Prospective attitudes toward the use of hospice care in a university population.

Tracy A. Little
University of Windsor

Follow this and additional works at: https://scholar.uwindsor.ca/etd

Recommended Citation
https://scholar.uwindsor.ca/etd/3212
INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

Bell & Howell Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600

UMI®
PROSPECTIVE ATTITUDES TOWARD THE USE OF HOSPICE CARE IN A UNIVERSITY POPULATION

by

Tracy A. Little

A Thesis
Submitted to the College of Graduate Studies and Research through the Department of Psychology in Partial Fulfillment of the Requirements for the Degree of Masters of Arts at the University of Windsor

Windsor, Ontario, Canada
1999

© 1999 Tracy A. Little
The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author’s permission.

L’auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

L’auteur conserve la propriété du droit d’auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-52600-3
ABSTRACT

Traditional medical institutions have recently come under scrutiny as questions are now being raised as to whether they are the ideal place to treat the terminally ill. With an emphasis on cure orientation, hospitals have paid little heed to the complex network of psychosocial issues displayed by the dying. Hospice care programs which stress a compassionate, humane, and patient-centred approach have become the care system of choice for many incurable individuals. The purpose of the present study was to construct a profile of an individual whose general attitudes and personality traits would predispose her/him to utilize hospice services if she/he became terminally ill. Based on previous research, it was hypothesized that the concepts of death anxiety, life satisfaction, responsibility for one's own health and specific personality traits would be important factors separating those persons who would use hospice care from those persons who would not. Exploratory variables of gender, ethnicity and level of religiosity were also examined. Participants consisted of 155 university students who completed a series of standardized measures. A principal components analysis on the self-constructed Attitudes Toward Hospice Care Scale revealed three significant factors: Preference for Quality of Life, Attitudes Toward Hospice, and Desire for Home Care. Multiple regression analyses suggested that individuals who
hold favourable attitudes toward the prospective use of hospice care tended to be women, conscientious and believe that others play a minimal role in the determination of their own health outcomes. Implications of the study's results and suggestions for future research were also discussed.
ACKNOWLEDGEMENTS

I would like to take this opportunity to thank several individuals who have made the completion of this thesis possible. First, I am particularly grateful to my committee members, Dr. Henry Minton and Dr. Sharon McMahon whose insightful comments and suggestions assisted me in producing a work that I am proud of. Secondly, I would like to thank my family, Chris, and Laura, who may not have always understood the scope of this project, but nevertheless continued to offer their love and support. Finally, to my friend and mentor, Dr. Kathryn Lafreniere, I will always be indebted to you for your unwavering belief in me. Thank you.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Section/Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Overview</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Epidemiology of Chronic Disorders</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Kubler-Ross' Theory of Dying</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Conventional Management of Advancing and Terminal Illness</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>The Hospice Movement</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>The Hospice Ideology and its Influences</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Evaluating Hospice Care</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Personality Influences and Attitudes</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Toward Hospice Care</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>Rationale and Hypotheses of the Present Study</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>METHOD</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Participants</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Measures</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Instruction Sheet</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Background Information Form</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Multidimensional Health Locus of Control Scale</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>NEO Five-Factor Inventory</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Death Anxiety Scale</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Satisfaction with Life Scale</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Attitudes Toward Hospice Care Scale</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Procedure</td>
<td>45</td>
</tr>
<tr>
<td>III</td>
<td>RESULTS</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Demographic Characteristics of the Sample</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Reliability Analyses</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Factor Analysis of the Attitudes</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Toward Hospice Care Scale</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Gender Differences</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Hierarchical Multiple Regression Analyses</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>Qualitative Data Analysis</td>
<td>63</td>
</tr>
</tbody>
</table>

iii

v

viii
IV DISCUSSION.......................................................... 66

Overview............................................................. 66
Findings and Implications of Death
  Anxiety............................................................ 67
Findings and Implications of
  Satisfaction with Life......................................... 69
Findings and Implications of Health
  Locus of Control................................................ 71
Findings and Implications of
  Personality Factors............................................ 74
Additional Findings............................................... 79
Limitations of the Present Study and
  Future Research Directions.................................. 80

REFERENCES.......................................................... 89

APPENDIX............................................................... 94

A CONSENT FORM.................................................... 94
B INSTRUCTION SHEET............................................... 96
C BACKGROUND INFORMATION FORM............................. 98
D MULTIDIMENSIONAL HEALTH LOCUS OF CONTROL
  SCALE (FORM A).................................................. 100
E MULTIDIMENSIONAL HEALTH LOCUS OF CONTROL
  SCALE (FORM B).................................................. 102
F NEO FIVE-FACTOR INVENTORY.................................... 104
G DEATH ANXIETY SCALE.......................................... 107
H SATISFACTION WITH LIFE SCALE.............................. 109
I ATTITUDES TOWARD HOSPICE CARE
  SCALE................................................................ 111
J PARTICIPANT POOL RECRUITMENT SCRIPT...................... 114
K DEBRIEFING STATEMENT.......................................... 116

VITA AUCTORIS......................................................... 118
**LIST OF TABLES**

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Means, Standard Deviations, Ranges and Reliability Coefficients for all</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>Scales and Subscales</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Factor Loadings for Principal Factors</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Extraction with Varimax Rotation of the Attitudes Toward Hospice Care Items</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Order in which Individual Attitudes</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Toward Hospice Care Items Contribute to Each of the Three Factors</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Intercorrelations Among Variables Included in Regression Analyses</td>
<td>58</td>
</tr>
<tr>
<td>5</td>
<td>Hierarchical Regression Analysis of Gender, Health Locus of Control and NEO</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>Personality Factors on &quot;Preference for Quality of Life&quot;</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Hierarchical Regression Analysis of Gender, Health Locus of Control and NEO</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>Personality Factors on &quot;Attitudes Toward Hospice&quot;</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Hierarchical Regression Analysis of Gender, Health Locus of Control and NEO</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>Personality Factors on &quot;Desire for Home Care&quot;</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

Overview

The concept of "death as an institution" has evolved during the twentieth century. In contrast to people of earlier times, contemporary North Americans are creators of a culture in which a "communal orientation [toward death] has been replaced by individualism and a sacred world view has been displaced by science" (Munley, 1983, p. 11). Consequently, death as an event has been supplanted by a process of dying; a process that has a well-defined conclusion but has only an ill-defined beginning with enigmatic effects (Bishop, 1994).

A mere one hundred years ago, the majority of people died at home primarily from acute, infectious diseases such as smallpox, diphtheria and measles (Grob, 1983, as cited in Sarafino, 1990). However, due to advances in public health measures such as enhanced personal hygiene, water purification, sewage treatment facilities and nutrition, as well as improved preventative medical technologies (most notably the discovery of antibiotics and effective vaccines), the death rate from these life-threatening, acute disorders declined sharply by the end of the nineteenth century (Brannon & Feist, 1992). As a consequence of these technical and medical innovations, the patterns of illness
affecting the health of North Americans in the twentieth century has been dramatically altered. Currently, the leading health problems and causes of death no longer stem from acute, infectious diseases, but rather from disabilitating, chronic disorders (Taylor, 1995). Contrary to acute illnesses, chronic illnesses are diseases that develop, persist, and recur over long periods of time. Typically, chronic illnesses cannot be cured, but only managed by patients and practitioners. Today, it is recognized that most individuals in North America will die in hospitals or nursing homes from lingering, chronic disorders such as cancer, heart disease, or AIDS (Taylor, 1995).

Paralleling these changes in our major health indicators have been massive reformations in our social and cultural responses to illness and death. Our fascination with a cure orientation, biomedical model of disease has segregated the process of death. No longer are people allowed to spend their final days at home tended to by family. Rather, death has become a sequestered event, occurring in bureaucratic, medical environments that are often de-personalizing and insensitive to patients' needs (Munley, 1983). As the belief in holistic treatment of the person has become more popular, the prescriptive atmosphere of hospitals and nursing homes has come under increasing scrutiny and many critics now argue that these
institutions are a less than satisfying arena for individuals and their families who are dealing the threat of terminal illness and death (Gates, 1991). It was the need for a more compassionate, humane and person-centred treatment of dying individuals which spawned the development of treatment alternatives.

In response to the perceived failure of hospitals and nursing homes to suitably care for terminally ill individuals, there has been a drive to de-technologize death and to re-orient health services to accept the perspective that death is a natural consequence of disease that is beyond cure (Viney, Walker, Robertson, Lilley, & Ewan, 1994). Today, the Hospice movement is the best known example of individualized, responsive, palliative care. An analysis of our society's death system as early, as the 1970's, demonstrated an acceptance of palliative care as a type of "comfort care". It began at that time to take its place along with the more dominant health care functions of conventional care (Kastenbaum, 1979). Although hospice is not the only reformist solution to the modern problems of alienated death, it is clearly one solution that has great potential to bring about lasting change in attitudes, beliefs, and values affecting dying individuals and those who care for them (Munley, 1983).

Hospice as a tool for improving the care of the terminally ill has been acknowledged and valued in the lives
of many. Several studies can also attest to the efficacy of hospice (Mount, 1994). DuBois (1980) evaluated patients who participated in a hospice program and patients who remained in a hospital setting and found that hospice patients reported having less pain. This was an outstanding benefit to the dying and allowed a more comfortable transition that required less analgesic use and pain alleviation modalities.

Hospice care has also been found to be beneficial to the families of terminally ill patients. Greater levels of satisfaction were reported from families who participated in palliative care programs than were expressed by families whose loved ones were exclusively hospitalized (Viney, et al., 1994). However, despite the many examples of the benefits of hospice care documented in the literature hospices remain greatly under-utilized.

Since its inception and throughout its evolution, hospice has challenged the assumptions of the mass culture regarding its ideology about death and the care of the dying. Not surprisingly, a multiplicity of reactions toward hospice and its doctrines has emerged. While past research has predominantly concentrated on describing and evaluating outcome measures (i.e., pain management and symptom control) from the perspective of patients, caregivers and medical professionals, few studies have focused upon the attitudes of the general public toward hospice. Therefore, this study
attempted to identify prospective hospice clients, namely, individuals whose attitudes and personality traits would predispose them to utilize hospice care services if they became terminally ill. It was anticipated that through the construction of a profile of a potential hospice client, terminally ill patients may be counselled early in their care choices in which hospice care would be presented as one of the options for their personal needs until their death. It was further hoped that this investigation may suggest why some individuals may be resistant to Hospice Service Programs and whether or not their attitudes may be altered through health or death education.

In the following sections the epidemiology of chronic disorders, Kubler-Ross' stage theory of dying and the conventional management of advancing and terminal illness, as they relate to the hospice concept, are reviewed. A discussion of the hospice movement, its ideology, the evaluation of hospice care, and attitudinal and personality influences toward hospice care are presented.

**Epidemiology of Chronic Disorders**

Although chronic diseases are not new, the proportion of individuals who die from them has spiraled over the last 100 years. In 1900, chronic illnesses such as heart disease, cancer, and stroke together accounted for approximately 16% of all American deaths (Brannon & Feist,
1992). However, by 1986, these diseases accounted for nearly 66% of all deaths in the United States (Brannon & Feist, 1992).

Furthermore, mortality rates for specific chronic diseases have been climbing. Particularly noteworthy are the recent increases in the percentages of deaths for various cancers and AIDS. In 1990, the U.S. Bureau of the Census reported that nearly 23% of all deaths in the United States were due to cancer alone (U.S. Department of Health and Human Services, 1990, as cited in Brannon & Feist, 1992). In Canada, more than 413,000 people had been diagnosed with cancer at the end of 1990 than in the previous ten years (National Cancer Institute of Canada, 1995). By the middle of 1992 the World Health Organization estimated that more than two million people worldwide had been diagnosed with the AIDS virus (U.S. Department of Health and Human Services, 1990, as cited in Brannon & Feist, 1992).

As the population ages, the number of new cancer cases and deaths continue to rise. An estimated 125,400 new cases of cancer and 61,500 deaths from cancer occurred in Canada in 1995 (National Cancer Institute of Canada, 1995). This represents an increase of 37% in incidence rates and an increase of 33% in mortality rates from a decade ago. Thus, on average, an additional 3,500 new cases of cancer and 1,500 deaths have occurred annually over the last ten years.
(National Cancer Institute of Canada, 1995). Although few of us like to contemplate our own death, these statistics reveal that most of us will eventually develop at least one chronic disease that may ultimately be the cause of our own death (Taylor, 1995). Chronic diseases have indeed become our main health nemesis.

Kubler-Ross' Theory of Dying

Exactly when an individual metamorphosizes from someone who is living to someone who is dying depends on the frame of reference used. For scientists, the determinants are biomedical. Individuals are defined as dying when they are diagnosed with a terminal condition or when nothing more can be done to preserve life (Taylor, 1995). For patients and their families, however, the primary determinants are psychosocial. While the medical diagnosis remains portentous, the patient is likely to see dying as a function of when these facts are communicated to her/him and when these facts are realized and ultimately accepted (Taylor, 1995).

The ideas that: (a) the dying process encompasses more than simply biological determinants; and (b) the fact that dying individuals often progress through a series of emotional phases before they come to terms with the prospect of their own death; have gained much popularity in the research literature on death and dying. Of the different
theories that have been advanced, the work of Elisabeth Kubler-Ross (1969, 1975) has been the most influential. By describing and chronicling patients' array of reactions to death, Kubler-Ross has managed to break through the silence and taboos surrounding death, making it an object of both scientific study and public sensitivity (Taylor, 1995).

Kubler-Ross (1969) delineates the process of dying as a series of five distinct stages: denial, anger, bargaining, depression, and acceptance. According to her theory, these stages, which begin at the time of a terminal diagnosis, differ in emotional content and intensity but are universal, normal ways dying individuals approach their own death.

Upon receiving a diagnosis of a life-threatening illness, an individual's initial reaction is that of denial. Denial occurs because the plans that have been made for the future have been disrupted as a consequence of a terminal diagnosis. Cognitive and emotional commitments to the future must now be withdrawn and re-evaluated and doing this takes time (Kubler-Ross, 1969). Thus, denial serves a protective function, as a "psychological shelter from reality until the dying individual can reconstruct a new future" (Taylor, 1995, p. 469).

For most individuals, denial usually abates after a few days as the illness itself creates immediate demands that must be met. Decisions regarding future treatments, how the patient will be cared for, and by whom, must be addressed.
This is often the stage when the patient's anger materializes. The patient begins to ask the question, "Why me?", and may begin to show resentment toward family, friends or anyone who is healthy.

During the next stage, anger is abandoned in favour of a different coping strategy: trading good behaviour for good health. Here, the dying individual attempts to alter her/his situation by striking a bargain with God, fate, or anything that can offer the hope of reprieve (Kubler-Ross, 1969). Dying patients' reactions of both anger and bargaining to death are manifestations of the principles of social exchange or equity theory (Lerner, 1970, as cited in Taylor, 1995). Individuals have a firm need to believe that the world is a just place and that good things happen to good people. Thus, when a threatening event such as terminal illness occurs, it appears to violate the natural order of the world (Lerner, 1970, as cited in Taylor, 1995). Accordingly, individuals make efforts to preserve their sense that the world is just, first by becoming angry at the violation and later by attempting to restore justice through bargaining.

