch when comparing the time spent by nurses dealing with the emotional needs of dying patients as opposed to non-dying patients. Similarly, a stopwatch was used to clock and record the elapsed time that the nurse spent with each patient and the frequency in which three target behaviors occurred; 1) giving just physical care, 2) giving physical care plus talking to the patient, and 3) just talking with the patient.

Because the training aspect of this inservice program was focused on empathic communication skills, this focus determined the observations recorded. Thus, the

<sup>12</sup>L.P.N. — Licensed Practical Nurse is achieved in a diploma course which consists of 9-12 months training depending on the program taken. Many of the duties are similar to that of a Registered Nurse, except for leadership responsibilities, administration of drugs and many of the treatments given to the patients.

criterion of the frequency and kind of talk during nurse-patient contact was established and adopted to assess the nurse's verbal responses to the patients. If the level of conversation was just "chit-chat", without any recognition of feelings and content (Level 1), nothing was recorded. The responses that were coded and recorded were as follows: Cl—those that clarified by asking questions pertinent to the patients' statements; Ref—those that reflected the content of the patients' statements; and E—those that reflected the patients feelings (empathic).

The pre- and post-inservice program shadowing observations were totalled and used for comparison purposes to evaluate any changes. These results are illustrated in Chapter IV.

To determine if any noted changes in the nurse's care of patients were due to the influence of patients' needs, an attempt was also made to assess the severity of the patients' status. For this, charts of the patients under her care were examined and the patients' age, length of hospital stay, if deemed terminal<sup>13</sup>, and family support (spouse, children) were recorded for a pre- and post-training comparison.

#### Interview.

Pre-inservice program interview was done immediately following the shadowing, to explore the nurse's beliefs, opinions, values, feelings and any difficulties experienced in caring for the emotional needs of the patients. The focus of the interview was care of dying patients, dealing with their families and any experiences that she found meaningful to her.

The post-inservice program interview was done following the post-training shadowing. The purpose at this time was to determine if there were perceived changes that could be related to the inservice training program. In other words, how did she feel

<sup>13</sup>By terminal, there is a "No Code" on their chart. This term indicates that there is not to be any invasive therapy done if there is a cardiac or respiratory arrest.



about the inservice program? Did it help her understand her patients any better? Did it improve her skill and comfort in coping with the patients' emotional distress?

Both interviews were taped. They were then typed, analyzed and reduced to the previously described themes related to the study--feelings and attitudes towards care of dying patients, empathic communication skills and impact on the actual nursing care.

#### Limitations.

Shadowing, as an evaluative process, is limited by three factors. First, the degree to which the presence of the observer changes the situation being observed. Second, the inability to assess for reliability estimates as only one observer is evaluating the situation. Third, the "halo effect"<sup>14</sup> can influence the observer's ratings of all observations.

The data gathered for hypothesis III is of a descriptive, qualitative nature and as such, cannot be used for statistical purposes with predictive value. However, the collecting, observing, documenting and coding schemes used are an attempt to offer the kind of construct and contextual validity described by Miles and Huberman (1984). Thus, these methods can be replicated by others wishing to do a similar study for comparison or confirmation purposes.

As well, the sample size is small preventing the findings from being generalized to other areas. It is also recognized that this study is subject to the investigator's personal biases and observational skills.

#### Conclusion

This chapter has covered the methodology and research design of this study by describing three procedural components of the inservice program: 1) the development,

<sup>14</sup> "halo effect"--The investigator forms an early impression of the person being observed and permits this impression to influence the ratings on all behaviors involving the subject (Borg & Gall, 1983).

2) the implementation, and 3) the evaluation. The evaluation investigations were determined by the three areas of concern described at the outset:

1) Will the inservice program have an impact on nurses' attitudes towards caring for the emotional distress presented in the hospital? To evaluate this, a Death Attitude Questionnaire was developed and given to the participants.

Hypothesis I: There will be no significant difference between pre- and post-measures in the Death Attitude Questionnaire.

2) Will the inservice program improve the communication skills necessary to cope with the patients' emotional distress? To evaluate this, a Communication Questionnaire and taped role-playing situations were developed and participants' responses assessed.

Hypothesis II: There will be no significant difference between pre and post-written and audio-taped responses of empathic communication.

3) Will the nurses' increased awareness and knowledge of patients' emotional distress as related to loss plus the acquisition of communication skills be transferred to the actual nursing care of patients in the hospital setting? To evaluate this, a variety of approaches were used: analyzing the charts and handovers, an interview with the charge nurse and a case study of a nurse using shadowing and interviewing techniques.

Hypothesis III: There will be attitudinal and communication changes after the inservice program which will be demonstrated in actual nursing care on the ward.

The last chapter presents the results of the data analyses of the above three hypotheses. This is followed by a discussion of the results, and subsequent conclusions, implications and recommendations for future research.

## Chapter IV Results and Discussion

### Introduction

The purpose of this study was to develop and implement a hospital inservice training program for nurses to 1) increase their awareness and knowledge in regard to the emotional needs of the patients and 2) to increase their communication skills to deal with this emotional aspect of care. Three hypotheses were tested to assess the effectiveness of the inservice program to determine a) if there were any changes in nurses' attitudes; b) if there were improved communication skills; and c) if there was any impact on the actual nursing care on the ward.

The first section of this chapter describes the data gathered on each of the hypotheses, followed by a discussion of these data. The second section deals with the conclusion, implications and recommendations for future research that are based on the findings.

### Results

Hypothesis I: There will be no significant difference between pre- and post- measures in the Death Attitude Questionnaire.

As previously stated in Chapter III, a Death Attitude Questionnaire was developed and used to determine if there were any changes in the participants' attitude towards death and dying following the inservice program. This questionnaire, consisting of thirty-six items, was based on a 5-point Likert scale with 5 rated as a positive attitude and 1 as a negative attitude. The participants completed this written questionnaire prior to and at the end of the inservice program.

Using SPSS, a matched t-test was done comparing pre- and post-mean scores of responses to the attitude questionnaire. Null Hypothesis I was determined at the .05 level of significance for a two-tailed test. The results are presented in Table IV.

TABLE IV

A COMPARISON OF PRE-AND POST-MEAN SCORES ON DEATH ATTITUDE QUESTIONNAIRE

Items	N	Mean		S.D.	DF	t-value
		Pretest	Posttest			
36	9	142.4	148.1	13.72	8	1.24*

\* Not significant at or beyond the .05 level.

Based on the data presented in Table IV, Hypothesis I could not be rejected. Although differences in the mean scores indicate increased positive attitude after the inservice program, these differences are not significant.

Hypothesis II: There will be no significant difference between pre- and post- written and audio-taped responses of empathic communication.

As previously described in Chapter III, participants completed a communication Questionnaire and participated in audio-taped role-playing exercises prior to and at the conclusion of the communication skills training portion of the inservice program. Carkhuff's Index of Communication (1969) was used to assess each participant's level of empathic response. Independent raters assigned ratings to each "helper" responses according to the levels illustrated in the Empathy Scale (Appendix E):

Level 1--the helper is unaware of even the most conspicuous surface feelings;

Level 2--the helper is partially aware of obvious feelings

Level 3--the helper accurately reflects the content and feelings (the recommended response in this training program).

Level 4--the helper achieves level 3 plus adds further meaning.

Level 5--the helper communicates an accurate empathic understanding of the deepest feelings.

For statistical analysis of the written questionnaire, the raters' scores of each participant were totalled, divided by nine, ( number of responses per participant), and the resulting mean scores were averaged to give the final score of each participant.

The audio-taped responses were similarly treated. Each rater designated a score to each "helper" response in the role-playing dyads. These scores were divided by the number of responses to determine the mean score. The raters' mean scores were averaged to give the final score and to allow for statistical comparisons. In keeping with Carkhuff's recommendations (see Chapter III), there were no less than two "helpee" responses in each dialogue and the modal level of communication was also determined for the participants' responses.

Using SPSS, a matched t-test was done to determine the significance of differences in pre- and post-training mean scores. Differences were accepted as significant if the probability that they arose from chance was less than .05 for a two-tailed test. Also, for further interpretation to be discussed later, a comparison of the audio-taped modal responses was done. The findings are given in Table V.

TABLE V

COMPARISON OF GROUP MEAN AND MODAL SCORES PRE- AND POST-INSERVICE TRAINING  
OF EMPATHIC COMMUNICATION

Variable	Number of Cases	Mean	Standard Deviation	(Difference) Mean	Standard Deviation	T Value
Pre-written	9	2.09	0.29	-0.28	0.24	-3.42**
Post-written		2.37	0.38			
Pre-Audio	9	1.83	0.36	-0.33	0.17	-6.03**
Post-audio		2.17	0.48			
Pre-modal	9	1.83	0.35	-0.17	0.25	-2.00
Post-modal		2.00	0.43			

\*\*Significant at the .01 level for a two-tailed test.

When comparing the pre- and post-means of the written and audio-taped measures, a significant difference at the .01 level of significance was found. Thus, according to the data in Table V, null Hypothesis II is rejected.

Hypothesis III: There will be attitudinal and communication changes after the inservice program which will be demonstrated in actual nursing care on the ward.

To determine the impact of the inservice training program on nursing care descriptive analyses were done on a variety of assessments which are discussed under the headings: 1) charts and handover reports, 2) interview of charge nurse and 3) a case

study. These assessments were carried out on one acute medical ward, in which five of the final participants were working.

Charts and Handover Reports.

Charts. As described in Chapter III, the investigator examined the charts prior to and following completion of the inservice program. The charts used were those of the patients assigned to the nurse in the case study. As described in Chapter III, the contents of a two-day period in each chart were analyzed according to criteria indicative of nursing attention to the emotional aspect of care. A pre- and post-inservice program recording of specified criteria is illustrated in Table VI.

TABLE VI

A COMPARISON OF NURSES' CHARTING OF EMOTIONAL ASPECT OF NURSING CARE.

<u>Criteria of emotional aspect of care</u>	<u>Pre</u>	<u>Post</u>
Reference to a patient's emotion/feeling	0	4
Reasons given for observed emotion of patient	0	1
Reference to emotional needs of a patient	0	0
Measures to alleviate a patient's emotional distress or pain	2	0
Reference to family visiting or family concerns	0	0
Total	2	5

The above table indicates very few references to the emotional aspect of nursing care that were charted by the nurses before or after the inservice program. Although a slight increase is noted following the program, the numbers are too small to be considered significant.

Handovers. As described in Chapter III, four handover reports were analyzed pre- and post-inservice program training to determine if there were any changes in the verbal reporting of the emotional aspect of care. Table VII illustrates the findings in the

hand-over reports of thirty-two patients on the medical ward. Each report is made by two nurses designated as the team leaders for that shift.

TABLE VII

A COMPARISON OF THE HANDOVER REPORTS PRE- AND POST-INSERVICE PROGRAM

<u>Criteria of emotional aspect of care</u>	<u>Pre</u>	<u>Post</u>
References to the patient's emotional state	8	7*
Reasons noted for a defined emotion	2	2
Reference to emotional needs of a patient	1	2
Measures to alleviate a patient's emotional distress or pain	3	1
Reference to family visits or family concerns	4	0
Total	18	12

- Also one instance when the nurse expressed a feeling for a patient.

The data in Table VII reveal very few references to the emotional aspect of care in the handover reports analyzed. Although a decrease is noted following the inservice program, the largest difference refers to "family visits or family concerns", which could be attributed to coincidence of an attentive or concerned family at that time. Thus, the changes shown in Table VIII are not considered significant.

The data collected from the charts and handovers are not significant therefore, they are not supportive of Hypothesis III.

Interview of Charge Nurse

The charge nurse was interviewed ten days following the inservice program to find out if she had noticed any changes on her ward since the onset of the inservice program. Three criteria had been established (see Chapter III) as reflecting impact on the ward: changes in nurses' behavior, changes in ward dynamics, and changes in nursing care of the dying.



Changes in nurses' behavior. The charge nurse had observed some changes which she believed could be attributed to the inservice program: the nurses were listening better; there was less complaining in the nurses' station about how to handle troubled behavior; and nurses had reported feeling more comfortable when working with palliative care patients.

Changes in ward dynamics. The charge nurse expressed some concern about the ward dynamics during the past few weeks. There was reference made to other changes taking place on the ward, such as the added load of palliative care patients along with preparations being made to take tracheotomy patients. She expressed concern that these changes had affected the interactions between her and her staff, suggesting that the nurses were more guarded and less communicative with her. She sensed that they were upset and frightened about the added responsibilities and expressed frustration in trying to alleviate their fears by providing adequate preparation.

Nurses' delivery of nursing care of the dying. To illustrate an observed change in the delivery of nursing care, the following example was described:

There is a dying patient on the ward who is unlikely to leave the hospital again. He is described as a "seedy character" --led a pathetic lifestyle, many social problems, and difficult to like. In the hospital, his response to his prognosis had been attention-seeking by frequently ringing his call bell. He had a tendency to deal with his illness in a bizarre way--talks about playing baseball soon in spite of disintegrated shoulders--which the nurses found difficult to handle.

The charge nurse describes having made a concerted effort to change the nurses' attitudes towards this patient by accepting his choice of fantasy to deal with dying and feels that they are now tolerating his "sick sense of humor" better. Also, because their listening skills have improved, they are reading between the lines better. Thus, they are avoiding him less and this attention has resulted in less ringing of the bell.

To summarize the findings in the interview of the charge nurse, two changes were observed: improved listening skills and increased comfort in caring for dying

patients. While, these observations indicate support for Hypothesis III, the supporting data are suggestive, rather than conclusive.

