To the Graduate Council:

I am submitting herewith a thesis written by Timothy James McBride entitled "Recreation Services in Tennessee Skilled Nursing Homes with a Focus on the Terminally Ill." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Recreation.

Martha Peters

Martha Peters, Major Professor

We have read this thesis and recommend its acceptance:

Tom Knecht

Accepted for the Council:

L Evans Roth

Vice Chancellor
Graduate Studies and Research

RECREATION SERVICES IN TENNESSEE SKILLED NURSING HOMES WITH A FOCUS ON THE TERMINALLY ILL

A Thesis

Presented for the

Master of Science

Degree

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Timothy James McBride

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ABSTRACT

The purpose of this investigation was to depict recreational services in Tennessee Skilled Nursing Homes, especially in regard to services provided for the terminally ill residents.

Activity Coordinators from sixty-one Skilled Nursing Homes in Tennessee were used in a census survey as the selected population. This population was chosen because the Activity Coordinators conduct the recreation programs and an assumption was made that there would be a higher proportion of terminal residents at Skilled Nursing Homes, than in other homes for the aged, since there is extensive medical supervision in them. The investigator designed a survey instrument containing three sections which sought information regarding the overall recreation program, services for the terminally ill, and the persons who conduct the program.

Thirty-one of the sixty-one Activity Coordinators responded to the questionnaire. Results showed that a varied selection of recreational activities were available to the residents, although few were designed specifically for the terminal residents. The respondents felt that their services could benefit the terminally ill in the remaining time they have, as well as help make dying an easier process to accept. Group interaction was encouraged between the terminal and non-terminal residents, and also among the terminal residents themselves. The responses were slightly in favor of allowing the resident to be alone instead of participating when he or she chose to be that way.

The average resident population of the thirty-one nursing homes in this study was 152.

Persons who conduct the recreation programs are most frequently called Activity Director or Activity Coordinator. The average length of time these persons had been employed by their agencies was three and one-third years. Educational attainment of these respondents ranged from a high school diploma to a doctoral degree, with a high school diploma being most representative. Only six had a college major in recreation. However, 63 percent had attended either Death Education courses or workshops concerning dying patients.

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CHAPTER I

INTRODUCTION

Therapeutic recreation services and personnel can perform a vital function for residents in nursing homes. Also, recreation has a place in the treatment for the terminally ill residents of these homes. Therapeutic recreation complements the treatment of the medical disciplines and helps the patient have a more positive attitude toward his or her remaining life. This mode of therapy is aimed at being both therapeutic and enjoyable for the participant.

The purposes of therapeutic recreation were stated by Gerald S. O'Morrow:

> To maintain the special population member's "wellness" (i.e., health wellness or social wellness), and if this state changes, to provide the amount and quality of therapeutic recreation experiences his situation demands to direct him back to wellness, and, if wellness cannot be achieved, to contribute to his quality of life, maximizing his resources within his limitations.[1]

When considering service to the terminally ill, the latter portion of that statement of purpose, "contribute to his quality of life," becomes important. The process of dying can be a frightening, lonely experience. The dying person faces a variety of problems that could be the concomitant effects of a terminal illness. Loss of a job, limited outside mobility, and loss of social contacts are potential

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[1]Gerald S. O'Morrow, Therapeutic Recreation—A Helping Profession, second edition, (Reston, Virginia: Reston Publishing Company, Inc., 1980), p. 192.

problems. Thus, therapeutic recreation, because of its enjoyable nature, could possibly offset the negative situations of a terminal illness and become a bright spot in the life of the dying person.

The potential benefits of therapeutic recreation, especially in regard to the terminal resident, were summarized by Dorothy Mullen, a recreation consultant to nursing homes. She stated:

> There is a realization that . . . recreation . . . can create the climate for better medical and nursing care, and for more satisfied patients. . . . The new nursing home is concerned with more than the physical needs of the patient. Nurses realize that patients sleep better and need fewer tranquilizing drugs when engaged in worthwhile, enjoyable activity. Confused patients become decreasingly so, thereby requiring less supervision and fewer restraints. The atmosphere changes to preoccupation with living, rather than with death.[2]

Purpose of the Study

The purpose of this research project was to determine the extent of therapeutic recreation services in Tennessee Skilled Nursing Homes, including a focus on those services provided for the terminally ill residents. In addition, the study was aimed at determining how therapeutic recreation services could benefit the terminal residents. A final purpose of this project was to add to the literature concerning recreation and the terminally ill.

Need for the Study

The simplest explanation depicting the need for this study was that death is something that everyone has to contemplate, either personally

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[2]Dorothy A. Mullen, Recreation in Nursing Homes, National Recreation and Park Association Management Aids Series No. 88, (Washington, D.C.: the Association, 1970), p. 7.

and/or professionally. The terminally ill population does fall within the realm of therapeutic recreational service. Yet, in the education of a therapeutic recreator, there tends to be little discussion about the terminally ill or how to serve them. Professional literature in the field of therapeutic recreation concerning the dying patient has also been quite scarce. Therefore, one purpose of this study was to add to the literature concerning recreation and the terminally ill.

Definition of Key Terms

Recreation: Defined as an "activity one enters into during his leisure time for the satisfaction derived from the experience."[3]

Therapeutic Recreation: The process of using the recreation experience to bring about desired effects, either physical, social, and/or mental.

Leisure: Free, unobligated time; a state of mind in which one feels free, at ease, unobligated, and able to rest from life's necessary duties.

Terminally Ill: "Death is probable within a year, if the unwholesome condition persists; and there is no known cure for the patient's condition."[4]

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[3]H. Douglas Sessoms, Harold D. Meyer, and Charles K. Brightbill. Leisure Services, The Organized Recreation and Park System, fifth edition, (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1975), p. 17.

[4]Elisabeth Kubler-Ross, Death—The Final Stage of Growth, (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1975), p. 77.

Skilled Nursing Home: A licensed, health care facility that provides "skilled nursing care, continuous nursing observations, restorative nursing, and other services under professional direction with frequent medical supervision."[5]

Limitations of the Study

The limitations of this study were as follows:

1. Questionnaires were mailed only to Activity Coordinators in Tennessee Skilled Nursing Homes. Activity Coordinators were chosen because they conduct the recreational programs in these facilities.

2. Only Skilled Nursing Homes in Tennessee were used because an assumption was made that, because of extensive medical supervision, there would be a higher proportion of terminally ill residents in this type of facility.

3. The instrument was designed to be used only with this study.

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[5]Scout Lee Gunn, Basic Terminology for Therapeutic Recreation and Other Action Therapies, (Champaign, Illinois: Stipes Publishing Company, 1975), p. 47.

