THE EFFECT OF HAPPINESS ON DEATH ANXIETY IN THE NURSING POPULATION

A Major Paper Submitted in Partial Fulfillment

of the Requirements for the Degree of

Master of Science in Nursing

in

The School of Nursing

Rhode Island College

May 2022

by

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Abstract

Background: Registered Nurses (RNs) are often exposed to death and dying, putting them at risk for increased levels of death anxiety due to frequent exposure. Researchers have identified personal resources that people can possess that may limit the amount of death anxiety they feel, such as happiness.

Purpose/Specific Aims: The purpose of this mixed-methods descriptive correlational study was to identify if a link exists between perceived happiness and death anxiety specifically within the acute care nursing population working in an urban VA hospital.

Methods: A convenience sample of inpatient RNs were recruited and asked to complete a questionnaire to assess their level of perceived happiness, fear of death and how working around death and dying influenced their own life choices.

Results: Sixteen RNs participated in the study. Two incomplete surveys were excluded, analyzed n=14). Mean happiness score was 5.27. Average scores for each scale were: Fear of your own death 2.1, Fear of your own dying 3.4, Fear of others death 3.19, and Fear of others dying 3. Each fear of death variable besides fear of others dying had a positive correlation with happiness, with high levels of happiness associated with high levels of fear of death.

Conclusion: Moderate positive correlation between happiness and fear of death suggests a relationship between these emotions; when a nurse is happier or more content with their life, their fear of death and dying increases. A larger study is recommended for more conclusive results.

Key Words: Happiness; Fear of Death; Nursing; Death Anxiety; End-of-Life

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THE EFFECT OF HAPPINESS ON DEATH ANXIETY IN THE NURSING POPULATION

Background and Significance

During the COVID-19 pandemic death rates surged. Many of these deaths took place in healthcare settings such as hospitals, nursing homes, congregate care settings and assisted living facilities (Lau-Ng et al., 2020). How have these deaths influenced those who work in healthcare settings? How does working in a profession where part of a persons' job description is post-mortem care affect a persons' outlook on death? In a commentary by British lecturer Brian Nyatanga (2016) it is suggested that caring for dying patients increases a persons' death anxiety by serving as a constant reminder of their own fragility, and that nurses are at risk for increased levels of death anxiety due to frequent exposure. Death anxiety is defined by the American Psychological Association (2020) as the emotional distress and insecurity a person feels due to reminders of their own mortality, including memories and thoughts of death. Research has been conducted identifying personal resources that people can possess that may limit the amount of death anxiety they feel. One such resource is happiness. The World Health Organization (WHO) has recognized happiness as an integral part of human health and governments are beginning to measure "general well-being" of their countries (WHO, 2011). Does a higher level of perceived happiness cause decreased death anxiety?

Problem Statement and Study Question

The purpose of this study was to identify if there is a link between perceived happiness and death anxiety specifically within the acute care nursing population working in an urban VA hospital. The intent is that future research could focus on this

link and provide interventions for increased happiness and the ability to cope with the dying process among health care professionals.

Literature Review

The Rhode Island College Library Databases were accessed to conduct the literature review. The database includes CINAHL, PubMed, and JSTOR and they were searched all at once. The terms “Happiness” and “End of Life Care” were initially searched with few results. “Happiness” “Death” “Elderly” “Happy” and “Hospice” were used in different combinations to return greater numbers of results. A separate search of the same databases was later initiated with the terms “Happiness” “Healthcare” “Nursing” and “End of Life” and “Death Anxiety Scale”. Three more studies were found using the ancestry approach.

Happiness / Well-being

Amongst the literature there are various different definitions of “happiness”. Beng et al. (2015) define happiness as a pleasant emotional experience due to involvement in pleasurable or meaningful activities, relationships or thoughts. Many of their subjects report happiness as having a good family life. Cottrell (2016), a nursing PhD student defined happiness as a stable long-term mental state attributed to satisfaction with ones’ life. This author pointed out that happiness needs to be actively pursued. In an editorial by Koenig (2000), it was hypothesized that happy people tend to be “less self-focused, less hostile, friendlier and more outgoing” (p.1525) and he cites that happiness is not highly dependent on external circumstances.

To study happiness and its effects on well-being, Beng et al. (2015) interviewed palliative care patients who reported feeling happy. The study focused on how patients remain happy knowing their time is limited. The study focused on 15 happy Malaysian palliative care patients. Well-being was influenced by positive attitude, positive

cognitions, positive emotions, engagement and relationships, as well as positive circumstances. These patients drew strength from faith in god, felt satisfied with the lives they had lived, and took part in enjoyable hobbies when they felt well enough. These themes were realized through semi-structured interviews that were recorded verbatim. The results were coded and statistically analyzed for numerical data. The implication of this study is that happiness can be intervened upon. They concluded that happiness was 25% attitude, 72% intentional activity and 3% circumstance (Beng et al., 2015, p. 501). All three of these components can be changed or improved upon with interventions that target these such as engagement in hobbies and a focus on personal relationships. This study, though it has a small sample size and focuses on only the Malaysian population, develops a theory that could be expanded upon for more concrete evidence and then translated into practice in a larger population.

Mohsen Joshanloo (2018) from Keimyung University in South Korea found that happiness can be intervened upon, or rather a person's belief about happiness could be intervened upon and that this could improve subjective well-being (SWB). The author hypothesized that regarding happiness as transient may contribute to a pessimistic outlook and this decreases a person's ability to actually achieve the happiness they seek. The study focused on 338 Korean subjects who responded to an online survey. The survey consisted of five previously validated scales including "The Satisfaction with Life Scale", and the "Valuing Happiness Scale". The results showed that in people with high levels of fragility of happiness, there was a negative correlation between valuing happiness and SWB. The paper concludes that interventions should aim to help people

capitalize on fleeting experiences of happiness, to savor positive experiences. This would in turn make happiness more sustainable and improve SWB (Joshanloo, 2018).

Ramirez and colleagues (2014) recognized that the elderly population is more at risk for a decrease in happiness and in turn decreased subjective well-being (SWB) and quality of life (QOL). The researchers aimed to develop a study to improve autobiographical memories as a way of improving happiness. Two mechanisms for doing this were used, gratitude and forgiveness. Forty-six participants completed the study, 26 in the experimental group and 20 in the placebo group with an average age of 71 years. Subjects were recruited from a day center in Martos, Spain. Six measurement scales were used pre and post intervention, including Lyubomirsky and Lepper's Subjective Happiness Scale. The participants were scored on anxiety, depression, happiness, life satisfaction, and general and specific memory. The experimental group underwent nine 1.5 hour weekly sessions of life review therapy devoted to being happier, gratitude, and life-review with autobiographical memory and positive emotions. The control group also focused on autobiographical memory but without the guidance for using positive emotions and gratitude. The results showed that participants in the training program had a significant reduction on depression and anxiety as well as a significant increase in life satisfaction and subjective happiness. However, the benefits were not maintained after 4 months, demonstrating that regular sessions would be necessary to maintain the benefits (Ramirez et al., 2014).

