ATTITUDES TOWARDS CARE OF DYING PATIENTS AMONG SOPHOMORE, JUNIOR, AND SENIOR PRE-LICENSURE NURSING STUDENTS AT A CHRISTIAN UNIVERSITY

WHILE CONTROLLING FOR RELIGIOSITY

by

Diane Carol Bridge

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

Liberty University

2017
ATTITUDES TOWARDS CARE OF DYING PATIENTS AMONG SOPHOMORE, JUNIOR, AND SENIOR PRE-LICENSURE NURSING STUDENTS AT A CHRISTIAN UNIVERSITY

WHILE CONTROLLING FOR RELIGIOSITY

by

Diane Carol Bridge
Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

Liberty University

2017

APPROVED BY:

Deanna Keith, Ed.D., Committee Chair

Shanna Akers, Ed.D., Committee Member

Kurt Y. Michael, Ph.D., Committee Member
ABSTRACT

There is a need for nurses who can effectively care for dying patients. The purpose of this study was to evaluate the attitudes of nursing students towards providing care of dying patients while controlling for religiosity. The study used a quantitative causal-comparative research design using two administered questionnaires, the Frommelt’s Attitudes Towards Care of the Dying (FATCOD B) and the Duke University Religion Index (DUREL). A convenience sample of 417 residential undergraduate nursing students were used in this study. The sample consisted of 137 sophomore, 142 junior, and 138 senior pre-licensure nursing students who attended a large Christian university located in the southeastern region of the United States. Using data that were collected from the questionnaires, the Analysis of Covariance (ANCOVA) was utilized to analyze research data. The null hypothesis was rejected indicating that a statistically significant difference does exist in attitudes towards care of dying patients between sophomore, junior, and senior nursing students at a Christian university while controlling for religiosity. Based upon results from the research study, students with more clinical hours and nursing training had a more positive attitude towards care of dying patients. Recommendations for future research includes consideration of additional variables that might influence nursing students’ attitudes towards care of dying patients in nursing programs at Christian and secular universities.

Keywords: attitudes towards dying, attitudes towards death, care of dying, attitudes towards care of dying
# Table of Contents

ABSTRACT ................................................................................................................................. 3

List of Tables ............................................................................................................................. 8

List of Figures ............................................................................................................................ 9

List of Abbreviations ................................................................................................................ 10

CHAPTER ONE: INTRODUCTION .............................................................................................. 11

Overview .................................................................................................................................... 11

Background ................................................................................................................................. 11

  Religious Attitudes towards Death and Christianity ................................................................. 14

  Nurses’ Attitudes towards Care of Dying ............................................................................... 15

  Background Summary ......................................................................................................... 18

Problem Statement ..................................................................................................................... 18

Purpose Statement ...................................................................................................................... 19

Significance of the Study ............................................................................................................ 19

Research Question ..................................................................................................................... 20

Null Hypothesis .......................................................................................................................... 20

Definitions .................................................................................................................................. 21

CHAPTER TWO: LITERATURE REVIEW ..................................................................................... 23

Overview .................................................................................................................................... 23

Theoretical Framework .............................................................................................................. 25

  Nursing Role Effectiveness Model ......................................................................................... 25

  Dreyfus Skills Acquisition Model ......................................................................................... 27

Empirical Evidence .................................................................................................................... 28
Related Literature ........................................................................................................................................ 29
Attitudes towards Death ......................................................................................................................... 29
Religiosity and Death Attitude ............................................................................................................... 31
Planning for Death ................................................................................................................................ 33
Dying Patients’ Attitudes towards Death ................................................................................................. 33
Attitudes of Nursing towards Death ...................................................................................................... 34
Nursing’s Attitude towards Care of Dying .............................................................................................. 37
Factors that Influence Nursing Attitudes .............................................................................................. 43
International Nursing Attitudes ............................................................................................................... 45
Student Nurses’ Attitudes towards Care of Dying .................................................................................. 46
International Nursing Student Attitudes ................................................................................................. 48
Student Anxiety Related to End-of-Life Care ......................................................................................... 49
Summary ............................................................................................................................................... 52

CHAPTER THREE: METHODS .............................................................................................................. 54
Overview ............................................................................................................................................... 54
Design .................................................................................................................................................. 54
Research Question ................................................................................................................................. 55
Null Hypothesis .................................................................................................................................... 55
Participants and Setting ......................................................................................................................... 55
Instrumentation ..................................................................................................................................... 58
Frommelt’s Attitudes towards Care of Dying ......................................................................................... 58
DUREL Index ......................................................................................................................................... 59
Procedures ............................................................................................................................................ 61
APPENDIX A: IRB Approval Letter ................................................................. 114
APPENDIX B: Permission to use FATCOD B Scale ........................................... 115
APPENDIX C: Permission to use the DUREL Index ......................................... 116
APPENDIX D: Permission from Dean .............................................................. 117
APPENDIX E: Script ....................................................................................... 118
APPENDIX F: Consent .................................................................................... 119
List of Tables

Table 4.1 Mean Attitudes towards Care of Dying by Year .................................................................66
Table 4.2 Adjusted Means by Year.......................................................................................................66
Table 4.3 Mean Religiosity by Year for Attitudes towards Care of Dying ........................................67
Table 4.4 Kolmogorov-Smirnov by Year for Attitudes towards Care of Dying .............................69
Table 4.5 Kolmogorov-Smirnov by Year for Religiosity ....................................................................69
Table 4.6 Levene’s Test.........................................................................................................................72
Table 4.7 Test of Homogeneity of Slopes ............................................................................................76
Table 4.8 Results of ANCOVA ...........................................................................................................78
Table 4.9 Bonferroni Comparison .......................................................................................................79
List of Figures

Figure 4.1 Box and Whiskers Plots for Attitudes ................................................................. 68
Figure 4.2 Box and Whiskers Plots for Religiosity ................................................................. 68
Figure 4.3 Attitudes by Year Histogram................................................................................... 70
Figure 4.4 Religiosity by Year Histogram................................................................................ 71
Figure 4.5 Sophomores Attitudes Scatterplot ....................................................................... 73
Figure 4.6 Juniors Attitudes Scatterplot ................................................................................... 74
Figure 4.7 Seniors Attitudes Scatterplot .................................................................................. 75
List of Abbreviations

Analysis of Covariance (ANCOVA)

Frommelt’s Attitude towards Care of Dying (FATCOD B)

Duke University Religiosity Index (DUREL)

Institutional Review Board (IRB)
CHAPTER ONE: INTRODUCTION

Overview

Studies exist that examine professional nurses’ attitudes towards caring for dying patients in the healthcare setting (Rooda, Clements, & Jordan, 1999; Solabarrieta, Richardson, & Addington-Hall, 2011). Several research studies examined the relationship of nursing students’ attitudes towards caring for dying patients before and after receiving education on death and dying (Henoch, 2016; Mallory, 2003; Osterlind et al., 2016) and several studies have also been conducted that show nurses and nursing students’ attitudes towards care of dying in nursing programs in other countries (Abu-El-Noor & Abu-El-Noor, 2016; Matsui, & Braun, 2010). The purpose of this study was to examine the attitudes of all students accepted into the nursing program at a Christian university to determine if religiosity had an impact on caring attitudes.

Background

Death, the end of physical life on earth, is an event that cannot be escaped; it is an event that will be experienced by all human beings and a topic that is often avoided (Adesina, DeBellis, & Zannettino, 2014). Kumar, Chris, Pais, Sisodia, and Kumar (2014) discussed death as a singular occurrence that each individual must encounter which is determined by cessation of brain activity, circulatory actions, and respiration function. For many individuals, death is not discussed and is considered the most dreaded of life events that one must try to prevent or delay. According to Yalom (2008) and Ka-Ying Hui and Coleman (2012), fear of death is the cause of extreme anxiety in most individuals and death frightens human beings because existence on earth ends, which causes distress due to uncertainty of what happens after death. Despite general consensus that the subject of one’s own mortality is avoided in conversation, the topic of death is everywhere. Freyer et al. (2006) suggested that death in the United States, although not
considered a pleasant topic or an event to anticipate, can bring about uncertainty for many while creating an attitude of intrigue and fascination for others. Most individuals being of sound health and mental cognition would agree that death is not an anticipated event, but the topic of death cannot be avoided because it is present in everyday surroundings. One’s curiosity about death may be triggered by a near death experience, the death of a loved one, engaging in risk-taking events, or just a natural curiosity of the unknown and what happens when physical life ceases to exist.

The historical overview of death shows that death of loved ones is often considered a crippling, life-altering experience (Bedner, 2005) and loss of life can bring about feelings of immense emotional trauma and shock, leaving those left behind often wondering if the deceased’s spirit continues to live (Rando, 1993). Despite the crippling effects of death on those left behind to carry on with life, history reveals the popularity of the topic of death obsession, which can be linked as far back as literature is found on the subject (Rome, 1938). Death is discussed in literature, religion, philosophy, and depicted through art (Spellman, 2014). Ancient collections on the topic of dying exist that address universal concerns regarding death, while recording ancient cultural rituals to care for the dying and burying the deceased (Belayche, 2001).

How society addresses the topic of death has changed significantly since the middle ages, where dying individuals bequeathed possessions on remaining loved ones, amended family problems, and dying occurred in the family home (Institute of Energy Medicine, 2011). Today, death appears to have taken on more of a clinical aspect; patients typically die in health-care facilities rather than dying at home, as was often the custom in earlier times (Phillips, 2015). Groves and Klauser (2009) address many concerns surrounding the struggles and fears that
accompany death while mapping many ancient cultural traditions surrounding the death event. Death can occur in many ways, and preparation of the body for its final resting place and saying good-bye to loved ones was an event that took place in the deceased’s home in years past (Mitford, 2000).

Exploration of death throughout history has found individuals who have been enamored with this event from the first documentation until present day (Belayche, 2000); however, a recent surge during the past decade about the subject of death has created a trend that continues to captivate the inquisitive side of many individuals (Outlaw, 2014). Human beings are very aware of death and the mystery that surrounds this event (Sheldon & Piven, n.d.) and fear of death is a widespread emotion that affects almost everyone (Gholamreza, 2009). Kumar et al. (2014) discussed death as the one event that will affect each person, and is the result of the cessation of brain activity, circulatory actions, and respiratory function, causing life on earth to end.

Society often appears infatuated with death. Although most people would admit they do not want to die or are not ready to die, the topic of death seems to be present in everyday activities. In the news, it is broadcasted daily how lives are cut short accidentally, through suicide, or by murderous acts. Outlaw (2014) noted that an insurmountable wave of infatuation related to death exists in society. Many weekly television programs and movies often have a plot that is centered on death, murder, the supernatural, zombies, or near-death scenarios. Video games that children, teenagers, and adults engage in most often have a theme that centers on death. Television programs often re-create events that focus on individuals who were on the brink of death but have lived to tell their horrific stories about what it was like to taste death (MacDonald, 1999; Outlaw, 2014). McIlwain (2005) discussed daytime soap operas that have
themes focused on death experiences to keep the audiences intrigued. Gibson (2001) indicated that film narrative creators are often infatuated with the mastery of death in attempt to portray what happens when death occurs. Bryant and Peck (2009) discussed the introduction of the video game industry in the 1970’s, where violence was very prominent and produced graphic death themed situations for the human players to engage.

In order to assist the changing societal and family needs in evaluating personal feelings towards death, the uncertainty surrounding the unknown, and the increased institutionalization of dying loved ones (Adesina et al., 2014), death education should be included as part of the public school and college curriculum to decrease anxiety about death and improve communication regarding death and dying concerns (Adesina et al., 2014; Stevenson, 2004).

**Religious Attitudes towards Death and Christianity**

Religious beliefs of an after-life allow individuals to have a more positive attitude towards death (Ka-Ying Hui & Coleman, 2012). The Bible is immersed with many accounts of death (Outlaw, 2014) including the death of Lazarus (John 11), how to bury the dead, avoid summoning the dead (Leviticus 19), and the death and resurrection of Christ (John 3). Reassurance of an existence in the after-life allows one to avoid viewing death as a permanent non-existence. Individuals with a greater intrinsic religiosity have a more positive attitude and acceptance of death because religious beliefs allow individuals to view death as the gateway to a better existence (Ka-Ying Hui & Coleman, 2012). Wittkowski (1988) also indicated that belief in God and an after-life led to a more positive view towards death.

According to Christian beliefs, after the fall of man in the Garden of Eden at the beginning of time (Romans 5:12; Genesis 3:6-19) death has been an unescapable event for every human being. Christianity can influence attitudes towards death and bring hope for an eternal
existence once physical life has ended (John 3:16). Freyer et al. (2006) specified that death and life are intertwined and regardless of beliefs about death, one cannot happen without the other. Knowing that there is hope after physical life has ended allows Christians to approach and discuss death without inducing extreme anxiety. Knowing that the Heavenly Father is in control brings a calm and peace (1 John 4:18) to Christians even when life on earth will end. Christianity has created a more positive attitude towards death due to the belief that individuals can have a personal relationship with Christ if they so desire. Christians believe that being absent from the body will mean being present with the Lord (2 Corinthians 5:8) and that when life on earth is over, the death of a Christian is precious to the Lord because His child is coming home (Psalm 116:15).

Nurses’ Attitudes towards Care of Dying

With growing concern over loss of life, a strong emphasis on end-of-life emerged in the United States during the early 1990’s. Recognizing that death is inevitable led to the development of the palliative care specialization that focused on providing care for the dying (Clark, 2015; Sullivan, Gadmer, & Block, 2009). With a newly found healthcare focus on specializing in providing end-of-life care, nurses must be prepared to effectively care for the dying patient’s physical, emotional, and spiritual needs. Van der Elst, De Casterlé, Biets, Rchaidia, and Gastmas’s (2013) study showed that good nurses are needed to display positive attitudes when providing supportive care to dying patients.

Nurses are faced with thoughts of death on a daily basis. Even though patients may not die each time a nurse is at work, the nurse is constantly concerned about patient outcomes and ensuring that everything possible is done to keep the patient alive while promoting the best possible healthcare outcomes for the patient. Ellershaw and Ward (2003) discussed the hospital
setting where healthcare staff focus intently on curing the patient and have difficulty diagnosing the dying patient. Healthcare members must recognize the signs and symptoms of dying and be able to communicate this to the patient (if able to be part of the discussion) and family members when there is no possibility of the patient’s ability to recover. When not properly trained in end-of-life care, nurses and healthcare staff will be reluctant to care for dying patients, place dying patients in secluded rooms on hospital units, and have minimal interactions with the patient and family during the dying process. Although this practice has been demonstrated by hospitals in years past, many healthcare facilities now recognize that dying patients need intensive palliative care in addition to emotional, social, physical, and spiritual care for families and the patient. Families of dying patients are often very involved in their loved ones’ care and may choose to provide a more personalized type of care in the patients’ own homes (Gagnon & Duggleby, 2014).