CHAPTER II

REVIEW OF LITERATURE

In reviewing the literature related to recreation services for the terminally ill, the investigator found there had been no studies specifically aimed at the status of therapeutic recreation services for the terminally ill in nursing homes. In fact, there have been relatively few articles written about serving the terminally ill by recreation professionals. Therefore, there is an obvious need for research in this area.

Since there has been little research in this service realm, the investigator reviewed literature from related areas. As well, this chapter has been divided into three sections regarding these areas. The first section deals with the process of dying and the subsequent needs of the individual which are initiated by this process. The second section of this chapter will provide information on service to the terminally ill by professionals other than in recreation. The third section will be directly related to recreation services for the terminally ill.

Process of Dying

The terminally ill person undergoes a process that he or she cannot escape. This process entails many problems for the dying person. For any professional to serve these patients, this process needs to be fully understood.

Dr. Elisabeth Kubler-Ross, who has been a major advocate of serving the terminally ill, has stated that death has been treated as a negative occurrence and this attitude has been reflected in the manner in which these patients have been served. She whote "that dying nowadays is more gruesome in many ways, namely, more lonesome, mechanical, and dehumanized."[1] Perhaps, as Dr. Kubler-Ross thinks, this negativity can be explained because death illustrates how vulnerable people are even though tremendous strides have been made medically and technologically.[2]

This attitude has tended to cause people to view death as cold and very impersonal. Yet, as Pattison stated, "Death is ultimately personal."[3] One must keep in mind that death is "an inevitable, intrinsic part" of life, it is something that everyone will have to face eventually.[4]

Two simple facts about this process are profoundly important, yet often forgotten by those serving the terminally ill. The first aspect concerns the point that although death can be considered an event,

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[1]Elisabeth Kubler-Ross, On Death and Dying, (New York: Macmillan Publishing Company, Inc., 1969), p. 8.

[2]Elisabeth Kubler-Ross, Death—The Final Stage of Growth, (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1975), p. 5.

[3]E. Mansell Pattison, The Experience of Dying, (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1977), p. 317.

[4]Andre de Vries and Amnon Carmi, editors, The Dying Human (Ramat Gan, Israel: Turtledove Publishing, 1979), p. 381.

dying has to be viewed as a process.[5] Dying occurs over a period of time, except in sudden death cases. The second point deals with two key terms that are used together—dying human. For some reason, people often forget that "the person who is dying is still, whatever his condition, a living human being."[6] Yet, the service that is given tends to dehumanize them. Norman Cousins, in Anatomy of An Illness, wrote that the "ultimate tragedy is depersonalization."[7]

Several writers have attempted to depict the primary problem that faces the terminal patient while going through this process. Wilcox and Sutton felt that the problem was the process itself. They wrote that "how one faces death and goes about the process of dying" is the main problem, that is that death is easy but dying is hard.[8] This attitude was shown by Henry Fielding when he wrote "It hath often been said that it is not death, but dying which is horrible."[9]

Other authors have attempted to point out feelings which occur during this process as being the primary problems for the terminally ill. During a symposium held at Ramat Gan, Israel, the delegates felt a crucial problem

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[5]Arnold Toynbee et al., Man's Concern with Death, (St. Louis: McGraw-Hill Book Company, 1968), p. 27.

[6]Andre de Vries, op. cit., p. 27.

[7]Norman Cousins, Anatomy of An Illness, (New York: W. W. Norton and Company, 1979), p. 133.

[8]Sandra Galdiera Wilcox and Marilyn Sutton, editors, Understanding Death and Dying, (Port Washington, New York: Alfred Publishing Company, Inc., 1977), p. 97.

[9]Gene Stanford and Deborah Perry, Death Out of the Closet, (New York: Bantam Books, 1976), p. 88.

for the dying was that they are no longer treated as humans. There is a tendency to depersonalize the ill and view them only in regard to their pathological conditions.[10] Several authors agreed that loneliness was the chief problem for the dying. The dying process becomes a lonely encounter for the person because so many people are withdrawing from the patient's environment at this time.[11] In our society, because dying is a painful process to watch, most people would rather withdraw from the situation.

From another viewpoint, Dr. Kubler-Ross has said the primary fear or concern for the dying person "was the fear of being a burden to others."[12] The terminally ill often develop a guilt complex because of the constant medical, and often personal, attention that must be given to them. The burden can also be due to the financial strain that is sometimes placed on the family.

Although death is a personal experience, since ultimately it is the individual who passes on, there are other people who are affected by this process of dying. One author wrote that "Death is dyadic or polyadic in quality" because there are other persons who have become involved in the situation."[13] The participants in this process include

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[10]Andre de Vries, op. cit., p. 93.

[11]Paul Ramsey, The Patient As Person, (New Haven: Yale University Press, 1970), p. 134.

[12]Kubler-Ross, Death—The Final Stage of Growth, p. 80.

[13]Andre de Vries, op. cit., p. 123.

the individual, the medical staff and other employees of the institution, and the family. Perhaps once death does occur, then it becomes a problem for the family; the process has now been completed by the individual. It has become, and will continue to be, a trying period for the family members. As Howard Congdon wrote "Certainly the inevitability of death does not entail that we should welcome it."[14]

A final point needs to be made concerning the process of dying and that is that death is a natural process. Birth and death are similar because all humans will experience both of them. Therefore, people need to relate to death as a natural phenomenon and not be so afraid of it. This concept was illustrated fairly well in a booklet put out in conjunction with the hospice program at Fort Sanders Presbyterian Hospital in Knoxville, Tennessee. It stated:

> Humans also experience a type of metamorphosis. Death is as natural as the transformation of the butterfly. As natural as birth. Yet too often it evokes fear, rage, and denial, rather than calm, if reluctant, acceptance on the part of those soon to encounter it.[15]

This review will now address the needs, emotions, and thoughts that are evoked in a dying person. The reader must remember that a terminal illness has more than physical consequences.

The emotional aspects of a terminal illness should also be a high priority for service to these patients. The psychological aspects are

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[14]Howard K. Congdon, The Pursuit of Death, (Nashville: Abingdon, 1977), p. 168.

[15]"Hospice," Fort Sanders Presbyterian Hospital, Knoxville, Tennessee, p. 1.

often the causes for the ups and downs that the patient experiences. Orville Kelley, a cancer victim himself, stated it thus: "The emotional problems caused by cancer are as devastating—if not more devastating—as the physical problems caused by the disease."[16] Other writers tend to agree that terminal illnesses have far reaching emotional impacts on the person. Some go so far as to state that the emotional struggle is actually more important than the physical one. Jane Brody wrote that "fighting cancer is as much an emotional battle as it is a war with surgical tools, potent drugs, and ionizing radiation."[17]

Therefore, in the treatment, as well as the service, to the terminal patient, one should consider the whole person and all of the consequences of the illness. A comprehensive treatment should be provided for the patient. This approach should include concern for the physical, psychological, and social problems that may occur.