Once it is apparent that terminal illness does not conform to the laws of justice, depression results. Kubler-Ross (1969) refers to this stage of depression as a time for "anticipatory grief", when individuals mourn the prospect of their own death. This grieving process occurs in two
phases: first, as the patient comes to terms with the loss of past valued activities and friends, and second, as the patient begins to anticipate the future loss of physical activities, appearance, and mental functioning (Kubler-Ross, 1969). While this stage of depression is far from pleasant, it can be very functional in helping dying individuals prepare for what lies ahead (Kubler-Ross, 1969).

In the final stage, acceptance, the individual is resigned to the prospect of her/his death. After the emotional turbulence of the previous four stages, a tired, peaceful, calm may descend (Kubler-Ross, 1969). It is during this stage of acceptance that the dying individual makes preparations on how to divide up her/his personal belongings. The terminal patient may also begin to disengage from all but a few close family members and friends in the process of saying goodbye.

Despite the criticisms that as a stage theory it should be able to demonstrate that every dying individual goes through each stage in the same manner, that her theory of dying is often confused with a prescription of how individuals should react to dying and that her theory does not fully acknowledge the importance of anxiety which may be present throughout the dying process, Elizabeth Kubler-Ross' (1969, 1975) work has had a tremendous impact on how society views the dying. Prior to her characterizations, the experiences and feelings of
dying patients were largely ignored. It is this belief that dying is more than simply a biological process but is a social process as well that captured the attention of individuals in the hospice profession who began to incorporate Kubler-Ross' (1969, 1975) tenets into hospice ideology.

Conventional Management of Advancing and Terminal Illness

Given the choice, most terminal patients would prefer to die at home rather than in an institution (Bishop, 1994). The reality, however, is that more than two thirds of Canadians and approximately 1.3 million Americans die in hospitals and nursing homes each year (Canadian Palliative Care Association, 1995; Taylor, 1995). The reasons for this are obvious; hospitals and other health care centres have the medical equipment and knowledge to deal with patients' physical symptoms and, where possible, to extend life. However, despite the advantages of these medical care institutions to prolong life, questions are currently being raised as to whether hospitals are the ideal place to treat terminal disease in terms of the effectiveness of care and the comfort level of patients (Scott, 1992).

Hospitals, oriented to the cure of illness, are practically and ideologically founded on the biomedical model of disease. This model explains illness solely in terms of biological parameters. It proposes that illness or
physical disorders result from abnormalities in biochemical or neurophysiological functioning and presumes that psychological and social processes are largely independent of the disease or dying process (Bishop, 1994). With their attention focused on specialization and life-extending medical technologies, most hospitals exclusively stress the physical care of the body and have been unable to address the complex network of psychosocial needs displayed by the dying individual and her/his family (Bass, 1985; Bishop, 1994; DuBois, 1980; Stoddard, 1978).

This emphasis on caring only for the body (rather than caring for the whole person) reflects an inherent faith in technology, and at the same time, a sense of complete hopelessness in the event that technology fails to cure the disease process (Stoddard, 1978). When disease cannot be cured, the hospital has few resources to help the individual live as fully as possible within the hospital structure. Due to budgetary restraints, understaffed hospital units may be incapable of providing the kind of skilled care and support patients and their families need to understand and cope with the effects of terminal illness (DuBois, 1980). In addition, hospitalized patients may be subjected to painful medical procedures at a time when they are least able to withstand them. Pain is one of the major symptoms in terminal illness and in the busy hospital atmosphere the ability of patients to get the kind and amount of pain
medication that they need can be compromised (Siebold, 1992). Thus, the fundamental philosophy and organization of most medical institutions makes these facilities incompatible with the long-term needs and wishes of individuals who are faced with the possibility of their own death (Gates, 1991).

Nursing or convalescent homes may not present a viable alternative for the care of terminal patients. These institutions are designed primarily to give long-term care for the elderly and to provide a recuperative period of rehabilitation for patients. Ill equipped to provide the additional attention to the physical, social and emotional needs of the terminally ill, much less to their families, death in these institutions can be a lonely, painful, and dehumanizing experience (DuBois, 1980).

The Hospice Movement

Until recently, there appeared to be no place for the terminally ill patient in our preventative and cure oriented society (Stoddard, 1978). Our fascination with the obliteraton of disease has segregated the process of dying and has lead to the charge that our current medical care system is more concerned with technology and "a counterphobic bravado, a desensitization toward death" (DuBois, 1980, p. 53) than with the humane care of dying and incurable patients.
In response to the fragmented, impersonal care often characteristic of hospitals and nursing homes, much attention has focused on palliative care and alternative treatment solutions. Hospice is perhaps the most renowned model of palliative care today. Shaped by a vision of what ought to be, hospice has become timely in its public appeal.

A diagnosis of a terminal illness brings with it a myriad of reactions from both the patient and the practitioner. The patient typically suffers a progressive deterioration in the feeling of well-being, and in her/his ability to function effectively. Thus, most terminal patients wish to avoid not only a lingering death, but a death that is undignified or degrading (Logue, 1994). The medical community's response to terminal illness has been curative, focusing solely on lengthening survival rates with little consideration of the psychological consequences of these illnesses or the effects of their treatments.

Psychosocial issues, such as the quality of life, have been regarded as inconsequential for the terminally ill. In fact an examination of the research literature on quality of life reveals that medical citations to works that assess morbidity and mortality outnumber psychological citations more than ten to one (Taylor, 1995). Furthermore, increased medical sophistication has made it possible to keep people alive almost indefinitely and this technology has raised many legal, moral, and ethical issues for terminally ill
patients. Dying individuals are beginning to question not only the quality of life that our medical science affords, but also the kind of care that can be obtained in institutions that may serve to dehumanize and isolate the patient. Thus, just as unorthodox therapies have become more popular partly from dissatisfaction, frustration, or anger with the formal health care system, hospice programs for terminal individuals arose primarily in response to the perceived psychosocial and practical limitations of traditional hospital care.

The modern hospice movement, with its emphasis on pain management and on dying as a process, originated in 1967 with the founding of St. Christopher's hospice in England, by Dr. Cecily Saunders. This hospice stressed the need for effective symptom control, care of both the patient and family as a unit, an interdisciplinary team approach, the use of volunteers, and a continuum of care (DuBois, 1980). St. Christopher's hospice is the oldest established terminal care facility to combine teaching and research with patient care (van Bommel, 1986). With its tradition of caring, St. Christopher's has become the working model for hospice care programs in Canada and the United States today.

The first American hospice opened in New Haven, Connecticut in 1974. A community-based hospice, the Connecticut Hospice was founded as a co-ordinating committee to extend both the scope and quality of care given to both
dying patients and their families (Corr & Corr, 1983). With an emphasis on home-care, the Connecticut Hospice contracted nursing services from existing associations for patient care during the day and volunteers extended these hours making care available to terminal patients and their families twenty-four hours a day (Corr & Corr, 1983). The convictions of the Connecticut Hospice aided in establishing hospice standards and criteria that extended the hospice ideology throughout the United States (Stoddard, 1978).

In contrast to its American counterpart, the Canadian hospice scene developed somewhat differently. While hospice care programs in the United States grew primarily from community home-care teams in the direction of autonomous free standing hospices, Canadian palliative care programs tended to be institutionally based, located within acute care wards of hospitals (Saunders, Summers, & Teller, 1981). Canadian hospice pioneers were committed to the university teaching hospital and it has been in this setting that most hospice developments in Canada have occurred (Saunders, et al., 1981). Under the direction of Dr. Balfour Mount, the first Canadian hospice care unit was opened in Montreal in 1975 at the Royal Victoria Hospital of McGill University. Originally a 13 bed unit, this hospice operated as a special care unit on a converted ward of the hospital's surgical pavilion. Modeled on the work of St. Christopher's, this unit demonstrated the value of the presence of a hospital-
based palliative care service in terms of close links between palliative care and active oncology, research, education on pain control, and in meeting the needs of the patients within our existing health care system (Sheehan & Forman, 1996). Today, the Royal Victoria Hospital offers an integrated program of hospice care by supplying outpatient clinics, consultation teams for inpatients, support services to all patients and family members, and bereavement follow-up programs. With a strong emphasis on comfort care, this centre has become the teaching model for terminal care in Canada.

The Hospice Ideology and its Influences

Although sparse in number in the early seventies, the evolution of hospice has been remarkable. It is currently estimated that approximately 1500 hospice programs are functioning in the United States and a further 200 hospice programs are in operation in Canada (van Bommel, 1986).

While tracking the growth of hospice care programs has been a relatively easy task, defining the term hospice has been somewhat more difficult due to the way hospice care evolved. During medieval times hospices were institutions that provided refuge for the sick or for weary travelers. Presently, contemporary hospices in Canada and the United States range from home-based care, to free-standing, autonomous facilities, to hospital-based subacute units.
However, regardless of the model of care, all hospice programs share the following formal characteristics that differentiate hospice terminal care from other forms of traditional health care.

First, hospices mandate that death be viewed as a normal, inevitable aspect of life. Drawing on the tenets of Kubler-Ross' (1969) philosophy, death is seen as part of the human existence, not to be avoided, but to be faced and accepted (Bass, 1985). Thus, hospices seek to empower dying patients to take control of their own death. Second, the dying patient and her/his family are considered the unit of care. Hospices attempt to assist patients and family members with the biopsychosocial issues of death, while enhancing the quality of life for the dying patient. Third, an interdisciplinary team of services (physicians, nurses, therapists, clergy, and volunteers) are provided by hospices to be available to both the dying patient and her/his family. Finally, the medical interventions provided by hospices focus primarily on pain management and symptom control rather than on life-extending procedures (Bass, 1985). It is in this area of pain control that the hospice movement has had its strongest influence on conventional medicine. Basic principles of hospice care such as using adequate doses of narcotics on an "as-needed" basis to prevent rather than to treat the patient's pain are now
widely practiced in conventional care settings (Rhymes, 1990).

Simple though these principles may be, they signaled a revolutionary approach in terminal health care. Hospice care is a reaction against the institutionalization of death created by our modern culture. It represents a shift back to the personal, simple, human values that technology denies (Stoddard, 1978). Hospice views each patient as a total person, one who has vital connections to others and who should not be expected to surrender her/his values and preferences developed over a lifetime in order to die in a manner convenient to a system (Kastenbaum, 1979). Hospice care stresses making possible a fitting death, which is defined as dying in the manner that one chooses. By creating an environment that encourages pain management, communication, choice, and the involvement of family members, hospices can assist in empowering terminally ill individuals to make their death more meaningful. Thus, the term hospice has come to signify a specialized, professional support system of care providing for the essential needs of dying patients and their families (Lev, 1991). It is for these very reasons that hospice care has become the system of choice for many terminal patients.

In the 20 years since its inception, hospice care in North America has progressed from an alternative health care milieu to an accepted part of the health care field (Rhymes,
1990). A corollary of this growth has been a permeation of the hospice ideology into the more conventional medical establishments allowing for "traditional hospital care with hospice overtones" (Seale, 1989, p.553). Views of the medical profession have now begun to move toward those of hospice practitioners on various aspects of terminal care (Adelstein & Brown, 1998). We are now witness to a changing hospital environment, one whose goal is to insure that the dying person is as pain-free as possible and that the family is supported and counselled during this process (Adelstein & Brown, 1998). This movement of palliative care into the hospital setting is evidenced by the growth of hospital support teams. These teams act as advisors to hospital staff in dealing with dying patients' needs and may have an indirect effect on raising the general standard of care in hospitals (Bircumshaw, 1993). Thus, the suggestion that "the general picture of poor treatment and a closed awareness context in hospitals may now be less appropriate" (Seale, 1989, pg. 553).

**Evaluating Hospice Care**

When hospice care was first implemented in North America there was some concern that moving an individual to a facility that specialized in death and dying would depress and upset both the patient and her/his family. Such fears have proved to be groundless (Wald, 1989). Hospices are
more than simply places where individuals go to die and hospice care entails more than a service delivery setting (Vandenbos, DeLeon, & Pallak, 1982).

Although hospices are sometimes perceived as hastening death, they neither hasten nor delay it (Sheehan & Forman, 1996). Instead, hospices attempt to provide physical, emotional, spiritual, and psychosocial care in a holistic framework. The primary goal of hospice care is the comfort of the terminal patient. In free-standing hospice facilities this is often achieved by encouraging patients to surround themselves with loved ones and to personalize their living areas as much as possible.

Another misinterpretation of hospice care is that it is assumed to be deficient in efforts to deal with pain and medical complications that surround a terminal illness (DuBois, 1980). However, contemporary hospice care is quite aggressive regarding the individual's physical or emotional state in treating pain, nausea, vomiting, infection, depression, fear, and anxiety. Hospice patients are less likely to receive intensive medical interventions such as chemotherapy, radiation therapy, or surgery in the weeks prior to death than are those in traditional hospital settings (Seale, 1991). Analgesics are more likely to be prescribed for pain on an "as-needed" basis in hospices rather than on a fixed administration schedule as in conventional care situations (Seale, 1991). Thus, the
ideology of hospice care is to provide medical and social support to help preserve existing relationships and not to be a faceless establishment that takes over the dying patient's life (Taylor, 1995).

Tabulating the number of patients who take advantage of hospice care services has been an easy task. Evaluating hospice care, and those individuals who choose it, has been more demanding. Patients are not randomly assigned to hospice or hospital care. Patients who enter hospice care programs usually do so as a result of a deliberate decision making process. Thus, patients ultimately self-select the type of care they desire. Of the studies that have evaluated hospice care, most have concentrated on assessing outcome measures that attest to the efficacy of hospice care. Fewer investigations have attempted to document the attitudinal or personality differences between patients who opt for conventional treatment and patients who choose alternatives forms of terminal care.

One study conducted by Cassileth, Lusk, Strouse, and Bodenheimer (1984) researched the use of alternative therapies by cancer patients. They found that patients who used unconventional therapies tended to be white, well educated, frequently asymptomatic, and in the early stages of disease. Interestingly, patients who utilized unorthodox therapies differed in their beliefs about illness and its treatment from patients who only used conventional
therapies. Major ideologies associated with the patients' use of alternative treatments included a belief that disease is caused by poor nutrition, stress and worry, dissatisfaction with conventional medical practitioners and the health care system, and a belief that patients should take an active role in their own health care (Cassileth, et al., 1984). Although the alternative treatments sampled by the researchers differed conceptually and mechanically, they shared an underlying perspective: to improve the patient's capacity to deal with their own illness (Cassileth, et al., 1984).

