THE RELATIONSHIP BETWEEN DEATH ANXIETY
AND LEVELS OF EMPATHY, RESPECT, AND
GENUINENESS AMONG COUNSELORS

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by
Christine I. Woods-Henderson, R.N., B.A.

The Ohio State University
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Approved by

[Signature]
Advisor
Department of Psychology
June 8, 1949 ........................................ Born, Westfield, New Jersey
June, 1967 ........................................ Completed high school education; Westfield Senior High School, Westfield, New Jersey
August, 1967 - August, 1970 ........................................ Completed Nursing Diploma Program; The Reading Hospital School of Nursing, West Reading, Pennsylvania
August, 1970 - September, 1974 ........................................ Full-time employment as a Registered Nurse in various nursing positions
September, 1974 - June, 1977 ........................................ Completed B.A. in Psychology; graduated summa cum laude, Jersey City State College, Jersey City, New Jersey
June, 1977 - June, 1978 ........................................ Full-time employment as a private-duty nurse; Muhlenberg Hospital, Plainfield, New Jersey
September, 1978 - June, 1979 ........................................ Student Personnel Assistant - Assistant Dormitory Director, Siebert Hall; Ohio State University, Columbus, Ohio
June, 1979 - June, 1980

Student Personnel Assistant - Financial Aids Counselor; Student Financial Aids Office; Ohio State University, Columbus, Ohio

September, 1978 - August, 1980

Completed M.A. in Counseling Psychology; Ohio State University, Columbus, Ohio
IV

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INTRODUCTION

What man shall live and not see death? (Psalms 89:49)

Death is... the only inescapable, unavoidable, sure thing. We are sentenced to die the day we’re born. I guess I fear death as much as you or anybody else. (Gary Gilmore, in a letter written before his execution)

These statements underscore an ever-present reality: death is a certainty in life.

And yet, since about 1900, death and dying have been considered taboo subjects in American culture. Pattison (1977) offered several possible reasons for this: wars were no longer fought on American soil, hence we ceased to experience or observe violent death en masse; the threat of infant mortality was largely removed due to medical advances; and increasing life expectancies permitted most adults to witness the youth of their grandchildren. These decades of repression and denial of death, however, have been followed by an emergence of a preoccupation with death in perverse forms, such as may be seen in the film Clockwork Orange. Fowles (1976) also addressed this notion:

As one social current has tried to hide death, to euphemize it out of existence, so another has thrust death forward as a chief element in entertainment: in the murder story, the war story, the spy story, the western. But increasingly, as our century grows old, these fictive deaths become more fictitious, and fulfill the function of concealed
euphemism. The real death of a pet kitten affects a child far more deeply than the "deaths" of all the television gangsters, cowboys, and Red Indians. (p.6)

Other developments in recent years have also brought death and dying back into focus. Progress in medical technology has prolonged the process of dying, the possibility of nuclear annihilation is a very real threat, and many people experience a crisis of living in a society where traditional values and religious supports have been highly challenged (Pattison, 1977). Fowles (1976) added an increased awareness of life factor.

In all the countries living above a base subsistence level, the twentieth century has seen a sharp increase in awareness of the pleasures of life. This is not only because of the end of belief in an afterlife, but because death is more real today, more probable, now that the H-bomb is. The more absolute death seems, the more authentic life becomes. (p.7)

Although many attitudes toward death exist in American culture, Pattison (1977) has described four basic cultural positions. The death-deifying attitude is especially evident among members of the medical profession, where there is a focus on the preservation of life, and a general apprehension and even avoidance of dying patients. Death-defying attitudes have been strongly influenced by religious doctrines and may also be evidenced among those who would "give up their life" fighting for causes, families, countries, or ideologies. Some may possess a
death-desiring attitude for themselves or others, as may be seen in those who advocate the concepts of euthanasia or suicide. Finally, death-accepting attitudes view death as a part of life and integral to human existence.

Quite recently, the United States and many eastern European countries seem to be moving from a death-denying perspective toward a more death-accepting viewpoint. Death and dying seminars are prevalent throughout the United States, and many colleges and universities, as well as some elementary and high schools, offer courses in death education. Hospices, hospitals that specialize in the care of the dying, such as St. Christopher's Hospice in London, New Haven Hospice in Connecticut, and Riverside Hospice in New Jersey, are growing in number. And an increasing interest in the field of thanatology — the study of death, dying, and life-threatening behaviors — is evolving.

This shift in cultural attitudes toward death and dying has allowed a special population of individuals to be rediscovered — the terminally ill. A Swiss psychiatrist, Elizabeth Kübler-Ross, has been prominent in this rediscovery. Her credo has inspired a new openness toward death and a more compassionate approach to the care of the dying: to help people live until they are ready to die (Kübler-Ross, 1969).
STATEMENT OF THE PROBLEM

Individuals from various helping professions have expressed their opinions on methods, styles, and techniques for counseling the terminally ill (Cappon, 1959; Hacker, 1977; Kübler-Ross, 1969; Le Shan & Le Shan, 1961; Pattison, 1967, 1977; Roose, 1969; Rosenthal, 1957; Saunders, 1969; Schulz, 1976; Vandenbergh, 1966; Waltzma, 1978). However, relatively little systematic research can be found in this area. Broadly speaking, it appears that research suggesting effective methods, styles, or techniques in the counseling of this special population of clients is needed. And yet first, a more basic research problem seems to warrant investigation.

A number of authors within the field of thanatology have stressed that medical caregivers who wish to help the terminally ill should consider and resolve their own anxieties and attitudes toward dying and terminal illness (Baker & Sorensen, 1963; Kübler-Ross, 1969; Laube, 1977; Quint, 1966; Reynolds & Kalish, 1974; Rothenberg, 1961; Shusterman, 1973; Strauss, 1969; Waltzma, 1978). This notion has also been addressed with respect to professional helpers in psychology (Abrams, 1971; Bugen, 1979; Le Shan & Le Shan, 1961; Manganello, 1977; Pattison, 1967, 1977; Shady, 1976). Without this resolution, helpers may experience hopelessness, helplessness, inadequacy, frustration, guilt, and failure (Kübler-Ross, 1971; Quint,
1966; Strauss, 1969), which may in turn affect their relationships with terminally ill patients in a negative manner.

The presence of anxiety in helping relationships has been documented by Carter and Pappas (1975), and Mooney and Carlson (1976), among others, have demonstrated that counselor-trainee/client relationships are particularly susceptible to high anxiety levels. Adding the dimension of a client's impending death has the potential for triggering within the counselor another set of anxieties -- anxieties which rarely may be considered, or to which the counselor has felt little need or desire to experience or resolve.

The importance of the interpersonal relationship in psychological counseling is widely recognized. Various theoretical viewpoints have proposed that this relationship may be represented by the behavior and attitudes of the counselor. For example, Rogers (1957) proposed that the necessary and sufficient characteristics of a therapeutic relationship include the counselor's experiencing an empathic understanding of the client's internal frame of reference; the counselor's experiencing unconditional, positive regard for the client; and the counselor's experiencing a state of congruency, or genuineness, in the relationship. Later investigators referred to these characteristics as "core" or "facilitative" conditions.
of counseling, and studies of their effects suggested that the counselor's level of empathy, respect, and genuineness is related to successful outcome in counseling (Carkhuff, 1969; Truax & Carkhuff, 1967; Truax & Mitchell, 1971). In addition, research has demonstrated that counselors functioning at high levels of the facilitative conditions contribute to positive changes within their clients, while counselors functioning at low levels of these attributes contribute to negative or no changes within their clients (Truax & Carkhuff, 1967; Truax & Wargo, 1966).

These constructs and their measurements provide a basis for investigating the association between the counselor's anxieties with respect to death and the nature of the relationship he or she establishes with a terminally ill client. A measure of each counselor's death anxiety will be collected through the use of the Death Anxiety Scale (Templer, 1970). Counselors will furnish audio-taped responses to the audio-taped concerns of a confederate, terminally ill client. Trained raters will then provide ratings of each counselor's responses in terms of empathy, respect, and genuineness, employing the Interpersonal Processes Scales (Carkhuff, 1969), as indicators of relationship quality in counseling.

The importance of this investigation is that it rep-
represents a first step in the direction of understanding counseling effectiveness with terminally ill clients. Specifically, the question to be examined in the present thesis is:

Is there a relationship between counselors' death anxiety and empathy, positive regard, and genuineness of their responses to a terminally ill client?
LITERATURE REVIEW

This thesis concerns counselor death anxiety and the quality of the relationship counseling provides to terminally ill clients. It seems appropriate to first review selected literature on the characteristics of terminally ill patients and stages in the dying process. This will be followed by a consideration of the characteristics of two medical caregivers, the physician and the nurse, and of counselors of terminally ill clients. Finally, the facilitative conditions as an indicator of relationship quality in counseling will be presented.

I. The Terminally Ill Patient

An examination of approximately one hundred journal articles, research reports and books yields a list of dying patients' characteristics most frequently cited by thanatology experts, medical professionals, and terminally ill patients themselves. While not exhaustive, this list includes the patient experiencing: loss of freedom, control, autonomy, and a sense of mastery; anticipatory grief with respect to significant others; pressure to conform to others' expectations (family, clergy, hospital staff); isolation, alienation, rejection, and loneliness; helplessness and hopelessness; denial; depression; guilt; anger, hostility, and agitation; physical and psychological regression; time distortions; and loss of the body, repre-
senting a narcissistic "blow" resulting in a fear of being unloved. Which of these are experienced depends in part upon the patient's life stage (Pattison, 1967; Waltzman, 1978). The mid-life adult presents perhaps the most challenging situation for caregivers, for most often at this stage, challenges have been met, achievements and competencies have been realized, and there is an emphasis upon family relationships. A diagnosis of terminal illness for this individual represents a great loss; in addition to coping with the anticipatory grief of family and friends, the patient experiences feelings of being deprived of the pleasures that decades of work may have promised (Waltzman, 1978).