A well-being study by Kuhn and Brule (2019) focused on the buffering effects material, social, religious and personal resources could have on negative life events. They operated under the assumption that negative life events have a greater effect on well-

being than positive life events. They used data from the Swiss Household Panel, an ongoing household survey, from 1999 to 2016. Allowing them access to answers from 28,101 individuals, though not all participants qualified for all measures of the survey. Their results showed that wealth and income had no buffering effect on negative life events. Religion and social engagement showed buffering effects with some life events but not others, and neuroticism had a negative effect on life events. Interestingly, they concluded that those with more resources had more to lose, for example, someone with higher levels of happiness experienced greater drops when negative events occurred. Those who were already unhappy felt less of an impact. This study began to explore the effects of events on overall happiness and well-being and vice versa. The implication of this study is that contrary to the Beng et al. (2015) study, intervening on a person's overall well-being and happiness may be less possible and less useful.

To measure happiness Lyubomirsky and Lepper (1999) developed and validated the Subjective Happiness Scale. Participants respond to two items to characterize their level of happiness, both as an absolute rating and relative to their peers. Two additional items describe happy and unhappy individuals and ask respondents how much they identify with those descriptions. The participants' responses are formatted using 7-point Likert scales (see Appendix A). The average of each person's responses gives that participant's Subjective Happiness from 1.0 -7.0. The reliability and validity of this tool was tested on 2732 participants from 14 separate samples in a variety of settings. Five previously developed scales for measuring happiness and well-being were used to assess validity. Internal consistency was tested using Cronbach's alpha and all four items tested good to excellent. The alphas ranged from 0.79 to 0.94. Only one of the 14 coefficients

fell below the conventional minimum of 0.80. Test-retest reliability was also tested using longitudinal data from five studies, the test-retest reliability ranged from 0.55 to 0.9. The authors note that this scale's brevity makes it easy to implement yet possesses measurement accuracy (Lyumbomirsky & Lepper, 1999).

Death Anxiety

One commonly used measure of death anxiety is the Collett-Lester fear of death scale. This scale was originally developed in 1969 and then revised in 1990 for ease of scoring. Both scales are published for general use. This tool consists of four separate subscales which measure: fear of death of self, fear of death of others, fear of dying of self and fear of dying of others. The original scale had a test-retest reliability of 0.55. The revised scale has a test-retest reliability of 0.85 for fear of death of self, 0.79 for fear of death of others, 0.86 for fear of dying of self and 0.83 fear of dying of others. The scale has been used frequently and found to have reasonable reliability, validity, and usefulness (Lester, 1990).

Death anxiety is not only felt by those approaching the end of one's own life, but also the loss of those closest to them including family, friends and caregivers. A study by French et al. (2017) sought to identify factors the influence a person's level of death anxiety. The researchers hoped the results of the study could be generalized to social and healthcare workers to implement support programs. Specifically, age, gender, religiosity and susceptibility to mortality cues was studied. The participants, 427 mostly Caucasian adults from Dignity in Dying social media pages, completed online self-report questionnaires. The Collett-Lester Fear of Death Scale was used to measure death anxiety. The results showed "Dismay", the tendency to think about one's own death and

anticipate distress due to the death of a loved one to be the strongest predictor of death anxiety. The researchers inferred that this was elicited by thoughts and reminders of death. Stoicism was found to negatively correlate with death anxiety. It was thought to be a more reflective response to death cues and reflect acceptance of the inevitability of death. The researchers felt that both predictors could be modified with training in health care providers (French et al., 2017).

In another study, a convenience sample of 501 university students from a western Canada university were surveyed. The students were from a variety of disciplines. They completed a 20-minute hard-copy survey which included Templer's Death Anxiety Scale. The independent variables were religiosity, purpose in life, life satisfaction and perceived family support. Gender, life-purpose, socioeconomic status, ethnic background and self-image were all found to significantly influence death anxiety. The subjects on average had a moderate amount of death anxiety, with females reporting higher levels. This was corroborated with findings from other studies. Those with a clear purpose in life tended to have lower levels of death anxiety, likely due to a strong desire to survive. Also consistent with other studies, the research found that loneliness was associated with increased death anxiety, representing the negative impact of psychological well-being on death anxiety. The researcher suggested that these findings could be used in the design of intervention and support services to decrease death anxiety and improve quality of life (Chow, 2017).

Nursing Perspectives

Many studies have sought to understand the resources that allow nurses to cope with the frequency in which they experience the deaths of others. Some have found that

nurses with better death self-efficacy are better able to cope; others report that nurses who are better able to manage their own death anxiety cope better and that those who cope well are able to show increased confidence in the care of the dying (Zheng et al., 2020). In a study by Zheng and colleagues, 298 Chinese new graduate nursing students were surveyed, and the researchers found that new graduate nurses had low death self-efficacy. New graduates were found to be anxious about death and a negative relationship between death anxiety and competency resulted. The nurses were identified at new nurse orientation from five metropolitan hospitals in northeast China. The participants completed a questionnaire containing three previously validated scales; the Death Self-Efficacy Scale, Bugen's Coping with Death Scale, and the Chinese version of the Templer Death Anxiety Scale. After completing the questionnaire 80.2% answered that they were afraid of death. Regarding coping with death, the item with the highest mean (5.67 out of 7) was "the quality of my life matters more than the length of it" (Zheng et al., 2020). Stress, emotion and cognition with life and death were identified as predictors of coping ability, implying that anxiety about death makes it more distressing and decreases the ability to cope with death issues. This study dealt with specifically Chinese new graduate nurses and although the researchers compared the results with those of western countries the results cannot be generalized across all cultures. The implication of the study was that the implementation of culturally sensitive interventions may better prepare nurses for coping with death.

Research suggests that developing a sense of meaning in life can help nurses to take better care of their patients and recently research was done to determine whether it can benefit their own mental health. Barnett and colleagues (2019) studied 90 hospice

nurses with the goal of determining whether there was a relationship between the presence of meaning in life and self-esteem, psychological distress, affect and burnout. The research was oriented around the terror management theory which states that a person's inability to accept their own inevitable mortality creates the need for an organizing structure such as meaning in life to guard against death anxiety. The nurses were recruited in the Southern United states through two hospice nursing conventions and presentations at their staff meetings. The 90 participants completed The Meaning in Life Questionnaire; The Depression, Anxiety, Stress Scale; The International Positive and Negative Affect Schedule Short Form; The Rosenberg Self-Esteem Scale; and the Maslach Burnout Inventory scale. The results showed that the presence of meaning in life was associated with lower psychological distress as well as with a higher positive affect. Additionally, meaning in life had a positive effect on self-esteem and self-esteem had a negative effect on psychological distress. The implications of these results are that positive organizational structures such as meaning in life can buffer against the negative outcomes caring for those that are dying can have on a nurse's psychological distress.

