

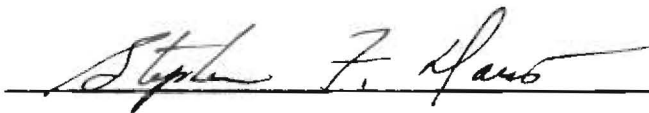
AN ABSTRACT OF THE THESIS OF

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Title: DEATH ANXIETY AND LEVEL OF SELF-ESTEEM IN THE ELDERLY

Abstract approved:



To date, a considerable amount of literature exists which speculates as to the death attitudes of older adults. A review of this research reveals much conflicting evidence and few consistent conclusions.

In an effort to reconcile inconsistencies in the literature, the present study sought to explore death anxiety in the elderly in two residential settings: apartment complexes for the aged and nursing homes. Attitudes toward death were measured using Templer's Death Anxiety Scale. A further purpose of the current study was to reexamine the relationship between death anxiety and level of self-esteem in older adults. The Texas Social Behavior Inventory-Form A was employed as an objective measurement of level of self-esteem.

The results of the study yielded a negative relationship between death anxiety and level of self-esteem which was discussed in terms of Frankl's "will to meaning" theory. Between-groups comparisons revealed less death anxiety and higher levels of self-esteem for those individuals living in nursing homes. Several possible explanations for this

finding were explored, including residents' dependency, cerebral deficits, socialization as preparation for death, denial, and Frankl's theory. The possible effects of sampling difficulties were also examined.

DEATH ANXIETY AND LEVEL OF SELF-ESTEEM
IN THE ELDERLY

A Thesis
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the Department of Psychology
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Finally, this manuscript is dedicated to Grandmother. During her life and her death, she served as a loving example of one who knows that life is quite meaningful and there is little to fear in death.

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Chapter 1

INTRODUCTION

The weariest and most loathed worldly life
That age, ache, penury, and imprisonment
Can lay on nature, is a paradise
To what we fear of death.

--Shakespeare, "Measure for Measure", III, I

Contemplation of one's death may be a universal concern that men have dealt with since, or even prior to, the time of Shakespeare. Although death may be a topic of concern, this society generally seems to encourage its members to avoid death. Even though death cannot ultimately be avoided, its reality is often altered or denied. Dead people are made to look as if they are only asleep and euphemisms are used when speaking of the dead. One has frequently heard the terms "passed on", "passed away", and "departed". This reluctance to put death into words may indicate that the fear of death is a human experience common to more than a few individuals. Indeed, Zilboorg (1943) goes so far as to state that, "no one is free of the fear of death" (p. 466).

Although the topic of death may generally be avoided by society, it has become quite popular and "almost chic" (Feifel, 1977, p. 4) as a topic for psychological research. To date, a considerable amount of literature exists which speculates on fear of death, death attitudes, death anxiety, and death concern and their relationships with a host of demographic and personality variables. A brief review of this

literature leads one to conclude, along with Nehrke, Bellucci, and Gabriel (1977), that "There is no dearth of equivocal data regarding . . . variables related to death anxiety" (p. 361).

A number of researchers (Berman & Hays, 1973; Iammarino, 1976; Koob & Davis, 1977; Lester, 1972; Ray & Najman, 1974; Selvey, 1973; Templer, Lester & Ruff, 1974; Templer, Ruff & Frank, 1971) found women to have a significantly greater fear of death. Others (Dickstein, 1972; Feifel & Branscomb, 1973; Kalish, 1963) found no relationship between sex and death anxiety. Bolduc (1972), Blake (1973), and Feifel and Branscomb (1973) found a relationship between age and death concern, while Kalish (1963), Templer, Ruff and Frank (1971), and Lester (1972) found no relationship. Some investigators (Patton & Freitag, 1977; Sadowski, Davis, Loftus-Vergari, 1979; Tolor & Reznikoff, 1967) concluded that locus of control can affect one's feelings about death, while others (Berman & Hays, 1973; Dickstein, 1972; Selvey, 1973) found opposing results. Dickstein (1972) and Neudfeldt and Holmes (1979) reported personality differences between people with high fear of death and those with low fear of death; Selvey's study (1973) did not uphold the hypothesis that death concerns are related to specific personality factors. As indicated by this brief overview, studies of death and related variables have resulted in a wide range of conflicting conclusions.

In past generations, infectious diseases and epidemics took many lives. Death in infancy and early childhood occurred quite often, and families frequently lost a family member at an early age. Today, with improvements in medicine, sanitation, and childcare, some illnesses have almost been eradicated, and there has been a definite decrease in the

number of premature fatalities due to disease (Kubler-Ross, 1969). This decrease in premature death has resulted in an increased life expectancy, and, therefore, an ever growing number of people live long enough to grow old. Brotman (cited in Brody, 1977) reports that of all people in the United States, one person in every ten is sixty-five or older, and, of those Americans who die each year, more than six in ten are from the sixty-five or older age group.

Death certainly occurs more frequently in the sixty-five or older age division. Consequently, the death attitudes of older individuals are of great interest, and a number of questions concerning these attitudes could be raised. How much does the older person think about death? Does death concern increase in later years? Does the older person fear death or look forward to it?