Gama, Barbosa, and Vieira (2012) specified that nurses working in medicine, oncology, and hematology specialties had higher fear-of-death attitudes, whereas palliative care nurses had lower fear-of-death attitudes. Solabarrieta, Richardson, and Addington-Hall (2011) suggested that many nurses hold negative attitudes towards death but valued the opportunities to care for dying patients when given enough time to meet the additional demands of dying patients and meeting the needs of loved ones. Burt, Shipman, Addington-Hall, and White (2008) shared that community nurses providing palliative care held lower attitudes towards care of the dying patient due to the increased workload that palliative care patients added to their already overbooked schedule. Several studies showed statistically significant relationships between years of nursing experience, prior experience caring for dying patients, and the scores on the Frommelt’s Attitude Towards Care of Dying (FATCOD) scale. Nurses with more years of experience and who had
more life experience had a significant impact on FATCOD scores (Gagnon & Duggleby, 2014; Lange, Thom, & Kline, 2008).

Arslan, Acka, Simsek, and Zorba (2014) noted that third-year nursing students in Central Antolia who had previous experience caring for dying patients had positive attitudes towards providing care for the dying than third-year nursing students who did not have experience with end-of-life care. Frommelt (2003) studied 115 undergraduate nursing students to determine if an educational class taken by some of the students would account for positive attitudes towards terminally ill patients. Students who participated in the study and took the end-of-life educational class had higher post-test attitude scores than students who did not. Leombruni et al. (2014) indicated the need to add end-of-life nursing care in nursing programs in Italy as results were inconclusive with the adaptation of the scale for Italian students.

The theory that underpinned the issue of attitudes of nursing students towards care of dying patients was the Nursing Role Effectiveness model, which provided a conceptual framework for this study (Lange et al., 2008). Developed by Irvine, Sidani, and McGillis (1998) the Nursing Role Effectiveness model explained different variables that may be present that interfere with the nurse’s ability to provide care, which could significantly impact patient care outcomes in either a positive or negative manner. Examination of this theory provided a way to conjecture how nursing care can be influenced by different variables present on diverse nursing units. Doran, Sidani, Keatings, and Doidge (2002) indicated that the Nursing Role Effectiveness Model demonstrated that patient and nurse structural variables were influential in the nurse’s role performance and accomplishment of patient outcomes. Manojlovich (2005) and Sodamo and Irvine (1999) discussed the Nursing Role Effectiveness Model and how organizational variables, the patient, and the healthcare environment all influence the nurse’s perception of the patient
care that is needed and influences patient outcomes. The nurse’s role directly affects patient outcomes and this model can be used to define patient-achieved outcomes in nursing care situations.

**Background Summary**

Death is something that every individual must encounter. Although death is not anticipated and measures are frequently taken to prolong life, death can often become a preoccupation for many individuals. Historically, the overview of death reveals the popularity of the topic as far back as literature can be found (Rome, 1978) and infatuation with death is still present (Outlaw, 2014). Society has promoted the development of movies, television programs, video games, and many other forms of entertainment that have death as a theme. Nursing is not exempt from the constant reminder that patient death is a reality, and nurses are constantly faced with the possibility of dying patients. Attitudes towards providing end-of-life care can affect the nurse’s ability to effectively care for dying patients and therefore solidifies the reason for this research study, to evaluate the attitudes of pre-licensure nursing students towards caring of dying patients at a Christian university while controlling for religiosity.

**Problem Statement**

The literature provides perspectives on nurses’ attitudes towards death and dying and providing care for the dying. Attitudes in nursing related to death and providing care for dying patients are more positive when death is viewed as an escape to a better after-life, and nurses with more work experience often exhibit a more positive attitude towards caring for the dying (Lange et al., 2008; Leombruni et al., 2014). The literature also provides information regarding several studies of upper-level nursing students and their attitudes towards care of dying. Anxiety and fear are common emotions expressed by nursing students regarding death, which impacts
attitudes towards care of the dying; personal fears regarding death can negatively impact care of the dying (Arslan, Acka, Simsek, & Zorba, 2014; Frommelt, 2003; Mastroianni et al., 2015). The problem is that the literature has not addressed attitudes towards care of dying in all levels of nursing students accepted in a pre-licensure BSN program at a Christian university while accounting for religiosity.

**Purpose Statement**

The purpose of this quantitative, causal-comparative study is to evaluate the attitudes of pre-licensure nursing students towards caring for dying patients at a Christian university while controlling for religiosity. A convenience sample of 417 residential undergraduate nursing students was used in this study, and consisted of 137 sophomores, 142 juniors, and 138 senior nursing students. The independent variable was the program year of nursing students. Sophomore nursing students were taking sophomore nursing classes and have started patient care experiences in the simulation lab and hospital. Junior nursing students were taking junior nursing classes and completing patient care experiences in the hospital and other healthcare settings. Senior nursing students were taking senior nursing classes and completing patient care experiences in the hospital and other healthcare settings. The dependent variable defined was attitudes of nursing students towards care of dying patients which was defined as positive or negative beliefs possessed by individuals who are providing care for dying patients (Lange et al., 2008). The covariate was religiosity which was defined as the effects of religion on the outcomes of healthcare (Koenig & Bussing, 2010).

**Significance of the Study**

The significance of this study was to add to the body of knowledge regarding attitudes in nursing towards providing care to dying patients. Information exists concerning nurses’ attitudes
towards care of the dying, but there is little research addressing the attitudes towards care of dying patients in all levels of nursing students accepted in a nursing program (sophomore, junior, and senior levels) who attend a Christian university while controlling for religiosity. Determining nursing student attitudes towards providing care to dying patients will encourage nursing programs to include education into curriculum that deals with care of dying, provide experiences to provide palliative care which is appropriate for learning students, encourage students to develop a personal philosophy regarding death that enables them to learn about the needs of dying patients, and assist students in learning how to provide care for the dying. Patients, family members, and the nursing profession will benefit from this research that will assist nursing students facing anxiety that is often experienced when providing care to dying patients, enable them to be more effective in providing palliative care, and develop student nurses into experienced nurses who are comfortable with meeting the needs of dying patients and their families (Bajer, 2012; Block, Ploeg, & Black, 2009; Efstathiou & Clifford, 2011; Emery, 2013).

**Research Question**

**RQ1:** Is there a difference in attitudes towards death and dying among sophomore, junior, and senior pre-licensure nursing students at a Christian university while controlling for religiosity?

**Null Hypothesis**

**H01:** There is no statistically significant difference in attitudes towards death and dying among sophomore, junior, and senior pre-licensure nursing students at a Christian university while controlling for religiosity.
Definitions

1. *Attitudes towards Dying:* positive or negative beliefs possessed by individuals who are providing care for dying patients (Lange et al., 2008).

2. *Year of Nursing Student:* sophomore nursing students have completed required prerequisite classes to reach sophomore status, are taking sophomore nursing classes, and have started completing patient care experiences in the simulation lab and hospital setting. Junior nursing students have completed required prerequisite classes to reach the junior level status, are taking junior nursing classes, and are completing patient care experiences in the hospital or other healthcare settings. Senior nursing students have completed required prerequisite classes to reach senior level status, are taking senior nursing classes, and are completing patient care experiences in the hospital or other healthcare settings.

3. *Death.* According to Emery (2013) death is defined as the cessation of respirations, heartbeat, brain activity, and cellular activity.

4. *Religiosity:* Koenig and Bussing (2010) defined religiosity as the amount of organizational religious activities, non-organizational religious activities, and intrinsic religious activities that are displayed by individuals. Organizational religious activities include attending church services, participating in prayer groups, involvement in religious study groups, etc. Non-organizational religious activities include: private worship, private prayer, private scripture study, and watching religious programs on television. Intrinsic religiosity refers to the amount of religious commitment that an individual displays.

5. *Clinical hours:* Clinical hours are defined as hands-on learning situations where students are providing direct patient care in the healthcare setting and hands-on learning where
students are providing care in the simulated healthcare setting that are scheduled for sophomore, junior, and senior nursing students (National Council of State Boards of Nursing, 2005).

6. *Children*: Children are defined as those in the period of time from 5 to 12 years of age (Learning Theories, 2015).

7. *Adolescence*: Adolescents are defined as those in the period of time from 12 to 18 years of age (Learning Theories, 2015).

8. *Young adult*: Young adults are defined as those in the period of time from 18 to 35 years of age (Learning Theories, 2015).

9. *Adult*: Adults are defined as those in the period of time from 35 to 65 years of age (Learning Theories, 2015).

10. *Older Adult*: Older adults are defined as those in the period of time from 65 years of age to death (Learning Theories, 2015).
CHAPTER TWO: LITERATURE REVIEW

Overview

This chapter presents a review of recent literature and includes a discussion of the theories that impact the nurse’s ability to provide patient care, promote the best possible outcomes for patients, and describe how nurses move through varying stages of nursing practice that promotes the most optimal patient care experience for patients and their families, even during end-of-life experiences. The review of literature included searches in the academic database using a combination of the following keywords: attitudes towards dying, attitudes towards death, care of dying, attitudes towards care of dying, palliative care, nursing attitudes towards care of the dying, and nursing student’s attitudes towards care of the dying. Results of the search produced a surplus of articles, many of which were not related to this study. The peer-reviewed scholarly articles that were selected for use in this study were specific to the research topic. Little research was available related to attitudes in nursing towards the care of dying from a Christian perspective and in particular from Christian universities and colleges.

Caring for dying patients is not an easy task. Nurses are continually surrounded by death or the potential for death each time they are providing patient care. According to Beauchamp and Sparkes (2014), nurses are responsible to provide care to assist patients during recovery. Ellershaw and Ward (2003) discuss the primary focus of nursing, which is to seek a cure or stabilization of the patient’s diagnosis; however, when the patient is unable to recover and death is imminent, many nurses are uneasy providing care to the dying patient (Andersson, Salickiene, & Rosengren, 2015). Inbadas (2016) noted that in order to provide palliative care that is culturally congruent, it is important for nursing to provide physical, emotional, and spiritual end-of-life care that is personalized to meet the cultural needs of the patient.
Although the primary focus of nursing care is curative and interactive with the healing process (Mendez, DaCruz, & Angelo, 2014), palliative care is often viewed as a failure to adequately heal the patient (Andersson, Salickiene, & Rosengren, 2015; Evardsson, 2015). Death is an intense experience and nurses often show distress when called upon to care for the dying, due to uncertainty regarding administering this type of care (Gagnon & Duggleby, 2014; Jafari et al., 2015). Without adequate preparation to provide end-of-life care, nurses often have pre-formed ideas and attitudes regarding death; many nurses are unsure how to meet the needs of dying patients and consequently possess negative attitudes towards palliative care. Iranmanesh, Axelsson, Haggstrom, and Savenstedt (2010) showed that nurses with positive attitudes towards provision of palliative care are essential in order to provide adequate end-of-life care.

Historically, upper-level nursing students have reported anxiety and fear when caring for dying patients, due to lack end-of-life training in nursing curriculum (Frommelt, 1991). The impact of end-of-life training provides some anxiety relief in providing end-of-life care, but negative attitudes towards caring for dying patients still persist (Frommelt, 2003). Although research varies in regard to nursing students’ attitudes towards palliative care, the general consensus reported by nursing students showed that negative attitudes exist related to inadequate end-of-life training (Frommelt, 1991; Frommelt, 2003) and little information is available regarding attitudes of nursing students who attend a Christian university towards providing care for dying patients.

The need to identify attitudes towards caring for dying patients in sophomore, junior, and senior nursing students while accounting for religiosity will be beneficial to determine reasons for attitudes towards care of dying patients that are found in students at a Christian university. Findings of this study can provide information on all levels of nursing students at a Christian
university and their attitudes towards care of the dying regardless of end-of-life training. Nurses with positive attitudes towards providing end-of-life care are needed to ensure that dying patients receive the best possible nursing care (Amaral, Fereira, Cardoso, & Vidinha, 2014).

Theoretical Framework

According to Udo, Melin-Johanssen, Henoch, Axelsson, and Danielson (2014), nurses often care for a variety of patients in recovery and palliative states. Flexibility of nursing is expected when providing care for patients with diverse healthcare needs in order to promote the best care possible (Sorenson & Iedema, 2011) but feelings of powerlessness are often associated with nursing expectations to provide curative and palliative care (Andersson, Salickiene, & Rosengren, 2016; Gagnon & Duggleby, 2013; Johanssen & Lindahl, 2012). Laschinger and Fida (2015) indicated that nurses develop close relationships with many patients during their hospital stay while focusing on implementation of doctors’ orders and monitoring the patient in order to promote the best possible outcome for each patient situation. Inability of the nurse to provide effective care will impede patient outcomes and places the patient at increased risk of harm. Nurses are accountable for providing quality patient care and have a responsibility to develop and maintain competencies in their practice areas. Nurses should be comfortable promoting health during recovery or comfort in dying while ensuring that each patient and family receives the best possible patient care experience (Irvine, Sidani, & McGillis, 1998; Pfitzinger & Becker, 2015).

Nursing Role Effectiveness Model

The Nursing Role Effectiveness Model provided a conceptual framework for this research study because it analyzes variables between the nurse and patient that might affect nursing role performance and patient outcomes. The Nursing Role Effectiveness Model was
developed to show the contributions of nursing that develop from formed relationships that are linked to provision of patient care, which in turn has a direct effect on the outcome of each patient (Amaral et al., 2014; Irvine, Sidani, & McGillis, 1998; Manojlovich, 2005) while promoting the value and effectiveness of nursing care and recognizing the role that expert nursing care plays in developing meaningful nurse-patient relationships (Amaral et al., 2014; Christensen & Hewitt-Taylor, 2006). A component of providing patient care involves providing end-of-life care to patients who are dying and ensuring a peaceful, respectful death. Caring for dying patients is something that all nurses will experience during their nursing careers, regardless of their desire to care for this patient population. Attitudes towards providing care of dying patients can significantly impact the type of care received during this critical time, and development of trusting relationships with dying patients can facilitate this process (Amaral et al., 2014; Pfitzinger & Becker, 2015).

Advancement of literature. The Nursing Role Effectiveness Model (Amaral et al., 2014) has been instrumental in advancing literature in the area of nursing education and nursing experience, which have had positive effects on improving patient experiences and outcomes. Nurses are expected to demonstrate proficiency in their current practice areas through development of therapeutic nurse-patient relationships, which promotes effective patient care. The Nursing Role Effectiveness Model explores relationships that exist between nursing staff, the nurse and the patient, the healthcare setting, the care provided, patient experiences, and the expected patient outcomes (Amaral et al., 2014; Christensen & Hewitt-Taylor, 2006).