Not only have differences been found in health beliefs between patients who use alternative treatments from patients who do not, but a difference between these two groups has also been documented in the area of quality of life. DuBois (1980) compared patients who participated in a hospice program with patients who remained in hospital settings and found that hospice patients displayed a number of positive benefits. Hospice patients were more mobile, reported having less pain, and were able to spend more time with their families, allowing patients to maximize their physical, psychological and social functioning. Parkes (1985) also found that patients using palliative care services reported less pain than those patients dying in hospitals and at home.
Supplementary studies have also revealed differences between individuals in palliative care units and those dying in hospitals. As hospices are better able to meet the psychosocial needs of their terminal patients, patients using such units appeared less likely than hospital patients to express anger either directly or indirectly (Seale, 1991). Anger is a typical response to terminal illness but if it is continually experienced it may impede the patient's psychological adjustment to her/his inevitable death. Also, due to the hospice's efforts to empower patients, individuals in hospice units were more likely to see themselves as capable and more likely to show positive emotions (Seale, 1991). One interesting finding of Seale's (1991) study was that hospice patients reported more anxiety about death but less anxiety about isolation. This may be explained by the fact that palliative care usually involves acknowledgment that death is near while hospitalization may allow patients to deny this fact. Supporting Seale's (1991) study, Viney, Walker, Robertson, Lilley, and Ewan (1994) found that while patients in hospices did not significantly differ from conventional patients in that they knew what was wrong with them, hospice individuals were more likely to know that they were going to die.

Counter to Seale's (1991) results however, Hendon and Epting (1989) found that hospice patients expressed less fear of death than patients in traditional hospital
environments. Despite the contradictory findings regarding death anxiety, these studies collectively appear to indicate that hospice patients were able and willing to cope with the knowledge of their own death to a greater extent than traditional care patients.

Further investigations have shown that individuals who selected a palliative care approach rather than curative treatment during the terminal phase of their disease appeared to do so in an effort to please family members. According to Prigerson (1992), as cited in Taylor (1995), palliative care was frequently chosen if the patient's primary caregiver accepted death. This study is important as it suggests that the immense outlays of resources for life-extending care may not be driven by the patient's desire for these procedures but rather by family members' preferences and fears.

Hospice care has also been found to be beneficial to the families of terminally ill patients. Following the patient's death, families who participated in hospice care reported greater levels of satisfaction with the patient's quality of life (Wallston, Burger, Smith, & Baughner, 1989) and with hospice care itself than families whose patient received only conventional care (Viney, et al., 1994).

Various aspects of hospice care received by dying patients in 31 hospices and 8 hospitals throughout the United States have been examined by the National Hospice
Demonstration Study (Mor, Greer, & Kastenbaum, 1988). In terms of cost, the study revealed that hospice care was generally less expensive than hospital care. This can probably be attributed to the fact that hospice patients spent more time at home and were less likely to receive intensive medical treatments which is what the majority of dying individuals want. The study also demonstrated that hospice patients obtained greater pain relief than did hospital patients. Particularly meaningful was that for hospice patients the social quality of their life remained quite high and they appeared to be able to spend their final days in the manner that they preferred (Mor, et al., 1988). Thus, the National Hospice Demonstration Study revealed that, at least for the organizations studied, hospice care is successful in fulfilling its objectives.

**Personality Influences and Attitudes Toward Hospice Care**

Hospice literature to date reveals that much attention has concentrated on evaluating the patient or family member(s) satisfaction with hospice care, the patient's quality of life, and the management of pain and symptom control as salient and appropriate outcome measures. Indeed, the field of hospice research is characterized by a number of studies assessing inquiries of patient self-esteem, depression, death anxiety, pain management,
interpersonal relationships, and a sense of being a burden to others.

Undoubtedly, past research has made remarkable progress in identifying possible problems and stressors which may be faced and exhibited by a terminally ill population and its primary caregivers. The majority of these studies, however, have largely focused on the hospice concept, the delivery of clinical care, and the management of pain associated with terminal illness. In fact some aspects of hospice, particularly in the area of pain and symptom control, have been so thoroughly explored that many researchers now argue that these areas have become exhausted (Sheehan & Forman, 1986). And, while some researchers have investigated general attitudinal issues toward the concept of hospice (Neubauer, 1988; Neubauer & Lai, 1988), few studies have examined specific personality characteristics and their relation to attitudes toward hospice care. Of the studies that have been conducted, some differences have been documented between patients who use hospice care services and patients who use more conventional forms of care. These differences have been noted in the areas of: beliefs about illness, its causes and its treatments (Cassileth et al., 1984); quality of life issues (DuBois, 1980; Parkes, 1985); levels of death anxiety (Hendon & Epting, 1989; Seale, 1991; Viney et al., 1994); and personal reasons for choosing hospice care (Prigerson, 1992, as cited in Taylor, 1995).
Evidence of these differences suggests that personality factors may distinguish between those individuals who would be predisposed to select hospice care from those who would not.

One personality variable that has received superficial attention in the hospice literature is the concept of locus of control. Locus of control refers to a belief in one's personal effectiveness and is an important factor influencing cognitive appraisals of stress, coping, and adaptational outcomes (Taylor, 1995). The Multidimensional Health Locus of Control Scale (Wallston, Wallston, & DeVellis, 1978), is an instrument that assesses these general beliefs about personal control over issues of health and illness. The MHLC Scale measures three factors: internal, powerful others and chance locus of control. The internal health locus of control subscale is measured by items such as, "I am in control of my own health". High scorers on the internal subscale would take an active interest in their health care as they see their health as under their own control. The powerful others health locus of control subscale is measured by items such as, "Whenever I don't feel well, I should consult a medically trained professional". The chance health locus of control subscale is measured by such statements as, "Luck plays a big part in determining how soon I will recover from an illness". High scorers on both the powerful others and chance subscale
would be less likely to take an active role in their own health care as they would see their health as under the control of external forces. Hospice care provides terminally ill patients a greater sense of involvement in their own health/death process. Thus, it may be that individuals who are high on the internal health locus of control subscale (or low on the powerful others health locus of control subscale) would be more likely to select hospice care if they were to become terminally ill.

A related construct to personal choice and control over one's own life (or death) is satisfaction with life. Satisfaction with life refers to the degree of excellence individuals appraise their lives to contain (Sarafino, 1990). And, while past studies have measured the concept of quality of life in relation to the hospice experience, it has primarily been assessed from a physical functioning level. Unlike the medical community, hospice advocates recognize that life satisfaction for terminal patients cannot be exclusively based on the objective indicators of physical functioning. Satisfaction with life is a multidimensional concept measured by physical, psychological and social status. It is a subjective experience that is best rated not by health care professionals, but by the patient her/himself. It is this more global aspect of satisfaction with life that requires investigation in relation to choices regarding hospice.
Hospice patients reported levels of fear or anxiety about death has produced mixed results. Seale (1991) found that hospice patients displayed more anxiety about their death but less fear of isolation than hospitalized patients. In contrast, Hendon and Epting (1989) found that hospice patients expressed less fear of death than hospitalized patients. How this variable of death anxiety relates to attitudes toward the prospective use of hospice care needs to be elucidated.

Our personality also influences how we experience our environment and affects the choices we make. According to Costa and McCrae's NEO Five-Factor Inventory (1989), personality traits can be summarized by five domains: neuroticism, extraversion, agreeableness, conscientiousness, and openness. Neuroticism is a general measure of emotional instability, reflecting the tendency to experience negative emotions such as anxiety and depression (Costa & McCrae, 1989). Individuals scoring high on this domain would tend to cope less well with stressful situations. Extraversion reflects high levels of activity, sociability, and assertiveness (Costa & McCrae, 1989). Individuals scoring high on this trait prefer being with others and are described as outgoing. Agreeableness reflects interpersonal tendencies of altruism and sympathy (Costa & McCrae, 1989). High scorers are trusting, compliant and co-operative. Conscientious individuals are determined, reliable, prefer
order and are strong willed (Costa & McCrae, 1989). Individuals who score high on this domain tend to be high achievers in employment and academic settings. Of particular interest to the present study is the domain of Openness as defined by Costa and McCrae. Individuals who are open are described as possessing "an active imagination, an aesthetic sensitivity, an attentiveness to inner feelings, a preference for variety, are intellectually curious, and have independence of judgement" (Costa & McCrae, 1989, p. 16). Persons scoring low on the openness trait tend to be conventional in behaviour and conservative in outlook. Contrarily, persons scoring high on this attribute are willing to entertain new ideas, adopt unconventional values, are prepared to question authority, and exhibit a willingness to try new and different activities (Costa & McCrae, 1989). As hospice care is a relatively new and unorthodox concept in health care, individuals who opt for this type of service may be expected to be described as more open. Currently, no investigations have attempted to link "pro-hospice" attitudes with specific personality domains as measured by the NEO Five-Factor Inventory.

Rationale and Hypotheses of the Present Study

The high prevalence of terminal illness and its devastating effects are of great concern for our society.
Statistics reveal that approximately 1 in 2.5 men will develop cancer during their lifetime, while more than 1 in 3 women can now be expected to develop cancer (National Cancer Institute of Canada, 1995). In addition, more people today survive to an older age and terminal diseases are more likely to afflict elderly individuals than younger individuals. Consequently, younger samples have often been omitted from hospice research as they are at a lower risk for contracting terminal illness. While it is true that a younger population may be placed in the position of having to provide a prospective viewpoint about hospice care, it is important to sample younger adults' reactions to, and beliefs about, hospice services. As it is during the young adult years that individuals formulate their beliefs, opinions and convictions about relevant issues, this sample may be able to shed some light as to why older, more ensconced individuals may be hesitant in opting for hospice care should they become terminally ill. It is for this reason that younger participants were chosen for the present study.

The primary intent of this study was not to provide auxiliary support for the efficacy of hospice care, but rather to address the dearth of literature which exists on the type of individual who would be predisposed to select hospice care if she/he were to become terminally ill. Thus, it was the aim of this investigation to construct a profile
of an individual who would tend to hold accepting attitudes toward the prospective use of hospice care. In order to achieve this goal a variety of well-established, objective measures were used as predictor variables. The criterion measure consisted of a self-constructed questionnaire which was designed to assess the attitudes of a sample of young adults toward the prospective use of hospice care. The construction of this questionnaire was guided by hospice literature and allowed the participants' views to be revealed affectively, behaviourally, and cognitively.

Specifically, the present study predicted that:

1) Individuals who hold positive attitudes toward the prospective use of hospice care will differ in their reported levels of death anxiety from those individuals who do not hold positive attitudes towards the prospective use of hospice care. Given the mixed findings in the literature, it is difficult to make a directional prediction regarding the issue of death anxiety.

2) Individuals who hold favourable attitudes toward the prospective use of hospice care will perceive a higher level of life satisfaction.

3) Individuals who hold more accepting attitudes toward the prospective use of hospice care will feel more responsible for their own health than will individuals who do not hold accepting attitudes toward the prospective use of hospice care.
4) Individuals who are more receptive to the prospective use of hospice care will be characterized by a high level of openness.

Exploratory variables of gender, ethnicity and religiosity were also investigated to identify other possible factors that may be related to the prospective use of hospice services. It is hoped that this study will go beyond a general level of description to develop a clearer picture of those individuals who are likely to use hospice services, in order to integrate this information into future educational efforts.
CHAPTER II
METHODOLOGY

Participants

The sample consisted of 155 full and part-time undergraduate psychology students in attendance at the University of Windsor. There were 102 females (65.8%) and 53 males (34.2%). Participants were recruited from a randomized psychology participant pool list. This list was comprised of the names and telephone numbers of psychology students who were willing to be contacted for possible participation in ongoing research projects.

Prior to volunteering for the study, participants were required to read and sign an informed consent form which described the study and its purpose, outlined the participant's task, rights, and responsibilities (Appendix A). Participants were further informed that their participation was strictly voluntary and that they could withdraw from the study at any time without penalty. Confidentiality was maintained by omitting any identifying personal information from all measures through coding of the participants' data. Volunteers received one experimental bonus mark as compensation for their participation in this study. All participants were treated in accordance with the "Ethical Principles of Psychologists and Code of Conduct" (American Psychological Association, 1992).
Measures

Data related to demographic characteristics, health behaviours, personality constructs, death anxiety, and satisfaction with life were collected through a variety of self-administered questionnaires. In addition, a measure was developed to assess individuals' attitudes toward the prospective use of hospice care using a combination of both forced and open-choice formats.

Instruction Sheet. This form outlined the purpose of the study, which was to investigate the relationship between personality styles and attitudes toward the prospective use of hospice care. It instructed the participants that they would be provided with a package of materials which they were to complete. For their reference, a brief definition of hospice was also provided (Appendix B).

Background Information Form. This form requested general information about the participants' gender, age, ethnicity, religious affiliation, level of religiosity, and beliefs in a higher power/supreme being (Appendix C).

Multidimensional Health Locus of Control Scale (MHLC). The Multidimensional Health Locus of Control scale was developed to tap beliefs that the source of reinforcement for health-related behaviours is primarily internal, under the control of powerful others, or is a matter of chance (Wallston, Wallston, & DeVellis, 1978). This scale was based on the earlier works of Rotter's (1966) social
learning theory and Wallston, Wallston, Kaplan, and Maides (1976) who developed the original Health Locus of Control (HLC) Scale (as cited in, Wallston, Wallston, and DeVellis 1978).

The original HLC Scale was a unidimensional measure designed to assess people's beliefs that their health is or is not determined by their behaviour. It is an eleven-item scale designed to yield a single score. Individuals with high scores are described as "health-externals" and are assumed to have generalized expectancies that the factors which determine their health are such things as luck, fate, chance, or others, all factors over which they have little control (Wallston, Wallston, & DeVellis, 1978). However, a problem of low alpha reliability with this scale (.40 to .54) was encountered with later samples. Factor analysis of the original HLC Scale revealed three dimensions of health locus of control beliefs and resulted in a reconceptualization of the concept of health locus of control along multidimensional lines.

The ensuing MHLC measure (Wallston, Wallston, & DeVellis, 1978) is considered by many today to be the standard in the field of health research. In order to assess the hypothesis that individuals who hold accepting attitudes toward the prospective use of hospice care will feel more responsible for their own health than will individuals who do not hold accepting attitudes toward
hospice care this 18 item, self-report questionnaire was utilized. The MHLC measures health related behaviours on three dimensions: internal, powerful others and chance. The internal health locus of control subscale is measured by such items as, "When I get sick I am to blame". The powerful others' health locus of control subscale is measured by such items as, "Regarding my health, I can only do what my doctor tells me to do". The third subscale, chance health locus of control, is measured by such items as, "No matter what I do, if I am going to get sick, I will get sick" (Wallston, Wallston, & DeVellis, 1978).

Participants are asked to rate their responses for each statement on a 6-point Likert scale from "Strongly Disagree" to "Strongly Agree". The higher the score on each subscale, the more internal outcome expectancies, powerful others, or chance plays in the individual's belief of locus of control. Alpha reliabilities for these subscales have been reported in the range of .67 to .77. The development of the MHLC Scale provides health researchers greater potential usefulness than the original HLC Scale. Scores can be obtained on three separate theoretically and empirically differentiated dimensions and two equivalent forms of the scale: Form A (Appendix D) and Form B (Appendix E) are available for mass testing and research designs which require repeated administrations. The MHLC Scale is intended for use with adults (16 years and older), most
persons with an eighth grade reading level, and individuals with no functional impairments (Wallston, Wallston, & DeVellis, 1978).

