THE EFFECT OF AN EXPERIENTIAL DEATH AND DYING AWARENESS WORKSHOP ON EXPRESSED ANXIETY TOWARD DEATH

by

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(ABSTRACT)

Volunteers from churches in the Washington, D.C. metropolitan area participated in a 10 to 12 hour experiential death education workshop. The program emphasized basic communication skills in exploring death and dying issues. Satir's communication patterns were used in a simulated family planning event; participants were encouraged to write in a journal after each exercise; directed fantasy explored the development in life of the individual's way of coping with loss; a role play used birth order and it's effects when a parent has a terminal illness; and guided imagery was used to explore the participant's death and funeral.

The workshop did not lower death anxiety in the 17 females and six males (aged 35-66) who participated. There was no significant difference when comparison was made on the pre- and post-Templer Death Anxiety Scale (TDAS) change scores between those particpants in the program and the control group, Virginia Polytechnic Institute and State University Northern Virginia Graduate Center students, who did not participate. Mean scores on TDAS were within the normal range of means for subjects established by Templer and Ruff. Participants stated that interactions which facilitated a self-discovery process had met a need for them.

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It was a special privilege to have Joel Wilcher share his expertise as co-director for the workshops. A special debt to my daughter, Lynnette Case, and John Hanks for computer and statistical consultation.

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My interest in death and dying was sparked by Dr. Elisabeth Kubler-Ross in her book, On Death and Dying. This interest has spurred me to explore my issues with the deaths of my father, Fred Pargeter Santee; my brother, Harold H. Santee; my sister, M. Louise Barton; and my son-in-law, Kenneth John Case. It is to all of these to whom I dedicate this study.

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THE EFFECT OF AN EXPERIENTIAL DEATH AND DYING AWARENESS WORKSHOP ON EXPRESSED ANXIETY TOWARD DEATH

The main motivation for man's activity in life is fear of death (Becker, 1973). Early Americans were ever aware of death. Children were exposed to the dying process and its final ceremony, preparing them early in life to deal with death (Coffin, 1976). In today's society the wonders of modern medicine have attempted to make death obsolete. Hospitals tend to conceal from patients that they may be dying and when death draws near the patient is whisked away, out of sight of others, into a remote section of the hospital (Dempsey, 1975). Grollman states that "the word D-E-A-D has become the new four letter work of pornography," (1970, p. ix), and therefore a taboo subject. Although children tend to be spontaneous and speak openly when death enters their thought process, silence is modeled for them by their parents, due to the anxiety the parents have about their fears of death (Hendin, 1973). Thus an intergenerational cycle of avoidance in communication about death is begun.

Death is discovered by children at an early age and causes great anxiety (Yalom, 1980). Since death tends to be a taboo subject, certain myths develop and spread from generation to generation. One myth is that children cannot comprehend death (Vernon & Payne, 1979). Parents attempt to shield their children from death while the children are very aware of their parents' anxiety and change in behavior. Thus the anxiety experienced about death may develop into an unrealistic fantasy or be transformed into a series of phobias (Yalom, 1980).

How or what to communicate is first learned as a child. Satir

(1972) pointed out that communication is the largest single factor that determines the kinds of relationships one makes with others and how one interacts in the surrounding world. When children are given honest answers, allowed free expression to their emotions, and encouraged to think their ideas through, they have the potential to adopt a healthy, realistic attitude toward death (Gordon & Klass, 1979). LeShan (1976, p. 1) stated that experts in understanding human emotions found "that the families who try to run away from their feelings suffer longer and often never recover from their grief." Those who face their grief become stronger and are able to grow and again live full and satisfying lives. Talking serves as a direct action approach in working through grief (Benton, 1978). It is important to acknowledge the loss and say, "yes" to that truth. Verbalizing the situation, sharing reactions with others (especially those who have a similar experience) helps one to face a loss as a reality (Albertson, 1980). Thus there is a need to incorporate death and dying issues into a non-threatening communication framework so death anxiety can be acknowledged and fear of death can be expressed and talked about openly as a part of the human experience.

McClam (1980) described a workshop composed of films, discussions and awareness exercises in which pre- and post-treatment measures of death anxiety were administered. No significant changes occurred as a result of workshop participation. McClam suggested that perhaps to successfully lower death anxiety a more experiential format for a death education course was needed.

The present study explored the effects of an experiential based death and dying workshop, designed by this researcher, in reducing the

expressed anxiety about death in a sample of adults. Emphasis in the workshop was placed on patterns of communication (Satir, 1976) and a series of rules in basic communication from Perls' Gestalt therapy (Passons, 1975) adapted into the language of awareness (Sweeney & Sweeney, 1981). Participants in the treatment groups explored communication skills in the form of a structured workshop specifically designed to facilitate the communication of adult children about their parents' possible terminal illnesses and eventual deaths. This indirect approach (e.g., focusing on parents' deaths) was used to encourage participants to be more open in the exploration of emotions that surround the phenomenon of their own deaths and to encourage them to break the cycle of silence about death with their own children and other loved ones. As participants explored their personal emotions about death, with the support of others, their anxiety levels about death were predicted to become lower and more of an acceptable part of life.