Studies on the topic of death attitudes in the elderly can roughly be divided into two categories. Those exploring death attitudes as they relate to personality variables and those exploring death attitudes as they relate to demographic variables. The studies that suggest demographic variables affect attitudes about death will be examined first. Demographic variables include a variety of factors such as age, sex, health, living arrangements, religiosity, and occupation.

Feifel (1956) investigated the conscious death attitudes of older persons who lived in a veterans hospital. The subjects consisted of 40 white, male veterans of World War I who were physically ill and unable to support themselves. The mean age of the group was 67, the mean educational level was 7.5 years, and the mean IQ was 99.1; none had ever been diagnosed as mentally ill. Data were collected by individually

interviewing subjects. Agreement on judges scores of response classification ranged from 86 to 94 percent indicating a good degree of consistency.

Results revealed two dominant outlooks on the meaning of death with about 40 percent of the subjects responding in each category. The first visualizes death as "the dissolution of bodily life and the doorway to new life" or "the beginning of a new existence" (p. 128). The second outlook views death with resignation as the "end of everything" or "you're through" (p. 128). Feifel (1956) cautioned his readers to remember that his interviewing technique resulted in data that pertained "to conscious and public attitudes more than they do to deeper layers of the personality" (p. 130). Further cautions include remembering the sample size was small and the sample, which consisted of institutionalized males with physical ailments and/or financial limitations, were not representative of the aged population.

Roberts, Kimsey, Logan and Shaw (1970) presented a paper that proposed to evaluate death attitudes of a nursing home population by use of an interview form that included self-rating items, sentence completion tasks, and open-ended questions. The sample was comprised of 57 persons, 17 men and 40 women. Residents who were younger than 60, comatose, grossly confused, or terminally ill were excluded from the study. When asked about their fear of death, only 16 percent reported any fear at all. To the stimulus word "death", 11 subjects gave a response that expressed positive feelings. However, the majority spoke in terms of the inevitability of death without either positive or negative feelings. The authors (Roberts et al., 1970) suggested that this absence of feeling might have been due to, at least in part, three factors. First

of all, there is "the possibility of massive denial" (p. 119). Secondly, the subjects could have some cerebral deficits which could mean they did not always understand the questions they were asked. Finally, in the light of the respondents' dependent living conditions, they might have been saying what they thought the interviewer wanted to hear. Controls, such as tests of organicity or an added group of respondents from independent living situations, might have provided a basis for comparison or reduced the impact of these factors. Roberts, et al. (1970) concluded that their study lends some support to the hypothesis that "the aged do come to grips with death and dying and do not see them (death and dying) in entirely negative terms" (p. 119).

Shrut (1958) studied subjects in two specific modes of institutional residences. Residents from the Home for the Aged and Infirm Hebrews of New York were compared with a similar population from the same institution's Central House. The basic difference in the two modes of residence was that the former lived in apartments much like other older people in the community while the latter lived in a much more traditional institutional setting in which they were more dependent on the institution per se.

Shrut (1958) evaluated attitudes toward death by means of a psychological test battery. The two equatable groups consisted of 30 ambulatory aged, currently unmarried, white females who lived in the two already specified settings. It was hypothesized that those subjects living under conditions approximating their previous mode of residence in the community would reflect a less apprehensive attitude toward death and generally be better adjusted to life around them. The results indicated that those living more independently showed significantly less

fear of death and less preoccupation with it. They made more realistic demands of their health, whereas the institutionalized subjects overestimated their good health perhaps as a compensatory mechanism to overcome anxiety in the health area.

Myska and Pasework (1978) theorized that since many perceive homes for the aged as locations for dying, it would seem valuable to differentiate how persons in institutionalized homes for the aged view death in comparison to those living independently in their homes. The sample included 40 institutionalized and 40 noninstitutionalized rural aged, ranging from 61 to 97 years of age, who reported themselves to be in fairly good health. Subjects were asked to complete a revised version of Middleton's questionnaire, Templer's Death Anxiety Scale, and seven added items. The results suggested no differences in attitude toward death associated with mode of residence and a generally realistic attitude toward death. Findings may have particular interest because the institutionalized group was significantly older than the noninstitutionalized sample.

In their 1972 study, Kimsey, Roberts, and Logan surveyed the attitudes toward death and dying of 57 members of nursing homes (institutionalized) and 123 members of a senior activity center (noninstitutionalized). The institutionalized subjects averaged 78 years of age, were two-thirds female, mostly white, widowed, and Christian. The noninstitutionalized subjects averaged 71.6 years of age, were three-fourths female and three-fifths were without mates; they were also healthier and more active than the other group. Neither group expressed great fear of death on an attitude questionnaire, but Thematic Apperception Stories of the institutionalized group demonstrated that 55 percent of them used

denial significantly more than the 16 percent of the noninstitutionalized group. The latter group also expressed more affect. Kimsey et al. (1972) concluded that aging as such does not result in fear of death, but sickness and dependency which compel an individual to face the dying process might cause denial and constriction of affect.

A research study from the Netherlands (Matse, 1975) investigated the reactions toward death among non-nursing staff working in residential homes for the aged. Data were collected by using a questionnaire that was filled in by 78 staff members who worked in a variety of residential homes. The questionnaire included three topics: the management of death in the residential homes, the reactions of the staff towards death, and the reactions of the residents toward death as perceived by the staff. The scope of this paper was concerned with the discussion of only the latter topic.