Alexander and Adlerstein (1959), Cramond (1970), Feder (1976), Feifel (1959), Pattison (1977), Weisman and Hackett (1961), and numerous others have suggested another characteristic of terminal illness experienced by many patients: fear of the dying process appears to produce greater distress than the fear of death itself. The former includes fears of mutilation, pain, dependency, abandonment, insanity, and regression into "nothingness" (Bakke, 1960; Cramond, 1970), while fear of death, or generalized "death anxiety," includes anxieties related to the unknown, afterlife, finality, premature death, powerlessness, and separation from others.
A few authors have sought to study the dying experience by further describing and examining various stages within the dying process. Noyes (1972) described three stages: "resistance," in which initial violent struggle, accompanied by anxiety, panic, and increased physical and mental activity eventually gives way to surrender, peace and calm; "review of life," in which the individual focuses on personal life events (usually pleasant scenes), often entailing regression; and "transcendence," in which one experiences a gradual "losing hold" with worldly reality, culminating in a sense of oneness with the universe. Pattison (1977) took a less philosophical view than Noyes, but also described three phases: "crisis of death knowledge," in which the patient copes with peak anxiety at the realization of his or her finality; "chronic living/dying," in which physical decline and fears of the dying process are experienced; and the "terminal phase," in which the patient begins to withdraw into the self.

Kübler-Ross (1969) identified five stages from over two hundred interviews with terminally ill patients. The first stage, denial and isolation, serves as a buffer for the often unexpected and shocking news. Within the anger stage, rage, envy, and resentment may be displaced in all directions at random, the occurrence of which usually produces frustrating interactions with both the hospital staff and family members. At the bargaining stage, the pa-
tient seeks to make an agreement, usually with an important religious figure, entailing wishes for extensions of life, or a few days without pain or discomfort. The depression stage is comprised of two phases; while "re-active depression" involves the patient experiencing unrealistic guilt or shame over past losses, "preparatory depression" entails an evolving sense of peace as the patient prepares for the impending loss of all love objects. "Preparatory depression" is believed to be a necessary and beneficial phase to be experienced if the patient is to die in the fifth stage of acceptance. Within this final stage, the patient experiences a full sense of inner peace and an increased need for silence and non-verbal communication. It is also suggested that "hope" in various forms persists throughout all five stages.

II. Characteristics of Caregivers

A. The Physician

Within the area of terminal cancer management, Rothenberg (1961) cited five interpersonal issues in which the feelings, attitudes, and anxieties of the physician play a significant role. Initially, if the physician has difficulty dealing with the fact that cancer is often uncontrollable, he or she may unintentionally convey this feeling to the patient, thereby increasing the individual's sense of loss of control and mastery. Should the physician deny that the patient's cancer exists, a "closed awareness"
phenomenon may result (Strauss, 1969) in which there is much game-playing by the hospital staff members to keep the diagnosis a secret despite the patient's suspicions. A physician who fosters the suppression of grief expression by the patient and the patient's family may be attempting to decrease his or her own sense of guilt, defeat, or failure; yet this may only serve to support the denial aspect. A physician experiencing a sense of failure—a failure to teach the patient preventive measures, to act quickly, or to discover a cure—may inadvertently contribute to the patient's sense of hopelessness and helplessness. Finally, the physician who "gives up" on the patient may influence the individual's sense of isolation and loneliness; the patient may then, in turn, respond to others by his or her own defensive isolation, which sets up a vicious cycle.

There is evidence to support the notion that terminally ill patients desire honest, sharing communication with their physician (Cappon, 1962; Feifer, 1959). There also exists at least tentative support for the hypothesis that there has been a shift toward more openness among physicians with regard to diagnosis disclosure over the last decade (Carey & Posavac, 1978-1979). Many physicians, however, continue to avoid "truth telling" and the perceived consequences (Feifer, 1965; Strauss, 1969) for protective reasons, believing that the patient is incapable
of "handling" such knowledge. Rothenberg (1961) provided a thought-provoking response to this concept:

The temptation to support processes such as denial, magical thinking, and the avoidance of issues stimulating unrealistic guilt may be dictated by the physician's inner conviction that death and dying cannot be faced realistically by the patient or by himself. This is not a necessary assumption. (p.1072)

Additional factors may interfere with the physician's meeting the needs of the terminally ill patient. Reynolds and Kalish (1974) in their observations of three "extended-care" wards in a Veteran's Administration hospital found that physicians' heavy patient loads and their experience of social and cultural gaps with patients shielded them from deeper involvement in their patients' deaths. Kastenbaum (1965) found that physicians' "life expectancy ratings" of terminally ill patients based on medical criteria consistently over-estimated longevity within the first year of hospitalization and that patients' "will to live" orientation influenced physicians' predictions: patients rated as "will to live extenders" received longer life expectancy ratings than did those rated as "will to live shorteners". These findings suggest that physicians may have the need to deny imminent death to avoid a negative effect on their daily interactions. Finally, the research of Schuls and Alderman (1978-1979) supported the hypothesis that patients of high death-anxious physicians
would survive longer than patients of low death-anxious physicians, based on the belief that physicians high in death anxiety would be less accepting of their patients' terminality and thus, more likely to use heroic measures to sustain life. While high death-anxious physicians may negatively affect their patients by prolonging physical and psychological distress, the attitudes taken by these healers may in fact save some lives, in contrast to their low death-anxious colleagues.

B. The Nurse

The health team professional likely to have the most contact with the terminally ill patient is the nurse. Yet studies by Polta (1963), Quint (1967), and Sudnow (1967) identified avoidance and denial as common behaviors of this staff member in interactions with dying patients. Quint (1966) found that nursing staffs experience the most distress in their care of two types of patients: the patient who is not to be informed of his or her diagnosis and prognosis, and the patient whose "dying behavior" does not conform to the staffs' expectations of "acceptable dying", particularly those who are angry, demanding, denying, or unable to accept reality. While the nurse's avoidance of terminally ill patients results in fewer questions being asked by the patient and may serve to protect the nurse from facing inner feelings, the nurse, as well as the patient, may gradually experience increasing
frustration and helplessness, thus encouraging the iso-
lation cycle discussed previously.

Baker and Sorensen (1963) have outlined eight styles
of responses that nurses frequently use in their communi-
cations with the terminally ill. For example, should the
patient ask, "Do you think I'll die today, nurse?", possi-
ble response styles cited by Baker and Sorensen include:
moralizing ("You shouldn't talk that way; no one knows
when they will die."); stating facts ("No, by your chart
records, it seems unlikely."); denial ("You won't die to-
day or even tomorrow."); changing the subject ("Would you
like some tea?"); referral ("Ask your doctor."); joking
("Oh come now; you'll outlive me!"); and avoiding the
question by silence and turning away. Reynolds and Kalish
(1974) found that "kidding and joking" was not only pre-
valent on the extended-care wards mentioned previously,
but seemed necessary for the staff to maintain a psycho-
logical distance and provide a sense of mastery over un-
alterable circumstances.

The responses above reveal that the nurse has ex-
presed his or her own feelings, instead of exploring the
feelings of the patient. Quist (1966, 1967) and Polta
(1963) have suggested that the reasons for this may lie
within conflicts experienced by the nurse. If the nurse
has not come to terms with personal feelings toward death,
the dying patient may represent a symbol of his or her own
mortality. Parallel with the physician, the nurse's primary objective is the preservation of life; the terminally ill patient signifies failure. The nurse may also not be sufficiently prepared to meet the needs of the dying; Quint (1967) found that 53% of one graduating class of nurses had no contact with terminally ill patients in their educational experience. Finally, Glaser and Strauss (1965) have reported that there exists much pressure on the nurse to maintain "professional composure." A frequent way of ensuring this with terminally ill patients is to restrict personal involvement, or, when avoidance is impossible, to immerse oneself in intense physical care so as to avoid verbal communication.

A vast amount of literature exists under the heading of "the medical staff and the terminally ill patient," a great deal of which is beyond the scope of this thesis. The previous discussions have been an attempt to present further insights into the interactions between professional medical staff members and patients with a limited life-span. Shusterman (1973) provides an appropriate summary at this point:

The imminent death of an individual also creates conflicts and tensions in those who are caring for him. The experience of the dying patient and the experience of the personnel responsible for his care are highly interdependent. Both staff and patients assume various types of postures in facing the patient's death,
which leads to different types of interactions between staff and patients. (p.467)

C. The Counselor

Although the literature encompassing medical approaches to the care of terminally ill patients is extensive, the same cannot be said with respect to psychological counseling. There is reason to suggest a growing interest among counselors within this area. For example, a recently-formed organization, The Forum for Death Education and Counseling, Inc. based in Arlington, Virginia, provides the following forms of assistance to educators and counselors: newsletters, referral and resource services, workshops and conventions, a code of ethics, and opportunities for certification. But realizing that counseling the terminally ill is in its infancy, the counselor may wish to draw upon the experience of professionals from other fields as a stepping stone in the development of his or her own approach. Nevertheless, there exists some literature with regard to counselor characteristics in general, and in relation to terminally ill patients, relevant to the present research.

Numerous studies have examined counselor anxiety as a factor that may interfere with counseling effectiveness (Bandura, 1956; Bergin & Solomon, 1970; Brans, 1961; Fennscott & Brown, 1972). Although a negative relationship
between counselor trait anxiety and counseling effectiveness was reported in these studies, there was no particular emphasis on state anxiety within the counseling interview. In researching this area among counselor-trainees, Bowman, Roberts and Giesen (1978) found that subjects experienced increased heart rate, skin conductance, and subjective anxiety during a ten-minute counseling interview, as compared with a neutral situation in which trainees read a counseling article.

In contrast to these results, Bowman and Roberts (1978) found no difference in counselor-trainees' anxiety levels when comparing self-report and physiological measures of anxiety under conditions of a counseling practicum interview and a conversation. However, in what was essentially a replication of their study, but with the addition of a third neutral baseline situation, Bowman and Roberts (1979) found that counselor-trainees experienced greater levels of anxiety as measured by skin conductance and subjective data during counseling than during a conversation, but not as measured by heart rate. The latter suggested that subjects experienced more anxiety in both counseling and conversation conditions, as compared with the neutral situation.

