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Relationships among exposure to death, death anxiety and repression in hospice workers.

Brenda L. McLister
University of Windsor

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THIS DISSERTATION HAS BEEN MICROFILMED EXACTLY AS RECEIVED
RELATIONSHIPS AMONG EXPOSURE TO DEATH,
DEATH ANXIETY AND REPRESSION IN HOSPICE WORKERS

by

Brenda L. McLister

HONS. B.A. University of Windsor, 1979

A Thesis
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ABSTRACT

The hypothesis of the present study was that death anxiety would tend to decrease with increasing exposure to death, and that this decrease in death anxiety would not be accompanied by an increase in repression. One hundred and five questionnaires were mailed to the staff of the Hospice of Windsor, and 59 hospice workers responded. A demographic questionnaire was used to obtain information regarding participants' exposure to death through hospice work and personal experience. Death anxiety was measured using the Templer/McMordie version of the Death Anxiety Scale (McMordie, 1979). The Reversal scale of the Defense Mechanism Inventory (Gleser and Ihilevich, 1969) was used as a measure of repression. The results of a Pearson product-moment analysis indicated a significant negative correlation between DAS scores and time since most recent experience with death (r = -.26, p < .05), and Reversal scores were not correlated with time since most recent experience with death. This finding was considered to provide some support for the hypothesis of the present study. It was also found that DAS scores were significantly negatively correlated with Reversal scores (r = -.40, p < .001), and Reversal scores were significantly correlated with time spent working with hospice patient/families (r = .27, p < .05). The implications of the results and directions for future research were discussed.
ACKNOWLEDGEMENTS

I would like to express my appreciation to my committee members, Dr. C. J. Holland and Dr. J. C. Hoffman, for their advice during the development of this project, and to my chairman, Dr. W. D. Balance, upon whom I could also count for patience and support during the difficult times. I would also like to thank Jane Boyd, Executive Director, and Carol Derbyshire, Volunteer Coordinator, and the other staff members of the Hospice of Windsor for their time and interest in participating in this project.
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CHAPTER I

INTRODUCTION

Fear of death is generally considered to be "a pervasive and paramount" human reaction (Feifel and Branscomb, 1973, pg. 282). Denial in defense against this fear is so common that it is characteristic at least of North American culture (Feifel, 1959; Kübler-Ross, 1969). Fear and avoidance of death can be adaptive responses that increase the probability of survival, but denial of death is unrealistic if not detrimental. Some authors suggest that denial of death results in impoverished intensity of living (Freud, 1915; Feifel, 1959). Others have reported relationships between fear of death and psychopathology (Templer, 1970; Templer, 1971a; Templer, 1972; Gielen and Roche, 1979-80; Pollak, 1979-80).

It would be of interest, therefore, to understand how people struggle to come to terms with the fear of death and the fact of mortality.

The hospice movement is a reaction against widespread denial of death. Hospice is an approach to palliative care that emphasizes maximizing the quality of living and accepting death when it comes; however painful the associated loss, as a natural life experience. Through their work and their philosophy, hospice workers confront death.

Exposure to death has been cited as a source of stress and anxiety (Freud, 1915; Kasper, 1959; Benoliel, 1977; Beszterczey,
1977; Garfield, 1977; White, 1977; Shanfield, 1978; Evans, Esbenson, and Jaffe, 1981) and has also been investigated as a means for resolving anxiety associated with death. The present study is an investigation of the relationships among hospice workers' exposure to death, death anxiety, and use of repression.

This investigation will begin with a brief historical perspective of the hospice movement in general and the Hospice of Windsor in particular. The Hospice of Windsor participated in the present study.

In order to develop the rationale and hypotheses for the present study, theoretical developments and empirical data will be reviewed with regard to: the anxiety/defense model as a framework for conceptualizing reactions to death; models developed to describe the process of working through death anxiety; the relationship between death anxiety and exposure to death associated with age, illness, bereavement, health care professions, and participation in death education programs.

In the present study, seven measures of the participants' exposure to death were considered: age, length of time since completing the hospice death education program, total number of hospice patient/families seen, number of patient/families seen in the previous four weeks, total hours spent doing hospice work in the previous four weeks, hours spent with hospice patient/families in the previous four weeks, and time since most recent experience
Conscious death anxiety was measured by the Death Anxiety Scale developed by Templer (1970), and denial and repression were measured by the Defense Mechanism Inventory developed by Gleser and Ihilevich (1969) and were considered as indications of adjustment to death.

The results of the present study could have practical implications for the hospice regarding the recruiting and training of workers. It was also hoped that the information obtained would provide some clues for developing an understanding of how people cope with the fear of death.

**Hospice: A Historical Perspective**

Hospices and hospitals have the same historic origins. Early hospice/hospitals provided shelter and care for the sick and for travellers (Cohen, 1979). These facilities were generally associated with religious orders (Cohen, 1979; Mueller, 1981; Samarin, 1981). The earliest documented hospice/hospital is estimated to have been operating in Greece in 1134 BC (Cohen, 1979). The nature and function of the hospice/hospitals varied over time depending on the social context (Samarin, 1981), and during the seventeenth and eighteenth centuries, the development of hospices and hospitals diverged. Hospitals became predominant and although hospices continued to exist, they were relatively obscure.