For the study (Matse, 1975), staff members were asked whether residents were noticeably affected by the death of another resident. Thirty-eight responded yes, eight responded no, and 25 gave rather complex responses that usually included an explanation. For example, it was observed that the affect of a resident's death was dependent upon the relationship people had with the resident, the personality of the resident, or on the circumstances of the death. Matse came to the conclusion that the reactions of the aged to the death of a resident are probably "very divergent" (p. 31) and there is not one dominant mode of expressing the feelings connected with the death of a resident. It should be remembered that data for this study was based on the way residents related to the death of a fellow resident as reported by staff

workers. The possibility exists that staff perceptions differ from residents' actual attitudes and feelings.

In a 1980 study, Sanders, Poole and Rivero investigated death anxiety among 31 black and 31 white elderly adults. The subjects, who were between the ages of 60 and 87, were randomly selected from a rural area of Mississippi. Each individual was asked to respond verbally to the items on the Templer's Death Anxiety Scale. No significant differences were found between the scores of black and white males or between the scores of black and white females. However, over-all male and female blacks had a significantly higher mean score than whites, and females, black and white, had a significantly higher mean score than males. Sanders et al. (1980) concluded by suggesting a need for further research in this area. It should be noted that the relatively small sample size of this study was limited to a specific location that is not necessarily representative of the entire population of aged persons.

Swenson (1959) described the purpose of his studies as "an attempt to obtain an objective measure of the death attitudes of a reasonably good cross-section of aged individuals" (p. 400). The procedure for accomplishing this task involved creating a 35-item check list of descriptive statements about death. Items on the check list fell in the following three categories: first, positive or forward looking attitudes; second, an evasive attitude toward death; third, a fearful death attitude. This Death Attitude Check List, along with a check list of interests, hobbies, and activities, was presented to 210 individuals, all over the age of 60 years and from three separate sources including homes for the aged, golden age clubs, and several industries or companies. Death attitude responses were assigned either a positive,

evasive, or fearful group and then the groups were analyzed to determine the relationship between attitude toward death and each of the following variables: age, physical condition, living arrangement, and religiosity.

Results revealed that 45 percent had a positive or forward-looking attitude toward death while distinctly evasive responses were given by 44 percent of the sample. Only 10 percent admitted to having any fear of the death experience. Swenson found a significant relationship between religiosity and death attitude with those who engaged in frequent religious activity either evasive or fearful of the death experience.

Swenson (1959, 1961) found a second relationship with regard to the living conditions of the subjects and their death attitudes. The evidence suggested that a fear of death was found most commonly in those individuals who lived alone rather than those who lived with relatives or in homes for the aged. Slight relationships between death feelings and level of education and conditions of health were also discovered. It seemed that educated subjects faced the problem of death by either looking forward to it or fearing it while less educated subjects tended to avoid the issue. In regard to health, the evidence suggested that those with good health were evasive while those with poor health tended to have a positive attitude. The author (Swenson, 1959, 1961) found no relationship between death attitude and sex, age, occupational status, or choice of income. In evaluation of this study, it should be remembered that neither reliability nor validity was reported for the Death Attitude Check List.

Marshall's research (1975) attempted to document the theory that impending death can be, and often is, accepted as a matter-of-fact

aspect of individual human lives. Marshall argued that one should view death as being "legitimate" or, in other words, "impending death can be seen as an appropriate end to one's biography" (p. 1143). Marshall further contended that congregate living facilities can provide optimal settings for socialization for impending death with such socialization basically being accomplished "in a conversational process" (p. 1141).

Data were collected by extensive field research and intensive interviewing techniques. Some 400 residents of the Retirement Village of Glen Brae, which has a campus-like setting, served as subjects. The mean age of the sample was 80, with a range of 64 to 96 years; they were almost exclusively Protestant, 78 percent were female, and four-fifths had more than a high school education. Marshall (1975) concluded that socialization in a retirement village can help one prepare for death. In evaluation of Marshall's study, it should be remembered that there were virtually no controls, the sample was not representative of the general population and it seems possible that some Rosenthal's bias was present.

Bascue's study (1973) explored the assertion that subjective time and the meaning of death are related in elderly people. The following inventories were used for the collection of data: the Death Anxiety Scale; the Josey Scale of Religious Development; the Time Reference Inventory; and the Time Attitude Scale. Respondents were 88 white, female volunteers, all over the age of 62, who were living in one of two residential facilities.

Results of the study supported the hypothesis and were also consistent with the belief that elderly people turn away from the future as a way of avoiding death anxiety. Bascue further concluded that

Information on an individual's time orientation and time attitudes can be useful in predicting death anxiety. It was also suggested that variables such as length of residing at their facility, income, and education do not relate to the fear of death in older people.

In a study of elderly and late middle-aged individuals, Templer (1971) examined the correlation between depression and death anxiety as well as the relationship between death anxiety and health. The instruments employed were the Death Anxiety Scale; the Depression Scale of the Minnesota Multiphasic Personality Inventory and the Cornell Medical Index, the latter for the purpose of health assessment. These three instruments were sent to 250 persons whose names were randomly obtained from a list of retired employees of the Western Union Telegraph Company. The questionnaires were anonymously completed and returned by 75 persons ranging in age from 51 to 92 years of age. The mean age of the group was 69.7 years, the mean education was 12 years, and 46 subjects were male while 29 were female.