Yet, there is a tendency to forget the emotional aspects of the illness. As Dr. Kubler-Ross wrote "It would take so little to remember that the sick person too has feelings, has wishes and opinions, and has—most important of all—the right to be heard."[18] That statement brought out another important concern—talking to the dying person. Any person, especially a dying one, needs to be able to communicate feelings. If

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[16]Orville E. Kelly, Make Today Count, (New York: Delacorte Press, 1975), p. 133.

[17]Jane E. Brody, You Can Fight Cancer and Win, (New York: McGraw-Hill Book Company, 1977), p. 183.

[18]Kubler-Ross, On Death and Dying, p. 8.

communication is denied, then the person becomes alienated and has "the feeling of being cut off from life."[19] Obviously, this act of abandonment could have a damaging effect upon the psyche of the individual.

Norman Cousins questioned that if abandonment could cause negative feelings, which in turn caused negative chemical changes, then what would be the effects of positive emotions? He believed these positive feelings have a therapeutic value for the ill person. He summed it up well when he wrote that "positive emotions are life-giving experiences."[20]

These needs should be considered by everyone who comes into contact with the dying person. Dying is a twenty-four hour vigil for those with a terminal condition, therefore, their needs should be constantly thought of by those serving them. The role of those professionals and lay people was described by Kubler-Ross:

> . . . it is evident that the terminally ill patient has very special needs which can be fulfilled if we take the time to sit and listen and find out what they are. The most important communication, perhaps, is the fact that we let him know that we are ready and willing to share some of his concerns.[21]

The review illustrates some key areas that should be addressed by those persons serving the terminally ill. As previously mentioned, Paul Ramsey felt that loneliness was the chief problem facing the terminally ill patient.[22] Thus, social relationships could be an

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[19]Ernest H. Rosenbaum and Isadora R. Rosenbaum, A Comprehensive Guide for Cancer Patients and Their Families, (Palo Alto: Bell Publishing Company, 1980), p. 2:7.

[20]Cousins, op. cit., p. 86.

[21]Kubler-Ross, On Death and Dying, p. 269.

[22]Ramsey, op. cit., p. 134.

important contribution to offsetting this problem. Helping the patient to feel useful and productive could aid in the battle against feeling like a burden to others and also help the person to resist depression at the same time. To help the dying person remain satisfied with life, one must keep the patient from feeling dehumanized by making his or her remaining time meaningful.

Service to the Terminally Ill by Professionals Other Than in Recreation

Service to the terminally ill is conducted by a multidisciplinary team of professionals as well as lay persons. This team includes physicians, nurses, social workers, therapists, chaplains, volunteers, administrative personnel, and dieticians. Furthermore, contact with the terminally ill is also made by other employees of the facility, such as the kitchen personnel.

Dr. Kubler-Ross feels that it takes a special person to serve a dying individual. Kubler-Ross depicted this special quality when she wrote that the person "cared enough to become involved in a field that too many people try to avoid."[23] The importance of serving this population was further described by Paul Ramsey. He stated "Attending and companying with the patient in his dying is, in fact, the oldest medical ethics there is."[24]

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[23]Elisabeth Kubler-Ross, To Live Until We Say Good-Bye, (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1978), p. 11.

[24]Ramsey, op. cit., p. 114.

Time is considered an important part of the service to the terminally ill. The patient especially considers time a valuable commodity. This was illustrated in the following statement:

> Time is one thing that patients need most from their doctors—time to be heard, time to have things explained, time to be introduced by the doctor personally to specialists or other attendants whose very existence seems to reflect something new and threatening.[25]

Some people feel an uneasiness when it comes to serving the terminally ill. There are two means to overcome this problem area. The first was depicted when one author wrote "they would have to confront their own feelings about death and dying before they could face death directly with their patients."[26] The second means, which should accompany the first one, dealt with information people needed to know before effectively working with this population. The person needed to know about attitudes toward death, cultural mores, and family dynamics.[27]

It requires a deep concern by those persons serving the dying population to be able to work with this group of patients. Obviously, because of its emotional outlays it is a very demanding job. Yet, difficult or not, the health field still has the responsibility of serving these clients. Ruth Purtilo stated it in this manner:

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[25]Cousins, op. cit., p. 137.

[26]Wilcox and Sutton, op. cit., p. 80.

[27]Elizabeth R. Prichard, "Planning for the Terminally Ill Patient: The Social Worker's Responsibility," Journal of Thanatology, (Volume 2, Numbers 1-2, Winter-Spring, 1972), pp. 601-2.

> The main challenge facing the terminally ill person is to live until he dies; the main challenge facing the health professionals working with him is to help him to live—not merely function physiologically—until he dies.[28]

Recreation Services for the Terminally Ill

Much of the literature that has been written on recreation and terminal illnesses was aimed toward cancer. Herbert Howe, a cancer victim himself, relied on active sports to help him overcome the negative emotional experiences and to help him offset the effects of chemotherapy. However, Howe could see the advantageous role that any form of recreation could play. He wrote:

> Sports are only one of many ways to assert one's individuality during a time of suffering and self-doubt. Some patients have taken up needlepoint, sculpture, playing the piano or gardening.[29]

After living past the expected period of time, Howe came upon information which stressed the importance of sports with cancer treatment. The following listed a few of the programs he found:

> Only in 1976—the year of my operation—did the Simontons seriously consider sports as contributing to cancer therapy. It is important to note that they prescribe their psychological approaches only in conjunction with standard chemotherapy and radiation treatments. Dr. Paul K. Hamilton, a Denver oncologist, says that about half of all cancer patients can do mild exercise, such as walking, while about a third can jog, swim, or play tennis. And the Presbyterian/St. Luke's

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[28]Ruth Purtilo, The Allied Health Professional and the Patient, (Philadelphia: W. B. Saunders Company, 1973), p. 191.

[29]Herbert Howe, "Do Not Go Gentle," Reader's Digest, (Volume 118, Number 705, January, 1981), p. 224.

> Medical Center in Denver has a cancer self-help program that actively encourages exercise, including running, for cancer patients.[30]

At the time of Howe's writing, the Simontons were working at the Cancer Counseling and Research Center in Fort Worth, Texas.