In the early nineteen hundreds, hospitals were for surgical
patients, patients with communicable diseases, and the poor. Most patients were not in hospitals. Physicians saw them in their homes where they were cared for by their families. Advances in medical technology during the first and second World Wars resulted in a shift in the concept of patient care, and hospitals became the acute care facilities they are today (Brown, 1978).

The emphasis of medical training (Skelton, 1982) and practice (White, 1977) is on technical effectiveness in prevention and cure of disease. Hospitals are designed to provide efficient treatment of physical symptoms (Rossman, 1977). For acutely ill patients, the benefits of increased curative effectiveness outweigh the disadvantages of more impersonal modern health care; but for the patient for whom no cure is yet available—the chronically and terminally ill—modern health care facilities often provide a prolonged but impoverished and dehumanizing existence since the needs of the chronically and terminally ill are inconsistent with the objectives of these acute care facilities (Rossman, 1977; Brown, 1978; Cohen, 1979; Goldenberg, 1979; DuBois, 1980).

Some authors have suggested that technical effectiveness supports the cultural tendency to deny death (Kubler-Ross, 1969; DuBois, 1980). Health care professionals may view terminally ill patients as both a personal threat, reminding them of their own mortality, and a professional failure (Kasper, 1959; White, 1977; Skelton, 1982). Kasper (1959) suggested that people who are
conscious of their anxiety about death avoid the medical profession.

It is widely believed, however, that in order to work effectively with terminally ill patients, professionals must stop denying and work through their feelings about personal mortality (Beszterczey, 1977; Garfield, 1977; Weisman, 1977; Shanfield, 1978; DuBois, 1980).

The modern hospice movement is an effort to make adequate health care services available to terminally ill patients. Dr. Cicely Saunders founded St. Christopher's Hospice in England in 1967 and is credited with beginning the modern hospice movement. Hospice refers to a philosophy of palliative care, rather than a particular type of facility, that emphasizes: symptom control, especially pain from degenerative diseases; patient/family as unit of care; an interdisciplinary approach to care that considers the social, emotional, and spiritual, as well as the strictly medical, needs of the patients (Rossman, 1977; Cohen, 1979). The goal of hospice programs is to help patients live the rest of their lives as meaningfully and comfortably as possible (Guthrie, 1979; Mueller, 1981).

The Hospice of Windsor

Canon Paul Chidwick became interested in the hospice movement as he was studying the issue of euthanasia. He felt that the more adequate care provided by hospice programs could in most cases relieve the problems that lead to consideration of euthanasia as
alternative. Canon Chidwick initiated the development of the Hospice of Windsor, which has provided services to the community since January 1980 (Samarin, 1981).

The Hospice of Windsor is a free-standing hospice, funded by the community, affiliated with Metropolitan Hospital. Services are available to patients both in hospital and in their homes. The Hospice of Windsor staff of over 100 is composed almost entirely of volunteer workers.

Hospice workers are required to participate in a death education program that deals with the dying process and needs of the terminally ill, examination of personal attitudes toward death, and ways to work effectively with the terminally ill. A detailed outline of this death education program is included in Appendix A.

Following the death education program, prospective hospice workers attend a personal screening interview for assessment of specific personal qualities to determine their suitability for various duties of hospice workers. Appendix B includes a list of some types of duties hospice workers engage in. The screening interview and death education program, particularly the examination of personal attitudes toward death, indicate that the Hospice of Windsor staff also believe that certain qualities and attitudes toward death are important factors affecting effectiveness in working with the terminally ill.
The Anxiety/Defense Model of Death Anxiety

According to the anxiety/defense model, fears and defenses against those fears are the basis of important personality structures. In a review of major theoretical models of death anxiety, Stolorow (1973) reported that there is agreement on the efficacy of the anxiety/defense model as an explanation of human reactions to death, and that these theories differ only with respect to whether death anxiety is considered to be a primary or secondary anxiety. Empirical evidence suggests that death anxiety is correlated with but distinct from state and trait general anxiety (Lucas, 1974; Patton and Freitag, 1977; Smith, 1977; Pollak, 1979-80; Hoelter and Hoelter, 1980-81).

The anxiety/defense model is generally used in empirical studies of death anxiety, however, it is usually given as a post hoc explanation of findings, which has resulted in inconsistent interpretations of data while failing to test the underlying assumptions of the model (Handal and Rychlak, 1971). For example, low death anxiety scores have been considered to reflect either lack of death anxiety or high repressed death anxiety. Both interpretations may be correct in some cases, but it is impossible to make this discrimination on the basis of death anxiety scores alone. Most death anxiety measures tap conscious death anxiety. Since this is the case, "death anxiety" will be used to denote conscious death anxiety unless otherwise specified. In order to
interpret results in terms of the anxiety/defense model, it is necessary to also consider some measure of defenses or repression. The relationship between conscious and unconscious reactions to death is as yet unclear (Pollak, 1979-80). A number of investigators have attempted to clarify this relationship.

Feifel and Branscomb (1973) reported an overall tendency for people to deny conscious death anxiety, while measures of unconscious reactions to death related material indicated a strong aversion. These findings are consistent with the suggestion of Feifel (1959), Freud (1915), Köbler-Ross (1969), and Beszterczey (1977) that people are inclined to deny the painful awareness of mortality.