### Case Study

The subject, a volunteer for the inservice training program, also agreed to participate as a case study. She had been a health care worker for nineteen years; fifteen years as a L.P.N. and six years as a Registered Nurse. Since graduation in 1982, she had been working on the same acute medical ward as a staff nurse. Her education experience had not included any specific training in interpersonal skills or in death and dying. Her clinical experience had included considerable experience in caring for dying patients and her personal experience included the death of someone close to her within the past two years. She rated her job satisfaction as very good and presented herself as being confident in her work. A strong affiliation with a religious belief was also present.

As previously described in Chapter III, arrangements were made to meet prior to and following completion of the inservice training program. It was explained that each meeting would involve shadowing and an interview. The shadowing consisted of the investigator spending three hours with the subject as she worked on the ward. The interview, which was taped, occurred immediately following the shadowing during the subject's "meal break" from work

Shadowing of the subject lasted three hours from 1900-2200 hours. A stop-watch was used for recording the time she spent with each patient. Each contact with a patient was recorded according to the time elapsed and the kind of care given using the criteria: talking (T), physical care (P), and both physical care and talking (B). The pre- and post-inservice program shadowing observations of nursing care during each nurse-patient contact are illustrated in Table VIII. For example, the subject had contact with patient 1 three times; spending thirty-five and forty-two seconds respectively, talking, and three minutes and thirty-two seconds giving both physical care and talking.

TABLE VIII

PRE- AND POST-INSERVICE PROGRAM SHADOWING TIME OBSERVATIONS OF NURSING  
ACTIVITIES\*

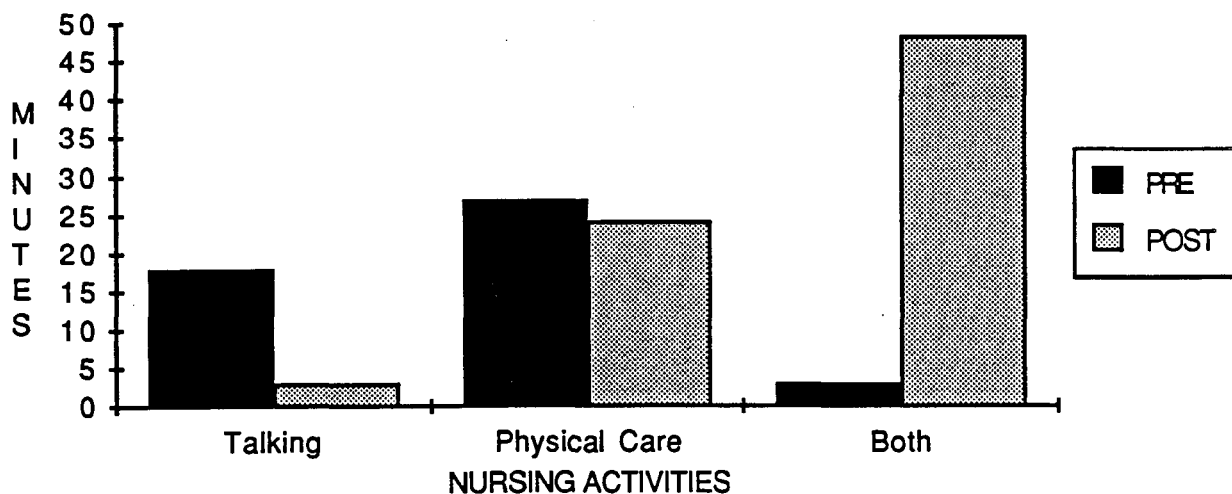
<u>Pre-inservice program</u>				<u>Post-Inservice Program</u>			
<u>Patient</u>	<u>Activity</u>			<u>Patient</u>	<u>Activity</u>		
1	T = .35	T = .42	B - 3.32	1	B = .52		
2	T = .55	P = 1.18		2	P = .05	B = 10.06	
3	P = .18	P = 1.18		3	P = .15	B = 7.26	
4	T = .18	P = 8.32	T = .45	4	T = .53	B = 12.43	P=6.43
5	T = .20	T = .22		5	B = 1.18	B = 6.43	P=7.37
6	T = 2.03	T = .51		6	P = 2.	T = .17	
7	T = .36	T = 4.10		7	B = .25	P = 7.0	
8	T = .43			8	T = .36		
9	T = .49	T = 4.10		9	T = .37	P = 2.51	
10	T = .45	T = .05	T = .25	10	B = .48	P = 2.51	
11	P = 1.60	P = 1.18	P = 12.17	11	(sleeping)		
				12	B = 8.22	T = .56	

\*Time measured in minutes and seconds

Codes: T = Talking only. P = Physical care. B = Both physical care and talking

For differential comparison of time spent in nursing activities when delivering care, the time spent for the three activities of nursing care was totalled. The comparison is illustrated in Figure 1.

Figure 1  
A comparison of time spent in nursing activities



Total time in pre-service program shadowing = 48 minutes.  
Total time in post-service program shadowing = 75 minutes.

As the graph reveals, the nurse spent more time with the patients at the end of the inservice training program which is partially accounted for by the increased workload of two patients. In the second shadowing, an increase from three to forty-eight minutes spent talking with the patients when giving physical nursing care is seen. In fact, an increase from forty-four to sixty-eight percent of total time giving nursing care was spent talking to the patients. A further clarification of the talking time is seen in Figure 2.

**Figure 2**  
**A comparison of pre- and post-inservice program responses of nurse when giving nursing care to patients**

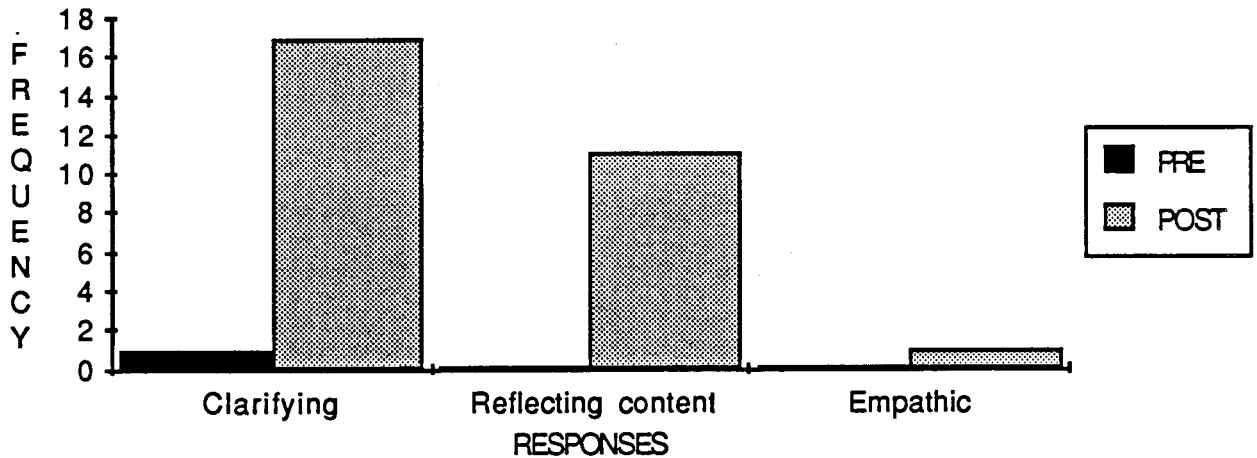


Figure 2 demonstrates a considerable change in nurse-patient communication after attendance in the inservice program. This graph illustrates that prior to the program, the nurse's talking with the patients consisted of general chit-chat. According to Carkhuff's Index of Communication (1969), these types of responses would be coded at a 1.0 level. In the post-inservice program observations, many more responses which were coded as clarifying responses (questions which promoted clarification of the patient's statements) are seen. As well, reflective responses (responses which reflected content) and empathic responses (responses which also reflected feelings) also increased. Although there was only one empathic response at the 3.0 level, all responses indicate increased awareness and listening to what the patients are saying and would be rated at a 2.0 - 2.5 level. According to the measure, the subject has demonstrated an increased level of empathic communication indicating transfer of communication skills to the nurse-patient context. Thus, the data collected through shadowing the nurse as she performed her nursing care, are supportive of Hypothesis III.

### Pre-inservice program interview.

The subject stated that she chose the inservice training program because of the new responsibility of care for the palliative care patients caused by closure of the palliative care unit in the hospital. She identified three concerns: 1) lack of a specific ward routine for caring of dying patients, 2) confusion around giving adequate emotional support to dying patients and their families, and 3) administration of medications to control the pain.

Although general confidence was expressed when nursing dying patients, she described difficulty in dealing with a patient's death when rapport<sup>15</sup> had not been established with the family. When this occurred, she felt awkward and unsure as to how to handle the situation and what to say to them. She had not developed any specific strategy for these situations but generally found it easier if the family asked some questions.

Throughout the interview, the subject expressed belief in establishing rapport with patients and their families as a means of enhancing work with the family and promoting discussion of dying with the patient. Rapport also reduces the likelihood of nurses becoming emotionally drained when nursing dying patients. Another belief expressed was the necessity of the nurse's acceptance of death as it is "meant to be", since this acceptance helps the nurse when a patient dies.

Some other difficulties working with dying patients were identified. First, if the doctor had not informed the patient of the terminal prognosis, there was difficulty pretending and not being honest with the patient. In these situations, she would request that the doctor inform the patient. If this was not done, she was reluctant to discuss dying with the patient.

<sup>15</sup>"rapport" in nursing care refers to the establishment of a trusting interpersonal nurse-patient relationship.

Second, if rapport had not been established with the patient, there was difficulty discussing the topic of dying; if rapport was established, there was no difficulty discussing the situation but the topic was never initiated by the subject.

Third, she had difficulty caring for dying patients who were the same age or younger than she. She expressed the feeling that working with older people dying "is not as difficult as they have had a good life". The subject attributed her beliefs and feelings to an experience which occurred when she was twenty-four years of age:

The experience occurred when working on an emergency ward. There was a twenty-four year old patient admitted with extreme abdominal pain. When he awakened from emergency surgery, he found that he had a colostomy and was given the diagnosis of terminal cancer.

At the time, he was engaged to be married and the couple wanted to continue with wedding plans but the parents were against this decision. There was considerable involvement with the patient and the family, who were very upset, as they worked through this difficult time. He died eight months later.

"I related so closely to their age (couple). . . I got to know them all and found it very difficult to work through as I was so involved."

To summarize, the subject, who has had years of clinical experience delivering nursing care to dying patients, found that problems arose when 1) there was no rapport established with the patient and/or family, 2) when the patient had not been informed of prognosis, 3) when the patient was approximately the same age or younger. The difficulty in these situations as described by the subject and identified by the investigator was *not knowing how to communicate* with them.

Post-inservice program interview . This interview was done one week after the completion of the inservice program to determine if there were any perceived changes that could be attributed to the efficacy of the training program.

The subject's self-observation was increased awareness of open-ended questions in communication: of the ability to use this style of communication if needed; of other people, such as doctors, using this style when talking to staff or patients. She

stated that she was not only more aware of the communication around her but found that she was listening more.

She denied consciously using or actually practicing her new communication skills in day to day conversation with the patients and/or staff. However, she stated that there were times when she thought ". . . maybe this is a good time to . . . and will try but do not feel comfortable yet." When the investigator commented on the observed change in her communication with the patients since the inservice program, she laughingly stated, "Yeah, but that's a little bit of a set-up. . . I know you're there, right?"

She voiced one difficulty with the inservice-program; she found that blocking off five weeks was too long.

Thus, according to the post-data collected in the case study, shadowing revealed an increase of attentive responses to the patients' statements (Figure 2) when the investigator was present. During the interview, the subject also described a self-reported increased *awareness* of and *listening* to others during interpersonal communication in the work setting .

To determine if there was any impact on actual nursing care three areas were investigated: charts and handovers, the view of a significant other, the charge nurse, and a case study, which involved shadowing and interviewing a nurse before and after the inservice program. The results of these investigations indicated that:

1) charts and handovers did not reveal any significant attitudinal or reporting changes regarding the emotional aspect of care.

2) the charge nurse reported two observed changes in the staff nurses: improved listening skills and increased comfort dealing with dying patients.

3) shadowing and interviewing the participant in the case study found an increased awareness of and practice of communication skills when delivering nursing care.



Hypothesis III is partially supported by some observed attitudinal and communication changes in actual nursing care on the ward. However, this impact did not extend to the written or verbal recording of nursing care on the ward.

### Discussion of the Results

In Chapter I, this study identified a deficiency in the delivery of nursing care -- the lack of attention to the emotional aspect of nursing care which results in avoidance of the patients. The defined problem was to provide a program to train nurses to a) decrease avoidance of patients and b) provide nurses with the ability to deal more effectively with the patients' emotional distress.

The literature reviewed in Chapter II indicated that an important facet of patient care is missing due to nurses' avoidance and lack of appropriate communication skills. Previous studies addressed this problem by offering death and dying education courses to change nurses' attitudes and communication training programs to improve helping skills of nurses. While attitudinal results were inconclusive and empathic communication skills appeared to improve following training programs, there was no evidence in the studies to indicate that there was a transfer of acquired knowledge and improved skills to the actual work setting.

The purpose of this study was to develop and implement a hospital inservice training program that would 1) improve nurses' attitudes toward care of dying patients through a developed awareness and sensitivity to patients' emotional needs, and 2) increase their empathic communication skills to deal with the emotional aspect of nursing care.

