View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by The University of North Carolina at Greensboro

# The Effect of a Death Education Course on Dying and Death Knowledge, Attitudes, Anxiety, and Fears

By: Daniel L, Bibeau, James M. Eddy, D.Ed.

Bibeau, D.* & Eddy, J.M. (1985). The effect of death education course on dying and death knowledge, attitudes, anxiety and fears. *Health Educator, 17*, 1,15-18.

Made available courtesy of Eta Sigma Gamma: http://www.etasigmagamma.org/

***** Note: Figures may be missing from this format of the document**

## Article:

### *INTRODUCTION*

It is believed that socio-historical changes in the way Americans view dying and death have increased the need for formal and informal instruction in this area (Kubler-Ross 1969, Farmer 1970, Pine 1977, Simpson 1979). These and other authors postulate there was a more positive attitude toward death in the nineteenth century due in part to higher childhood mortality rates, large extended families, and shorter life expectancies. These factors often brought people into direct contact with death experiences. However, in the twentieth century, childhood mortality rates decreased, families developed a more nuclear structure, and death was removed from the family residence to institutions such as hospitals (Simpson 1970). For these reasons, it is believed that death became a taboo topic of discussion (Feifel 1963, Wass and Shaak 1976).

However, there has been recent evidence that the taboo levied on discussions of death and dying has been weakened. This weakening is demonstrated by the proliferation of death and dying educational experiences being offered in a variety of settings, including public schools and colleges (Leviton 1977, Eddy and Alles 1983). Also, death education courses are being offered by a variety of disciplines including health education, psychology, sociology, philosophy, medicine, and nursing (Crase and Crase 1974, Eddy and Alles 1983).

As stated above, health educators are involved in death education and those in both school and community settings have recognized the need to include instruction on dying and death related issues at all points across the lifespan. Leviton (1969) was one of the first health educators to call for the teaching of death education by health educators. Subsequently, several other health educators have supported this need for death education (Crase and Crase 1974, Hardt 1975, Russell 1977, Middleton 1979, Eddy, St. Pierre, and Alles 1980), In addition, Leviton (1977), Crase and Crase (1979), and Eddy, St. Pierre, Alles and Shute (1980) have suggested death and dying topics appropriate for health education curricula. Finally, Noland and Crosby (1983), have well described the conceptual and practical links between health education and death education in the social, physical, mental/emotional, and spiritual dimensions of health.

As part of this increased attention by health educators toward death education, Knott and Prull (1976) and Crase (1978) have stated a need for more systematic assessments of the impact of death education on students. For health educators, complete assessment of the impact of death education experiences must include evaluation of both the outcomes and the process of the experience. Investigating outcomes without regard to method would be of no use in the advancement of under-standing appropriate health education interventions.

This study was designed to assess the impact of a traditional cognitive-oriented instructional approach to death education on changes in death knowledge, attitudes, anxiety, and fear. The study was conducted to determine if an educational intervention designed to increase student knowledge would also positively enhance student attitudes, anxiety and fear. The importance of this study is threefold, First, Knott (1979) and Gordon and Klass (1979) have stated that information sharing and affective development are vital goals of death education, Second, health educators are interested in both cognitive and affective changes in the audience, since it is believed that health decisions and behaviors are influenced by both cognitive and affective factors. Finally,

there has been an unwarranted paucity of death education studies that have assessed a traditional education outcome—changes in knowledge levels.

## RELATED RESEARCH

A variety of studies have been conducted assessing the effectiveness of death education programs. The vast majority of these studies have focused solely on affective changes. For example, reseachers have evaluated the impact of death education experiences on attitudes (Hardt 1976, Watts 1977) anxiety (Laube 1977, Coombs, 1981, Yarber, Gobel, and Ruble 1981), and fear (Mueller 1976, Leviton and Fretz 1978-79) related to death and dying. In addition, Crase (1978) in calling for more systematic assessment of death education cited eight examples of completed research, all focused on affective outcomes. Leviton and Fretz (1978-79) have suggested that this attention to affective outcomes may be a result of death educators' beliefs that death education can be assured a more permanent status in the curricula if positive gains in psychologically healthy attitudes toward life and death can be clearly attributed to such courses. However, the results of the studies mentioned above have been mixed and clear-cut positive affective outcomes from death education have been been realized.

