

1-1-1997

The Impact of an Educational Program on Anxiety of Student Nurses Related to Perinatal Loss

Connie Telles
San Jose State University

Follow this and additional works at: https://scholarworks.sjsu.edu/etd_projects



Part of the [Maternal, Child Health and Neonatal Nursing Commons](#), and the [Psychiatric and Mental Health Nursing Commons](#)

Recommended Citation

Telles, Connie, "The Impact of an Educational Program on Anxiety of Student Nurses Related to Perinatal Loss" (1997). *Master's Projects*. 889.
DOI: <https://doi.org/10.31979/etd.dhcf-r5xq>
https://scholarworks.sjsu.edu/etd_projects/889

This Master's Project is brought to you for free and open access by the Master's Theses and Graduate Research at SJSU ScholarWorks. It has been accepted for inclusion in Master's Projects by an authorized administrator of SJSU ScholarWorks. For more information, please contact scholarworks@sjsu.edu.

Perinatal Loss 1

THE IMPACT OF AN EDUCATIONAL PROGRAM ON ANXIETY
OF STUDENT NURSES RELATED TO PERINATAL LOSS

by

Connie Telles RNC, MSN, SJSU, CA

And Susan Murphy D.N.S., Professor, School of Nursing, SJSU, CA

Perinatal Loss 2

Author: Connie Telles, RNC (inpatient obstetric nursing). Current employment: Charge Nurse, Family Birthing Center, St. Rose Hospital, Hayward, California. Part time Nursing Instructor at Chabot College, Hayward CA. Education: MSN, 1998, San Jose State University, California. Past experience: Registered Nurse for 17 years. Experience includes 5 years as a medical-surgical nurse and 12 years in maternal child care.

Susan Murphy, D.N.S., Professor, School of Nursing, SJSU

Perinatal Loss 3

Abstract

1
2
3 **Objective:** To measure the effectiveness of a perinatal loss workshop on death
4 anxiety of nursing students.

5 **Design:** Simple, pretest-posttest.

6 **Setting:** A classroom at a State University in California.

7 **Participants:** 20 junior students in a baccalaureate nursing program in a maternal-
8 child rotation.

9 **Intervention:** A 60-minute perinatal loss workshop including Worden's tasks of
10 mourning, therapeutic and non-therapeutic nursing interventions, photographs,
11 poetry, and coping skills.

12 **Main Outcome Measure:** Anxiety towards perinatal death was measured by
13 Spielberger's State Trait Anxiety Inventory (STAI Form Y-1). Data were also
14 gathered with a demographic questionnaire and a posttest.

15 **Results:** The mean score on the PRESTAI was 52.3 and the mean score on the
16 POSTSTAI was 44.8. Post workshop scores decreased by 7.5 points indicating a
17 decrease in anxiety. When asked, "If you had the chance to choose your
18 assignment in labor and delivery how likely would you choose the woman with the
19 intrapartum death?" the mean score changed from 2.6 before the workshop to 3.3
20 after the workshop ($p < .05$).

Perinatal Loss 4

21 Conclusions: Students that participated in an educational program on perinatal
22 loss reported a decrease in anxiety level towards death. Future studies should
23 include a control group to compare educational interventions to the current
24 curriculum in nursing programs.

25

Perinatal Loss 5

26

Callouts

- 27 1. Death of a child can be the most devastating event in a parent's life.
- 28 2. Nurses play a significant part in the grieving process that begins in the hospital.
- 29 3. Mean scores for the PRESTAI and the POSTSTAI show a significant decrease
- 30 in the anxiety level.

31

Perinatal Loss 6

32 “When your parent dies you have lost your past. When your child dies you
33 have lost your future” (Walsh & McGoldrick, 1991, p. 38). Death of a child can be
34 the most devastating event in a parent’s life. Even if that child has been in a
35 woman’s womb for only a few months, the death of a baby can be as traumatic as
36 the death of a grown child. Thomas (1997) reports that 20% of all pregnancies end
37 in miscarriage. Many families are torn apart after the death of a child. “Perinatal
38 grief has been associated with the loss of self, self-esteem, sexual problems, and
39 marital discord” (Wallerstedt & Higgins, 1996, p.390). Relationships between
40 spouses are changed forever. The loss of a child may bring them closer or tear
41 them apart. Mothers and fathers mourn for their child in different ways. Society
42 expects fathers to be stoic and hold the family together. Mothers are allowed to
43 grieve longer and express emotion.