Another important piece of literature on recreation and cancer was an article in Postgraduate Medicine by J. Herbert Dietz. He felt that the important role that recreation could play was to offset the unpleasantness of cancer treatment. In particular, he stated "Recreational activities can be used to interest, motivate, and distract the patient; these can be coupled with activities prescribed to achieve specific exercise goals."[31]

Other recreational activities were also valued by the different writers. Volunteering, reading, writing, and photography were some of the suggested activities for the dying. Edith Mize wrote that "Reading and writing proved to be my therapy."[32]

The particular role that recreation can play in serving the terminally ill was discussed in several articles. The overall importance of therapeutic recreation services is "to help the patient maintain his dignity and self-esteem."[33] In cases where children have

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[30] Ibid.

[31] J. Herbert Dietz, "Adaptive Rehabilitation in Cancer—A Program to Improve Quality of Survival," Postgraduate Medicine, (Volume 68, Number 1, July, 1980), p. 146.

[32] Edith Mize, "When We Grieve," Home Life, (Volume 33, Number 1, October, 1978), p. 22.

[33] Barbara Newman, "The Role of Paramedical Staff with the Dying Adult Patient," Therapeutic Recreation Journal, (Volume VIII, Number 1, First Quarter, 1974), p. 30.

terminal illnesses, the recreation program can be a vital resource for the child. As Betty Lovelace stated "the recreation program may be the influencing factor in maintaining a semblance of normality in his life."[34]

Daniel D. Ferguson felt that there were specific implications for therapeutic recreation when serving the terminally ill population. He outlined these implications when he wrote:

> This means that recreation personnel must be open to listening when a resident expresses a desire to talk about dying; they must be open to disclosing their own true feelings or fears about dying; they must be open to crying when they feel the tears about to flow; but they must never be open to denying that death will eventually be experienced by all.[35]

Obviously, the emotional outlay needed by the recreation therapist will be significant. They need to take the time to help these residents whenever possible. As one author wrote, "sharing is a vital service that can be provided by a recreation specialist."[36]

A reason that the therapeutic recreator can effectively serve these terminal residents is because they come in close contact with the individuals. So do other professionals, yet in a different perspective. Donald Pelegrino illustrated the unique relationship when he wrote that

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[34]Betty M. Lovelace, "The Role of the Recreation Therapist with the Terminally Ill Child," Therapeutic Recreation Journal, (Volume VIII, Number 1, First Quarter, 1974), p. 26.

[35]Daniel D. Ferguson, "Working with the Terminal Patient: Implications for Therapeutic Recreators," Leisurability, (Volume 6, Number 2, April, 1979), p. 34.

[36]Kathleen Linnihan Cannon, "Death and Attitudes Toward Death—Implications for Therapeutic Recreation Service," Therapeutic Recreation Journal, (Volume VIII, Number 1, First Quarter, 1974), p. 40.

the recreation therapist "sees the client in a variety of informal, casual, almost non-hospital, non-institutional settings."[37]

Therefore, the recreation therapist does play a vital role in service to the terminally ill. But the therapist needs to be trained in meeting the special needs of the dying and understanding their concerns. As one author stated, "We're dealing with people and with people's happiness, we're dealing with people's needs."[38]

General Summary

A general summary of this chapter reveals that death is just a single event, yet dying is a process that the individual must endure. Several authors depicted the problem of the dying person in one of the following ways: the process itself, not being treated as living humans, depersonalization, loneliness, and the feeling of being a burden to others. An additional aspect that needs to be considered is the emotional aspect of a terminal illness, which some authors considered more devastating than the physical aspects.

It takes a concerned individual to effectively serve terminal patients. Also, it requires a team of professionals and lay persons to adequately serve this population. Because of the non-medical atmosphere of therapeutic recreation services, it should be included

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[37]Donald A. Pelegrino, "Death and Dying Counseling and the Recreation Therapist," Leisurability, (Volume 1, Number 3, July, 1974), p. 16.

[38]"Access National Parks—A Guide for Handicapped Visitors," National Park Service, Director William Whalen, 1978, p. vii.

as a part of the team approach. Participation in recreation activities by the terminal resident can aid in his or her struggle against the emotional aspects of the condition.

CHAPTER III

METHOD OF RESEARCH

This chapter is concerned with the methodological procedures that were used in conducting this investigation. A descriptive research format was used. The purpose was to depict recreation services in Tennessee Skilled Nursing Homes with a focus on the terminally ill.

Selecting the Sample

Activity Coordinators from Skilled Nursing Homes located throughout the state of Tennessee were chosen as the population for this investigation. A directory of all sixty-one nursing homes classified in this category was received from Quality Assurance in Nashville, Tennessee. Activity Coordinators were chosen as respondents because they perform therapeutic recreation services in these nursing homes. Furthermore, Skilled Nursing Homes were chosen because of the requirement for extensive medical supervision at these homes. Because of the medical implications of a terminal illness, an assumption was made that there would be a larger proportion of terminal residents in this type of nursing home compared to a retirement home.

Development of the Instrument

A basic questionnaire was devised by the investigator in order to depict recreation services at Tennessee Skilled Nursing Homes. Questions were aimed at overall program information, service to the terminally ill, and information regarding the Activity Coordinators.

The following is a listing of the types of questions included in this survey instrument:

1. yes/no
2. short answer
3. check list
4. open ended
5. ranking

In all, there were twenty-four questions included in the questionnaire. A copy of the questionnaire and cover letter sent to the Activity Coordinators appears in Appendix A.

Four graduate students in the School of Health, Physical Education, and Recreation reviewed the questionnaire and cover letter for purposes of format, clarity, and readability only.

Three sections of questions were included in the survey instrument. The first section had questions regarding general program information concerning recreation services. This involved questions one through four. The second section, which was the area of focus, concerned itself with recreation services for the terminally ill and was represented by questions five through eighteeen. Finally, the third section sought information about the Activity Coordinators. Questions nineteen through twenty-four were in this section.

Collecting the Data

Questionnaires were sent to Activity Coordinators at sixty-one Skilled Nursing Homes and a stamped, self-addressed envelope was

included for return mailing. Sixty-one represented the entire population of nursing homes classified as Skilled throughout the state of Tennessee. Consent was explained in the cover letter which stated that return of the questionnaire indicated the respondent granted his or her consent for participation. The questionnaires were numerically coded so that the investigator would know who responded to the first mailing.

Respondents were given ten days to return the initial mailing of the questionnaire. A follow-up was conducted by telephoning a random sampling of the nonrespondents. The investigator repeated the questions for the Activity Coordinators during a telephone interview. The questions were repeated exactly as they had been written on the questionnaire.