Based on previous studies and techniques, the inservice program described in Appendix A was developed and implemented with ten nurses and one occupational therapist from medical wards in an acute care hospital. The program which included didactic, experiential and modeling components, consisted of ten hours over a five-week period.

The effectiveness of the training program was evaluated by 1) comparing pre-and post-program attitude measures, 2) comparing pre-and post-program communication measures, and 3) an assessment of transfer of acquired skills to the work situation. In the pre- and post-program comparisons the findings were:

- 1) There was no significant difference found on the written Death Attitude Questionnaire following the inservice program.
- 2) There was a significant difference found on the posttest ratings of written and audio-taped responses in empathic communication.
- 3) There were some attitudinal and communication changes demonstrated on the ward following the inservice program but these did not extend to the written and verbal recording by the nurses.

The results and further interpretations of the data will now be discussed under the three areas of concern in this study: attitudes towards death and dying; empathic communication skills; and transfer of newly acquired skills to the delivery of nursing care.

To determine if there was an attitudinal change towards death and dying.

In Table IV, comparison of pre-and post-attitude measures indicated an increased positive attitude after the inservice program but the difference was not significant. Hypothesis I could not be rejected. This lack of positive attitudinal change supported the findings of Hopping (1977) and added to the mixed results from the various studies described in Chapter II. It is difficult to compare the various studies on death/dying education because of lack of description of the education program used as well as omission of the instrument used to evaluate attitudinal change.

A further examination of comparisons of the pre- and post-program means of the individual items in the Death Attitude Questionnaire was made. The only two items which showed a significant difference are illustrated in Table IX.

These two items stated:

Item 13--"I feel uneasy talking to patients with a fatal prognosis."

Item 15--"I would feel very uncomfortable if I entered the room of a terminally ill patient and found him/her in tears."

**TABLE IX**

**A COMPARISON OF PRE- AND POST-MEANS OF ITEMS IN DEATH ATTITUDE QUESTIONNAIRE**

Item	Time	N	Mean	Difference	SD	T value
13	Pre-	9	3.333	0.8889	0.782	3.41**
13	Post	9	4.222			
15	Pre	9	3.444	0.8889	1.167	2.29*
15	Post	9	4.333			

\* Significant at the .05 level in a two-tailed test.

\*\*Significant at the .01 level

Both items reflect feelings of discomfort when dealing with dying patients' emotional distress. Although the sampling is small, these findings tend to suggest an increased feeling of comfort or confidence when communicating with dying patients following the inservice program.

The review in Chapter II revealed that although attitude studies had mixed results, hypotheses had been investigated which linked nurses' attitude to variables such as personal experience with a death, family attitudes, and clinical experience with dying patients (Coty, Tamlyn, 1984; Coolbeth, Sullivan, 1984; Denton, Wisenbaker, 1977). When testing the Death Attitude Questionnaire used in this study, an item analysis indicated that some of the items in the attitude questionnaire were correlated to independent variables such as age, previous training, clinical experience, and recent death of a close person (Table II). However, when a total item analysis was done with the

independent variables in the demographic data, there were no significant correlations found and thus, the findings do not support the previous studies.

As indicated by the findings in this study, exposure to the inservice training program was not associated with significantly increased scores on the Death Attitude Questionnaire. Considering the many variables which could affect one's attitude towards death and dying, perhaps it is unrealistic to expect changes in attitudes in a five-week course. However, some factors which could have influenced these results are: the instrument used, the experience or age of the participants and the average age of the participants' patients.

The instrument. The complexity of developing a measure which reflects beliefs and attitudes was discussed in Chapter III. The indicators of attitude toward death used on the Death Attitude Questionnaire for this study were developed by the investigator and have not been fully validated through research as actual measures of this attitude. As such, the use of this questionnaire to indicate the participants' attitudes toward death and dying might constitute a limitation.

Experience or age of the participants. As previously described, the participants in this study were generally a mature, experienced group with considerable experience in caring for dying patients. During the discussions in the inservice program, the investigator found the nurses to be well-equipped with the technology of death (equipment, medication) and the psychology of death involving stages of grieving, spiritual and family needs. One could suggest that many of their attitudes toward care of dying patients were quite firmly rooted and would require a more extensive inservice experience before change would occur.

Average age of the patients. The participants worked on medical wards which consist of patients who are generally elderly and have chronic medical illnesses. Vachon (1984) had found that nurses had most difficulty with patients with whom they could identify, such as similar age. This finding was confirmed in the pre-inservice program interview of the participant in the case study. One could infer that giving nursing care to

the dying is not as stressful with elderly patients and thus, would not motivate a search for attitudinal changes or strategies to reduce anxiety.

Another factor is the elderly patients' attitude towards dying which could influence the nurses' attitude when caring for them. One of the biggest differences noted in the elderly is the lack of intense fear of death. Munnichs, in 1965, did seven studies of the elderly person's orientation towards "the end" and found that "...only a small category of old people were in fear of the end" (Kastenbaum & Aisinberg, 1972: 81). One nurse related a conversation with an eighty-nine year old patient.

During the conversation, although expressing his frustration with a declining memory, he did not complain about his state of health or future. He stated, with a big toothless grin, that he would like to go back to a Nursing Home rather than stay with kin because, "... in the home, we're all in the same boat. We know we're on the last stop and we have a good time!"

It would appear that with advanced age one reaches a gradual acceptance of death and this acceptance by a patient may allow the nurse to accept it also. This view was alluded to by the participant in the pre-inservice interview and supported in the literature review (Kübler-Ross, 1969).

To determine if there was improved communication skills in coping with patients' emotional distress.

The data in Table V substantiates that following the inservice program, there was significant improvement in the ability of the participants to formulate written and verbal empathic responses to "helpee" statements in the written and audio-taped measures. After training, the group mean level on the written "helper" responses increased from 2.08 to 2.36 showing a difference of .27; the verbal "helper" responses in the audio-taped dialogues increased from 1.8 to a 2.1 level showing a difference of .33. Although the verbal responses were at a lower level pre- and post-training, the improvement was slightly greater. Both results were significant below the .01 level in a two-tailed test.

These findings were consistent with previous studies described in Chapter II in which group training of nurses, using Carkhuff's Index of Communication and an integrative approach, effectively increased empathic communication skills (Carkhuff, 1969; La Monica et al., 1976; Kalish, 1973).

The findings on Table V also support the findings in the literature which reveal that nurses have a low level of empathy (La Monica, Karshmer, 1978; Kalish, 1973; Anderson, 1980). In the pre-test measures, it is seen that the mean scores representing the level of empathic communication of this group were 2.08 in the written questionnaire, 1.83 in the audio-taped measures with the most frequent response at level 2.0. Although these pretest scores of the nurses are somewhat higher than the group mean of 1.48 reported by La Monica (1976), they nevertheless reflect levels that were previously defined as subtractive. The responses range from Level 1.0, in which they give no or only partial awareness of the "helpee's" surface feelings to Level 2.0 responses that give premature, superficial advice, ask questions to gather more data or behave in a manner congruent with some preconceived role. (Carkhuff, 1969). Thus, we see that although the findings show a significant improvement following training, the mean level of empathic communication remains below the suggested minimally facilitative level of 3.0 considered necessary for enhancing growth in a helping relationship.

As previously stated, the modal level of communication was also determined for the participants' responses in the audio-taped measures. Table V reveals an increase in the group modal level of communication from 1.8 to 2.0 which is not significant at the .05 level. Thus, even though a significant increase in the mean level of empathic communication was achieved, indicating more responses at a higher level of empathy following training, the responses most frequently used by the participants remained at the same level. One factor that could have contributed to this lack of increase in modal level of communication might be the length of some of the dialogues. The investigator neglected to establish a maximum duration of dyadic exchanges which resulted in a variation of "helper" responses from one to many. An average was calculated for each

participant. Consequently, although a few of the participants responded frequently at a 3.0 level of empathy which appeared to stimulate longer dialogues than their counterparts, there was an increased opportunity to return to "old" responses.

For further examination of the findings, Table X illustrates the individual pre- and post-training mean scores on the communication measures.

**TABLE X**  
**A COMPARISON OF INDIVIDUAL MEAN SCORES OF WRITTEN, AUDIO-TAPED AND MODAL**  
**RESPONSES RATED FOR EMPATHY**

<u>Subject</u>	<u>Written</u>			<u>Audio-taped</u>			<u>Modal (Audio)</u>		
	<u>Pre</u>	<u>Post</u>	<u>Change</u>	<u>Pre</u>	<u>Post</u>	<u>Change</u>	<u>Pre</u>	<u>Post</u>	<u>Change</u>
1	2.3	2.8	.5	2.1	2.4	.3	2.0	2.0	.0
2	1.9	2.0	.1	1.7	2.1	.4	2.0	2.0	.0
3	1.9	2.6	.7	2.0	2.3	.3	2.0	2.0	.0
4	2.2	2.4	.2	2.0	2.6	.6	2.0	2.5	.5
5	1.9	1.8	-.1	1.0	1.0	.0	1.0	1.0	.0
6	1.6	2.0	.4	1.6	1.9	.3	1.5	2.0	.5
7	2.5	2.9	.4	2.1	2.5	.4	2.0	2.5	.5
8	2.1	2.3	.2	2.0	2.4	.4	2.0	2.0	.0
9	2.4	2.5	.1	2.0	2.4	.4	2.0	2.0	.0

Looking at the individual scores, it is seen that eight of the nine participants improved their empathic responses in both the written and audio-taped measures. Although the mean levels of three subjects were in the 2.5 to 2.9 range in the posttests, no one achieved a mean level of 3.0, the minimally facilitative level. In the modal tabulation of responses, three out of nine mean scores showed a changed level. This indicates that although the participants' responses achieved a higher mean level of

empathic communication, the most frequently used mode of responses remained the same. Level 2.0 was the response most frequently used by the participants in this study.

The written scores of subjects 1 and 3 showed the greatest difference following training. These subjects were the only two who had taken previous communication courses, which could confirm the value of retraining to quickly restore a higher level of facilitative functioning (Collingwood, 1971). When comparing the written scores with the audio-taped scores, it is seen that the changes are not consistent with each other. For example, the difference in the scores of subject 3 favors the written responses while subject 4 favors the verbal responses. In other words, achieving a significant increase in written skills did not ensure an increase in verbal skills and vice versa. These findings substantiate the need for both written and verbal practice in communication skills training.

Using SPSS, Pearson's correlation was done to determine if the differences in the pre- and post-training mean scores were due to the influence of any demographic variables. Only one independent variable, age correlated at or below the .05 level of significance, as illustrated in Table XI.

**TABLE XI**

**CORRELATION OF MEAN SCORES FOR EMPATHIC COMMUNICATION WITH INDEPENDENT VARIABLE AGE**

Written Responses		Audio-Tapes		Modal Response	
<u>Pre-</u>	<u>Post</u>	<u>Pre</u>	<u>Post</u>	<u>Pre</u>	<u>Post</u>
-.7012	-.4355	-.6446	-.7206	-.7556	-.5695
p = .03*	p = .24	p = .06	p = .02*	p = .01*	p = .10

\* significant at or below the .05 level.

Three of the above results show a significant negative correlation of age with the participants' mean scores below the .05 level. These data indicate that the older the participant, the lower the mean score or level of empathic communication according to the above measures. If age influences the effectiveness of the training program, this



could indicate that the longer trainees have been using lower level communication, the more difficult it is to retrain.

In summary, the results support the concept of a training program which includes didactic, experiential and modeling components to increase empathic communication skills. Empathy was described earlier as the key ingredient in a helping relationship and thus, essential in the nurse-patient relationship to cope with patients' emotional distress. By responding to the content and feelings expressed by the "helpee", an opportunity for growth and development ensues. The above data comparing pre- and post-training scores indicates an increased ability of the subjects to perceive and respond with empathy. Even though the suggested level of 3.0 was not reached, the differences noted indicate that "helper" growth was significant in four to six hours of training.

#### To determine if this inservice program had an impact on actual nursing care

The purpose of the inservice program was to provide the participants with coping skills to deal with the emotional distress of the patients when experiencing loss. The expectation was that following the program, nurses would have increased awareness and knowledge of patients' emotional distress and improved communication skills. This acquisition would be manifested in less avoidance of dying patients and lead to more effective helping nurse-patient relationships. An added benefit would be nurses' increased feelings of comfort and confidence when delivering nursing care. Transfer of any newly acquired skills to the ward setting was determined by three measures previously described: charts and handovers, interview of significant other and a case study.

Charts and handovers were examined for written or verbal references to patients' emotional state/needs/care and the findings illustrated in Table VI and Table VIII. It can be seen that minimal attention was given to the emotional aspect of care in both of these indexes. In pre-post-program comparisons, an increase in charting references to emotional care (Table VI) and a decrease in verbal references to emotional care (Table VII) is seen. Considering the amount of recording done on each patient, the small number of

is seen. Considering the amount of recording done on each patient, the small number of references to emotional concerns was not considered adequate for any conclusions. For example, in Table VII, there are only 18 references made in the pre-training program handover and 11 references in the post-training program handover. When one considers that this total is taken from reporting on 128 patients (four handovers X 32 patients) over a period of approximately 40-60 minutes (four handovers X 10-15 minutes), the numbers and difference of six are insignificant.

The accepted standard of nursing care in the hospital presents a barrier to change in nurses' charting. The focus of nursing care is on the physical aspect of care and the charts reflect that focus with no requirements for recording emotional factors. Emotional caring would need to be more formally recognized and attention to emotional care instituted across the organizational structure of the hospital.