Since quality of patient care can be affected by many psychological and sociocultural attributes, nurses’ attitudes and perceptions towards providing care can have a significant impact on how care is provided and the outcome that is achieved (Arslan et al., 2014; Doran, Sidani,
Keatings, & Doidge, 2002; Manojlovich, 2005). Attitudes towards providing care to patients with a poor prognosis can be impacted by cultural beliefs, socialization, previous experiences, and the realization the continued care will be futile to promote patient recovery. It is important for nurses to demonstrate competence in both curative and palliative care in order to effectively provide the best possible patient care in all situations while effectively managing nurse-patient relationships in the patient’s final days (Bailey, Murphy, & Porock, 2011; Moreland, Lemieux, & Myers, 2012; Sidani, Doran, & Mitchell, 2004). Providing quality end-of-life care requires nurses who are committed to caring for dying patients and their families (Iranmanesh, Axelsson, Haggstrom, & Savenstedt, 2010).

**Dreyfus Skills Acquisition Model**

The Dreyfus Skills Acquisition Model as applied to nursing provided a conceptual framework for this research study because it analyzes variables that occur between the nurse and the patient that might affect the nurse’s performance in caring for the patient and in all types of care situations (Benner, 2001). The Dreyfus Skills Acquisition Model was developed initially to describe how the student passes through five stages as skills are learned and competence is developed. As students become more skilled, they will depend less on abstract information that has been learned about the skills and base practice upon concrete experiences gained through particular learning exercises (Dreyfus & Dreyfus, 1980). The principles of the Dreyfus Skills Acquisition Model as applied to nursing describe how the nurse moves through the all five stages of skill acquisition in providing effective patient care (Benner, 2001).

**Advancement of literature.** In the 1980’s Patricia Benner used the Dreyfus Skills Acquisition Model to develop the Novice to Expert Theory in order to explain the different stages of nursing practice (Benner, 2001). The Dreyfus model suggests that during skill learning
and development, students will pass through several proficiency levels that demonstrate improvements in skill performance (Dreyfus & Dreyfus, 1980). The Novice to Expert Theory has advanced the literature in the area of nursing education and nursing experience by explaining how nurses and nursing students work through beginning stages and advance to the level of nursing expertise (Benner, 2001). Nursing practice grows through clinical experiences that take place in real-time settings as the student moves from reliance of intangible ideas to the use of actual past experiences as examples to guide practice. Since nursing expertise is considered paramount to delivery of expert patient care (Christensen & Hewitt-Taylor, 2006), one of the main goals of the Novice to Expert Theory is to show the caring practices that encompass excellent nursing care and to create learning environments that facilitate the development of caring practices that promote healing and provide comfort and support in end-of-life care (Benner, 2001).

**Empirical Evidence**

Previous research related to nursing students’ attitudes towards care of dying patients is limited to studies that have select groups of nursing students, beginning nursing students and graduating students, at different points in time in nursing programs (Arslan et al., 2014). Due to high anxiety levels related to patient care that most students report prior to starting their patient care experiences, lack of patient care knowledge when combined with thoughts of providing end-of-life care can often be overwhelming to beginning nursing students (Conner, Loerzel, & Uddin, 2014; Lopez-Perez, Ambrona, & Hanoch 2016; Osterlind et al., 2016; Van der Wath & Du Toit, 2015).

Although literature does address attitudes of nursing towards care of dying patients, attitudes of nursing students at different levels in their nursing education, and the effects of
religiosity on attitudes towards death, research has not included all levels of pre-licensure nursing students that attend a Christian university and their attitudes towards care of dying patients, while accounting for religious beliefs.

**Related Literature**

**Attitudes towards Death**

Death is an intrinsic part of life that everyone will experience (Kopka, Aschenbrenner, & Reynolds, 2016) and many attitudes and beliefs towards death exist (Grubb & Arthur, 2016). Attitudes towards death are often formed at a young age, such as when the death of a loved one is experienced, and can have a lasting impression on individuals throughout their lives (Field, 2000; Khader, Jarrah, & Alasad, 2010). Many individuals believe in the possibility of existence after physical life ends (some are assured that the soul lives for eternity), and others believe that when the last breath is taken, the person’s existence is gone forever. Death is an event that cannot be fully understood and because of the mystery surrounding the cessation of physical life that affects each human being, anxiety and fear often develops (Adesina et al., 2014; Johanssen & Lindahl, 2012; Penson et al., 2005). Unfinished business, impact on loved ones, leaving family behind, unresolved personal relationship issues, and concern for what happens after death for the person dying and those left behind, are several reasons that many individuals are fearful when physical life is drawing to a close (Holland, Thompson, & Lichtenthal, 2013). Fear of dying is often the direct result of being uncertain of the existence of an after-life and what actually happens after the last physical breath is taken (Penson et al., 2005).

**Children, adolescents, and young adults.** Many things influence an individual’s thoughts about death. Younger individuals typically place thoughts regarding death on hold, thinking that many years are left to plan for this unescapable event (Griffith et al., 2013).
Attitudes towards death in the younger population may show empathy towards those approaching death but many younger individuals often have pre-formed ideas about death that will cause them to disengage from the older adult population that is nearing the end of life (Bergman & Bodner, 2015). Attitudes towards death are often affected by the age of individuals (Niemeyer, Currier, Coleman, Tomer, & Samuel, 2011) and previous encounters of death that may have been experienced (Conner et al., 2014). Young children and adolescents often think less about death, since many times their only experience with death may be the loss of a pet or a very early recollection of losing a grandparent. Young individuals live with anticipation that they still have their entire lives before them (Niemeyer et al., 2011). Children, adolescents, and young adults expect to live a full life and never plan for an untimely death. When asked, adolescents admit that they have good attitudes about death when they foster strong religiosity because of the expectation of an after-life, and adolescents who have little or no relationship with a spiritual being show a less positive attitude when thinking about death because of the uncertainty of what happens to them after physical life on earth is done (Dezutter, Luyckx, & Hutsebaut, 2009; Griffith et al., 2013).

**Middle age.** Middle-aged adults may begin thinking about end-of-life planning, but usually not to the extent of older adults who often think more about dying, pre-plan their funerals, and set-up advanced directives that will guide loved ones with difficult health-care decisions that may be needed as death approaches (Holland et al., 2013). Middle-aged adults are in the midst of building their careers, raising families, and the beginning stages of retirement planning, but may find themselves thinking more about end-of-life matters as different life events occur. Middle-aged adults often have a different perspective on life than their younger counterparts, and those who have a strong relationship with God or another professed spiritual
entity have a more positive outlook towards death than middle-aged individuals with little or no religiosity. Some middle-aged individuals report that lack of time hinders their ability to focus on religious matters, which may cause more death anxiety in these individuals (Dezutter et al., 2009; Ka-Ying Hui & Coleman, 2012).

**Older adults.** As people age, it is most often assumed that death is something that older individuals have planned for and are prepared to experience. Common assumptions regarding older adults being more fearful of impending death are unfounded (Niemeyer et al., 2011). Many older adults have a more positive attitude regarding death, which may be related to impairment caused by physical problems and over-all decline of health, causing them to anticipate the pain and struggling to be over. Older adults typically have a more positive outlook towards death and palliative care measures when strong religious beliefs are present (Fortner & Niemeyer, 1999; Ka-Ying Hui & Coleman, 2012) but living in pain, isolation, or thoughts of impending doom often leave older adults anticipating death in order to be relieved of suffering (Soon, Ok, & Nam, 2015). Older adults’ death attitudes often differ depending on the quality of life they are experiencing. Living with chronic debilitating illnesses may cause some older adults to welcome death as an escape from pain and difficult living (Bookwala et al., 2015). Research has shown that older adults in general have more positive attitudes towards death as end-of-life care and expectations are discussed (Manu et al., 2012; Soon, Ok, & Nam, 2015).

**Religiosity and Death Attitude**

Religiosity is defined as the amount of organizational, non-organizational, and intrinsic religious activities displayed by individuals (Koenig & Bussing, 2010) and religiosity can have an impact on end-of-life beliefs (Feiss, 2015). Life and death are interwoven (Hudson, 2014) and regardless of what individuals believe about their own mortality, death is inescapable. Many
individuals who have suddenly become ill and find their mortality threatened report that they find themselves thinking about death and the possibility that their life may come to an end (Abu-El-Noor & Abu-El-Noor, 2016) and Feiss (2015) urges those without faith to trust in Christ to allow Him to be with them through the peaks and the valleys. Religious beliefs of life after death allow many individuals to have a more positive attitude towards death because people who believe that the inner-being lives on after death often anticipate living a more glorious after-life (Ka-Ying Hui & Coleman, 2012). A more optimistic outlook towards death is found in individuals who demonstrate a strong religious commitment, especially when linked to the belief of an after-life in heaven (Coleman, McKiernan, Mills, & Speck, 2007; Flannelly, Christopher, Galek, & Silton, 2012; Thiselton, 2012) and those consistent in their religious beliefs and worship methods have a more positive outlook towards end-of-life matters (Coleman et al., 2007). Many individuals with a belief in the afterlife may assist in dealing with major life problems and loss of life (Flannelly, Ellison, Galek, & Koenig, 2008; Harding, Flannelly, Weaver, & Costa, 2005), and high levels of intrinsic religiosity, or deep commitment to God, often leads to decreased anxiety towards death and a positive outlook regarding educating patients about end-of-life care expectations (Bjarnason, 2010; Daaleman & Dobbs, 2009).

Religious beliefs held by those professing to be of the Christian faith acknowledge that death is inescapable and will affect every person (Romans 5:12). Hope of life after death for Christians (1 John 4:18) allows professing Christians to calmly discuss and approach death, recognizing that the end of physical life does not end the individual’s existence. Personal knowledge that the Heavenly Father is in control of those who have placed their trust in Him provides an everlasting peace (Isaiah 26:3), while belief in an afterlife and the existence of God allows Christians to approach death calmly and employ a more positive attitude towards death.
(Fortner & Niemeyer, 1999; John 3:16; Niemeyer et al., 2011). Christians who demonstrate high intrinsic religiosity demonstrate a strong relationship with God and find this relationship comforting when making plans as physical life draws to a close (Ka-Ying Hui & Coleman, 2012). Christians believe that God’s promise of being absent from the body will mean being present with Him (2 Corinthians 5:8). Death for a Christian means the soul will ascend to heaven to be with Christ, which is viewed to be far superior to life on earth (Living His Word, 2016).

**Planning for Death**

People approaching the end of life are faced with many thoughts, emotions, and decisions, including the type of care that will be administered (Carrese & Rhodes, 2016). Dying patients who are of sound cognitive function often evaluate personal and spiritual well-being when considering end-of-life options (Edwards, Pang, Shiu, & Chan, 2010) realizing that extreme physical, spiritual, and emotional suffering may occur, effective care management is needed to manage all symptoms to promote a peaceful, dignified death (Rome, Luminais, Bourgeois, & Blais, 2011). Although many individuals carefully anticipate and plan for death, meticulous planning does not always ease the decision making that may be needed when individuals become ill or severely debilitated (Carrese, Mullaney, Faden, Wagley, & Finucane, 2011).

**Dying Patients’ Attitudes towards Death**

Hospice patients who are facing a life-limiting illness or disease and only expect to live six months or less often demonstrate more positive attitudes towards death, which may be related to stronger religiosity due to a known shortened life expectancy (National Hospital and Palliative Care Organization, 2016). Individuals nearing the end of life often seek to make amends for wrongdoings in order to prepare to meet God, and increased spirituality improves attitudes
towards death and acceptance that life will soon be over (Ingebretsen & Sagbakken, 2016; Ruff, Jacobs, Fernandez, Bowen, & Gerber, 2011). Dying patients who recognize that life will soon be ending may choose to initiate a closer relationship with God, especially if the patient believes in an afterlife (Ardelt & Koenig, 2006; Koenig & Bussing, 2010), and if the patient has come to the realization that an account must be given for earthly actions (Romans 14:12). Although it is recognized that physical loss will be apparent in death, it will not be a spiritual loss for those with strong religiosity and a belief in life after death (Cicirelli, 2006; John 3:16).

Planning end-of-life care may bring about unexpected anxiety for the dying patient and their loved ones. If the pending death has been anticipated, less death anxiety may occur, but sudden events that precipitate death often produce extreme anxiety, despair, and negative attitudes regarding death. Chronically ill adults nearing the end of life that reported a strong closeness to God were more likely to plan in advance for end-of-life care (Dobbs, Emmett, Hammarth, & Daaleman, 2011). Physicians report that patients with a strong closeness to God often have a death plan in place and strong intrinsic religiosity is linked to more positive attitudes towards death (Fried, Bullock, Iannone, & O’Leary, 2009). According to Daalemen and Dobbs (2010), positive attitudes towards death are tied into the belief of an afterlife, and religiosity is closely linked with improved psychological well-being and approach towards death.

**Attitudes of Nursing towards Death**

Preservation of life is the main focus of nursing care, but death is an unavoidable event at some point in every person’s life (Sinclair, 2011). Nurses provide the first line of care to those near death, and their attitudes towards death are vital in delivery of care (Grubb & Arthur, 2016). Research has shown that nurses’ attitudes towards death can adversely affect their ability to provide effective end-of-life care (Deffner & Bell, 2005) and a combination of social, economic,
and environmental factors has changed how nurses in the 20th century view and deal with death (Bailey, Murphy, & Porock, 2011). Nurses hold a pivotal role in the type of care patients receive at the end of life, and nurses who develop good relationships with long-term patients have a more positive attitude towards death (Tranter, Josland, & Turner, 2016; Zomorodi & Lynn, 2010). Development of strong nurse-patient relationships not only enhances the delivery of patient care but recognizes the patient, as a human being, can have a significant impact on personal attitude development towards patient care (Ingebretsen & Sagbakken, 2016). In addition, nurses with more patient care experience tend to demonstrate a more positive attitude towards death than nurses with little or no patient care experience (Gama, Filipe, & Vieira, 2012).

Facing death can be formidable (Henoch et al., 2014), and nurses often create barriers of protection to alleviate feelings of loss and despair that may be experienced personally and professionally (Bailey et al., 2011). Research has shown that some nurses admit to providing professional, respectful end-of-life care without allowing themselves to become too attached to dying patients (Broom et al., 2015; Gerow et al., 2010). Feelings of ambiguity regarding death cause nurses to avoid death topics and often contribute to negative attitude formation towards death and avoidance of palliative patient care assignments (Peterson et al., 2010). However, one research study reported that nurses who had repeated exposure to dying patients and provided end-of-life care indicated that these experiences gave them a more positive outlook on life (Sinclair, 2011).