Analyzing the Data

The majority of the data were calculated in a fashion that depicted the percentages and/or frequencies of the answers that were given. These calculations were used to determine the extent to which certain services were being provided, certain situations occur, number of times specific programs were offered, and level of education attained by the respondents. Short answer questions were reviewed so that supportive information could be received. For questions regarding the "number of residents served," "number of years employed by the agency," and "size of staff," a range, mean, and median were calculated for each. Open ended questions were analyzed to determine the frequency of similar responses. The final type of question, which required the

respondent to rank four items in order of preference, was reviewed and a mean was determined, as well as the frequencies for each numerical rank.

CHAPTER IV

DATA COLLECTION AND ANALYSIS

For the initial mailing of the questionnaire, twenty-five out of sixty-one Activity Coordinators responded to the inquiry. This represented a return rate of 41 percent. A telephone interview was used to conduct a follow-up. Six of the thirty-six nonrespondents were randomly selected to be used in the follow-up. This represented 17 percent of the nonrespondents. Thus, there was an overall response rate of 51 percent for this investigation.

The first section of the questionnaire dealt with general program information. On Question 1, regarding whether all of the residents were served by the recreation program, 97 percent of the Activity Coordinators responded that all were served. The aim of Question 2 was to determine the activities that are provided for the residents of the nursing homes. Table 1 depicts the frequencies of programs that were listed by the investigator. Furthermore, there was space available for the Activity Coordinators to list additional programs that they offered their residents. Table 2 portrays the additional activities that the Activity Coordinators supplied to Question 2.

Question 3 related to whether volunteers were utilized in the recreation program. All thirty Activity Coordinators who responded to this inquiry stated that they used the services of volunteers. The size of the recreation staff, excluding volunteers, was the information desired in Question 4. The range of staff sizes was from one to twenty

TABLE 1

Frequency of Participation in Programs
Identified by Investigator

Activity	f
Music and Singing	31
Entertainment	31
Special Events	31
Arts and Crafts	30
Games	29
Exercise Programs	27
Outings	25
Individual Counseling	20

TABLE 2

Frequency of Participation in Programs
Added by Respondents

Activity	f
Church	15
Bible Study	8
Reading/Library	6
Service Projects	5
Cooking	4
Resident Council	3
Parties	3
Gardening	3
Special Interest Groups	3
Reality Orientation	3
Rhythm Band	2
Remotivation	2
Current Events	2
Story Telling	2
Luncheons	1
Intellectual Improvement	1
Printing Newspaper	1
Creative Drama	1
Lecturers	1
Group Counseling	1
Movies	1
Spelling Bee	1
Ice Cream Cart	1
Butter Churning	1
Happy Hour	1

persons, with the mean being 2.84. Furthermore, the median response was two.

The second section of questions dealt with recreation services for the terminally ill. This was the focus area of this investigation.

The first inquiry in this section, Question 5, related to whether the Activity Coordinators were informed if a resident had a terminal condition. Thirty out of thirty-one respondents were informed when a terminal condition existed. This represented 97 percent of the respondents.

Questions 6 through 8 were concerned with participation of the terminally ill residents in the recreation program. In regard to Question 6, thirteen out of thirty-one Activity Coordinators stated that the majority of the terminal residents do participate on a voluntary basis. Required participation, or non-voluntary, was not reviewed since it did not reflect the residents' personal desires. However, as asked in Question 7, all residents were encouraged to participate in the recreation program. The final question of the three, number 8, asked if the Activity Coordinator had ever been reluctant to serve any of these terminal residents because of their medical prognosis. All respondents stated that they, as Activity Coordinators, had not been reluctant to serve their dying residents.

Question 9, an open ended inquiry, dealt with how the Activity Coordinator's services played a role in the quality of the terminal patient's remaining time. The responses were grouped according to their similarities, and are listed with their frequencies in Table 3.

TABLE 3

Frequency of Responses to Question 9: How Do Your Services Play a Role in the Quality of the Terminal Patient's Remaining Time

	Response	f
1.	keep kind on something else	11
2.	feel useful	9
3.	reduce depression	8
4.	live life to fullest	7
5.	socialize residents	7
6.	put happiness into their lives	5
7.	feel needed	4
8.	use their talents	4
9.	feel wanted	3
10.	keep them active	3
11.	give them positive attitude	3
12.	continue to feel loved	2
13.	promote Activities of Daily Living	2
14.	feeling of accomplishments	2
15.	feel normal	2
16.	relieve anxiety	2
17.	keep them to date on happenings	1
18.	they are still citizens	1
19.	feel someone cares	1
20.	provide someone to talk to	1
21.	play a major role	1
22.	minimize isolation	1
23.	give support	1
24.	meet psychological needs	1
25.	give a choice in treatment	1

The next three questions, numbers 10 through 13, were concerned with the terminal residents and group interaction. Regarding Question 10, twenty-six of the thirty-one respondents stated that they had discussed death with these residents. However, only 7 percent of the respondents had discussed it with more than half of the terminally ill residents. There were individual counseling sessions where topics besides death were discussed in 74 percent of the cases. Question 11 asked if group interaction was encouraged among the terminal residents. Seventy-four percent responded that this interaction was encouraged. Similarly, Question 12 asked if interaction was encouraged between the terminal and non-terminal residents. All Activity Coordinators responded that this form of interaction was encouraged. However, the response to Question 13 showed that during 53 percent of these interactions, the residents would discuss their medical conditions.

Question 14 required the respondents to list any activities that were specifically designed for the terminally ill. Seventeen persons responded that there were no special activities for the dying patients. One-on-one relationships were listed seven times, while each of the following was listed twice: Reality Orientation class, crafts, and bedside activities. Finally, checkers, bingo, short term projects, chapel, social parties, and a "What Do You Want to Talk About?" class were all listed once.

Whether the Activity Coordinator had ever had to tell a resident he or she had a terminal condition was asked in Question 15. Only one of thirty-one Activity Coordinators had ever informed a resident that

he or she had a terminal illness. Furthermore, this respondent was the only one who felt the responsibility for telling the resident.

In regard to a terminal resident ever being left alone, Question 16 sought whether it was appropriate to leave the person alone instead of participating with others. Seventeen Activity Coordinators stated that it was all right for the residents to be alone at times.

Question 17 required the respondents to answer an open ended question concerning how recreation activities can make dying an easier process to accept for the terminally ill. The responses were very similar to those given for Question 9. Table 4 provides the responses and frequencies for each one.

Question 18 was concerned with the value of recreation to the terminal patient in regard to: (1) social relationships, (2) feeling useful and needed, (3) satisfaction with life, and (4) resistance to depression. The frequencies and means of responses are given in Table 5.