As predicted, there was a positive correlation between death anxiety and depression. Significant correlations were also found between the Death Anxiety Scale and the psychiatric and total scores of the Cornell Medical Index. Templer (1971) maintained that "this was to be expected as previous research has demonstrated that both the Death Anxiety Scale and the Cornell Medical Index correlate substantially with indicators of general anxiety or maladjustment" (p. 522). Death anxiety, it was concluded, is usually "Related more to degree of personality adjustment and subjective state of well-being than to reality based factors" (p. 522).

Nehrke, Bellucci, and Gabriel (1977) attempted to collect data that would substantiate Erikson's theory of the final developmental stage of ego integrity versus despair. Erikson hypothesized that an individual with high internal control and high life satisfaction will have a low death anxiety.

Nehrke et al. (1977) also hoped to clarify some of the conflicting relationships regarding correlates of death anxiety. Subjects were 120 residents of nursing homes, public housing units, and the general community (40 from each) who were all over 60 years of age. Although each residence group included an equal number of males and females, they differed considerably from each other in terms of age and educational level. Each subject was asked to complete the following questionnaires: Rotter's Locus of Reinforcement Control Scale; Life Satisfaction Index A; Boyar's Fear of Death Scale; and Templer's Death Anxiety Scale.

Due to the significant difference among the three residence samples on the variables of age and education, the data were analyzed using both analysis of variance and covariance techniques. Erikson's hypothesis was supported only by the public housing data. The remaining data supported a conflicting hypothesis based on the work of Monsoff and Sterns (cited in Nehrke et al., 1977) which suggests that elderly persons expressing low levels of general anxiety associated with internal control and high life satisfaction would evidence the greatest fear of death.

Nehrke et al. (1977) concluded that "the use of life satisfaction, locus of control, and death anxiety as a complex criterion indexing the successful or unsuccessful resolution of the final psychosocial crisis does not appear to be justified unless other variables are brought to

bear" (p. 163). It was specifically suggested that along with living arrangement, the variables of health status and independence be included in future studies.

One hundred acute psychiatric patients who were admitted consecutively to the psychiatric wards of San Francisco General Hospital were examined in Christ's study (1961). All of the patients were 60 years or older and none had required psychiatric treatment prior to the age of 60. Of the 100 patients, 62 were able to respond and give relevant answers to most of the questions. The data were collected in interviews with each subject in which they were questioned on their death attitudes and given a word association test that included some "death words" (p. 56).

Responses were rated so that each subject could be given a fear of death score. Scores were investigated in terms of their relationship to the following variables: health, age, religiosity, religion, schooling, and sex. Of the six variables, only the first proved to be significantly related to death; those patients with only better health were less afraid of death than those with poorer health. Eighty-seven percent of the sample stated that they never had talked about death or dying before. Christ (1961) speculated that at least some of the psychiatric symptoms, which included fear of being poisoned, killed, or thrown out of their homes, and other delusions, may have been symptoms of denial of death.

During a two hour social history interview that was part of a two day series of examinations, Jeffers, Nichols and Eisdorfer (1961) asked 260 community volunteers two death-related questions. The subjects, all 60 years of age or older, were asked, "Are you afraid to die?" and "Do you believe in life after death?" (p. 54). Responses to the fear of

death question were explored in relation to 52 variables including a variety of demographic, physical, psychological, psychiatric, and social variables.

When examining responses to the fear of death question, Jeffers et al., (1961) concluded that factors associated with no fear of death include a tendency to read the Bible more frequently, more belief in future life, reference to death with more religious connotations, few feelings of rejection and depression, higher scores on full scale and performance IQ, and more Rorschach responses.

The inquiry on belief in life after death (Jeffers et al., 1961) was examined in relation to 37 demographic, physical, psychological, psychiatric and social variables. The results indicated that religious activities appear to be the most important variables associated with belief in life after death, but depression, intelligence, and socio-economic status may also be associated. In evaluation of this study, one should bear in mind that no institutionalized subjects were included in the study and there could be some denial in responses as a result of the direct questioning.

Rhudick and Dibner (1961) investigated the relationship between "death concerns in an aged sample" and "personality factors" because "high death concern in older persons is associated with neurotic tendencies" (p. 45). They also studied health attitudes of the same sample hypothesizing that "older persons who are concerned about death are concerned about their own health" (p. 45).

For this study (Rhudick & Dibner, 1961), there were 58 subjects who lived independently in the community and were described as healthy individuals. Included in the group were members of both sexes, married

and unmarried, working and non-working. Ages ranged from 60-86 years. Each subject completed the Minnesota Multiphasic Personality Inventory, the Cornell Medical Index, and twelve standard cards from the Thematic Apperception Test. Death concern was operationally defined as introduction of death in response to a TAT card. The reliability of the measure was reported as the 90 percent agreement in scoring by two judges. Because some TAT cards elicit death responses more frequently, the cards were weighted accordingly and one's score was the numerical sum of the weighted death references totaled for all 12 cards.

Results of the Rhudick and Dibner study (1961) indicated that higher death concerns were exhibited by those subjects who also scored significantly higher on the MMPI dimensions of Hypochondriasis, Hysteria, Dependency, and Impulsivity. There was also a slight, although not significant, relationship between high death concern and the Depression scale. It was concluded that death concern seemed to be related to certain neurotic tendencies. On comparison of the Cornell scores with death concern, those subjects who admit both more physical and psychological disturbance showed significantly higher death concerns than those who list fewer health complaints.