**Religiosity in nursing.** Nurses have the responsibility of caring for the whole patient. Starting with the head-to-toe physical assessment, nurses have the responsibility to include a spiritual assessment to meet the needs of recovering and dying patients (Smyth & Allen, 2011;
The Joint Commission, 2016). Although it is a requirement to address the spiritual needs of all patients, healthcare facilities have the liberty to determine what is included during a spiritual assessment completion (The Joint Commission, 2016). Research confirmed the importance of integrating individual spirituality when providing end-of-life care, and many nurses recognize the importance of incorporating spirituality that is congruent with the patient’s beliefs when providing care (Nascimento et al., 2016; Pang, Shiu, & Chan, 2010). While accrediting bodies require the inclusion of a spiritual assessment for all patients and though research supports inclusion of spirituality in patient care, many nurses still avoid spiritual assessment due to the overlap of spirituality, religious beliefs, and addressing a topic that often brings discomfort and fear (Johnston, Park, & Pfeiffer, 2014).

Nurses who have a strong belief in an afterlife existence have a more positive attitude towards dying, and nurses who provided care frequently to dying patients reported that a combination of repeated exposure, personal beliefs, and end-of-life training also played a factor in their positive attitudes towards care of the dying (Dunn, Otten, & Stephens, 2005). Feudtner et al. (2007) and Virginio et al. (2014) showed that nurses with high levels of hope in life after death had more positive attitudes towards providing palliative care, had a good understanding of personal views on mortality, and were able to communicate more easily regarding end-of-life matters than nurses who had negative attitudes towards caring for dying patients.

Studies have shown that positive attitudes towards providing care to the dying is strongly linked to the nurse having a personal comfort with dying, hope in life after death, holding religious beliefs that influence feelings towards death, and religious views that helped nurses cope with end-of-life adversity (Bakibinga, Vinje, & Mittelmark, 2014; Frommelt, 2003; Kane, Hellsten, & Coldsmith, 2004; Solabarrieta et al., 2011). Nurses who profess spirituality often
report a more positive formation of death attitudes and demonstrate a more positive attitude towards caring for dying patients in the clinical setting because spiritual hope can be offered when physical hope is gone (Abu-El-Noor & Abu-El-Noor, 2016; Mallory & Allen, 2006). Braun, Gordan, and Uziley (2010) show that many nurses recognize the importance of religious practices and the belief in God to promote a more positive attitude towards living out their last days.

Nursing’s Attitude towards Care of Dying

Personal values and experiences influence attitude formation that is often manifested through certain actions which may be displayed in personal and professional behaviors (Mendez et al., 2014; Rassin, 2008). Research has shown that death of a patient is a major stressor for nurses, and since experiencing the death of a patient is an event that most nurses will face during their nursing career, these experiences will elicit various personal physical and emotional responses that affect attitude formation towards caring for dying patients (Buurman, Mank, Beijer, & Olff, 2011; Wilson & Kirshbaum, 2011); nurses who have a strong anxiety regarding death in general may already have negative attitudes regarding provision of end-of-life care (Peters et al., 2013).

Palliative care experts emphasize the importance of competent, expert, end-of-life care (Melvin, 2012) while recognizing the strain that is placed on nurses who provide care to dying patients (Huang, Chen, & Hsien-Hsien, 2016). Nurses who have experienced early exposure to dying patients need to develop their own self-awareness regarding death, and these nurses often report negative attitudes towards provision of palliative care (Brockopp, King, & Hamilton, 1991); nurses that have already formed an attitude towards providing care to dying patients often find it difficult to provide effective palliative care when negative attitudes are held towards
caring for the dying. Many nurses experience difficulty facing or even thinking about death, which can significantly hinder their ability to provide effective care to dying patients (Brockopp et al., 1991; Abu-El-Noor & Abu-El-Noor, 2016; Anderson, Kent, & Owens, 2014). Personal issues regarding death have negatively impacted nurses’ attitudes towards provision of palliative patient care (Luckett et al., 2014) and generalist nurses carrying out palliative care duties requiring specific skill sets in non-specialty units presents additional challenges that often create added emotional distress (American Nurses Association, 2015a; Johanssen & Lindahl, 2012).

Nurses provide some type of patient care each time they step into the healthcare setting and expect to help their patients reach an optimal level of functioning, but at times every nurse is faced with providing care to a dying patient in both emergent and end-of-life situations (Gagnon & Duggleby, 2014; Johanssen & Lindahl, 2012). Since science has advanced the ability to keep patients alive longer, and nursing’s general focus is aimed at providing physical care to improve patient conditions while returning to optimum levels of functioning, providing care to dying patients goes against the nurses training to bring each patient back to health. For this reason, caring for dying patients is often viewed as an overwhelming task, both emotionally and physically, that may unmask deep-rooted personal feelings about death while possibly cause feelings of nursing care failure (Andersson et al., 2016; Gilliland, 2015). Frustration is experienced by many nurses when the focus of care shifts from curative to palliative, which is often out of their practice area or comfort zone (Zomorodi & Lynn, 2010).

Nursing care is absorbed with restoration of well-being and health maintenance in most clinical settings, but challenges exist and feelings of powerlessness develop when nurses are expected to carry a mixed patient load that consists of providing competent care for recovering and dying patients at the same time (Andersson et al., 2016; Ellershaw & Ward, 2003; Gagnon &
Dubbleby, 2013; Johanssen & Lindahl, 2012). Although most nurses must care for a dying patient during their careers, death can create emotionally charged situations, causing extreme stress for nurses (Heise & Gilpin, 2016). Nurses must also be prepared to provide proficient care in rapidly deteriorating situations when it is determined that patients may only have days or hours to live. Since many nurses work in settings where death may be an infrequent occurrence, personal attitudes towards providing care to the dying may hinder their abilities to provide effective care (Beauchamp & Sparkes, 2014). Gama, Barbosa, and Vieira (2012) indicated the importance of nurses’ attitudes towards care of the dying in order to provide a positive end-of-life experience (Chang et al., 2012). Positive nurse attitudes towards care of the dying are linked to more effective end-of-life care, and Johanssen and Lindahl (2012) and Thompson (1985) theorized that the more nurses care for the dying the more comfortable they will become with providing palliative care.

According to the views discussed by Marcysiak and Dabrowska (2013), nurses will often indirectly project negative attitudes towards care of the dying on other nurses and nursing students, which may influence the development of negative attitudes towards palliative care in these other nurses and nursing students. Research shows that lack of education during nurses’ training, personal experiences, and cultural beliefs about death often influences the formation of attitudes towards death that nurses possess, and unfortunately, many times the attitudes towards caring for dying patients is not one that is viewed in a positive manner (Iranmanesh et al., 2010). Nurses have a responsibility to provide a peaceful and qualitative end-of-life experience for dying patients (International Council of Nurses, 2016). Nurses enrolled in end-of-life training demonstrated a more positive attitude towards care of dying patients after training was completed, but one study showed that nurses needed more education related to emotional support
towards care of dying than actual training in end-of-life care (Johanssen & Lindahl, 2012).

Although end-of-life education is important, attitudes towards death are still a key factor in providing effective care to dying patients (Mastroianni et al., 2015).

Nurses who provide care to the terminally ill find this task overwhelming because they are the professional caregivers with the greatest contact with dying patients (Grubb & Arthur, 2016) and this care requires close observation, frequent medication administration, continual family support, and completion of all basic patient care needs which are in addition to carrying a full patient load (Gagnon & Duggleby, 2014). Nurses also report emotional instabilities, remembrance of previous death experiences, and self-conflict when continually faced with palliative care patients, which causes significant difficulty switching between the care provided to dying patients and then to other patients who are on the road to recovery (Cook et al., 2012; Gagnon & Duggleby, 2014; Liu et al., 2011). As nurses become overwhelmed physically and emotionally when providing palliative care, an increased awareness of personal mortality emerges, which can cause even more emotional distress and fear of personal overload (Andersson et al., 2016; Gagnon & Duggleby, 2014; Johanssen & Lindahl, 2012; Redinbaugh, Shuerger, Weiss, Brufsky, & Arnold, 2001).

Nurses are often overwhelmed when assigned to recovering and dying patients at the same time, and this can create negative feelings towards palliative care (Gagnon & Duggleby, 2014) while dealing with the expectation to deal periodically with balancing curative and palliative care, an expectation that many nurses report as difficult (James, Andershed, Gustavsson, & Turnestedt, 2010). As a result of the daunting task of providing care to dying patients, many nurses develop negative attitudes towards palliative care due to fear and anxiety related to the possibility of their own death. Negative attitudes towards death and providing care
to dying patients creates negative attitudes regarding the provision of palliative care in an effective manner and attempts to avoid end-of-life patient care assignments (Cook et al., 2012; Gama, Barbosa, & Vieira, 2012; Jeong, Higgins, & McMillan, 2011; Lange et al., 2008; Sneesby, Satchell, Good, & van der Riet, 2011). Nurses that report inadequate end-of-life training often develop negative attitudes towards caring for dying patients, but clinical experience with end-of-life care improves the nurse’s ability to communicate with and care for dying patients (Ellershaw & Ward, 2003; Gagnon & Duggleby, 2014).

Nurses have the responsibility to care for wounded, traumatized, chronically ailing, and acutely ill patients, often at the same time as managing the care for the dying (Coetzee & Klopper, 2010). Since nurses have a responsibility to provide holistic patient care to all patients, including the dying (American Nurses Association, 2015b; Gagnon & Duggleby, 2014), it is important for nurses to have a positive attitude towards dying patients in order to adequately meet their end-of-life needs. Leininger’s (2002) Cultural Care Theory indicates that care of the dying elicits different emotions from past experiences with death, which can result in positive or negative attitude development. Dunn, Otten, and Stephens (2005) showed that nurses who provided care consistently to dying patients and had years of experience doing so had a more positive attitude towards care of the dying (Lange et al., 2008; Rooda et al., 1999). Gagnon and Duggleby (2014) noted similar findings, however, one significant factor in this study revealed that most nurses were from a Catholic background and held a baccalaureate degree in nursing.

**Professional responsibility towards care of dying.** Nurses have a professional responsibility in both curative and palliative settings to care for all patients’ physical, emotional, and spiritual needs (American Nurses Association, 2015a; Giske & Hone, 2015) and the nurse’s primary commitment is to provide physical, emotional, and spiritual care in end-of-life settings
without proselytizing their own religious views while skillfully meeting all the patient’s needs (Taylor, Park, & Pfeiffer, 2014). The Institute of Medicine (2008) reported that the number of older adults continues to grow, and as this population increases, responsibility will be placed on nursing to provide effective, competent end-of-life care. Research has shown that incorporation of spiritual care to dying patients results in better end-of-life outcomes, and nurses are responsible to incorporate spiritual care as desired by the patient during any healthcare visit or hospital stay (Johanssen & Lindahl, 2012). Completion of a spiritual assessment is now a required assessment when patients are admitted to the hospital for any reason (American Nurses Association, 2015a; The Joint Commission, 2016). Regardless of the patient’s prognosis, the International Council of Nursing (2012) Code of Ethics denoted that nursing care should be consistent for all patients, which includes assessment of spiritual needs. Although it is the nurse’s responsibility to provide holistic care to dying patients (American Nurses Association, 2015a), the nurse’s attitude towards providing palliative care will have a significant impact on his or her ability to do so effectively (Doran, Sidani, Keatings, & Doidge, 2002; Johanssen & Lindahl, 2012; Manojlovich, 2005).

Since nurses have the responsibility to provide individualized, holistic care (Christensen & Hewitt-Taylor, 2006) to both palliative and curative patients, it is important for nurses to address their own attitudes regarding death and prior death experiences (Braun, Gordon, & Uziley, 2010) while recognizing that caring for dying patients may suddenly bring back prior experiences with death that may cause extreme emotional pain (Huang et al., 2016). Research suggests that nurses working consistently in palliative care settings have personal attitudes towards death and dying that are directly linked with previous personal experiences with dying
patients, and negative attitudes towards death may cause nurses to struggle with the responsibility to provide effective palliative care (Braun, Gordon, & Uziley, 2010).

Factors that Influence Nursing Attitudes

Experience and emotions. Many factors influence the development of personal attitudes and beliefs, and it is important for nurses and nursing students to identify and work through personal feelings, attitudes, and beliefs regarding death and not allow these areas to interfere with providing effective, competent care to patients with unique end-of-life care needs (Arslan et al., 2014). Research has suggested that nursing students’ first exposure to death can be pivotal in attitude formation regarding end-of-life care, and strong support is needed during early clinical encounters to ensure positive attitudes develop about provision of palliative care (Henoch et al., 2014). Failure to deal with personal feelings and beliefs about death may lead to development of negative attitudes towards end-of-life care and hinder nurses’ abilities to provide appropriate care to dying patients and their families (Anderson, Kent, & Owens, 2014; Arslan et al., 2014). Due to the strong focus on promotion of health and curative nursing measures, many nursing students feel inadequately prepared to provide physical and spiritual care to dying patients, which leads to high anxiety and development of negative attitudes towards palliative care (Mallory, 2003; Moreland et al., 2012).

Jenkins (2011) discussed the emotional trauma that a dying patient places on nursing students, as this often negatively affects attitude formation towards care of the dying. Failure to address personal feelings about death and care of dying patients combined with feelings of unpreparedness to deal with patients in palliative care settings will most likely produce nurses who develop negative attitudes towards providing end-of-life care (Poultney, Berridge, & Malkin, 2014). Nursing students often view care of the dying as one of the most unpleasant tasks
that they will ever perform, and the uncertainties about care expectations for this patient population is often the reason for development of negative attitudes towards provision of palliative care (Allchin, 2006; Jenkins, 2011). Nursing students have the potential to develop positive attitudes towards the care of dying patients, and positive attitude development is strongly influenced by the type of end-of-life exposure experienced (Grubb & Arthur, 2016; Henoch et al., 2014). Since death produces fear and anxiety for many nurses and nursing students, these feelings significantly impact attitudes towards death (Gama, Vieira, & Barbosa, 2012). Nursing students who report a low level of death acceptance also report a more negative attitude towards caring for dying patients (Marcysiak & Dabrowska, 2013) but students who met and cared for dying patients expressed a more positive outlook when faced with providing end-of-life care (Hagelin et al., 2009).