Similarly, with handover reports, there would need to be a change in ward focus before the handovers would likely reflect changes.

Interview of significant other. In a previous study, personality changes were found but when significant others were interviewed, they did not perceive any changes (Martin, Carkhuff 1968). To determine if there were any changes noted by a significant other in this program, the charge nurse of five of the participants was interviewed. Two changes were observed which could be attributed to impact of the inservice program: improved listening skills and increased comfort caring for dying patients.

It is recognized that the findings are confounded by other variables: the introduction of another change on the ward concomitant with the inservice program (this effect was also noted in the implementation of the inservice program--refer to the description of the third session, Chapter III); and the effect of the charge nurse on fostering positive attitudes towards nursing care of the dying. While it would be nice to assume that these changes came from participants' experiences in the program, the limitations of assessment coupled with confounding variables may not allow such claims to be made.

Case study The findings when comparing pre- and post-in-service program shadowing and interviews of the subject revealed an increased awareness of and listening to not only the patients but co-workers on the ward. Also, a considerable increase in more effective communication skills when delivering nursing care was observed by the investigator. This demonstration reflected the subject's increased ability to discriminate and respond to the patients. One cannot underestimate the effect of the investigator's presence in influencing these results. This finding could generate the hypothesis that the trainer's presence is a required motivator to encourage the trainees to practice newly acquired skills and ensure transfer to the work setting.

Generally, Hypothesis III was supported by some noted attitudinal and interpersonal communication changes demonstrated in actual nursing care on the ward but not reflected in the more enduring practice on a ward -- the technology of recording information, charts and handovers.

A variable which could have contributed to post-program differences found on the ward would be the status of the patients. To ascertain if the nursing needs/care required by the patients was relatively similar, a further analysis was done and is illustrated in Table XII.

TABLE XII

A COMPARISON OF PATIENTS' STATUS PRE- AND POST-INSERVICE PROGRAM

OBSERVATIONS

<u>Variables</u>	<u>Pre</u>	<u>Post</u>
Number of Patients	10	12
Average age of the patients	67.4	67
patients over 80 years old	2	5
patients under 40 years old	1	1
Average length of time in hospital since admission (days)	6.3	10.4*
Patients described as "No Code"	4	6
Family support indicated on chart	4	6

\*One patient was omitted from this average as he was a young man whose stay exceeded four months, which was not the norm.

A pre and post-inservice program comparison does indicate some minimal differences in the independent variables. Perhaps a more thorough comparison of the patients would find other discriminators which could influence the emotional state and needs of the patients -- i.e. such as type of illness, previous illness, recent loss of spouse. From Table XII, one could infer that the patients are similar in age, severity of illness, and thus, representative of the same population with similar nursing care requirements.

Conclusions

The conclusions drawn from this study were:

1. The hospital inservice program designed for this study was not effective in changing the participants' attitude towards death/dying as measured by the Death Attitude Questionnaire.
2. According to the written and verbal measures used in this study, the hospital inservice program was effective in significantly increasing the participants' empathic

communication responses but the minimally facilitative level considered necessary for a helping relationship was not achieved.

3. There were some changes in participants' attitude and interpersonal communication observed on the ward following the inservice program indicating some transfer of acquired knowledge and skills to the work setting.

### Implications

The inadequacies found in the emotional aspect of nursing care led to the design of the study. The literature suggested deteriorative consequences from unresolved grief encountered by patients when experiencing loss. The literature also suggested that for facilitative functioning in a helping relationship, there must be empathy. This study, like previous ones, found nurses to have a low level of empathy. The study demonstrated that nurses may be trained in a relatively short inservice program, using didactic, experiential and modeling components, to significantly improve their empathic communication skills. However, the participants did not achieve the recommended minimally facilitative level which suggests some changes may be required in future inservice programs, such as, longer training period, more practice, more examples.

The findings in the study suggest other considerations for future inservice programs. The results from the two participants who had had previous training supported the value of retraining. Both made significant gains over and above the rest of the trainees. Age also influenced achievement of communication skills suggesting different learning needs related to different age levels. Shift-work affected participants' attendance for all sessions in the intervalled schedule used for the study. Different scheduling of sessions may be indicated.

The results of the study showed no significant changes in participants' attitude towards death and dying. Self-selection may represent subjects with a more positive attitude towards death and dying prior to the training, reducing potential for change in a written measure. However, the participants' observed behavior on the ward did reflect an increased level of confidence or comfort when delivering nursing care to the dying

patients. This could imply the instrument, used for the first time, provided an inadequate measure of attitude towards death and dying. But, assuming that the attitude measure was valid, another implication could be that attitude towards death and dying is the wrong attitude to measure in this type of study. Perhaps, different attitudes need to be considered. For example, could the attitude of hope, as previously posited (Beck, Weissman, 1974) and suggested by the findings in the study, have an influence on nurses' attitude towards care of the dying patients? Could the nurses' role perception as an authority figure influence nursing care? One could speculate that if the nurse's role was perceived as provider of answers and advice, avoidance of patients' distress could result when there were no answers available. Could the nurses' perception of "caring" influence the nursing care? For example, if this attitude implied *doing for* the patients, the resultant nursing care would focus on physical nursing tasks and making the decisions rather than facilitating patient autonomy.

Regarding the transfer of the training program to the work setting, the subject's communication skills improved when the investigator was present. Although reportedly self-conscious, practicing the new skills appeared to be reinforced. Possibly, this type of follow-up by the trainer is a necessary component of a training program to ensure practice of acquired skills in the work setting.

In reference to the low level of empathic communication found in the participants' responses, it would seem beneficial to provide inservice programs to all staff on a ward. Kübler-Ross (1969) and Vachon (1980) recommended a team approach to deal with the emotional distress experienced by patients and staff. The acquisition of empathic communication by all staff would enhance the trusting, supportive milieu required for effective interpersonal communication.

The lack of change in the focus of nursing care in the charts and handovers may be a function of the stability of this recording procedure. This mode of task accountability is very durable as it is maintained by habit, legality, and accepted rules. The complexity of

making changes may require cross-organizational consensus and implementation before actual recording changes would be made by the nurses.

### Recommendations for Further Research

As a result of the study some recommendations for further research are suggested.

Cross-sectional studies are necessary before generalizations can be made. Replications of the study could be done with nurses working in areas where sudden deaths are more frequent, such as emergency wards, intensive care units and surgical wards, nurses delivering care to acutely-ill patients the same age or younger, and nurses reflecting different age groups and experience. These situations might be helpful in delineating more clearly for which nurses the inservice program is effective and to what extent.

Longitudinal case studies should be done to assess the trainees' level of empathic communication at specific periods following training. This would assist trainers to determine the long-term effects of a short-term program and the retraining needs to maintain high levels of interpersonal communication.

Quasi-experimental research should be done in which all staff on one ward receive the inservice program, including the trainer's presence on the ward when nurses are delivering nursing care and interacting in staff meetings. Evaluation could include pre- and post-training interviews and questionnaires with staff and patients. This would test the posited trainer-effect on motivating transfer of acquired skills to the work setting and the effectiveness of a team approach.

An experimental research design could be used to compare attention to emotional aspect of care if different charting formats are implemented on two wards. One ward could use a flow sheet which necessitated observations of emotional aspect of nursing care; the other could continue with present charting format. Pre- and post-assessments of impact on nursing care could determine the effect of technological changes on nurses' attitudes towards patients' emotional needs.

## Appendices

### Introduction

This section consists of a complete description of the written materials developed for this study. The inservice training program material includes an outline for the five, two-hour training sessions, two Guide handbooks, pencil and paper exercises and sample situations for audio-taped role-playing situations. Other forms used for data collection include the demographic data form, death attitude questionnaire and consent form.

It is hoped that this material may prove useful to others interested in pursuing further research in this area or in establishing similar inservice training programs for health care workers.



Appendix A  
Hospital Inservice Program Plan

OBJECTIVES

STRATEGIES

Day I: Awareness

The instructor will:

- |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ol style="list-style-type: none"><li>1. establish an open atmosphere</li><li>2. explore and share experiences with death and dying.</li><li>3. encourage awareness and acceptance of own feelings re: death/dying.</li></ol> | <ul style="list-style-type: none"><li>• lead a relaxation exercise</li><li>• give a questionnaire to obtain a baseline of attitudes and experiences with death and dying (Appendix I)</li><li>• divide into dyads to listen and share personal experiences re: death/dying, using Exercise 1 (Appendix B).</li><li>• lead a group discussion which will be open-ended but with a focus on the <i>feelings</i> related to the experiences.</li><li>• close with distribution of Guide (Appendix C)</li></ul> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## OBJECTIVES

### Day 2 Knowledge

The instructor will:

1. establish an open atmosphere
2. teach knowledge re: death and dying and its impact on the patient and his/her family.
3. promote awareness of emotional needs of patients while in hospital.
4. present strategies of coping with patients emotional stress.

## STRATEGIES

- lead a relaxation exercise.
- utilize strategy of brainstorming to establish nurses knowledge re: emotional impact of death/dying.
- use flip chart and Guide for group discussion to share knowledge and experience re: loss including:
  - relationship of death/dying to all loss.
  - impact on patients and families with focus on role changes and subsequent loss.
  - impact of grieving on physical health.
  - signs/symptoms of grieving by patients in the hospital
  - relationship of change events due to experiencing loss to stress.
  - strategies to deal with grieving patients

## OBJECTIVES

### Day 3 awareness

The instructor will:

1. establish an open atmosphere.
2. explore individual modes of communicating with nurse-patient situations
3. promote awareness of own interpersonal interactions.
4. promote awareness of the process of helping.

## STRATEGIES

- lead a relaxation exercise.
- give each nurse a written questionnaire requesting their responses to patient-stimulus\* expressions in hospital situations.
- form dyads and role-play some patient-stimulus situations using Samples (Appendix D). Each dyad will tape their role-playing.
- lead group discussion to explore and share the feelings in the different role-playing situations. There will be a focus on effectiveness of different nurse responses on patients expressed concerns/emotions.
- Distribute Guide to Empathic Communication (Appendix E)
- \* patient-stimulus = a concern or emotion expressed by a patient, verbally and/or non-verbally.

## OBJECTIVES

### Day 4 Knowledge

The instructor will:

1. establish an open atmosphere.
2. teach empathic communication skills as defined by Gazda (1984).

## STRATEGIES

- lead a relaxation exercise.
- discuss Guide to Empathic Communication
- video-tape role-playing examples of nurse-patient situations modeling inappropriate and appropriate responses, as recommended by Gazda (1984).
- group discussion of each example with clarification of skills used and subsequent effect on the interpersonal interaction.

### Day 5 Skills

The instructor will:

1. establish an open atmosphere
  2. promote familiarity of empathic communication skills.
  3. develop nurses ability to communicate empathically.
- lead a relaxation exercise.
  - replay video role-playing examples and discuss and evaluate the effectiveness of each one. Compare with the Levels described in the Guide.
  - divide nurses into dyads to practice skills by role-playing nurse-patient situations—each dyad will tape their interaction.
  - lead group discussion of role-playing experiences to determine if effective in communicating.

## Appendix B

### Exercise 1

This is an exercise to explore your feelings. Choose a partner - one will be A and the other B. First, A will ask B to finish the following statements, one at a time, allowing person B to finish all of them with person A just listening. Then, exchange roles. When finished all the statements, return to large group and share what you heard.

1. My greatest fear about dying is.....
2. When I try to express my feelings about dying with friends and/or family, the usual response is..... and this makes me feel.....
3. The ways that I sometimes avoid expressing my feelings about dying are.....
4. The ways that I can help patients deal with their feelings about dying are.....
5. When I am nursing a dying patient, I think my greatest strength is.....
6. When I am dealing with an expression of strong emotions, i.e. anger, crying, apathy, my greatest problem is.....
7. I wish/want.....

## Appendix C

### A Guide for Gaining Knowledge in Caring for the Grieving Patient

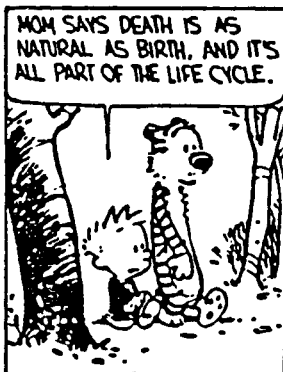
This packet is for you to use as a guide to explore your feelings, your attitudes and philosophy when delivering nursing care, often to a dying patient. Please, read it slowly, think about it, write your own thoughts in it and through our discussions and sharing, we will gain knowledge about ourselves and a basic foundation on which to care for others.

Dying is one phase of *living* in the cycle of life. I stress the word 'living' as we often treat it differently, even in the hospital. Weissman has described different phases of dying:

- 1) existential plight—manifested mostly by numbness and shock.
- 2) mitigation and accommodation - when there is a very real possibility of relapse. The person tries to seek a balance between a new role as potentially dying and energy directed towards the previous lifestyle.
- 3) decline and deterioration - dying becomes more concrete with increased intensity of symptoms. Now it becomes increasingly difficult to deny and to maintain hope.
- 4) preterminality and terminality - there is a shift towards palliation rather than 'cure'. There is a recognition of time limitations, thus, it becomes essential to alter goals.

GRIEVING IS A NATURAL, NORMAL PROCESS

CALVIN & HOBBS



SHE SAYS WE DON'T REALLY UNDERSTAND IT, BUT THERE ARE MANY THINGS WE DON'T UNDERSTAND, AND WE JUST HAVE TO DO THE BEST WE CAN WITH THE KNOWLEDGE WE HAVE.