44 Nurses are often the first ones present when a woman learns that her baby
45 is dead and what a nurse says and does will be remembered by this woman forever.
46 Leoni and Woods (1997) and Lowe and Neuman (1995) describe ways to help
47 families deal with loss. Nurses need to offer nonjudgmental caring and personal
48 involvement. Parents must be allowed to express grief in unique ways. Nurses can
49 facilitate relationships between spouses by informing parents of the stages of grief
50 and the importance of open communication

Perinatal Loss 7

51 The term “perinatal loss” includes miscarriage (loss before 20 weeks),
52 stillbirth (death in utero after 20 weeks), and neonatal death (death of a liveborn
53 neonate up to 28 days after birth). In the *Annual Summary of Vital Statistics*,
54 Guyer, Martin, MacDorman, Anderson, and Strobino (1997) reported that the
55 1996 infant mortality rate in the United States was 7.2 deaths per 1000 live births.
56 These authors estimated that there were 28,237 infant deaths in the United States
57 in 1996. The infant mortality rate by race was highest among African Americans,
58 twice the rate of the Hispanic and White populations. In comparison to other
59 countries with at least 2 million population, the United States and Greece have the
60 highest infant mortality rate (IMR). Sweden has the lowest IMR at 3.7 percent for
61 1995 (Guyer et al.).

62 The curricula in nursing schools often do not allow enough time to
63 thoroughly cover perinatal loss. Consequently, students spend limited time on this
64 topic. Many nurses have complained about the lack of educational programs about
65 death, dying, and bereavement in nursing schools. (Coolican, Stark, Doka, & Corr,
66 1994). When dealing with perinatal loss Vogel (1996) feels caregivers “freeze up”
67 and do nothing because they are afraid of saying the wrong thing. He suggests that
68 this fear is based on ignorance or unfamiliarity with death.

69 This author has 12 years experience in labor and delivery, and realizes that
70 nurses sometimes avoid dealing with perinatal loss. When assignments are made in

Perinatal Loss 8

71 the hospital the patient experiencing fetal or neonatal death is often a nurse's last
72 choice. The lack of education regarding death may be a contributing factor.

73 The purpose of this study was to determine if an educational program on
74 perinatal loss would decrease the anxiety level of nursing students about caring for
75 a grieving patient. The expectation of this researcher is that if nursing students
76 learn while in nursing school how to therapeutically care for grieving patients, they
77 may experience less anxiety and not avoid this type of patient in the future.
78 Furthermore the skills learned in communicating with bereaved parents could be
79 transferred when dealing with other situations involving death and bereavement.

80 Literature Review

81 Much of the literature on perinatal loss focuses on parents and how nurses
82 can help them cope. The nursing literature also includes a large number of studies
83 regarding nurses' attitudes towards grief; most of these studies involve pediatric,
84 AIDS, or oncology patients. Various studies have been done regarding student
85 nurses' attitudes towards death and dying, but this researcher found no studies
86 which specifically addressed perinatal loss with student nurses.

87 In the literature regarding nurses Hinds et al. (1994) did a study using a
88 grief workshop to compare the grief and stress responses of experienced nurses
89 (two to five years) to nurses with less experience (six months to two years).
90 Findings indicated that the grief workshop caused significantly higher stress levels

91 in the experienced nurses. The authors attributed the greater stress in experienced
92 nurses either to the nurses realizing they were using defense mechanisms to protect
93 themselves from the pain of loss or to an ineffective workshop. This author feels
94 further qualitative research needs to be done to discover the reasons for the greater
95 stress in experienced nurses.

96 In the literature on students attitudes towards death and dying Clingerman
97 (1996) tested two unique teaching strategies during an oncology rotation in a
98 baccalaureate-nursing program: *AIDS: A Frame of Reference* (an art gallery) and a
99 bereavement service. Students provided artistic collections for an art gallery on
100 campus. The bereavement service allowed students to light candles and share
101 thoughts and prayers. Students cried together and held one another. These
102 strategies allowed students to explore their feelings about death. Both strategies,
103 Hinds et al. and Clingerman, were identified as a success with students requesting
104 more classes.