**NEO Five-Factor Inventory (NEO-FFI).** The NEO-FFI (Costa & McCrae, 1989) is a shortened version of the Revised NEO Personality Inventory which is an extensive 240 item measure of the five major domains of personality and some of the more important facets that define each domain. The NEO-FFI is a briefer, 60 item, self-report instrument. It provides a comprehensive measure of the five major personality dimensions of neuroticism, extraversion, openness, agreeableness, and conscientiousness and was employed in this study to assess the hypothesis that certain personality factors (i.e., openness) may differentiate between individuals who are more receptive to the prospective use of hospice care from individuals who are not (Appendix F). The NEO-FFI consists of five 12-item subscales that measure each domain. Responses are rated on a 5-point Likert scale based on how strongly the respondent agrees or disagrees with each statement. If ten or more items have been left unanswered the test is considered invalid and should not be formally scored (Costa & McCrae, 1989).

The five factors comprising the NEO-FFI represent the most basic dimensions underlying the traits identified in psychological questionnaires (Costa & McCrae, 1989) and all five were investigated in an exploratory manner in the
present study with a particular interest in the domain of openness. The domain of neuroticism represents the general tendency to experience negative affect such as fear, sadness, embarrassment, anger, or guilt. It is measured by items such as, "I often feel inferior to others". Individuals who score high on the dimension of neuroticism tend to be emotionally unstable, susceptible to psychological distress and tend to cope more poorly than others with stress (Costa & McCrae, 1989). The dimension of extraversion describes individuals who are sociable, assertive, active, talkative, cheerful, and prefer large groups. It is measured by items such as, "I laugh easily". People who score high on this dimension are upbeat, energetic, and optimistic (Costa & McCrae, 1989). Elements of the openness domain are an active imagination, aesthetic sensitivity, attentiveness to inner feelings, independence of judgment, and divergent thinking. The domain of openness is measured by items such as, "I often try new and foreign foods". Open individuals are curious about their inner and outer worlds, they are willing to entertain new ethical, social, and political ideas, and hold unconventional values (Costa & McCrae, 1989). The domain of agreeableness, like the domain of neuroticism, represents a dimension of interpersonal tendencies. It is measured by items such as, "Most people I know like me". Individuals who score high on agreeableness tend to be altruistic, sympathetic to others,
and eager to help (Costa & McCrae, 1989). The dimension of conscientiousness represents a more active process of self control, planning, and organization. It is measured by such items as, "I strive for excellence in everything I do". The conscientious individual is purposeful, strong willed, determined, punctual, and reliable (Costa & McCrae, 1989).

The NEO-FFI scales carry with them some portion of the demonstrated validity of the full scales. Validity analyses reveal correlations ranging from .56 to .62. In addition, the NEO-FFI has been found to reliably distinguish between the five subscales of personality factors. Internal consistencies for the five individual scales range from .60 to .90. When correlated with the domain scale, coefficients were .92, .90, .91, .77, and .87 for the personality factors of neuroticism, extraversion, openness, agreeableness, and conscientiousness respectively.

The NEO-FFI requires a sixth grade reading level and may be appropriately used with individuals who are 17 years of age or older. It has been used successfully in college age persons. The NEO-FFI shows the same factor structure in white and non-white respondents and has been extensively validated in women as well as men. Individuals who are suffering from disorders that affect their ability to complete self-report measures should not be asked to complete the NEO-FFI (Costa & McCrae, 1989).
The NEO-FFI is an instrument that has many varied applications. Of specific relevance to this study is in the domain of health habits and attitudes as this is an area in which personality variables can be illuminating. The use of personality traits to predict health behaviours is important because it may make it possible to identify individuals who are more likely to benefit from an intervention program or who are in need of more intensive efforts and attention from their physician or psychologist.

**Death Anxiety Scale (DAS).** Developed by Templer (1970), the DAS has been used quite extensively in the realm of death and dying research. Much of the reason for the scale's popularity lies in its simplicity. Items on the DAS reflect a wider range of life experiences than previous fear of death measures which covered primarily the act of dying, the finality of death, and corpses and their burial (Templer, 1970). The DAS (Appendix G) consists of 15 short statements which the respondent endorses as true or false (e.g., "I am very much afraid to die" and "I am often distressed by the way time flies so very rapidly"). The number of responses indicative of a negative reaction is taken as a measure of death anxiety. This scale was used to test the hypothesis that individuals who hold positive attitudes toward the prospective use of hospice care will differ in their reported levels of death anxiety from individuals who do not hold positive attitudes toward
hospice care. Reliability estimates on the DAS have been moderately high ranging from .76 to .80, demonstrating reasonable internal consistency. Acceptable test re-test reliability between two sets of scores during a three week period has also been demonstrated by a Pearson correlation of .83. Response sets of social desirability and agreement response tendency have not been found to correlate significantly with DAS scores. Further, a high degree of construct validation for the DAS has been provided by its moderate positive correlations with other measures of death, fear and general anxiety. The DAS, originally utilizing a college student sample, has been found to be an appropriate instrument for use in many populations and is permissible to administer to college/university students (Templer, 1970).

**Satisfaction with Life Scale (SWLS).** The SWLS is a short, 5 item, unidimensional instrument that was employed in this study to address the prediction that individuals who hold favourable attitudes toward the prospective use of hospice care will perceive a higher level of life satisfaction. Developed by Diener, Emmons, Larsen, and Griffin (1985) the SWLS was designed to measure subjective well-being and refers to the cognitive-judgmental aspects of general life satisfaction (Appendix H). In contrast to measures that apply some external standard, the SWLS reveals an individual's own judgement of her/his quality of life. Participants are asked to rate their responses to each of
the 5 short statements from 1 (Strongly Disagree) to 7 (Strongly Agree). Item scores are summed for a total score, which ranges from 5 to 35. Higher scores reflect greater satisfaction with life. The instrument’s internal consistency has an alpha of .87 and has excellent test-retest reliability with a correlation of .82 for a two month period, suggesting it is very stable. Originally developed on a sample of 176 undergraduate students from a major university, the SWLS has been tested for concurrent validity using two samples of college students. Scores correlated with nine measures of subjective well-being for both samples (Diener, et al., 1985). As satisfaction with life is often a key component of mental well-being, the SWLS may have utility with a wide range of individuals, including adolescents undergoing identity crises or adults experiencing life crises. The SWLS has also been shown to correlate with self-esteem, a checklist of clinical symptoms, neuroticism, and emotionality (Diener, et al., 1985).

Attitudes Toward Hospice Care Scale (ATHC).

This questionnaire was designed to measure individuals' attitudes toward the use of hospice services as possible prospective patients using an open-ended and forced-choice format (Appendix I). The development of this instrument was guided by previous hospice literature concerning attitudes toward issues related to the personal choice of hospice care
(Neubauer, 1988) and by the notion that attitudes may be revealed in three ways: affectively (e.g., "I am not afraid to die"), behaviourally (e.g., "I would rather live as long as possible under any circumstance than to die") and cognitively (e.g., "I think death should be avoided at all costs"). The resulting measure consisted of two parts. The first section allowed participants to provide a response in their own words by asking them to describe their thoughts about and/or reactions to the idea of hospice care. A brief definition of hospice was provided. The second part of the ATHC Scale consisted of a total of 15 items which were selected by a judgmental rating procedure from an initial pool of 25 items. Participants are asked to rate their responses for each statement on a 6-point Likert scale from "strongly agree" to "strongly disagree". Approximately half of the items were worded in a reversed direction to minimize the impact of response sets. Higher scores on the ATHC Scale indicate a more accepting attitude toward the prospective use of hospice care. Correlations, item and reliability analyses of the attitudinal measure were empirically determined for the present sample.

Procedure

Participants were recruited from a randomized list of volunteers generated from the psychology department's "participant pool". This pool was comprised of psychology
students who were willing to participate in current research projects. Each participant was initially contacted by telephone by the researcher using a standardized recruitment script (Appendix J). The participant was told the researcher's name, the reason for the call and a brief description of the study. This was done to provide the potential participant with adequate information so that reasonable consent to participate could be obtained. Once consent to participate was indicated, the researcher informed the participant of the date, time and location of the study. Information on how to contact the researcher if the participant had to cancel her/his appointment was also provided.

Participants were surveyed individually or in small groups of 5 to 10 in a quiet testing room on the University of Windsor campus. Upon arrival, participants were informed that they would be participating in a study designed to explore general attitudes toward the prospective use of hospice care. Volunteers were further advised that their task would be to complete several measures requiring approximately 45 minutes of their time. As remuneration for their participation, participants were informed that they would receive one bonus point.

Prior to receiving the measures, each participant was given a consent form. This form described the present study, its purpose, and what was required of the
participant. It also indicated that participation was strictly voluntary, that the participant could withdraw from the study at any point without penalty, and that all responses would be kept in complete confidence. The signing and returning of the consent form to the researcher indicated that the participant had read and understood the information and that she/he freely agreed to participate in this project.

Once consent was acquired, participants were provided with a manila envelope containing the following items: a background information sheet, a Multidimensional Health Locus of Control Scale (either Form A or Form B), a NEO Five-Factor Inventory, a Death Anxiety Scale, a Satisfaction with Life Scale, and an Attitudes Toward Hospice Care Questionnaire. Within each package the measures were randomly ordered to prevent unreliability for particular inventories as a result of fatigue effects. A set of instructions, stapled to the outside of the envelope, informed the participant to read the directions for each measure thoroughly, to respond as honestly as possible, and to complete the measures in the order in which they were presented. Participants were given an opportunity to ask questions and clarify any misunderstandings before commencing their task.

After the participants had completed and returned the questionnaire packages to the researcher, the researcher
sealed the envelope and the participants' participation in the study was fulfilled. The participants were then provided with a debriefing information sheet describing the rationale for the study (Appendix K). Contact names were also included so that participants had the option of obtaining further information about the study if they so desired. Lastly, participants were thanked for their interest and participation in this investigation.
CHAPTER III

RESULTS

Demographic Characteristics of the Sample

The distribution between the sexes (102 women and 53 men) reflected the general preponderance of women enrolled in psychology courses. The age range was 18 to 42 years with a mean age of 20.65 (SD=3.32), with 93.5% of the participants falling into the 18-24 age range. The ethnic background of the participants was as follows: White (86.5%), African American/Canadian (7.1%), Asian (1.9%), Native (.6%), and "other" (3.9%). Participants' religious affiliation consisted of Catholic (42.6%), Protestant (12.9%), Christian with no denomination (16.8%), Jewish (.6%), Agnostic (5.8%), and "none or other" (21.3%). In addition, 23.9% of the participants described themselves as "not very religious", 50.3% indicated that they were "moderately religious", and 9.7% of the participants reported being "very religious". A belief in a supreme being or higher power was indicated by 81.3% of the participants, while 14.2% indicated that they did not believe in a supreme being or higher power. Only 4.5% of the participants responded to the "other" category option.

Reliability Analyses

The means, standard deviations, range of scores and reliability coefficients for all scales and subscales are
presented in Table 1. Alpha reliability coefficients for all measures ranged from .51 to .85. A Cronbach's alpha reliability coefficient of .60 was considered adequate for internal consistency for this study. Each of the measures demonstrated acceptable alpha reliability with the exception of the Chance subscales on both forms of the Multidimensional Health Locus of Control Scale. The Chance subscale was measured by items such as, "Even when I take care of myself, it's easy to get sick" and "No matter what I do, I'm likely to get sick". Perhaps this subscale was seen by participants not as factors specifically associated with luck, fate, or chance but as general factors external to their own health control. Thus, the Chance subscale may have been assimilated by the Powerful Others subscale. As the Chance subscales of the MHLC Scale failed to reached adequate alpha reliability they were not employed in further analysis. The Attitudes Toward Hospice Care Scale (ATHC) approached adequate reliability (alpha=.59) and was therefore retained for subsequent analysis.

Factor Analysis of the Attitudes Toward Hospice Care Scale

Examination of the ATHC Scale revealed that many of the corrected item-to-total correlations were at an unacceptably low level. Exploratory factor analysis was used to examine the properties of the scale. Principal factors extraction with varimax rotation was performed on all 15 items of the
Table 1

Means, Standard Deviations, Ranges and Reliability

Coefficients for all Scales and Subscales

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multidimensional Health Locus of Control (Form A)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td>25.78</td>
<td>3.91</td>
<td>10</td>
<td>34</td>
<td>.71</td>
</tr>
<tr>
<td>Powerful Others</td>
<td>17.16</td>
<td>4.04</td>
<td>9</td>
<td>26</td>
<td>.63</td>
</tr>
<tr>
<td>Chance</td>
<td>17.78</td>
<td>4.17</td>
<td>6</td>
<td>29</td>
<td>.54</td>
</tr>
<tr>
<td>Multidimensional Health Locus of Control (Form B)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td>25.96</td>
<td>3.76</td>
<td>18</td>
<td>35</td>
<td>.73</td>
</tr>
<tr>
<td>Powerful Others</td>
<td>18.08</td>
<td>3.93</td>
<td>8</td>
<td>27</td>
<td>.63</td>
</tr>
<tr>
<td>Chance</td>
<td>18.63</td>
<td>3.85</td>
<td>10</td>
<td>28</td>
<td>.51</td>
</tr>
<tr>
<td>NEO Five-Factor Inventory</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neuroticism</td>
<td>34.54</td>
<td>8.48</td>
<td>16</td>
<td>78</td>
<td>.64</td>
</tr>
<tr>
<td>Extraversion</td>
<td>44.17</td>
<td>5.74</td>
<td>29</td>
<td>56</td>
<td>.75</td>
</tr>
<tr>
<td>Openness</td>
<td>42.12</td>
<td>5.83</td>
<td>29</td>
<td>55</td>
<td>.71</td>
</tr>
<tr>
<td>Agreeableness</td>
<td>43.58</td>
<td>5.88</td>
<td>23</td>
<td>57</td>
<td>.75</td>
</tr>
<tr>
<td>Conscientiousness</td>
<td>44.03</td>
<td>6.97</td>
<td>20</td>
<td>59</td>
<td>.85</td>
</tr>
<tr>
<td>Death Anxiety Scale</td>
<td>22.63</td>
<td>2.92</td>
<td>17</td>
<td>31</td>
<td>.66</td>
</tr>
<tr>
<td>Satisfaction with Life Scale</td>
<td>25.23</td>
<td>6.19</td>
<td>7</td>
<td>35</td>
<td>.84</td>
</tr>
<tr>
<td>Attitudes Toward Hospice Care Scale</td>
<td>69.37</td>
<td>6.77</td>
<td>51</td>
<td>88</td>
<td>.59</td>
</tr>
</tbody>
</table>

Note.
* Form A (N=77)
  Form B (N=78)
ATHC Scale. Principal components extraction was used prior to principal factors extraction to estimate the number of factors, presence of outliers and absence of multicollinearity. Factor analysis of the ATHC Scale revealed a significant five factor solution (see Table 2). Only factors with an eigenvalue of 1.00 or greater were retained in subsequent analyses. Only variables with loadings on a factor of .45 or higher (20% of variance) were interpreted. Adhering to this criterion only one item ("I am glad when people drop by to visit me when I am at home"), did not load on any factor. Items 2, 6, 11 and 13 loaded most heavily on the first factor. Items 5, 7, 9 and 12 loaded most heavily on the second factor. Items 3, 10 and 15 loaded most heavily on the third factor. Items 4 and 14 loaded most heavily on the fourth factor, while items 3, 8 and 11 loaded most heavily on the fifth factor.