Research results within the area of counselor anxiety appear to be mixed and further studies may be warranted. The work of Malmo (1959), however, seems related and de-
serves mention. Malmo suggested that there is a relationship between the level of activation and the level of performance, such that as activation increases, performance rises toward an optimum. Once this optimum is reached, however, the increase in activation is reflected in a fall in performance. This hypothetical relationship has often been described as an "inverted U" and is a more recent formulation of the Yerkes-Dodson law (1908) that related drive to performance in a similar manner. It seems reasonable to assume that Malmo's hypothesis could be operating within counseling relationships as well: moderate levels of counselor anxiety may be related to counseling effectiveness, whereas both low and high levels of counselor anxiety may be related to ineffective counseling.

Spensley and Blacker (1976) focused on the feelings of the therapist within the therapeutic relationship. These authors expressed the view that the therapist frequently experiences conflict which leads to stress. He or she is usually required to "bottle up" feelings provoked by the interpersonal situation. Empathy with the client must take place, yet the therapist often cannot experience his or her own feelings fully, as to do so would distract from the individual's ability to understand and communicate that understanding. The therapist may also be subject to feelings of conflict and stress in a relationship where the client experiences great distress, as in terminal ill-
ness, in which case the helper may view his or her therapeutic efforts as useless. Finally, termination of the relationship may also present the therapist with stress, as he or she experiences a sense of grief over the "loss" of the client. This last concept is especially complicated should the loss of the client occur through death.

Two studies have examined the association between counselor anxieties and counselor interactions with terminally ill patients. Bugen (1979) investigated the relationship between counselor-trainees' state anxiety and their perceptions of a terminally ill patient's "dying stages" as defined by Kübler-Ross (1969). The researcher hypothesized that high-anxious subjects, as compared with low-anxious subjects, would differentially perceive the dying patient as being more denying, angry, bargaining, depressed, and less accepting. Twenty male and female graduate trainee students enrolled in a death and dying seminar completed a scale to assess levels of state anxiety with respect to their "here and now" feelings. After listening to a female leukemia patient's presentation of her personal dying experience, the trainees rated the patient on a Likert scale of Kübler-Ross' five dying stages, to which the dimension of hope was added. The six items were rated on five-point scales, ranging from "not at all" to "very much so." Based on their state anxiety scores, subjects were divided into high and low-anxious groups. A statis-
tically significant difference was found between high and low-anxious trainees on the items of denial and hope (p < .05): high-anxious subjects perceived the patient as more denying and less hopeful. Statistically significant differences were also found between the two groups on the items of anger and acceptance (p < .01): high-anxious trainees perceived the patient as more angry and less accepting. No significant differences were found between high and low-anxious subjects on the items of bargaining and depression, although the results were in the predicted direction. Bugen stated that the high-anxious counselor-trainees may have projected their own negative feelings with respect to death and dying onto the terminal patient, and he concluded that high anxiety may be especially important to consider in a counseling relationship in which the client faces a terminal illness.

A study by Manganello (1977) examined whether the variables of attitude toward afterlife, fear of death, and denial affect counselor empathy when interviewing a terminally ill patient. Thirty clergy and thirty seminarian "counselors" were grouped according to their attitude toward afterlife, which resulted in three, rather highly-complex categories. Subjects completed a personal data questionnaire, a defense mechanism inventory, the Collett-Lester Fear of Death Scale (1969), and a scale to assess levels of counselor empathy. After a one-week interval,
subjects in the experimental condition viewed a videotape of six statements made by a terminally ill female patient, to which they responded in a "helpful manner" via tape recording. Subjects in the control condition did the same in response to a female client seeking general counseling. The Collett-Lester Fear of Death Scale and the personal data questionnaire were administered to both groups at the conclusion of the experiment. A number of relationships were then examined, such as fear of death and use of denial; fear of death and afterlife orientation; level of empathy and use of denial; and level of empathy and afterlife orientation. However of particular interest to the present research are Manganello's findings that:

1. those who feared death least had a low empathy level;
2. those with a high fear of death had a high empathy level;
3. when interviewing a terminally ill patient, those who feared death least had a low level of empathy; and
4. when interviewing a terminally ill patient, fear of death increased and empathy decreased.

The researcher also found that subjects with experience in counseling the terminally ill had a lower fear of death than those who had no counseling experience in this area.

IV. Facilitative Conditions in Counseling

There is research evidence to suggest that the counselor's level of empathy, positive regard, and genuineness is related to counseling outcome (Carkhuff, 1969; Truax &
Carkhuff, 1967; Truax & Mitchell, 1971; Truax & Wargo, 1966). The definition and measurement of these facilitative conditions will be considered before proceeding to selected research concerning their possible effects on counseling outcome. Although the reference for the following discussion is, for the most part, Carkhuff and Benson (1977), two other researchers deserve mention. Carl Rogers first defined the counseling "core conditions" and described their relationship to therapeutic change in 1957. Barrett-Lennard (1962) developed the Relationship Inventory, which had different forms for the client and counselor, and which was designed to study five dimensions of the counseling relationship, including empathic understanding, regard, and congruence. Barrett-Lennard may be credited with having designed one of the earliest measurements of the facilitative conditions.

Empathy involves the counselor experiencing the client's feelings or viewing the world as the client sees it, and being in touch with his or her own feelings as well. The helper strives to respond to the client's deeper feelings, as well as to superficial feelings. Carkhuff and Benson (1977) have stated:

The helper's ability to communicate at high levels of empathic understanding appears to involve the helper's ability to allow himself to experience or merge with the experience while suspending his own judgments, tolerating his own anxiety and communicating
Ultimately, the helper's effectiveness is considered to be related to a continuing depth of understanding throughout the relationship. At level three of the Empathic Understanding in Interpersonal Processes Scale (Carkhuff, 1969), expressions of the client and counselor are essentially interchangeable. At less than level three, the counselor’s responses detract significantly from the expressions of the client, while above level three, the counselor’s responses are additive in nature.

Positive regard entails the counselor avoiding judgmental behavior, offering no advice or direction, genuinely accepting the client's present state of being, and trusting that the client will reach toward actualization. This facilitative condition is based on the counselor's communication of a positive respect and concern for the client's feelings, experiences, potentials, and worth as a person, and as a free individual. At level three of The Communication of Respect in Interpersonal Processes Scale (Carkhuff, 1969), the counselor conveys positive regard at a facilitative level. At less than level three, there is a lack of respect evidenced, while above level three, there exists a communication of deepening levels of respect.

Genuineness, or congruence, requires that the counselor relies on his or her own moment-to-moment felt ex-
experiencing in the relationship; the helper trusts inner organismic responses in the experience, and conveys those feelings he or she believes will be relevant. Furthermore, the counselor provides no discrepancies between what is verbalized and what other cues indicate he or she is feeling. Barrett-Lennard (1962) stated:

The degree to which one person is functionally integrated in the context of his relationship with another, such that there is an absence of conflict or inconsistency between his total experience, his awareness and his overt communication is his congruence in the relationship. (p.4)

At level three of the Facilitative Genuineness in Interpersonal Processes Scale (Carkhuff, 1969), the counselor reveals congruence which is minimally facilitative. At less than level three, there exist cues indicating non-genuine responses and discrepancies in counselor expressions. Above level three, the counselor's expressions indicate spontaneity and an openness to all experiences; he or she is freely and deeply one's self in the relationship.

Several studies have examined counselor characteristics with respect to the facilitative conditions. Bergin and Solomon (1970) reported that counselor personality disturbance interferes with the quality of the therapeutic relationship and the ability to empathically understand the client. Foulds (1969), who utilized an inventory to measure particular personality variables commonly associa-
ted with self-actualization, positive mental health, and psychological well-being, found that certain positive personality characteristics of the counselor appear to be significantly associated with the helper's level of interpersonal functioning and the ability to provide the overall facilitative conditions of empathy, respect, and genuineness. Feebles (1977) administered the Rorschach, MMPI, A-B Scale, and a personal therapy questionnaire to eighteen advanced students in clinical psychology. Subjects were also required to submit tapes of practicum interviews. Feebles found that student therapists who were most effective at displaying the facilitative conditions were neither defensive nor labile; these subjects tended to be open, with resilient defenses, having easy access to their inner feelings without accompanying anxiety. Although the specific performance characteristics of empathy, respect, and genuineness were not exemplified in all of the counseling interactions examined, Swenson (1970) found that high performance among counselors was related to several helper personality factors. High-performance counselors were neither extremely aloof nor extremely sociable; neither extremely conservative nor extremely experimenting; neither extremely lax nor extremely controlled; and tended to be somewhat casual in their manner.

O'Mahoney (1973) investigated the relationship between a client's perception of counselor empathy, respect, and
congruence by examining the counselor's verbal behavior and the client's self-report of conduct and experience in the therapeutic encounter. Although the resulting relationship between categories of counselors' verbal behaviors and perceptions by clients of the facilitative conditions proved not to be a strong one, there was some indication to suggest that silent counselors were viewed as non-empathic, counselors who asked many simple questions were described as both non-empathic and incongruent, and counselors who used clarification and direct guidance tended to be viewed as generally facilitative. Clients also expressed feelings that their counselor's level of regard for them was the aspect of the helper's attitude most related to their positive experience in the relationship.

Carkhuff and Berson (1977) provide a closing statement for this section:

In general, we might hypothesize that the levels at which an individual functions with others reflect the levels of his or her attitudes and comprehension of himself; that is, the individual is as empathic, respectful, and genuine concerning a wide range of feelings in himself. The individual's understanding and attitudes toward himself underscore the need for levels of minimally facilitative conditions. (p.7)

An Integrative Statement

The preceding review has been an attempt to present some of the many intricacies and dynamics that surround
the research problem. Attributes and stages of the terminally ill patient often interact with medical staff members' characteristics. As a result, the counselor may be faced with already complex circumstances at the point in which he or she enters into the dying patient's care. Additionally, the counselor who experiences many of the same conflicts and feelings expressed by physicians and nurses, could be confronted with a situation of greater complexity.

With emphasis on the counselor, then, it may be stated that the helper's anxieties with respect to death and dying clearly have the potential for influencing the nature of counselor/client encounters. Focusing on one aspect of these encounters -- facilitative conditions in counseling -- the present research seeks to examine the possible relationship between these variables.
Population

For purposes of this study, the target population consisted of counselors. Experienced counselors, rather than counselor-trainees, were recruited in order to enhance the generalizability of the research. Experienced counselors were defined as those individuals having earned at least a Master's degree in Counseling or Clinical Psychology, having a minimum of one year counseling experience post Master's education, and actively engaged in client counseling, as opposed to full-time administrative duties.