The tendency of death educators to focus on affective out-comes has resulted in the omission of a traditional measure of educational experiences, the increase in knowledge of the participants. Only two studies have reported assessing cognitive outcomes of students in a death education course. Bell (1975) conducted a study designed to assess the impact of an 18-week course concerning social aspects of dying and death on changes in cognitive aspects of attitudes. The investigator developed and used cognitive and affective scales to measure change in student attitudes. The results showed a significant change in the cognitive aspects of attitudes and a non-significant change in affective aspects of attitudes for the experimental group as compared to a control group. In the other study, Nichol (1980) examined the effects of a death education unit on knowledge acquisition, attitudes toward death, and levels of anxiety in high school students. In this study, the investigator used the Berg and Daugherty Fact Sheet, the Hardt Death Attitude Scale, and the Templer Death Anxiety Scale. The results indicated a significant increase in knowledge and improvement in death attitudes for the death education students as compared to a control group. No differences between groups were found on the death anxiety measure. It is apparent that the body of literature which measures the effects of death education programming on changes in cognition is limited. Therefore, this study was conducted to further the understanding of the impact of death education on both cognitive and affective changes in students.

## TREATMENT OF THE SUBJECTS

A quasi-experimental design with an experimental and a control group was used for this study since students self-selected into courses. The experimental group (n = 85) consisted of students who enrolled in a one-credit health education course entitled "Death Education: Concepts Across the Lifespan," at the Pennsylvania State University. The control group (n = 97) consisted of students enrolled in other one-credit health education courses such as human sexuality and alcohol education. All courses met for 75 minutes once a week for 10 weeks. The lecture method format was used in all courses in the study with limited discussion occurring as a result of student initiated questions. Because the purpose of the study was to assess the impact of a cognitive approach to death education on changes in dying and death knowledge, attitudes, anxiety, and fears, the course did not include instruction which would normally be considered in the affective or life skills domains.

## INSTRUMENTATION

Four instruments were used to measure death knowledge, attitude, anxieties, and fears. These instruments were the Eddy Knowledge Test of Death and Dying (Eddy 1979), the Hardt Death Attitude Scale (Hardt 1975), the Templar Death Anxiety Scale (Templer 1970), and the Collett-Lester Fear of Death Scale (Collett and Lester 1969). All instruments have been shown to be reliable and valid evaluative tools.

## RESULTS

A multiple regression/correlation analysis of the data was used to determine statistically significant posttest score diffferences between the experimental and control groups on the variables of knowledge, attitude, and

fear. The pretest was entered first into the regression analysis to act as a covariate in the traditional analysis of covariance model. The results are shown in Tables 1-7. Significant differences were found between the groups on posttest knowledge scores and on the posttest "fear of dying other" (FODYO) subscale of the Collett-Lester Fear of Death Scale. The experimental group, as one would expect with a cognitive oriented treatment, had a significantly (p .001) higher mean knowledge score (36.54) on the posttest than did the control group (26.98). These mean scores represented 69.2 percent and 52.8 percent, respectively, of the questions answered correctly on the posttest. In the other significant (p = .0206) findings, the mean posttest score for the experimental group on the Fear of dying Other (FODYO) scale was -0.961 and for the control group, -0.822. This indicates a slightly higher fear of others dying held by the control group.

**Table 1**

***The Effect of Treatment on Posttest Knowledge Scores While Controlling for Pretest Scores***

| | B | T | Sig T |
|---|---|---|---|
| Treatment Effect | -8.4549 | -15.215 | 0.000 |
| Knowledge Pre-Test | 0.4885 | 9.394 | 0.000 |
| Constant | 23.0210 | 15.393 | 0.000 |
| $R^2$ = .6892 | F = 200.6758 | | Sig F = .0000 |

**Table 2**

***The Effect of Treatment on Posttest Attitude Scores While Controlling for Pretest Scores***

| | B | T | Sig T |
|---|---|---|---|
| Treatment Effect | 0.06714 | -1.444 | 0.1506 (N.S.) |
| Attitude Pre-Test | 0.6220 | 11.808 | 0.000 |
| Constant | 1.2299 | 7.505 | 0.0000 |
| $R^2$ = 0.4521 | F = 70.5431 | | Sig F = 0.0000 |