Reliability analyses of these five factors revealed mixed results. The subscale devised from factor 1 revealed acceptable overall reliability (alpha=.71) and corrected item-to-total correlations (all greater than .30). The subscale devised from factor 2 also revealed acceptable overall reliability (alpha=.62) and corrected item-to-total correlations (all greater than .30). The subscale devised from factor 3 demonstrated marginal reliability (alpha=.56) and corrected item-to-total correlations (all greater than .30) and was, therefore, included in further analyses. The
Table 2

Factor Loadings for Principal Factors Extraction with Varimax Rotation of the Attitudes Toward Hospice Care Scale

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
<th>Factor 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-.1848</td>
<td>.3978</td>
<td>.3084</td>
<td>-.0842</td>
<td>.1180</td>
</tr>
<tr>
<td>2</td>
<td>.5945</td>
<td>.0612</td>
<td>-.0667</td>
<td>.4348</td>
<td>-.0967</td>
</tr>
<tr>
<td>3</td>
<td>.1227</td>
<td>.0256</td>
<td>.6109</td>
<td>.2670</td>
<td>-.4804</td>
</tr>
<tr>
<td>4</td>
<td>.2741</td>
<td>.1035</td>
<td>.1786</td>
<td>.5725</td>
<td>.0680</td>
</tr>
<tr>
<td>5</td>
<td>-.1680</td>
<td>.6330</td>
<td>.2321</td>
<td>-.1136</td>
<td>.1823</td>
</tr>
<tr>
<td>6</td>
<td>.8106</td>
<td>-.0774</td>
<td>-.0242</td>
<td>.0513</td>
<td>.1508</td>
</tr>
<tr>
<td>7</td>
<td>-.0923</td>
<td>.7458</td>
<td>-.0526</td>
<td>-.0663</td>
<td>.1571</td>
</tr>
<tr>
<td>8</td>
<td>.0525</td>
<td>.1205</td>
<td>.0177</td>
<td>.3589</td>
<td>.7263</td>
</tr>
<tr>
<td>9</td>
<td>.2395</td>
<td>.6615</td>
<td>-.1326</td>
<td>.2966</td>
<td>-.1017</td>
</tr>
<tr>
<td>10</td>
<td>-.1925</td>
<td>.2111</td>
<td>.7395</td>
<td>.1022</td>
<td>.0697</td>
</tr>
<tr>
<td>11</td>
<td>.4899</td>
<td>-.0450</td>
<td>.2984</td>
<td>-.1169</td>
<td>.5006</td>
</tr>
<tr>
<td>12</td>
<td>.0012</td>
<td>.6808</td>
<td>-.0239</td>
<td>.1369</td>
<td>-.3268</td>
</tr>
<tr>
<td>13</td>
<td>.8517</td>
<td>-.1243</td>
<td>.0265</td>
<td>-.1274</td>
<td>-.0407</td>
</tr>
<tr>
<td>14</td>
<td>-.3282</td>
<td>-.0924</td>
<td>.0503</td>
<td>.7049</td>
<td>.1205</td>
</tr>
<tr>
<td>15</td>
<td>.1686</td>
<td>-.1406</td>
<td>.7402</td>
<td>.0156</td>
<td>.0796</td>
</tr>
</tbody>
</table>

Note.
*Items correspond to the Attitudes Toward Hospice Care Scale (see Appendix I)*
subscapes devised from factor 4 and factor 5 demonstrated low alpha reliabilities .19 and .07 respectively and poor corrected item-to-total correlations (all less than .30). Therefore only factors 1, 2, and 3 were retained for all subsequent analyses. Interpretive labels for each of these 3 factors were as follows: factor 1 (Preference for Quality of Life), factor 2 (Attitudes Toward Hospice), factor 3 (Desire for Home Care). The order (by size of loadings) in which each of the individual items of the Attitudes Toward Hospice Care Scale contributed to the three factors is presented in Table 3.

Gender Differences

Independent samples t-tests were employed to examine the possibility of any gender differences on all predictor variables. T-tests revealed significant gender differences on the following subscapes of the NEO Five-Factor Inventory: the Agreeableness subscale t(153)=-3.45, p<.001, such that women were more agreeable (M=44.72) than men (M=41.40), the Conscientiousness subscale t(153)=-2.79, p<.01, such that women were more conscientious (M=45.13) than men (M=41.91), and the Extraversion subscale t(153)=-2.24, p<.05, such that women (M=44.90) were more extraverted than men (M=42.75). T-tests also demonstrated significant gender differences on two of the three factors of the Attitudes Toward Hospice Care Scale: Desire for Home Care t(153)=-2.59, p<.05,
### Table 3

**Order in which Individual Attitudes Toward Hospice Care Items Contribute to Each of the Three Factors**

<table>
<thead>
<tr>
<th>Factor 1: Preference for Quality of Life</th>
<th>Factor 2: Attitudes Toward Hospice</th>
<th>Factor 3: Desire for Home Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would want every effort to be made to preserve my life.*</td>
<td>I would choose hospice care if I had a terminal illness.</td>
<td>When the time comes, I think I would rather die in my own home than in a hospital.</td>
</tr>
<tr>
<td>I would rather live as long as possible under any circumstance than to die.*</td>
<td>I believe that hospices are places where people go to die.*</td>
<td>I am grateful to have a close family member who would be willing to help me stay at home if I became terminally ill.</td>
</tr>
<tr>
<td>I think death should be avoided at all costs.*</td>
<td>I feel uncomfortable with hospices as they are places that deal only with death.*</td>
<td>If I was very sick, I would rather be in a hospital than be a burden to my family at home.*</td>
</tr>
<tr>
<td>I would not want to receive intensive medical interventions in the final weeks of my life.</td>
<td>I feel fortunate to have programs like hospice that are cost effective.</td>
<td></td>
</tr>
</tbody>
</table>

**Note.**
Most important items are near top of columns.
Proposed labels are in italics.
* items have been reverse coded
indicating that women had a greater desire to remain at home if terminally ill (M=13.80) than did men (M=12.66) and Attitudes Toward Hospice \( t(151) = -2.23, p < .05 \), indicating that women held more positive attitudes toward the concept of hospice (M=18.57) than men (M=17.31).

Hierarchical Multiple Regression Analyses

Hierarchical multiple regression analyses were performed to investigate whether the personality subscales of the NEO Five-Factor Inventory made a unique contribution to the prediction of attitudes toward the prospective use of hospice care beyond what was accounted for by gender and health locus of control. This examination consisted of three separate hierarchical multiple regression analyses conducted on each of the three factors (Preference for Quality of Life, Attitudes Toward Hospice and Desire for Home Care) of the criterion variable, the Attitudes Toward Hospice Care Scale. Each analysis examined, as predictor variables, gender, the Multidimensional Health Locus of Control and the NEO Five-Factor Inventory. Due to the weak correlational findings with the criterion measure, results for the variables of Death Anxiety and Satisfaction with Life failed to provide strong enough support to be included in the hierarchical multiple regression analyses and were, therefore, excluded from further analysis.
For each of the three factors of the Attitudes Toward Hospice Care Scale, participant gender was entered as the sole predictor on the first block to determine whether this variable accounted for a significant proportion of the variance. Scores on the Internal and Powerful Others subscales of the Multidimensional Health Locus of Control Scale were entered simultaneously in the second block. In the third, and final block, scores on the five personality dimensions of the NEO Five-Factor Inventory (Openness, Conscientiousness, Agreeableness, Neuroticism, Extraversion) were enter simultaneously to determine if any of these variables accounted for any of the variance in the dependent variables beyond what was accounted for by gender and health locus of control. For all analyses, squared semi-partial correlations were calculated at each step to determine the unique predictive ability of each predictor variable. Correlations between variables included in these regression analyses are illustrated in Table 4.

The final regression model that resulted from the first hierarchical regression analysis on the Preference for Quality of Life factor of the Attitudes Toward Hospice Care Scale is presented in Table 5. The overall model was significant ($R=0.407$, $p<.001$), with the predictors collectively accounting for 16% of the variance on the Preference for Quality of Life factor of the ATHC Scale.
### Table 4
Intercorrelations Among Variables Included in Regression Analyses

<table>
<thead>
<tr>
<th>Var.</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>--</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>-.107</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>.096</td>
<td>.056</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>-.206*</td>
<td>-.094</td>
<td>.106</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>.053</td>
<td>-.076</td>
<td>.070</td>
<td>-.116</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>-.309**</td>
<td>.063</td>
<td>.034</td>
<td>.139</td>
<td>-.111</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>-.152</td>
<td>-.057</td>
<td>-.174*</td>
<td>.340**</td>
<td>-.200*</td>
<td>.189*</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>.009</td>
<td>.140</td>
<td>.230**</td>
<td>-.025</td>
<td>.289**</td>
<td>.016</td>
<td>-.330**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>.202*</td>
<td>.016</td>
<td>.082</td>
<td>-.111</td>
<td>.085</td>
<td>-.212**</td>
<td>-.147</td>
<td>.164*</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>.074</td>
<td>.216**</td>
<td>.192*</td>
<td>-.009</td>
<td>.060</td>
<td>.060</td>
<td>-.159*</td>
<td>.202*</td>
<td>-.012</td>
<td>--</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>.006</td>
<td>.259**</td>
<td>.232**</td>
<td>-.028</td>
<td>.042</td>
<td>.112</td>
<td>-.276**</td>
<td>.298**</td>
<td>-.083</td>
<td>.313**</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>.009</td>
<td>.128</td>
<td>.190*</td>
<td>-.190*</td>
<td>.236**</td>
<td>-.004</td>
<td>-.442**</td>
<td>.437**</td>
<td>.041</td>
<td>.174*</td>
<td>.289**</td>
<td>--</td>
</tr>
<tr>
<td>13</td>
<td>-.232**</td>
<td>-.026</td>
<td>.069</td>
<td>.183*</td>
<td>-.038</td>
<td>.185*</td>
<td>.159*</td>
<td>.114</td>
<td>-.046</td>
<td>.126</td>
<td>.051</td>
<td>.00</td>
</tr>
</tbody>
</table>

**Note.**
* * P<.05
** ** P<.01

Variables: 1=ATHC Scale (Preference for Quality of Life factor), 2=ATHC Scale (Attitudes Toward Hospice factor), 3=ATHC Scale (Desire for Home Care factor), 4=Death Anxiety Scale 5=MHLC Scale (Internal subscale), 6=MHLC Scale (Powerful Others subscale), 7=NEO-FFI (Neuroticism subscale), 8=NEO-FFI (Extraversion subscale), 9=NEO-FFI (Openness subscale), 10=NEO-FFI (Agreeableness subscale), 11=NEO-FFI (Conscientiousness subscale), 12=Satisfaction with Life Scale, 13=Level of Personal Religiosity
Table 5

Hierarchical Regression Analysis of Gender, Health Locus of Control and NEO Personality Factors on "Preference for Quality of Life"

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Beta</th>
<th>sr²</th>
<th>R²-change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.140</td>
<td>.019</td>
<td>.019</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.175</td>
<td>.030*</td>
<td></td>
</tr>
<tr>
<td>Multidimensional Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locus of Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td>.020</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>Powerful Others</td>
<td>-.325</td>
<td>.104***</td>
<td>.106***</td>
</tr>
<tr>
<td>Step 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.205</td>
<td>.035*</td>
<td></td>
</tr>
<tr>
<td>Multidimensional Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locus of Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td>.013</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>Powerful Others</td>
<td>-.271</td>
<td>.065***</td>
<td></td>
</tr>
<tr>
<td>Neo-Five Factor Inventory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Openness</td>
<td>.147</td>
<td>.020</td>
<td></td>
</tr>
<tr>
<td>Conscientiousness</td>
<td>-.017</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>Agreeableness</td>
<td>.040</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Neuroticism</td>
<td>-.136</td>
<td>.014</td>
<td></td>
</tr>
<tr>
<td>Extraversion</td>
<td>-.099</td>
<td>.007</td>
<td>.039</td>
</tr>
</tbody>
</table>

*p<.05
**p<.01
***p<.001
R²-model=.164
R model=.407
In step 1, gender did not account for a significant proportion of the variance in the dependent variable. Addition of the Multidimensional Health Locus of Control subscales to the regression analysis in step 2 resulted in a significant, and large, change in $R^2$ ($R^2$-change=.106, \(p<.001\)), suggesting that the inclusion of the powerful others subscale significantly improved the prediction of the Preference for Quality of Life factor of the ATHC Scale. Examination of the squared semi-partial correlations indicated that gender, i.e., being female ($sr^2=.030$) emerged as a positive predictor of the Preference for Quality of Life factor, while the powerful others subscale of the Multidimensional Health Locus of Control ($sr^2=.104$) negatively predicted favourable attitudes to the Preference for Quality of Life factor. Each of these variables accounted for 3% and 10% of the variance, respectively. The internal subscale of the Multidimensional Health Locus of Control Scale failed to make a unique contribution to the prediction of the Preference for Quality of Life factor. Addition of the personality dimensions of the NEO Five-Factor Inventory to the regression model in step 3 did not account for a significant improvement in the prediction of the Preference for Quality of Life factor of the ATHC Scale beyond what was accounted for by gender and the powerful others subscale.
The final regression model that resulted from the second hierarchical regression analysis on the **Attitudes Toward Hospice** factor of the Attitudes Toward Hospice Care Scale is presented in Table 6. The overall model was significant (R=.336, p<.05), with the predictors collectively accounting for 11% of the variance on the **Attitudes Toward Hospice** factor of the ATHC Scale.