Hypotheses were concerned with pretest-posttest patterns of mean differences on the TDAS for treatment and control group subjects. Each hypothesis was tested at the .05 alpha level.

Methodology

Treatment Groups

The treatment groups consisted of 23 volunteers (6 men, 17 women), ages 35-66, from Northern Virginia and the Washington, D. C., metropolitan area churches. These volunteers expressed interest in communication skills and a desire to explore death and dying issues. Five subjects had attained high school diplomas and twelve had attained some graduate work beyond college. Participants attended a 10 to 12

hour course on adult children and their aging parents. The course was divided into three segments covering three consecutive evenings or one evening, one morning, and one afternoon.

Each participant was exposed to experiential exercises designed to facilitate awareness of feelings, communication skills, and discussion of death and dying. When participants were able to talk openly about their parents' possible terminal illness and death, it was hypothesized that their level of death anxiety would be reduced and they would be able to talk of their own deaths and the deaths of their spouses and children. The researcher and a fellow colleague trained in communication skills at the Center for Study of Human Systems, Chevy Chase, Maryland were group facilitators.

Control Group

The control group consisted of 23 persons (6 men, 17 women), ages 26-54 enrolled in a class, other than death and dying, at the Virginia Polytechnic Institute and State University Northern Virginia Graduate Center. This group was given the TDAS (Templer, 1970) twice, with a three week interval between administrations.

Instrumentation

The TDAS was used to test the expressed death anxiety levels of participants. One point is scored on the TDAS for each statement answered in the high death anxiety direction. A score could be as high as 15, very high anxiety, or as low as 0, very low anxiety. Templer (1970), administered the TDAS to two groups, psychiatric patients and college students, to establish construct validity. TDAS scores correlated significantly (.74) with the Boyar's Fear of Death Scale.

Psychiatric patients' scores on the Minnesota Multiphasic Personality Inventory (MMPI) and TDAS were positively correlated ($p < .01$) on three MMPI subscales (.56 for Sc, .49 for Pt, .47 for D) which supports the literature that "schizophrenics, obsessive-compulsives, and depressed persons have a high level of death anxiety (Templer, 1970, p. 175)."

Vargo (1980) found the TDAS and the four subscales of the Collett-Lester Fear of Death Scale positively correlated. Product-moment correlations were significant ($p < .01$) between TDAS and fear of death of self subscale ($r = .609$), fear of dying of self subscale ($r = .524$), fear of death of others subscale ($r = .434$), and fear of dying of others subscale ($r = .396$). McClam (1980) used the TDAS and the fear of death of self subscale of Collett-Lester to measure the death anxiety of healthcare and helping professions personnel in a death education program. Participation in the workshop, composed of films, discussions and awareness exercises, did not lower mean scores on TDAS ($t = .41$) and fear of death of self subscale ($t = .51$).

Adult Children and Aging Parents: Experiential Death Education Workshop.

Segment 1 - Communication: Each workshop segment was begun with singing and a few minutes of meditative silence. This was done to encourage participants to set aside outside worries and concerns and be more fully present (Kubler-Ross, 1982).

One by one, the 13 language of awareness rules (Sweeney & Sweeney, 1981) were related to the life of each participant, e.g. make I statements rather than ask questions. The application of these basic rules was encouraged in the discussion with other participants after each of the structured exercises.

Patterns of communication (Satir, 1976), placating, blaming, superreasonable, irrelevant and congruent, were physically and verbally explored with a partner. The group was then divided into simulated families, mother, father, two children, and a grandparent. Each was assigned a pattern of communication and as a group were asked to plan a family outing. After three minutes of planning each family member was assigned a new pattern of communication and they were asked to continue. After a third rotation of assigned communication patterns they were asked to finish planning their outing with all family members using Satir's communicative style of congruence. They were asked to write about the patterns of communication used in their family of origin as well as patterns of communication used by their parents with the parents' siblings.

Participants were encouraged to write in a journal (Progoff, 1975) after each exercise in order to describe on paper the facts of each inner experience as it occurred. New insights to personal wisdom were recorded so they could be picked up at a later time and expanded. The journal also described the progression of thoughts and evolution the participant experienced from the beginning to the end of the workshop.

Segment 2 - Family Coping Patterns: Participants were led on a directed fantasy (Passons, 1975) through losses they had experienced in their lives beginning with the most recent and going back to pre-school age losses. On the fantasy journey from the early years to the present they were asked to find a theme or pattern of how they dealt with loss that was building from pre-school to the present.

Birth order position shows a tendency toward specific strengths and weaknesses (Forer, 1976). Participants were assembled in four

sides of the room, oldest children, middle children, youngest children, only children. Each expressed to others in their group what it was like to be in their particular sibling position. The groups were asked to assume the other possible sibling positions and after assumption of each to discuss rules and expectations of each birth order position (e.g. youngest is helpless; oldest takes charge). They were then asked to choose which position they liked best. In order to focus on the roles members of the family play in a time of crisis, a role play (Gordon & Klass, 1979; Sternberg & Sternberg, 1980) was designed around a terminal illness of the father. Each birth order group was assigned an age, 14 for oldest, 10 for middle, and six for youngest. The only children group was incorporated into the oldest children group (Toman, 1976). Participants were then asked to apply the birth order exercise to their parents' family of origin to gain insight to the parents' roles in times of crises.