In Japan, Takeda and colleagues (2020) were interested in studying how the subjective happiness of nurses is affected by pleasant activities. In their review of the literature, they found that nurses are leaving the workforce in increasing numbers due to depression and overwork. With an aging population, the fear is that this would decrease the quality of nursing care the elderly population is receiving. Using the applied behavior analysis model, the study worked under the assumption that by manipulating a person's environment, a person's behavior can be modified. Given that behavior that results in a pleasurable feeling is known to be a protective factor against depression, they sought to

correlate pleasurable feelings in the workplace environment with subjective happiness. Questionnaires were distributed to and completed by 143 Japanese nursing staff from two long term care facilities. The questionnaires asked about years in the nursing profession and whether they worked night shift. The Lyubomirsky and Lepper Subjective Happiness Scale (SHS) was used. The participants then answered an open-ended question on what activity they routinely do to make the workplace enjoyable. The researchers found that those with higher SHS scores reported more pleasant activities in the workplace. They also found that the night shift partook in fewer pleasant workplace activities and had lower SHS scores; this appeared to be due to less staffing on the night shift. There was no correlation with work experience. A pleasant activity shared by groups with high subjective happiness was "reframing." This is an attempt to change one's viewpoint and look at things from a different perspective, which requires cognitive flexibility. Cognitive flexibility has been found to be related to resilience, which is linked to subjective happiness. A pleasant activity category shared by groups with low subjective happiness was "establishing goals." Though generally found to increase motivation, in this case the researchers concluded that establishing goals that are too high makes it difficult to achieve them, the person therefore never feels a sense of accomplishment, and this lowers a person's subjective happiness. This study highlights the importance of happiness in nursing and additionally supports that interventions can be put into place to influence a person's subjective happiness.

Studies have been done to show the importance of maintaining happiness in the nursing population. It is shown that when people are happy, the probability of these happy people focusing on the needs and desires of others increases, a main objective in

nursing (Gurdogan & Uslusoy, 2019). However, nursing happiness (NH) differs from general happiness in that a nurse's journey to happiness involves caring for others' needs first, which can lead to disregard of their own emotional well-being (Ozkara San, 2015). Additionally, other studies have reported that nurses work under difficult conditions such as heavy workloads, insufficient personnel, unsupportive management systems and policies and lack of resources which have also been shown to affect the subjective well-being of nurses and the care they provide (Gurdogan & Uslusoy, 2019). In a study aimed at determining the relationship between quality of work life and happiness, Gurdogan and Uslusoy (2019) sought to identify factors affecting happiness in nursing. Data was collected from 345 nurses working in a Turkish hospital via a questionnaire. The questionnaire included sociodemographic information and working history. The data also included the Quality of Nursing Work Life Scale (QNWL), and the Short Form of the Oxford Happiness Questionnaire (OHO-SF). In the study the nurses scored the highest on the job perception dimensions of the QNWL and lowest on the work environment dimension, meaning that regulations are needed regarding the work environment of nurses. On the OHO-SF the nurses scored a little above average showing that the physical and psychological conditions of the nurses in the study are not ideal. There was a positive significant relationship between the quality of work life of the nurses and their happiness levels. The study also found that work location was a factor in quality of work life and happiness. Nurses working on inpatient medical units scored lower on both scales. The researchers inferred that these nurses often do not see the positive outcomes of the care provided leading to less job satisfaction, negative effects of quality of work life, and unhappiness.

Combining these studies shows that thoughts and reminders of death can cause increased death anxiety, but that an improved psychological well-being may be able to decrease death anxiety. Psychological well-being, such as happiness, can be intervened upon with improved personal relationships and increased gratitude and forgiveness. Nurses are frequently exposed to death and dying putting them at risk for greater death anxiety; this may negatively impact their ability to care for those that are dying. Systemic interventions to increase psychological well-being and happiness may be important and beneficial for those in the nursing profession.

Purpose Statement and Specific Aims

Does a higher level of perceived happiness cause decreased death anxiety? The purpose of this study was to identify if there is a link between perceived happiness and death anxiety specifically within the acute care nursing population. The student was interested in the lived experiences of the participants that lead to their current beliefs about death and dying, but also wanted to measure how these experiences affect their end-of-life choices and death anxiety.

Conceptual/Theoretical Framework

The question of the effect of happiness on death anxiety can be discussed within the framework of Fredrickson's (2004) Broaden and Build Theory of Positive Emotions. The theory, which originated in the field of positive psychology, is used to describe both the short- and long-term effects that positive emotions, such as joy, can have on a person's well-being. The theory was developed out of a lack of focus on positive emotions in both research and psychology. Negative emotions have greater recognition in research for multiple reasons. First, they are known to produce negative effects on health causing anxiety, stress, aggression, and violence as well as physiologic detriments such as cardiovascular disease. Secondly, negative emotions are associated with specific actions, for example fear incites a fight or flight response. Positive emotions have a much more subtle effect and more general human response.

The Broaden and Build Theory focuses on three main emotions: joy, interest and contentment. The theory focuses on how emotions both negative and positive effect a persons' "thought-action repertoire", how a thought or emotion influences a person to act in a particular way. Fear may cause a person to attack or escape. The theory assumes that negative emotions narrow a person's focus or "thought-action repertoire" while positive emotions broaden it, widening the possible array of thoughts or actions that come to mind. Fredrickson gives the example of interest which "creates the urge to explore, take in new information and experiences, and expand the self in the process" (Fredrickson, 2004, p.1369).

The "build" portion stems from these broadened experiences. Fredrickson theorizes that the effects of positive emotions have long term adaptive benefits that build

enduring personal resources. Children at the playground are used as an example (see Appendix B). Joy, from play encourages more playful behavior, which in turn builds social resources by creating new and solidifying existing human bonds which can be called upon later in life. Play creates intellectual resources by developing problem-solving skills and learning new information; physical resources develop through increased coordination, strength, and cardiovascular health. Play can also help children to develop a sense of identity, resilience, and optimism. Joy, by encouraging the broad thought-action repertoire of play, allowed the development of these personal resources (Fredrickson, 2003). In theory, these resources are then available later in life making a person more resilient during times of emotional strife.

Within the framework of this theory the current study looks to see if happiness has the ability to broaden the thought-action repertoire of nurses, if in being happy they have built additional adaptive resources making them more resilient to death anxiety.

Methods

Design

This quality improvement project included a survey utilizing a mixed methods design, both quantitative and qualitative in nature. The qualitative measures can also generate further hypotheses to be tested quantitatively. The quantitative portion of the study was non-experimental. Participants were asked to partake in a self-reporting questionnaire.

Participants/Site

The sample was a non-probability convenience sampling of nurses on four inpatient acute care medical units at the Providence VA Medical Center. In total, approximately 100 nurses were asked to participate with a goal of receiving 40 complete responses. Participants were registered nurses, currently working in the inpatient setting. Reasons for exclusion included incomplete questionnaires.

The questionnaires were distributed on the four inpatient medical units at the Providence VA Medical Center (PVAMC). The PVAMC is a 73-bed hospital affiliated with the Alpert Medical School at Brown University.