In step 1, gender accounted for 3% of the variance in **Attitudes Toward Hospice** factor (R^2 change=.032, p<.05), suggesting that females hold more accepting attitudes toward hospice. Addition of the Multidimensional Health Locus of Control subscales to the regression analysis in step 2 did not result in a significant change in the proportion of variance in the dependent variable. However, addition of the personality dimensions of the NEO Five-Factor Inventory in step 3 resulted in a significant change in R^2 (R^2 change=.074, p<.05), and specifically, the inclusion of the Conscientiousness subscale of the NEO-FFI significantly improved the prediction of the **Attitudes Toward Hospice** factor. Examination of the squared semi-partial correlations indicated that the Conscientiousness subscale (sr^2=.027) made a unique contribution to the prediction of the **Attitudes Toward Hospice** factor, accounting for approximately 3% of the variance in this variable.
Table 6
Hierarchical Regression Analysis of Gender, Health Locus of Control and NEO Personality Factors on "Attitudes Toward Hospice"

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Beta</th>
<th>$r^2$</th>
<th>R-change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.179</td>
<td>.032*</td>
<td>.032*</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.174</td>
<td>.030*</td>
<td></td>
</tr>
<tr>
<td>Multidimensional Health Locus of Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td>-.070</td>
<td>.005</td>
<td></td>
</tr>
<tr>
<td>Powerful Others</td>
<td>.034</td>
<td>.001</td>
<td>.007</td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.094</td>
<td>.007</td>
<td></td>
</tr>
<tr>
<td>Multidimensional Health Locus of Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td>-.113</td>
<td>.011</td>
<td></td>
</tr>
<tr>
<td>Powerful Others</td>
<td>.010</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>Neo-Five Factor Inventory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Openness</td>
<td>.026</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Conscientiousness</td>
<td>.186</td>
<td>.027*</td>
<td></td>
</tr>
<tr>
<td>Agreeableness</td>
<td>.130</td>
<td>.014</td>
<td></td>
</tr>
<tr>
<td>Neuroticism</td>
<td>.004</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>Extraversion</td>
<td>.076</td>
<td>.004</td>
<td>.074*</td>
</tr>
</tbody>
</table>

* $p < .05$  
** $p < .01$  
*** $p < .001$  
R-model = .336  
R-model = .113
The final regression model that resulted from the third hierarchical regression analysis on the Desire for Home Care factor of the ATHC Scale is presented in Table 7. The overall model was significant (R=.352, p<.05), with the predictors collectively accounting for 12% of the variance on the Desire for Home Care factor.

In step 1, gender accounted for 4% of the variance in Desire for Home Care factor (R^2 change=.042, p<.05), suggesting that females have a greater desire for home care than do their male counterparts. Addition of the Multidimensional Health Locus of Control subscales to the regression analysis in step 2 did not result in a significant change in the proportion of variance in the dependent variable. However, addition of the personality dimensions of the NEO Five-Factor Inventory in step 3 resulted in a significant change in R^2 (R^2 change=.076, p<.05), suggesting that the inclusion of the personality subscales of the NEO-FFI collectively significantly improved the prediction of the Desire for Home Care factor of the ATHC Scale, accounting for 7.6% of the variance.

Qualitative Data Analysis

All (100%) of the participants responded to the open-ended component of the Attitudes Toward Hospice Care Scale. Although no formal statistical analysis was performed on the data, a thematic categorization of the participants'
Table 7

Hierarchical Regression Analysis of Gender, Health Locus of Control and NEO Personality Factors on "Desire for Home Care"

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Beta</th>
<th>( \text{sr}^2 )</th>
<th>( R^2 \text{-change} )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.205</td>
<td>.042*</td>
<td>.042*</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.204</td>
<td>.041*</td>
<td></td>
</tr>
<tr>
<td>Multidimensional Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locus of Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td>.075</td>
<td>.006</td>
<td></td>
</tr>
<tr>
<td>Powerful Others</td>
<td>.021</td>
<td>.000</td>
<td>.006</td>
</tr>
<tr>
<td>Step 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.157</td>
<td>.020</td>
<td></td>
</tr>
<tr>
<td>Multidimensional Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locus of Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td>.009</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>Powerful Others</td>
<td>.036</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Neo-Five Factor Inventory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Openness</td>
<td>.073</td>
<td>.005</td>
<td></td>
</tr>
<tr>
<td>Conscientiousness</td>
<td>.114</td>
<td>.010</td>
<td></td>
</tr>
<tr>
<td>Agreeableness</td>
<td>.074</td>
<td>.005</td>
<td></td>
</tr>
<tr>
<td>Neuroticism</td>
<td>-.113</td>
<td>.009</td>
<td></td>
</tr>
<tr>
<td>Extraversion</td>
<td>.101</td>
<td>.008</td>
<td>.076*</td>
</tr>
</tbody>
</table>

\*\*\*<.05\quad R\text{-model}=.124
\*\*\*<.01\quad R model=.352
\*\*\*<.001
responses revealed that the majority of individuals viewed hospice as a good idea. Participants saw hospice: as helping the terminally ill and their families deal with the emotional and physical needs of terminal illness, as helping the terminally ill deal with their own death, and as helping the terminally ill die in the way they wish. Few individuals expressed negative feelings about or reactions to hospice. However, some of the participants' concerns included the fact that hospice would not be for everybody and that, "I am happy there is a program like this [hospice] available for people who choose to enter it, but I don't think I would want to be there if I were terminally ill" (participant #038).
CHAPTER IV
DISCUSSION

The primary purpose of the present study was to develop a profile that discriminated between individuals who would be predisposed to utilize hospice care from those individuals who would not. Based on previous research findings, particular attributes of personality, life satisfaction, death anxiety, and responsibility for one's own health were predicted as pivotal factors differentiating these two groups. Other potential predictors were also explored in terms of their effects on accepting attitudes toward hospice care. These included gender, ethnicity and degree of religiosity.

In order to achieve this goal, many standardized measures and a self-constructed questionnaire (Attitudes Toward Hospice Care Scale) were utilized. Upon preliminary analysis, the ATHC Scale revealed that many of the corrected item-to-total correlations were at an unacceptably low level. Thus, the 15 item scale was subjected to a factor analysis. The findings suggested that the ATHC Scale was not a unidimensional measure as three subscales with moderate to high factor loadings emerged. Each of the three subscales was assigned an interpretive label (i.e., Preference for Quality of Life, Attitudes Toward Hospice and Desire for Home Care). The presence of such factors seems
to suggest that attitudes toward hospice care are complex and may encompass a variety of diverse domains.

The present study's findings are discussed in terms of its ability to identify individuals whose characteristics would predispose them to use hospice care services, limitations of the current study and potential future directions.

The hypothesis that individuals who hold positive attitudes toward the prospective use of hospice care will differ in their reported levels of death anxiety from those individuals who do not hold positive attitudes toward the prospective use of hospice care was not supported. Although reports in the literature on the benefits of hospice care and reported levels of death anxiety are mixed, no directional support was confirmed by the present study. Scores on the Death Anxiety Scale failed to correlate with either the Attitudes Toward Hospice factor or the Desire for Home Care factor of the ATHC Scale. However, a significant negative correlation was found between death anxiety scores and the Preference for Quality of Life factor on the ATHC Scale, suggesting that individuals who have a higher preference for quality of life would display less anxiety about death. This finding is contrary to Seale's (1991) study which reported that hospice patients reported more anxiety about death but less anxiety about isolation. However, this finding lends support to Hendon and Epting's
(1989) investigation which illustrated that hospice patients expressed less fear of death than patients in traditional hospital settings. Individuals who value a high quality of life may gravitate toward hospice care programs because of the emphasis hospices place on promoting quality of living and palliative comfort care, rather than on the prolongation of a painful, restricted life. In addition, the fact that hospices view death as a natural phenomenon may be intrinsically appealing to terminal patients. One role of hospice care programs is to aid the patient in seeing death as an inevitable aspect of life, something that is to be faced and accepted. By embracing this philosophy, hospices can help patients take control over their own death which may actually reduce the anxiety that surrounds their dying process.

Although this finding is engaging, it represents only a trend in the data. While the correlation between the Preference for Quality of Life factor and scores on the Death Anxiety Scale was found to be negatively significant, it represented only a weak correlational finding (less than .30). Thus, the results for the variable of death anxiety did not provide strong enough support for the original hypothesis and this variable was omitted from inclusion into the hierarchical multiple regression analyses.

Perhaps a reason for this lack of support comes from the connotation that the Death Anxiety Scale does not
operate as a unidimensional scale and may be measuring other concerns related to the issue of death (Neubauer & Lai, 1988). In order to investigate the possible relationship between death anxiety and public attitudes toward the prospective use of hospice services, Neubauer and Lai (1988) conducted a random telephone survey. The authors hypothesized that individuals with a high degree of death anxiety would be less likely to think that they would select hospice care if they became terminally ill. They discovered that death anxiety did not appear to be related to attitudes toward the prospective personal use of hospice services. However, other elements emerged as being significantly related to specific items with the Death Anxiety Scale (i.e., fear of dying, fear of life after death, fear of operations). As death is as complex an issue as are attitudes toward hospice care, it may be that the selected measure of death anxiety was not suitable for the current study and perhaps issues of isolation, rejection, or abandonment, as they relate to the process of dying, were being assessed.

The hypothesis that individuals who hold favourable attitudes toward the prospective use of hospice care will perceive a higher level of life satisfaction was also not supported by the current study. Scores on the Satisfaction with Life Scale did not correlate with either the Preference for Quality of Life factor or the Attitudes Toward Hospice
factor of the ATHC Scale. However, scores on the Satisfaction with Life Scale and the Desire for Home Care factor of the ATHC Scale were positively, significantly correlated, suggesting that individuals who perceive a high level of life satisfaction would desire home care more than individuals who perceive a low level of life satisfaction. Logically, this finding is not surprising. Terminally ill persons high in life satisfaction would be expected to maintain an active level of control and functioning over their daily routines. Such individuals would want to be in familiar and comforting surroundings, to remain connected to personal items and family members, and to make decisions about what to eat, when to sleep, and when to have visitors. Hospice home care service affords terminally ill patients the opportunity for preserving their life satisfaction.

This finding of the present study corroborates the evidence yielded by Seale's (1991) study. Seale (1991) reported that individuals in hospice units were more likely to see themselves as capable and in control of their lives. In addition, DuBois (1980) also found that patients in hospice setting exhibited several positive benefits related to life satisfaction. Hospice patients reported less pain, were more mobile, and were able to spend more time with family and friends than their hospitalized counterparts. But, while this trend of individuals who hold favourable attitudes toward the prospective use of hospice care
perceiving higher levels of life satisfaction is in the expected direction, the correlation between the Satisfaction with Life Scale and the **Desire for Home Care** factor of the ATHC Scale was weak (less than .30). As with death anxiety, support for the satisfaction with life variable was not strong enough to be retained for entry into the hierarchical multiple regression model and, consequently, was excluded from further analysis.

One possible explanation for the lack of support for the satisfaction with life variable may be with the scale itself. The Satisfaction with Life Scale, in its simplicity, may be too global. As the scale consists of only five general statements, perhaps a measure that specifically addresses health care issues and life satisfactions levels would be more appropriate when attempting to assess the intricate issue of attitudes toward hospice care programs. Thus, it may be that the Satisfaction with Life Scale was not solely measuring life satisfaction levels, but the more multifarious issues of self-esteem and empowerment. As past research has only grazed the issue of empowerment in hospice care programs (DuBois 1980; Seale, 1991) future research into this topic is warranted.

The hypothesis that individuals who hold more accepting attitudes toward the prospective use of hospice care will feel more responsible for their own health than individuals
who do not hold accepting attitudes toward the prospective use of hospice care was supported. The two subscales of the Multidimensional Health Locus of Control (MHLC) Scale were examined as predictors of positive attitudes toward the prospective use of hospice services. Scores on the internal subscale of the MHLC Scale failed to correlate with any of the three factors of the Attitudes Toward Hospice Care Scale. And, while scores on the powerful others subscale of the MHLC Scale also did not correlate with either the Attitudes Toward Hospice factor or the Desire for Home Care factor on the ATHC Scale, the powerful others subscale did negatively, significantly correlate with the Preference for Quality of Life factor. This correlation was moderately strong, suggesting that individuals who have a high preference for quality of life see powerful others as having little impact on their health outcomes. The powerful others subscale of the MHLC Scale was subsequently entered into the second block of the multiple regression analyses.

As expected, when the powerful others subscale of the MHLC Scale was entered into the multiple regression analyses it failed to account for a significant proportion of the variance on both the Attitudes Toward Hospice factor and the Desire for Home Care factor of the ATHC Scale. However, in the regression model the powerful others subscale did significantly predict attitudes toward the Preference for Quality of Life factor of the ATHC Scale, accounting for
approximately 10% of the variance. Items on this scale were measured by statements such as, "Other people play a big part in whether I stay healthy or become sick" (Wallston, Wallston, & DeVellis, 1978). Respondents' scores on the powerful others subscale were inversely related to their attitudes toward the Preference for Quality of Life factor. Thus, it was found that participants who scored low on the powerful others subscale held preference for quality of life in higher regard. These individuals would be presumed to take a more active self-care role as they would view their health as substantially under the control of personal forces rather than under the control of doctors, nurses, family or friends. As the premise of hospice care is to provide a high quality of life through increased patient control and limited intrusive intervention, it intuitively follows that individuals who hold more accepting attitudes toward the prospective use of hospice care services would be less inclined to have others (i.e. powerful others) manage their lives.

The results of the current study validates the findings of Cassileth, Lusk, Strouse, and Bodenheimer. Cassileth et al., (1984) illustrated that patients who had used unorthodox treatments differed in their beliefs about illness and personal responsibility toward health care from patients who had utilized conventional treatments only. Major beliefs associated with patients' use of alternative
therapies include disappointment with conventional practitioners and a dissatisfaction with medical institutions (Cassileth, et al., 1984) and were among the reasons cited by many of the present study's research participants as to why they would prefer hospice care if they became terminally ill. A common theme expressed in the qualitative component of the ATHC Scale was that respondents did not want to die alone but wanted to be in a supportive, comfortable, caring, respectful environment, and it was felt that hospices could provide this climate. As one respondent (#086) succinctly stated, "I have seen family members slowly die from cancer...hospitals hide dying patients away and isolate them at a time when they need love and comfort the most...the care that these facilities [hospices] provided are invaluable".

The prediction that individuals who are more receptive to the prospective use of hospice care will be characterized by a high level of openness was not supported by the present study. Yet, some unexpected personality characteristics emerged as significant predictors of positive attitudes toward the concept of hospice.

The premise for this hypothesis comes in part from Costa and McCrae's (1989) definition of openness. In its broadest terms, openness is defined by an openness to experience. Individuals who are open are described as intellectually curious and as having a preference for
variety (Costa & McCrae, 1989). Low scorers tend to engage in more conventional behaviour and have a more traditional perspective, whereas high scorers are willing to entertain new ideas, adopt unconventional values, and exhibit a willingness to try new and different activities (Costa & McCrae, 1989).

Scores on the openness subscale of the NEO-FFI did not correlate with either the Attitudes Toward Hospice factor or the Desire for Home Care factor of the ATHC Scale. However, openness was positively, significantly correlated with the Preference for Quality of Life factor of the ATHC Scale, suggesting that individuals who perceive a high preference for quality of life would be depicted as more open. Open individuals' attraction to new concepts and alternative value systems may result in them seeking alternative, unconventional care practices toward their own health if they should become terminally ill, thereby making hospice a viable choice. The inclusion of the openness subscale in the multiple regression model, however, did not significantly improve the prediction of attitudes toward the Preference for Quality of Life, beyond what was accounted for by the other predictors.