Segment 3 - Terminal Illness and Death: Participants were led on a directed fantasy (Passons, 1975) in which they (1) were told they had two years to live, (2) were instructed to identify the priorities they would then have for their lives, and (3) were asked to rank-order their priorities. After general discussion about the experience of the exercise, participants were asked to apply the fantasy to their parents' lives.

Guided imagery (Sternberg & Sternberg, 1980) was used for participants to experience their own deaths and funerals. They were taken from the time of the death through the burial in the cemetery and ended with "how do you want to be remembered?" Participants were asked to

reflect on how their parents want/wanted to be remembered.

For the final directed fantasy (Gawain, 1978), a pillow was placed in the middle of the floor and the group was asked to allow an image of someone to appear on the pillow with whom they had something to say, (e.g. perhaps some unfinished business to discuss). Participants were told that the imagined person could be dead or alive. After three minutes they were asked to write in their journals about the experience and then talk with the group about the experience if they so wished. The facilitator then asked if there was one who wanted to volunteer to develop a role play around their conversation (Gordon & Klass, 1979). The person on the pillow was portrayed by one of the facilitators, and the other facilitator guided the role play. Participants were asked to review the exercises from all three segments and write in their journals any new insights about their parents, themselves, and their children.

A break of ten minutes between exercises was thought important. Tea, coffee, and snack foods were available at all times. Facilitators typically led stretching exercises after each fantasy, making sure participants were out of the fantasy and into the real world. Discussions were held after each exercise. Participants expressed to the whole group what they had experienced.

The role of the facilitator was to provide a nonjudgmental atmosphere of trust, unconditional love and support (Kubler-Ross, 1982). Care was taken to allow participants to relax before beginning a fantasy or guided image, and time was allowed for them to finish their fantasies prior to returning to reality. It is important to derole participants after a role play so there will be no emotional confusion between reality

and fantasy. Ample time was allowed for the "deroleing" process.

It is beneficial for the facilitators to have worked through personal issues around death so they are comfortable with and can be supportive of others' death issues (Sternberg & Sternberg, 1980; Gordon & Klass, 1979).

Results

A static group comparison, pseudoexperimental design, was used in the study (Huck, Cormier & Bounds, 1974). Mean scores of both the treatment and control group were within the normal range of means for subjects established by Templer and Ruff (1971), 4.5 to 7, with standard deviations around 3.0. There was no statistically significant gender difference on pretest TDAS scores: treatment, $\underline{t}$ (21) = -.326, $\underline{p} > .374$; control, $\underline{t}$ (21) = -.736, $\underline{p} > .235$. Age was not a significant factor when treatment (ages 35-66) and control group (ages 26-54) TDAS scores were compared for those above the mean (treatment group $\bar{X}$ = 48.65; control group $\bar{X}$ = 37.57) with those below the mean age in their respective groups: treatment group, $\underline{t}$ (21) = .713, $\underline{p} > .242$; control group, $\underline{t}$ (21) = .924, $p > .183$.

Neither the treatment nor the control group showed any significant changes on the TDAS when pretest-posttest scores were compared. See Table 1. No significance was found when the control group TDAS change scores were compared with the treatment group change scores, $\underline{t}$ (22) = .115, $\underline{p} > .455$.

Discussion

McClam's (1980) death education program for healthcare and helping professions personnel did not seem to lower death anxiety and suggested

Table 1

TDAS pretest-posttest scores						
Group	Pretest M	Pretest SD	Posttest M	Posttest SD	t	p
Treatment	6.522	3.043	6.261	2.435	.663	.257*
Control	6.500	3.273	6.478	2.810	.074	.471*
*df = 22						

a program based on more experiential learning. The emphasis on the present study was experiential learning, and the results showed that the death anxiety level did not seem to be lowered significantly. Perhaps a certain amount of anxiety is needed for receptivity and openness in working through an issue that is in some ways fearful to explore. Yalom (1980) stated that we can not live life or face death without anxiety. High anxiety needs to be lowered and perhaps low anxiety needs to be raised to a comfortable level to increase awareness and further maturation. In 1908, Yerkes and Dodson found that with low anxiety there was no motivation; with high anxiety the individual was believed to be the preferred condition an individual needed to be attentive and alert for a task (Mishel, 1976).

Participants in the workshop expressed that the workshop had met a need for them in resolving the deaths of loved ones or in facing a death event that was soon to occur. One subject stated that, "the exercises and discussions were particularly valuable in facilitating a self-discovery process, I was forced to face some pain of grieving that

I had pushed aside (when my father died) while I dealt with my mother's needs." A subject with cancer stated that, "while the information was not terribly earth-shattering, the interactions and reactions that came out of the various exercises were indeed revealing." Another participant expressed that the key for her was "love and how it can be used in any crisis."

One control group participant stated her belief that pretest-posttest differences on TDAS were greatly influenced by her immediate mood when responding to the TDAS. A possible study to see what relationships exist between self-esteem and death anxiety might provide insight on receptiveness to death education that allows for growth around fearful issues that create anxiety.