Procedure

Permission from the Deputy Nurse Executive was necessary to begin the study. Institutional Review Board (IRB) approval was obtained prior to administration of the questionnaires in December 2021. Subjects were recruited from the inpatient units at the Providence VA Medical Center in Providence, Rhode Island. Recruitment occurred via introductory email on the private PVAMC email server sent on November 28, 2021. The introductory email included the purpose of the study, an explanation of the questionnaire,

discussed consent and confidentiality of the survey, and any potential risk to the participants. The student also provided contact information for any questions or concerns regarding the study (see Appendix C). Additionally, a follow-up email was sent to encourage participation (see Appendix D) on December 8, 2021. The email was distributed by the Clinical Nurse Educator at the PVAMC to maintain the student's anonymity. The survey was delivered via the online research platform QUALTRICS. The link to access the survey was distributed in the introductory email and could only be accessed by the registered nurses that were invited to participate. The survey was open to the participants for a 3-week period between November 28 and December 18, 2021

The questionnaire was anonymous beginning with basic demographic information including only shift worked and years in the medical field. Years in the medical field was divided into four categories, less than five, five to ten, ten to fifteen, or greater than fifteen years. No personal information was gathered. The questionnaire consisted of two existing valid and reliable questionnaires.

The qualitative portion of the questionnaire consisted of student-developed open-ended questions designed to gain further insight into the participants' perspectives of death and dying. The open-ended questions were reviewed for content validity by an expert. Participants were asked how they feel working in health care has influenced their thoughts about death and dying, as well as how it has affected their own end-of-life plans and choices (see Appendix E).

Once collected, the questionnaires were stored within the Rhode Island College QUALTRICS database and were only accessible to the student with a password protected login. No personal information was stored. All surveys were assigned a number, and only

that reference number was used for identifying and analyzing the data. After completion of analysis and dissemination of the results the questionnaires were deleted.

Measures

The student sought to measure the subjective happiness of the nurses as well as their level of death anxiety in order to determine if one affects the other. The Subjective Happiness Scale (SHS) was used for the survey (Lyumbomirsky & Lepper, 1999). The Subjective Happiness Scale is a 4-item measurement of global subjective happiness, formatted using 7-point Likert scales (see Appendix A). Each scale is scored from one to seven and the average score of the four scales is calculated; higher scores indicate greater happiness.

The portion of the questionnaire to measure death anxiety utilized the Collett-Lester Fear of Death Scale (Lester, 1990). This consists of four subscales: fear of death of self, fear of death of others, fear of dying of self and fear of dying of others, each with 8 items. The items are scored using a 5-point Likert Scale (see Appendix F). Each subscale consists of eight items, each item is scored between one and five and the average score of the items in each scale reflects the fear of death; higher scores indicate higher levels of death anxiety.

Analysis

Data analysis was completed in March 2022. The student was most interested in how levels of perceived happiness affect levels of death anxiety. To describe this relationship between variables bivariate descriptive statistics were used; specifically, correlation was used to determine to what extent the variables are related. The data were

measured on an ordinal level making Spearman's rho an appropriate correlation index for this study (Polit & Beck, 2017, p. 698-699).

Qualitative data, which consisted of open-ended questions, were reviewed to identify common themes regarding how the participants' lives have shaped their responses. For the qualitative data, a coding scheme was developed after multiple read-throughs of the responses. Responses were placed into categories and new categories were developed as needed. The responses were then reread to ensure material that had already been coded was appropriately designated into the newly developed categories (Polit & Beck, 2017, p.1003).

Ethical Considerations

As the study involved human subjects and focused on a sensitive topic a full IRB review through RIC was required. Participants completed an informed consent to participate in the study. The introductory email to the questionnaire explained the study and associated risks and provided links to resources if nurses felt they needed psychological support prior to or after completing the study (see Appendix C). Participation in the study was voluntary and no personal identifiers were used. Consent was required before proceeding with the survey and was stated in the initial email. The PVAMC offers Employee Assistance Programs (EAP) for those dealing with grief or trauma, which was made available to participants who requested support. To ensure adequate support, the student orchestrated an online psychoeducational session addressing death anxiety and coping mechanisms led by a content expert RIC faculty. The information about this web communication seminar, including the date and time was distributed with the introductory and reminder emails. The Microsoft Teams

link to the session on December 21, 2021 at 11am was distributed to all eleigble participants VA email addresses.

Organizational Factors/Barriers

The PVAMC is a teaching hospital which supports educational programs. Research and utilization of evidence-based practice is encouraged. The NEC and unit managers are familiar with the educational process of RIC and were asked to support the project. Organizational barriers included time constraints on the nurses, unit staffing and temporary unit closures. Additionally, though the survey only takes approximately 10 minutes, it was 38 items long which could have possibly impacted participation rate.

Results

In total, 16 responses to the survey were reviewed, two were excluded due to incomplete surveys (sample analyzed n=14). The nurses were asked which shift they work; days (n=8, 56.1%) evenings (n=4, 28.6%) and nights (n=2, 14.3%). Additionally, they were asked how many years they had worked as a registered nurse; zero to five (n=5, 35.7%) five to ten (n=6, 42.9%) ten to fifteen (n=2. 14.3%) and greater than fifteen (n=1, 6.7%). Happiness was scored using The Subjective Happiness Scale (SHS) by Lyumbomirsky & Lepper (1999). Participants received a score between one and seven, with seven indicating a greater level of subjective happiness. The average happiness score was 5.27 (SD 1.47). When separated by shifts: days, evenings and nights, average happiness scores were 5.78 (SD0.95), 4.88 (SD1.36) and 4 (SD 3.18) respectively. This is depicted in Figure 1. Figure 2 represents average happiness score when split by years worked as a Registered Nurse; 0-5 years 5.8 (SD 0.93), 5-10 years 4.93 (1.6), 10-15 years 3.5, and greater than 15 years 7.

Figure 1

Happiness Score by Shift

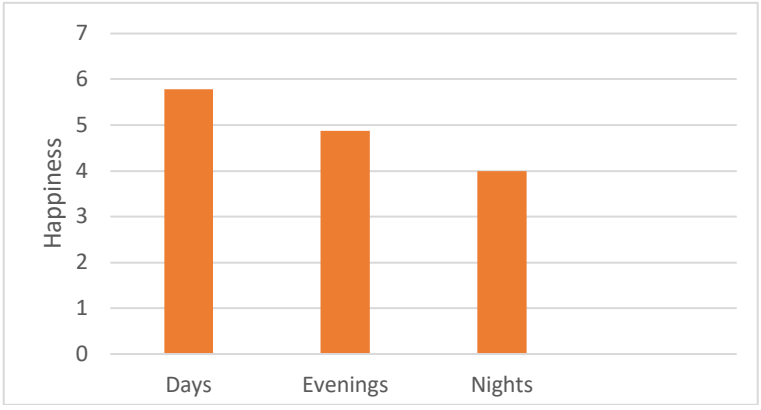
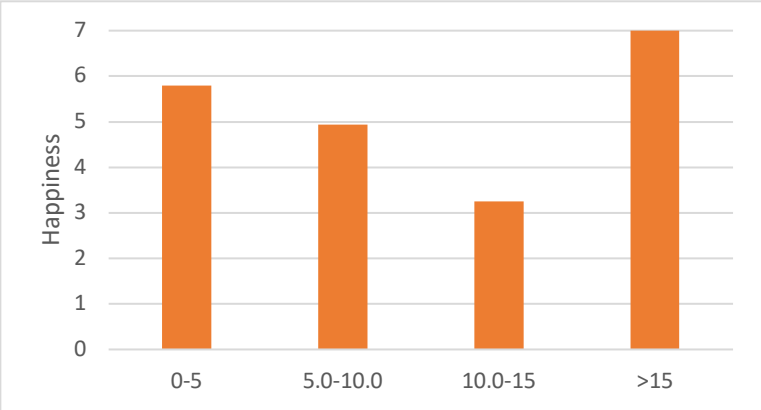