**Table 3**

***The Effect of Treatment on Posttest Anxiety Scores While Controlling for Pretest Scores***

| | B | T | Sig T |
|---|---|---|---|
| Treatment Effect | 0.4952 | 1.675 | 0.0958 (N.S.) |
| Anxiety Pre-Test | 0.7856 | 15.209 | 0.0000 |
| Constant | 1.2209 | 2.589 | 0.0104 |
| $R^2$ = 0.4284 | F = 64.4518 | | Sig F = 0.000 |

**Table 4**

***The Effect of Treatment on Posttest Fear of Death of Self Scores While Controlling for Pretest Scores***

| | B | T | Sig T |
|---|---|---|---|
| Treatment Effect | -0.1525 | 1.643 | 0.1021 (N.S.) |
| Fear of Death of Self Pre-Test | 0.5105 | 11.351 | 0.0000 |
| Constant | 1.8041 | 9.247 | 0.0000 |
| $R^2$ = 0.4284 | F = 64.4518 | | Sig F = 0.0000 |

**Table 5**

***The Effect of Treatment on Posttest Fear of Death of Other Scores While Controlling for Pretest Scores***

| | B | T | Sig T |
|---|---|---|---|
| Treatment Effect | -0.0581 | -0.643 | 0.5209 (N.S.) |
| Fear of Death of Other Pre-Test | 0.3924 | 8.260 | 0.0000 |
| Constant | 2.7718 | 13.143 | 0.0000 |
| $R^2$ = 0.3045 | F = 37.6457 | | Sig F = 0.0000 |

**Table 6**

***The Effect of Treatment on Posttest Fear of Dying Self Scores While Controlling for Pretest Scores***

| | B | T | Sig T |
|---|---|---|---|
| Treatment Effect | 0.0724 | 0.848 | 0.3974 (N.S.) |
| Fear of Dying Self Pre-Test | 0.31339 | 7.199 | 0.0000 |
| Constant | 2.4938 | 13.194 | 0.0000 |
| $R^2 = 0.2288$ | F = 26.1026 | | Sig F = 0.0000 |

**Table 7**

***The Effect of Treatment on Posttest Fear of Dying Other Scores While Controlling for Pretest Scores***

| | B | T | Sig T |
|---|---|---|---|
| Treatment Effect | 0.1862 | 2.336 | 0.0206 |
| Fear of Dying Other Pre-Test | 0.2547 | 6.292 | 0.0000 |
| Constant | 1.9470 | 14.176 | 0.0000 |
| $R^2 = 0.1902$ | F = 20.6645 | | Sig F = 0.000 |

Although there were no statistically significant differences between the groups on the other measures, it is appropriate to examine the means and within group changes as evidenced in Table 8. On the anxiety measure, the experimental group evidenced a slight decrease in anxiety while the control group had a slight increase from pre- to post-test. In terms of attitude, both groups pre- and post-test attitude was best described by the statement "to think of death is common." However, only the experimental group evidenced an improvement toward the next more favorable attitude on the posttest, In examining the changes in mean scores of the other three fear subscales, fear of death of self (FODS), fear of death of other (FODO), and fear of dying self (FODYS), one can see that in all cases the control group reported greater fear on the posttest than on the pretest.

Conversely, the experimental group reported less fear on the posttest than on the pretest on the FODS and FODYS scales and greater fear only on the FODO scale. It should be noted however that both groups' means indicate only a slight degree of fear in all areas represented by these three scales.

## DISCUSSION

The findings of this investigation indicate that increasing an adolescent's or young adult's knowledge concerning death and dying will not significantly impact on his or her attitude, anxiety, or fear toward death and dying. Since the mean scores on the attitude, anxiety, and fear scales indicated that both groups of students remained in the range of scores that are interpreted as indifferent, there is a need to include affective education in a death education experience in an attempt to favorably influence these factors, Thus, it appears that a cognitive-oriented approach to death education is not an acceptable one for health educators in dealing with these groups.