Since with whom and what to communicate is learned as a child (Satir, 1972), it seems humans begin early in life to maintain silence about death; thus anxiety grows. Without the freedom to express their fear about loss and death, individuals learn a coping mechanism of avoidance and develop unrealistic fantasies or phobias (Yalom, 1980). Because of the fear that grows around death anxiety, individuals cling to their coping pattern of avoidance on the subject of death despite the fact it is self-defeating and leads to dissatisfaction and unhappiness--a neurotic paradox (Coleman, 1976). With open communication as a major focus in this study, volunteers were exposed to various exercises which encouraged them to express their fears and anxieties about death. Although the anxiety was not reduced significantly, the taboo about silence seemed to be broken so that the topic of death could be acknowledged and dealt with constructively. Others have expressed

that honest communication builds trust and helps to dissipate fear when a serious illness or death occurs, whether with a child and the family (Renshaw, 1980; Atkinson, Stewart & Gardner, 1980) or with adults (Shepherd, 1975; Dempsey, 1975). A testing instrument to measure pre- and post-communication skills might be more valuable in evaluating an individual's ability and/or willingness to openly express death anxiety. Developing communication skills that enable one to openly express fear and anxiety can provide a healthy outlet for future experience with loss and death.

Appendix A

Review of Selected Literature

Review of Literature

Denial and Lack of Communication

Death anxiety begins at an early age and continues across the life cycle. Due to the denial of death an individual's perception of a problem in midlife may be distorted (Gaston, 1980). Since the cultural norm tends to deny death, family and friends are unable to discuss death and dying and are unable to provide situational support to the individual in a crisis. Gaston (1980) has suggested integrating Kubler-Ross's (1969) theory of death and dying, midlife crisis and crisis intervention and using this theory as a foundation for clinical application.

Parents tend to model death anxiety for their children. When a hospitalization is necessary the fear can be overwhelming unless the children are helped to understand what the experience will be like. Assurance plus friendly and informative communication can help to make their stay more secure. A hospital communications study at the A. I. duPont Institute in Delaware (Klinzing, Klinzing, & Schindler, 1980) provided insight to the actual communication process and possibilities to make communication more effective in the future for both young patients and their families. Renshaw (1980) stated that lying to children is a mistake. When they discover the truth they tend to feel angry, distrustful and alone. Being honest allows the children and the family to share in expressing tears of sorrow and regret and a building of security and closeness. Words are often misleading when body language is saying the opposite of what the words say and there is a need to allow the expression of true feeling.

As people age they become socialized to their own death. They have worked through the loss of friends, mates, and other loved ones. In data analyzed from structured interviews, Keith (1979) identified older men and women as positivists (having attained goals in life); negativists (loss of ego integration); activists (death curtails opportunity to continue life's ambition); passivists (respite from life's woes). Women were inclined to have a more positive perception of life and death than men. Those in the passivists category tended to have isolated themselves and were lonely. They diminished their church involvement and lost their informal social contacts.

Loneliness reflects a deficiency in one's social relationships and is usually accompanied by a feeling of discomfort. Gerson and Perlman (1979) examined communication skills, via videotapes, of female subjects who were either chronically lonely, situationally lonely, or not lonely. The situationally lonely subjects were more successful as communication senders than were the chronically lonely or non-lonely subjects. Lonely people talk more about themselves and ask others fewer questions.

Lynch and Convey (1979) have outlined and documented the thesis linking loneliness to disease and premature death. Hypertensive patients were found to be socially isolated and had difficulty relating to other people. Initially, they were unable to verbalize their feelings and were unaware of strong emotional reactions to interpersonal interactions.

Death Education and Communication

Being able to verbalize fear and anxiety is an important key for the integration of death into life. Fear and anxiety about death tends to intensify when a person's health is poor. Health care professionals

are entrusted with the task of insuring wellness. With the onset of symptoms, regardless of how insignificant, fear and anxiety of a terminal illness are often experienced (if not expressed). When told the problem is minor, patients take their medicine and do as the professionals instruct, grateful for a reprieve. If symptoms are serious and hospitalization is required, the anxiety and fear levels tend to heighten. It is at this time that health care professionals are looked to for assurance and support. They are expected to have the necessary skills to deal with the issues surrounding mortality so that comfort in a time of severe stress is available to their patients.

The majority of articles that currently exist on the topic of death education workshops concern themselves with the education of health care professionals so that they may be better able to work with dying patients and their families. What follows is a review of several studies which emphasize the need of health professionals to develop communicative skills and coping strategies to deal, not only with the deaths of their patients, but with the fears and anxieties that surround their own deaths. These articles are included here, not only because of their emphasis on death education components, but because they provide examples of the struggles health professional students experience as human beings in coping with their anxieties about mortality. Several articles show how health care professionals apply the learning from their own death education experience in their own immediate health care setting, nursing, speech pathology, etc.