Another subscale of the NEO-FFI, conscientiousness, did significantly improve the prediction of the Attitudes Toward Hospice factor of the ATHC Scale. Scores on both the agreeableness and conscientiousness subscales were
positively, significantly correlated with the **Attitudes Toward Hospice** factor, implying that individuals who are more accepting of hospice care are characterized as more agreeable and conscientious. The inclusion of all five personality dimensions of the NEO-FFI in the multiple regression model resulted in only the conscientiousness subscale significantly predicting attitudes toward hospice, accounting for approximately 3% of the variance in this variable.

Conscientiousness, as defined by Costa and McCrae (1989) represents the more active process of self-control, planning, and organization. Individuals who score high on this trait are described as purposeful, strong-willed, and determined (Costa & McCrae, 1989). Terminal patients know that they are going to die and those patients who are depicted as highly conscientious may want to take an active process not only in the planning and decision making of their remaining days but also in their inevitable death. Hospitals, concentrating on the cure of illness, may make them incompatible for individuals who are faced with the possibility of their own death. With their attention focused on life-extending procedures, hospitals exclusively stress the physical care of the body. Little notice is paid to the complex demands of the dying patient. Hospices, on the other hand, seek to assist terminal patients with the psychosocial issues of death and encourage patients to take
control of their own death process. Hence, hospice programs and/or facilities may be more appealing to highly conscientious terminally ill individuals as they provide an environment in which their needs of planning and organization can be fulfilled.

Of the five personality factors of the NEO-FFI, four subscales were found to significantly correlate with the **Desire for Home Care** factor of the ATHC Scale. Curiously, the only personality dimension that failed to correlate with the **Desire for Home Care** factor was the openness subscale. The neuroticism subscale was negatively correlated with the **Desire for Home Care** factor. Individuals who score high on neuroticism tend to be emotionally unstable, susceptible to psychological distress and cope more poorly with stress (Costa & McCrae, 1989). These individuals may be too fearful to remain at home and may select traditional hospital environments to avoid any stress related decisions concerning their own health status. Scores on the extraversion subscale were strongly, positively correlated with the **Desire for Home Care** factor. Extraverted individuals are described as being highly social, active, cheerful, and optimistic (Costa & McCrae, 1989). A home environment would be more welcomed for these individuals as it would afford them the opportunity to be socially active without imposed restrictions (i.e. visiting hours). Scores on the conscientiousness subscale were also strongly,
positively correlated with the **Desire for Home Care** factor, suggesting that individuals who are conscientious would have a greater desire to remain at home if they became terminally ill. In light of the fact that conscientious people require a high level of self and environmental control this finding makes perfect sense. Interestingly, conscientiousness was not empirically found to significantly correlate with the internal subscale of the MHL. Lastly, scores on the agreeableness subscale were positively correlated with the **Desire for Home Care** factor of the ATHC Scale. Agreeable individuals are characterized as sympathetic, eager to help, and having an altruistic disposition (Costa & McCrae, 1989). Individuals who are agreeable may have a greater desire to stay at home if they believe that their family or caregivers would want this option for them. This assumption is supported by Prigerson's (1992) study, as cited in Taylor (1995), which suggested that palliative care may not be directly selected by the patients themselves but driven by the patients' family members and their desires for palliative care.

When all personality dimensions of the NEO-FFI were entered into the multiple regression analysis they did **collectively** significantly improve the prediction of attitudes toward the **Desire for Home Care**, accounting for approximately 7.5% of the variance. However, no one individual factor predicted a significant proportion of the
variance in this variable. Thus, while openness was not supported as a predictor of attitudes toward hospice care, it appears as though other personality factors (i.e. conscientiousness) may be important in predicting accepting attitudes toward the prospective use of hospice care.

Analysis of the sundry demographic variable of gender revealed two significant gender differences on the **Attitudes Toward Hospice** factor and the **Desire for Home Care** factor of the ATHC Scale. Women tend to hold more positive attitudes toward the concept of hospice than do men, and women also have a greater desire to remain at home if they became terminally ill than do their male counterparts. These gender findings may be explained by the fact that in the past women have often been ostracized from the decision making process regarding their own health care. As women have become better educated, more empowered, and more active in the utilization of medical services, women's beliefs about the efficacy of alternative treatment options has become consequential. Today's terminally ill woman may be committed to taking increased control of her own well-being, not only in the realm of traditional medical therapies but also in the area of more unconventional approaches to health care. Also, in this investigation, the fact that more women were favourable to the concept of hospice may be a reflection of the younger, more educated/informed sample employed.
When the demographic variable of religiosity was analyzed it was found to negatively, significantly correlate with the **Preference for Quality of Life** factor of the ATHC Scale. Interestingly, the greater the individuals's preference for quality of life, the lower the level of personal religiosity. Terminally ill individuals who perceive a high quality of life may wish to avoid prolonging their painful life through extensive pharmacological or surgical intervention. This acceptance of a "premature" death stands in contradistinction to many religions that sanction life at all costs. This negative correlation may be a manifestation of this philosophy.

**Limitations of the Present Study and Future Research Directions**

This study's principal objective was to develop a profile that differentiated individuals having a proclivity to utilize hospice care services if they became terminally ill from those individuals who would not. The findings of this study uncovered mixed results. While statistical analyses revealed that the variables of death anxiety and satisfaction with life did not make a significant and unique contribution to the prediction of accepting attitudes toward the concept of hospice care, some support was provided for gender, responsibility for one's own health and particular personality characteristics. In conclusion, it can be said
that individuals who hold favourable attitudes toward the prospective use of hospice care services tend to be women, conscientious, and believe that powerful others play a minimal role in their determining their own state of health.

As the hypotheses of the present study received only partial support, limitations of the investigation need to be addressed. First, some of the predictor measures in the present study were moderately dated and may have slightly compromised the statistical results of the investigation. All measures were, however, selected on a grounded rationale. The Death Anxiety Scale (Templer, 1970), for example, although not a contemporary scale, was chosen for its ability to reflect a wider range of life experiences (rather than issues of burial, body decomposition) which was regarded as pivotal in assessing younger individuals' prospective attitudes toward hospice care. The Multi-dimensional Health Locus of Control Scale, (Wallston, Wallston, & DeVellis, 1978) which measures the degree to which people perceive themselves to be in control of their own health, perceive powerful others to be in control of their health, or regard chance as a major determinant of their health, is also a somewhat historical measure.

However, these three subscales are important to explore especially when attempting to assess how individuals' health behaviours and choices are influenced by their perceptions. Current writings in health literature continue to cite the
MHLC Scale as one of the most widely used measures (Taylor, 1999).

Second, these findings have only limited generalizability to other populations as the sample in the current study was obtained by convenience. Since the sample consisted exclusively of university students, certain demographic variables tended to be homogeneous (age, ethnicity, socioeconomic status, and educational level). Obviously, this is not representative of the general public who tend to be much more heterogeneous on population statistics.

Of particular concern in this research investigation was the congruous developmental stage of the participants. The respondents' role in the present study was to reply to questions designed to assess their attitudes and personality traits toward the prospective use of hospice care if they became terminally ill. As the average age of the sample was approximately 21 years of age this assignment may have been beyond their developmental functioning level. According to Erikson (1968), as cited in Santrock (1981), adolescence or youth is a period of formulation. It is during this phase that individuals begin to search for their identity and may experience a variety of different roles and different ideologies before a true sense of self is formed. In fact, some researchers believe that the most important identity changes occur in late adolescence between the ages of 18-21
and that the college years may be especially important in identity development (Santrock, 1981). According to Costa and McCrae (1989), research suggests that although "the levels of personality traits are very stable in adulthood, there are significant changes between adolescence and early adulthood" (pg. 43). Older individuals tend to be "slightly lower on neuroticism, extraversion and openness and slightly higher on agreeableness and conscientiousness than younger individuals, precisely the differences seen between adults as a whole and college students" (pg. 55). Thus, the personality characteristics exhibited now by these younger participants may not necessarily be representative of what they would believe in later adulthood. Therefore, some caution must be taken when making any long-term predictions regarding younger participants personality differences.

Furthermore, the sample embodied a relatively healthy population. In order to obtain a more accurate profile of individuals who would be receptive to the idea of hospice care, it would be interesting to conduct this study with older individuals who hold more established views and/or with individuals who exhibit serious health problems or who are in the active stages of terminal illness. Hence, the present findings can only be considered valid for this particular sample.

Third, the criterion measure employed in this study also needs to be scrutinized. The self-constructed measure,
Attitudes Toward Hospice Care Scale, was designed to assess attitudes toward the prospective use of hospice care. It was a brief, 15 item measure that was found upon further investigation to be a multi-dimensional questionnaire, suggesting that attitudes toward hospice care are not unidimensional but multi-faceted. Internal consistencies for each of the three emerging factors ranged from .71 (Preference for Quality of Life), .62 (Attitudes Toward Hospice) and .56 (Desire for Home Care). These values are considered to be acceptable for research purposes. The true value of a measure lies in its ability to show meaningful relations to external criteria. Some evidence for construct validity for the ATHC Scale was found. For example, the Preference for Quality of Life factor was found to be negatively correlated with the powerful others subscale of the Multidimensional Health Locus of Control Scale.

Administration of this scale to other populations is necessary to determine whether the factors of the ATHC Scale remain stable and are predictive of other relationships in the health care field. Specifically, future research should be conducted to investigate whether or not scores on the ATHC Scale correlate with other terminally ill related concepts such as assisted suicide. As one participant (#088) stated, "The idea of prolonging life through medical intervention bothers me. I believe that if someone is terminally ill they should be allowed to die on
their own terms, when and how they want". Overall, the self-constructed ATHC Scale was psychometrically sound.

An area of concern with the ATHC Scale, however, was social desirability. In the self-report component of the questionnaire, the bulk of respondents, even those who initially stated that they were unfamiliar with the concept of hospice, stated that hospice, "is a great idea" (participant #025), "is a moral service" (participant #005) and "is a definite need for our society" (participant #086). This willingness to been seen as "pro-hospice" may have served to skew the relationship between how the participants wanted to be seen and their actual beliefs on the topic of hospice care.

Finally, hospice care programs themselves have inherent limitations. Hospice programs care for only a percentage of terminally ill individuals, that is those individuals who find hospice's goals compatible with their own (Muzzin, et al., 1994). In addition, patients with terminal diseases other than cancer or AIDS, such as the severely demented and the extremely aged suffering from multiple, overlapping chronic conditions are generally excluded from hospice care (Logue, 1994). However, the shortcomings of hospice care are more intractable than sheer insufficiency of numbers (Logue, 1994). The general public continues to be skeptical regarding the convictions of hospice and what hospice care can provide for dying individuals (Burucoa, 1993; Roy,
1992). It was not uncommon to see the following sentiments in several participants' statements: "I think hospice care is a complete waste of time...people should not have to wait to die in some place" (#144); "I believe that people should know more about hospice care as too many people relate hospice to death and dying instead of living and peace" (#125); "Living in an atmosphere of death and dying I imagine would be very depressing" (#074). Given these comments, it is not too surprising to see why some individuals may be reluctant to seek out hospice services. Future research in the area of hospice care should focus on implementing awareness campaigns aimed at dissociating hospice with the very publicized euthanasia movement and at increasing knowledge about, and the efficacy of, hospice care. Enunciated by one respondent (#138), "I would go use hospice if I were diagnosed with a terminal illness...I would want to receive information and strategies that enable me to feel empowered". Establishing death education and hospice information programs (via seminars, media or print strategies) would hopefully reduce the suspicion that still seems to surround hospice.

Since its outset and throughout its development, hospice has confronted society's assumptions regarding the care of our terminally ill. The past two decades have been an exciting time for the progress of hospice programs. Hospice as a tool for improving the care of the dying has
been substantiated in the lives of many individuals (Mount, 1994). In fact, several studies attest to the ability of hospice to meet the physical, and psychosocial needs of the terminally ill.

This study advances that it is possible to identify certain individuals who possess specific characteristics (i.e., being female, responsible for one's own health and conscientious) which enable them to hold positive attitudes toward the prospective use of hospice care. These traits may indicate a type of person who is resourceful, seeking to use all means available to maintain a standard of optimal living in the face of terminal disease. Such persons may be more receptive to persuasive communications regarding alternative treatments consistent with their own health beliefs.

Thus, establishing a profile of an individual who is more likely to employ hospice services is justified for two reasons. First, it allows hospice providers a fuller understanding of individuals who want to use their services and why. Second, such a profile may make it possible to identify potential future hospice patients who would be more apt to benefit from intervention programs or who are in need of more intensive efforts and attention from health care providers in coming to terms with the end of their lives. As one participant (#079) so aptly commented, "just because
they [terminally ill patients] are going to die, doesn't mean that they are dead already...and should be able to do so in an environment that is comforting and supportive". 
REFERENCES


APPENDIX A

CONSENT FORM
Consent Form

This study is designed to investigate attitudes toward the prospective use of hospice care. This study is being conducted as a requirement for a Master's Thesis in psychology. For this study you will be asked to complete several brief questionnaires which should take approximately 45 minutes of your time. If you are currently a psychology student, you will receive one experimental bonus point for your participation.

Your participation in this investigation is completely voluntary and you are free to withdraw from participating in the study at any time without penalty. At no time will your identity (e.g., name or student number) be reported with your results. All results will be added to those of other participants and reported in group form to ensure your confidentiality.

This research has been approved by the University of Windsor's Ethics Committee. If you have any concerns or questions about the research, you may contact Dr. Doug Shore, Chair of the Psychology Department's Ethics Committee (253-3000 ext. 2217) or the principal investigator Tracy Little (253-4232 ext. 2220).

After you have participated in the study, the researcher will discuss the study further with you. At a later date, if you are interested, the researcher will inform you of the final results.

Please sign the Consent Form at the bottom of this page, detach it, and return it to the researcher immediately prior to your participation. You may retain the top portion for your records.

Thank you for your participation.

Consent Form

I have read the above Informed Consent information regarding the study about attitudes toward the prospective use of hospice services. I understand the information provided and am aware that the information I give will be kept completely confidential. I give my consent to participate with my signature below. My signature also acknowledges that I have been provided with a copy of the Informed Consent information.

Name (print) ___________________________ Date ___________________________

Signature ___________________________
APPENDIX B

INSTRUCTION SHEET
Instruction Sheet

This research is designed to investigate the relationship between personality styles and attitudes toward the prospective use of hospice care. You have been provided with a package containing several brief measures. Please read the instructions for each new measure carefully as the scales for each questionnaire may differ. Remember that all your responses will be kept strictly confidential and that there are no "right" or "wrong" answers, so please respond to the statements as honestly as possible.

For your reference, a brief definition of hospice is provided below:

hospice[-is] n. obs. a facility or program designed to provide an environment for supplying physical and emotional needs of the terminally ill.

If you have any questions at this point please let the researcher know, if you do not, turn the page and begin.
APPENDIX C

BACKGROUND INFORMATION FORM
Background Information Form

**DIRECTIONS:** Please answer the following questions by circling the number in front of the answer that best describes you or by filling in the blank where appropriate. All responses will be kept completely confidential.