A black and white comic panel showing Calvin on the left and Hobbes on the right. Calvin is speaking.



Calvin & Hobbes  
© 1987 Universal Press Syndicate.  
Reprinted with permission. All rights reserved.

Vachon described three stages of grieving:

- 1) Shock—there is dazed belief and denial.
- 2) Disorganization—there is a loss of patterns of conduct.
- 3) Turmoil—depression, anger, guilt, passively suicidal, despair.

We are all familiar with the stages described by Kübler-Ross:

- 1) denial
- 2) anger
- 3) bargaining
- 4) depression
- 5) acceptance

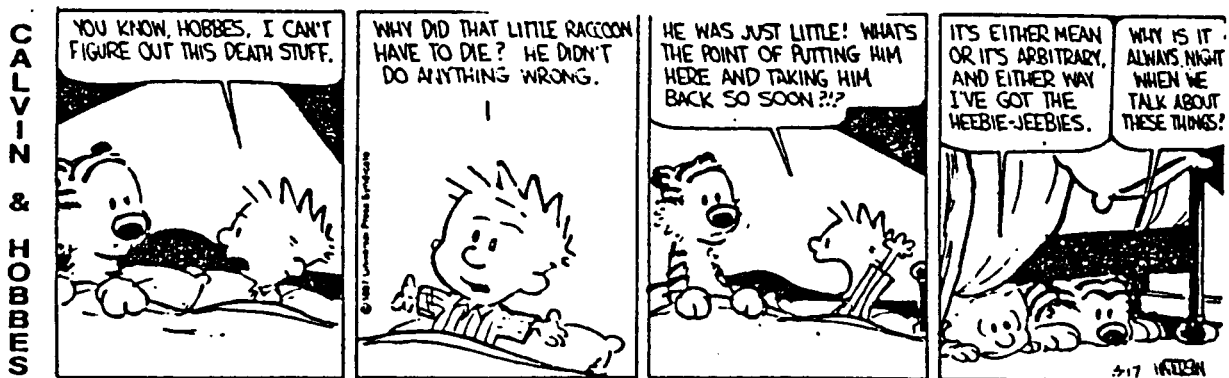
Below are other noted signs and symptoms. Have you experienced any of these symptoms? When? Please add any that you have experienced or noted.

fear  
sadness  
detachment

shock  
despair  
insomnia

crying  
disorganization  
loss of appetite

"Grief is a complex of symptoms and processes that constitutes the acute reaction to a significant loss".  
(Gonda, p. 3)



In the hospital, many patients, if not most, are experiencing a loss and/or crisis in their lives. The patients that we see could be in any one of the phases described by Weisman, Vachon or Kübler-Ross. What manifestations of the grieving process have you noticed in your patients?

blaming

mutual pretense

Does grieving have an impact on one's health? Is it necessary for us, to consider the emotional aspects of grieving? We have enough to do coping with their physical care. It has been written that when there is unresolved grieving, there is a prolonged failure to re-establish oneself and it could develop to a pathological phase in which there could be denial, manic escape, dysfunctional hostility, depression, etc. But, is it our responsibility to deal with this in an acute care hospital? If so, why? If not, why not?



**FAILURE TO MANAGE PSYCHOLOGICAL DISTRESS CAN PROLONG AND MAGNIFY  
PHYSICAL PAIN**

**Coping Strategies**

1. To achieve maximum psychological comfort, patients need to retain some sense of autonomy in decisions remaining to them.
2. It is the patients right to chart *their* own course - *their* definition of quality of life.

How can we facilitate the patients autonomy and dignity? Some suggestions are:

- do not discuss the clinical picture of the patient within earshot.
- be honest when giving them information about their illness.
- LISTEN to what they are saying
- Silence
- Demystify medical information - speak their language.

What do these suggestions mean to you? Can you add ideas that you have found successful?



I DIDN'T EVEN KNOW HE EXISTED A FEW DAYS AGO AND NOW HE'S GONE FOREVER. IT'S LIKE I FOUND HIM FOR NO REASON. I HAD TO SAY GOOD-BYE AS SOON AS I SAID HELLO.



Calvin & Hobbes  
 © 1987 Universal Press Syndicate.  
 Reprinted with permission. All rights reserved.

COMMUNICATION; DONT JUST DO SOMETHING SIT THERE

It has been documented in many studies that we nurses tend to respond to patients feelings/concerns with avoiding, denying or pacifying statements. Does this description fit with your approach? Is it important for the patient to talk about his/her illness or dying?

"Actually, my findings indicate that patients want very much to talk about their feelings and thoughts about death but feel that we, the living, close off the awareness for their accomplishing this." (Feifel (1959, p. 23). What are your views?

There is no time now for the game  
 Of mutual pretense.  
 To act as if I'm still the same  
 Quite simply makes no sense.

Observe me here, the worn remains  
 Of what I used to be.  
 This weary mass of aches and pains  
 Is plain for all to see.

But still it loves and wants to share  
 Its feelings with its friends.  
 So listen now and show some care  
 Before my sweet life ends.

by Lewis R. Aiken.

DONT JUST DO SOMETHING SIT THERE.

For communication to occur, it is important for the nurse to recognize and understand the messages from the mind and body of the patient.

Before we can assist the patient to cope with their problems, we must explore *their* feelings, *their* needs, and *their* wishes. What are your views about how this might be done? What examples can you give from your experience?



"He who has a why to live for can bear almost any how." Hope is essential. Can you give some examples of ways that you have used to facilitate hope and that have worked for you?

PATIENTS AND FAMILYS NEEDS BASED ON PATIENT'S DESIRE RATHER THAN ILLNESS.

Is it necessary to spend time with the patients family? How does the illness affect their lives? Will they manifest any signs/symptoms of grieving? What have they lost?

As a member of a nursing team, do you need to share your problems and feelings with others? When there are problem patients on your ward, are there any changes that occur between nurses? Think about it. What examples can you give from your experience?



Calvin & Hobbes  
© 1987 Universal Press Syndicate.  
Reprinted with permission. All rights reserved.

## Bibliography

- Aiken, Lewis (1985). Dying, death and bereavement. Boston. London. Sydney. Toronto: Allyn & Bacon.
- Cartoons by Waterson. Courtesy of Universal Press Syndicate Company, Kansas.
- Feifel, Herman (ed.) (1959). The meaning of death. New York: McGraw-Hill.
- Gonda, Thomas, Ruark, John (1984). Dying dignified: the health professionals guide to care. U.S.A. London. Amsterdam. Ontario. Sydney: Addison-Wesley.
- Kübler-Ross, Elizabeth (1975). Death: The final stage of growth. New Jersey: Prentice.
- Vachon, Mary (1986). "Coping with people in crisis." Journal of the Canadian intravenous nurses association. 2(1): 10-15.
- Vachon, Mary, Lyal, W., Freeman, S. (1978). "Measurement and management of stress in health professionals working with advanced cancer patients." Death Education. 1: 365-375.

**Appendix D**  
**Sample Situations**

- 1. Situation:** You are a patient, very upset as you are not improving.

**Statement:** "Nurse, call my doctor and tell him that he is giving me the wrong medications. it just isn't helping me at all."
  
- 2. Situation:** You are a patient, angry at the length of time it is taking you to recover. A nurse is bringing you a fluid diet:

**Statement:** "What! Some more of that garbage? How do you expect me to get better eating that stuff?!!"
  
- 3. Situation:** You are a nurse, feeling very uncertain about your performance. You are talking.

**Statement:** "My head nurse doesn't trust me at all. She's always asking me questions about what I've done. if that's how she feels, I may as well quit.!"
  
- 4. Situation:** You are a patient having many tests done. A nurse enters your room.

**Statement:** "My doctor is calling in a specialist to look at me. I wonder what they're looking for."

5. **Situation:** You are a nurse working full time and having problems keeping up. You discuss this with another nurse:
- Statement:** "I don't think it's fair for them to make us rotate shifts when some people want to work nights all the time. I'm such a bear when I work nights - - - it's driving my family crazy".
6. **Situation:** You are a patient, very ill with reoccurring cancer.
- Statement:** "Nurse, I'm really scared that I'll never leave here. I find not knowing really hard. Will I ever get better? The doctor never tells me anything."
7. **Situation:** You are a patient about to undergo surgery for cancer of the uterus.
- Statement:** "Nurse. That woman in the other bed that died yesterday had this same operation, didn't she?"
8. **Situation:** You are a patient for diagnosis. You have been feeling weak and "fluish" for past few weeks. The nurse enters the room:
- Statement:** "Is the doctor telling me everything? I've had 3 x-rays now and I've lost count of the blood they've taken."
9. **Situation:** You are a nurse and feeling considerable stress in your work. You discuss this with another nurse.
- Statement:** "I get so frustrated working with so many dying patients. In the last place I worked, I only had 4 patients at a time and could give them complete care."

10. **Situation:** You are a mother of a patient who just had surgery and has had you worried for a couple of weeks. You approach your daughter's nurse:
- Statement:** "We just found out that Kathy's surgery went well and she will be okay. It's such a relief." (start to cry).
11. **Situation:** Your husband is a terminal care patient.
- Statement:** "I sit here and watch him getting weaker and weaker and I just can't do anything to stop it."
12. **Situation:** You are a patient who has no family visiting you. You are getting better.
- Statement:** "I'm so grateful to you - you're the only one in my life who has cared for me."
13. **Situation:** Your husband is a patient with cancer of the bowel and you are frustrated with his poor progress.
- Statement:** "My husband just keeps getting worse. Those medicines aren't helping a bit. I don't think the doctor is right but he won't talk to me about it."
14. **Situation:** You came in to see your husband and found that he had just died.
- Statement:** "Why didn't you call me? Now he's dead and I wasn't there. I told you to call me if he got worse!"



15. **Situation:** You are a nurse and you've had a frantic week at work. One of your patients died in the morning.
- Statement:** "I just feel terrible. I'm so tired and I just blew up at one of the patients."
16. **Situation:** You have been watching your sister suffer after being in an M.V.A. A nurse enters the room in answer to the call light which has been on for five minutes.
- Statement:** "Why don't you do something for her? She has been in pain for two days now."
17. **Situation:** You are a patient that has been in the hospital for a few weeks with minimal family/friends around.
- Statement:** "Boy, am I glad to see your shift come on duty. Those other nurses don't care about us at all."
18. **Situation:** You are a patient that has had a mastectomy and are now receiving chemotherapy.
- Statement:** "I keep having nightmares about people dying—I don't even recognize their faces, and I just can't get back to sleep."
19. **Situation:** You are a patient about to be transferred to a nursing home. Your family is selling your apartment as you are unable to manage it alone.
- Statement:** "How do they expect us to manage with so little closet space. I don't even have room here for a few nighties."

20. **Situation:** You have been a patient for a few weeks without a sign of going home yet.

**Statement:** "Two days ago I felt great, yesterday I felt rotten. Today I feel okay but it's hard to enjoy it because I keep wondering if tomorrow I'm going to feel lousy again."

21. **Situation:** You are a nurse and have felt very stressed with the work load and the patients you have.

**Statement:** "My two older sisters went into medical work, so I never thought about doing anything else. Sometimes I wonder what I might be doing now if I had considered other things."

## Appendix E

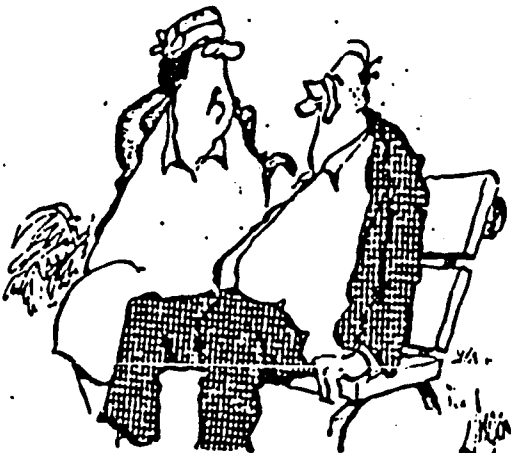
### Introduction to Empathic Communication for Health Care Workers

As health care workers, we become members of a "helping profession", which has many implications for us. It means that others come to us with specific problems in which we are the experts. We are expected to recognize their problem; to have the knowledge and capability of alleviating or reducing their problem; to *help* them with *their* problem. It also means that *we* expect to recognize their problems; to have the knowledge and capability of alleviating or reducing their problems; to *help* them with *their* problems. In other words, because of our combined belief, we undertake the responsibility of *doing* something to help them. In this modern age of technology, there has been extensive progress in finding new methods, techniques and equipment to assist us in this designated task of helping. These have enabled us to feel even more successful in helping the patients achieve a 'cure'. However, despite the evident progress in medicine, we are still confronted with patient's suffering, patient's obvious pain, patient's unhappiness, and often, patient's dying. There are times that we must switch our approach from 'curing' to 'caring'. This is when many of us feel frustrated, helpless and inadequate, as there does not appear to be anything we can *do* for them anymore.

Somehow, in our faith in medical progress, we have focussed on how we can help the patient's physical problems and have forgotten the importance of our opportunity to help through the interpersonal relationship - the necessity of a *trusting, genuine* relationship with

open communication. We feel that if we are not *doing* something, we are not helping. We have forgotten the importance of listening to the patient. We are often unaware of our own communication style and how we may believe we are listening to the patient, but actually may be cutting the patient off with our responses. We often do not know how to LISTEN?