In a study by Bell and Batterson (1979, p. 72), the effects of "contemporaneous circumstances on death attitudes of older adults" were examined. Three causal models that might explain death attitudes were formulated by abstracting relevant variables from the literature on death. The first model incorporated the following dimensions: retirement, life satisfaction, and religiosity. Model two incorporated five causal variables: retirement, subjective age, health, life satisfaction, and religiosity. Finally, model three incorporated a variety of causal

factors: retirement, subjective age, socioeconomic status, sex, life satisfaction, religiosity, spouse's health, and living arrangement. These models were subsequently tested on data derived from interviews with 220 elderly male and female respondents residing in an urban area of the Midwest. The data lend little support to any of the models. In general, less than 13 percent of the attitudinal variance was accounted for by the factors or events employed. Bell and Batterson suggest that, according to their finds, "the present social and psychological environment of the aged plays a less significant role in their attitudes toward death than is presently reflected in social gerontology" (p. 72).

The average person may ponder death often but encounters it only occasionally with the loss of a friend or relative. However, the person living in a residence for the aged will necessarily meet sickness, the process of dying, and the resultant death on a much more frequent basis. It seems possible that these frequent encounters with death would have some impact on the attitudes toward death of those who live in institutions for the elderly. One purpose of the present study will be to investigate differences between the level of death anxiety in the elderly who live in nursing homes and those who live in apartment complexes exclusively for the aged.

Some researchers have attempted to establish a theoretical foundation for the understanding of death anxiety. For example, Diggory and Rothman (1961) postulated that humans try to extend objects that are valued highly, while those of low value are treated with indifference or destroyed. Thus they reasoned that an individual who values himself highly would try to extend his life and, therefore, should be more afraid of death than an individual who places a low value on his life.

In other words, "a person who values himself highly should be more afraid of death than one whose self-esteem is low" (Diggory & Rothman, 1961, p. 205).

To test this hypothesis, subjects were asked to complete a "questionnaire on various aspects of attitudes toward death" (p. 205). No validity or reliability were reported for the measures. Results indicated that the 563 participants in the study were particularly concerned that death would result in the loss of experiences, the inability to complete projects, and the inability to care for dependents. The researchers interpreted these results as being supportive of their theory since the data imply that subjects fear death because it eliminates attainment of goals that are important to self-esteem. It is worth noting that there was no systematic attempt to choose a sample representative of the general population, rather "the questionnaires were handed to groups or individuals wherever we had an opportunity . . ." (Diggory & Rothman, 1961, p. 205).

In their 1980 study, Aronow, Raushway, Peller, DeVito attempted to substantiate Diggory and Rothman's theory that greater fear of death would be associated with greater self-esteem. Measures for the study, which involved 117 undergraduate students, were the Templer Death Anxiety Scale, three scales of the California Psychological Inventory (Self-Acceptance, Sense of Well-Being, Self-Ideal Discrepancy) and three specially constructed items. The results of this study did not support Diggory and Rothman's theory. There was actually a trend in the opposite direction with death anxiety being negatively related to self-esteem. In discussion of their results, the authors suggested that

Frankl's "will to meaning" theory may provide an explanation for their findings.

In his existential argument, Frankl (1965) focused on the importance of death in one's life. According to Frankl, the "will to meaning" is the essence of human motivation. "Will to meaning" is a phenomenological force through which one attempts to achieve purpose and meaning in his life activities. In order to find true purpose and meaning in life, however, an individual must accept and find meaning in his suffering and ultimately his own death. Death actually becomes a factor in life's meaningfulness. The issue is not that life has no meaning because one's death is an unpredictable happenstance; rather, if death has no meaning, life has none either. Frankl's notion that there is meaning in suffering and death would lead one to expect a negative relationship between purpose in life and fear of death.

Aronow et al. (1980, p. 42) reasoned that "individuals who find life more meaningful have more positive feelings toward themselves and their lives", i.e. a higher level of self-esteem. Thus, utilizing Frankl's viewpoint, those people who have a higher self-esteem would also find their lives to be more purposeful and meaningful and, in turn, would be expected to have less fear of death.

In an attempt to provide empirical data to support Frankl's theory, Durlak (1972b) studied a total of 120 high school and college students using Lester's Fear of Death Scale and the Purpose in Life Test. The results supported Frankl's theory with participants who reported less purpose and meaning in life having a higher fear of death and a less accepting attitude toward it.

In later investigations, Durlak (1972a, 1973) again found a significant negative relationship between purpose in life and fear of death. The 1973 study, which involved aged subjects, included 39 female residents from two retirement homes. Respondents completed the Marlow Crowne Social Desirability Scale, the Purpose in Life Test, and Lester's Fear of Death Scale. The author cautioned that the results are only suggestive as the size of the samples was small. Nevertheless, three separate experimental studies by Durlak consistently yielded a negative relationship between purpose in life and fear of death.

Aronow et al. (1980) concluded their study by suggesting a need for further research to investigate the relationship between death anxiety and level of self-esteem. Hence, a final purpose of the present study, in addition to exploring the difference between death anxiety in the elderly who live in apartments for the aged and those who reside in nursing homes, was to explore and compare the relationship between death anxiety and level of self-esteem in these two populations.

