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DEATH AND THE SELF

A Thesis

Presented to

The Faculty of the Department of Sociology

The College of William and Mary in Virginia

In Partial Fulfillment

Of the Requirements for the Degree of

Master of Arts

by

Jo Ann Miller

1980

APPROVAL SHEET

This thesis is submitted in partial fulfillment of the requirements for the degree of

Master of Arts

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Approved, April 1980

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Marion G. Vanfossen

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ABSTRACT

One purpose of this study is to explore how the individual's responses to thoughts concerning future death affect the self or identity. Another purpose is to explore how the person constructs a definition of personal death.

Two clinical case studies of disasters are used to determine possible responses to the threat and reality of death. Additionally, observational studies of medical staffs and patients illustrate typical responses to dying and death. It is suggested that death concern can motivate behaviors for some individuals.

A compilation of studies that correlate death concern with attitudes, behaviors and personality characteristics identifies individuals whose purposeful behaviors are influenced by thoughts of nonexistence. A theoretical model that explains the emergent self and links the self to behavior predicts overt and covert behaviors of death concerned persons.

Processes of conformity and cognitive dissonance are described in order to examine the issue of social control within dying and death studies. It is suggested that propositions concerning cognitive dissonance should be integrated with those explaining the self for accurate predictions concerning the reciprocal relationship between death and the self.

DEATH AND THE SELF

INTRODUCTION

This project explores how an individual's perceptions of eventual nonbeing affect the self and behavior and how a person defines his death. The task and the topic preclude an approach restricted to an inductive or deductive examination of narrowly defined concepts. Rather, a blend of processes that meet the emergent needs of empirical findings and theoretical interpretations of complex issues are used to reach project goals.

For the person, death is the ultimate control over his life's plans and activities. Empirical studies demonstrate possible responses to thoughts of personal death and responses to the deaths of others. This exploratory effort begins with examples of these studies and a discussion on how future death can motivate presently oriented behaviors.

Suggesting that thoughts of nonbeing motivate behavior necessitates an attempt to define those who are overly concerned with death. Research findings allow the conclusion that perceived consequences of death are influenced by enacted or imagined social and personal roles. Furthermore, researchers find that the elderly are not most concerned with death. Younger adults,

especially women, appear to manifest considerable concern; ambivalent or contradictory responses are typical.

In order to explore how cognitive awareness of finitude affects the self, a theoretic framework that uses explanations based on social and personal roles is necessary because thoughts of death are based on these roles. The McCall and Simmons role identity model, as outlined in chapter three, is appropriate for the study because it applies to young, relatively independent persons who acknowledge a finite nature. Its use of a symbolic interaction orientation is particularly important, since the meanings of personal death must be constructed and defined by the individual. Empiricists cannot explain the nature of death.

The McCall and Simmons model is limited by its voluntaristic postulate. Its authors acknowledge that they do not consider how social control affects the self. Dying and death research findings are amenable to analyses based on principles of conformity and cognitive dissonance. These processes represent mechanisms of social control and are used to judge the adequacy of the role identity model's explanations.

Contemporarily, death is a complex phenomenon. A 1957 contributor to the Atlantic Monthly wrote:

> There is a new way of dying today. It is the slow passage via modern medicine. If you are very ill, modern medicine can save you. If you

> are going to die, it can prevent you from doing so for a very long time . . . an incredible battle between spirit and medicine takes place. It may continue for weeks, sometimes for months. But the victim is going to die. It is just a question of time.

Sensitive medical instrumentation, the ability to transplant human organs, suicide, abortion, cryonics, euthanasia and other issues continue to confront those who attempt to define human death in a technologically advanced society. The Harvard Committee on Brain Death (1968) recommended that cessation of brain functions should determine death. Current statutes show that the definition of death varies among the states, although medical practitioners generally adopt criteria proposed by the Harvard Committee (Meyers, 1977).

Agich (1976), a medical ethicist, argues brain death presumes rather than establishes a definition for death. That is, brain death operationalizes death of the body but a definition for death of the person has not been formulated. Veatch (1976) extends the argument by suggesting that the definition should be determined by what is significant to the nature of man. The task needs philosophical and theological reflection, not merely biological investigation.