**Religiosity.** Religiosity influences death attitude formation and needs to be recognized as attitudes towards death are evaluated. Religious beliefs that are influenced by culture and ethnicity may have a huge impact on how individuals view death and how end-of-life care is provided (Bharathy, Malayapillay, & Russell, 2013; Holloway, 2006). Studies conducted in the United States indicate that nurses and students with more religiosity had more positive attitudes towards caring for dying patients, and students who had little or no religiosity displayed more negative attitudes towards providing care for the dying (Frommelt, 1991; Frommelt, 2003). Students with high after-life expectations often have more of a positive attitude towards dying patients, and many nursing students with little or no religiosity report more negative attitudes and anxiety when faced with providing care to dying patients (Fabro, Schaffer, & Scharton, 2014; Gesser, Wong, & Reker, 1987; Moreland et al., 2012).
International Nursing Attitudes

Death is a universal phenomenon that occurs all over the world, and nurses in almost every setting will have the opportunity to care for dying patients (Henoch et al., 2014). Exploration of nursing attitudes towards caring for dying patients outside of the United States revealed findings that were consistent with nurses’ attitudes towards death in the United States, but there were some noted differences. Korean nurses demonstrate more positive attitudes towards care of the dying the longer they have practiced nursing (Park & Yeom, 2014) but Egyptian nurses’ attitudes towards care of dying was not dependent on length of time in nursing (Waafa & Nahed, 2010). Research in Nigerian hospitals revealed that attitudes towards palliative care were more concerned with types of treatment than attitudes of nurses towards providing the actual end-of-life care (Fadare, Obimakinde, Afolayan, Popoola, & Adoloju, 2014). A review of Greek nurses’ attitudes towards care of dying revealed more neutral attitudes to provision of palliative care in nurses with more experience in the healthcare setting (Zyga, Malliarou, Lavdaniti, Athanasopoulou, & Sarafis, 2011). Japanese nurses demonstrated negativity towards care of dying patients when their own fear of death was high (Matsui & Braun, 2010) and fear of death was an overwhelming factor in attitudes towards providing care to dying patients in Iranian nursing facilities (Iranmanesh, Savenstedt, & Abbaszadeh, 2008). Broom et al. (2015) reported interesting research findings that showed that Australian nurses did not have a problem providing competent, professional care to dying patients but made sure to distance themselves from becoming too attached to this patient population. Henoch et al. (2014) compared death attitudes among nurses in the United States, Israel, Sweden, and Japan and this research showed that although attitudes towards death had some minor differences, the attitudes towards death in the United States were very similar to those demonstrated in Israel, Sweden, and Japan.
Student Nurses’ Attitudes towards Care of Dying

Nursing students eagerly anticipate the start of clinical exercises and the ability to receive patient care experiences in the hospital setting. Many emotions arise as nursing students interact with patients, clinical faculty, healthcare workers, and other students as adjustments are made to meet nursing unit expectations. Many nursing students report high anxiety when entering the healthcare setting due to lack of clinical experience, the threat of possible exposure to dying patients, and provision of palliative care (Arielli, 2013; Melincalvage, 2011). Many nursing students have classified caring for dying patients as frightening, while overall experiences surrounding death can impact student nurses’ attitude development towards providing care to dying patients; these factors often cause students to have high levels of emotional distress while facing mortality on a more personal level (Conner, Loerzel, & Uddin, 2014; Lopez-Perez et al., 2016; Osterlind et al., 2016; Van der Wath & Du Toit, 2015). Nursing students who are training to become the future of tomorrow’s nursing care providers are often fearful that they will be assigned to care for a dying patient during their time on an assigned clinical unit (Pfitzinger & Becker, 2015; Waters, 2008). Clinical faculty will often avoid assigning nursing students to a dying patient in order not to overwhelm them as they learn to provide patient care. However, electing to avoid allowing nursing students the chance to provide care to the dying can negatively impact future attitude formation related to caring for dying patients (Abu-El-Noor & Abu-El-Noor, 2016). If nursing students are assigned to care for a dying patient, students report feeling unsupported by nursing staff and faculty and develop high anxiety towards provision of end-of-life care (Heise & Gilpin, 2016; Pfitzinger & Becker, 2015). Depending on the type of patients that the nursing instructor selects or the nurses recommend for student assignments,
some nursing students may have the opportunity to provide care to dying patients while other students might not have this experience until they have become a registered nurse.

Ensuring that nursing students are providing exposure to dying patients under close supervision during clinical experiences can better prepare nursing students to provide palliative care and form positive attitudes towards caring for dying patients (Iranmanesh et al., 2010) and although Poultney, Berridge, and Malkin (2014) report that student nurses will have end of life exposure as soon as nursing education is started, this exposure is often limited to classroom experience with the intermittent possibility that will enable students to actually provide physical end-of-life care to dying patients in the clinical setting (Ek et al., 2014). The limitation to actual exposure to providing palliative care in the clinical setting is for several reasons: (a) nursing staff on clinical units often instruct clinical instructors to avoid assigning nursing students to dying patients because families are on edge and do not want the added stress of having students practicing nursing skills on their dying loved one, (b) nursing students do not want to be assigned to a dying patient, especially at lower levels in the nursing program, and (c) actively dying patients may not be on the units where the students are assigned for clinical. Finding ways to ensure that all nursing students have increased exposure to providing end-of-life care to dying patients in addition to classroom lectures and seminars is vital to assisting them in developing positive attitudes towards caring for dying patients (Pfitzinger & Becker, 2015; Poultney et al., 2014).

Meeting the needs for dying patients is overwhelming to nursing students as they find it difficult to effectively deal with the physical suffering that many dying patients experience (Arslan et al., 2014). Studies have shown that through the years, many nursing students report anxiety related to clinical performance, demonstration of skill competence, and the death of
patients, which are often related to the development of personal negative feelings towards providing end-of-life nursing care (Fabro et al., 2014; Grassi-Russo & Morris, 1981). Although first year nursing students anxiously anticipate the start of clinical experiences, historically, many students also faced anxiety related to the physical suffering of dying patients that was witnessed during clinical experiences (Arslan et al., 2014; Cooper & Barnett, 2005). Since approximately 76% of dying patients are provided hospital care, it is important that nursing students formulate positive attitudes towards death in order to promote effective and proficient provision of end-of-life care (Bailey et al., 2011). Feelings of competence in care of the dying promotes development of more positive attitudes towards death (Moreland et al., 2012).

**International Nursing Student Attitudes**

Review of research conducted in nursing programs in different countries revealed opposite findings of nursing students in the United States. Iranmanesh, Axelsson, Haggstrom, and Savenstedt (2010) reported that Swedish and Iranian nursing students with more religiosity demonstrated more negative attitudes towards providing care to dying patients and students who reported little religiosity displayed more positive attitudes towards providing care to dying patients in the clinical setting. Interestingly, nurses from different countries report more negative attitudes towards care of the dying than nurses’ in the Western cultures where a majority of nurses identify themselves with Christianity (Dong et al., 2015). Some cultures consider discussion of death offensive, and Liu et al. (2011) noted that Taiwanese nursing students consider the topic of death taboo, but research enabled these students to recognize the importance of exploring their own attitudes towards death to assist them in providing effective end-of-life care. Research findings showed over half of the student participants refused to provide palliative care due to pre-conceived negative attitudes regarding death and dying (Arslan
et al., 2014) while senior level Palestinian nursing students demonstrated poor attitudes towards care of dying related to high anxiety and lack of preparedness (Abu-El-Noor & Abu-El-Noor, 2016). Nursing students surveyed in the United Kingdom interestingly showed that female students have a slightly more positive attitude towards death than their male colleagues, but the overall attitude towards caring for dying patients was mainly positive (Grubb & Arthur, 2016).

**Student Anxiety Related to End-of-Life Care**

As student nurses prepared to provide care in the clinical setting, it is a normal finding to experience some pre-clinical apprehension (Hung, Huang, & Lin, 2009). Student nurses often suffer high anxiety related to providing nursing care in the clinical setting, especially as beginning students (Cooper & Barnett, 2005); students often report that anxiety is due to feeling helpless, fear of being inadequately prepared, guilt and lack of clinical skills knowledge to provide effective care in end-of-life situations, and fear of nurses and family members reaction to their novice clinical skills ability (Colley, 2016; Liu et al., 2011). Specialized knowledge is needed to assist in providing effective end-of-life care, and although most student nurses feel prepared to provide basic nursing care, many nursing students report feelings of ill-preparedness when assigned to provide care for the dying. These nursing students report high anxiety related to the provision of palliative care and their perceptions of decreased ability to effectively provide this care in addition to being anxious related to the overall clinical experience (Conner et al., 2014; Leombruni et al., 2014).

Practicing nurses are expected to skillfully care for dying patients while ensuring they die a peaceful, dignified death. This same expectation is held for all levels of nursing students (Lippe & Becker, 2015). Multiple expectations for end-of-life care exist, and nursing students are often expected to provide palliative care at the level of experienced nurses. Nursing students who
already have high anxiety related to providing general nursing care often develop negative feelings towards providing palliative care when assigned to a dying patient (Heise & Gilpin, 2016; Iranmanesh et al., 2010). Faced with the reality of death and fears associated with providing palliative care can significantly influence nursing students’ attitude formation regarding care of dying patients (Loerzel, 2016; Parry, 2011), and nursing students who develop negative attitudes towards care of dying patients will experience difficulty in their abilities to provide effective end-of-life care to dying patients and their families (Gibbons et al., 2011; Henoch et al., 2014; Iranmanesh et al., 2010; Leombruni et al., 2014).

Previously formulated death attitudes. Some students may already have experienced providing care to a dying person, the death of a loved one, or have pre-conceived ideas regarding death, which has caused them to formulate positive or negative death attitudes due to the impact experienced from the end-of-life care they were able to deliver (Arslan et al., 2014; Leombruni et al., 2014). Many students report that watching someone close to them experience death is extremely influential in the type of attitude that was developed towards death and care of the dying prior to entering nursing school (Grubb & Arthur, 2016). It is important that students’ previous attitudes towards death and providing end-of-life comfort care are recognized and evaluated in order to allow them to deal with their own thoughts and feelings that may interfere with effective patient care (Colley, 2016). Loss of a loved one or providing care for a dying relative created the most significant impact on forming an attitude towards death, both positive and negative (Franke & Durlak, 1990; Niemeyer et al., 2011), and senior-level nursing students involved in providing end-of-life care had more positive attitudes towards care of dying patients than lower level students (Arslan et al., 2014).
Dealing with personal issues related to personal death experiences (Huang et al., 2016) and receipt of palliative care training have also been reported by nursing students as helpful measures to prepare them to formulate more positive attitudes towards care of dying patients while learning what to expect and the type of care that is needed in end-of-life situations (Leombruni et al., 2014). Nursing students who completed end-of-life care training reported feelings of better proficiency and more positive attitudes towards caring for the dying than students at the same training level that did not have training or any end-of-life provision of care experiences (Bray, 2012; Frommelt, 2003; Mastroianni et al., 2015). Arslan et al. (2014) also showed that dealing with personal death feelings and learning about end-of-life care helped nursing students develop more positive attitudes towards caring for the dying.

**Novice to expert theory.** Due to nursing student’s novice state of providing patient care, nursing students are more task-oriented and may not be able to critically determine emotional needs of dying patients and their families. It does not come naturally to actively listen and respond empathically to dying patients and their families; many students feel that they need to have profound words to convey in end-of-life situations and indicate helplessness when they cannot do anything to help the dying patient and his or her family. It is difficult for nurses and nursing students alike to recognize that there is a time when nothing additional can be done to prolong the patient’s life, and this may evoke the arousal of personal anxieties, fears, and interaction skills regarding death that has been learned from family and life experiences; these areas must be channeled into positive learning to better assist the dying patient and their family (Benner, 2001).
Summary

Death is something that will affect every person sooner or later and is an emotionally charged issue that is often avoided (Adesina et al., 2014). Nurses will be exposed to death and dying during their careers, and regardless of years in nursing, death experiences leave an impression that lasts a lifetime. Dying patients present a unique set of care needs that are often overwhelming for many nurses to handle effectively. Personal beliefs and views towards death by patients and nurses can hinder the ability of the nurse to provide effective care; nurses’ personal beliefs and views can significantly impact the ability to meet the needs for dying patients and their families (Lange et al., 2008). Nurses with strong religiosity have more positive attitudes towards providing end-of-life care to dying patients (Solabarrieta et al., 2011). Nursing students present with the same attitudes towards care of dying patients that are influenced by personal beliefs and cultural views and clinical experiences, or lack thereof, with dying patients can lead to development of negative attitudes towards care of the dying. Religiosity has a major impact on attitude formation related to death; the higher the reported religiosity, the more positive the attitudes towards providing care for the dying (Leombruni et al., 2014). Christianity provides eternal hope of life after death for all believers in Jesus Christ (John 3:16) and individuals with a strong hope and belief in life after death have the most positive attitudes towards providing care for the dying (Arslan et al., 2014).

Although the literature addresses multiple areas regarding death, attitudes towards death, and nursing’s attitude towards care of dying patients, the gap identified is that the literature has limited research on all levels of pre-licensure nursing students’ feelings about death and literature has not addressed attitudes towards care of dying of all levels of pre-licensure nursing students that attend a Christian university while accounting for religiosity. Investigating the
attitudes of all levels of pre-licensure nursing students at a Christian university while accounting for religiosity may yield information regarding Christian nursing students’ attitudes towards providing care to dying patients. The information from this study may provide information that suggests Christian nursing students at a Christian university should display the highest attitudes towards providing care for the dying, because when prognosis is poor, spiritual hope still exists.
CHAPTER THREE: METHODS

Overview

The purpose of this quantitative causal-comparative study was to examine the attitudes of sophomore, junior, and senior nursing students towards the care of dying patients at a Christian university while controlling for religiosity. Analysis of Covariance (ANCOVA) was used to determine if attitudes towards care of dying patients are affected by religious beliefs. Chapter Three will include a discussion of the study’s design, research questions and hypothesis, participants, setting, procedures, and data analysis.

Design

A quantitative, causal-comparative research design was used for this study. According to Gall, Gall, and Borg (2007), a causal-comparative research design should be used to determine if an independent variable has an effect on the dependent variable between pre-existing groups. Since this study’s purpose was to determine attitudes towards caring for dying patients while controlling for religiosity in pre-licensure sophomore, junior, and senior nursing students, the causal-comparative research design was appropriate for this study.

The independent variable in this study was the program year of nursing students: sophomore nursing students were taking 200 level nursing classes and completing clinical experiences appropriate for sophomore level nursing students, junior nursing students were taking 300 level nursing classes and completing clinical experiences appropriate for junior level nursing students, and senior nursing students were taking 400 level nursing classes and completing clinical experiences appropriate for senior level nursing students.

