FACTORS IMPACTING DEATH ANXIETY

KATHERINE M. SCALLY

FACTORS IMPACTING DEATH ANXIETY

An Abstract

Presented to the

Graduate and Research Council of

Austin Peay State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

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by

Katherine M. Scally

April 1992

ABSTRACT

The objectives of this study were two-fold: to determine if women involved in home health and hospice would report higher death anxiety than female university students, and to assess if those who reported higher death anxiety scores also reported higher death involvement.

The results indicated that the health care providers did have significantly higher death involvement scores than the students. However, there was no significant difference between the two groups' death anxiety score, and a significant relationship was not found between death anxiety scores and death involvement scores.

Future research could be valuable to determine if other factors effect death anxiety and the importance of the relationship of death anxiety to death involvement.

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To Graduate and Research Council

I am submitting herewith a Thesis written by Katherine M. Scally entitled "Factors Impacting Death Anxiety." I have examined the final copy of this paper for form and content and I recommend that it be accepted in partial fulfillment of the requirements for the degree Master of Science with a major in Guidance and Counseling.

Major Professor

Second Committee Member

Third Committee Member

Accepted for the
Graduate Council:

Dean of the Graduate School

ACKNOWLEDGEMENTS

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CHAPTER 1

Introduction

Death is multidimensional and varies for each individual. Individuals' concepts of death change through out their lives. According to Feifel (1969) the field of psychology did not take an interest in death's relevance toward individuals' lives until it felt the need to be independent of philosophy and ethics, and when the over all tone of death became less sacred. Feifel (1969) considers death to remain a formidable source of anxiety for most, because of the complexity of the meaning of death. As late as 1957, Alexander, Colley, and Adlerstein considered psychology's ignorance of death and the anxiety produced by the contemplation of death to be due to the methods psychology used to gather data. During World War II, psychologists were motivated to look at death due to the war, the Holocaust, and changing social problems. The most compelling factor that forced not only psychology, but humanity to contemplate death was the production and consequent release of the atomic bomb. This factor presented mass destruction which could eradicate life of all forms (Feifel, 1990).

Feifel and Branscomb (1973), state that the problem of death is essentially the fear of death. They go on to say

that anxieties about death are the cause of various psychological symptoms and disturbances. Until more recent times, research to prove this theory largely consisted of case studies and theoretical deduction.

Definition of Terms

In order to make sense of death and death anxiety these terms must be operationally defined. It would be helpful to determine if death anxiety produces any variables which directly effect change in individuals' conceptualization of death. As Feifel (1969) states, only by understanding the concept of death in oneself can one truly understand oneself.

Death anxiety is sometimes defined as simply the fear of death (Hoelter, 1979; Conte, Weiner, & Plutchik, 1982). Martin (1982-83) used Templer's working definition, "an unpleasant emotional state precipitated by contemplation of one's own death" (p. 54). Death anxiety is a fundamental anxiety that is multidimensional in character (Lonetto & Templer, 1986). These definitions imply that death anxiety is not a fixed state, and thus is sensitive to environmental changes and therapeutic intervention (Murray, 1974). The definition of death anxiety which will be used for the purpose of this research incorporates all of these principles. Death anxiety is a transitory emotional state which occurs in response to particular death experiences. This state includes feelings of tension and apprehension along

with increased autonomic nervous system activity (Johansson & Lally, 1990-91).

Purpose of Study

Homan (1990) explored the concept of health professionals frequent exposure to death by reviewing the literature and referring to a case study. He concluded that exposure increases vulnerability to severe anxiety. Those who must deal with the reality of the finite nature of life feel more threatened by death.

This study compared the death anxiety of health care providers to university students in order to assess if health care providers would have higher death anxiety. Also, the study looked at reported death involvement to determine if high death anxiety was associated with high death involvement.

CHAPTER 2

Review of Related Literature

The results of research on death anxiety have been inconsistent (Oranchak & Smith, 1988-89; Iammarino, 1975; Dattel & Neimeyer, 1990; Frank & Durlak, 1990; Nelson, 1979-80; & Stevens, Cooper, & Thomas, 1980). In these studies, several different variables have been studied to assess their relationship to death anxiety. Oranchak and Smith (1988-89) found a positive correlation between Death Anxiety Scale (DAS) scores obtained prior to a death stimulus of watching videotaped auto accidents and overall changes in levels of depression and general anxiety as measured with a Mood Scale they devised for the study. They suggested that a real-life death stimuli may make individuals more vulnerable to depression or anxiety. Iammarino (1975) researched the relationship between DAS scores to religion, sex, and sibling placement in the family. He found the mean score for females to be higher and no significant relationship to religion or place in the family. He found the mean score for females to be higher and no significant relationship to religion or placement in the family. Dattel and Neimeyer (1990) attempted to prove the sex differences on DAS scores were due to emotional expressiveness. However, they were unable to support their

hypothesis and found sex differences in death attitudes to be real. Franke and Durlak (1990) looked at life factors such as: death of a significant other, religion, near-death experience, formal and informal education, and work experience. They found that the life factor the participant felt was the most important played the most significant role in their feelings about death. They could not prove any one factor was significantly related to death attitudes. Nelson (1979-80) predicted that death anxiety varies directly with social status and was able to support his hypothesis with his research. Stevens, Cooper, and Thomas (1980) studied age norms of the DAS and found that people over sixty had a lower fear of death than the remainder of their adult sample.