Dietrich (1980) expressed that the need for health professionals to understand their own beliefs and values about death were dependent

on their likely involvement with terminally ill patients. Those professionals having little exposure to persons experiencing death could elect to take an education course on death and dying, while Dietrich felt such a course was mandatory for those routinely exposed to the deaths of others. A special emphasis is needed on the development of active listening skills in order to be supportive of the dying patient and their significant others. Those in charge of dying patients and their families are aware of their discomfort and feel a need for experienced resource people and informal programs dealing with the care of dying patients (Scurry, Bruhn, & Bunce, 1979). The majority of students and new physicians surveyed at the Downstate Medical Center in New York reported that patients with terminal illness should be told their diagnosis (Blumenfield, Levy, & Kaufman, 1979). They also emphasized a need for a course to be taught on an individualized approach to the dying patient.

A death education class with an emotional/personal approach was described as the most exhausting teaching experience an allied health educator could have (Dietrich, 1980). Such classes conducted by Dietrich tended to run overtime, students repeatedly dropped in for personal consultation, and students often cried and released repressed anger in class settings. Students' expression of emotions about death can be turned into rich learning experiences for the entire class when death educators are appropriately trained and have worked through their own emotionality about death.

Videotaping simulated situations between physicians-in-training and mothers/parents has been an effective way to teach communication

skills in the Department of Pediatrics at the University of Iowa (Wolraich & Reiter, 1979). Some errors picked up in the review/feedback sessions for residents interaction with mothers/parents included: (1) too many technical terms used at inappropriate times in their descriptions; (2) did little to reinforce and encourage the parents; (3) problems dealing with silence, too much information without checking if the parent understood; and, (4) avoiding the emotional reactions the parents were experiencing.

Using clinical examples, Murphy (1979) expressed her evolution as a nurse in learning to communicate with dying patients. The first phase was avoidance; conversation was limited as she cared for their physical needs. In the second phase, talk was used as a shield. Allowing herself to go into the patient's world unprotected resulted in tears for the third phase. This passed on to the fourth phase of being with the patient and family without becoming overwhelmed.

Staff team work is important for the patient and their family. Each member of the health professional team should accumulate, evaluate and record knowledge and observations in a form available to all involved. Renshaw (1980, p. 61) felt the more the imminent death of a child is discussed and handled by the team of health professionals, "the more understandable and manageable this final life-period of the child should become for all involved."

A model for developing team work of health professionals was developed by Anderson (1979). A case history used for a problem-solving exercise was first discussed in dyads, then in groups of four, then in groups of eight and eventually the total group to provide a team

work atmosphere. This model allows each person to express and discuss feelings with another and eventually arrive at a mutual solution, a product of team involvement and decision making.

In critical care settings, meetings with the family and the medical team increased the family's sense of involvement with their loved one's treatment and care. "Warmth and trust (of the team) provide the bedrock for all dealings with families" and for supporting each other (Atkinson, Stewart, & Gardner, 1980, p. 43). This initial trust building allows for a joint venture of family and professionals in helping the patient to adjust to their loss of function. For example, discomfort is often felt by health care workers in working with patients who are unable to express themselves in a normal way. Families may even withdraw due to lack of information, and the patient becomes isolated. The presence of a speech-language pathologist on the team provides a model for the most effective ways to communicate with the non-verbal patient (Potter, Schneiderman, & Gibson, 1979). A health care professional being able to step in and express in some way, "I understand," speaks volumes.

Personal Experience

What follows are some expressions of the grieving process by children, a young wife, an older wife of a marriage of 40 years, and a social worker and an older male patient who were terminally ill. The personal experience of these persons stresses the importance of verbal expression in dealing with fear and anxiety of death and the grieving process.

Interviews conducted by Krementz (1981) with children who had lost a parent revealed a desire by children (1) to know as much information

around the death as possible and, (2) to express their feelings and openly discuss the death. Laurie, age 12, stated, "it's like you're in suspense all the time and you just want to get the facts so that you won't have to think about it again," (p. 3). Tora, age 10, expressed, "I wish I knew more details because it would help me get over it faster--I'd like to know just what happened. It would help me to realize that it really did happen . . . my mother thinks she's making things easier for me by not talking about it, but I want to know everything--even if it does make me cry," (p. 57). Gardner, age 16, found a counselor helpful for his family; "he just came over and we talked about our problems. He kind of prepared us for Mom's dying and he went to the hospital and helped her too," (p. 69). Carla, age 11, shares that she was close to her now deceased father; "I never thought my mother loved me, I thought she was closer to Jackie, and I used to keep all this stuff bottled up inside me, which made us fight a lot. So talking it out was the only way," (p. 83).

Albertson (1980) shared some reflections after the death of her husband, Mark. Albertson realized shortly after the terminal diagnosis that protective silence was a waste of their quality time left together and tended to be an obstacle to an honest closure of one's life. Some of their grieving was done together in shared tears and talking about the problems. At the end much of the day was spent just being quietly present, they experienced no need to talk, no sense of unfinised business between them. Care must be taken during a terminal illness to make sure all family members are not dying. Life must go on and it is important for the family to carry on life's activities. Family members

need to be included in caring for the ill member. This helps to reduce their anguish and sense of uselessness.