From a pedagogical viewpoint, there are many reasons that necessitate changing attitude, anxiety, and fear in a favorable direction. When a person is indifferent toward the issues surrounding death or dying, this attitude may act as a block to receiving new information concerning these issues, Any blocking of new information puts a person at greater risk of making inappropriate decisions in the future. The point being made here is best represented by a statement from Feifel (1977):

> Because we as humans possess the capacity to conceptualize a future, and along with it an inveitable death, the meaning of and attitudes toward death that we hold can be an important variable in determining what we do with our lives in the pre-sent. (p. 5)

By educating people away from these neutral attitudes, it makes it possible for students to more deeply examine the meaning of their life.

Another reason for educating toward more favorable attitudes deals with the knowledge, attitude, and behavior relationship. The effect of attitude on knowledge was discussed above. It is believed that behaviors are the result of a person knowing something and their feelings attached to that knowledge. Therefore, even if the knowledge is present, life-enhancing behavior may not occur if attitudes are indifferent or unfavorable. This occurrence is readily observable in our everyday life in the many high-risk behaviors that adolescents exhibit as though they were invincible. The failure of most people to make out wills is another example of how indifferent attitudes block appropriate behavior and may even lead to the distress of others by burdening them with our unfinished business when we die.

Finally, there are social and mental health reasons that necessitate educating for favorable attitudes. A person with in-different or unfavorable attitudes may feel discomfort when he or she encounters an aged person, as we often associate age with death (Noland & Crosby, 1983). This can lead to avoidance and isolation of the elderly, as has been a recent trend in our society. Also, a person that understands dying persons and has a favorable attitude toward them is more likely to be able to interact positively with that person in a time of need. This is important for most people in our culture in dealing with close friends and relatives, especially our parents, who are likely to die during our lifetime. Associated with this occurrence is an assertion by Leviton (1976) that the death-educated person will experience a healthier bereavement in a loss situation.

Although the above conclusions follow from the results of this and other studies, there are three points that must be raised about the validity of the conclusions. First, it is possible that there will be a delayed impact on death attitudes, anxiety, and fear as a result of this education experience, This suggests the need for studies to include long term follow-up measures on death education students. Second, changes in the length of the course or the number of meeting times per week may have altered the results obtained in a favorable direction. Finally, we must be cautious in directing or facilitating predetermined changes in the affective domain when we have little or no in-formation on the "ideal" levels for an individual regarding death attitudes, anxiety, or fear.

At this point we must recommend more than a cognitive approach to dying arid death education if the goal of the experience is to have the participant "know" about dying and death through the cognitive, affective, and life skills domains.

**Table 8**

***Means and Standard Deviation for Experimental and Control Groups on Pre- and Post-Tests***

| Scale/ Possible Range | Experimental (N = 85) | | | | Control (N = 97) | | | |
|---|---|---|---|---|---|---|---|---|
| | XPre | SD | XPost | SD | XPre | SD | XPost | SD |
| Knowledge (0-52) | 26.62 | 5.47 | 36.54* | 4.44 | 25.41 | 5.01 | 26.98* | 4.54 |
| Anxiety (11-15) | 8.05 | 2.93 | 7.58* | 2.98 | 7.21 | 2.80 | 7.35 | 2.92 |
| Attitude (1,1 -4,9) | 3.01 | 0.46 | 3.12* | 0.40 | 3.05 | 0.43 | 3.06 | 0.42 |
| FODS (-3 + 3) | 0.50 | 1.16 | 0.49 | 1.08 | 0.39 | 1.05 | 0.53* | 0.96 |
| FODO (-3 + 3) | 0.67 | 0.89 | 0.73 | 0.92 | 0.34 | 0.81 | 0.44 | 0.80 |
| FODYS (-3 +3) | 0.48 | 0.77 | 0.40 | 0.76 | 0.30 | 0.94 | 0.34 | 0.81 |
| FODYO (-3 +3) | -0.82 | 0.72 | -0.96 | 0.68 | -0.92 | 0.74 | -0.82 | 0.76 |
| FEAR (-3 + -3) | 0.19 | 0.65 | 0.04* | 0.62 | -0.05 | 0.63 | 0.04* | 0.56 |

* Significant ($p < .05$) pre- to post-test differences within each group

## REFERENCES

Bell, B. "The Experimental Manipulation of Death Attitudes: A Preliminary investigation." *Omega,* 6(1975):199-205.

Collett, L. and Lester, D. "The Fear of Death and the Fear of Dying," *The Journal of Psychology, 72* (1969):179-181.