The dependent variable in this study was attitudes of sophomore, junior, and senior nursing students towards care of dying patients. According to Emery (2013), death was defined
as the cessation of respirations, heartbeat, brain activity, and cellular activity. Attitudes towards care of dying patients are defined as positive or negative beliefs possessed by individuals who are providing care for dying patients (Lange et al., 2008).

The covariate in this study was religiosity. According to Koenig and Bussing (2010) religiosity was defined as the amount of organizational religious activities, non-organizational religious activities, and intrinsic religious activities displayed by individuals who consider themselves to be religious. Organizational religious activities include attending church services, participating in prayer groups, involvement in religious study groups, etc. Non-organizational Religious Activities include private worship, private prayer, private scripture study, and watching religious programs on television. Intrinsic religiosity refers to the amount of religious commitment that an individual displays towards a religious belief.

Research Question

RQ1: Is there a difference in attitudes towards care of dying patients among sophomore, junior, and senior pre-licensure nursing students at a Christian university while controlling for religiosity?

Null Hypothesis

H01: There is no statistically significant difference in attitudes towards care of dying patients among sophomore, junior, and senior pre-licensure nursing students at a Christian university while controlling for religiosity.

Participants and Setting

The population for this study was taken from nursing students who attended a faith-based university located in a small, middle-class city in the southeastern region of the United States. Although many local students from the city and surrounding counties attend the university,
students from all over the United States and many different countries choose to attend this university.

The sampling procedure used for this study was convenience sampling of all pre-licensure nursing students 18 years or older in the fall 2016 nursing classes at a large Christian university. The sample was identified as all students who have been accepted into the nursing program and were taking required core nursing courses at the sophomore, junior, and senior levels.

The participants for this study were selected by the researcher and consisted of 137 sophomores, 142 juniors, and 138 senior pre-licensure nursing students. The total number of participants in the study was 417 nursing students, which, according to Gall, Gall, and Borg (2007), exceeds the minimum sample size of 126 for adequate analysis to obtain a medium effect size at the .05 alpha level with a statistical power of .7. The study was introduced to the sample through pre-determined nursing courses, which included a detailed explanation of the research study and that participation in the research would consist of completing two brief, self-report questionnaires during a pre-determined time in one of their scheduled nursing classes. Elicitation of participation was gained by explaining to students that nursing practice is based on evidence gained through research, and their participation in this research study would yield important evidence regarding nursing attitudes towards care of dying patients. Participation in this study allowed students to be assistive in contributing to the body of nursing knowledge that guides nursing care. Students were made aware that they had the option to choose not to participate in the research study. At the time of the study, the sample of nursing students consisted of an average range of 18-22 years of age and the sample was 8.4% male and 91.4% female students, while one student failed to report gender (0.2%). Ethnicity was broken down and was reported as
predominantly Caucasian at 89.7%, Asian-Pacific Islander 5.5%, African American 1.4%, Latino/Hispanic 2.4%, and other 0.7%.

The setting for this study was inside a closed environment, in an auditorium style classroom that had Wi-Fi access and overhead projector capabilities. Pre-determined undergraduate residential nursing classes were used for survey administration. The Health Assessment course (NURS 210) was used to administer the surveys to sophomore nursing students, the MedSurg course (NURS 301) was used to administer the surveys to junior nursing students, and the Nursing Leadership course (NURS 490) was used to administer the surveys to senior nursing students.

The group of sophomore nursing students was a naturally occurring group of students that declared nursing as a major, were taking sophomore level nursing classes, and had approximately 200 clinical hours. The Health Assessment course (NURS 210) was used to administer the surveys to sophomore nursing students. The ages of students consisted of 95% in the 18-22 years old age range, 2.9% in the 23-27 years old age range, 0.7% in the 28-32 years old range, 0.7% in the 33-37 years old age range, 0.7% in the > 38 years old range, and gender consisted of 7.3% males and 92.7% female students. Ethnicity of sophomore students was broken down into 86.9% Caucasian, 0.7% African American, 2.9% Hispanic/Latino, 8% Asian/Pacific Islander, and 1.5% listed as other.

The group of junior nursing students was a naturally occurring group of students that declared nursing as a major, were taking junior level nursing classes, and had approximately 300 cumulative hours of clinical experience. The MedSurg course (NURS 301) was used to administer the surveys to junior nursing students. The group of junior nursing students consisted of 88.8% of students in the 18-22 years old age range, 9.8% in the 23-27 years old age range,
1.4% in the 33-37 years old age range, with 11.2% being males and 88.8% females. Ethnicity of senior students was broken down as 90.9% Caucasian, 2.1% African American, 0.7% Hispanic/Latino, 4.2% Asian/Pacific Islander, and 1.4% listed as other.

The group of senior nursing students was a naturally occurring group of students that declared nursing as a major, were taking senior level nursing classes, and had a total of 500+ cumulative hours of clinical experience. The Nursing Leadership course (NURS 490) was used to administer the surveys to senior nursing students. The group of senior nursing students consists of 75.2% of students in the 18-22 years old age range, 19.7% in the 23-27 years old age range, 5.1% in the 33-37 years old age range, with 6.6% being males and 93.4% being females. Ethnicity of senior students is broken down as 90.5% Caucasian, 1.5% African American, 3.6% Hispanic/Latino, and 4.4% Asian/Pacific Islander.

**Instrumentation**

The present study used two instruments to collect data, the Frommelt’s Attitude towards Care of Dying (FATCOD B) and the Duke University Religiosity Index (DUREL). The FATCOD B scale was developed in 1991 by Dr. Katherine H. Murray Frommelt to determine nurses’ attitudes towards providing care to dying patients (Frommelt, 1991). The Duke University Religiosity Index (DUREL) was developed in 1997 Bussing by Dr. Harold Koenig to determine the effect of religiosity on healthcare outcomes (Koenig & Bussing, 2010).

**Frommelt’s Attitudes towards Care of Dying**

The purpose of the FATCOD B scale was to measure attitudes towards care of dying patients in nursing (Frommelt, 2003). The FATCOD B scale has been used in multiple studies (Arslan et al., 2014; Lange et al., 2008; Leombruni et al., 2014). Validity and reliability has been established many times for the FATCOD using the test-retest method and a Cronbach’s alpha of
.93 was found (Lange et al., 2008). The FATCOD B scale, a 30 question Likert scale survey was an appropriate tool for this research as it was designed to measure attitudes of individuals providing care to the dying. Dr. Frommelt provided written permission to use the FATCOD B survey for this research study (see Appendix D).

Following Frommelt’s (1991) scale instructions, students responded to 30 self-report items that were designed to elicit attitudes towards care of dying patients. The instrument used a five-point Likert scale that ranged from strongly agree to strongly disagree. Responses were as follows: SD = Strongly Disagree, D = Disagree, U = Uncertain, A = Agree, and SA = Strongly Agree. Positive worded items were scored from 1 for strongly disagree to 5 for strongly agree. The scoring was reversed for negative worded items. Positive worded items were 1, 2, 4, 10,12,16,18, 20, 21, 22, 23, 24, 25, 27, and 30. Negative worded items were 3, 5, 6, 7, 8, 9, 11, 13, 14, 15, 17, 19, 26, 28, and 29. The combined possible score on the FATCOD B ranges from 30 to 150 points. A score of 30 is the lowest possible score, meaning that a negative attitude towards care of dying was reflected, and a score of 150 is the highest possible score, meaning that a positive attitude towards care of dying was reflected; therefore, higher scores reflected more positive attitudes and lower scores reflected more negative attitudes towards providing care for dying patients. The research assistant reviewed the purpose of the study and the instructions for questionnaire completion provided with the survey. The survey was administered by the research assistant and took approximately 20 minutes to complete. The researcher scored the surveys once they were completed.

DUREL Index

The purpose of the DUREL Index was to determine if a relationship existed between religious beliefs and healthcare outcomes. The instrument was developed to meet the need for a
brief, comprehensive, low-measure of religiosity that could easily be included in research studies (Koenig & Bussing, 2010). The DUREL Index has been used in multiple studies (Lucchetti et al., 2012; Szaflarksi et al., 2013; Wilkerson, Smolensk, Brady, & Rosser, 2013). Internal consistency was demonstrated by a Cronbach’s alpha between .78 and .91 and the test-retest for reliability demonstrated a correlation coefficient of .91. The DUREL Index, a five question self-report survey that measures religious involvement of individuals was an appropriate tool for this research since attitudes towards care of dying patients was measured in all nursing students at a Christian university. Dr. Koenig provided written permission to use the DUREL Index for this research study (see Appendix E.).

Koenig and Bussing (2010) indicated that students would respond to five self-report items that assess three major dimensions of religious activity: (a) organizational religious activities, (b) non-organizational religious activities, and (c) intrinsic religious activities. Organizational religious activities include attending church services, participating in prayer groups, involvement in religious study groups, etc. Non-organizational religious activities include private worship, private prayer, private scripture study, and watching religious programs on television. Intrinsic religiosity refers to the amount of religious commitment that an individual displays. The instrument used a six-point Likert scale for item 1 that ranges from never to once a week. Responses were as follows: 1 = Never, 2 = Once a year or less, 3 = A few times a year, 4 = A few times a month, 5 = Once a week, and 6 = More than once a week. A six-point Likert scale is used for item 2 that ranges from rarely or never to daily. Responses were as follows: 1 = Rarely or never, 2 = A few times a month, 3 = Once a week 4 = Two or more times a week, 5= Daily, and 6 = More than once a day. A five-point Likert scale was used for items 3-5 that ranges from definitely not true to definitely true of me. Responses were as follows: 1 = Definitely not
true, 2 = Tends not to be true, 3 = Unsure, 4 = Tends to be true, and 5 = Definitely true of me.

The DUREL Index has an overall score range from 5 to 27. The combined possible score on the DUREL Index ranged from 0 to 27 points. A score of 5 was the lowest possible score, indicating that religious activities do not impact perception of daily life activities, and a score of 27 is the highest possible score, meaning that religious activities were an integral part of daily living and impacted all perceptions and areas of life.

Since the FATCOD B and the DUREL Index were administered at the same time, the research assistant reviewed the purpose of the DUREL Index at the same time the purpose of the FATCOD B was reviewed. The research assistant reviewed the instructions for the DUREL Index questionnaire completion at the same time the instructions for the FATCOD B were provided. The survey was administered by the research assistant and took approximately 10 minutes to complete. The researcher scored the surveys once they were completed.

**Procedures**

The researcher secured permission from the IRB and conducted the research study (see Appendix C). Upon receiving permission from the School of Nursing Dean to conduct the research study (see Appendix F), the researcher worked with nursing faculty and determined the class, date, and time for survey administration. Sophomore, junior, and senior nursing students received information related to the study in pre-selected, required nursing classes that explained the purpose of the study and information to elicit participation by placing emphasis on the value of research to produce evidence that guides nursing practice (see Appendix G). Students were notified that all survey responses would be anonymous and they could choose not to participate.

An auditorium style classroom with Wi-Fi access and overhead projector capabilities will be used for survey administration. On the day of the survey administration, the professor left the
classroom and the research assistant read a script that described the purpose of the study and instructions on how to participate in the survey, as well as proper procedures if students decided not to participate in the research study (see Appendix G). The survey instructions included information regarding the purpose of the study, eligibility to participate, instructions on survey completion, and information on confidentiality. Participants were instructed to exclude any personal identifying information on the consent form or surveys. After the research assistant finished reviewing the purpose of the study and survey instructions, the research assistant passed out the survey packets with pencils. The survey packet included the consent form (see Appendix H), the FATCOB B survey with demographic form, and the DUREL Index. All nursing students who reviewed the consent form and did not opt out of the study through completion of both surveys affirmed their consent to be included in the study. Students who opted out were asked to remain in their seats and work quietly on other course assignments. After receipt of the survey packet, students began completion of both surveys. Students who chose not to participate submitted a non-completed survey packet. The FATCOD B survey took approximately 20 minutes to complete and the DUREL Index took approximately 10 minutes to complete for a total of 30 minutes to complete both surveys. After 30 minutes, the research assistant collected the survey packets that were placed back inside the manila envelope to ensure that each student’s survey responses remained anonymous. The research assistant thanked the students for their participation after all surveys were collected. The completed survey packets were kept in sealed envelopes and were not removed from the envelopes until the data were entered into SPSS. In order to ensure responses remained anonymous and confidential, surveys were unable to be matched with student participants in any way. The participants were instructed to omit any
personal identifying information (such as student ID or name) on the surveys. The same protocol was utilized for each classroom of participants during survey administration.

The data were collected from the student responses provided on the FATCOD B and the DUREL Index. The Statistical Package for the Social Sciences 23 (SPSS 23) software was used to record and analyze data received from each of the surveys. Appropriate statistical testing was conducted to determine differences between the groups.

**Data Analysis**

The purpose of this research was to investigate the attitudes towards care of dying patients of all pre-licensure students at a Christian university while accounting for religiosity of all students surveyed. The data analyzed came from the FATCOD B survey and the DUREL Index survey. Descriptive statistics were used that included year in nursing program, age, ethnicity, primary language, previous history of caring for dying or previous end-of-life care training, while evaluating the score distribution of the 30 question FATCOD B scale, and the five question DUREL Index. The ANCOVA was used to determine if a difference was detected between groups on a dependent variable while controlling for a covariate. Use of the ANCOVA was beneficial to control for initial differences that were detected before determining variances that are present within and between the groups. The ANCOVA was also helpful because it was not possible for the researcher to select comparison groups that were well-matched except on the variable that is being studied (Gall, Gall, & Borg, 2007).

A box-and-whisker plot was used to test for extreme outliers when conducting this research study. Warner (2008) noted that use of a box-and-whisker plot is a procedure that tests for extreme scores that are high or low (outliers) when conducting research. Assumption of normality was tested with the Kolmogorov-Smirnov test since the sample size was greater than
50 participants for each group (Warner, 2008). Gall, Gall, and Borg (2007) noted that assumption of linearity and bivariate normal distribution is demonstrated through use of scatterplots. The Levene’s test was used to demonstrate that each group variance was the same. Assumption of homogeneity of slopes examined the similarity of slopes relating the covariate to the dependent variable (Green & Salkind, 2011). The Analysis of Covariance (ANCOVA) was the statistical analysis technique used for this research study and used an alpha level of .05. The effect size was reported as partial eta squared (Gall, Gall, & Borg, 2007). The Statistical Package for the Social Sciences (SPSS) was used to enter, collate, and perform statistical analysis on collected data.
CHAPTER FOUR: FINDINGS

Overview

The purpose of this study was to determine the attitudes towards care of dying patients among sophomore, junior, and senior pre-licensure nursing students at a Christian university while controlling for religiosity. Further, the study was designed to determine if religiosity had an effect on student attitudes towards care of dying patients. In this chapter, descriptive statistics, assumption testing, and results for the null hypothesis are presented for the attitudes towards care of dying patients of all program years of nursing students. The chapter concludes with a summary of study findings.