Sample

The researcher approached the following local sources seeking experienced counselors to voluntarily participate as subjects in the research: ten community mental health centers in the Columbus area; two community mental health centers in nearby counties; three university counseling centers; one university mental health clinic; a Veteran's Administration clinic; Counseling and Clinical Psychology graduate departments at a university; and counselors in private practice. A cover letter, a brief form of the research proposal, and information for potential subjects (Appendix A) were sent to the directors of the community mental health centers, university counseling centers, and the university mental health clinic. Counselors from other
source areas were contacted by phone and read the information for potential subjects (Appendix A) as an introduction to their participation.

The sample consisted of 23 female and 17 male counselors. A minimum sample size of 40 counselors was required for the statistical analysis. The numbers of counselors participating from the various sources were:

- community mental health centers - 12
- university counseling centers - 12
- university mental health clinic - 1
- Veteran's Administration clinic - 2
- university Counseling and Clinical Psychology graduate departments - 8
- private practice - 5

The ages of female counselors ranged from 23 to 56, the mean being 31.2. Years of counseling experience for female counselors ranged from 1 to 26, the mean being 5.1; 13 had Master's degrees, while 10 had PhD degrees. The ages of male counselors ranged from 26 to 46, the mean being 35.4. Years of counseling experience for male counselors ranged from 2.5 to 23, the mean being 8.5; 7 had Master's degrees, while 10 had PhD degrees. It is believed that this sample is representative of experienced counselors as described in the population.

**Instruments**

**Death Anxiety Scale (DAS)**

Templer's (1970) Death Anxiety Scale was used to assess each counselor's death anxiety. This scale consists of fifteen items to which the subject is asked to respond.
either "true" or "false", and it reflects a range of personal experiences -- for example: death concern, fear of the dying process, and fear of corpses (Appendix B). In the construction and validation of the DAS, thirty-one items were selected by a judgmental rating process from an initial pool of forty items. After point-biserial correlations were computed for three independent groups of college students (total n = 141), the fifteen items having significant item-test score correlations were retained for inclusion in the scale. Phi coefficients were then computed as a means of determining relative independence of items; as none of the correlation coefficients between the retained items exceeded .65, Templer concluded there was no excessive item-item redundancy. With respect to reliability, over a three-week interval the test-retest reliability coefficient was found to be .83, and a coefficient of .76 demonstrated internal consistency among thirty-one of the subjects originally studied. Templer used two procedures to assess the validity of the DAS: 1) female and male psychiatric patients, whose ages ranged from 21 to 74, and who were presumed to have high death anxiety (they spontaneously verbalized fear of or occupation with death) were administered the DAS and scored significantly higher than control patients matched on diagnosis, sex, and appropriate age (p < .01); 2) DAS scores were correlated with Boyar's (1964) Fear of Death Scale,
yielding a statistically significant correlation of .31 (p < .05). While the first procedure provided evidence for construct validity, the second offered support for criterion validity.

In analyzing the data from seven different studies involving over thirty-six-hundred adults and adolescents, Templier and Ruff (1971) found that the means of "psychologically healthy" individuals tended to fall between 4.5 and 7.0 (scale scores range from 0 to 15) and standard deviations were slightly over 3.0. Psychiatric patients obtained higher scores than non-psychiatric patients, and females had consistently higher scores on the DAS than males. No relationships between DAS scores and age were found. Although the original scale was embedded in the last two-hundred items of the MMPI, Templier and Ruff (1971) found that the embedding of DAS items had little or no effect upon scores. Kurlychek (1978-1979), who, in reviewing the available methods in the assessment of attitudes toward death and dying, stated that "the DAS has, perhaps, the most normative data available of all death attitude measures" (p. 41).

Interpersonal Processes Scales for Empathy, Respect and Genuineness

Three of Carkhuff's (1969) seven Interpersonal Processes Scales relevant to this study were briefly discussed in the literature review and are presented in their
entirety in Appendix C. Each of the scales used consists of five levels: level 1 represents ineffective counselor responses, level 3 represents the minimal level of facilitative interpersonal functioning, and level 5 represents highly effective facilitative counselor responses; levels 2 and 4 represent midpoint levels.

Difficulties in quantifying counselor responses seem to have led many researchers to rely upon the use of rating scales such as those devised by Carkhuff. The employment of these measures, however, is not without problems. For example, Gormally and Hill (1974) criticized the Carkhuff scale points for lacking "operational specificity which makes it difficult to maintain objectivity and standardization of scale use in rating" (p.542); "Although proof for a global quality of therapists is not definitive, evidence for the independence of the scales is clearly lacking" (p.543); and "rater's sex, level of functioning, and counseling experience affect rating accuracy" (p.543). In addition, data on the reliability and validity of the 1969 Carkhuff scales is not available. Because of this, Gormally and Hill (1974) caution that even when raters are trained in the use of the Interpersonal Processes Scales, conclusions should be regarded tentatively. Despite these problems, the researcher considered the employment of the Interpersonal Processes Scales appropriate based on an examination of numerous studies, such as
those cited in the literature review, that also utilized Carkhuff's scales to assess levels of the facilitative conditions in counseling relationships.

The Carkhuff Interpersonal Processes Scales for empathy, respect, and genuineness are revisions and modifications of the earlier Truax scales of Accurate Empathy (1961), Unconditional Positive Regard (1962), and Genuineness (1962). Truax and Carkhuff (1967) presented evidence for the reliability of the latter scales; a summarization of the correlation coefficients for twenty-eight studies involving a variety of therapist and patient populations was provided. The authors stated:

The answer in general, then, seems to be that most often a moderate to high degree of reliability is obtained with the scales whether measurement is of counseling or therapy, group or individual. (p.44)

Although precise validity evidence for the scales is not available, Truax and Carkhuff reported that "these scales are significantly related to a variety of client therapeutic outcomes." (p.44)

Procedures

Confederate Client Procedures

The researcher first wrote a script, containing five client excerpts adapted from Kübler-Ross' (1969) interviews with terminally ill patients. Excerpts were based on the five "dying stages" outlined by Kübler-Ross and each
consisted of a few sentences (Appendix D). Because the research employed a confederate terminally ill client, the wording of these excerpts was important in attempting to accurately represent the thoughts, feelings, and concerns of an individual faced with a terminal illness.

Three adult females served as confederate clients. After a brief rehearsal of the excerpts by these individuals, they were recorded on audio-tape. Two Counseling Psychology professors, two Registered Nurses, and two Student Personnel graduate students then served as judges. They listened independently to the recordings and gave their opinions as to which tape was most believable and effective in its representation of a terminally ill client's concerns. Five out of six judges agreed on one recording that met these criteria; this recording was subsequently used in the research.

Subject Procedures

Subjects who agreed to participate in the study were first assured anonymity in that numbers only would be used to identify the data they provided. Counselors were asked to complete a brief personal data sheet, which consisted of the following items: age, sex, education, years of counseling experience, and extent of counseling contact with terminally ill clients (Appendix E). The Death Anxiety Scale was then administered. Following completion of this scale, counselors were explained the use of the tape re-
corders before the researcher left the room. Subjects then listened to the following instructions at the beginning of the confederate client tape:

You are about to hear five sets of client statements, identified as "Excerpt A, B, C, D, and E". These statements have all been made by a 43 year-old female client, who shall be known as "Jane", and who is dying of a terminal illness. Assume this client has come to you for counseling. After the first excerpt, stop the recorder. Take a moment to reflect on the client's statements if you wish. Once you have formulated a response, record your statements using the second tape recorder. Please be sure to then verbally label your response as "Response A". You may then stop the recorder, and start the first one again to hear Excerpt B. Follow the same procedures for client excerpts B, C, D, and E. (pause) Begin Excerpt A.

Subjects then recorded their responses to each client excerpt. At the conclusion of this task, counselors were thanked and debriefed. Debriefing consisted of informing participants that the client was a confederate, and that the questionnaire was the Death Anxiety Scale, used to assess death anxiety. In addition, the researcher briefly discussed the findings of Manganello (1977), the nature of the present study, and the relevance of the research. Counselors were also asked not to discuss the debriefing information with other subjects until completion of the research.

To control for order effects, the first, third, fifth,
(etc.) counselor fulfilled the tasks in the order described. Even-numbered counselors listened and responded to the tape recording before completing the data sheet and the DAS.

**Rater Procedures**

One third-year and five first-year Counseling Psychology graduate students volunteered to serve as raters in the research. Two-hour experiential training sessions on the use of the Interpersonal Processes Scales based on the Carkhuff (1969) training model were conducted in the following manner. In phase one of the discrimination training process (Carkhuff, 1969), raters met with the researcher in pairs. Raters were first introduced to the Gross Ratings of Facilitative Interpersonal Functioning exercise (Appendix F) and asked to independently provide ratings for helper responses to six examples of client excerpts. Individual ratings were then discussed within the group. Carkhuff (1969) suggested a rationale for this procedure:

> It is most helpful in the introduction to rating to move from the global or general to the specific. Before making assessments of individual dimensions by individual rating scales, it is effective to employ some means of making gross assessments. (p.170)

Each trainee is requested to record and share his estimate, along with the reasons for it, with the entire group. This procedure not only provides immediate and concrete informational feedback to each and every
trainee but also establishes the basis for discussion of the dimensions involved and, perhaps most important, initiates communication among trainees. (p. 171)

Phase two of the discrimination training encompassed the following goals outlined by Carkhuff (1969):

1. to articulate the dimensions involved;
2. to clarify the functions and effects of these dimensions;
3. to put into operation the assessments of these dimensions;
4. to shape trainee discriminations to the levels of these dimensions.

A pair of raters was randomly assigned to independently rate helper responses on the facilitative dimensions of empathy, respect, or genuineness for ten client excerpts similar to those employed in the first phase of the training. A discussion of each dimension and of the appropriate Interpersonal Processes Scale used to assess the dimension preceded the rating process by each pair. Raters also discussed their independent ratings with each other after each client excerpt. The researcher facilitated this process. Two raters were thus trained to rate each of the facilitative conditions.