Chapter 2

METHOD

Subjects

The subjects for this study were 33 elderly persons living in two residential settings: nursing homes, and apartment complexes exclusively for older individuals. The former type of dwelling was defined as a residential home that is meant to give accommodation and care to aged people who can no longer live by themselves (Matse, 1975), while the latter was described as a building in which each person lives independently in his/her own apartment with a number of peers living in close proximity. The elderly were considered to be those individuals who live in either of the previously mentioned residential settings.

Apparatus

As noted, the purpose of the current study was to investigate the relationship between death anxiety and level of self-esteem in the aged in the two living situations described above. Death anxiety was measured by Templer's (1970) Death Anxiety Scale (DAS). The DAS consists of fifteen true or false statements. Scores on the scale can range from zero to fifteen. Concerning the validity of the DAS, Templer (1970) has shown that it correlates significantly with Boyar's (1964) Fear of Death Scale ($r = .74$), the Manifest Anxiety Scale ($r = .39$), and the Welsh Anxiety Scale ($r = .36$). Templer (1970) also reported the test-retest reliability of the DAS to be .83.

No actual norms have been established for the DAS; however, Templer and Ruff (1971) collected and combined DAS data from seven different studies using 3600 adults and adolescents. The authors computed the mean scores of normal subjects and found they tended to range from 4.5 to 7.0 with the standard deviation being a little over 3.0.

Level of self-esteem, which refers to "social competence" (Helmreich & Stapp, 1974), was measured with the Texas Social Behavior Inventory-Form A (TSBI-A). The TSBI-A contains sixteen items consisting of declarative statements for which there are five response alternatives with scores ranging from zero to four in value; thus, a maximum high self-esteem score would be 64. The response alternatives include: "Not at all characteristic of me", "Not very", "Slightly", "Fairly", and "Very much characteristic of me". The TSBI-A is a short form of the original Texas Social Behavior Inventory which contains 32 items. The TSBI-A yielded correlation coefficients with the original long form of .973 for males and .974 for females. The authors concluded that the TSBI-A "can be used with confidence to provide reliable indices of self-esteem" (Helmreich & Stapp, 1974, p. 475).

Procedure

The administration of the two instruments (DAS and TSBI-A) took place within the residential setting of each subject. Subjects were tested according to the guidelines mandated by the administrative staff of each particular facility. Thus, all nursing home residents were tested on an individual basis with the examiner reading the questions aloud to each participant while those in the apartment complexes were tested in a group setting with each subject completing the questionnaire by himself/herself.

Chapter 3

RESULTS

Age

The 18 apartment complex subjects ranged in age from 67 years to 91 years. The age of one subject in this group was not available. The mean age for these subjects was 78.11 years with a variance of 48.44 and a standard deviation of 6.96 years.

The 15 nursing home subjects ranged in age from 59 to 92 years. The mean age for these subjects was 77.20 years with a variance of 125.44 and a standard deviation of 11.20 years.

To insure age comparability of these two groups, the following statistical tests were performed. First, an independent-groups (non-directional) t test was employed to make mean comparisons. The results of this test failed to yield significance, $t(32) = .31$, $p > .50$. Second, Hartley's F_{MAX} test was used to compare the variances of the two groups. As with the mean comparison, the results of this test failed to yield significance, $F_{MAX}(2,17) = 2.59$, $p > .05$. Table 1 in the Appendix summarizes the means, variances, and standard deviations for these groups.

Death Anxiety

As can be seen from Table 1 in the Appendix, the mean DAS score for the apartment complex subjects was 7.26 (variance = 6.09, standard deviation = 2.46), while the mean DAS score for the nursing home subjects was 5.07 (variance = 9.92, standard deviation = 3.15). The non-

directional, independent-groups t test was used to compare the means of these two groups. The results of this analysis indicated that the apartment complex subjects had significantly, $t(32) = 2.68$, $p < .02$, higher death anxiety than did the nursing home subjects.

Self-esteem

The TSBI-A means, variances, and standard deviations for the two groups are also presented in Table 1. As can be seen, the mean TSBI-A score for the apartment complex subjects was 35.05, while the mean TSBI-A score for the nursing home subjects was 41.60. Analysis (non-directional t tests for independent samples) of these mean differences indicated that the nursing home residents had significantly, $t(32) = 4.25$, $p < .001$, higher self-esteem scores than did the apartment complex subjects.

Relationship Between Death Anxiety and Self-esteem

Additionally, the correlation between DAS scores and TSBI-A scores was calculated for each group. The correlation coefficient for the apartment complex subjects was $r = -.63$ ($p < .01$, two-tailed test), while that for the nursing home subjects was $r = -.58$ ($p < .02$, two-tailed test).

Chapter 4

DISCUSSION

In their study of college students, Davis, Martin, Wilee, and Voorhees (1978) employed the DAS and TSBI-A and reported obtaining a negative relationship between death anxiety and level of self-esteem. Certainly, the results of the current study are consistent with their findings.