The final section of the questionnaire dealt with general information concerning the Activity Coordinators themselves. The first question, number 19, asked for the official title of the respondent. Fifteen responded that Activities Director was their title, while twelve stated Activities. The following titles were listed once: Director of Adjunctive Therapies, Director of Activities, Director of Recreation Therapy, and Director of Therapeutic and Resident Activities. Social Worker was listed twice as a dual title and Director of Social Services was listed once as an added title.

TABLE 4

Frequency of Responses to Question 17: How Can Recreational Activities Make Dying An Easier Process to Accept for the Terminally Ill

Response	f
1. keep mind on something else	16
2. feel productive	10
3. encourage social interaction	6
4. make remaining time meaningful	6
5. help them to cope	4
6. make dying an easier process	4
7. release anxieties	4
8. brighten the day	4
9. come to grip with own feelings	3
10. give peer support	3
11. promote self-worth	3
12. promote happiness	3
13. concern with life rather than death	3
14. feel wanted	2
15. give better perspective on life	2
16. work out anger and frustration	2
17. give aura of normality	2
18. help adjust to limitations	1
19. promote Activities of Daily Living	1
20. give special attention to the person	1
21. fulfill time	1

TABLE 5

Frequencies and Means of Responses to Question 18: Ranking of Recreational Activities in Specified Areas

Item	High 1	2	3	Low 4	Mean
Feeling Useful or Needed	13	3	9	6	2.258
Satisfied with Life	10	9	5	7	2.290
Resisting Depression	4	14	7	6	2.483
Social Relationships	4	5	10	12	2.967

The number of years employed by the agency was the response required for Question 20. The range of responses was from two months to seventeen years, while the mean was three years four months and the median was two years six months.

Question 21 was concerned with the number of residents that the nursing homes were capable of serving. The range was forty-nine to five hundred and fourteen. For the responses to this question, the mean was calculated to be 151.96 residents and the median was 153.

What educational degrees the Activity Coordinators had attained was asked in Question 22. The frequencies for the responses are shown in the following table.

TABLE 6

Frequency of Responses to Question 22: Check Highest Degree You Have Received

Degree	f
High School Diploma	13
Two-Year College Degree	5
Bachelor's Degree	9
Master's Degree	3
Doctoral Degree	1

In addition, further educational development of the respondents was listed as workshops, LPN training, University of Tennessee correspondence courses, and the Basic Activity Coordinator Course. All were listed only once, except for the latter which was noted three times. Of the

respondents who had received college degrees, only one-third had majored in recreation. Sixty-three percent had participated in workshops regarding the dying patient or taken Death Education courses.

Summary of Findings

1. The recreation programs offer a wide selection of activities to the residents of Skilled Nursing Homes in Tennessee.

2. Nearly all persons conducting the recreation programs were informed if a resident had a terminal illness. This made it possible for them to serve these residents better in regard to the emotional aspects of the illness.

3. All respondents stated that they had never been reluctant to serve the terminal residents of their facilities.

4. The responses given for Questions 9 and 17 were very similar to each other. Also, the four items in Question 18 that were ranked in preference of order were noted strongly in these two questions.

5. Group interaction, which would aid socialization, was encouraged.

6. The respondents were mixed in their views on whether the terminal residents should ever be left alone instead of participating with others.

7. Activity Director and Activity Coordinator were the two listed most often as the official title of the respondents.

8. Academic preparation by the persons conducting the recreation program was varied and presented no set pattern.

9. Of the college graduates, only one-third had majored in recreation.

10. Nearly two-thirds of the respondents had taken Death Education courses or participated in workshops concerning the dying patient.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this investigation was to depict recreational services in Tennessee Skilled Nursing Homes, especially in regard to the services provided for the terminally ill residents.

Activity Coordinators from sixty-one Skilled Nursing Homes located throughout the state of Tennessee were used in a census survey. The Activity Coordinators were chosen as the population because they conduct the recreation programs in these nursing homes. An assumption was made that, because of the extensive medical supervision at Skilled Nursing Homes, there would be a higher proportion of terminally ill residents in these homes compared to a retirement home.

The investigator designed an instrument to be used specifically in this study. There were three sections included in the questionnaire. The first section dealt with general program information, while the second section was concerned with recreational services to the terminally ill residents. This was a focus area of the investigation. The third section of the questionnaire dealt with information regarding the Activity Coordinators themselves. There was a total of twenty-four questions included in the instrument.

Twenty-five of the sixty-one Activity Coordinators responded to the mailing of the questionnaire. Six of the remaining thirty-six

nonrespondents were used in a follow-up study conducted over the telephone. Results showed that a varied selection of activities were available to the residents, although none were specifically designed for the terminal residents. The respondents felt that their services could benefit the terminally ill in the remaining time they have. Furthermore, the Activity Coordinators felt that they could make dying an easier process to accept by getting the dying residents to participate in recreation activities. Group interaction was encouraged between the terminal and non-terminal residents, as well as among the terminal residents themselves. The responses were slightly in favor of allowing the terminal resident to be alone when he or she chooses to be that way. Respondents determined that recreational activities could help the dying residents to feel useful and needed. In regard to the person who conducts the recreation program, Activity Director and Activity Coordinator were listed fifteen and twelve times respectively as their official title. Approximately one hundred and fifty-two residents were the average number of persons served by the persons conducting the recreation program. The average respondent had been employed by the agency for three years and four months. For the level of education attained by the respondents, a high school diploma received the most responses with thirteen. Regarding the college graduates, only one-third had majored in recreation. Approximately two out of three had participated in workshops about the dying patient or taken Death Education courses.

Conclusions

1. The responses illustrated that participation in recreation activities can help in offsetting the problems faced by the dying person. Particular problems that can possibly be aided by recreation are loneliness, depersonalization, depression, and the feeling of being a burden to others.

2. Participation in recreation activities can help the terminal resident to continue to feel his or her life has not already ended. Group interaction and support can help contribute to his positive feeling.

3. The vast majority of Activity Coordinators do attempt to serve the terminal residents and become a supportive agent for them. There is no attempt to single them out as being different from the non-terminal residents, yet there is concern for the special problems they may have to face.

4. The Activity Coordinators did not force the terminal residents to participate but did encourage them to do so. This granted the residents the freedom to make a choice, which would contribute to allowing the resident to continue to feel like he or she is still alive and able to make decisions.

Recommendations

1. Additional research on the benefits of participation by the terminally ill in recreation activities needs to be conducted. Future studies should attempt to determine what activities best meet the needs

of the terminal residents. Specifically designed activities for serving the needs of the dying should be developed.