In her letter to seminar students in Methods in Intervention with Dying, Lois Jaffe wrote:

> It is fascinating that I used the same coping mechanisms during my semi-comatose periods as when I am normal. I have often said that my way of coping with my terminality has been to talk openly about death and dying, to write about it, and even to teach it . . . talking about my feelings releases energy when I am well; obviously it also served as a viable safety valve when I was stuporous.
>
> The role of my children was pivotal in my ability to cling to life. During the three year period of my first remission, we had talked openly, at each of the children's own pace, about my impending death . . . during those critical days we cried together, and expressed our feelings of love and fears of loss. We even found time to laugh . . .
>
> What my previous experiences with dying did help me with was my ability to be vulnerable with others, to know that my fears were natural and not aberrant. Part of being human is to realize that, under great stress, we all suffer--often inflict painful feelings in one way or another. Given love, people understand . . . I remember thinking that my will to live was contingent upon three factors: (1) my doctor's belief that I could make it; (2) the constant care and demonstrated love and (3) my own self-image (1976, pp. 6-9).

When cancer ended the life of her husband of close to 40 years Pincus stated:

> Whatever it was that Fritz wanted to express, he felt that during these last months of his life, he had acquired a new intensity of perception, of enjoyment, of being in touch with what was beautiful, and I could share, on our gentle walks, his sheer delight in small children, birds, flowers, trees, clouds. We were probably closer during that time, more united in mutual trust, than at any other time in our long marriage (1974, p. 4).

Smith (1965, p. 6) concluded that "once we accept the fact that we shall disappear, we also discover the larger self which relates us to our family and friends, to our neighborhood and community, to nation and humanity, and, indeed, to the whole creation out of which we have sprung."

Summary

All will die one day and the reality of death anxiety runs across the life cycle. Denial of death and loss tends to maintain a silence about the reality of a terminal situation. There is a need to seek out non-threatening ways to explore the forbidden subject of death. Death education emphasizing basic communication skills in a non-threatening atmosphere is indicated across the life cycle to help persons be open about their fears of death and dying. Getting adults to open up and talk about death as a part of living will model for children of future generations, breaking the cycle of silence. The acceptance of death will leave energy for a deeper enrichment of life.

Appendix B

Templer Death Anxiety Scale

(TDAS) Information

TDAS Information

The main motivation for man's activity in life is his fear of death (Becker, 1973). Humans try various ways to deny death, hoping to overcome it, and busy themselves to avoid the fatality of death. In recent years, scales have been devised to measure man's anxiety and fear of death. Two of these are the Templer Death Anxiety Scale (1970) and the Collett-Lester Fear of Death Scale (1969). The TDAS was designed to reflect a wide range of life experience.

Point biserial correlations were computed on 31 items, selected by a judgemental rating procedure. Fifteen items were found to have significant item-total score correlations. Thirty-one college participants demonstrated an acceptable test-retest reliability on two sets of scores with a product-moment correlation coefficient of .83. The internal consistency was a coefficient of .76. The TDAS was administered to two groups, psychiatric patients and college students, to establish construct validity. TDAS scores correlated significantly (.74) with Boyar's Fear of Death Scale for emotionality. Psychiatric patients scores on the MMPI and TDAS were positively correlated ($p < .01$) on three MMPI subscales (.56 for Sc, .49 for Pt, .47 for D) which supports the literature that "schizophrenics, obsessive-compulsives, and depressed persons have a high level of death anxiety (p. 175)."

Other studies that utilized TDAS follow: Vargo (1980) found that TDAS and the four subscales of the Collett-Lester Fear of Death Scale were positively correlated. Product-moment correlations were significant ($p < .01$) between TDAS and fear of death of self subscale ($r = .609$), fear of dying of self subscale ($r = .524$), fear of death of

others subscale (r = .434), and fear of dying of others subscale (r = .396). McClam (1980) used the TDAS and the fear of death of self subscale of Collett-Lester to measure the death anxiety of health care and helping professions personnel in a death education program. Participation in the workshop, composed of films, discussions, and awareness exercises, did not lower mean scores on TDAS (t = .41) and fear of death of self subscale (t = .51). It was suggested that perhaps more experiential learning was needed.

The TDAS was used in a factor analytic study of Lonetto, Fleming and Mercer (1979). They found four major death anxiety patterns to be common in their subjects: (a) cognitive-affective (afraid to die or uneasy about discussing death); (b) physical alterations (having surgery or viewing a corpse); (c) awareness of time (passing of time, shortness of life); and (d) stressors and pain (cancer, heart attack, painful death). Neufeldt and Holmes (1979) used the TDAS to study the relationship between personality traits and fear of death. Participants scores on the TDAS were divided into low (0-1), moderate (6-8) and high (11-15) fear groups. One-way analyses of variance were run on each of the 16 Personality Factors on the questionnaire. Five factors were correlated with the fear of death. Subjects with a high fear of death were not necessarily abnormal but seemed to be more easily affected by feelings ($F_{2,72}$ = 9.05, $p < .01$), were less trusting ($F_{2,72}$ = 5.58, $p < .01$), less self-assured ($F_{2,72}$ = 7189, $p < .01$), less socially controlled and precise ($F_{2,72}$ = 5.11, $p < .01$), and more frustrated than subjects with a low fear of death ($F_{2,72}$ = 6.19, $p < .01$).

TDAS

Directions: Please indicate your age, sex, race, and other information, and then the 15 questions. If a statement is true or mostly true as applied to you, circle "T". If a statement is false or mostly false as applied to you, circle "F".