Following the training sessions, raters first listened to the confederate client tape recording, including the taped instructions to counselors. Raters then listened independently to the forsy counselor audio-taped recordings, and made overall ratings for each counselor on one of the
facilitative conditions. With this procedure, each counselor received two independent ratings for empathy, two for respect, and two for genuineness. Inter-rater reliability coefficients were computed and are presented in Chapter 5. The mean of the two ratings was then obtained so that each counselor received a single score for each of the three facilitative conditions.

Hypotheses

Because this thesis is in a relatively new area of study, little empirical evidence exists on which to base research hypotheses. With the exception of Manganello’s (1977) findings discussed in the literature review regarding the positive relationship between death anxiety and empathy, the research hypotheses are a product of the researcher’s professional experience and her knowledge and understanding of the research topic. Because respect encompasses such concepts as “the counselor’s avoiding judgmental behavior,” “offering no advice or direction,” and most importantly, “genuinely accepting the client’s present state of being,” it seems reasonable to expect a high death-anxious counselor to respond with low levels of respect, and a low death-anxious counselor to respond with high levels of respect when counseling a terminally ill client. A similar relationship is anticipated with respect to genuineness; it seems likely that a high death-anxious counselor may provide “discrepancies between what is ver-
nalized and what other cues indicate he or she is feel-
ing," whereas a low death-anxious counselor may give
evidence of greater congruency in the encounter.

Based on the preceding discussion and the literature
reviewed, then, the following hypotheses are set forth:

Death anxiety will be

1. positively correlated with empathy
2. negatively correlated with respect
3. negatively correlated with genuineness

Statistical Analyses

Inter-rater Reliability

Rater reliability indicates the extent to which raters
agree in their judgment of the phenomenon being measured.
Since the data from the Interpersonal Processes Scales
are interval in nature, the Cronbach Alpha procedure (Cron-
bach, 1970) for determining inter-rater reliability was
considered most appropriate.

The Pearson r

The relationships between death anxiety and levels of
the facilitative conditions were determined by Pearson
product moment correlation coefficients. This statistic
was considered appropriate since the research entailed in-
terval scaled or continuous variables; both the magnitude
and direction of the relationships of these variables was
revealed. However because the Pearson r reflects only the
linear relationship between two variables, it was also
appropriate to plot the resulting data to determine
whether the variables were related in a nonlinear
fashion.

Multiple Regression

Additional information was gained from the employment
of multiple regression. This technique allowed the re-
searcher to examine 1) the overall relationship between
death anxiety and the facilitative conditions, 2) the re-
lationship between death anxiety and one of the facilita-
tive conditions while the other two were held constant,
and 3) the relationship between death anxiety and inter-
actions of the facilitative conditions.
RESULTS

This section presents the results of the statistical analyses. Inter-rater reliability coefficients for ratings on the Interpersonal Processes Scales will first be presented. This will be followed by a presentation of the descriptive statistics for both the Death Anxiety Scale and the Interpersonal Processes Scales. Finally, the Pearson product moment correlation coefficients and multiple regression results will be presented.

Inter-rater Reliability

Inter-rater reliability coefficients were obtained for ratings on each of the three Interpersonal Processes Scales. Because the data were interval in nature, Cronbach's Alpha procedure (Cronbach, 1970), which utilizes a random-effects analysis of variance model, was employed.

Tables 1, 2, and 3 summarize the results of Cronbach's Alpha procedure for the Interpersonal Processes Scales of Empathy, Respect, and Genuineness, respectively. An examination of these tables reveals the following inter-rater reliability coefficients:

- Emphatic Understanding in Interpersonal Processes Scale - .98
- The Communication of Respect in Interpersonal Processes Scale - .95
- Facilitative Genuineness in Interpersonal Processes Scale - .52

These coefficients were accepted as being adequate.
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<td>Items</td>
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<tr>
<td>Residual</td>
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<td>9.2000</td>
<td>.2359</td>
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<td>47.9500</td>
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</table>

$\alpha = 1 - \frac{.2359}{12.8000}$  

$\alpha = .9816$
Table 2
Summary Table for Cronbach's Alpha Procedure for
The Communication of Respect in
Interpersonal Processes Scale Ratings

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<th>MS</th>
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<td>Items</td>
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<tr>
<td>Residual</td>
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<td>.3561</td>
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<tr>
<td>Total</td>
<td>79</td>
<td>65.1875</td>
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\[
\alpha = 1 - \frac{MS}{SS}
\]

\[
\alpha = .9461
\]
### Table 3

Summary Table for Cronbach's Alpha Procedure for Facilitative Genuineness in Interpersonal Processes Scale Ratings

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<td>1.2500</td>
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<td>Items</td>
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<td><strong>Total</strong></td>
<td>79</td>
<td>51.5500</td>
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</table>

\[ \alpha = 1 - \frac{MS_{Residual}}{MS_{Total}} \]

\[ \alpha = .8205 \]
Descriptive Statistics

**Death Anxiety Scale**

Scores on the Death Anxiety Scale (DAS) ranged from 1 to 10, out of a possible 0 to 15. The mean was 6.55, with a standard deviation of 2.19. Two modes resulted: 6 and 8.

Table 4 presents a summary of counselor DAS scores subdivided by two variables, sex and education level. An examination of this table suggests that female counselors experienced higher death anxiety than male counselors as measured by the DAS. A t-test of the differences in death anxiety scores between female and male counselors was significant (t=2.37; p < .05, 2-tailed probability). No significant differences in death anxiety scores between Master's level and PhD level counselors were revealed.

**Interpersonal Processes Scales**

Ratings of counselor responses on the Interpersonal Processes Scales ranged from 1.0 to 3.5 on the scale for empathy; from 1.0 to 4.5 on the scale for respect; and from 1.5 to 4.5 on the scale for genuineness, all out of a possible 1.0 to 5.0. Ratings on the Empathic Understanding in Interpersonal Processes Scale resulted in a mean of 2.73, a standard deviation of 0.58, and a mode of 2.5. Ratings on The Communication of Respect in Interpersonal Processes Scale resulted in a mean of 2.69, a standard
deviation of 0.76, and a mode of 2.5. Ratings on the Facilitative Genuineness in Interpersonal Processes Scale resulted in a mean of 2.93, a standard deviation of 0.73, and a mode of 3.0.

Table 5a presents a summary of ratings of counselor responses on the Empathic Understanding in Interpersonal Processes Scale, subdivided by sex and education level. No significant differences in ratings of counselor responses on empathy between female and male counselors, or between Master's and PhD level counselors were found.

Table 5b presents a summary of ratings of counselor responses on The Communication of Respect in Interpersonal Processes Scale, subdivided by sex and education level. No significant differences in ratings of counselor responses on respect between female and male counselors, or between Master's and PhD level counselors were found.

Table 5c presents a summary of ratings of counselor responses on the Facilitative Genuineness in Interpersonal Processes Scale, subdivided by sex and education level. An examination of this table suggests that female counselors' responses were rated higher in genuineness than male counselors' responses. A t-test of the differences in genuineness ratings of counselor responses between female and male counselors
was significant (t=2.68; p=0.01, 2-tailed probability). No significant differences in genuineness ratings of counselor responses between Master's and PhD level counselors were revealed.
### Table 4

**Summary Table of Death Anxiety Scale Scores by Sex and Education Level**

<table>
<thead>
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<th>Mean</th>
<th>SD</th>
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<th>P</th>
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<td>Males (n=17)</td>
<td>5.65</td>
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<tr>
<td>Master's Level (n=20)</td>
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<td>.67</td>
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<td></td>
<td>Mean</td>
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<td>p</td>
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<tr>
<td>----------------</td>
<td>------</td>
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<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Females (n=23)</td>
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<td>0.65</td>
<td>-1.1</td>
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<td>0.82</td>
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<tr>
<td>PhD Level (n=20)</td>
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<td>0.63</td>
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Table 5b
Summary Table of Ratings of Counselor Responses on The Communication of Respect in Interpersonal Processes Scale by Sex and Education Level

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<tr>
<td>Males</td>
<td>2.53</td>
<td>0.54</td>
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<td>(n=17)</td>
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<tr>
<td>Master's</td>
<td>2.75</td>
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<td>Level</td>
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<td>PhD Level (n=20)</td>
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</table>
Pearson Product Moment Correlation Coefficients

Table 6 presents the Pearson correlation coefficient matrix that was computed between the variables. An examination of this table reveals that death anxiety was not significantly correlated with any of the facilitative conditions.

The facilitative conditions were all significantly correlated with each other in the following manner:

- the relationship between empathy and respect revealed the highest correlation ($r = .80; p < .0001$);  
- the relationship between respect and genuineness revealed the second highest correlation ($r = .53; p < .001$);  
- the relationship between empathy and genuineness revealed the third highest correlation ($r = .45; p < .01$).

Pearson correlation coefficient matrices were also computed for the following four subgroups: female counselors, male counselors, Master’s level counselors, and PhD level counselors. Table 7 presents the matrix for female counselors. For this subgroup, death anxiety was found to be significantly correlated with empathy ($r = .42; p < .03$). No significant correlations between death anxiety and levels of the facilitative conditions were found within the remaining subgroups.

Scatter plots were utilized to determine if the variables of death anxiety and levels of the facilitative conditions were related in a non-linear fashion. No curvilinear relationships were found.
Table 6

Pearson Correlation Coefficient Matrix

<table>
<thead>
<tr>
<th></th>
<th>DA</th>
<th>EMP</th>
<th>RESP</th>
<th>GEN</th>
</tr>
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<td>0.18329</td>
<td>0.19870</td>
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<td>p=0.001</td>
<td>p=0.005</td>
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</tr>
<tr>
<td>RESP</td>
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<td>0.00000</td>
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</tr>
<tr>
<td></td>
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<td>p=0.001</td>
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<tr>
<td></td>
<td>DA</td>
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<td>RESP</td>
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<td>------</td>
</tr>
<tr>
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<td>0.4245</td>
<td>0.3191</td>
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</tr>
<tr>
<td></td>
<td>*p&lt;.0001</td>
<td>*p&lt;.045</td>
<td>*p&lt;.137</td>
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<td>*p&lt;.0001</td>
<td>*p&lt;.0001</td>
<td>*p&lt;.0001</td>
</tr>
</tbody>
</table>
Multiple Regression

A multiple regression was computed using the general linear models procedure (Goodnight, 1976). This procedure employed one dependent variable (death anxiety) and four independent variables (sex, and levels of empathy, respect, and genuineness). Level of education was not employed as an independent variable in the multiple regression, as an examination of this variable in previous analyses revealed no significant differences.