105 Calhoun (1994), Thomas (1997) and Primeau and Lamb (1995) studied
106 parents' perceptions of nursing interventions after the death of their child. Findings
107 indicated that parents were grateful that the nurse cared enough to cry. Tears
108 validated their loss and showed the nurse's compassion. However, health
109 professionals often feel that crying is "unprofessional" and they try to avoid
110 showing their own grief (Saunders & Valente, 1994).

Perinatal Loss 10

111 Saunders and Valente (1994) interviewed over 300 nurses that attended
112 their bereavement workshops. These authors feel nurses must understand theories
113 of bereavement to facilitate their own grief and make sense of death. To cope
114 effectively with dying clients nurses must come to terms with their feelings related
115 to dying and mortality. Findings concluded that nurses get very little training in
116 how to deal with death.

117 In the literature regarding perinatal loss Kavanaugh (1997) interviewed
118 eight parents who had experienced the death of a newborn weighing less than 500
119 grams at birth. The findings indicate that having a newborn on the margin of
120 viability demands supportive, caring behaviors from the nursing staff. The data in
121 this study also suggest that these mothers may have an increased sensitivity to pain
122 because of the emotional pain of their loss.

123 Armstrong and Hutti (1998) measured anxiety of 31 expectant mothers
124 who had previously experienced a perinatal loss. Results showed greater levels of
125 anxiety and lower levels of prenatal attachment compared to a group of
126 primiparous women of similar gestational age. The authors suggest that nurses
127 working with these mothers need to be aware of the heightened anxiety and
128 encourage actions to decrease the level of anxiety.

129

130

Perinatal Loss 12

151 less likely to accept the assignment of a patient who was experiencing a perinatal
152 loss.

153 A mediator or filter according to Elliot and Eisdorfer is a factor which
154 modifies consequences. The workshop on perinatal loss was intended to be a
155 mediator to modify the student nurses' attitudes and decrease anxiety. The
156 intention of this workshop was that students would be less anxious and more
157 confident about caring for a patient experiencing a perinatal loss.

158 Worden's Four Tasks of Mourning

159 The theoretical framework on which the perinatal loss workshop was based
160 is Wordon's task based model. Coolican et al. (1994) surveyed 650 baccalaureate-
161 nursing programs and recommended Worden's task model when teaching nursing
162 students about death. Worden (1991) uses the term mourning to indicate the
163 process that occurs with a loss, and grief as the personal experience of the loss.
164 There are four tasks which Worden suggests are necessary for dealing with a loss.

165 Task 1: To accept the reality of the loss. Many times parents will ask the
166 nurse to check again for a heart rate after learning that the baby is dead. This
167 response is a simple example of the initial reaction of disbelief which people
168 experience when they first hear of a death. In the workshop, students were
169 provided examples of how to assist parents with this task.

Perinatal Loss 14

190 A simple, pretest-posttest design was used for this pilot study. Because of
191 the nature of the course calendar one class session served as its own control group.
192 Students completed a demographic questionnaire and then viewed the video, *When*
193 *the Bough Breaks*. This is the story of a family that experienced the death of a
194 child soon after birth. After the video, anxiety levels were measured using the
195 STAI Form Y-1. A one-hour workshop including Worden's framework followed.
196 After the workshop students again completed the STAI and a posttest.

197 Instruments

198 The instruments used included a consent form, a demographic
199 questionnaire, a brief posttest, and the Spielberger State-Trait Anxiety Inventory,
200 Form Y-1. The researcher developed the demographic questionnaire and posttest.
201 The demographic questionnaire consisted of 12 questions regarding age, gender,
202 religious affiliation, and previous experience dealing with death. The demographic
203 questionnaire and the posttest had two identical questions using a Likert scale
204 asking the students to identify their comfort level in caring for a patient
205 experiencing a perinatal loss. See table 1 for the three questions that were used on
206 the demographic questionnaire and the posttest. The posttest consisted of four
207 questions to evaluate the course objectives and three questions (two the same as
208 the demographic questionnaire) regarding comfort level in caring for a patient with
209 a perinatal loss.