Some researchers have found evidence of a negative correlation between death anxiety and repression (Tolor and Reznikoff, 1967; Handal and Rychlak, 1971; Handal, 1975). Handal (1975) has suggested that death anxiety scores are therefore an acceptable measure of repression. Other data are inconsistent with such a simple inverse relationship between death anxiety and repression.

In Feifel and Branscomb's (1973) study, a small subgroup deviated from this pattern: out of a sample of 371 subjects, six had consistently low scores and 19 had consistently high scores on measures of both conscious and unconscious death anxiety. Golding, Atwood, and Goodman (1966) and Fleming (1977) found that subjects generally had higher recognition thresholds for death
related than for "neutral" words, suggesting that death related words have high emotional content, but recognition thresholds did not differentiate between subjects with high and low death anxiety scores.

Handal and Rychlak (1971) predicted that subjects with high and low death anxiety scores would be similar in that they would demonstrate more unconscious preoccupation with death than subjects with moderate death anxiety scores. Unpleasant and death dream content was considered as a measure of unconscious preoccupation with death. This hypothesis was supported. There was, however, a subgroup of subjects within both the high and low death anxiety groups that did not report more death dream content than the moderately death anxious group.

In general, two different types of measures of unconscious death anxiety have been used. One type measures unconscious reactions to death, i.e., word association test, colour-word interference test (Feifel and Branscomb, 1973), recognition threshold (Golding, Atwood, and Goodman, 1966; Fleming, 1977), and dream content (Handal and Rychlak, 1971). The other type specifically measures use of repression, i.e., the Repression-Sensitization scale (Tolor and Reznikoff, 1967; Handal and Rychlak, 1971), and the Reversal scale of the Defense Mechanism Inventory (Handal, 1975). That these two measures are distinct is supported by the results of a study of Templer (1971b) comparing death anxiety
scores, GSR responses to death related material, and Repression-
Sensitization scores. Repression-Sensitization scores and GSR
responses were not correlated, and Templer (1971b) concluded that
autonomically detected death anxiety is independent from and not a
measure of repressed death anxiety.

Templer (1971b) proposed that as death anxiety is increasingly
conscious and reported, the strength of autonomic responses to
death decrease. This author disagrees with this formulation. To
the extent that death anxiety is conscious, it is not unconscious,
not repressed. In the absence of repression, it seems reasonable
to expect that reactions to death would be consistent. For example,
scores on measures of conscious death anxiety would be positively
correlated with scores on measures of less consciously controlled
death anxiety, such as GSR response, word association test, colour-
word interference test, recognition threshold, and dream content,
and not negatively correlated as Templer (1971b) predicts. A
discrepancy between conscious and less consciously controlled
indications of death anxiety implies defensiveness or repression
but does not directly assess this. Given this consideration, the
research results suggest the following conclusions.

The findings of Feifel and Branscomb (1973) suggest an overall
aversion to the thought of death, and those of Golding, Atwood,
and Goodman (1966) and Fleming (1977) support the idea that death related
material is highly emotionally toned. Studies that report a
negative correlation between death anxiety and repression, suggesting that death anxiety tends to increase to the extent that it is not repressed, support this also.

There may be a general tendency to repress awareness of death anxiety (Feifel and Branscomb, 1973), but death anxiety and repression appear to be independent, since every possible combination of scores has been reported. In a highly selected population such as hospice workers, the distribution may differ from the general population. For example, if there is a high frequency of hospice workers with low death anxiety scores and low repression scores, death anxiety and repression would not be negatively correlated as in other populations. It is important to consider both variables and not infer one from the other.

People are not invariably fearful of death. Feifel and Branscomb (1973) and Handal and Rychlak (1971) reported small subgroups of subjects with both low death anxiety scores and low unconscious aversion or low repression, respectively. This suggests that it may be possible to resolve death anxiety.

Models of Resolution of Death Anxiety

Several models have been proposed to describe the working through of death anxiety. These are based on the anxiety/defense model. They begin with the premise that awareness of death is repressed until defenses are weakened, i.e., as concerns the present study, through exposure to death.
The best known of these models was described by Kübler-Ross (1969) supported by her observations of the reactions of terminally ill patients. She proposed that these patients progress through five stages in coming to terms with the idea of personal death: denial, anger, bargaining, depression, and acceptance.

A similar model has been proposed by Leviton (1975) who studied the reactions of college students participating in death education courses. Leviton described a five stage progression: shock, denial, anger, depression; and synthesis.

Both of these models are described in terms of abstract concepts that are difficult to operationalize. Bailis and Kennedy (1977) outlined a three stage model to describe the working through of death anxiety in terms of the relationship between conscious death anxiety and repression, and this model is consistent with the reactions observed by both Kübler-Ross (1969) and Leviton (1975). They proposed that initial exposure to death results in increased death anxiety and bolstering of repression to combat this anxiety. In the second stage, defense mechanisms are examined and discarded. In the third stage, anxieties are confronted and resolved. Bailis and Kennedy compare this to the process of psychotherapy and the working through of any type of anxiety. This model lends itself most readily to empirical investigation. Standardized measures of death anxiety and repression are available, and the model predicts specific relationships among these variables and exposure to death.
Death Anxiety and Exposure to Death

Age

Death is associated with older age groups and it has been suggested that age may be a factor affecting subjective proximity to personal death. Increasing age is also associated with greater life experience, including the deaths of friends and family members.