The only consistency has been in the area of mental health. White and Handal (1990-91) reported high death anxiety females were more distressed and less satisfied with life. Frazier and Foss-Goodman (1989-90) also found high death anxiety correlated with increased emotionality.

A small amount of research has looked at life events that might influence death anxiety. Ursano and McCarroll (1990) assessed the nature of traumatic stressors, such as the psychological effects of viewing dead bodies and body parts. They hypothesized that an individual's involvement with the deceased prior to death would increase distress and anxiety after the death. Franke and Durlak (1990)

postulated that current attitudes toward death are influenced by modeling effects from significant relationships. Hoelter and Hoelter (1980-81) found that exposure to the dying process positively correlated with fear of dying and fear of premature death.

In order to discern these views on exposure to death, some research has been conducted using health professionals and those whose professions deal with death and dying. The research has been inconclusive concerning the connection between job title and death anxiety. Pepitone-Arreola-Rockwell (1981) compared the death anxiety of psychiatrists, psychologists, suicidologists, and funeral directors, and found no significant differences among the professions, even though psychologists had the highest scores and funeral directors had the lowest scores. Hare and Pratt (1989) studies nurses' fear of death and comfort level with dying patients. Their results showed that nurses with more exposure to patients with a poor prognosis were more comfortable working with them. This study also revealed that the professional nurse was more comfortable with patients with poor prognosis than were paraprofessionals. Martin (1982-83) found a significant inverse relationship between social desirability and "death anxiety denial." Johnson (1980) assessed death anxiety of rehabilitation counselors and clients. She found the DAS scores to be comparable to those of the general public and a

significant inverse age relationship for the clients; thus, the younger clients had higher DAS scores. Liberman, Handal, Napoli, and Austrin (1983-84) studies doctor-patient interactions concerning death anxiety in hopes of finding a communication style which could reduce doctors death anxiety and thus promote better patient relations. Their study did not produce any single significant method that accomplished this goal. From this information, the common denominator was that death anxiety was independent of profession.

In order to carry out the research on death anxiety, an appropriate tool must be used to measure death anxiety. Several tools have been used in death anxiety research, each instrument having varying degrees of reliability and validity (Klug & Boss, 1976; McMordie, 1979; Conte, et al., 1982; Hoelter, 1979; Templer, 1970). The tool which will be used in this study is the DAS developed by Templer (1970). This tool will be used to compare the death anxiety scores of a group of health care providers to those of a university student population, and also to assess involvement factors which may produce increased death anxiety.

Durlak (1982) suggests that the DAS may not be suitable because of the multidimensional aspect of death anxiety, and the single score obtained from the DAS. He cautions that the DAS has from three to five different

factors involved and that the multiple factorial component makes the single answer obtained uninterpretable.

However, several studies have demonstrated that the DAS is both valid and reliable (Levin, 1989-90; Templer & Lester, 1974; Templer & Ruff, 1971). Templer (1970) has shown a product-moment correlation coefficient of .83 for test-retest reliability. Kuder-Richardson Formula 20 demonstrated reasonable internal consistency with a coefficient of .76. In order to test for validity, Templer (1970) correlated the DAS with Boyar's Fear of Death Scale (FOD), a sequential word association task, and the Minnesota Multiphasic Personality Inventory (MMPI). He found significant correlation with the FOD and the sequential word association task. The correlation to the MMPI was variable due to the definition of anxiety being vague and multidimensional. The DAS did correlate with three of the conventional MMPI scales. The mean of normal scores range from 4.5 to 7.0 with a standard deviation of slightly greater than 3.0 (Pepitone-Arreola-Rockwell, 1981; White & Handal, 1990-91).

Hypothesis

Thus, the hypotheses for this study are as follows: 1. women involved in home health and hospice will report higher death anxiety scores than female university students, 2. women who report high death anxiety scores will also report high death involvement scores. Experience with

death and dying will be assessed by looking at self-reported involvement with a dying person, funeral attendance, and touching or handling of a dead body. Only women will participate in this study to control for any inconsistency in DAS scores due to gender. Lonetto and Templer (1986), Dattel and Neimeyer (1990), and Iammarino (1975) have all found significant differences between male and female DAS scores.