Figure 2

Happiness Score by Years Worked as Registered Nurse



Death anxiety was measured using the Collett-Lester Fear of Death Scale (Lester, 1990). Participants received scores from one to five on four separate subscales, with a higher score indicating a greater level of death anxiety. The average scores for each scale were as follows: fear of your own death 2.1 (SD .89) fear of your own dying 3.4 (SD 0.79) fear of others death 3.19 (SD 0.86) and fear of others dying 3 (SD 1.06). When divided by shift worked mean scores are shown in Table 1. In order of level of fear the results were as following; fear of own death: evenings 2.66 (SD0.94), days 1.97 (SD0.84) and nights 1.63 (SD 0.88), fear of own dying: evenings 3.91 (SD0.76), nights 3.31 (SD0.97) and days 3.19 (SD 0.76), fear of other deaths: nights 3.88 (SD4.13), evenings 3.75 (SD0.84) and days 2.73(SD 0.64), and fear of others dying: nights 4.13 (SD0.71) evenings 3.34 (SD1.26) and days 2.55 (0.83).

Table 1

Mean Scores by Shift

	Days		Evenings		Nights	
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**
Happiness	5.78	0.96	4.88	1.36	4	3.18
Fear of Own Death	1.97	0.84	2.66	0.94	1.63	0.88
Fear of Own Dying	3.19	0.76	3.91	0.75	3.31	0.97
Fear of Others Death	2.73	0.64	3.75	0.84	3.88	4.13
Fears of Others Dying	2.55	0.83	3.34	1.26	4.13	0.71

Years working as a Registered Nurse was also a factor considered as shown in Table 2. The scores listed from greatest level of anxiety in decreasing order were as follows; fear of own death were zero to five years 2.43 (SD0.8), five to 10 years, 2.04 (SD1.03), greater than 15 years 2, and10 – 15 years 1.25; fear of own dying: zero to five years 3.7 (SD 0.89), five to 10 years, 3.41 (SD0.64), 10 – 15 years 3.38 and greater than 15 years 2; fear of others death: zero to five years 3.43 (SD 1.03), five to 10 years, 3.14 (SD0.89), and 2.75 for both 10-15 years and greater than 15 years. The fear of others dying was greater than 15 years 3.25, five to 10 years 3.12 (SD1.2), zero to five years 2.9 (SD 1.15) and 10-15 years 2.25.

Table 2

Mean Scores by Years Worked

	0-5 yrs		5-10 yrs		10-15 yrs	>15 yrs
	Mean	**SD**	**Mean**	**SD**		
Happiness	5.8	0.93	4.93	1.6	3.25*	7*
Fear of Own Death	2.43	0.8	2.04	1.03	1.25*	2*
Fear of Own Dying	3.7	0.89	3.41	0.64	3.38*	2*
Fear of Others Death	3.43	1.03	3.14	0.89	2.75*	2.75*
Fears of Others Dying	2.9	1.15	3.12	1.2	2.25*	3.25*

**only one RN completed the survey*

A regression analysis was performed to identify a relationship between happiness and each of the fear of death measurements. These results are depicted in Figure 3 and described in Table 3. Each fear of death measurement besides fear of others dying (r =0.01, p=0.97) had a positive correlation with happiness, however with this sample size none were statistically significant ($p<0.05$). Both fear of own death ($r = 0.49$, $p = 0.08$) and fear of others death ($r = 0.3$, $p = 0.29$) had a moderate correlation, while fear of own dying had a weak correlation ($r=0.3$, $p = 0.34$).

Figure 3

Happiness and Fear of Death and Dying

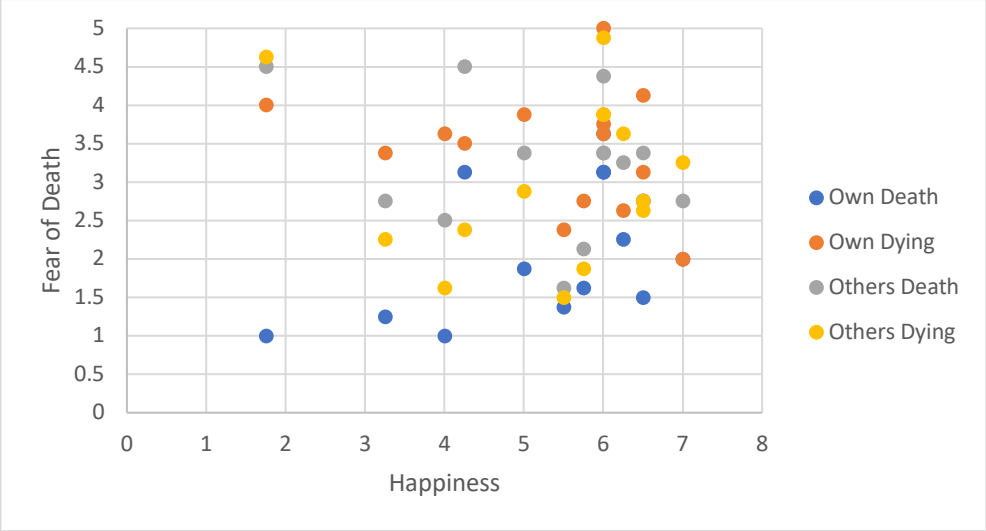


Table 3

Relationship between Happiness and Fear of Death

	r	p*
Own Death	0.49	0.08
Own Dying	0.28	0.34
Others Death	0.3	0.29
Others Dying	0.01	0.97

**p<0.05 signifies statistical significance*

The participants were also asked open-ended questions regarding death and dying. These were reviewed for common themes. The participants were first asked how they feel working as a registered nurse has influenced their thoughts about death and dying. Thirteen participants answered the question. The answers depicted three main themes.

1.1 Removed/compartmentalize

Some of the nurses felt that working as a nurse has made them less empathetic about death. They felt they took good care of their patients, but that death no longer affected them. “It has almost made me feel numb, cold-hearted.” “Working as an RN as made me feel less empathetic towards dying/death.” “I am very removed from emotions when it comes to death and dying.” Working as a nurse has made me “able to better compartmentalize feelings of sadness”.

1.2 Understand suffering

A common theme was increased understanding of the dying process, and the suffering people may endure. “Working as an RN has opened my eyes to the difference between a ‘good death’ and a ‘bad death’.” “It has made me see how much unnecessary suffering patients may be subjected to in the futile aim of ‘curing’ their diseases...” “Showing me that even if we make a choice about what we want in the end of life, that is not always what happens...”