Perinatal Loss 15

210 The STAI Form Y-1 evaluates apprehension, tension, nervousness, and
211 worry--how respondents feel "right now". State anxiety is a reaction at a given
212 time. Trait anxiety (STAI Form Y-2) refers to individual differences between
213 people and how they typically respond to stressful situations. For this study the
214 researcher used the anxiety portion of the STAI Form Y-I. Possible scores range
215 from 20 to 80 points, which includes 20 statements based on a four point Likert
216 scale and takes about six minutes to complete. Sample questions include, "I feel
217 nervous," "I feel upset," and "I feel at ease."

218 Spielberger established construct validity by comparing the mean scores of
219 various neuropsychiatric patient groups with those of normal subjects. Lower
220 scores of the character disorder group, for whom the absence of anxiety is part of
221 their illness, provided further evidence of construct validity of the STAI.

222 Cronbach's alpha coefficients were .91 for males and .93 for females when testing
223 stress levels of college students. Alpha reliability coefficients were higher when the
224 scale was given under conditions of stress. The STAI is considered to be a valid
225 and reliable instrument for measuring anxiety and is widely used for this purpose.

226 Perinatal Loss Workshop

227 The 60-minute workshop included Worden's tasks of mourning, types of
228 perinatal loss, therapeutic and non-therapeutic nursing interventions, spirituality,
229 poetry, music, and caregiver coping skills. Photographs from the book by Johnson,

230 Cunningham, Weinfeld and Gough (1997) entitled, *A Most Important Picture* were
231 shown to the students. The researcher obtained permission from the author of the
232 book to use the photographs in the research. These are tasteful pictures of families
233 holding dead babies. The fear of what a dead baby looks like is often worse than
234 the baby's true appearance. The workshop outline is shown in Table 2.

235 Results

236 Demographic Data

237 The convenience sample was comprised of 18 female and 2 male nursing
238 students (n = 20). Eighteen subjects were age 20 to 30 and two were age 30 to 50.
239 Seventeen subjects were single and three were married. Twenty-five percent have
240 children, and 85% indicated some religious affiliation. All of the subjects had had
241 someone close to them die and 10% had themselves experienced a perinatal death.
242 Thirty-five percent had attended a class on death and dying and 45% had
243 experience with death in a clinical practicum (10% neonatal death and 35% adult
244 death). See table 3 for further demographic data.

245 Question number 11 on the demographic questionnaire and question
246 number 5 on the posttest is, "How comfortable do you think you would be taking
247 care of a woman experiencing a stillbirth?" The pre workshop mean score was 2.5
248 and the post workshop mean score was 2.6. This represents only a tenth of a
249 change after the workshop and is not significant.

Perinatal Loss 17

250 However, question number 12 on the pretest and question number 6 on the
251 posttest, "If you had the chance to choose your assignment in labor and delivery
252 how likely are you to choose the woman with the intrapartum death?" showed a
253 significant change after the workshop ($p < .05$). The mean score to this question
254 changed from 2.6 before the workshop to 3.3 after the workshop. This suggests
255 that the subjects are more likely to choose this assignment after the workshop. One
256 subject did not answer this question.

257 A five point Likert scale was used for the posttest question, "How do you
258 feel this workshop affected your ability to care for a patient experiencing a fetal
259 loss?" with scores ranging from 1 (not at all) to 5 (very much so). The mean for
260 this question was 4.37 which means the workshop affected them "very much so" in
261 their ability to care for a perinatal loss patient.

262 Mean scores for the PRESTAI were 52.3 ($SD = 9.3$) and POSTSTAI
263 scores were 44.8 ($SD = 9.6$) These scores show a significant decrease in anxiety
264 level by 7.5 points. Means and standard deviations of PRESTAI and POSTSTAI
265 were computed with differences between means analyzed by the use of a t test
266 (paired samples test). The mean score was 7.50, $SD = 9.68$, $t = 3.5$, $df = 19$, $p <$
267 $.003$.

268

269

270

Discussion

271

272

273

274

275

276

277

278

279

280

281

282

283

284

Limitations and recommendations for further research.

285

286

287

288

According to Elliot and Eisdorfer's stress model the workshop was a mediator for the student nurses anxiety level. All 20 questions on the STAI showed a decrease in anxiety level after the workshop. The difference between the preworkshop scores for "If you had the chance to choose your assignment in labor and delivery how likely would you choose the woman with the intrapartum death?" and to the post workshop scores, showed a 30% increase in students likely or very likely to accept this assignment after the workshop. This indicates that the workshop was a positive mediator to prevent avoidance of perinatal loss patients. Because the students reported positive results after the workshop in their ability to care for the fetal loss patient, these findings support the importance of classes on perinatal in nursing programs. Comments from students to the researcher after class included, "I wish I had this workshop earlier in the program." "Now I know what to say to these patients." and "I'm so glad its OK to cry."