CHAPTER 3

Methodology

Subjects

A total of 56 subjects were used. The subjects consisted of 36 Austin Peay State University students and 20 Clarksville Memorial Hospital staff members. The subjects were recruited from undergraduate and graduate level psychology classes, and from the Clarksville Memorial Home Health and Hospice staff. All participants were volunteers and could be removed from the study at any time if they so desired. Subjects were required to sign a consent form and were informed of their rights (see Appendix A for the consent form).

Research Instruments

The DAS was used to determine the death anxiety score. The remaining three questions were written by the researcher to determine the subjects' recent experiences with death and dying in an attempt to prove the second hypothesis. This tool was titled the Death Involvement Scale (DIS). The questions were formulated after considering the postulations and hypotheses in the research by Holman (1990), and Ursano and McCarroll (1990) (see Appendix B for a sample questionnaire).

Procedure

The questionnaire was given to a group of health care providers from Clarksville Memorial Home Health and Hospice at their weekly organizational meeting. This group consisted of registered nurses, licensed practical nurses, home health aides, and social workers. The same questionnaire was also given to a group of female students from Austin Peay State University. The questionnaires were given in graduate and undergraduate psychology classes. The classes were chosen because of the instructors willingness to facilitate the research. Participants received no outside incentive from the researcher to participate. Prior to administration of the questionnaire, all participants were presented with their rights and signed the informed consent. The test was administered in groups and the researcher read the directions and answered any pertinent questions that the subjects might have had. After completion of the questionnaire the participants were told the research hypothesis and purpose of the study and the researcher answered any questions. Subjects were allowed to voice any feelings they may have encountered while participating in the study. The researcher then collected all tests for completion of analysis. Results will be made available to the subjects upon completion of the entire research project.

Method of Data Analysis

All questionnaires were initially scored for an overall death anxiety score (Templer, 1970). A t-test was used to compare death anxiety scores of the health care providers to those of the university students. This was used to determine if the health care providers' death anxiety scores were significantly higher than the university students'.

The second analysis was an f-test, a comparison between groups. All of the tests, from the health care providers and the student, were combined and then put into three groups depending on the death anxiety score. Those scoring greater than 7.0 were in the high group, those with a score between 4.5 and 7.0 were in the normal group, and those with a score below 4.5 were in the low group as indicated by Templer (1970). The three questions on the second half of the questionnaire were scored as follows: past month = 5, past six months = 4, past year = 3, past five years = 2, and never = 1. A total death involvement score was obtained by adding together the scores from the three questions. Using the f-test, a comparison between groups was done. Each group of death anxiety (high, medium, and low) was compared using the death involvement score.

Finally, a correlational study was used to see if any one of the three questions from the DIS was more

significant in indicating high death anxiety. This was done by comparing each question individually among the same question in each of the groups (high, medium, and low).

CHAPTER 4

Results

A t-test to compare the DAS scores of the home health and hospice staff to the university students proved not to be significant at $p<.05$ level. The mean score of the health care providers was 7.4 and 7.11 for the university students. Both of these average scores are only slightly above the average DAS score. Average death anxiety using the DAS is a range between 4.5 and 7.0 (see Table 1).

Table 1

Comparison of Difference of DAS Scores for Health Care Providers and Students

Status	Number of Subjects	Mean	F	p
Health Care Providers	20	7.40	.157	.693
Students	36	7.11		

A F-test was performed to look at the total DIS score and assess for significance to a high, medium, or low DAS score. Again, the results were not significant. A significant relationship between death involvement and death anxiety was not found at $p<.05$ level (see Table 2).

Table 2

Comparison of Total DIS Score to Rating of DAS Score

DAS Score	Number of Subjects	Mean	F	p
High (above 7.0)	26	9.12	.900	.413
Medium (4.5 - 7.0)	21	10.29		
Low (below 4.5)	9	9.00		

A correlational study was done to see if there was a significant relationship between any of the individual DIS questions and the DAS score or the rating of the DAS score as high, medium, or low. A negative correlation was found for all except one case, but the results were not significant at $p<.05$ level (see Table 3).

Table 3

Correlation of Each DIS Question to the DAS Scores

	DIS Question		
	#1	#2	#3
DAS	-.1566 (NS)	-.0161 (NS)	-.0555 (NS)
Rating of DAS	-.1377 (NS)	.0298 (NS)	-.0128 (NS)

#1 - When was your most recent involvement with someone dying?
#2 - When did you last attend a funeral?
#3 - When have you touched or handled a dead body?
NS - Non-significance

As was expected in the study, the health care providers had significantly higher DIS scores than the students. This premise was assumed on initiation of the study in order to test the hypotheses.