2. Because of the probability that death will occur often in these nursing homes, the Activity Coordinator needs to be educated about the process of dying, cultural mores, and family dynamics.

3. In nursing homes where this has not already been accomplished, the Activity Coordinator needs to become a part of the treatment team so that the physical, social, and emotional needs of the dying person can be met by the team.

CHAPTER VI

EPILOGUE

A volunteer at a local nursing home who knew about my interest concerning the terminally ill told me about the following incident. Her assignment that afternoon was to visit several residents' rooms and to have a social conversation with each person on a one-to-one basis. During each of the conversations, the talk was generally about such topics as the resident's family, weather, coming events, and so forth. However, one resident decided she wanted to discuss her terminal illness, and consequently the fact that she was dying, with this volunteer.

A social worker had told the resident that she had the terminal illness. She resented the fact that her doctor had not informed her about the situation and also that the social worker had told her such dreaded news. She felt like there was no one to talk with about her illness, therefore, she kept it to herself. When the recreation volunteer approached her that day, she decided to disclose her innermost feelings about the whole situation. She felt that no one had the time to listen to her and perhaps even if they did she might remain quiet about the subject. The resident did not care to hear medical jargon or any professional language—she just wanted to discuss her feelings. She felt she could possibly do this while having a conversation with this particular volunteer.

Why had she chosen this volunteer? In fact, what made her ready to discuss her true feelings at all? Perhaps as the literature review revealed, terminally ill persons need to talk in order to cope with the emotional aspects of the disease. The reason she chose this volunteer will never be known, yet we can make some guesses as to why she chose this one. The volunteer could easily have been viewed as non-medical and non-institutional. There had been happy occasions while participating in recreational activities at the nursing home so perhaps this also led to her decision to talk to this volunteer.

The primary importance of the incident was that a therapeutic recreator, even though a volunteer at the time, was able to help a person in a true time of need. A dying person was able to express her innermost feelings about a very personal situation. In the future, perhaps, more therapeutic recreators will be able to aid the terminally ill with the emotional aspects of their illnesses.

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APPENDICES

APPENDIX A

COVER LETTER AND QUESTIONNAIRE

1914 Andy Holt Boulevard
University of Tennessee
Knoxville, Tennessee 37916
July 5, 1981

Dear Activity Coordinator:

I am conducting a research study which investigates the status of recreation services in relation to the terminally ill in Skilled Nursing Homes throughout Tennessee. The purpose of the study is to determine how the terminally ill population is being served at these facilities.

The only task that is required of you is to take approximately thirty minutes to answer the enclosed questionnaire. After you complete it, please return it in the enclosed stamped, self-addressed envelope by July 15, 1981.

Return of the questionnaire will express your consent for the information to be used in the final results. No names of agencies or individuals will be used. The questionnaires have been numerically coded in order to aid the response rate.

Therefore, if you could please fill out the questionnaire I would appreciate it. If you would like a copy of the summarized results, include your address at the end of the questionnaire or in a separate letter, whichever you prefer.

Thank you for your time and cooperation.

Sincerely,

Timothy James McBride
Graduate Teaching Assistant

Number _____

STATUS OF RECREATION SERVICES TO THE TERMINALLY ILL
QUESTIONNAIRE

lease answer the following questions and return in the enclosed nvelope. The majority of the questions require only a short answer, uch as yes/no or checking the appropriate blank. Some questions equire a longer answer with more insight. Your cooperation in this tudy is greatly appreciated.

ROGRAM INFORMATION

1. Does your recreation or activity program serve all of the residents of your facility? Yes_____ No_____

2. What types of activities are provided for the residents in your facility? Check all that apply.

Arts and Crafts	_____
Music and Singing	_____
Entertainment	_____
Outings	_____
Games	_____
Special Events	_____
Exercise Programs	_____
Individual Counseling	_____
Other (Specify)	_____
	_____
	_____
	_____

3. Do you use volunteers in your program? Yes_____ No_____

4. Excluding volunteers, how large is the staff of your recreation program?_____

ERMINAL PATIENT INFORMATION

5. Are you informed if a resident has a terminal condition? (incurable disease and/or limited life expectancy) Yes_____ No_____

6. Do the majority of the terminally ill residents take part in your program on a voluntary basis? Yes_____ No_____

7. Are they encouraged to take part in recreation activities? Yes_____ No_____

8. Have you ever been reluctant to serve these residents because of their conditions? Yes_____ No_____

9. In your opinion, how do your services play a role in the quality of their remaining time? _____
_____
_____
_____

10. Have you ever discussed the topic of death with any of these residents? Yes_____ No_____

    (a) Do you discuss it with a majority of them? Yes_____ No_____
    (b) Do you have individual counseling sessions with them where topics besides death are discussed? Yes_____ No_____

11. Do you encourage group interaction among the terminal residents? Yes_____ No_____

12. Do you encourage interaction among the terminal and non-terminal residents? Yes_____ No_____

13. During these interactions, do the residents discuss their conditions? Yes_____ No_____

14. What special activities in your program are specifically designed for these residents? _____
_____
_____

15. Have you ever had to tell a resident that he or she had a terminal condition? Yes_____ No_____

    Did you think it was your responsibility? Yes_____ No_____

16. Should these residents ever be left alone instead of participating with others? Yes_____ No_____

17. How can recreational activities make dying an easier process to accept for the terminally ill? _____
_____
_____
_____
_____
_____

18. Please rank the items below in regard to how recreational activities can help the terminal residents with these specific areas. Number 1 will be the highest, number 2 second, and so forth.

Social Relationships _____
Feeling Useful or Needed _____
Satisfied with Life _____
Resisting Depression _____

GENERAL INFORMATION

19. What is your official title? _____

20. How many years have you been employed by this particular agency?

_____

21. How many residents is your facility capable of handling?

_____

22. Please check the highest degree you have received. Place an asterisk in the appropriate blank if you are currently working on a higher one.

High School Diploma _____
Two Year College _____
Four Year College _____
Master's Degree _____
Other (Specify) _____

23. If you have received a college degree, was it in recreation?
Yes_____ No_____

24. Have you ever taken any courses in death education or participated in workshops under this topic? Yes_____ No_____

APPENDIX B

HUMAN SUBJECTS FORM

FORM B

CRP#_____

Date Received_____

THE UNIVERSITY OF TENNESSEE, KNOXVILLE

Application for Review of Research Involving Human Subjects (In accordance with general institutional assurance dated July 15, 1975, as amended November 25, 1975)

I. Identification of Project: Thesis Date: June 25, 1981
Project Director: Dr. Martha Peters
Co-Director: Timothy James McBride
Title of Project: THE STATUS OF THERAPEUTIC RECREATION SERVICES FOR THE TERMINALLY ILL IN TENNESSEE SKILLED NURSING HOMES
Department: Recreation
Estimated Completion Date: August 1, 1981

II. Objectives of Project: To determine the extent of therapeutic recreation services for the terminally ill in Skilled Nursing Homes located in Tennessee. Furthermore, to ascertain whether therapeutic recreation can improve the quality of life for the terminally ill in regards to (1) social relationships, (2) productivity, (3) life satisfaction, and (4) ability to resist depression.