Across a wide variety of age groups, it has often been reported that there is no significant correlation between death anxiety and age (Pollak, 1979-80). Feifel and Branscomb (1973) reported a negative correlation between age and death anxiety, but a positive correlation between age and unconscious aversion to death, and concluded that subjective proximity to personal death lead to increased repression of death anxiety.

In studies of the aged, a negative correlation was reported between age and death anxiety (Patton and Freitag, 1977; Nehrke, Bellucci, and Gabriel, 1977-78). These findings, however, were confounded with type of residence. Nursing home residents had lower death anxiety scores than community residents. It was suggested that lower death anxiety could be the result of decreased purpose in life and poor health. Age segregated residents, however, may have more contact with sickness and death and may be more desensitized (Nehrke, Bellucci, and Gabriel, 1977-78).

Physical Illness

It has been consistently reported that death anxiety is not
correlated with physical health (Templer, 1971a; Feifel and Branscomb, 1973; Lucas, 1974; Selby, 1977; Geilen and Roche, 1979-80; Devins, 1980-81), but is correlated with measures of psychological adjustment (Templer, 1971a; Geilen and Roche, 1979-80).

Zuehlke and Watkins (1975) reported a greater increase in death anxiety in terminally ill patients who received psychotherapy than in terminally ill patients who received no psychotherapy. The patients reported that psychotherapy had been a positive experience, however, and that the opportunity to discuss their feeling about death had been appreciated. Kübler-Ross (1969) also reported that many terminally ill patients welcomed an opportunity to discuss their feelings about death.

**Bereavement**

Selby (1977) and Smith (1977) reported no significant correlation between death anxiety and recent death of a friend or relative. Increases in death anxiety following bereavement were, however, reported by Lester and Kam (1971).

Differences have been found between bereaved groups. Hoelter and Hoelter (1980-81) reported that higher death anxiety was correlated with death of a member of immediate family versus death of a more distant relative or friend, however, type of relationship was confounded with recency of death in this study. Patton and Freitag (1977) reported that death anxiety decreased as length
of time since death of a friend or family member increased.

Health Care Professionals

Studies indicate discomfort in health care professionals with respect to terminally ill patients. Personnel avoided directly discussing death (Brown, 1978; Webster, 1981), and this was attributed to lack of training and the fact that talking to patients is not traditionally accepted as appropriate use of staff time. Staff delayed longer and spent less time with terminally ill patients than with patients with a better prognosis (Skelton, 1982).

Beszterczey (1977) cited exposure to death as a source of stress for staff of a palliative care unit. This is supported by the results of a study by Geizhals (1975) finding that ICU nurses had higher death anxiety scores than a control group of occupational therapists.

Death Education

Studies concerning the effects of death education courses on death anxiety have generally predicted that death anxiety would decrease following death education, indicating an improved adjustment to death. Watts (1977) reported a decrease in death anxiety scores following a death education course. The bulk of the data, however, do not support this hypothesis.

Bell (1975), Mueller (1976), Bugen (1978), Bohart and Bergland (1979), and McClam (1980) reported no significant change in death anxiety following death education. Bailis and Kennedy
(1977), Durlak (1978-79), and Wittmaier (1979-80) reported increased death anxiety following death education. A number of possible explanations of these discrepant findings have been suggested.

Since different measures of death anxiety apparently tap different factors contributing to death anxiety, it is possible that death education affects these factors unequally. The studies also involve a variety of approaches to death education, and some may be more effective in reducing death anxiety than others (McClan, 1980).

Other explanations raise questions regarding the nature of death anxiety. Durlak (1978-79) reported that although there was an increase in death anxiety following death education, subjects were judged to have greater acceptance of death. Durlak concluded that death anxiety and acceptance of death are not mutually exclusive. This conclusion is supported by the finding by Wittmaier (1979-80) that subjects showed an increase in death anxiety, yet reported that they would feel more comfortable talking with terminally ill patients than did control subjects. Bugen (1978) concluded that death anxiety is a stable characteristic, and that efforts should be directed to improving coping with death rather than reducing death anxiety.

That a number of studies do report changes in level of death anxiety suggests that it is not a stable characteristic, but there
is support for Bugen's (1978) conclusion that reduction of death anxiety is not necessarily an appropriate goal for death education.

The studies cited do not consider repression in relation to death anxiety. When a change in death anxiety has been observed following death education, it has been observed that death anxiety increases. Acceptance of death may be incompatible with repression rather than death anxiety. Does acceptance of death, removal of repression, require maintained high conscious death anxiety?

Murray (1974) reported that although death anxiety did not decrease immediately following death education, it did decrease during a four week follow-up period. She concluded that it takes time to incorporate the new learning. This is supported by research on bereavement and death anxiety. Since no measure of repression has been used, however, it is impossible to determine whether the decrease in death anxiety is the result of an opportunity to incorporate new learning or an opportunity to repress anxiety.

Hypothesis

The hypothesis of the present study was based on Bailis and Kennedy's model describing the resolution of death anxiety. It was predicted that death anxiety would tend to decrease with increasing exposure to death, and that this decrease in death anxiety would not be accompanied by an increase in repression.