CHAPTER 5

Conclusions and Recommendations

The results of the research were unable to support the hypotheses. The health care providers did not report significantly higher DAS scores than those reported by the students. Those individuals from both groups with higher DAS scores did not show significantly higher DIS scores. There were no significant correlations between any of the death involvement questions and the reported death anxiety as measured by the DAS. However, the assumption that the health care providers would have more involvement with death and dying was shown to be significant through the DIS scores.

Limitations

There are several possibilities for these inconclusive results. One factor may be the small sample size. A replication of this study or a modified study using more subjects from multiple environments may prove to be very insightful. A variation of this study in a longitudinal form may also be useful to determine how individual views of death change over time and effect death anxiety and specifically the DAS score.

There are several other possibilities for the results

attained in this study. This study was carried out in a small segment of the population; thus, environmental factors and social customs for the area of Clarksville, Tennessee may have contributed to the findings. This area is particularly well known as the Bible Belt; religious beliefs may have influenced how this population views death and death anxiety. Family attitudes may also contribute to how people view death or deal with death anxiety. The acceptance of death may be influenced by family members' views.

As the Ursano and McCarroll (1990) article alluded to, the personal involvement may be a key factor. Although the literature gave a basis for the hypotheses, the emotional involvement with the person who is dying may play a more integral part in individual death anxiety. Involvement with a dying person may only be part of the cause for death anxiety. This approach could still look at death anxiety as a fundamental anxiety (Lonetto & Templer, 1986), but search into the dimension of the character of death anxiety.

One other flaw of the study may be the sole use of the DAS to measure death anxiety. Although this scale has proven validity and reliability (Levin, 1989-90; Templer & Lester, 1974; Templer & Ruff, 1971), a combination of tests may give a better indication of all dimensions of death anxiety.

Suggestions for Further Research and Practice

Murray (1974) stated that death anxiety was not a fixed entity and was sensitive to the environment and therapeutic intervention. Death anxiety may be changed through education as has been researched in a very small amount of research (Glass, 1990; Trent, Glass, & McGee, 1981; Bohart & Bergland, 1979). If research can find what causes increases in death anxiety or what leads to dysfunctional death anxiety, an education program could be initiated as a preventative measure.

The researcher's recommendation is for continued study of death anxiety to determine the variables which do influence high and low death anxiety. This research could then lead to appropriate measures of assisting individuals with high death anxiety find a means of better dealing with this particular type of anxiety.

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APPENDIX A

Informed Consent Statement

The purpose of this study is to investigate death anxiety. Your responses will be confidential. Your answers will remain anonymous and no one except for the investigators will see your responses. The demographic information will be used for purposes of analysis. Your participation is completely voluntary, and you are free to terminate your participation at any time without any penalty. There is no risk involved in this study.

The scope of the project will be explained fully upon completion of the study. Thank you for your cooperation.

I agree to participate in the present study being conducted by Katherine M. Scally under the supervision of Dr. Stuart B. Bonnington, in the department of Psychology at Austin Peay State University. I have been informed that there will be no discomforts or risks involved. The investigator has offered to answer any further inquiries I have regarding the procedures. I understand that I am free to terminate my participation at any time without penalty or prejudice and to have all data obtained from me withdrawn from the study and destroyed.

_____

Name (please print)

_____

Signature

_____

Date

APPENDIX B

****

This study is being conducted to investigate death anxiety. On the following pages are several questions concerning death anxiety and death. Please answer the questions as truthfully as you can. A full explanation will be given after all data has been collected. Thank you for your cooperation in this study.

****

1.	I am very much afraid to die.	T	F
2.	The thought of death seldom enters my mind.	T	F
3.	It doesn't make me nervous when people talk about death.	T	F
4.	I dread to think about having to have an operation.	T	F
5.	I am not at all afraid to die.	T	F
6.	I am not particularly afraid of getting cancer.	T	F
7.	The thought of death never bothers me.	T	F
8.	I am often distressed by the way time flies so very rapidly.	T	F
9.	I fear dying a painful death.	T	F
10.	The subject of life after death troubles me greatly.	T	F
11.	I am really scared of having a heart attack.	T	F
12.	I often think about how short life really is.	T	F
13.	I shudder when I hear people talking about a World War III.	T	F
14.	The sight of a dead body is horrifying to me.	T	F
15.	I feel that the future holds nothing for me to fear.	T	F

Death Involvement Scale

On question 1-3 please put an X next to the answer which is true for you. Feel free to explain your answers on the line following the question.

1. When was your most recent involvement with someone dying?

   within the past month _____

   within the past 6 months _____

   within the past year _____

   within the past 5 years _____

   never _____

---

2. When did you last attend a funeral?

   within the past month _____

   within the past 6 months _____

   within the past year _____

   within the past 5 years _____

   never _____

---

3. When have you touched or handled a dead body?

   within the past month _____

   within the past 6 months _____

   within the past year _____

   within the past 5 years _____

   never _____