1. What is your gender?
   (1) MALE
   (2) FEMALE

2. What is your age? ________________

3. What is your race/ethnic background?
   (1) WHITE
   (2) AFRICAN AMERICAN/AFRICAN CANADIAN
   (3) ASIAN
   (4) HISPANIC
   (5) NATIVE
   (6) OTHER (specify) ____________________

4. What is your religious affiliation?
   (1) ROMAN CATHOLIC
   (2) PROTESTANT
   (3) CHRISTIAN - NO DENOMINATION
   (4) JEWISH
   (5) ISLAMIC
   (6) HINDU
   (7) AGNOSTIC/ATHEIST
   (8) NONE
   (9) OTHER (specify) ____________________

5. Do you consider yourself to be a religious person?
   (1) NOT AT ALL RELIGIOUS
   (2) NOT VERY RELIGIOUS
   (3) MODERATELY RELIGIOUS
   (4) VERY RELIGIOUS
   (5) OTHER (specify) ____________________

6. Do you believe in a Higher Power or Supreme Being?
   (1) YES
   (2) NO
   (3) OTHER (specify) ____________________
APPENDIX D

MULTIDIMENSIONAL HEALTH LOCUS OF CONTROL SCALE
(FORM A)
Multidimensional Health Locus of Control Scale (Form A)

DIRECTIONS: Please read each statement carefully. For each statement circle the appropriate letter that best represents your response.

SA = STRONGLY AGREE
A = AGREE
AM = AGREE MORE than DISAGREE
DM = DISAGREE MORE than AGREE
D = DISAGREE
SD = STRONGLY DISAGREE

1. If I get sick, it is my own behaviour which determined how soon I get well again.
   SD D DM AM A SA

2. No matter what I do, if I am going to get sick, I will get sick.
   SD D DM AM A SA

3. Having regular contact with my physician is the best way for me to avoid illness.
   SD D DM AM A SA

4. Most things that affect my health happen to me by accident.
   SD D DM AM A SA

5. Whenever I don't feel well, I should consult a medically trained professional.
   SD D DM AM A SA

6. I am in control of my health.
   SD D DM AM A SA

7. My family has a lot to do with my becoming sick or staying healthy.
   SD D DM AM A SA

8. When I get sick I am to blame.
   SD D DM AM A SA

9. Luck plays a big part in determining how soon I will recover from an illness.
   SD D DM AM A SA

10. Health professionals control my health.
    SD D DM AM A SA

11. My good health is largely a matter of good fortune.
    SD D DM AM A SA

12. The main thing which affects my health is what I myself do.
    SD D DM AM A SA

13. If I take care of myself, I can avoid illness.
    SD D DM AM A SA

14. When I recover from an illness, it's usually because other people (for example, doctors, nurses, family, friends) have been taking good care of me.
    SD D DM AM A SA

15. No matter what I do I'm likely to get sick.
    SD D DM AM A SA

16. If it's meant to be, I will stay healthy.
    SD D DM AM A SA

17. If I take the right actions, I can stay healthy.
    SD D DM AM A SA

18. Regarding my health, I can only do what my doctor tells me to do.
    SD D DM AM A SA
APPENDIX E

MULTIDIMENSIONAL HEALTH LOCUS OF CONTROL SCALE
(FORM B)
Multidimensional Health Locus of Control Scale (Form B)

**DIRECTIONS:** Please read each statement carefully. For each statement circle the appropriate letter that best represents your response.

SA = STRONGLY AGREE
A = AGREE
AM = AGREE MORE than DISAGREE
DM = DISAGREE MORE than AGREE
D = DISAGREE
SD = STRONGLY DISAGREE

1. If I become sick, I have the power to make myself well again. **SD D DM AM A SA**

2. Often I feel that no matter what I do, if I am going to get sick, I will get sick. **SD D DM AM A SA**

3. If I see an excellent doctor regularly, I am less likely to have health problems. **SD D DM AM A SA**

4. It seems that my health is greatly influenced by accidental happenings. **SD D DM AM A SA**

5. I can only maintain my health by consulting health professionals **SD D DM AM A SA**

6. I am directly responsible for my health. **SD D DM AM A SA**

7. Other people play a big part in whether I stay healthy or become sick. **SD D DM AM A SA**

8. Whatever goes wrong with my health is my own fault. **SD D DM AM A SA**

9. When I am sick, I just have to let nature run its course. **SD D DM AM A SA**

10. Health professionals keep me healthy. **SD D DM AM A SA**

11. When I stay healthy, I'm just plain lucky. **SD D DM AM A SA**

12. My physical well-being depends on how well I take care of myself. **SD D DM AM A SA**

13. When I feel ill, I know it is because I have not been taking care of myself properly. **SD D DM AM A SA**

14. The type of care I receive from other people is what is responsible for how well I recover from an illness. **SD D DM AM A SA**

15. Even when I take care of myself, it's easy to get sick. **SD D DM AM A SA**

16. When I become ill, it's a matter of fate. **SD D DM AM A SA**

17. I can pretty much stay healthy by taking good care of myself. **SD D DM AM A SA**

18. Following doctor's orders to the letter is the best way for me to stay healthy. **SD D DM AM A SA**
APPENDIX F

NEO FIVE-FACTOR INVENTORY
NEO Five-Factor Inventory

**DIRECTIONS:** Read each statement carefully. For each statement circle the response that best represents your opinion at this time. Circle only one response for each statement. There are no right or wrong answers and you need not be an "expert" to complete this questionnaire. Please describe yourself honestly and state your opinions as accurately as possible.

**SA** = if you STRONGLY AGREE  
**A** = if you AGREE  
**N** = if you are NEUTRAL or CANNOT DECIDE  
**D** = if you DISAGREE  
**SD** = if you STRONGLY DISAGREE

1. I am not a worrier.  
2. I like to have a lot of people around me.  
3. I don't like to waste my time daydreaming.  
4. I try to be courteous to everyone I meet.  
5. I keep my belongings clean and neat.  
6. I often feel inferior to others.  
7. I laugh easily.  
8. Once I find the right way to do something, I stick with it.  
9. I often get into arguments with my family and co-workers.  
10. I'm pretty good about pacing myself so as to get things done on time.  
11. When I'm under a great deal of stress, sometimes I feel like I'm going to pieces.  
12. I don't consider myself especially "light-hearted".  
13. I am intrigued by the patterns I find in art and nature.  
14. Some people think I'm selfish and egotistical.  
15. I am not a very methodical person.  
16. I rarely feel lonely or blue.  
17. I really enjoy talking to people.  
18. I believe lecturing students near controversial speakers can only confuse and mislead them.  
19. I would rather cooperate with others than compete with them.  
20. I try to perform all the tasks assigned to me conscientiously.  
21. I often feel tense and jittery.  
22. I like to be where the action is.  
23. Poetry has little or no effect on me.  
24. I tend to be cynical and skeptical of others' intentions.  
25. I have a clear set of goals and work toward them in an orderly fashion.
26. Sometimes I feel completely worthless.  
27. I usually prefer to do things alone.  
28. I often try new and foreign foods.  
29. I believe that most people will take advantage of you if you let them.  
30. I waste a lot of time before settling down to work.  
31. I rarely feel fearful or anxious.  
32. I often feel as if I'm bursting with energy.  
33. I seldom notice the moods or feelings that different environments produce.  
34. Most people I know like me.  
35. I work hard to accomplish my goals.  
36. I often get angry at the way people treat me.  
37. I am a cheerful, high-spirited person.  
38. I believe we should look to our religious authorities for decisions on moral issues.  
39. Some people think of me as cold and calculating.  
40. When I make a commitment, I can always be counted on to follow through.  
41. Too often, when things go wrong, I get discouraged and feel like giving up.  
42. I am not a cheerful optimist.  
43. Sometimes when I am reading poetry or looking at a work of art, I feel a chill or wave of excitement.  
44. I'm hard-headed and tough-minded in my attitudes.  
45. Sometimes I'm not as dependable or reliable as I should be.  
46. I am seldom sad or depressed.  
47. My life is fast-paced.  
48. I have little interest in speculating on the nature of the universe or the human condition.  
49. I generally try to be thoughtful and considerate.  
50. I am a productive person who always gets the job done.  
51. I often feel helpless and want someone else to solve my problems.  
52. I am a very active person.  
53. I have a lot of intellectual curiosity.  
54. If I don't like people, I let them know it.  
55. I never seem to be able to get organized.  
56. At times I have been so ashamed I just wanted to hide.  
57. I would rather go my own way than be a leader of others.  
58. I often enjoy playing with theories or abstract ideas.  
59. If necessary, I am willing to manipulate people to get what I want.  
60. I strive for excellence in everything I do.
APPENDIX G

DEATH ANXIETY SCALE
Death Anxiety Scale

DIRECTIONS: Read each statement carefully. For each statement circle either TRUE or FALSE to best represent your feelings at this time. Circle only one response for each statement. There are no right or wrong answers so please try to describe your opinions as honesty as possible.

1. I am very much afraid to die.   TRUE   FALSE
2. The thought of death seldom enters my mind.   TRUE   FALSE
3. It doesn't make me nervous when people talk about death.   TRUE   FALSE
4. I dread to think about having to have an operation.   TRUE   FALSE
5. I am not at all afraid to die.   TRUE   FALSE
6. I am not particularly afraid of getting cancer.   TRUE   FALSE
7. The thought of death never bothers me.   TRUE   FALSE
8. I am often distressed by the way time flies so very rapidly.   TRUE   FALSE
9. I fear dying a painful death.   TRUE   FALSE
10. The subject of life after death troubles me greatly.   TRUE   FALSE
11. I am really scared of having a heart attack.   TRUE   FALSE
12. I often think about how short life really is.   TRUE   FALSE
13. I shudder when I hear people talking about a World War III.   TRUE   FALSE
14. The sight of a dead body is horrifying to me.   TRUE   FALSE
15. I feel that the future holds nothing for me to fear.   TRUE   FALSE
APPENDIX H

SATISFACTION WITH LIFE SCALE
Satisfaction with Life Scale

**DIRECTIONS:** Below are five statements with which you may agree or disagree. Using the scale provided below, indicate your agreement with each item by placing the appropriate number on the line preceding that particular item. Please be open and honest in your responding.

1 = **STRONGLY DISAGREE**
2 = DISAGREE
3 = SLIGHTLY DISAGREE
4 = NEITHER AGREE NOR DISAGREE
5 = SLIGHTLY AGREE
6 = AGREE
7 = **STRONGLY AGREE**

______ 1. In most ways my life is close to my ideal.
______ 2. The conditions of my life are excellent.
______ 3. I am satisfied with my life.
______ 4. So far, I have gotten the important things I want in life.
______ 5. If I could live my life over, I would change almost nothing.
APPENDIX I

ATTITUDES TOWARD HOSPICE CARE SCALE
Attitudes Toward Hospice Care Scale

DIRECTIONS: This questionnaire is designed to investigate individuals' views toward hospice care as prospective patients. It should be noted that there are no "right" or "wrong" answers, so try to be as honest as possible with your answers.

PART I

In the space provided below, please describe your thoughts about and/or your reactions to the idea of hospice care.

hospice[-is] n. obs. a facility or program designed to provide an environment for supplying physical and emotional needs of the terminally ill.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

If you require additional space, please use the reverse side of this page.
PART II DIRECTIONS: Please read each of the following statements carefully. For each statement, circle the response that best represents your opinion at this time according to the scale below. Circle only one response for each item. Please describe your opinions as honestly and accurately as possible.

SA = if you STRONGLY AGREE
A = if you AGREE
AM = if you AGREE MORE than DISAGREE
DM = if you DISAGREE MORE than AGREE
D = if you DISAGREE
SD = if you STRONGLY DISAGREE

1. I am glad when people drop by to visit me when I am at home. SA A AM DM D SD

2. I think death should be avoided at all costs. SA A AM DM D SD

3. If I was very sick, I would rather be in a hospital than be a burden to my family at home. SA A AM DM D SD

4. I believe that hospice care is similar to euthanasia. SA A AM DM D SD

5. I feel fortunate to have programs like hospice that are cost effective. SA A AM DM D SD

6. I would rather live as long as possible under any circumstance than to die. SA A AM DM D SD

7. I would choose hospice care if I had a terminal illness. SA A AM DM D SD

8. I think that people have the right to die with dignity. SA A AM DM D SD

9. I feel uncomfortable with hospices as they are places that deal only with death. SA A AM DM D SD

10. I am grateful to have a close family member who would be willing to help me stay at home if I became terminally ill. SA A AM DM D SD

11. I would not want to receive intensive medical interventions in the final weeks of my life. SA A AM DM D SD

12. I believe that hospices are places where people go to die. SA A AM DM D SD

13. I would want every effort to be made to preserve my life. SA A AM DM D SD

14. If I was terminally ill I would be angry if my doctor did not tell me the truth about my condition. SA A AM DM D SD

15. When the time comes, I think I would rather die in my own home than in a hospital. SA A AM DM D SD
APPENDIX J

PARTICIPANT RECRUITMENT SCRIPT
Participant Pool Recruitment Script

Hello, (insert individual's name)? My name is Tracy Little. I am a graduate student at the University of Windsor and I received your name from the psychology participant pool that you registered for earlier in the semester.

I am currently conducting research for my Master's Thesis on attitudes toward the prospective use of hospice care. If you would like to participate in this project you would be required to complete several brief questionnaires that should take approximately 45 minutes of your time. For your participation in this study you would receive one bonus mark. Would you be interested in participating?
APPENDIX K

DEBRIEFING STATEMENT
Debriefing Statement

As previously indicated to you, this research was concerned with investigating attitudes toward the prospective use of hospice care.

Earlier research has concentrated mainly on describing and evaluating hospice care from the perspectives of patients, caregivers and medical professionals, while little attention has been devoted to the attitudes of the general public. Such research has indicated that the "hospice concept" is viewed very favourably, however, statistical evidence indicates that hospice care programs are greatly under-utilized.

The purpose in conducting this study is to explore this discrepancy and it is hoped that the perspectives toward hospice care which emerge from this investigation can be used to determine why people choose or resist in choosing hospice care if they become terminally ill and how the public may be better educated in order to encourage use of hospice services by those for whom it is appropriate. Before individuals become dying patients, people need to learn that hospice is a kind of medical care which they may someday choose for themselves. The choice between alternative modes of care will be much more difficult if the patient has never heard of a hospice program prior to becoming terminally ill. In addition, hospice education can prepare family members, friends, counsellors and others to help a dying individual to make a more informed life choice.

I thank you for your participation in this research project. If you have any questions or concerns about the study, please feel free to contact myself through the University of Windsor, Psychology Department (253-4232, ext. 2220) or my research advisor, Dr. Kathryn Lafreniere (253-4232, ext. 2233).
VITA AUCTORIS

Tracy A. Little (nee Tattrie) was born in 1963 in Hamilton, Ontario. She graduated from the University of Western, Ontario in 1986 where she obtained a Bachelor of Arts degree in Business Administration. Upon re-evaluation of her career choice, she returned to school at the University of Windsor where she graduated with a B.A. (Honours) degree in Psychology in 1995. Currently, she is enrolled in the Applied Social Psychology doctoral program at the University of Windsor.