The present study was not intended to determine whether the
relationship among death anxiety, repression, and exposure to
death is the result of change due to exposure to death, self-
selection, or an interaction between exposure and self-selection.
It was intended as a preliminary investigation into the relation-
ships among exposure to death, death anxiety, and repression in order
to determine whether Bailis and Kennedy's model is supported and
to suggest directions for further research.

Research on death anxiety and exposure to death has not
previously included measures of repression. The results suggest
that exposure to death is followed by an initial increase in death
anxiety and a reduction of death anxiety over time. It is uncertain
whether the reduction in death anxiety is related to repression or
resolution of anxiety. It is hoped that the present study will
help to clarify this.
CHAPTER II

METHOD

Participants

The staff of the Hospice of Windsor were asked to participate in the present study. All of the participants had completed the hospice death education program.

Instruments

Demographic Questionnaire

Participants were asked to fill out a brief demographic questionnaire to obtain information regarding their exposure to death, including: age, length of time since completing the hospice death education program, total number of hospice patient/families seen, number of patient/families seen in the previous four weeks, total hours spent doing hospice work in the previous four weeks, hours spent with hospice patient/families in the previous four weeks, and time since most recent experience with death (see Appendix C).

Death Anxiety Scale

Of the numerous measures of death anxiety that have been developed, the Death Anxiety Scale (DAS) developed by Templer (1970) is among the most commonly used and psychometrically adequate (Pollak, 1979-80). The DAS consists of 15 true/false items. The scale items were selected from a pool of rationally derived items. Items were discarded on the basis of failure to meet specified
criteria in ratings of face validity, and results of item analyses to determine internal consistency and item independence.

Reliability coefficients of .83 (Templer, 1970) and .84 (McMordie, 1979) have been reported. Acquiescence sets did not significantly affect DAS scores (Templer, 1970; Warren and Chopra, 1978-79). Templer (1970) reported that DAS scores were not significantly correlated with social desirability scores; Dickstein (1977-78) and McMordie (1979), however, reported a negative correlation.

Various findings support the validity of the DAS. Templer (1970) and Dickstein (1977-78) reported correlations between DAS scores and scores on other death anxiety measures. Templer (1970) also reported relationships between DAS scores and measures of anxiety and sensitization; verbalization of fear or preoccupation regarding death in psychiatric patients; measures of psychopathology—specifically schizophrenia, obsessive-compulsive disorders, and depression—in psychiatric patients, which is consistent with the clinical literature stating that persons with these disorders have high death anxiety.

According to McMordie (1979), the discriminant power of the DAS is limited by the true/false format. McMordie (1979) reported a correlation between the DAS using a Likert format (Templer/McMordie) and a true/false format, coefficient .85, and a test-retest reliability coefficient of .85 for the Templer/McMordie DAS.
The Templer/McMordie DAS was used in the present study.

**Defense Mechanism Inventory**

The Defense Mechanism Inventory (DMI) is a paper and pencil test developed by Gleser and Ihilevich (1969) that purports to measure use of various defense mechanisms. The present study will consider the Reversal scores on the DMI as a measure of denial and repression. Gleser and Ihilevich (1969) defined Reversal defense mechanisms as follows:

This class includes defenses that deal with conflict by responding in a positive or neutral fashion to a frustrating object which might be expected to evoke a negative reaction. Defenses such as negation, denial, reaction formation, and repression are subsumed under this category. (p. 52)

The DMI consists of ten stories describing interpersonal situations. Respondents are requested to choose from a series of alternatives the reactions both most and least characteristic of themselves with respect to actual behaviour, fantasy behaviour, thoughts, and feelings. There are slightly different forms for females and males.

Gleser and Ihilevich (1969) reported test-retest reliability coefficients across all five defense categories ranging from .69 to .93. Separate reliability coefficients for Reversal scores were not reported by these authors. Weissman, Ritter, and Gordon (1971) reported a test-retest reliability coefficient of .80 for
Reversal scores.

Content validity of Reversal scale is supported by results of inter-rater agreement studies. Gleser and Ihilevich (1969) reported over 60% agreement, Blacha and Fahcher (1977), 72%. In addition, Reversal scores have been reported to be positively correlated with alcoholism (Gleser and Ihilevich, 1969), negatively correlated with dream recall (Gleser and Ihilevich, 1969) and acting out (Juni, 1982), and these findings are considered to support the validity of the Reversal scale.

Procedure

Copies of the demographic questionnaire, the DAS, and the DMI were mailed to 105 Hospice of Windsor staff members along with a return envelope and a covering letter explaining the purpose of and instructions for participating in the present study. A copy of the covering letter is included in Appendix D.

Instructions

It was explained that the purpose of the present study was to develop an understanding of hospice workers' attitudes toward death. The questionnaires were described briefly.

Those who wished to participate in the present study were asked to fill out the questionnaires, in one sitting if possible, and to return them using the enclosed envelope. They were asked not to write their names or other identifying information on the questionnaires to assure their anonymity, and informed that no
individual results would be reported--only group results. Those who did not wish to participate in the present study were asked to return the blank questionnaires using the enclosed envelope. They were also told that a copy of the results of the present study would be available to them in the Hospice of Windsor office.
CHAPTER III
RESULTS

Fifty-nine hospice workers returned completed questionnaires. The information obtained from two of the participants was not used in the data analysis because the DMI answer sheets were filled out incorrectly and Reversal scores could not be calculated.