Table 8 presents a summary of the multiple regression. The computed F, F (4,35) = 2.03, was not significant; thus, a linear relationship between death anxiety and the four independent variables was not found. Further statistical procedures for this multiple regression were, therefore, not warranted.

A second multiple regression was computed using the general linear models procedure that employed one dependent variable (death anxiety) and seven independent variables (sex; levels of empathy, respect, and genuineness; and the interactions of levels of empathy and respect, of respect and genuineness, and of empathy and genuineness). Table 9 presents a summary of the second multiple regression. Again, the computed F, F (7,32) = 1.20, was not significant; a linear relationship between death anxiety and interactions of the independent variables of empathy, re-
spect, and genuineness was not found. Further statistical procedures for the second multiple regression, then, were also not warranted.
<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>r-square</th>
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<tr>
<td>Model</td>
<td>4</td>
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<td>8.8526</td>
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<td>.19</td>
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<td>Error</td>
<td>35</td>
<td>152.4894</td>
<td>4.3568</td>
<td></td>
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<td>Corrected</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Total</td>
<td>39</td>
<td>187.9000</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Table 9

Multiple Regression:
General Linear Models Procedure

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<th>Source</th>
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<th>F</th>
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<tr>
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<tr>
<td>Total</td>
<td>39</td>
<td>187.9000</td>
<td></td>
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</tr>
</tbody>
</table>
DISCUSSION

This thesis sought to examine the relationship between counselors' death anxiety and the level of facilitative conditions they offer in an analogue counseling situation with a terminally ill client. The overall results revealed the absence of a relationship between these variables for the subjects in the sample; thus the hypotheses were unsupported.

The statistically significant results that were found deserve discussion. First, in examining the DAS scores for female and male counselors, a significant difference was found between the two groups ($p < .05$). This finding offers support for previous research which asserted that females consistently have higher DAS scores than males (Templer & Ruff, 1971). Second, in examining the ratings of counselor responses on the Facilitative Genuineness in Interpersonal Processes Scale for female and male counselors, a significant difference was found between the two groups ($p = .01$). Finally, the present study revealed that among female counselors, death anxiety was positively correlated with empathy ($r = .42$; $p < .05$). This finding offers at least tentative support for Manganello's (1977) finding that a high fear of death was related to a high empathy level.

The significant results of this thesis must be regarded with caution because of a small sample size and...
because of the lack of controls involved in correlational research in general. It is interesting, however, to speculate on the meaning of the results. Why females have higher BAS scores than males is a question that perhaps deserves investigation in and of itself. Perhaps influenced by societal expectations, women have been given greater freedoms to express their fears and anxieties than men, or perhaps men have experienced greater denial with respect to death anxiety.

The second significant finding seems to suggest an area for further research. Although a correlation between death anxiety and genuineness was not found, female counselors' responses on the facilitative condition of genuineness were rated higher than male counselors' responses. Female counselors may reveal a greater degree of congruency than male counselors when counseling a terminally ill client, which may be facilitative.

The third significant finding, that among female counselors, death anxiety was positively correlated with empathy, may also have modest implications for terminal illness counseling. Perhaps high death anxiety among female counselors may be facilitative in a helping relationship with a terminally ill client if it is associated with high levels of empathic understanding. And yet, if positive regard and genuineness on the part of the counselor are equally important facilitative conditions in the help-
ing process, and if relationships between these conditions and death anxiety cannot be found, then only tentative conclusions, if any, may be drawn.

There are several possible explanations for the overall results of this thesis. First, and probably most important, the use of the Death Anxiety Scale as a measure of death anxiety presented problems that may have affected the results. Although DAS scores can range from 0 to 15, the scores of subjects in this study ranged from 1 to 10; consequently, the upper 31% of the scale was not utilized. In addition, the "true/false" nature of the DAS did not allow subjects to express degrees of agreement or disagreement with the items. For example, it seems reasonable to believe that an item such as #5, "I am not at all afraid to die," may be more accurately assessed by a Likert-type format. Indeed, many of the counselors expressed their dissatisfaction with the DAS in these terms during the debriefing process. These factors may have contributed to decreasing the variability among the subjects sampled, and the possibility of an inaccurate representation of death anxiety cannot be overlooked.

A second possible explanation for the results entails the concept of denial. Numerous authors have expressed the view that denial may be a powerful defense operating within professional helpers when confronted with a terminally ill client's concerns (Abrams, 1971; Bugen, 1979; Le Shan
& Le Shan, 1961; Manganello, 1977; Pattison, 1967, 1977; Shady, 1976). Counselors as individuals, removed from the helping setting, may also experience death-denying attitudes (Pattison, 1977) as a result of social, cultural, religious, and familial influences. Although denial may be adaptive and appropriate for both the counselor and the terminally ill client at various stages in the helping process (Pattison, 1977; Watzman, 1978) the assessment of the effect of this defense mechanism on measures of death anxiety may prove to be a difficult task. The employment of the DAS in this study did not allow for the assessment of subjects' denial with regard to their feelings and attitudes about death.

A possible explanation for the lack of relationships between respect and death anxiety and genuineness and death anxiety may lie in the rating scales and the rating process. Although a considerable amount of variability was evidenced among the ratings of counselor responses across the three Interpersonal Processes Scales, and inter-rater reliability coefficients were high, the question of rating accuracy must be addressed. The Interpersonal Processes Scales have been criticized on several dimensions, perhaps the most crucial being their subjective nature. Gormally and Hill (1974) asserted that raters can be most objective when determining level 3.0 responses, but degrees above and below this level are poorly defined and raters are
more apt to rely upon their own subjectivity when rating responses at levels other than 3.0. There is also evidence to suggest that respect and genuineness may incorporate numerous non-verbal behaviors on the part of the counselor (Carkhuff, 1969). Because this thesis employed audio-taped excerpts and responses, the accuracy of counselor respect and genuineness ratings may be limited.

A final explanation for the overall results of this thesis is that a relationship between counselor death anxiety and levels of the facilitative conditions in the counseling of a terminally ill client simply did not exist for this sample.

Suggestions for Further Research

Because terminal illness counseling is a very recent addition to the field of helping professions, and because little systematic research in this area can be found, the results of this thesis have offered a contribution. For although a relationship between death anxiety and levels of the facilitative conditions was not found overall, the investigation has suggested three areas for further study that may contribute to the understanding of counseling effectiveness with terminally ill clients.

First, this thesis should be regarded as primarily exploratory in nature; before more definitive statements can be made regarding the relationship between death
anxiety and levels of the facilitative conditions among counselors, further research that takes into account assessment factors is suggested. It is the researcher's opinion that attempts to develop a more accurate measure of death anxiety should be pursued. Because denial with respect to death anxiety may be a significant factor to consider, a death anxiety measure that provides for the assessment of denial seems warranted.

Second, the development or employment of a more objective measure may be needed to accurately assess levels of the facilitative conditions in counseling. In the assessment of respect and genuineness, it seems especially important to consider counselor non-verbal behaviors; the employment of video-tape counseling interactions is thus suggested.

The third area for potential research inquiry involves subject selection. The present study sampled experienced counselors who had varying amounts of contact with terminally ill clients; twenty-seven counselors had no previous terminal illness counseling experience. This variability in the sample may have affected the research results. Perhaps further studies should consider employing samples of experienced terminal illness counselors so that issues unique to this specialized field of counseling may be researched as an area of and by itself.
In the researcher's opinion, the field of Counseling Psychology has the potential to contribute to the growing body of knowledge that emphasizes effective and humanistic approaches in the psychological care of terminally ill clients. Terminal illness counseling may provide a fruitful area for future counseling research.


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Appendix A:
I. Sample Cover Letter

December 17, 1979

Dear

I am presently a second year graduate student in Counseling Psychology at The Ohio State University, seeking the assistance of experienced counselors to volunteer as subjects in my Master's thesis research. This research involves an examination of counselor responses in the counseling of a terminally ill client. While various members of the medical team have long experienced and responded to the needs and concerns of the dying patient, counseling and clinical psychologists are just beginning to enter into the field of terminal illness counseling with any great depth. This area is of particular interest to me and I am enthusiastic to have members of the (name of the organization inserted here) join me as participants in what might be termed "pioneer research."

I have included a brief form of my proposal to increase your knowledge and understanding surrounding the particulars of the study. Please do not share this proposal with potential subjects. I have also included a short information sheet addressing subject requirements and activities which may be shared with interested counselors. Counselors who agree to participate as subjects
will be informed of all aspects of the research during the debriefing process, as outlined in the proposal.

The research will be conducted during the Winter Quarter; I would like to begin arranging meeting times with counselors during the week of January 7th. I will be contacting you by phone on January 7th to answer any questions you might have and to discuss your response to my request.

Thank you so much for your time and cooperation.

Sincerely yours,

Christine Henderson
Appendix A:
II. Brief Research Proposal

Research Proposal: The Relationship Between Death Anxiety and Levels of Empathy, Respect, and Genuineness Among Counselors

As the field of thanatology grows, and as the creation of hospices for the care of the terminally ill becomes increasingly popular, it seems evident that there will be a demand for professionals who specialize or are knowledgeable in the counseling of dying patients, or clients. An examination of counselor characteristics and counseling dynamics within this area, then, seems warranted.

The researcher will approach local community mental health centers, university counseling centers, and psychologists in private practice seeking experienced counselors to serve as volunteer subjects in the proposed study. Experienced counselors will be defined as those individuals having earned at least a Master's degree in Counseling or Clinical Psychology; having a minimum of one year experience following graduate training; and actively engaged in the counseling of clients, as opposed to full-time administrative duties. Potential subjects will be told that the research involves an examination of counselor responses in the counseling of a terminally ill client. Counselors will also be told that they need not have had any prior experience in terminal illness counsel-
ing. Potential subjects will be informed that they will be asked to complete a short questionnaire with respect to their feelings about death, and that in addition, they will be asked to respond via tape recorder to five taped client excerpts, each approximately 35 seconds in length, expressing the concerns of a terminally ill female client. Counselors will also be informed that they will be asked to complete a brief personal data sheet of general interest to the research, consisting of the following items: age, sex, education, years of counseling experience, and degree of counseling contact with terminally ill clients. Finally, counselors will be assured anonymity in that numbers only will be used to identify both data sheets and counselor tapes; informed that each individual's participation will take approximately 25 to 40 minutes; and told that the nature of their taped responses to the client will be examined as part of the research.