Although the concept has various interpretations, the following discussions are based on a definition of death that is social in nature. Death can refer to the

cessation of biological functions; in this instance it refers to the termination of all human experience. As an event, it is distinguishable from the process of dying. This definition does not challenge prevailing medical or legal definitions of death, nor does it debate the question of an afterlife. It is congruent with generally accepted conceptualizations of self and identity and it encourages an investigation of social and symbolic life.

G.H. Mead provides a definition for the self. He identifies self as distinguishable from a physical entity. Self is a "social structure [that] arises in social experience." By adopting objective and impersonal attitudes toward oneself and the social situation, a person develops self-consciousness; a person becomes an object of its own reflection (Strauss, 1964: 204). Because of multiply relevant relationships and associations with others, a "multiple [self] is in a certain sense normal" but a unified self that is stabilized by one's most significant others also emerges (Mead, 1934: 142).

Identity serves as a mechanism to operationalize the more abstract self. It refers to a system of idealized personal and social roles that an individual adopts in order to present appropriate situational selves and to maintain a more enduring and unified self (McCall and Simmons, 1978).

CHAPTER I

RESPONSES TO DEATH

G.H. Mead posits that the individual's consciousness develops through a teleological process. "The conduct of the conscious organism is determined both by a physiological system from behind and also by a consciousness that reaches into the future. This can of course take place only in a present in which both the conditioning past and the emerging future are to be found" (1932: 60).

Human beings, compared to other forms of living entities, have the unique ability to know that their eventual fate is nonexistence. One approach to exploring Mead's thought is to examine how and why cognitions of future death affect present oriented behaviors and a definition of the self. This approach raises the preliminary question of whether or not an individual can understand the nature or meaning of his own death. Examining circumstances that illustrate responses toward the deaths of others, and settings that specialize in the management of dying and death are additional prerequisites for interpreting how and why thoughts of future nonexistence affect the individual's conception

of self and his behaviors.

When a person responds to the process of dying, he can reflect upon suffering, pain, dependency, confinement and loss of control over activities and functions. These are observable life processes. When a person responds to another's death he can consider the loss and separation, realizing that like others, he also is limited. Personal death is an event that ends experience. Suggesting that thoughts of it affect behaviors and the self implies that a person gives meaning to eventual nonexistence. Though nonexistence cannot be operationalized, observed, measured or interpreted empirically, individuals can and do reason and symbolize in order to understand abstract constructs. Freud posits that although consciousness is capable of conceiving its own negation, an individual is not capable of conceiving his own death. "At the bottom, no one believes in his own death . . . everyone of us is convinced of his own immortality" (1959). Van Evra (1971) contends that the nature of death is unknowable but the person conceptualizes "limit" and thus gives a meaning to death that can be used as an operational device. He writes:

> To say that death functions as a limit . . . is simply to say that we build, to a considerable extent, our conceptual lives with the use of it. The general realization that we are approaching the limit often impels us; e.g., to truncate projects so that we can go on to others; it forces us to pick and choose those tasks . .

> which are more "worthwhile." In general, we form a "set," i.e., a context, from which life is viewed via the realization that life is limited, and that we are approaching the limit. All of this can be accomplished without any conception of experienceless, literally thoughtless "self" whatsoever.

This interpretation is congruent with the work by Rosenblueth et al. (1943) who posit a teleological explanation for motivation. The authors suggest that a presently experienced cognition is necessary to determine behavior. A present intention to realize a future phenomenon, rather than a future oriented goal, is experienced by the person and motivates or causes behavior. Thus, it is possible to conclude that purposeful behavior is influenced by perceiving the future and that nonexistence, the person's ultimate future, can motivate behavior.

Because a person can never experience nonbeing, some thoughts of an inevitable demise are influenced by the deaths of others. Social scientists who study dying and death find natural laboratories for exploring how survivors respond to human tragedy. Seventeen years after the event, Robert Lifton (1976) interviewed two groups of "hibakusha," surviving victims of the A-bomb, as part of a larger field study on Hiroshima. One group included 33 individuals randomly chosen from the files of the Hiroshima University Research Institute for Nuclear Medicine and Biology. The second group of 42 respondents

included physicians, university professors, city officials and others who were particularly knowledgeable of the ways people handled the problems and effects of the bomb. All were interviewed at least twice and each session of semi-structured questioning lasted approximately two hours. Three dimensions of A-bomb problems and results were discussed: a) recollection of the experience and its current meanings; b) residual concerns and fears, especially those of radiation effects; and c) the hibakusha's sense of self and society.