1.3 Advocate for and provide comfortable dignified death

Many of the nurses expressed a desire to provide for a comfortable and dignified death for their patients. “Even though dying is a sad experience, as a nurse, I have found peace in it. I consider it making someone comfortable and allowing them to die with dignity. I feel that I have more compassion because I have experienced people dying in

many ways." "... it is my job to make them comfortable..." "I feel better about my patients passing when I know that they are not suffering, and their wants/desires are met." "My experiences have galvanized my belief in the role of early hospice intervention; open and frank discussions about goals of care and [end of life] wishes... and encouraging a focus of quality of life over length of life" "Working as a registered nurse... is helpful in being able to advocate for patients and family members to die with more dignity."

When asked how working as a registered nurse affected their own end-of-life plans three themes were evident. Three nurses were not comfortable discussing their end-of-life plans, 11 participants chose to answer.

2.1 Comfortable, dignified death.

The nurses expressed that working alongside those who are dying has shown them the importance of having a comfortable death on their own terms. "I imagine that when I am faced with my own death, I will lean towards comfort care rather than treatment to have a more dignified death" Two participants mentioned moving to locations where physician assisted suicide is an option. "I plan on moving to a state that allows physician assisted suicide. I want to be comfortable and die peacefully." "... I will do my best to peacefully exit this life on my own terms... that may mean moving to a state or country where physician assisted suicide is an option".

2.2 Advocacy, planning for own death

Many of the nurses spoke of how frequently dealing with death and dying has prompted them to plan for their own death. They know they must have hard discussions with their family members to advocate for their own end-of-life wishes. "[It has] encouraged me to have hard conversations with family members and advocate for a plan

to be in place." "Increased advocacy for myself and ability to set up a Power of Attorney (POA) and advanced directives to alleviate stress from family members. Ability to be informed and discuss end of life wishes with family members and medical providers." "I definitely feel that I will ensure I have a durable POA and living will to delineate my wishes for end-of-life care"

2.3 Not affected

Two nurses felt that their current profession has not affected their end-of-life choices.

Discussion

The student recognizes that using convenience sampling for the participant selection process may have created a sampling bias, and that the small sample and single site study could have greatly impacted the results. However, the results are promising and show similarities to previous studies. According to the creators of the SHS, the mean happiness score is from about 4.5 to 5.5, depending on variables such as age, gender, occupation and ethnicity; working adults and older retired people average 5.6 (Lyumbomirsky & Lepper, 1999). The mean happiness score of all nurses was 5.27 which falls within this average range. Happiness levels were highest on the day shift. Decreased happiness when working non-day shift could be due to things such as greater conflict with work –life balance, or mental and physical tiredness. These results are similar to previous studies. A study of Croatian nurses found that nurses working the morning shift have greater life satisfaction (Simunić & Gregov, 2012); while a study done on health care workers in five different nations, including the United States, showed that night shift workers were both more physically and mentally tired than those who were not night shift, and inferred that this could have significant implications for the overall well-being of healthcare workers (Tepas et al., 2004). A similar study completed in a single hospital in Turkey found that there was no significant different in nurse happiness when comparing age, sex, marital status, number of children, educational status, the clinical unit where nurses were employed, professional experience (in years), length of employment at the organization, position, monthly income and family type (Genc Kos et al., 2018). Contrarily, in the current study it appears that nurses are happiest

in the beginning years of their careers, though significance was not calculated for this particular measure.

Previous studies of death anxiety have shown that death anxiety decreases with age, though women have a slight spike in their 50s (Russac et al., 2007). In this study, both fear of own dying and fear of own death decreased with years of experience, it is likely that registered nurses with more experience are older in age, fitting in with the previous research. Reasons for this have been theorized including: a continued developmental process where a person comes to terms with their own mortality, denial of the reality of impending death, a diminished quality of life or a greater number of death-related experiences in people's lives as they age (Russac et al., 2007). Newer nurses had the highest fear in all categories except fear of others dying. In a study of Chinese new graduate nurses, it was demonstrated that new graduate nurses had low death self-efficacy, were anxious about death and found coping with death challenging and they would seek advice from more experienced nurses (Zheng et al., 2020). Milligan and Almomani suggest that a decrease in death anxiety as nurses are exposed to death and dying for greater periods of time may suggest compassion fatigue, that it may be easier to adopt a neutral, less emotional approach to death to as a coping mechanism to continue to function in their clinical roles (2020).

One focus of this study was to determine whether increased death anxiety may be the reason for decreased happiness as nursing careers progress. The moderate positive correlation between happiness and fear of death suggests that there is a relationship between these emotions, however opposite of what the student initially hypothesized. That is, that when a nurse is happier or more content with their life, their fear of death

and dying increases. An explanation for this could be that as people are more content, they feel they have more to lose. In a study by Kuhn and Brule, the Swiss Household Panel was used to determine the buffering effects of material, social, religious, and personal resources on negative life events; the researchers concluded that, in general, people with more resources always had more to lose, and that external resources had minimal buffering effect but that internal resources such as personality and spirituality were more likely to help someone process a negative event (Kuhn & Brule, 2018). In a study of Turkish ICU nurses a relationship between nurses' emotions and their attitude towards death was found to be significant. Nurses' fear of death increased both with increased negative and positive emotional states (Peker et al., 2021).

Limitations

Using convenience sampling to recruit participants increased the chance of sampling bias, especially considering the nursing profession is mostly women and that those who volunteered to participate may have different beliefs and opinions than those who did not volunteer. Other limitations to the study include the limited sample size and recruitment of participants from a single research site.

Recommendations and Implications for Advance Nursing Practice

As this study was limited by small sample size and a single research site, recommendations for further research could include an expanded study to other hospitals, or nurses in other disciplines. The themes identified in the qualitative portion could be studied more in-depth and in a quantitative nature. Research could also expand to other populations, including those receiving palliative care, further insight could be gained into the death anxiety of those who are actively dying and whether increased happiness or positive emotions could ease their anxieties.

With more evidence of how working as a nurse affects fear of death, Advanced Practice Nurses (APNs) could develop courses to help prepare nurses for the added anxieties they may face when frequently exposed to death and dying. APNs could advocate for workplaces to offer registered nurses increased resources, such as the seminar offered to the participants, to help cope with the difficult emotions that working around death provokes. They could also argue for places of refuge for RNs after dealing with an emotional situation along with a break from their other responsibilities for a short while so they can better process their emotions and anxieties. APNs should also work to promote an environment of happiness and well-being within their own team and unit, modeling these behaviors for their fellow nurses.

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Appendix A

Subjective Happiness Scale
Lyumbomirky & Lepper 1999

For each of the following statements and/or questions, please circle the point on the scale that you feel is most appropriate in describing you.

1. In general, I consider myself:

1	2	3	4	5	6	7
not a very happy person						a very happy person

2. Compared with most of my peers, I consider myself:

1	2	3	4	5	6	7
less happy						more happy

3. Some people are generally very happy. They enjoy life regardless of what is going on, getting the most out of everything. To what extent does this characterization describe you?