Research Question

RQ1: Is there a difference in attitudes towards care of dying patients among sophomore, junior, and senior pre-licensure nursing students at a Christian university while controlling for religiosity?

Null Hypothesis

H01: There is no statistically significant difference in attitudes towards death and dying among sophomore, junior, and senior pre-licensure nursing students at a Christian university while controlling for religiosity.

Descriptive Statistics

Exploring the data set of 450 pre-licensure nursing students, sophomore through senior level, 33 students were excluded for incomplete surveys. The total sample of pre-licensure nursing students who participated in the study was 417.

Data were obtained for the differences in sophomore, junior, and senior nursing students’ attitudes towards care of dying patients from their scores on the FATCOD B questionnaire. The
The mean score for *attitudes towards care of dying patients* by year in nursing program is found in Table 4.1. The adjusted means for *attitudes towards care of dying patients* is found in Table 4.2.

The covariate variable, *religiosity*, can be found in Table 4.3.

### Table 4.1

**Dependent Variable: Mean Attitudes Towards Care of Dying by Year**

<table>
<thead>
<tr>
<th>Year</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sophomore</td>
<td>121.233</td>
<td>8.3685</td>
<td>137</td>
</tr>
<tr>
<td>Junior</td>
<td>123.781</td>
<td>8.6320</td>
<td>142</td>
</tr>
<tr>
<td>Senior</td>
<td>127.177</td>
<td>8.5104</td>
<td>138</td>
</tr>
</tbody>
</table>

### Table 4.2

**Dependent Variable: Adjusted Means by Year for Attitudes towards Care of Dying**

<table>
<thead>
<tr>
<th>Year</th>
<th>Mean</th>
<th>SE</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sophomore</td>
<td>121.168</td>
<td>.725</td>
<td>137</td>
</tr>
<tr>
<td>Junior</td>
<td>123.841</td>
<td>.712</td>
<td>142</td>
</tr>
<tr>
<td>Senior</td>
<td>127.511</td>
<td>.722</td>
<td>138</td>
</tr>
</tbody>
</table>

*Note*. Covariates appearing in the model are evaluated at the following values:

DURELScore = 24.1874
Data Screening

The data for each group were initially screened for incomplete submissions. Of the 450 cases, 33 cases were removed due to incompleteness, for a total sample of 417 students. Categorical data (gender, age, year in program, ethnicity, prior experience) were checked for errors by examining the maximum and minimum nominal values to confirm data entry. After removal of incomplete surveys, data screening was followed by assumption testing.

Box-and-Whiskers Plot

The data were analyzed according to the analysis of covariance (ANCOVA) for the first null hypothesis. The data for the dependent variable, *attitudes towards care of dying patients*, and the covariate, *religiosity*, were screened for outliers using a box-and-whiskers plot to determine outliers in each group (see Figure 4.1). Several outliers for the covariate, *religiosity*, were identified (see Figure 4.2). Further examination of the outliers for the covariate variable indicated extreme reports of religiosity (high and low) as reported by survey participants. Further analysis of the 5% trimmed mean yielded similar results to the mean which provided additional confirmation to retain the outlying cases since they were not extreme (Pallant, 2013; see Figures 4.1 and 4.2).

### Table 4.3

*Covariate Variable: Mean Religiosity by Year for Attitudes towards Care of Dying*

<table>
<thead>
<tr>
<th>Year</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sophomore</td>
<td>24.55</td>
<td>2.482</td>
<td>137</td>
</tr>
<tr>
<td>Junior</td>
<td>23.00</td>
<td>2.502</td>
<td>142</td>
</tr>
<tr>
<td>Senior</td>
<td>24.18</td>
<td>2.532</td>
<td>138</td>
</tr>
</tbody>
</table>
Figure 4.1. Attitudes towards care of dying.

Figure 4.2. Religiosity score.
Assumption Tests for the Null Hypothesis

**Kolmogorov-Smirnov test.** The Kolmogorov-Smirnov test was used to assess the normality of the dependent and covariate variables because the sample size was greater than 50 students (Gall, Gall, & Borg, 2007). The assumption of normality was violated for the dependent and covariate variables (see Table 4.4 and Table 4.5). However, the ANCOVA is considered a robust test, and therefore the researcher continued with the analysis.

<table>
<thead>
<tr>
<th>Year</th>
<th>Kolmogorov-Smirnov</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURS 210 Sophomore</td>
<td></td>
<td>.046</td>
</tr>
<tr>
<td>NURS 301 Junior</td>
<td></td>
<td>.025</td>
</tr>
<tr>
<td>NURS 490 Senior</td>
<td></td>
<td>.087</td>
</tr>
</tbody>
</table>

Table 4.4

**Kolmogorov-Smirnov Test of Normality for Attitudes towards Care of Dying (AttScore)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Kolmogorov-Smirnov</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURS 210 Sophomore</td>
<td></td>
<td>.000</td>
</tr>
<tr>
<td>NURS 301 Junior</td>
<td></td>
<td>.000</td>
</tr>
<tr>
<td>NURS 490 Senior</td>
<td></td>
<td>.000</td>
</tr>
</tbody>
</table>

Table 4.5

**Kolmogorov-Smirnov Test of Normality for Religiosity (DUREL)**
Histograms

**Attitudes (AttScores).** A second set of assumption testing for normality was conducted, which was the histogram for the dependent variable, *attitudes towards care of dying patients*, and covariate variable, *religiosity*. Analysis of the histograms for the dependent variable indicated that normality was tenable for the attitudes towards care of dying scores for sophomore, junior, and senior nursing students, as assessed by visual inspection of the bell-shaped curve in the histograms below (see Figure 4.3).

*Figure 4.3. Attitudes for sophomores, juniors, and seniors.*
Religiosity (DURELScore). Analysis of the histograms for the covariate variable indicated that normality was tenable, even though slightly negatively skewed, for religiosity of sophomore, junior, and senior nursing students as assessed by visual inspection of the bell-shaped curve in the histograms below (see Figure 4.4).

Homogeneity of Variance

The homogeneity of variance was checked using the Levene’s test. The results of the Levene’s test showed that $F(2, 414) = .018, p = .98$ which were not significant. The assumption of equal variance was not violated since $p > .05$. See Table 4.6 for results of Levene’s test.
Table 4.6

Levene’s Test for Dependent Variable, AttScore

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>.018</td>
<td>2</td>
<td>414</td>
<td>.983</td>
</tr>
</tbody>
</table>

Note. Design: Intercept + DURELScore + Year

Scatterplots

Scatterplots comparing attitudes towards care of dying and religiosity by year were examined to test the assumptions of linearity and bivariate normal distribution. Bivariate outliers identified on the scatterplot were further analyzed by evaluating the original mean and the 5% trimmed means, which did not show a significant difference between the values and the identified outliers. Since the outliers did not have a strong influence on the mean it was determined that the assumption of linearity and bivariate normal distribution was met (see Figures 4.5, 4.6, and 4.7).
Figure 4.5. Scatterplot for sophomore attitudes towards care of dying.
Figure 4.6. Scatterplot for junior attitudes towards care of dying.
Figure 4.7. Scatterplot for senior attitudes towards care of dying.
Homogeneity of Regression Slopes

The assumption of homogeneity of slopes was tested, and the interaction was not statistically significant. The assumption of homogeneity of slopes was met since the significance level was $F(2, 411) = .61, p = 0.54$ with a small effect size $\eta^2 = 0.003$ (see Table 4.7).

Table 4.7

Test of Homogeneity of Slopes for Attitude Towards Care of Dying (AttScore)

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>$F$</th>
<th>Sig.</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year*</td>
<td>79.412</td>
<td>2</td>
<td>44.251</td>
<td>.614</td>
<td>.542</td>
<td>.003</td>
</tr>
<tr>
<td>DURELScore</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Error</td>
<td>29523.169</td>
<td>411</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6462850.000</td>
<td>417</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Results

Null Hypothesis One

Analysis of Covariance (ANCOVA) was conducted to see if there was a difference in attitudes towards care of dying patients among sophomores, juniors, and senior pre-licensure nursing students at a Christian university while controlling for religiosity. The independent variable was the year of nursing student, the dependent variable was the attitudes towards care of dying patients, and religiosity was used as the covariate in this analysis. Preliminary checks were conducted to ensure that there was no violation of the assumptions of normality, linearity, homogeneity of variances, and homogeneity of regression slopes. Because the data did not
violate the homogeneity of slopes, the ANCOVA was used to determine if a difference was detected between groups on a dependent variable while controlling for a covariate (Gall, Gall, & Borg, 2007; Green & Salkind, 2011). Use of the ANCOVA is beneficial to control for initial differences that are detected before determining variances that are present within and between the groups. The ANCOVA was also helpful because it was not possible for the researcher to select comparison groups that are well-matched except on the variable that is being studied (Gall, Gall, & Borg, 2007).

**Test of Between Subjects Effects.** The Test of Between Subjects Effects showed a statistically significant difference at the 95% confidence level between groups on the adjusted means where $F(2, 413) = 19.382, p < .001$, partial $\eta^2 = .086$ (Table 4.8). The effect size of $\eta^2 = .086$ was considered a medium effect size and represents 8.6% of the variance in attitudes towards care of dying patients that can be explained by year of the nursing student. Because the null was rejected, a post hoc analysis was conducted using a Bonferroni comparison (see Table 4.9).
Table 4.8

Results of ANCOVA for Dependent Variable, Attitudes Towards Care of Dying Patients

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>DURELScore</td>
<td>251.113</td>
<td>1</td>
<td>251.113</td>
<td>3.492</td>
<td>.062</td>
<td>.008</td>
</tr>
<tr>
<td>Year</td>
<td>2787.837</td>
<td>2</td>
<td>1393.919</td>
<td>19.382</td>
<td>.000</td>
<td>.086</td>
</tr>
<tr>
<td>Error</td>
<td>29523.169</td>
<td>413</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6462850.000</td>
<td>417</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Bonferroni Comparison.** Since the statistical analysis in the research study compared differences among three groups and significance was found, a post hoc analysis was performed using a Bonferroni Comparison (Green & Salkind, 2011; Laerd Statistics, 2015). Differences among the adjusted means were between sophomore $M_{adj} = 121.168$, $SE = .725$ and juniors $M_{adj} = 123.841$, $SE = .712$ where $p = .027$. Differences among the adjusted means between sophomores $M_{adj} = 121.168$, $SE = .725$ and seniors $M_{adj} = 127.511$, $SE = .722$ where $p = .000$. Differences among adjusted means were between juniors $M_{adj} = 123.841$, $SE = .712$ and seniors $M_{adj} = 127.511$, $SE = .724$ where $p = .001$ (see Table 4.2 for Adjusted Means and Table 4.9 for Bonferroni Comparison). According to the results of the Bonferroni, a statistically significant difference was found between all groups.
### Table 4.9

**Bonferroni Comparison**

<table>
<thead>
<tr>
<th>Year (I)</th>
<th>Year (J)</th>
<th>Mean Difference (I-J)</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sophomore</td>
<td>Junior</td>
<td>-2.673*</td>
<td>.027</td>
</tr>
<tr>
<td></td>
<td>Senior</td>
<td>-6.343*</td>
<td>.000</td>
</tr>
<tr>
<td>Junior</td>
<td>Sophomore</td>
<td>2.673*</td>
<td>.027</td>
</tr>
<tr>
<td></td>
<td>Senior</td>
<td>-3.670*</td>
<td>.001</td>
</tr>
<tr>
<td>Senior</td>
<td>Sophomore</td>
<td>6.343*</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Junior</td>
<td>3.670*</td>
<td>.001</td>
</tr>
</tbody>
</table>

*Note.* Based on estimated marginal means. Adjustment for multiple comparisons: Bonferroni.

* The mean difference is significant at the .05 level.
CHAPTER FIVE: CONCLUSIONS

Overview

Chapter Five provides an overview of the research study, which explored the attitudes of sophomore, junior, and senior pre-licensure nursing students towards the care of dying patients at a Christian university while controlling for religiosity. The purpose of the study is briefly discussed, while review of the null hypothesis and implications drawn from the research study are explored. Review of study limitations provided additional insight on factors that may have impacted research outcomes, and recommendations for future research provide areas of consideration for possibility of future research studies.

Discussion

The purpose of this quantitative, causal-comparative study was to evaluate the attitudes of pre-licensure nursing students towards caring for dying patients at a Christian university while controlling for religiosity. The Frommelt’s Attitude Towards Care of Dying (FATCOD B) was used to compare attitudes towards care of dying patients between sophomore, junior, and senior nursing students. There were 137 sophomores, 142 juniors, and 138 seniors for a total of 417 participants. The data were analyzed for differences between the scores for attitudes towards care of dying and the year of the nursing students while controlling for religiosity. It is believed that many nurses are overwhelmed when caring for dying patients, and personal beliefs and views can significantly impact the ability to meet the needs of dying patients and their families (Lange et al., 2008). Religiosity has a major impact on attitude formation related to death: the higher the reported religiosity, the more positive the attitudes towards providing care for the dying (Leombruni et al., 2014). Christianity provides eternal hope of life after death for all believers in Jesus Christ (John 3:16), and individuals with a strong hope and belief in life after death have the
most positive attitudes towards providing care for the dying (Arslan et al., 2014). It is believed that nurses with strong religiosity may have more positive attitudes towards providing end-of-life care to dying patients. Nursing students present with similar attitudes towards care of dying patients that are influenced by personal beliefs, cultural views, and clinical experiences (or lack thereof) with dying patients can lead to development of negative attitudes towards care of the dying (Solabarrieta et al., 2011).