Most individuals recalled the shift from a "normal" existence to one defined by death. The sudden, absolute encounter produced "an emotional theme within the victim that remains with him indefinitely: the sense of a more or less permanent encounter with death" (Lifton, 1976: 184). Psychological closure, or the inability to "feel," is described as a common yet somewhat ineffective defensive maneuver to cope with widespread death and destruction. The price for this defense appears to be a sense of guilt or feeling ashamed for "selfishly" surviving while others died.

Soon after the event, rumors of continued death and destruction circulated throughout Hiroshima. Some were told that all those exposed to the bomb would be dead within three years. Others believed that trees and grass would never grow. These rumors help explain

survivors' anxieties over personal health. Physicians describe an "A-bomb neurosis," or hypochondriasis, general weakness and dependency among survivors. Most hibakusha are concerned with potential health problems of their offspring and many report restricted employment and marriage opportunities result from exposure to the bomb with its related health problems (Lifton, 1976: 193-194).

Some hibakusha are physically identifiable through keloids left from exposure. Most are affected by laws enacted since 1957 that provide medical coverage and "certify" individuals as victims. Thus, an hibakusha becomes a member of an unchosen group and outsiders react to the symbolism of group membership. An hibakusha bears the "taint of death" and evokes a sense of rejection. Generally, he considers himself a member of a minority group and of an outcast group. Lifton concludes that a victim's identity is based on an intimate identification with the dead. "Survivors seem not only to have experienced the atomic disaster, but to have imbibed it and incorporated it into their beings, including all of its elements of horror, evil and particularly of death. They feel compelled virtually to merge with those who died" (1976: 199-200).

Cities and townships in the United States have been destroyed by floods, hurricanes, tornadoes and fires. A gemeinschaft community, characterized by few status

differentiations, close networks of interpersonal relationships and feelings of attachment to the land got an "advance look at hell" in 1972 when a dam burst, setting off mud waves and explosions.

Erikson (1976) observed the aftermath of the Buffalo Creek flood that killed at least 125 people from a West Virginia coal mining area. He found a remarkable similarity in responses among 142 individuals whose accounts of the flood are reported in 30,000 pages of transcript. Moreover, this community's experience with death produced psychopathological syndromes similar to those of the typical hibakusha. Anxiety, depression, phobia, hypochondriasis, apathy and insomnia are commonly diagnosed by physicians. Some physicians and psychologists estimate that over 90% of survivors suffer from some form of emotional disorder and Erikson concludes that confusion, despair and hopelessness characterize the typical survivor (1976: 136-157).

Similar to Lifton's findings of psychological closure among the hibakusha, Buffalo Creek victims identify with death--an identification that produces a numbness or apathy toward the deaths of others. Erikson writes, "the dead have no warrant to mourn the dead" (1976: 145). Several survivors report a feeling of guilt or shame for being alive. The source of guilt might be that the "human mind has its own probability

theories," and each death made the odds of self-survival greater (1976: 169). Death anxiety is manifested by children who often draw pictures depicting bodies floating in muddy water. Members of a once gemeinschaft community became alienated from each other and reflect this new sense of aloneness in dreams. "One theme that appears again and again in those dreams is the feeling that one is dead and being buried by people who were once quite close. It is as if one's alienation from others is a form of death, a grim rehearsal for that final act of separation" (Erikson, 1976: 243).

These clinical case studies suggest that experiences with death can affect the individual and the community in ways that can be irreversible. Resolution of the disaster might be impossible for survivors. In both examples, communities somewhat acknowledged an impending threat of death. Lifton's historical review of Hiroshima's status in the war revealed a general apprehension, a feeling that the Americans "must be preparing something extraordinarily big for the city" existed (1976: 183). A few stray warning bombs and leaflets concerning the A-bomb reached Hiroshima. The people of Buffalo Creek lived with the reality of black lung, fatal coal mining accidents and the dangers of nature. "The mountains are their security as well as their curse . they can become a terrible threat with

scarcely a moment's notice" (Erikson, 1976: 130). In both cases, sudden and traumatic events made anticipating and preparing for death's reality impossible.

The tragedy of multiple deaths does not represent the typical encounter with mortality. Disasters, however, do serve to illuminate some of the responses individuals manifest toward the threat of personal death. In technologically advanced nations that can hide the process of dying by institutionalizing the terminally ill or by masking the signs of protracted dying, disasters remind spectators of their mortal nature.