Age _____ Sex _____ *Race _____

*Are you a parent? _____

*Marital Status:
Married _____ Single _____ Widowed _____ Divorced _____

*Educational attainment, last grade completed:

Primary 1-6	Middle 7-9	High School 10-12	College 13-16	Graduate 17+
_____	_____	_____	_____	_____

T F 1. I am very much afraid to die.

T F 2. The thought of death seldom enters my mind.

T F 3. It doesn't make me nervous when people talk about death.

T F 4. I dread to think about having to have an operation.

T F 5. I am not at all afraid to die.

T F 6. I am not particularly afraid of getting cancer.

T F 7. The thought of death never bothers me.

T F 8. I am often distressed by the way time flies so very rapidly.

T F 9. I fear dying a painful death.

T F 10. The subject of life after death troubles me greatly.

T F 11. I am really scared of having a heart attack.

T F 12. I often think about how short life really is.

T F 13. I shudder when I hear people talking about a World War III.

T F 14. The sight of a dead body is horrifying to me.

T F 15. I feel that the future holds nothing for me to fear.

*Additional information requested by this researcher that was not included in Templer's DAS.

Appendix C

Additional Results

Additional Results

A static group compariosn, pseudoexperimental design was used in this study (Huck, Cormier & Bounds, 1974). Comparisons were made between 23 treatment group participants who were exposed to an experiential death and dying workshop and 23 control group participants who were not exposed to the treatment variable.

Hypothesis 1

Hypothesis 1 stated that there would be no gender differences on TDAS scores when pretested. The *t* tests were computed to determine whether men and women differed significantly on TDAS scores. The data concerning the results are shown in Table 1. The *t* tests were not significant at the .05 alpha level of confidence and hypothesis 1 was not rejected.

Table 1

Groups	Men			Women				
	N	M	SD	N	M	SD	*t*	*p*
Treatment	6	6.167	3.920	17	6.647	2.805	-.326	.374*
Control	6	5.667	3.141	17	6.824	3.358	-.736	.235*

* df = 21

Hypothesis 2

Hypothesis 2 stated that there would be no age difference on TDAS scores when pretested. The *t* tests were computed to determine whether there was a difference between those above the mean age group and those below the mean age group. The data concerning the results are in Table 2. The *t* tests were not significant at the .05 alpha level of confi-

dence and hypothesis 2 was not rejected.

Table 2

Comparison of age difference on TDAS pretest scores								
Groups	Below Group Mean			Above Group Mean			t	p
	N	M	SD	N	M	SD		
Treatment	13	6.923	3.662	10	6.000	2.055	.713	.242*
Control	13	7.077	3.523	10	5.800	2.936	.924	.183*
* df = 21								

Hypothesis 3

Hypothesis 3 stated that participants in the death and dying workshop would show no significant changes on the TDAS when pretest-posttest scores were compared. A t test was computed to determine whether significant differences existed. The data from this computation are in Table 3. The t test was not significant at the .05 alpha level of confidence and hypothesis 3 was not rejected.

Table 3

Comparison of pretest-posttest TDAS scores of subjects in death and dying workshop.				
TDAS scores	M	SD	t	p
Pre	6.522	3.043	.668	.257*
Post	6.261	2.435		
* df = 22				

Hypothesis 4

Hypothesis 4 stated that control group participants would show no significant changes on the TDAS when pretest-posttest scores were compared. A *t* test was computed to determine whether they differed significantly. The data from this computation are in Table 4. The *t* test was not significant at the .05 alpha level of confidence and hypothesis 4 was not rejected.

Table 4

Comparison of pretest-posttest TDAS scores for control group.

TDAS scores	M	SD	*t*	*p*
Pre	6.500	3.273	.073	.471*
Post	6.478	2.810		

*df = 22

Hypothesis 5

Hypothesis 5 stated that there would be no significant difference when the control group TDAS change scores were compared with the treatment group change scores. A *t* test was computed to determine whether there was a difference. The data concerning the results of the *t* test are shown in Table 5. The *t* was not significant at the .05 level of confidence and hypothesis 5 was not rejected.

Table 5

Comparison of pretest-posttest TDAS change scores between treatment group and control group.

Groups	M	SD	t	p
Treatment	.217	1.930	.115	.455*
Control	.130	2.912		

*df = 22

Selected References

References

Albertson, S. H. Endings and beginnings. New York: Random House, 1980.

Anderson, J. L. A practical approach to teaching about communication with terminal cancer patients. Journal of Medical Education, 1979, 54, 823-824.

Atkinson, J. H., Stewart, N. & Gardner, D. The family meeting in critical care settings. The Journal of Trauma, 1980, 20, 43-46.

Becker, E. The denial of death. New York: The Free Press, 1973.

Benton, R. G. Death and dying. New York: Van Nostrand Reinhold Company, 1978.

Blumenfield, M., Levy, N. B. & Kaufman, D. Current attitudes of medical students and house staff toward terminal illness. General Hospital Psychiatry, 1979, 1, 306-310.

Coffin, M. M. Death in early America. Nashville: Thomas Nelson Inc., 1976.