Pearson product-moment correlation coefficients were calculated. In the present study, a significant negative correlation ($r = -.40, p < .001$) was found between DAS scores and Total Reversal scores (Table 1). This relationship is accounted for by the significant negative correlation between DAS scores and scores on the Fantasy Behaviour ($r = -.43, p < .001$) and Affect ($r = -.42, p < .001$) subscales of the Total Reversal scale. This suggests that lower conscious death anxiety is associated with greater use of Reversal defense mechanisms, such as denial, with respect to impulsive and affective responses.

Scores on all four Reversal subscales were significantly correlated with scores on the Total Reversal scale. Somewhat higher correlation coefficients were obtained in comparisons of Total Reversal scores with scores on the Fantasy Behaviour ($r = .82, p < .001$) and Affect ($r = .84, p < .001$) subscales than with the Actual Behaviour ($r = .57, p < .001$) and Thought ($r = .73, p < .001$) subscales (Table 1).

One measure of exposure was correlated with DAS scores:
Table 1
Intercorrelation Matrix for the Reversal Scales and the DAS

<table>
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<tr>
<th></th>
<th>Actual Behaviour</th>
<th>Fantasy Behaviour</th>
<th>Thought</th>
<th>Affect</th>
<th>Total Reversal</th>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>.73***</td>
<td>.84***</td>
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<td>DAS</td>
<td>-.23</td>
<td>-.43***</td>
<td>-.19</td>
<td>-.42***</td>
<td>-.40***</td>
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</tbody>
</table>

*p < .05

**p < .01

***p < .001
length of time since most recent experience with death (r=.26, p < .05, Table 2). The results indicate that conscious death anxiety tends to decrease as more time elapses since most recent experience with death. Although there was an overall negative correlation between DAS scores and Total Reversal scores, Total Reversal scores were not correlated with length of time since most recent experience with death (Table 2).

Total Reversal scores were correlated with one measure of exposure: time spent working with hospice patient/families in the previous four weeks (r=.27, p < .05, Table 2). This suggests that hospice workers who spend more time working with hospice patient/families use more Reversal defense mechanisms. Once again, although there was an overall negative correlation between DAS scores and Total Reversal scores, DAS scores were not correlated with time spent working with hospice patient/families.
Table 2

Pearson Product-Moment Correlations Between Measures of Exposure to Death and DAS Scores and Total Reversal Scores

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<th>Measure of Exposure</th>
<th>DAS</th>
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</thead>
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<td>0.04</td>
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<tr>
<td>months since death education</td>
<td>-0.11</td>
<td>-0.03</td>
</tr>
<tr>
<td>patient/families total seen</td>
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<td>0.06</td>
</tr>
<tr>
<td>patient/families number seen in past 4 weeks</td>
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<td>0.14</td>
</tr>
<tr>
<td>hours doing hospice work in past 4 weeks</td>
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<td>0.10</td>
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<td>hours with patient/families in past 4 weeks</td>
<td>0.03</td>
<td>0.27*</td>
</tr>
<tr>
<td>months since most recent experience with death</td>
<td>-0.26*</td>
<td>0.07</td>
</tr>
</tbody>
</table>

*p < .05
CHAPTER IV
DISCUSSION

The results of the present study replicate Handal's (1975) finding of a negative correlation between DAS scores and Total Reversal scores, and are consistent with the literature suggesting that death anxiety tends to increase to the extent that it is not repressed. Although Handal reported that DAS scores were relatively more closely associated with Affect than Fantasy Behaviour subscale scores, the results of the present study indicate a virtually equal relationship between DAS scores and the Affect and Fantasy Behaviour subscale scores. That the results of the present study are so similar to Handal's findings with a population of college undergraduates suggests that the results obtained with hospice workers may be more applicable to the general population than was considered at the outset of this study.

Handal (1975) also reported somewhat higher correlation coefficients for comparisons of Total Reversal scores with Affect and Fantasy Behaviour subscale scores than with Actual Behaviour and Thought subscale scores similar to those reported in the present study. If the Affect and Fantasy Behaviour subscales generally tend to be more highly correlated with the Total Reversal scale than the other subscales, this would suggest that these subscales may be more adequate measures of Reversal defenses than the other subscales. The finding reported by Handal (1975) and in the
present study that the negative correlation between DAS scores and Total Reversal Scores was accounted for by a significant negative correlation between DAS scores and scores on the Affect and Fantasy Behaviour subscales may reflect properties of the Reversal subscales rather than differential use of Reversal defenses across levels of behaviour. Inter-correlations for Total Reversal and Reversal subscale scores were not reported by the authors of studies concerning the validity and reliability of the DMI cited in this paper.

It is also possible that different defensive styles are associated with different levels of behaviour. For example, overt behaviour and thought may involve more delay than impulsive and affective responses and may be associated with more sophisticated defenses than Reversal defenses, such as intellectualization.

The results of the present study provide support for the hypothesis that death anxiety would tend to decrease with increasing exposure to death, and that this decrease in death anxiety would not be accompanied by an increase in repression. A negative correlation between conscious death anxiety and time since most recent experience with death has been reported by other authors (Patton and Freitag, 1977; Hoelter and Hoelter, 1980-81) as well as in the present study.