III. Description of Subjects: Activity Coordinators from sixty-one Skilled Nursing Homes in Tennessee will be used in a census survey to acquire the necessary information. Activity Coordinators were chosen as subjects because therapeutic recreation is their responsibility and Skilled Nursing Homes are being used to define the population since extensive medical services are provided for the residents at these facilities.

IV. Method of Procedure: Information will be derived from a questionnaire designed by the investigator for this particular study which will be sent to each Activity Coordinator.

V. Protection Measures: No names will be stated as to their personal responses to the questionnaire instrument and data will be reported in group figures only.

VI. Method of Obtaining "Informed Consent" from Subjects: Consent will be discussed in the cover letter which will be sent to each Activity Coordinator along with the questionnaire. Consent will be expressed by the return of the questionnaire by the participant.

VII. Responsibility of Project Director:

By compliance with the policies established by the University Committee of Research Participation, the Project Director subscribes to the broad principles stated in "The Declaration of Helsinki" and standards of professional ethics in all research, development and related activities involving human subjects under the auspices of The University of Tennessee, Knoxville.

a. When appropriate, Form DHEW 596 will be completed and returned to the Office of the Vice Chancellor for Graduate Studies and Research, 404 Andy Holt Tower.
b. Approval will be obtained from the University Committee prior to instituting any change in project protocol.
c. Development of any unexpected risks will be reported to the University Committee.
d. Signed consent statements will be kept for the duration of the project and for at least three years thereafter.
e. A Status report (Form D)4 will be submitted at 12 month intervals, or as requested, attesting to the current status of the project.

Signature:

Project Director_____

Date_____

VIII. Departmental Review:

COMMENTS/RECOMMENDATIONS:

The application described above has been subjected to departmental review and has been approved.

Signatures:

Department Head_____Date_____

Chairman, Departmental Committee_____Date_____

APPENDIX C

LIST OF TENNESSEE SKILLED NURSING HOMES

LIST OF TENNESSEE SKILLED NURSING HOMES

1. Alexian Brothers Rest Home (Signal Mountain)
2. Anderson County Health Care Center (Clinton)
3. Applewood Nursing Home, Inc. (Franklin)
4. Asbury Acres Health Center (Maryville)
5. Athens Convalescent and Nursing Center (Athens)
6. Brakebill Nursing Homes (Knoxville)
7. Brandywood (Gallatin)
8. Bradley County Nursing Home (Cleveland)
9. Claiborne County Nursing Home (Tazewell)
10. Colonial Hill Nursing Home (Johnson City)
11. Columbia Nursing Facility (Columbia)
12. Cookeville Health Care Center (Cookeville)
13. Elm Nursing Home (Lawrenceburg)
14. Fairhaven Corporation (Pulaski)
15. General Care Convalescent Center of Clarksville (Clarksville)
16. Green Valley Haven, Inc. (Dickson)
17. Hamilton County Nursing Home (Chattanooga)
18. Hillcrest-Beverly (Knoxville)
19. Hillcrest Medical Institute West (Knoxville)
20. Hillhaven Convalescent Center (Madison)
21. Hillview Haven (Columbia)
22. Imperial Manor Nursing Home (Madison)
23. Jackson Specialty Hospital (Jackson)
24. Knoxville Convalescent and Nursing Home, Inc. (Knoxville)
25. Knoxville Health Care Center, Ltd. (Knoxville)
26. LaFollette Community Nursing Home (LaFollette)
27. Masters Health Care Center (Algood)
28. McKendree Manor (Hermitage)
29. McMinnville Health Care Center (McMinnville)
30. Memphis Health Care Center (Memphis)
31. Quality Care Nursing Center (Lebanon)
32. Ridgewood Health Care Center, Inc. (Milan)
33. Merihill Nursing Home, Inc. (Lewisburg)
34. Middle Tennessee Mental Health Institute (Nashville)
35. The Allen Morgan Nursing Center (Memphis)
36. Murfreesboro Nursing Facility (Murfreesboro)
37. Nashville Health Care Center (Nashville)
38. Nashville Metropolitan Bordeaux Hospital (Nashville)
39. Oakville Health Care Center (Memphis)
40. Oak Ridge Health Care Center, Inc. (Oak Ridge)
41. Oakwood Hall (Lewisburg)
42. Parkwood-Chattanooga Convalescent and Nursing Home (Chattanooga)
43. Rockwood Health Care Center (Rockwood)
44. Rosewood Nursing Center (Memphis)
45. Robertson County Health Care Center (Springfield)
46. Reelfort Manor Nursing Home (Diptonville)

47. St. Peter Villa (Memphis)
48. Sequatchie Health Care Center (Dunlap)
49. Sevier County Nursing Home (Sevierville)
50. Sevier County Health Care Center (Sevierville)
51. Shannondale Health Care Center (Knoxville)
52. Somerville Health Care Center (Somerville)
53. Springfield Health Care Center (Springfield)
54. Sparta Health Care Center (Sparta)
55. St. Barnabus Nursing Home, Inc. (Chattanooga)
56. Sunny Point Nursing Home, Inc. (Smithville)
57. Trevecca Health Care Center (Nashville)
58. Unicoi County Nursing Home (Erwin)
59. University Nursing Home (Nashville)
60. Wilcox Hall (Kingsport)
61. Union City Health Care Center (Union City)

VITA

Timothy James McBride was born in Morehead City, North Carolina, on November 22, 1957. He attended elementary schools in that city and was graduated from West Carteret High School in June 1976. The following August he entered The University of North Carolina, Chapel Hill, and in May 1980 he received a Bachelor of Arts degree in Recreation Administration. In the fall of 1980 he accepted a teaching assistantship at The University of Tennessee, Knoxville, and began study toward a Master of Science degree. This degree was awarded in August 1981.

His interest in service to the terminally ill was due to the death of his father at an early age from a brain tumor and his mother's battle against cancer during his collegiate years.

He is married to the former Deborah Springs of Monroe, North Carolina, who was also a recipient of a Master's degree from The University of Tennessee, Knoxville.