**Null Hypothesis**

The null hypothesis stated that there is no statistically significant difference in attitudes towards care of dying patients among sophomores, juniors, and senior pre-licensure nursing students at a Christian university while controlling for religiosity. The researcher rejected the null hypothesis, indicating that there was a significant difference in the adjusted attitudes of sophomore, junior, and senior nursing students. Post hoc analysis was conducted and significant differences were found between all groups. The adjusted means were as follows: sophomore $M_{adj} = 121.168$, juniors $M_{adj} = 123.841$, and seniors $M_{adj} = 127.511$. The adjusted means demonstrate that as students progressed through the program, they became more caring about the dying. This finding may be due to two reasons: experience and training. Sophomore nursing students in NURS 210 do not receive exposure to dying patients and would not be expected to provide care to dying patients. Junior nursing students in NURS 301 will receive exposure to dying patients and begin to provide care to the dying. Senior nursing students receive more exposure to dying patients and provision of end-of-life care. As students progress through the nursing program, training is provided on caring for dying patients, which can also have an impact on attitudes towards the care of dying.
The results of this study are supported by previous studies. Several studies have shown that upper-level nursing students demonstrate a higher attitude towards the care of dying than lower-level nursing students (Leombruni et al., 2014). Arslan et al. (2014) noted that third year nursing students in Central Anatolia who had previous experience caring for dying patients had more positive attitudes towards providing care for the dying. This study is unique in that it addressed students enrolled in a nursing program at a faith-based university on attitudes towards the care of dying patients. While literature has shown that nurses and upper-level nursing students with religious beliefs, death education training, and experience providing end-of-life care often have higher attitudes towards providing care to dying patients, the literature review did not reveal research studies on the attitudes towards care of dying patients of students enrolled in a nursing program at a Christian university while accounting for religiosity. The covariate in this study was religiosity. When examining the results of the covariate, there was little difference in the mean score of the three groups, Sophomore \( (M = 24.55) \), Junior \( (M = 23.00) \) and Senior \( (M = 24.18) \). Religiosity in this study had little effect on the outcome of the results. Thus, the differences can truly be attributed to sophomore, junior, or senior class standing.

**Implications**

This study showed that attitudes towards care of dying patients was higher as students progressed through the nursing program in a Christian university. This study showed clinical relevance because attitudes towards care of dying patients were higher as students progressed from sophomore to senior level. The reported findings support literature, which indicated that the more students are exposed to providing care for dying patients, the more comfortable they become taking care of this patient population and develop higher attitudes towards the care of dying patients. The reported findings also support literature, which indicates that the longer
students are in the nursing program, the more end-of-life training they receive, the more prepared they feel taking care of this patient population, and the higher their attitudes develop towards providing care to dying patients.

In this study, religiosity had little to do with the attitudes towards care of dying; however, conditions require that religiosity should not be ignored since a religious emphasis is an important part of a holistic patient assessment to determine the need for religious belief incorporation into the patient’s plan of care (The Joint Commission, 2017). This finding is also indicative that faith-based institutions are delivering the same instructions as other institutions, faith-based or secular nursing programs. Faith-based institutions may consider taking a more active role in approaching the topic of dying through integration of faith-based principles in the classroom and clinical setting. Even though the covariate had little effect on this study, religion is still a very important part of providing care for the dying.

Limitations

There were several limitations to this study. Students involved in the study were not randomly chosen or randomly assigned to a group and may not be generalizable to other nursing program populations. All students enrolled in the undergraduate, pre-licensure nursing program were utilized in the study since a large sample size of nursing students, sophomore through senior level, were needed for this study. The gender of the students was predominantly female (91.3%), and the lack of adequate male representation could affect the outcome of the study. The ethnicity of the study was predominantly Caucasian, and because 89% of the students in the study were Caucasian, the results may not be generalizable to the ethnicity population that is present in other nursing programs. Nursing programs at other institutions that have higher
percentages of different ethnicities may also have a different study outcome based on cultural view of care of dying.

Due to the close-knit atmosphere of the nursing program used in this study, students may have felt obligated to complete surveys or may have been concerned that the professor would be disappointed if they chose not to participate. Students that attend a faith-based nursing program may have provided survey responses in a manner they felt would be expected at a Christian university. Students had to complete several surveys within a short period of time, and this may have caused students to falsely convey their true beliefs by hurriedly placing a response to the survey questions. Since there were a total of 45 responses that students had to provide, and some questions involved careful reading of the information before responding, students may have hurriedly placed responses in order to finish the survey or may not have fully comprehended what the question was asking. Students may also have suffered from a phenomenon called survey fatigue, which is a tendency to respond without critically thinking (Wise & Barnham, 2012).

**Recommendations for Future Research**

There are several recommendations for future research as a result of this study. Conducting similar research in nursing programs at other faith-based institutions may give more insight into the role that one’s faith plays in the development of attitudes toward caring for the dying. In light of the fact that this study showed religiosity to have little effect on nursing students’ attitudes towards care of the dying, it would be interesting to see if conducting the same research at other faith-based institutions produced similar results. According to Davignon (2014), the majority of college students based their college choice on religious affiliation in
addition to financial aid capabilities and academic status, which would seem to indicate that religiosity is an important factor in the lives of many college students.

Conducting similar research in nursing programs at secular institutions would be beneficial to see if the results are similar or different based on the religiosity component. Since a large portion of students attending a faith based institutions typically have similar religious beliefs (Davignon, 2014), the results of a study conducted at a secular institution may produce similar or distinctly different results.

Since other healthcare workers often deal with dying patients, similar research could be recommended for other healthcare disciplines. Conducting similar research with medical students at a faith-based institution could provide significant results regarding attitudes towards care of dying patients. Conducting similar research with medical students at secular schools of medicine may also prove beneficial to confirm or disprove that religious beliefs in healthcare workers provides a basis for high or low attitudes towards care of dying patients.

It would be of great interest to see similar research conducted in nursing programs by measuring attitudes towards care of dying patients in all years of nursing students towards care of dying patients after all levels of students have received end-of-life training. Adding the religiosity covariate after looking at pre- and post-end-of-life training results may produce some significant findings in both secular and faith-based institutions.
REFERENCES


Kumar, S., Chris, E., Pais, M., Sisodia, K., & Kumar, K. J. (2014). Nursing students’ perceived attitudes towards death: a cross-sectional survey. *Indian Journal of Forensic Medicine, 7*(1), 5.


APPENDIX A: IRB Approval Letter

LIBERTY UNIVERSITY
INSTITUTIONAL REVIEW BOARD

September 29, 2016

Diane Bridge
IRB Exemption 2631.092916: Attitudes towards Care of Dying among Freshman, Sophomore, Junior, and Senior, Pre-Licensure Nursing Students at a Christian University While Controlling for Religiosity

Dear Diane Bridge,

The Liberty University Institutional Review Board has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under exemption category 46.101(b)(2), which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:101(b):

(2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior, unless:
(i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Please note that this exemption only applies to your current research application, and any changes to your protocol must be reported to the Liberty IRB for verification of continued exemption status. You may report these changes by submitting a change in protocol form or a new application to the IRB and referencing the above IRB Exemption number.

If you have any questions about this exemption or need assistance in determining whether possible changes to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
The Graduate School

LIBERTY UNIVERSITY
Liberty University | Training Champions for Christ since 1971
APPENDIX B: Permission to use FATCOD B Scale

Bridge, Diane C (Nursing)
RE: Seeking Permission to use FATCOD Form B

To: Bridge, Diane C (Nursing)
Subject: Re: Seeking Permission to use FATCOD Form B

I am assuming that you have a copy of the tool and the scoring instructions, therefore I am hereby giving you permission to use the tool.

Good luck with your research.

Dr. Katherine H. Murray-Frommelt

Sent from my iPad

On Oct 13, 2015, at 12:48 PM, Bridge, Diane C (Nursing) <dbridget@liberty.edu> wrote:

Dr. Frommelt,

Thank you so much for providing your email contact. I am an assistant professor of nursing at Liberty University and I am also a doctoral student. I would like to conduct research to determine attitudes towards care of dying patients in nursing students at the freshman, sophomore, junior, and senior levels. I would like to ask permission to use the Frommelt Attitudes Toward Care of Dying (FATCOD) Form B scale.
APPENDIX C: Permission to use the DUREL Index

Wed 11/4/2015 12:04 PM
Harold Koenig, M.D. <harold.koenig@duke.edu>
RE: Requesting Permission to use DUREL survey

To: Bridge, Diane C (Nursing)

You replied to this message on 11/4/2015 8:17 PM.

You have permission. I will be speaking at Liberty in two weeks.

Best from my Verizon Wireless iPhone

Original message

From: "Bridge, Diane C"<dianec@liberty.edu>
Date: 11/04/2015 10:48 AM (EDT -0500)
To: "Harold Koenig, M.D."<harold.koenig@duke.edu>
Subject: Requesting Permission to use DUREL survey

Dr. Koenig

I am an assistant professor of Nursing at Liberty University and I am also a doctoral student. I am planning research for my dissertation and am seeking permission to use the DUREL survey. If denied, I am happy to provide details regarding my planned research.

Respectfully,
Diane

Diane Bridge, Ph.D, MSN, RN
Chair, PhD Program
Assistant Professor of Nursing
School of Nursing
(434) 297-2168
LIBERTY UNIVERSITY
Liberty University | Training champions for Christ and our nation
APPENDIX D: Permission from Dean

If applicable, have you defended and passed your dissertation proposal? ☐ Yes ☐ No

If no, what is your defense date?

Co-Researcher(s):

School/Department(s):

Telephone(s): LU/Other Email(s):

Faculty Advisor/Chair/Mentor: Dr. Deanna Keith

School/Department: School of Education

Telephone: 434-582-2417 LU Email: dkeith@liberty.edu

Non-key Personnel (i.e., reader, assistants, etc.):

School/Department:

Telephone: LU Email:

Consultants (required for School of Education EdD candidates): Dr. Kurt Michael

School/Department: School of Education

Telephone: 434-582-3760 LU Email: kmichael9@liberty.edu

Liberty University Participants:
Do you intend to use LU students, staff, or faculty as participants or LU student, staff, or faculty data in your study? If yes, please list the department and/or classes you hope to enlist, and the number of participants/data sets you would like to enroll/use. If you do not intend to use LU participants in your study, please select “no” and proceed to the section titled “Funding Source.”

☐ No ☐ Yes 600 students (150 students at each level) Number of participants/data sets

School of Nursing
Sophomore, Junior, Senior Nursing students

Freshman, Class(es)/Year

In order to process your request to use LU participants, we must ensure that you have contacted the appropriate department and gained permission to collect data/include their students. Please obtain the original signature of the department chair in order to verify this.

Dr. Deanna Britt, Dean, School of Nursing

Name of Department Chair/Dean

5/31/16 Date

Signature of Department Chair/Dean
APPENDIX E: Script

Script for Research Study

You are invited to be in a research study to determine the attitudes of all levels of pre-licensure nursing students towards care of dying patients. You were selected as a possible participant because you are currently enrolled as a pre-licensure nursing student at Liberty University. Since nursing practice is driven through evidence gained through research, your participation would be greatly appreciated as it will help further the nursing body of knowledge and improve nursing care.

Each participant will receive a survey packet, which will consist of two surveys, a demographic form and a consent form. Both surveys will be taken at the same time during a required nursing course. All participants will receive the same surveys.

You will be asked to provide demographic data but no identifying information. After all surveys have been completed, survey responses will not be able to be linked to any student. During the time prior to data entry, all data will be secured in a locked cabinet housed in a locked office. Once data is entered into the computer program SPSS, the data will be password protected. Data will be destroyed within three years of collection.

Please read the consent form included in the survey packet. If you agree to participate in this study, this will be affirmed by survey completion. Please do not sign the consent form. Do not include any personal or identifying information on the surveys, demographic form, or consent form.

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future course grades. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships. Nursing students who decide not to participate in the study can do so by returning the survey packet in its entirety and foregoing completion of both surveys.

Upon completion of the data collection and its analysis, you may request generalized overall results via email. Information on receiving research study results are provide on the consent form inside the survey packet.
APPENDIX F: Consent

CONSENT FORM

ATTITUDES TOWARDS CARE OF DYING AMONG FRESHMAN, SOPHOMORE, JUNIOR, AND SENIOR PRE-LICENSENURSE NURSING STUDENTS AT A CHRISTIAN UNIVERSITY WHILE CONTROLLING FOR RELIGIOSITY

Diane C. Bridge
Liberty University
School of Education

You are invited to be in a research study of determining attitudes of pre-licensure nursing students towards care of dying patients. You were selected as a possible participant because you are a nursing student in the School of Nursing. I ask that you read this form and ask any questions you may have before agreeing to be in the study.

Diane Bridge, a doctoral candidate in the School of Education at Liberty University, is conducting this study.

Background Information:

The purpose of this study is to see if a difference exists in attitudes towards death and dying among freshmen, sophomores, juniors, and senior pre-licensure nursing students at a Christian University while controlling for religiosity?

Procedures:
If you agree to be in this study, I would ask you to do the following things:

For students enrolled in the School of Nursing at Liberty University, there are no additional tasks or procedures required outside of completion of two surveys in a pre-determined nursing course in which you are enrolled; all you have to do is complete the FACTOD B scale and the DUREL survey. For all students who have agreed to take the surveys, the surveys will take a combined total of 20-30 minutes to complete, your participation in this study is both very important and appreciated. Please complete both surveys honestly about what you actually believe and think and not according to how you think others would expect you to answer the questions.

Risks and Benefits of being in the Study: The risks involved in this study are no more than you would encounter in everyday life.

The benefits to participation are for future nursing students, future patients, and future provision of nursing care in healthcare settings. Your honest and thoughtful answers in both surveys will help future nursing students/nurses as they provide care to dying patients.
Compensation: Participants will not receive compensation for participating in this study.

Confidentiality: The records of this study will be kept private. In any sort of report that might be published, information will not be included that would make it possible to identify participants in the study. Research records will be stored securely and only the researcher will have access to the records. While participants will include basic demographic information, demographic information will not contain personal identifiable information. Surveys will be stored in a secure office in a locked file cabinet until data is entered into SPSS. SPSS data will be stored as an encrypted Word document that is accessible only to the researcher and it will be used only as anonymous data in any type of publication. After three years, any and all data will be purged.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships. Nursing students who decide not to participate in the study can do so by returning the survey packet in its entirety and forego completion of both surveys.

Contacts and Questions:
If you have any questions, please contact the School of Nursing secretary @. After data collection is complete and analyzed, you may request a copy of the overall results.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, you are encouraged to contact the Institutional Review Board, 1971 University Blvd, Carter 134, Lynchburg, VA 24515 or email at irb@liberty.edu.

Please notify the researcher if you would like a copy of this information to keep for your records.

Statement of Consent:
I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study which is indicated by completion of both surveys. By not opting out of this study, you agree that you have read and understood the above information, you have asked questions and have received answers, and you consent to participate in the study.

(Note: Do not agree to participate unless IRB approval information with current dates has been added to this document.)
If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, you are encouraged to contact the Institutional Review Board, 1971 University Blvd, Carter 134, Lynchburg, VA 24515 or email at irb@liberty.edu.

Please notify the researcher if you would like a copy of this information to keep for your records.

Statement of Consent:

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

(Note: DO NOT AGREE TO PARTICIPATE UNLESS IRB APPROVAL INFORMATION WITH CURRENT DATES HAS BEEN ADDED TO THIS DOCUMENT.)