The negative correlation between death anxiety and time since most recent experience with death may represent a return to baseline
after an initial increase in conscious death anxiety following bereavement rather than a reduction from premorbid death anxiety. Lester and Kam (1971) reported an increase in death anxiety following bereavement. A longitudinal study of fluctuations in death anxiety over time may clarify whether death anxiety returns to baseline or there is a net reduction in death anxiety following exposure to death.

In any case, that the decrease in conscious death anxiety over time following bereavement was not accompanied by an increase in Total Reversal scores suggests that death anxiety has been resolved by some means other than increased use of Reversal defense mechanisms, such as denial.

Measures of exposure to death other than time since most recent experience with death were not found to be correlated with conscious death anxiety. The DAS may be insensitive to slight fluctuations in death anxiety or may not tap the aspects of death anxiety affected by these other types of exposure. Or the measures of exposure used in the present study may not be relevant to conscious death anxiety.

On the basis of the results of the present study, the following comments may be made regarding Bailis and Kennedy's (1977) model describing the resolution of death anxiety. The overall negative correlation between conscious death anxiety and use of Reversal defense mechanisms is consistent with the view
that death anxiety tends to be repressed, and tends to increase to the extent that it is not repressed. The results are consistent with the model's prediction that conscious death anxiety will increase following exposure to death and then decrease over time. It is not clear whether this represents a decrease compared to premorbid death anxiety, as the model predicts, or a return to baseline as discussed above. The model also predicts that the increase in conscious death anxiety following exposure to death will be accompanied by an increase in use of defense mechanisms, and that use of defense mechanisms will decrease over time as they are examined and discarded. In the present study, use of Reversal defense mechanisms was not found to fluctuate with conscious death anxiety across exposure, and in this respect, Bailis and Kennedy's model was not supported.

The Reversal scale may be insensitive to change in use of Reversal defense mechanisms. In addition, the DMI is a measure of general defensive style, and while it is likely that one's approach to death related issues reflects general defensive style, changes in specific areas of conflict may be diluted when a global measure is used. It is also possible that use of Reversal defense mechanisms is a stable characteristic.

The finding that greater use of Reversal defense mechanisms was associated with more time spent working with hospice patient/families was unexpected. Whether this relationship reflects a
self-selection process or a coping reaction is unclear. This author speculates that the former is the case since conscious death anxiety did not fluctuate across time in contact with patient/families. Regardless of the etiology of this relationship, it has been generally assumed that defensiveness interferes with effective counselling. The results of the present study suggest that it will be important to investigate whether use of Reversal defense mechanisms prevents hospice workers from working effectively with patient/families or represents a necessary self-protection in what are often stressful situations.
APPENDIX A

The Hospice of Windsor, Inc.

Training Programme for Volunteers
THE HOSPICE OF WINDSOR, INC.

Training Programme for Volunteers

The main objectives of the course are to help the volunteer understand the specific needs of the dying person and his/her family; to identify the appropriate response to these needs; to focus on one's own thoughts and feelings about death, both with respect to oneself and that of others, and to help the volunteer understand his/her reason for undertaking this work along with a clearer understanding of the specific role which he/she might wish to assume.

The first sessions start with some basic content on the process of dying and an understanding of the needs of the dying person and then build up to a more personal contact with one's own attitude towards death.

The last sessions deal with the way we respond appropriately to the physical, emotional and spiritual needs of the dying person and his/her families, together with an opportunity for the volunteer to identify his/her role within the organization.
SESSION I

INTRODUCTION TO THE HOSPICE MOVEMENT AND PALLIATIVE CARE

Objective: The purpose of this session is to provide some general background of the Hospice Movement together with specific information regarding the origin of the Hospice of Windsor; to explain why such a service is needed and what we are trying to provide for the dying person; and to identify the appropriate responses of the caring community to the patient and his/her family.

Content: origin of the movement
different models of Palliative Care Service
origin of the Hospice of Windsor and how it functions
the basic purpose of our work
identification of the needs of the dying person
view the videotape "The Last Days of Living", a visual on the work done in the Palliative Care Unit at Royal Victoria Hospital, Montreal.

Group Work: The volunteers will be given the opportunity to identify what they consider appropriate care. This film will also help them draw out their personal feelings about death and their ability to respond appropriately.
SESSION II

THE RESPONSIBILITY OF THE CARING COMMUNITY AND THE DYING PERSON

Objective: This session will provide the volunteer with an understanding of the dying process and focus on ways we can enable the dying person to retain his/her self-respect. It will also involve an initial attempt for the volunteer to identify his/her own feelings about death.

Content:

: the various stages of dying

: death with respect to the child, the adolescent and the adult

: understanding the role of the doctor, the nurse and the family

: an awareness of one's own death and meeting death in others

: identification of "little deaths"

: various experiences of death - vicarious, dramatic and symbolic deaths

: the process of unintentional rejection and abandonment

: the dying person's parting gift

: identification of the patient's responsibilities to family, medical staff, nursing staff

: how we are to act as facilitators in order that those responsibilities may be fulfilled

Group Work: This will involve a further opportunity for the volunteer to share experiences of death and how they were handled and to come into touch with his/her own feelings. The session may include a presentation of a film interview with a dying person, in which the person indicates how it is possible to act responsibly in this kind of situation.
SESSION III
THE PHYSIOLOGICAL ASPECTS OF DYING

Objective: This session will attempt to give a more detailed understanding of the physiology of death, some basic knowledge about cancer and the various means of pain control.