Durlak (1972a, 1972b, 1973) and Aronow et al. (1980) also found death anxiety and level of self-esteem to be negatively related. Durlak evaluated his findings within the framework of Frankl's "will to meaning" theory, and Aronow and his associates followed suit. According to Frankl, the essence of human motivation is each individual's attempt to achieve purpose and meaning in life. In order to find true meaning in life, however, a person must find meaning in death because if suffering and death are meaningless then "ultimately there is no sense in surviving. For a life whose meaning stands or falls upon whether one survives or not, a life, that is, whose meaning depends upon such a happenstance, such a life would not really be worth living at all" (Frankl, 1962, p. 103). If death has no meaning, life has none either.

Based on Frankl's theory that life's meaning is enhanced as one finds meaning in death, Durlak (1972a, 1972b, 1973) hypothesized that people who have meaningful lives, i.e., have positive feelings toward themselves or positive self-concepts, will also have less fear of death. The current results would appear to support this notion. Those

subjects who reported a high level of self-esteem also reported less fear of death. To make the picture complete, all one needs to do is assume that higher self-esteem equates to more meaningfulness in one's life.

Surprisingly, the nursing home residents in the present study exhibited significantly higher levels of self-esteem and lower death anxiety than their counterparts in the apartment buildings. It would seem likely that the reverse would occur with those individuals who are able to exert greater control over their lives (i.e., apartment dwellers) having enhanced feelings of self-esteem and less concern with death. Undoubtedly, nursing home residents have little control over their environments. One wonders if the dependent-living situation of these respondents could have influenced their responses. As suggested by Roberts et al. (1970), it is possible that the nursing home residents may have been saying what they thought the interviewer wanted to hear because, in their state of increased dependency, they dared not incur the displeasure of the interviewer.

A second factor to be considered in evaluation of the present results is the possibility that some of the nursing home participants may have cerebral deficits which could result in their not always being able to understand the questions. The typical reason for placing an older person in a rest home is diminished physical and/or mental ability which is usually manifested in a limited capacity to care for one's self. Consequently, it seems that the nursing home residents would be particularly likely to suffer from some cerebral deficits. Although such deficits were not readily apparent during the interviews, each resident's ability to participate in the study was determined only by

staff members of the various institutions whose assessments were subjective and might have been imprecise.

Marshall's (1975) hypothesis offers a further explanation for the differences found between the two groups. He suggests that a major facet of aging is adjustment to one's impending death. As stated in the literature review, this adjustment process is referred to as legitimation which means the elderly individual comes to accept death and consider it to be appropriate and nonproblematical.

Marshall believes that legitimation of death is a sociological process that is accomplished primarily through conversation. In reference to Hochschild's (1973) work with the elderly, Marshall suggests that being in a community for the aged where death is frequently present not only provides opportunities for conversing about death but also allows a person to observe death and reactions to it "in a kind of role-modeling process" (Marshall, 1975, p. 1141). This socialization for death allows the elderly to accept it as a matter-of-fact aspect of individual human lives rather than having a fearful or anxious reaction to death. If one assumes that death occurs more frequently in nursing homes, thereby supplying the occupants with more chances for socialization of death, this theory offers a viable explanation for the outcome of the current study.

A fourth consideration in assessing the current results is that of denial. Our culture as a whole tends to handle the topic of death with denial. Hence, it would not be surprising if the aged also use this technique. In their study of 254 community volunteers who were 60 years of age and older, Jeffers, Nichols, and Elsdorfer (1961) reported that 90 percent answered "no" when asked "Are you afraid to die?" These

responses lead the researchers to conclude that "Denial is a very important mechanism for dealing with anxiety in old age" (p. 55). Denial may have been a factor in the responses of the current investigation but, since all the participants were considered to be in the old-age category, that does not explain why there was such a difference between the two groups.

Several persons from the nursing homes made spontaneous comments about answering the questionnaires on the basis of "my real life" or life "on the outside". These phrases seem to imply that the individuals did not consider life within the nursing home to be real; they may be denying the reality of their current living situations. Just as remembering past events often makes those events seem more pleasant than they were in actuality, answering questions about self-esteem in retrospect may result in enhanced and exaggerated feelings about one's self.

If a person uses denial to deal with an undesirable living situation it is likely that he/she would use the same mechanism to deal with the unacceptable reality of death. One can easily imagine the effect upon death anxiety of already leading an existence where one considers oneself to be "functionally dead". Assuming that those who live in apartment complexes do not find it necessary to deny their current lifestyles, these subjects may have been able to respond to the questionnaire utilizing more honesty and less denial.

Frankl's theory may offer yet another explanation for the differences in responses between the two groups of subjects. During World War II, Frankl was imprisoned in several German concentration camps where the prisoners had virtually no control over their external environments,

and the camps were often thought of as places to go to die. These two characteristics are also frequently used to describe nursing homes.

In spite of the conditions of the camp, Frankl discovered that the sort of person a prisoner became was not the result of camp influences alone, but the result of an inner decision. Human beings are not merely the playthings of circumstances or, as Frankl (1959) stated it, ". . . everything can be taken away from a man but one thing: the last of the human freedoms—to choose one's attitude in any given set of circumstances, to choose one's own way" (p. 65). Frankl acknowledges that the majority of the inmates ignored the challenge of their circumstances and chose to vegetate, to succumb to mental and physical decay. There were a few exceptions, however, who viewed their circumstances as an opportunity for inner growth beyond their outward fates.