1	2	3	4	5	6	7
not at all						a great deal

4. Some people are generally not very happy. Although they are not depressed, they never seem as happy as they might be. To what extent does this characterization describe you?

1	2	3	4	5	6	7
not at all						a great deal

Appendix B

Broaden and Build

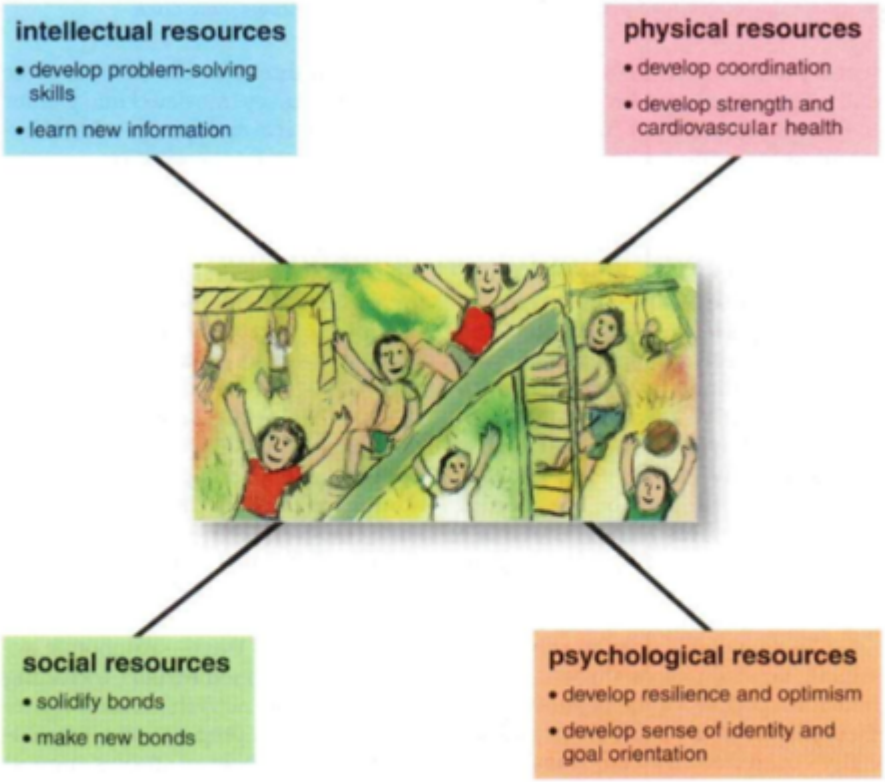

Figure 4. Positive emotions broaden people's momentary thought-action repertoires. Joy, for example, encourages playful behavior. These broadened thought-action repertoires in turn build intellectual, physical, social and psychological resources for the future. Such resources translate into greater odds of survival and reproductive success.

Appendix C

Introductory Email

Attention Inpatient Nurses at the Providence VA Medical Center,
I have been asked by a Nurse Practitioner student at Rhode Island College to assist in the distributions of a quality improvement survey for a masters project. The student is studying how working in a profession that so frequently deals with death and dying affects nurses' own thoughts about end of life and end of life care. Additionally, the student aims to determine whether being a "happier" person changes how nurses feel about death and dying.
I am emailing on the student's behalf to ask you to take a 10-minute survey addressing this topic.

Study Information
You must be a nurse to take part in the research. Participation is completely voluntary and anonymous. You may withdraw from the study at any time.
Please click on the link at the end of this email to access the Qualtrics Survey.
The survey begins with basic demographic information, shifts work and years in the medical field. Years in the medical field is divided into four categories less than 5, 5-10, 10-15, or greater than 15 years. No personal information will be gathered.
The Subjective Happiness Scale (Lyumbomirsky & Lepper, 1999) is a 4-item measurement of global subjective happiness. The Collett-Lester fear of death scale (Lester, 1990) consists of four subscales: fear of death of self, fear of death of others, fear of dying of self and fear of dying of others, each with 8 items. Additionally, there are two open ended questions designed to gain further insight into participants' perspectives of death and dying.
The survey will remain active for three weeks for you to complete at your convenience. Completed questionnaires will be kept secured and confidential with access limited only to the student researcher and destroyed after completion of data analysis and dissemination of results. None of the information you provide will have your name or any information that can identify you personally.
Due to the potentially triggering nature of this topic, the following resources are available to you if necessary.

- At the VA: The Employee Assistance Program is a work-based program that offers free short-term counseling, referrals, and follow-up services to employees to help cope with problems that may be adversely affecting work attendance, performance or life in general. These problems may involve work related stress or emotional or personal concerns. It is managed by a licensed independent clinical social worker who can be reached by phone at (401) 273 - 7100 x13425
- In Providence: There are multiple crisis hotlines
    - BH Link: (401) 414 Link (5465)
    - The Samaritans of Rhode Island: (401) 272-4044 or (800) 365-4044
    - National Suicide Prevention Lifeline: (800) 273-TALK (8255)

- On Microsoft Teams: Professor Kathleen Smith, a RIC faculty within the School of Nursing who specializes in psychiatric mental health nursing, will offer a psychoeducational session addressing death anxiety and coping mechanism. This will be on Tuesday, December 21 at 11am, the link to the Teams Meeting will be sent to your VA email.

If you have any questions regarding this study or the survey you may contact the Principal Investigator Jennifer Fearon- Lynch, PhD, RN at 401-456-9715.
Thank you!

Link to to survey:
https://ric.qualtrics.com/jfe/form/SV_3JkerFJaJq2XF0G

Appendix D

Reminder Email

Dear Nurses,

This is a reminder email to encourage you to participate in the research study described below if you have not yet done so.

I have been asked by a Nurse Practitioner student at Rhode Island College to assist in the distributions of a quality improvement survey for a masters project. The student is studying how working in a profession that so frequently deals with death and dying affects nurses' own thoughts about end of life and end of life care. Additionally, the student aims to determine whether being a "happier" person changes how nurses feel about death and dying.

I am emailing on the student's behalf to ask you to take a 10-minute survey addressing this topic.

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Please click on the link at the end of this email to access the Qualtrics Survey.

The survey begins with basic demographic information, shifts work and years in the medical field. Years in the medical field is divided into four categories less than 5, 5-10, 10-15, or greater than 15 years. No personal information will be gathered.

The Subjective Happiness Scale (Lyumbomirsky & Lepper, 1999) is a 4-item measurement of global subjective happiness. The Collett-Lester fear of death scale (Lester, 1990) consists of four subscales: fear of death of self, fear of death of others, fear of dying of self and fear of dying of others, each with 8 items. Additionally, there are two open ended questions designed to gain further insight into participants' perspectives of death and dying.

The survey will remain active for three weeks for you to complete at your convenience. Completed questionnaires will be kept secured and confidential with access limited only to the student researcher and destroyed after completion of data analysis and dissemination of results. None of the information you provide will have your name or any information that can identify you personally.

Due to the potentially triggering nature of this topic, the following resources are available to you if necessary.