**HERMAN**



"I'd let you talk more, but you're not as interesting as me."

Herman.  
© 1987 Universal Press Syndicate  
Reprinted with permission. All rights reserved.

Before we can assist the patients to cope with their problems, we must explore *their* feelings, *their* needs and *their* wishes.

How do we do that? By being empathic. Empathy means the ability to accurately perceive what another person is saying, and the ability to communicate to that person that you have heard and understood both the content and the surface feelings that are being expressed. It means the ability to put yourself in another person's shoes, and what's more, to communicate to him that you have done so. When we accomplish this, we are saying to the patient:

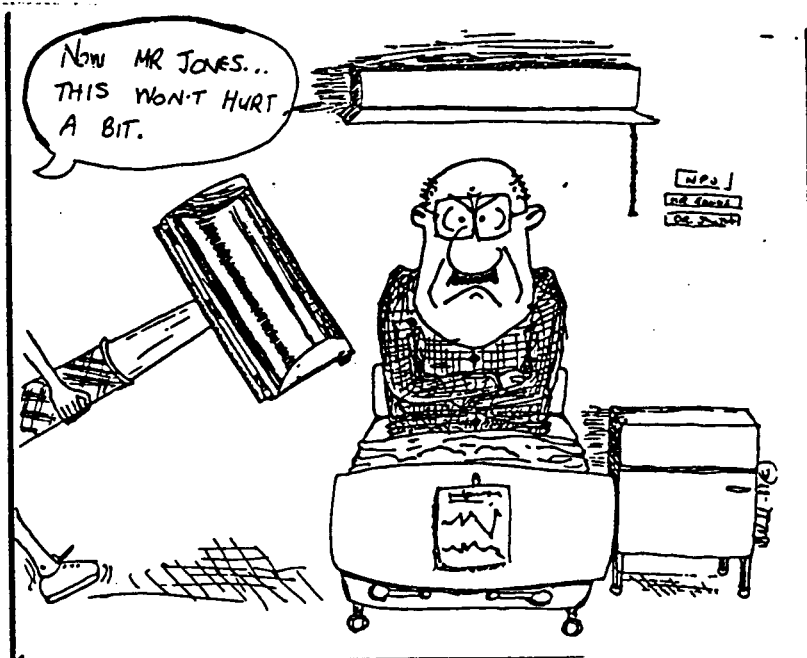
"I am with you."

"I can understand the feelings you are expressing".

Through this communication, we can add to and build the relationship. Our responses will then be interchangeable with the patient's ideas and feelings. Our response will be additive and will truly be 'in tune' with *their* problems, and serve to clarify and expand their exploration of their ideas and/or feelings.

To do this we need to recognize how we generally respond; do we have a tendency to give advice, moralize, preach or tell the patient what to do? This low level empathic response could be subtractive, perhaps harmful to the patient seeking our help.

Thus, first we need to LISTEN. This involves the ability to perceive what the patient is saying to you verbally and non-verbally.



Empathic communication is a skill. It requires awareness of our own communication styles in responding to the patients; discovering the areas that require improvement; and practicing new skills until we are comfortable using them. The acquisition of this skill will enable us to respond to patients in ways that will help them; it will increase our understanding of the process of helping; it will increase our skills in responding with accurate empathy; and it will increase our confidence in coping with situations that before appeared hopeless, leaving us with feelings of frustration and inadequacy.

#### Learning to Perceive and Respond with Empathy.

The two main components in empathy training are perceiving and responding. The different levels of accurate empathy<sup>1</sup> are illustrated here with examples of responses. At this time, the expectation is to learn to respond at the "interchangeable" level, level 3 - in a genuine and natural way. This means that we will be able to respond reflectively in ways which communicate accurate understanding of the patient's message. The stress in this course is coping with the patients in the hospital as effective "helpers" but is not meant to exclude other interpersonal relationships. This method of communication is an additive to all relationships in which we wish to communicate a warmth, a respect, a positive regard and an understanding that we value the other person's ideas, opinions or feelings. We can practice with each other - try it and discover for yourself how wonderful it is to be *heard*.

Here are some guidelines that may be helpful in getting you started:<sup>2</sup>

**A. Concentrate first on verbal behavior.**

- Listen to what the patient is saying.
- Listen for tone of voice, rapidity of speech, nuances of expression.
- Try to identify the surface feeling being expressed.
- Try to identify the obvious content of the patient's message.
- Try to formulate a response which reflects back to the patient the obvious feeling and meaning of statement—a level 3 response.
- Practice doing this many times.

**B. Concentrate next on non-verbal behavior;**

- Look at posture; placement of hands and feet.
- Watch facial expressions—tightening or relaxing of muscles, mouth, eyes, forehead furrowing.
- Observe physiological reactions, such as flushing, or perspiring, facial tics.
- Watch body responses.
- Observe eye contact.

As you work in your practice sessions, try to remember the following<sup>3</sup>:

- a) Concentrate intensely on verbal and non-verbal cues.
- b) Concentrate initially on responding at level 3 to the content and surface feeling.
- c) Practice responses which try to capture the critical meanings of the patient's message. Good reflective responses used repeatedly will help in building a good relationship.
- d) Formulate responses in the patient's language. Use the language that the patient is most likely to understand.
- e) Use a tone of voice that is compatible with the patient's tone of voice.
- f) Concentrate on the possible hidden messages the patient is sending.
- g) Try to retain data from the interchange. This may be of some use in future responses.

- h) Only after a relationship has been established should you attempt to increase your level of response to level 4.

---

<sup>1</sup> These levels, originally derived from Truax and Carkhuff, have been borrowed and modified from "Interactions II: Introduction to Interpersonal Skills Training" Prepared by Selma Wassermann, Simon Fraser University.

<sup>2</sup> We strongly advise that you not respond at level 5 until you have "earned the right" to do so. Probing at underlying feelings can be very risky for the patient. Unless there is a healthy and effective rapport established with the patient, and until you have acquired a lot of data, sensitivity and skill, you are advised not to try to respond at level 5. A mis-fired probe (level 5) becomes a level 2 response and is subtractive in the relationship. If level 3 responses are maintained throughout the relationship, this can be powerfully effective response in itself.

<sup>3</sup> It is very difficult for some health care workers to maintain a position of facilitator in a helping relationship. There is often a for him. That type of intervention is generally borne out of the helper's need to be perceived as effective and the helper's belief that to be effective, it is essential to *do* something. Beware then, of your own needs. When you see yourself directing, pushing, asking for more information, giving advice, interpreting, and probing, try to find out why you seem to be manifesting the need to take the responsibility for getting the patient to work through his problem your way.

**SCALE 1 - A SCALE FOR HEALTH CARE WORKERS**

**RESPONDING WITH ACCURATE EMPATHY**

Level	Nature of Response	Example of Response
<p style="text-align: center;"><b>1</b></p> <p><b>SUBTRACTIVE</b></p>	<p>"Nurse, call my doctor and tell him that he is giving me the wrong medications. It just isn't helping me all."</p>	
	<p><b>IGNORES PATIENT'S FEELINGS:</b></p> <p><b>Insensitive to most obvious feelings</b></p> <p><b>Shifts topic away from patient's</b></p> <p><b>Irrelevant response</b></p> <p><b>Criticizes: is judgmental, hurtful, devaluing, ridiculing, rejecting</b></p> <p><b>Denies patient's reality</b></p>	<p>"Why don't we go for a walk in the corridor?"</p> <p>"I see you had lots of visitors today."</p> <p>"If you wouldn't refuse the ensure, maybe you'll feel better."</p> <p>"If you would cooperate more with physio, you would feel stronger."</p> <p>"Then what would you find to complain about?"</p> <p>"Are you sure you aren't improving?"</p>



Level	Nature of Response	Example of Response
<p style="text-align: center;"><b>2</b></p> <p><b>SUBTRACTIVE</b></p>	<p><b>SHOWS PARTIAL AWARENES OF OBVIOUS FEELINGS:</b></p>	
	<p>Denies the patient the right to feel that way</p>	<p>Aah, don't worry about it. It will be okay.</p>
	<p>Disallows patient's feelings</p>	<p>Don't feel bad—lots of patients feel the same way.</p>
	<p>Moralizes, sermonizes</p>	<p>The doctor is such a busy man. We shouldn't bother him for that.</p>
	<p>Gives advice; tells him what to do</p>	<p>If you would eat more and get more exercise, you would get better faster.</p>
	<p>Tells the patient how he/she (nurse) feels</p>	<p>I know how you feel. Last month when I had the flu for so long, I wanted the doctor to cure it too.</p>
	<p>Asks stupid questions</p>	<p>Why didn't you ask the doctor when he was here?</p>
	<p>Misses the meaning</p>	<p>Oh, I'm sorry to hear that it isn't helping—it just takes time.</p>
	<p>Reflects content only</p>	<p>You want me to call the doctor for you.</p>
<p>Makes excuse for not helping</p>	<p>I'll be glad to talk to you about it some other time.</p>	

Level	Nature of Response	Example of Response
<p style="text-align: center;"><b>3</b></p> <p><b>INTERCHANGE</b></p>	<p><b>REFLECTS BACK SURFACE FEELINGS:</b></p> <p>Includes content of patient's statement and attends to surface feelings.</p> <p>Communicates to patient that s/he has heard what the patient said.</p>	<p>"You are upset that you aren't feeling better and think it's the medication."</p> <p>"You are feeling anxious because you aren't improving and want the doctor to make some changes."</p>
<p style="text-align: center;"><b>4</b></p> <p><b>ADDITIVE</b></p>	<p><b>CONTAINS ALL ELEMENTS OF LEVEL 3 AND:</b></p> <p>Adds a new meaning (thought) which is related to the patient's statement.</p> <p>Enables patient to examine a new dimension of his expression</p>	<p>"Not only are you not feeling better, but you are beginning to question your doctor. It's important for you to believe in him."</p>

Level	Nature of Response	Example of Response
<p style="text-align: center;"><b>5</b></p> <p>ADDITIVE</p>	<p>CONTAINS ALL ELEMENTS OF LEVEL 3 AND:</p> <p>Adds a probe towards disclosing the patient's underlying feeling.</p> <p>Understands and communicates the hidden message which the patient is sending.</p>	<p>"It's really frightening to be following doctor's orders and not feel better. It may be that you're beginning to feel hopeless of ever feeling better."</p>

#### Bibliography

Carkhuff, Robert (1969) Helping and human relations, Vol. I and II. New York: Holt, Rinehard and Winston, Inc.

Gazda George, Walters,, Richard, Childers, William (1975). Human relations development: A manual for health sciences. Boston. London. Sydney. Toronto: Allyn and Bacon, Inc.

Wassermann, Selma. "Introduction to Interpersonal Skills Training", Mini Handbook prepared for the Interactions Centre, Faculty of Education, Simon Fraser University.

Cartoon by Jim Unger, Courtesy of Universal Press Syndicate Company, Kansas.

## Appendix F

### A Special Inservice on Palliative Care for Nurses

*This is your opportunity to experience, learn and practice coping strategies in a pilot project dealing with the emotional aspect of nursing care. You will gain awareness and knowledge of:*

- self-attitudes/feelings regarding death/dying
- "loss"- what is it? how does it affect nursing care?
- patients' emotional needs when "grieving"
- coping strategies to deal with emotional aspect of care
- self-awareness of present interaction skills
- communication skills to deal with patients' emotional distress
- the fun of learning and practicing in a group setting

The course will consist of five two-hour weekly sessions. It is important that you attend all sessions.

Where: Sherbrooke Lounge

Dates: Tuesdays: March 1, 8, 15, 22, 29

Time: 1400 - 1600

If interested, contact your Head Nurse or Loretta Wideen -4399/4665

Appendix G (i)  
Demographic Data

You are a participant in a research project which will examine the effect of a hospital palliative care inservice training. It is necessary to collect pertinent information from each participant. The confidential nature of the completed questionnaire will be carefully maintained.

Instructions

Please complete the questionnaire by checking the box opposite the answer which describes data relevant to you.

Number: \_\_\_\_\_

1. Sex:

Female

Male

2. Age group:

Under 20

20 - 30

30 - 40

40 - 50

Over 50

3. Family status:

single

married

parent

4. Please check any combination of responses that describes your academic preparation:

Registered Psychiatric Nurse

Registered Nurse

Bachelor's Degree Nursing

Bachelor's Degree (in other areas)

5. Have you participated in any training program specifically related to death/dying?

Yes

No

6. Have you participated in any training program specifically related to interpersonal skills training programs?

Yes

No

7. If Yes, please indicate below if:

Human relations model (Gazda, Carkhuff)

Other

8. How many years of clinical nursing experience have you had?

None

1 - 3 years

4 - 6 years

7 - 10 years

Over 10 years

9. In your experience, to how many terminal patients have you provided nursing care?

None

0 - 2

2 - 5

5 - 10

over 10

10. How recently have you experienced a patient die?

never

within past 6 months

within past 0 - 2 years

within past 2 - 5 years

over 5 years ago

11. How recently have you experienced the death of a close relative or friend?

never

the past 6 months?  
the past 1 - 2 years?  
the past 5 - 10 years?