Counselors who agree to serve as subjects will be administered the 15-item Death Anxiety Scale (Templer, 1970) to assess levels of counselor death anxiety. Subjects will also be asked to listen to audio-taped concerns of a confederate, female terminally ill client, and to respond also via audio-tape recording. During the latter process, the researcher will leave the room so as to provide the counselor privacy; clear instructions have been taped pre-
ceding the client excerpts. Counselors will be instructed on the use of the tape recorders. Following the tape recording portion of the procedure, counselors will be thanked and debriefed.

Debriefing will consist of informing subjects that:

1) the questionnaire was a scale designed to assess levels of death anxiety;

2) the client was a confederate;

3) trained raters will later rate their taped responses as to levels of empathy, respect, and genuineness using the Interpersonal Processes Scales devised by Carkhuff (1969);

4) the relationship between counselors' levels of death anxiety and levels of the facilitative conditions (empathy, respect, and genuineness) offered during taped "counseling" will be examined by the researcher.

Counselors will also be requested not to discuss the information revealed during the debriefing to other subjects until completion of the research.

The researcher will offer to inform subjects of the results of the study and discuss the possibility of presenting a program encompassing the research topic at a later date.
Appendix A:

III. Information for Potential Subjects

The research involves an examination of counselor responses in the counseling of a terminally ill client. I am approaching local community mental health centers, university counseling centers, and psychologists in private practice seeking experienced counselors to serve as volunteer subjects in the proposed study. Experienced counselors will be defined as those individuals having earned at least a Master's degree in Counseling or Clinical Psychology; having a minimum of one year experience following graduate training; and actively engaged in the counseling of clients, as opposed to full-time administrative duties. Counselors need not have had any prior experience in the counseling of a terminally ill client.

Counselors who meet the criteria outlined above and who agree to participate in the study will be asked to complete a short questionnaire with respect to their feelings about death. Subjects will then be asked to respond via audio-tape recording to five, brief, audio-taped client excerpts, each approximately 35 seconds in length, expressing the concerns of a terminally ill female client. During this procedure, the researcher will leave the room so as to provide the counselor privacy; clear instructions have been taped preceding the client
excerpts. Counselors will also be asked to complete a brief personal data sheet of general interest to the research consisting of the following items: age, sex, education, years of counseling experience, and degree of counseling contact with terminally ill clients. These procedures will be carried out on an individual basis; each counselor's participation will take approximately 25 to 40 minutes, at most. Subjects can be assured anonymity in that numbers only will be used to identify both data sheets and counselor tapes. The nature of the counselors' taped responses to the client will be examined as part of the research.
Appendix B:
The Death Anxiety Scale (Templer, 1970)

<table>
<thead>
<tr>
<th>Key</th>
<th>Items</th>
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</thead>
<tbody>
<tr>
<td>T</td>
<td>I am very much afraid to die.</td>
</tr>
<tr>
<td>F</td>
<td>The thought of death seldom enters my mind.</td>
</tr>
<tr>
<td>F</td>
<td>It doesn't make me nervous when people talk about death</td>
</tr>
<tr>
<td>T</td>
<td>I dread to think about having to have an operation.</td>
</tr>
<tr>
<td>F</td>
<td>I am not at all afraid to die.</td>
</tr>
<tr>
<td>F</td>
<td>I am not particularly afraid of getting cancer.</td>
</tr>
<tr>
<td>F</td>
<td>The thought of death never bothers me.</td>
</tr>
<tr>
<td>T</td>
<td>I am often distressed by the way time flies so very rapidly.</td>
</tr>
<tr>
<td>T</td>
<td>I fear dying a painful death.</td>
</tr>
<tr>
<td>T</td>
<td>The subject of life after death troubles me greatly.</td>
</tr>
<tr>
<td>T</td>
<td>I am really scared of having a heart attack.</td>
</tr>
<tr>
<td>T</td>
<td>I often think about how short life really is.</td>
</tr>
<tr>
<td>T</td>
<td>I shudder when I hear people talking about a World War III.</td>
</tr>
<tr>
<td>T</td>
<td>The sight of a dead body is horrifying to me.</td>
</tr>
<tr>
<td>F</td>
<td>I feel that the future holds nothing for me to fear.</td>
</tr>
</tbody>
</table>
Appendix C:
Three Interpersonal Processes Scales (Carkhuff, 1969)

I. Empathic Understanding in Interpersonal Processes
Level 1

The verbal and behavioral expressions of the helper either do not attend to or detract significantly from the verbal and behavioral expressions of the helpee(s) in that they communicate significantly less of the helpee's feelings and experiences than the helpee has communicated himself.

Example: The helper communicates no awareness of even the most obvious expressed surface feelings of the helpee. The helper may be bored or disinterested or simply operating from a preconceived frame of reference which totally excludes that of the helpee(s).

In summary, the helper does everything but express that he is listening, understanding, or being sensitive to even the most obvious feelings of the helpee in such a way as to detract significantly from the communication of the helpee.

Level 2

While the helper responds to the expressed feelings of the helpee(s), he does so in such a way that he subtracts noticeable affect from the communications of the helpee.
Example: The helper may communicate some awareness of obvious, surface feelings of the helpee but his communications drain off a level of the affect and distort the level of meaning. The helper may communicate his own ideas of what may be going on, but these are not congruent with the expressions of the helpee.

In summary, the helper tends to respond to other than what the helpee is expressing or indicating.

Level 3

The expressions of the helper in response to the expressions of the helpee(s) are essentially interchangeable with those of the helpee in that they express essentially the same affect and meaning.

Example: The helper responds with accurate understanding of the surface feelings of the helpee but may not respond to or may misinterpret the deeper feelings.

In summary, the helper is responding so as to neither subtract from nor add to the expressions of the helpee. He does not respond accurately to how that person really feels beneath the surface feelings; but he indicates a willingness and openness to do so. Level 3 constitutes the minimal level of facilitative interpersonal functioning.

Level 4

The responses of the helper add noticeably to the expressions of the helpee(s) in such a way as to express feelings a level deeper than the helpee was able to
express himself.

Example: The helper communicates his understanding of the expressions of the helpee at a level deeper than they were expressed and thus enables the helpee to experience and/or express feelings he was unable to express previously.

In summary, the helper's responses add deeper feeling and meaning to the expressions of the helpee.

Level 5

The helper's responses add significantly to the feeling and meaning of the expressions of the helpee(s) in such a way as to accurately express feelings levels below what the helpee himself was able to express or, in the event of ongoing, deep self-exploration on the helpee's part, to be fully with him in his deepest moments.

Example: The helper responds with accuracy to all of the helpee's deeper as well as surface meanings. He is "tuned in" on the helpee's wave length. The helper and the helpee might proceed together to explore previously unexplored areas of human existence.

In summary, the helper is responding with a full awareness of who the other person is and with a comprehensive and accurate empathic understanding of that individual's deepest feelings.
II. The Communication of Respect in Interpersonal Processes

Level 1

The verbal and behavioral expressions of the helper communicate a clear lack of respect (or negative regard) for the helpee(s).

Example: The helper communicates to the helpee that the helpee's feelings and experiences are not worthy of consideration or that the helpee is not capable of acting constructively. The helper may become the sole focus of evaluation.

In summary, in many ways the helper communicates a total lack of respect for the feelings, experiences, and potentials of the helpee.

Level 2

The helper responds to the helpee in such a way as to communicate little respect for the feelings, experiences, and potentials of the helpee(s).

Example: The helper may respond mechanically or passively or ignore many of the feelings of the helpee.

In summary, in many ways the helper displays a lack of respect or concern for the helpee's feelings, experiences, and potentials.

Level 3

The helper communicates the minimal acknowledgement of regard for the helpee's position and concern for the help-
ee's feelings, experiences, and potentials.

Example: The helper communicates an openness to the prospect of the helpee's ability to express himself and to deal constructively with his life situation.

In summary, in many ways the helper communicates the possibility that who the helpee is and what he does may matter to the helper, at least minimally. Level 3 constitutes the minimal level of facilitative interpersonal functioning.

Level 4

The helper clearly communicates a very deep respect and concern for the helpee.

Example: The helper's responses enable the helpee to feel free to be himself and to experience being valued as an individual.

In summary, the helper communicates a very deep caring for the feelings, experiences, and potentials of the helpee.

Level 5

The helper communicates the very deepest respect for the helpee's worth as a person and his potentials as a free individual.

Example: The helper cares very deeply for the human potential of the helpee and communicates a commitment to enabling the helpee to actualize this potential.

In summary, the helper does everything he can to enable the helpee to act most constructively and emerge most
fully.

III. Facilitative Genuineness in Interpersonal Processes

Level 1

The helper's verbalizations are clearly unrelated to what he appears otherwise to be feeling at the moment, or his only genuine responses are negative in regard to the helpee(s) and appear to have a totally destructive effect upon the helpee.

Example: The helper may appear defensive in his interaction with the helpee(s), and this defensiveness may be demonstrated in the content of his words or his voice quality. When he is defensive he does not employ his reaction as a basis for potentially valuable inquiry into the relationship.

In summary, there is evidence of a considerable discrepancy between the helper's inner experiencing and his current verbalizations, or where there is no discrepancy the helper's reactions are employed solely in a destructive fashion.

Level 2

The helper's verbalizations are slightly unrelated to what he appears otherwise to be feeling at the moment, or when his responses are genuine they are negative in regard to the helpee and he does not appear to know how to employ his negative reactions constructively as a basis for inquiry into the relationship.
Example: The helper may respond to the helpee(s) in a "professional" manner that has a rehearsed quality or quality concerning the way a helper should respond in that situation.

In summary, the helper is usually responding according to his prescribed role rather than expressing what he personally feels or means. When he is genuine his responses are negative and he is unable to employ them as a basis for further inquiry.