It is Frankl's belief that the suffering experienced during exceptionally difficult external situations often provides the greatest opportunity for growth. Suffering and death are an ineradicable part of life, so if life has meaning at all, then there must be meaning in suffering and death. Keeping this in mind, it is possible that the nursing home residents, who have more restricted external lifestyles than their counterparts in apartment complexes, also have a greater opportunity for inner growth. Some residents may refuse the challenge, choose instead to believe life is meaningless, and begin to decline mentally and/or physically. Because of their deterioration, these nursing home residents would not have been chosen to participate in the current study. However, other residents may have made an inner decision to retain their human dignity in spite of their living conditions. For them, life has meaning and death presents little to fear.

Unfortunately, there would not appear to be any clear-cut reason for favoring one of these interpretations of the present data over the others. Perhaps each interpretation is appropriate for some specific individuals. In his discussion of the contributions of Feifel's book (1959), Gardner Murphy concludes by stating that, "It is apparent that fear of death is not psychologically homogeneous at all, even in a narrowly defined cultural group" (p. 335). Schilder (1942) suggested that there may be no common human idea of death because it may be an extremely individualized concept. Obviously, death anxiety is a complex topic for study. Untangling the various interpretations that are often intertwined with the methodological problems noted below offers a considerable challenge to future researchers.

With concern for future research in this area, it should be noted that several difficulties and/or problems were encountered during the conduct of the present study. For example, the sample of apartment dwellers were individuals who happened to attend a social event for their complex and, at that time, agreed to participate in the study. On the other hand, the nursing home subjects were always carefully and individually chosen by the administrators of the institutions. Certainly, some persons in rest homes may be incapable of responding to a questionnaire, while others were excluded due to their terminal illnesses. However, administrator's comments such as "I'll feel-out residents to see how they will respond to the topic" strongly suggest that ability may not have been the only criterion considered while choosing individuals to participate. Hence, the conduct of such research with the elderly is quite likely to be plagued with subject-selection problems.

When asked the first question on the DAS, one potential nursing home subject responded with comments such as the following: "Don't ask me questions like that!"; "Go ask morticians, funeral directors, and ministers."; "That just makes me too sad!" This woman did not take part in the study; however, her emotional reaction was such that it seems possible, if not probable, that she has experienced considerable anxiety regarding death. While collecting data, the experimenter always tried to keep ethical principles to the fore. Hence, some potential subjects may have been excluded in this manner, and another source of sample bias possible introduced. Certainly, these considerations suggest that conclusions derived from between-group comparisons should be carefully scrutinized.

Perhaps the obstacles that were encountered during the study are more informative than the quantifiable data itself. As noted, the primary difficulty was that of obtaining subjects to participate in the study. There are any number of possible reasons for refusing to get involved in research investigations. One might argue that individuals do not receive any direct benefit from their participation and are, therefore, wasting their time. It might also be said that adults, particularly the elderly, are unaccustomed to testing situations and that this lack of familiarity might result in confused or otherwise invalid responses. Although these factors were cited by at least one administrator as reasons for hesitating to become involved, they did not seem to be the decisive elements. This same administrator concluded her comments by saying that there would be no problem with the TSBI-A by itself; however, she was not willing to have her residents answer the DAS. She stated, "We could handle any other topic but death." The

complex director said she would be willing to allow only one group to respond to the entire questionnaire, that being a Bible study group who "have a deep faith." However, the following day she refused to allow even this group to participate. In the light of her comments, one might hypothesize that her refusal to respond to the DAS could be indicative of her own anxious feelings about death.

Another possible indication of death concern came from two administrators who, after perusing the questionnaire, spent considerable time discussing their own personal encounters or near encounters with death, i.e., heart attacks and death of spouses. Staff members from all institutions that agreed to participate promised to provide many more subjects than they actually did. Perhaps the reduced sample size was due to some fear regarding the subject matter. For example, the activity director from one facility stated her feelings about the questionnaire as follows: "This is freaky. It was bad enough when I thought I had to fill this out, but now I find out it's for the residents. It might be OK for the general population, but not here. Most people have the idea that a rest home is a place to come to die."

The difficulties encountered during the current investigation have not been exclusively limited to the present study. As noted in the review of the literature, other researchers who have examined death concern in the elderly have also encountered difficulties obtaining a desirable number of subjects, as well as problems with choosing samples that are representative of the population being studied. It is quite likely that these obstacles have, at least in part, contributed to the opposing conclusions that are frequently found in death-related research. Hopefully, the present study has contributed some data and observations

that will prove helpful in unravelling the complexities found in this research area.

The one certainty of life that is shared by all human beings is death. Although death is universal, it is ultimately an individual journey that can be shared with no one. Each person must undergo death in solitude. Thus, death is a very personal and intimate experience. Perhaps the aloneness associated with dying coupled with its very personal nature make death a topic that is particularly illusive to objective analysis.

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APPENDIX: TABLE

Table 1
Means, Variances, and Standard Deviations of Apartment Complex
and Nursing Home Subjects

Subjects	Measure	Mean	Variance	Standard Deviation
Apartment Complex	Age	78.11	48.44	6.96
	Death Anxiety (DAS)	7.26	6.09	2.46
	Self-esteem (TSBI-A)	35.05	140.38	11.85

Nursing Home	Age	77.20	125.44	11.20
	Death Anxiety (DAS)	5.07	9.92	3.15
	Self-esteem (TSBI-A)	41.60	66.83	8.17