12. How often have you been in a situation when you thought you were going to die?

never  
once  
twice  
more than twice

13. Have you attended a funeral?

never  
in the past 0 - 2 years  
in the past 2 - 4 years  
in the past 5 - 10 years  
over 10 years ago

14. If you were to rate your job satisfaction, you would find it:

poor  
fair  
good  
very good  
excellent

15. If you were to rate your affiliation with a religious belief, it would be:

none  
fair  
average  
strong

Appendix G (ii)  
Demographic Data Results

- |                                                                                |          |           |         |           |           |
|--------------------------------------------------------------------------------|----------|-----------|---------|-----------|-----------|
| 1. Sex:                                                                        | Female   | Male      |         |           |           |
|                                                                                | 9        |           |         |           |           |
| 2. Age:                                                                        | Under 20 | 20-30     | 30-40   | 40-50     | Over 50   |
|                                                                                | 0        | 1         | 4       | 2         | 2         |
| 4. Academic:                                                                   | R.P.N.   | R.N.      | B.S.N.  | B.A.      | Other     |
|                                                                                | 8        |           |         | 1         |           |
| 5. Participated in training program related to death/dying?                    | Yes      | No        |         |           |           |
|                                                                                | 1        | 8         |         |           |           |
| 6. Participated in interpersonal skills training program?                      | Yes      | No        |         |           |           |
|                                                                                | 2        | 7         |         |           |           |
| 7. If yes, indicate if human relations modes (Gazda, Carkhuff)                 | Yes      | No        |         |           |           |
|                                                                                | 1        |           |         |           |           |
| 8. Years of clinical nursing experience?                                       | None     | 1-3       | 4-6     | 7-10      | Over 10   |
|                                                                                |          | 2         | 1       | 2         | 4         |
| 9. How many terminal patients have you provided nursing care?                  | None     | 0-2       | 2-5     | 5-10      | Over 10   |
|                                                                                |          |           |         |           | 9         |
| 10. How recently have you experienced a patient die?                           | Never    | past 6 mo | 0-2 yr  | 2-5 yrs   | 5 yrs     |
|                                                                                |          | 7         | 2       |           |           |
| 11. How recently have you experienced death of close relative or friend?       | Never    | past 6 mo | 1-2 yrs | 5-10 yrs  |           |
|                                                                                | 1        |           | 3       | 5         |           |
| 12. How often have you been in a situation when you thought you would die?     | Never    | once      | twice   | more      |           |
|                                                                                | 6        | 3         |         |           |           |
| 13. Have you attended a funeral? (Years)                                       | Never    | 0-2       | 2-4     | 5-10      | over 10   |
|                                                                                |          | 6         | 2       |           | 1         |
| 14. If you were to rate your job satisfaction, you would find it:              | poor     | fair      | good    | very good | excellent |
|                                                                                |          | 2         | 4       | 2         | 1         |
| 15. If you were to rate your affiliation with a religious belief, it would be: | none     | fair      | average | strong    |           |
|                                                                                |          | 2         | 2       | 5         |           |



Appendix H  
Consent Form

1. I understand that this research project is designed to study the effect of a hospital palliative care inservice training program.
2. My participation consists of answering a questionnaire. In addition, I will complete situations, both prior to and following the training.
3. I understand that all data will be strictly confidential and will be used for research purposes only.
4. As a participant in this research project, I will attend a five week palliative care training program designed and conducted by the researcher, Loretta Wideen.
5. I am free to discontinue my participation at any time.
6. I understand that I may register any complaint I might have about the Project with the chief researcher named above to my Director of Nursing, Joanne Konnert or Dr. S. Shapson, Faculty of Education, Simon Fraser University.
7. Summaries of the study will be made available to the Royal Columbian Hospital of which I am a member. At the time of completion, the researcher will contact the library at Royal Columbian Hospital.

My signature below certifies that I consent to the experimental conditions outlined in this document.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## Appendix I

### Death Attitude Questionnaire

Read each question carefully and choose which reply best shows how you feel about the statement. Choose your replies from this list and circle the number on your answer sheet. There are no right or wrong answers so please be honest.

		<u>Strongly Disagree</u>	<u>Undecided</u>	<u>Strongly Agree</u>		
1.	I believe that a dying person wants to talk about his approaching death.	1	2	3	4	5
2.	I believe that there is a life after death.	1	2	3	4	5
3.	Children should attend funerals.	1	2	3	4	5
4*	Nurses should control their emotions when nursing the patients.	1	2	3	4	5
5.	I have great faith in the future.	1	2	3	4	5
6*	I feel uneasy/nervous when caring for patients with a fatal progress.	1	2	3	4	5
7.	Children should be allowed to visit and stay with a dying person.	1	2	3	4	5
8.	The patient should be told right away if he is terminally ill.	1	2	3	4	5

		<u>Strongly</u> <u>Disagree</u>	<u>Undecided</u>	<u>Strongly</u> <u>Agree</u>		
9.	The 1:1 relationship between nurse and patient is the most important aspect of nursing care.	1	2	3	4	5
10.	When things are going badly, I am helped by knowing it can't stay that way forever.	1	2	3	4	5
11*	All possible efforts should be made to keep a terminal patient alive?	1	2	3	4	5
12*	There is no reason in trying to get what I want because I probably won't get it.	1	2	3	4	5
13*	I feel uneasy/nervous when caring for patients with a fatal prognosis.	1	2	3	4	5
14*	It is the nurse's responsibility to make the decisions for the patient.	1	2	3	4	5
15*	I would feel very uncomfortable if I entered the room of a terminally ill patient and found him/her in tears.	1	2	3	4	5
16*	Even if the patient knows s/he is dying, I would feel uncomfortable discussing his impending death.	1	2	3	4	5
17.	One can always find something to look forward to.	1	2	3	4	5

		Strongly <u>Disagree</u>	<u>Undecided</u>		Strongly <u>Agree</u>	
18*	It is important that the patient not make the decisions about his care.	1	2	3	4	5
19*	Discussions with the dying about their feelings/fears should only be done by people trained for this.	1	2	3	4	5
20.	I cannot become involved with the emotional care of a patient as it takes too much time.	1	2	3	4	5
21.	Families must be involved in discussing the terminal patient's situation and making decisions regarding care.	1	2	3	4	5
22*	I feel uncomfortable riding the elevator when there is a patient being transferred to the morgue.	1	2	3	4	5
23*	When I answer the call light of a patient who is critically ill, I often am concerned that s/he might die when I am in the room.	1	2	3	4	5
24.	After the death of a patient, it should be discussed with the other patients in the room.	1	2	3	4	5

		Strongly <u>Disagree</u>	<u>Undecided</u>		Strongly <u>Agree</u>	
25*	I would rather take care of a comatose patient who is terminally ill than one who is conscious and aware of impending death.	1	2	3	4	5
26.	It is my responsibility to discuss a fatal prognosis with a patient.	1	2	3	4	5
27*	I find it more comfortable to care for terminal patients who have not been informed of their progress.	1	2	3	4	5
28.	When a friend or close neighbor is seriously ill I visit them immediately.	1	2	3	4	5
29*	A nurse should never let a patient know if she is upset about his condition.	1	2	3	4	5
30*	It is important for a nurse not to express her feelings to the patient's family.	1	2	3	4	5
31*	A terminally ill patient who talks about his death is more difficult to care for than a terminally ill patient who discusses more cheerful topics.	1	2	3	4	5

On the scale below, circle the number on the continuum that best reflects your opinion:

- |     |                                                                                                                                   |                                    |   |   |                                       |   |
|-----|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---|---|---------------------------------------|---|
| 32* | What does death represent to you?                                                                                                 | 1                                  | 2 | 3 | 4                                     | 5 |
|     |                                                                                                                                   | a loss<br>of<br>control            |   |   | a change<br>of<br>existence           |   |
| 33. | Do you believe emotions should be                                                                                                 | 1                                  | 2 | 3 | 4                                     | 5 |
|     |                                                                                                                                   | expressed?                         |   |   | controlled?                           |   |
| 34. | How often do you talk about death with<br>others?                                                                                 | 1                                  | 2 | 3 | 4                                     | 5 |
|     |                                                                                                                                   | frequently                         |   |   | never                                 |   |
| 35. | If assigned to a dying patient, what<br>aspect of his care would concern you<br>most?                                             | 1                                  | 2 | 3 | 4                                     | 5 |
|     |                                                                                                                                   | how he felt<br>about his<br>dying? |   |   | his care<br>plan, meds<br>treatments? |   |
| 36. | When in the presence of a dying<br>person, what are your feelings (or<br>expected feelings if you have not been<br>in situation)? | 1                                  | 2 | 3 | 4                                     | 5 |
|     |                                                                                                                                   | helpful                            |   |   | helpless                              |   |

## Appendix J

### Communication Questionnaire

In this pencil and paper task, you are asked to write responses to 14 different helpee expressions. "Helpee", in these situations, could be a patient, visitor of a patient, or another co-worker who has come to you seeking assistance. These statements are not related to each other, but are examples of the varying types of situations that could occur on a regular working day at the hospital.

Please, read the helpee's expressions carefully and then formulate your response accordingly.

#### Situation #1

A patient is trying to walk with a walker for the first time: "You don't know how stupid I feel trying this. All my life I've been the laughing stock because I'm so clumsy."

#### Situation #2

Patient to nurse who is taking his vital signs: "How can anyone get any rest around here? What kind of a hospital is this anyway. First of all, that old woman down the hall was ranting around half the night and now you wake me up."

### Situation #3

Patient to nurse: "I can't stand the sight of my colostomy. Every time I change it, I wonder if it's worth living like this."

### Situation #4

Patient's spouse talking to the nurse: "I hate seeing him suffer. He's getting so much worse since the doctor told him he has cancer. It seems as if he has given up."

### Situation #5

Patient to nurse: "I heard the doctor talking to you about me but couldn't understand what he was saying. I guess it's really serious."



### Situation # 6

Visitor to nurse about her aging mother, who had a hip replacement: "Mom is fine until you nurses come in and move her to the other side. I think she would be better off resting than being constantly bothered."

### Situation #7

Patient to nurse: "I've just about had it up to here with you people. Nobody cares about what I say or want to do. You people act as if I'm some sort of a baby or something. My doctor never visits me! You better do something before I explode!"

### Situation #8

Patient to nurse: "My daughters try to come and see me but they are so busy with their work and families. You know what it's like when you have kids in school...one takes piano lessons, the other plays ball all the time. Oh well,—I can't expect to have company every night."

Situation #9

Patient's husband talking to the nurse: "My wife saw the doctor a couple of months ago - even had x-rays - he said he couldn't find anything. Now, he says she is full of cancer and they can't even operate."

Situation #10

Patient to nurse: "I have trouble sleeping at night ...I keep thinking about everything I want to do and haven't done yet."

Situation #11

Patient to nurse: "Next week I'm being transferred to Eagle Ridge Hospital. I'm really looking forward to it. I've heard that the staff *there* are just wonderful."

Situation #12

Patient to nurse: "I'm not going to any old nursing home. I've heard lots about those places!"

Situation #13

Nurse to nurse: "It would be a lot easier here if the hospital would enforce shorter visiting hours. I spend half my time stepping over people's legs in those little rooms."

Situation #14:

Patient's husband to nurse: "My wife just keeps getting worse. Those medicines aren't helping her at all. I don't think the doctor is giving her the right treatment but he won't talk to me about it. What do you think?"

## Bibliography

- Aiken, Lewis (1985). Dying, death and bereavement. Boston: Allyn & Bacon.
- Anderson, Mary Joan (1980, May). The development and evaluation of an interpersonal skills' training program implemented for nurse educators. M.A. (Education Thesis). Simon Fraser University, Burnaby.
- Appleyard, Janet (1982). The facts of life. In Nursing Mirror, 155 (4), 61-63.
- Barrow, Robin (1976) Common sense and the curriculum. Connecticut: Linnett.
- Beck, Aaron, & Weissman, Arlene (1974). The measurement of pessimism: the hopelessness scale. Journal of Consulting and Clinical Psychology, 42 (6), 861-865.
- Becker, Ernest (1973). The denial of death. New York: Free Press.
- Becker, Ernest (1973). The denial of death. New York: Free Press.
- Bennett, Michael, & Bennet, M. (1984). The uses of hopelessness. American Journal of Psychiatry, 141 (4), 559-562.
- Berenson, Bernard, Carkhuff, Robert, & Myrus, Pamela (1966). The interpersonal functioning and training of college students. Journal of Counseling Psychology, 13 (4), 441-446.
- Borg, Walter, & Gall, Meredith (1983). Educational research: An introduction. New York: Longman.
- Bowlby, John (1961). Processes of Mourning. In International Journal of Psychoanalysis, 42., 317-340.
- Bowlby, John (1973). Separation: Anxiety and anger. Vol. II. New York: Basic.
- Brammer, L.M. (1973). The helping relationship. Englewood Cliffs: Prentice.
- Brasch, Pickard, Cindy (1987). Vera's gifts In Occupational Therapy Forum, II (41), 2-4.
- Brophy, Jere (1983). If only it were true: a response to Greer. Educational Researcher 12 (1), 10-13.
- Carkhuff, Robert, & Berenson, Bernard (1973) . The skills of teaching: Interpersonal skills. U.S.A.: HRD.
- Carkhuff, Robert, Berenson, Bernard (1977). Beyond counseling and therapy: second edition. U.S.A.: Holt.