Content: physiological changes in a dying patient
what happens when a person dies and what is the appropriate response
the nature of pain
various means of symptom control
basic knowledge about cancer and definition of terms
various forms of treatment
 coping with cancer
emotional reactions to cancer

Group Work: The opportunity will be given for volunteers to ask questions in a plenary session.
SESSION IV

EMOTIONAL ASPECTS OF THE BEREAVEMENT PERIOD

Objective: This session will provide the volunteer with an understanding of the grieving process and its effects on both patient and family.

Content:
: the emotional and physical effects of grief
: appropriate and inappropriate responses to those in grief
: the duration of the grieving process
: origins of guilt and the process of absolution
: needs of the bereaved person
: bereavement follow-up
: different cultural methods of dealing with grief
: what facilities are available for the bereaved
: identification of experiences relating to grief, separation and loss

Group Work: The volunteers will be given the opportunity to meet with persons who have recently been bereaved and discuss how they have been able to cope with their grief.
SESSION V

RELIGIOUS AND VALUE CONCERNS OF THE TERMINALLY ILL AND THEIR FAMILIES

Objective: This session will examine religious and value statements made by dying persons and their families and attempt to search for appropriate responses.

Content: what constitutes a religious or value concern

: particular questions or statements raised by dying persons

: statements relating to life after death

: appropriate responses to these religious and value concerns

: the relevancy of prayer

: religious ceremonies after death

: significant practices in other religions

Group Work: The volunteers will be asked the issues which they would want to discuss if they knew that they were dying. This very often constitutes "unfinished business" which needs to be resolved for the benefit of the dying person and also the family. These will then be shared in a plenary session.
SESSION VI
THE ROLE OF THE VOLUNTEER

APPROPRIATE RESPONSES TO THE INDIVIDUAL AND FAMILY

Objective: This session will endeavour to help the volunteer identify his/her role and clarify those attitudes which are necessary to fulfill those roles. It will also acquaint them with some of the practicalities relating to the care of patients at home and in the hospital.

Content:
- appropriate responses to the thoughts and feelings of the dying patient
- a description of the various duties which may be required as a visitor or in an administrative capacity
- attitudinal criteria of a volunteer
- building trust relationships
- how to deal with frustration, anger, disappointment, rejection
- the volunteer agreement with Hospice
- the relationship of the volunteer with Hospice and Metropolitan Hospital
- support systems
- preparation for visitation
- hospital routine and protocol
- home care and protocol with other community service organizations
- deportment and dress
- eye contact and the importance of touching
Group Work: The volunteers will have the opportunity to discuss these various roles with volunteers who have already been involved with the work of Hospice.
APPENDIX B

Some of the Duties of Volunteers
Some of the Duties of Volunteers

- Provide support and companionship.
  - being a friend to patients and family members.
- Transportation to doctor's office or for lab work or a blood transfusion.
- Feeding patients in the hospital.
- Staying all night with a patient in the hospital or home.
- Staying with patient at home to relieve the family or person looking after the patient so he can go out for the afternoon or evening.
- Family shopping.
- Simple household chores.
- Taking the patient out for a drive or out in a wheelchair.
- Babysitting.
- Letter writing.
- Bereavement follow-up.
- Office-related duties.
APPENDIX C

Demographic Questionnaire
DEMOGRAPHIC QUESTIONNAIRE

1. What is your sex? _______
2. What is your age? _______
3. How old were you when you had your first experience with death? _______
   Who was it that died? _______________________
4. How many experiences have you had with death?
   (indicate number) _______ grandparent
   _______ parent
   _______ sibling
   _______ spouse
   _______ child
   _______ friend
   _______ other (please specify) _______
   _______ pet
5. When was your most recent experience with death? _______ month _______ year
   Who was it that died? _______________________
6. Have you ever had a life threatening illness or injury? _______
   If yes: How old were you? _______
   What type of illness or injury did you have? _______
   How long were you ill? _______
7. When did you complete the hospice volunteer training program?
   _______ month _______ year
8. How many patient/families have you had contact with since you began working with the hospice? ________

9. How many patient/families have you had contact with in the past four weeks? ________

10. Approximately how many hours have you spent doing hospice work in the past four weeks? ________

11. Approximately how many hours have you spent with hospice patient/families in the past four weeks? ________

12. How helpful do you feel the work you do for the hospice is to the hospice patient/families?

   1  2  3  4  5
not at all moderately extremely helpful helpful helpful

13. Do you participate in support groups for hospice workers? ________
APPENDIX D

Instructions
APPENDIX E

Raw Data
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<th>Subject</th>
<th>Age</th>
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<th>Hours doing work in past 4 weeks</th>
<th>Hours with patient/families in past 4 weeks</th>
<th>Months since most recent experience with death</th>
<th>BPS</th>
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REFERENCES


VITA AUCTORIS

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1979: Honours Bachelor of Arts Degree, from
       University of Windsor, Windsor, Ontario