- At the VA: The Employee Assistance Program is a work-based program that offers free short-term counseling, referrals, and follow-up services to employees to help cope with problems that may be adversely affecting work attendance, performance or life in general. These problems may involve work related stress or emotional or personal concerns. It is managed by a licensed independent clinical social worker who can be reached by phone at (401) 273 - 7100 x13425

- In Providence: There are multiple crisis hotlines
    - BH Link: (401) 414 Link (5465)
    - The Samaritans of Rhode Island: (401) 272-4044 or (800) 365-4044
    - National Suicide Prevention Lifeline: (800) 273-TALK (8255)
- On Microsoft Teams: Professor Kathleen Smith, a RIC faculty within the School of Nursing who specializes in psychiatric mental health nursing, will offer a psychoeducational session addressing death anxiety and coping mechanism. This will be on Tuesday, December 21 at 11am, the link to the Teams Meeting will be sent to your VA email.

If you have any questions regarding this study or the survey you may contact the Principal Investigator Jennifer Fearon- Lynch, PhD, RN at 401-456-9715.
Thank you
Link to to survey:
https://ric.qualtrics.com/jfe/form/SV_3JkerFJaJq2XF0G

Appendix E

Questionnaire

Demographic Information

What shift do you currently work?

a. Days
b. Evenings
c. Nights

How long have you worked in the medical field?

a. 0-5 years
b. 5 – 10 years
c. 10-15 years
d. > 15 years

Subjective Happiness Scale

Instructions to participants: For each of the following statements and/or questions, please circle the point on the scale that you feel is most appropriate in describing you.

1. In general, I consider myself:

1 2 3 4 5 6 7
Not A very
A very happy
happy person
person

2. Compared to most of my peers, I consider myself:

1 2 3 4 5 6 7
Less more
Happy happy

3. Some people are generally very happy. They enjoy life regardless of what is going on, getting the most out of everything. To what extent does this characterization describe you?

1 2 3 4 5 6 7
Not at A great
all deal

4. Some people are generally not very happy. Although they are not depressed, they never seem as happy as they might be. To what extend does this characterization describe you?

1 2 3 4 5 6 7
Not at A great
all deal

The Revised Collett-Lester Scale

Instructions to participants: How disturbed or made anxious are you by the following aspects of death and dying? Read each item and answer it quickly. Don't spend too much time thinking about your response. We want your impression of how you think right now. Circle the number that best represent your feeling.

	very		somewhat		not
Your Own Death	5	4	3	2	1
1. the total isolation of death	5	4	3	2	1
2. the shortness of life	5	4	3	2	1
3. missing out on so much after you die	5	4	3	2	1
4. dying young	5	4	3	2	1
5. how it will feel to be dead	5	4	3	2	1
6. never thinking or experiencing anything again	5	4	3	2	1
7. the possibility of pain and punishment during life-after-death	5	4	3	2	1
8. the disintegration of your body after you die	5	4	3	2	1
Your Own Dying					
1. the physical degeneration involved in a slow death	5	4	3	2	1
2. the pain involved in dying	5	4	3	2	1
3. the intellectual degeneration of old age	5	4	3	2	1
4. that your abilities will be limited as you lay dying	5	4	3	2	1
5. the uncertainty as to how bravely you will face the process of dying	5	4	3	2	1
6. your lack of control over the process of dying	5	4	3	2	1

7. the possibility of dying in a hospital away from friends and family	5	4	3	2	1
8. the grief of others as you lay dying	5	4	3	2	1
The Death of Others					
1. the loss of someone close to you	5	4	3	2	1
2. having to see their dead body	5	4	3	2	1
3. never being able to communicate with them again	5	4	3	2	1
4. regret over not being nicer to them when they were alive	5	4	3	2	1
5. growing old alone without them	5	4	3	2	1
6. feeling guilty that you are relieved that they are dead	5	4	3	2	1
7. feeling lonely without them	5	4	3	2	1
8. envious that they are dead	5	4	3	2	1
The Dying of Others					
1. having to be with someone who is dying	5	4	3	2	1
2. having them want to talk about death with you	5	4	3	2	1
3. watching them suffer from pain	5	4	3	2	1
4. having to be the one to tell them that they are dying	5	4	3	2	1
5. seeing the physical degeneration of their body	5	4	3	2	1
6. not knowing what to do about your grief at losing them when you are with them	5	4	3	2	1
7. watching the deterioration of their mental abilities	5	4	3	2	1
8. being reminded that you are going to go through the experience also one day	5	4	3	2	1

Open-Ended Responses:

Instructions to participants: Briefly answer the following:

1. How do you feel working in the medical field has influenced your thoughts about death and dying?

2. How has working in the medical field affected your own end-of-life plans and choices?

Appendix F

Collett-Lester Fear of Death Scale

Appendix B

The Revised Collett-Lester Scale

How disturbed or made anxious are you by the following aspects of death and dying? Read each item and answer it quickly. Don't spend too much time thinking about your response. We want your first impression of how you think right now. Circle the number that best represents your feeling.

	very		somewhat		not
Your Own Death					
1. the total isolation of death	5	4	3	2	1
2. the shortness of life	5	4	3	2	1
3. missing out on so much after you die	5	4	3	2	1
4. dying young	5	4	3	2	1
5. how it will feel to be dead	5	4	3	2	1
6. never thinking or experiencing anything again	5	4	3	2	1
7. the possibility of pain and punishment during life-after-death	5	4	3	2	1
8. the disintegration of your body after you die	5	4	3	2	1
Your Own Dying					
1. the physical degeneration involved in a slow death	5	4	3	2	1
2. the pain involved in dying	5	4	3	2	1
3. the intellectual degeneration of old age	5	4	3	2	1
4. that your abilities will be limited as you lay dying	5	4	3	2	1
5. the uncertainty as to how bravely you will face the process of dying	5	4	3	2	1
6. your lack of control over the process of dying	5	4	3	2	1
7. the possibility of dying in a hospital away from friends and family	5	4	3	2	1
8. the grief of others as you lay dying	5	4	3	2	1
The Death of Others					
1. the loss of someone close to you	5	4	3	2	1
2. having to see their dead body	5	4	3	2	1
3. never being able to communicate with them again	5	4	3	2	1
4. regret over not being nicer to them when they were alive	5	4	3	2	1
5. growing old alone without them	5	4	3	2	1
6. feeling guilty that you are relieved that they are dead	5	4	3	2	1
7. feeling lonely without them	5	4	3	2	1
8. envious that they are dead	5	4	3	2	1

The Dying of Others	very			somewhat	not
1. having to be with someone who is dying	5	4	3	2	1
2. having them want to talk about death with you	5	4	3	2	1
3. watching them suffer from pain	5	4	3	2	1
4. having to be the one to tell them that they are dying	5	4	3	2	1
5. seeing the physical degeneration of their body	5	4	3	2	1
6. not knowing what to do about your grief at losing them when you are with them	5	4	3	2	1
7. watching the deterioration of their mental abilities	5	4	3	2	1
8. being reminded that you are going to go through the experience also one day	5	4	3	2	1