- Carkhuff, Robert, & Bierman, Ralph (1970). Training as a preferred mode of treatment of parents of emotionally disturbed children. Journal of Counseling Psychology, 17(2), 157-161.
- Carkhuff, Robert, Kratochvil, Daniel, & Friel, Theodore (1968). Effects of professional training: communication and discrimination of facilitative conditions. Journal of Counseling Psychology, 15(1), 68-74.
- Carkhuff, Robert (1969) Helping and human relations: A primer for lay and professional helpers. Vol. I. New York: Holt
- Caty, Suzanne, & Tamlyn, Deborah (1984). Positive effects of education in nursing students' attitudes toward death and dying. Nursing Papers, 16(4), 41-53.
- Clayton, P., Desmarais, L., & Winokur, J. (1968). A study of normal bereavement. In the American Journal of Psychiatry, 125, 168-178.
- Collingwood, Thomas (1969). The effects of large group training in facilitative interpersonal communication. Journal of Clinical Psychology, 25, 461-462.
- Collingwood, Thomas (1971). Retention and retraining of interpersonal communication skills. Journal of Clinical Psychology, 27, 294-296.
- Coolbeth, Lucie, & Sullivan, Lorelei (1984). A study of the effects of personal and academic exposures on attitudes of nursing students toward death. Journal of Nursing Education, 23(8), 338-341.
- Cumming, Elaine & Williams, Henry (1961). Growing old: The process of disengagement. New York: Basic.
- Davies, I.K. (1969). Writing general objectives and writing specific objectives. Objectives in teaching and learning: a perspective. Chapters 6 & 7. London: McGraw.
- Davis, M., Eshelman, E.R, & McKay, M. (1982) The Relaxation and stress reduction workbook. California: New harbinger.
- Denton, John, & Wisenbaker, Vance (1977). Death experience and death anxiety among nurses and nursing students. Nursing Research, 26(1), 61-64.
- Deutsch, H. (1937). The absence of grief. In The Psychoanalytical Quarterly, 6, 12-22.
- Eisner, Elliott (1983). Anastasia might still be alive, but the monarchy is dead. Educational Researcher, 12(5), 13, 14, 23-24.
- Ellerbroek, Wallace (1978). Language, thought and disease. The Co-Evolution Quarterly, 30-38.
- Ellerbroek, Wallace. Depression as behavior: a psycholinguistic approach. Energy/Medicine Number One, 61-69.

- Engram, Barbara, & Vandergoot, David (1978). Correlation between the Truax and the Carkhuff scales for measurement of empathy. Journal of Counseling Psychology, 25(4), 349-351.
- Enlow, Pamela (1986, July). Coping with anticipatory grief. Journal of Gerontological Nursing
- Feifel, Herman (Ed.) (1959). The meaning of death. New York: McGraw-Hill.
- Fetterman, David (1982). Ethnography in educational research: the dynamics of diffusion. Educational Researcher, 11 (3), 17-22.
- Fleming, Stephen, & Brown, Isabel (1983). The impact of a death education program for nurses in a long-term care hospital. The Gerontologist, 23 (2), 192-195.
- Foulds, Melvin (1969). Self-actualization and the communication of facilitative conditions during counseling. Journal of Counseling Psychology, 16 (2), 132-136.
- Frankl, Viktor (1946). Man's search for meaning. New York: Pocket.
- Friel, Ted, Kratochvil, Dan, & Carkhuff, Robert (1968). The effects of the manipulations of 'client' depth of self-exploration upon helpers of different training and experience. Journal of Clinical Psychology, 24, 247-249.
- Furman, Erna (1974) A child's parent dies: Studies in childhood bereavement. New Haven & London: Yale.
- Gazda, George, Walter, Richard, & Childers, William (1975). Human Relations Development: A manual for health sciences. Boston: Allyn and Bacon.
- Gazda, George, Asbury, Frank, Balzer, Re., Childers, William, & Walters, Richard (1984). Human relations development: A manual for educators. Third Edition. Boston: Allyn & Bacon.
- Giovaccini, M.D. (1981) The urge to die. U.S.A.: Penguin
- Glick, Ira, Weiss, Robert & Parkes, C. Murray (1974). The first year of bereavement. New York: Yale.
- Golby, Michael, Greenwald, Jane, & West, Ruth (1975). Curriculum design. Great Britain: The Open University Press.
- Grollman, Earl (1967). Explaining death to children. Boston: Beacon.
- Grollman, Earl (1981). What helped me when my loved one died. Boston: Beacon.
- Guzzetta, Roberta (1976). Acquisition and transfer of empathy by the parents of early adolescents through structured learning training. Journal of Counseling Psychology, 23(5), 449-450.

- Hirst, Paul , & Peters, R.S. (1970). The concept and aims of education. The Logic of education. London: Routledge & Kegan: 19-28.
- Hirst, Paul H. (1974). Knowledge and the curriculum: A collection of philosophical papers. London: Routledge & Kegan.
- Hopping, Betty (1977). Nursing students' attitudes toward death. Nursing Research, 26(6): 443-447.
- Hunsinger, George (1969). Kierkegaard, Heidegger, and the concepts of death. An honors essay. California: Stanford.
- Inglis, Fred (1974) Ideology and the curriculum: the value assumptions of system builders. The Journal of Curriculum Studies, 6(1), May.
- Iveson-Iveson, Joan (1983). Concepts of death. Nursing Mirror, 156(6), 42.
- Johnston, Wayne (1985). To the ones left behind. American journal of Nursing, (8), 936.
- Jourard, S.M. (1971). The transparent self. Second edition. New York: Van Nostrand.
- Kalish, B.J. (1971). An experiment in the development of empathy in nursing students. Nursing Research 20: 202-211.
- Kalish, Beatrice (1973). "What is empathy?" American Journal of Nursing, 73(9): 1548-1552.
- Kastenbaum, Robert & Aisinberg, Ruth (1972). The psychology of death. New York: Springer.
- Keck, Virginia, & Walther, Louise (1977). Nurse encounters with dying and nondying patients. Nursing Research, 26(6), 465-469.
- Knowles, Donald & Reeves, Nancy (1983). But won't granny need her socks? Dealing effectively with children's concerns about death and dying. Victoria: Kendall.
- Kratochvil, Daniel, Aspy, David, & Carkhuff, Robert (1967). The differential effects of absolute level and direction of growth in counselor functioning upon client level of functioning. Journal of Clinical Psychology, 23, 216-217.
- Kübler-Ross, Elisabeth (1975). Death: The final stage of growth. New Jersey: Prentice.
- Kübler-Ross, Elisabeth (1978). To live until we say goodbye. New Jersey: Prentice.
- Kübler-Ross, Elisabeth (1981). Living with death and dying. New York: MacMillan.
- LaMonica, Elaine, Carew, Donald, Winder, Alvin, Haase, Ann Marie, & Blanchard, Kenneth (1976). Empathy training as the major thrust of a staff development program. Nursing Research, 25(6), 447-451.

- LaMonica, Elaine, Karshmer, Judith (1978). Empathy, educating nurses in professional practice. Journal of Nursing Education. 17 (2), 3-11.
- Meen, Donald (1986). Enhancement of communicated empathy through modeling and corrective feedback in-process of dyadic practice. PhD. Thesis. Winnipeg, Manitoba.
- Miles, Mathew, & Huberman, A. Michael (1984). Qualitative data analysis. California: Sage.
- Lev, Elise (1986). Teaching humane care for dying patients. Nursing Outlook. Sept/Oct., 241-243,
- LLewelyn, Susan, & Fielding, Guy (1983). Am I dying nurse? Nursing Mirror. 156 (16), 30-31.
- MacMillan, C.J.B. & Garrison, James (1984). Using the new philosophy of science. In Educational Researcher. 13 (10), 15-21.
- Martin, James, & Carkhuff, Robert (1968). Change in personality and interpersonal functioning of counselors-in-training. Journal of Clinical Psychology. 24, 109-110.
- May, Rollo (1969). "Love and death". In Love and will New York: Dell. 98-120.
- McCaffery, Deborah (1984). Promoting the empathetic development of nursing students in the care of the patient with cancer. Journal of Nursing Education. 23 (2), 73-76.
- Miles, Mathew, Huberman, Michael (1984). Drawing valid meaning from qualitative data: toward a shared craft. Educational Researcher. 13 (9), 20-30.
- Milton, Isabel (1984). Concerns of final year baccalaureate students about nursing dying patients. Journal of Nursing Education. 23 (7), 298-301.
- Moody, Raymons A. (1975). Life after life . New York: Bantam.
- Mullins, Larry, Merrian, Sharon (1983). Nurses react to death anxiety. Journal of Gerontological Nursing. 9 (9), 487-492.
- Murphy, Patricia (1986). Reduction in nurses' death anxiety following a death awareness workshop. The Journal of Continuing Education in Nursing. 17 (4), 115-118.
- Nicassio, Perry and Bootzin, Richard. (1974) A comparison of progressive relaxation and autogenic training as treatments for insomnia. Journal of Abnormal Psychology. 83 (3): 253-260.
- Noddings, Nell (1984) Moral Education in Caring: A feminine approach to ethics and moral education. W. Cal Press. 171-200.



- Northouse, Peter (1979). Interpersonal trust and empathy in nurse-nurse relationships. Nursing Research, 28(6), 365-368.
- Norton, Maryann (1985). Daring to care. American Journal of Nursing, 10, 1098-1099.
- Oakeshott, Michael (1967). Learning and teaching. The concept of education. Edited by R.S. Peters. New York: Routledge & Kegan.
- Parker, Rossman (1977). Hospice. New York: Fawcett.
- Payne, Paul, Weiss, Stephan, & Kapp, Richard (1972). Didactic, experiential and modeling factors in the learning of empathy. Journal of Counseling Psychology, 19(5), 425-429.
- Pelletier, K. E. (1977). Mind as a healer, mind as a slayer. New York: Dell.
- Phillips, D.C. (1983) After the wake: positivistic educational thought. Educational Researcher, 12(5), 4-12.
- Pierce, Richard, Carkhuff, Robert, Berenson, Bernard (1967). The differential effects of high and low functioning counselors upon counselors-in-training. Journal of Clinical Psychology, 23, 212-215.
- Raths, Louis, Harmin, Merrill, Simon, Sidney (1978). Values and teaching: Working with values in the classroom. Second edition. Columbus: Merrill.
- Raths, Louis, Wassermann, Selma, Jonas, Arthur, Rothstein, Arnold (1967). Teaching for thinking: Theory and application. U.S.A.: Merrill.
- Rogers, Carl (1961). On Becoming a person. Boston: Houghton.
- Rogers, Carl. (1951). Client-centred therapy: Its current practise, implication and theory. Boston: Houghton.
- Rosenthal, Ted (1973) How could I not be among you? New York: Venture.
- Scarf, Maggie (1980). Unfinished business. New York: Ballantine.
- Schneider, John (1984). Stress, loss & grief. Baltimore: University.
- Schneidman, E. (1980) Voices of death. Toronto: Bantam.
- Schoenberg, Bernard, Carr, Arthur, Peretz, David, & Kutscher, Austin, (Editors), (1970). Loss and grief: Psychological management in medical practice. New York: Columbia.
- Schon, Donald A. (1983). The reflective practitioner. New York: Basic.
- Schrock, Miriam, & Swanson, Elizabeth (1981). The effect on nursing students of direct-care experience with death and dying. Nursing Forum, 20 (2), 213-219.

- Schunior, Charles (1985) Balloons in the CCU. Nursing. 280(5), 112
- Smith, John (1983). Quantitative versus qualitative research: an attempt to clarify the issue. Educational Researcher. 12(3), 6-13.
- Solnit, Albert (1961). A study of object-loss in infancy. In Psychoanalytic Study of the Child. Vol. xxv. 257-272.
- Solnit, Albert, & Stark, Mary (1961). Mourning and the birth of a defective child. In Psychoanalytic Study of the Child. Vol. XVI, 523-537.
- Soltis, Jonas (1984). On the nature of educational research. Educational Researcher. 13 (10), 5-10.
- St. Johns, & Adela Rogers (1981) No good byes. My search into life beyond death. New American Library.
- Stetler, Cheryl (1977). Relationship of perceived empathy to nurses' communication. Nursing Research. 26 (6), 432-435.
- Stoller, Eleanor (1980). Effect of experience on nurses responses to dying and death in the hospital setting. Nursing Research. 26 (1), 35-38.
- Stowers, Susan (1983). Nurses cry too. Nursing Management. 14 (4), 63-64.
- The adolescent in despair (1985). In Emergency Medicine. New York. 17(16), 50-66.
- Truax, Charles, Wittmer, Joe, & Wargo, Donald (1971). Effects of the therapeutic conditions of accurate empathy, non-possessive warmth, and genuineness on hospitalized mental patients during group therapy. Journal of Clinical Psychology. 27, 139-142.
- Turton, Pat (1986). Wall of silence. Nursing Times. 82 (15), 23.
- Vachon, Mary (1986). Coping with people in crisis. Journal of the Canadian Intravenous Nurses Association. 2 (1), 10-15.
- Vachon, Mary, Lyall, W., Freeman, S. (1978). Measurement and management of stress in health professionals working with advanced cancer patients. Death Education. 1, 365-375.
- Walker, C. Eugene (1975). Learn to relax. New Jersey: Prentice.
- Weiss, Robert (1973). Loneliness: The experience of emotional and social isolation. Cambridge: MIT.
- Weissman, Myrna & Paykel, Eugene (1974). The depressed woman: A study of social relationships. Chicago. London: University of Chicago Press.
- Wilson, Colin (1975). The supernatural powers. London: Aldus.

Wolfenstein, Martha (1969). How is mourning possible? In Psychoanalytic Study of the Child, Vol. XXI , 93-123.

Wolfenstein, Martha (1969). Loss, rage and repetition. In Psychoanalytic Study of the Child, Vol. XXIV , 432-462.

Zilboorg, G. (1943). Fear of death. In Psychoanalytic Quarterly. 12, 465-475.