Level 3

The helper provides no "negative" cues of a discrepancy between what he says and what he appears otherwise to be experiencing, but he provides no positive cues to indicate a really genuine response to the helpee(s).

Example: The helper may listen and follow the helpee(s), committing nothing more of himself, but communicating an openness to further commitment.

In summary, the helper appears to make appropriate responses that do not seem insincere but that do not reflect any real involvement either. Level 3 constitutes the minimal level of facilitative interpersonal functioning.

Level 4

The helper presents some positive cues indicating a genuine response (whether positive or negative) in a
nondestructive manner to the helpee(s).

Example: The helper's expressions are congruent with his feelings, although he may be somewhat hesitant about expressing them fully.

In summary, the helper responds with many of his own feelings and there is no doubt as to whether he really means what he says. He is able to employ his responses whatever the emotional content, as a basis for further inquiry into the relationship.

Level 5

The helper appears freely and deeply himself in a nonexploitative relationship with the helpee(s).

Example: The helper is completely spontaneous in his interaction and open to experiences of all types, both pleasant and hurtful; and in the event of hurtful responses the helper's comments are employed constructively to open a further area of inquiry for both the helper and the helpee.

In summary, the helper is clearly being himself and employing his own genuine responses constructively.
Appendix D:
Confederate Client Excerpts

Excerpt A

What brought me here? Oh. Well, I hadn't been feeling well for about six months; I lost a lot of weight, (anxious laughter) which I thought was great!! But my husband and family doctor insisted that I have some tests done in the hospital. They say I have a tumor. I know there's a mistake. (joyfully) Why, I never felt better! (hesitantly) Except for this feeling of... Nevermind. Everything will be fine because... Say, would you like to see a picture of my daughters?

Excerpt B

(angrily) There I was yesterday, flat on my back, infusions going in both arms, tubes in my nose, and all that (sarcastically) darling little Florence Nightingale could say was (again, sarcastically) "Are you comfortable, Jane?"

And those interns!! They stand around your bed gawking and whispering their fancy terms. They don't fool me! I know what's happening. (pause) -- And another thing -- everybody always comes in at the wrong time. Don't they know I just want to be left alone!! And when I do need something, they make me wait twice as long as the other patients. I just can't win!!
Excerpt C

(croly) I'll let you in on a secret. I told the chaplain the other day that if he'd just pray for me and ask God to give me a few more years, I'll be the perfect wife and mother, and really make an effort to be a better person. (somewhat desperately) Just two years!! Is that too much to ask? Then I could see my youngest graduate from college. (optimistically) You'd see, I'd really change!!

Excerpt D

(voice rather flat) I'm so tired. And the pain -- it keeps getting more intense. (pause) I'm losing everything. My husband doesn't want to talk about it, but I know our savings is going fast with all the medical bills he's had to pay. (sympathetically) He looks so drained when he comes. And the girls -- they come so infrequently anymore. (pause) I guess I don't blame them. I look so frightful. If only I could make it up to all of them. (pause) There's just no energy left.

Excerpt E

(slowly) I'm feeling weak today, but I'll talk with you a little while. (pause) Something came over me last night. It's hard to describe. I've just decided to take each day as it comes, one step at a time from now on. I have a loving husband and wonderful daughters. It's been
a good life. (pause) But I know my time is coming soon. I think I'm ready to face whatever comes next. I feel kind of (pause) -- at peace.
Appendix E:
Counselor Personal Data Sheet

Please provide the information requested below:
1. Age:
2. Sex:
3. Graduate degree(s) attained and area of specialization:

4. Number of years of counseling experience, post Master's degree:

5. Have you had experience in the counseling of terminally ill clients?

6. If you answered "yes" to question 5, please describe the experience(s) briefly below.
Appendix F:
Gross Ratings of Facilitative Interpersonal Functioning
(Carkhuff, 1969)

The facilitator is a person who is living effectively and who discloses him/herself in a genuine and constructive fashion in response to others. He/she communicates an accurate empathic understanding and a respect for all of the feelings of other persons and guides discussions with these persons into specified feelings and experiences. He/she communicates confidence in what he/she is doing and is spontaneous and intense. In addition, while he/she is open and flexible in his/her relations with others, in his/her commitment to the welfare of the other person he/she is quite capable of active, assertive, and even confronting behavior when it is appropriate.

The following pages include six excerpts taken from therapy sessions. Four helper responses are offered for each excerpt. Please rate each response using the continuum below. Each response should have a rating of either 1.0, 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, or 5.0.

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1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0
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1.0 = None of these conditions are communicated to any noticeable degree in the person.

2.0 = Some of the conditions are communicated and some are not.
3.0 = All of the conditions are communicated at a minimally facilitative level.

4.0 = All of the conditions are communicated, and some are communicated fully.

5.0 = All of the conditions are fully communicated simultaneously and continually.

1. **Client:** I love my children and my husband and I like doing most household things. They get boring at times but on the whole I think it can be a very rewarding thing at times. I don't miss working, going to the office everyday. Most women complain of being just a housewife and just a mother. But, then, again, I wonder if there is more for me. Others say there has to be. I really don't know.

**Helper Responses:**

1. **Hmm. Who are these other people?**

2. **So you find yourself raising a lot of questions about yourself -- educationally, vocationally.**

3. **Why are you dominated by what others see for you? If you are comfortable and enjoy being a housewife, then continue in this job. The role of mother, housemaker can be a full-time, self-satisfying job.**

4. **While others raise these questions, these questions are real for you. You don't know if there is more out there for you. You don't know if you can find more fulfillment than you have.**

2. **Client:** They wave that degree up like it's a pot of gold at the end of the rainbow. I used to think that, too, until I tried it. I'm happy being a housewife; I don't care to get a degree. But the people I associate with,
the first thing they ask is, "Where did you get your degree?" I answer, "I don't have a degree." Christ, they look at you like you are some sort of freak, some backwoodsman your husband picked up along the way. They actually believe that people with degrees are better. In fact, I think they are worse. I've found a lot of people without degrees that are a hell of a lot smarter than these people. They think that just because they have degrees they are something special. These poor kids that think they have to go to college or they are ruined. It seems that we are trying to perpetuate a fraud on these kids. If no degree, they think they will end up digging ditches for the rest of their lives. They are looked down upon. That makes me sick.

Helper Responses:

1. You really resent having to meet the goals other people set for you.
2. What do you mean by, "it makes me sick"?
3. Do you honestly feel a degree makes a person worse or better? And not having a degree makes you better? Do you realize society perpetuates many frauds and sets many prerequisites such as a degree. You must realize how doors are closed unless you have a degree, while the ditches are certainly open.
4. A lot of these expectations make you furious. Yet, they do tap in on something in yourself you are not sure of -- something about yourself in relation to these other people.

Client: I get so frustrated and furious with my daughter. I just don't know what to do with her. She is
bright and sensitive, but damn, she has some characteristics that make me so on edge. I can't handle it sometimes. She just -- I feel myself getting more and more angry!! She won't do what you tell her to. She tests limits like mad. I scream and yell and lose control and think there is something wrong with me -- I'm not an understanding mother or something. Damn!! What potential!! What she could do with what she has. There are times she doesn't use what she's got. She gets by too cheaply. I just don't know what to do with her. Then she can be so nice and then, boy, she can be as onery as she can be. And then I scream and yell and I'm ready to slam her across the room. I don't like to feel this way. I don't know what to do with it.

Helper Responses:
1. So you find yourself screaming and yelling at your daughter more frequently during the past three months.
2. Why don't you try giving your daughter some very precise limitations. Tell her what you expect from her and what you don't expect from her. No excuses.
3. While she frustrates the hell out of you, what you are really asking is, "How can I help her? How can I help myself, particularly in relation to this kid?"
4. While she makes you very angry, you really care what happens to her.

Client: He is ridiculous! Everything has to be done when he wants to do it, the way he wants it done. It's as if nobody else exists. It's everything he wants to do. There is a range of things I have to do -- not just be a
housewife and take care of the kids. Oh no, I have to
do his typing for him, errands for him. If I don't do
it right away, I'm stupid -- I'm not a good wife or
something stupid like that. I have an identity of my
own, and I'm not going to have it wrapped up in him.
It makes me -- it infuriates me!! I want to punch him
right in the mouth. What am I going to do? Who does he
think he is anyway?

Helper Responses

1. It really angers you when you realize in how many
ways he has taken advantage of you.

2. Tell me, what is your concept of a good marriage?

3. Your husband makes you feel inferior in your own eyes.
You feel incompetent. In many ways you make him
sound like a very cruel and destructive man.

4. It makes you furious when you think of the one-sided-
ness of this relationship. He imposes upon you every-
where, particularly in your own struggle for your own
identity. And you don't know where this relationship
is going.

5. Client: I finally found somebody I can really get
along with. There is no pretentiousness about them at
all. They are real and they understand me. I can be my-
self with them. I don't have to worry about what I say
and that they might take me wrong, because I do sometimes
say things that don't come out the way I want them to.
I don't have to worry that they are going to criticize
me. They are just marvelous people! I just can't wait to
be with them! For once I actually enjoy going out and in-
teracting. I didn't think I could ever find people like
this again. I can really be myself. It's such a won-
derful feeling not to have people criticizing you for
everything you say that doesn't agree with them. They
are warm and understanding, and I just love them! It's
just marvelous!

Helper Responses
1. Sounds like you found someone who really matters
to you.
2. Why do these kind of people accept you?
3. That's a real good feeling to have someone to trust
and share with. "Finally, I can be myself."
4. Now that you have found these people who enjoy you
and whom you enjoy, spend your time with these people.
Forget about the other types who make you anxious.
Spend your time with the people who can understand and
be warm with you.

Client: I'm really excited the way things are going at
home with my husband. It's just amazing! We get along
great together now. Sexually, I didn't know we could be
that happy. I didn't know anyone could be that happy. It's
Just marvelous! I'm just so pleased, I don't know what
to say.

Helper Responses
1. It's a wonderful feeling when things are going well
maritally.
2. It's really exciting to be alive again, to feel your
body again, to be in love again.
3. Is your husband aware of these changes?
4. Now don't go overboard on this right now. There will
be problems that lie ahead and during these periods
that you have these problems I want you to remember
well the bliss you experienced in this moment in time.