The lack of a control group and the use of a convenience sample are two limitations to this study. Due to the limited number of subjects and the lack of a control group the results cannot be generalized to other baccalaureate nursing schools.

289 Further studies with a larger sample size and a control group are
290 encouraged. A study using a mix of qualitative and quantitative data is also
291 recommended. Research could be done comparing the anxiety of experienced
292 nurses working in birthing centers to their educational background. Follow up data
293 could be gathered at six months and one year after the workshop to see if anxiety
294 levels were maintained.

295 Implications for Nursing Practice

296 Nursing educators need to include content on death and dying. Maternity
297 nursing instructors need to provide students with various opportunities to learn to
298 respond to perinatal loss. Strategies that influence the affective domain appear to
299 work well when teaching death and dying (Clingerman, 1996). This author feels
300 that movies, pictures, music, and poetry are some strategies that made this class so
301 effective. The students in this study were very moved by the pictures of dead
302 babies and the stories of past experiences of the researcher. Death is a part of the
303 circle of life and as nursing educators we must thoroughly teach death to students
304 in nursing school.

304

References

305

Armstrong, D., & Hutti, M., (1998). Pregnancy after perinatal loss: The

306

relationship between anxiety and prenatal attachment. Journal of Obstetric,

307

Gynecologic, and Neonatal Nursing, 27, 183-189.

308

Calhoun, L. (1994). Parents perceptions of nursing support following

309

neonatal loss. Journal of Perinatal and Neonatal Nursing, 8, 57-66.

310

Clingerman, E. (1996). Bereavement tasks for nursing students. Nurse

311

Educator, 21, (3), 19-22.

312

Coolican, M., Stark, J., Doka, K., & Corr, C. (1994). Education about

313

death, dying, and bereavement in nursing programs. Nurse Educator, 19, (6),

314

35-40.

315

Elliot, G., & Eisdorfer, C. (1982). Stress and human health: Analysis and

316

implications of research. New York: Springer.

317

Guyer, B., Martin, J., MacDorman, M., Anderson, R., & Strobino, D.

318

(1997). Annual summary of vital statistics. Pediatrics, 100, 905-918.

319

Hinds, P., Puckett, P., Donohoe, M., Milligan, M., Payne, K., Phipps, S.,

320

Davis, S., & Martin, G. (1994). The impact of a grief workshop for pediatric

321

oncology nurses on their grief and perceived stress. Journal of Pediatric Nursing,

322

9, 388-397.

Perinatal Loss 21

323 Johnson, J., Cunningham, J., Weinfeld, I., & Gough, M. (1997). A most
324 important picture. Omaha, NE: Centering Corporation.

325 Kavanaugh, K. (1997). Parents' experience surrounding the death of a
326 newborn whose birth is at the margin of viability. Journal of Obstetric,
327 Gynecologic, and Neonatal Nursing, 26, 43-51.

328 Leoni, L. & Woods, J. (1998, February). Caring for patients after
329 pregnancy loss. Lifelines, 2, 56-58.

330 Lowe, M., & Neumann, M. (1995, May). Perinatal loss: How to deal with
331 a difficult situation. National Certification News, 5-8.

332 Primeau, M., & Lamb, J. (1995). When a baby dies: Rights of the baby and
333 parents. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 3, 206-208.

334 Saunders, J., & Valente, S. (1994). Nurses' grief. Cancer Nursing, 17,
335 318-325.

336 Spielberger, C. (1983). State-Trait Anxiety Inventory (Form-Y). Palo Alto,
337 CA: Mind Garden.

338 Thomas, S. (1997, December). Working through prenatal loss. Lifelines,
339 79-80.

340 Vogel, G. (1996). A caregiver's handbook to perinatal loss. St. Paul, MN:
341 deRuyter-Nelson.

Perinatal Loss 22

342 Wallerstedt, C., & Higgins, P. (1996). Facilitating perinatal grieving
343 between the mother and the father. Journal of Obstetric, Gynecologic, and
344 Neonatal Nursing, 25, 389-394.