Coleman, J. C. Abnormal psychology and modern life. Palo Alto, Ca: Scott, Foresman and Co., 1976.

Collett, L. & Lester, D. Fear of death and fear of dying. Journal of Psychology, 1969, 72, 179-181.

Dempsey, D. The way we die. New York: Macmillan Pub. Co., Inc., 1975.

Dietrich, M. C. A proposed curriculum on death and dying for the allied health student. Journal of Allied Health, 1980, 9, 25-32.

Forer, L. The birth order factor. New York: Pocket Books, 1976.

Gaston, S. K. Death and midlife crisis. JPN and Mental Health Services, January 1980, 21-35.

Gawain, S. Creative visualization. New York: Bantam Books, 1978.

Gerson, A. C. & Perlman, D. Loneliness and expressive communication. Journal of Abnormal Psychology, 1979, 88, 258-261.

Gordon, A. K. & Klass, D. They need to know: How to teach children about death. Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1979.

Grollman, E. A. Talking about death: A dialogue between parent and child. Boston: Beacon Press, 1970.

Hendin, D. Death as a fact of life. New York: W. W. Norton and Co., Inc., 1973.

Huck, S. W., Cormier, W. H. & Bounds, W. G., Jr. Reading statistics and research. New York: Harper & Row, Pub., 1974.

Jaffe, L. Letter to seminar students in methods of intervention with dying. Graduate School of Social Work, University of Pittsburgh, July 11, 1976.

Keith, P. M. Life changes and perceptions of life and death among older men and women. Journal of Gerontology, 1979, 34, 870-878.

Klinzing, D. R., Klinzing, D. G. & Schindler, P. D. Communicative interaction between hospital personnel and hospitalized children in an orthopedic hospital. Delaware Medical Journal, 1980, 52, 255-263.

Krementz, J. How it feels when a parent dies. New York: Alfred A. Knopf, 1981.

Kubler-Ross, E. On death and dying. New York: Macmillan Pub. Co., Inc., 1969.

Kubler-Ross, E. Working it through. New York: Macmillan Pub. Co., Inc., 1982.

LeShan, E. Learning to say good-bye when a parent dies. New York: Macmillan Pub. Co., Inc., 1976.

Lonetto, R., Fleming, S. & Mercer, G. W. The structure of death anxiety: a factor analytic study. Journal of Personality Assessment, 1979, 43, 388-391.

Lynch, J. J. & Convey, W. H. Loneliness, disease, and death: alternative approaches. Psychosomatics, 1979, 20, 702-708.

McClam, T. Death anxiety before and after death education: negative results. Psychological Reports, 1980, 46, 513-514.

Mischel, W. Introduction to personality. New York: Holt, Rinehart & Winston, 2nd ed., 1976.

Murphy, J. C. Communicating with the dying patient. American Journal of Nursing, 1979, 79, 1084.

Neufeldt, D. E. & Holmes, C. B. Relationship between personality traits and fear of death. Psychological Reports, 1979, 45, 907-910.

Passons, W. R. Gestalt approaches in counseling. New York: Holt, Rinehart & Winston, 1975.

Pincus, L. Death and the family. New York: Vintage Books, 1974.

Potter, R. E., Schneiderman, C. R. & Gibson, G. M. Understanding death, dying, and the critically ill: a concern for speech-language pathologists. Journal of Communication Disorders, 1979, 12, 495-502.

Progoff, I. At a journal workshop. New York: Dialogue House Library, 1975.

Renshaw, D. C. The dying child. Proceedings of the Institute of Medicine of Chicago, 1980, 33, 59-61.

Satir, V. Peoplemaking. Palo Alto, Ca: Science & Behavior Books, Inc., 1972.

Satir, V. Making contact. Millbrae, Ca: Celestial Arts, 1976.

Scurry, M. T., Bruhn, J. G. & Bunce, H. The house officer and the dying patient, attitudes, experiences, and needs. General Hospital Psychiatry, 1979, 1, 301-305.

Shepard, M. Someone you love is dying. New York: Harmony Books, 1975.

Smith, B. Dear gift of life. Lebanon, Pa.: Sowers Printing Co., 1965.

Sternberg, F. & Sternberg, B. If I die and when I do. Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1980.

Sweeney, J. & Sweeney, V. Use of 'Language of Awareness' in teaching partnering, in Gurman, A. S. (Ed.), Questions and answers in the practice of family therapy. New York: Brunner/Mazel Pub., 1981.

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

Templer, D. I. & Ruff, C. F. Death anxiety scale means, standard deviations, and embedding. Psychological Reports, 1971, 29, 173-174.

Toman, W. Family constellation. New York: Springer Pub. Co., 3rd ed., 1976.

Vargo, M. Relationship between the Templer death anxiety scale and the Collett-Lester fear of death scale. Psychological Reports, 1980, 46, 561-562.

Vernon, G. M. & Payne, W. D. Myth-conceptions about death, in A time to die. Washington, D.C.: University Press of America, Inc., 1979.

Wolraich, M. L. & Reiter, S. Training physicians in communication skills. Developmental Medicine and Child Neurology, 1979, 21, 773-778.

Yalom, I. D. Existential psychology. New York: Basic Books, Inc., 1980.

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