Coombs, D. "The Effects of Selected Death Education Curriculum Models on Death Anxiety and Death Acceptance." *Death Education,* 5(1981): 75-81.
Crase, D. "The Need to Assess the Impact of Death Education." *Death Education, 1(1978):423-431,*
Crase, D. and Crase, D. "Live Issues Surrounding Death Education.'" *The Journal of School Health,* 44(1974):70-73.
Crase, D. and Crase, D. "Emerging Dimensions of Death Education." *Health Education,* 10(1979):26-29.
Eddy, J. "The Development and Validation of a Knowledge Test of Death and Dying for College Students." Unpublished Dissertation, the Pennsylvania State University, 1979.
Eddy, J. and Alles, W. *Death Education.* St. Louis: C.V. Mosby Company, 383.
Eddy, J,, St. Pierre, R., and Alles, W. "Consumer Aspects of Death and lying." *Health Education,* /1(198000-12.
Eddy, J., St, Pierre, R., Alles, kV., and Shute, R. "'Conceptual Areas of Death Education." *Health Education, II* (1980):14-15,
Farmer, J. "Death Education: Adult Education in the Face of a Taboo." *Omega,* 1(1970):109-113.
Feifel, H. Death. In Farberow, N. editor: *Taboo Topics.* New York: Atherton Press, 1963.
Feifel, H. "Death and Dying in Modern America:' *Death Education,* ;1977):5-14.
Gordon, A, and Klass, D. *They Need to Know: How to Teach Children About Death.* Englewood Cliffs, NJ.: Prentice-Hall, Inc. 1979.
Hardt, D. "Development of an Investigatory Instrument to Measure Attitudes Toward Death." *The Journal of School Health,* 45(1975):96-99.
Hardt, D. "A Measurement of the Improvement of Attitudes Toward Death." T*he Journal of School Health,* 46(1976):269-270.
Knott, J. "Death Education for All." In Wass, H. editor: *Dying: Facing The Facts.* New York: McCraw-Hill Book Co., 1979.
Knott, J. and Prull, R. "Death Education: Accountable to Whom? For What?" *Omega,* 7(1976):177-181.
Kubler-Ross, E. *On Death and* Dying. New York: Macmillan, 1969.
Laube, J. "Death and Dying Workshop for Nurses: Its Effect on Their Death Anxiety Level." *International Journal of Nursing Studies,* /4(1977):111-120.
Leviton, D. "Education for Death." *Journal of Health, Physical Education, and Recreation,* 40(1969):46-47,
Leviton, D, "The Stimulus of Death," *Health Education,* 7(1976):17-20. Leviton, D. "The Scope of Death Education." *Death Education, 1(1977);41-56,*
Leviton, D. and Fretz, B. "Effects of Death Education on Fear of Death and Attitudes Towards Death and Life. *Omega,* 9(1978-79):267-277.
Middleton, K. "Strategies for Teaching About Death and Loss.'" *Health Education.* 10(1969):36.
Mueller, M. "Death Education and Death Fear Reduction." *Education,* 97(1976):145-148.
Nichol, J. "A Study of the Effects of a Death Education Unit Upon Secondary Students." *Dissertation Abstracts International, 41(1980):2545A.*
Noland, NI. and Crosby, R. "The Link Between Health Education and Death Education:" *Health Education,* 14(1983):34-37.
Pine, V. "A Socio-Historical Portrait of Death Education." *Death Education, I* (1977):57-48.
Russell, R. "Educating About Death." *Health Education,* 8(1977):8-10. Simpson, M. *The Facts of Death.* Englewood Cliffs, New Jersey: Prentice Hall, Inc., 1979,
Templer, D. "The Construction and Validation of a Death Anxiety Scale." Journal *of General Psychology,* 82(1979):165-177.
*Wass,* H. and Shauk, J. "Helping Children Understand Death Through Literature" *Childhood Education,* 53(1976):80-85.
Watts, D. "Evaluation of Death Attitude Change Resulting From a Death Education Instructional Unit." *Death Edueation,* /(1977):187-193.
Yarber, W , Gobel, P., and Rublee, D, "Effects of Death Education on Nursing Students' Anxiety and Locus of Control." *The Journal of School Health,* 5/ (1981):367-372.