345 Walsh, F., & McGoldrick, M. (1991). Living beyond loss. Death in the
346 family. New York: Norton.

347 Worden, J. W. (1991). Grief counseling and grief therapy (2nd ed.). New
348 York: Springer.

349

350

351

352

Table 1: Sample Questions Demographic Data/Posttest

353

Please answer the following questions using the scales provided:

354

1. On a scale of 1 to 5 how comfortable do you think you would be taking care of

355

356

a woman experiencing a stillbirth? *

357

358

1

2

3

4

5

359

very

slightly

simply ok

comfortable/

completely

360

uncomfortable

uncomfortable

at ease

comfortable

361

362

2. If you had the chance to choose your assignment in labor and delivery how

363

364

likely are you to choose the woman with the intrapartum death? *

365

366

1

2

3

4

5

367

very unlikely

unlikely

not sure

likely

very likely

368

369

3. How do you feel this workshop has affected your ability to care for a patient

370

experiencing a fetal loss? * *

371

1

2

3

4

5

372

not at all

somewhat

no difference

moderately so

very much so

373

374

*Demographic Questionnaire #11 and 12; # 5 and 6 on the posttest

375

376

** Posttest only

377

378

379

380

381

382

383

384

385

386

387

388

389

390

391

392

393

394

395

396

397

398

399

400

401

402

403

404

405

406

407

408

409

410

411

412

413

414

415

416

417

418

419

420

Table 2: Perinatal Loss Workshop Outline

Introduction: Procedure, purpose, consent, confidentiality, and demographic questionnaire.

Movie: *When the Bough Breaks, Working With Families who have Experienced the Death of an Infant.*

Complete the STAI.

Objectives

Upon completion of the workshop, the student will be able to:

1. describe the difference between stillbirth and neonatal death.
2. discuss what nursing interventions are therapeutic and non-therapeutic when dealing with a family experiencing perinatal death.
3. state two self-care activities that can facilitate your grieving.
4. explain one of Worden's four tasks of mourning.

I. Worden's four tasks of mourning

II. Types of perinatal loss

III. At the time of the loss

IV. Therapeutic and non-therapeutic nursing interventions

V. Photographs from *A Most Important Picture*

A. How to take a good picture: Mementos

VI. Special cultural considerations/spirituality

VII. Caregiver coping skills/resources

STAI/Posttest

383

384

Table 2: Perinatal Loss Workshop Outline

385

386

Introduction: Procedure, purpose, consent, confidentiality, and demographic questionnaire.

387

388

389

Movie: *When the Bough Breaks, Working With Families who have Experienced the Death of an Infant.*

390

391

392

Complete the STAI.

393

394

Objectives

395

Upon completion of the workshop, the student will be able to:

396

397

1. describe the difference between stillbirth and neonatal death.

398

399

2. discuss what nursing interventions are therapeutic and non-therapeutic when dealing with a family experiencing perinatal death.

400

401

402

3. state two self-care activities that can facilitate your grieving.

403

404

4. explain one of Worden's four tasks of mourning.

405

406

I. Worden's four tasks of mourning

407

408

II. Types of perinatal loss

409

410

III. At the time of the loss

411

412

IV. Therapeutic and non-therapeutic nursing interventions

413

414

V. Photographs from *A Most Important Picture*

415

A. How to take a good picture: Mementos

416

417

VI. Special cultural considerations/spirituality

418

419

VII. Caregiver coping skills/resources

420

421

STAI/Posttest

Table 3 Demographic Data (n=20)		
	Frequency	Percent
Age:		
20-30	18	90.0
30-40	1	5.0
40-50	1	5.0
Gender:		
Male	2	10.0
Female	18	90.0
Marital Status:		
Single	17	85.0
Married	3	15.0
Children:		
Yes	5	25.0
No	15	75.0
Religious Affiliation:		
Yes	17	85.0
No	3	15.0
Years of College (n=19)		
2-4	2	10.0
4 and above	17	85.0
Anyone close to you ever die?		
Yes	20	100.0
No	0	0
Ever had a stillborn, miscarriage or neonatal death?		
Yes	2	10.0
No	18	90.0
Ever attend class on death and dying?		
Yes	7	35.0
No	13	65.0
Ever experience death in clinical practicum?		
Yes	9	45.0
No	11	55.0