Those with medical occupations, like surviving victims, are also atypical in their experiences with death. In American hospitals and nursing homes, physicians, nurses and other staff members face the fragility of human life on a daily basis. "Detached concern" enables practitioners to accept the deaths of those with whom they engage in sustained relationships. Goffman's discussion of role distance elaborates some of the tactics used by surgeons to ensure completion of a complex and risky task that requires cooperation of team members. Identifying with the mortal man can be disruptive for a person whose role necessitates a constantly maintained sense of composure and control, and for the person who is trained to preserve physical life. Joking with surgical staff members and using humorous and nontechnical

terms for medical instruments are examples of ways in which a surgeon exhibits a "disaffection from or resistance against" his putative role (Goffman, 1961). To fulfill his commitment to the situated activity system, the surgeon acts "in the name of some other socially created identity." Thus, invoking role distance serves the purpose of allowing the physician to contribute to the management of an organization designed to provide efficient medical services to a large number of patients, including those who die.

Gubrium (1975) observed interactions of clients and staff in a nursing home. "Patients," those diagnosed critically or terminally ill, were separated from "residents," or comparatively healthy clients. Although "dying and death are commonly recognized occasions considered characteristic of the setting by all its participants" the process and the event are defined differently by interactants. The "top staff" does administrative death work. They arrange procedures to take care of the deceased, notify family and maintain order in the home, but they never see death. The "floor staff" includes nurses and aides. These workers often witness deaths of patients and their duties are directly concerned with the dead. The "clientele" physically and emotionally experience the dying process and the deaths of others. They perceive the nursing home as a place to

die. A feeling of abandonment is commonly expressed and clients establish intimate relationships with each other while breaking ties with those on the "outside" (Gubrium, 1975: 89). Rather than plan activities for the future, clients are concerned with filling the present time by walking, watching and talking. They engage in a daily routine of "passing time." Floor staff and the administration are concerned with maintaining order in the home. Patients and residents are not encouraged to interact since witnessing terminality can be disruptive for the more healthy clients. "Herding" patients into dayrooms and bribing troublemakers are means for dealing with annoyances or disruptions of routinized activities.

In the past, dying was a process that usually lasted for a short period and families, rather than a nursing staff, cared for the terminally ill. Acute, contagious disease, high infant mortality and occupational deaths don't allow individuals to enact a role signaling death. Sontag's review of literary references to illness shows that the "dying role" belonged almost exclusively to tuberculosis patients until the end of the 19th Century. Before scientists identified bacterial causes, the victim was "identified with death itself" and had a "tubercular look considered a mark of distinction, of breeding" (Sontag, 1979: 28). The "sickness" was associated with a sentiment of sadness

and defined a romantic stance to life. A protracted illness, with phases of exuberance and gaiety, followed by phases of weakness and frailty was common among the creative artists compared to the diseases afflicting other occupations.

Lofland (1978) posits that the interrelationships of six factors account for prolonged dying among a significant proportion of contemporary Americans: 1) a high level of medical technology, 2) early detection of disease, 3) a complex definition of death, 4) a high incidence of degenerative disease, 5) a low incidence of fatal injuries, and 6) a curative orientation toward the dying with a complementary high value placed on prolonged life. Contemporarily, in addition to medical professionals, more of the general population encounter persons enacting a dying role. Lofland finds that selecting a "dying script" is problematic because dying is "transitional, irreversible, and characterized by an absence of 'graduates'" (1978: 45). Entrance to a dying role is defined by the medical profession that often tries to avoid disclosing terminal conditions. Expectations for the stance, or emotional tone expressed by an occupant of the role are not clearly defined. They range from an expectation of dying bravely to one of sensing the futility of life. Furthermore, all components of dying are both subject "to choice and

constrained by circumstance, by social organization, and by other human beings" (Lofland, 1978: 57). Organizations and institutions can encourage role exits, relatives can disapprove of a dying style and the dying can be confined to hospitals and nursing homes.

Glaser and Strauss (1965) studied interactants in American hospitals. Probing the question of "whether people can die socially before they die biologically" researchers interpreted their observations of terminally ill patients, relatives and staff members, organized around an "awareness context" of the situation. They focused upon the possible combinations in awareness of a patient's fate for all interactants and observed behavioral tactics employed by participants that influence changes occurring in the interaction. Closed awareness, suspected awareness, mutual pretense and open awareness represent a typology of situational context. Each type prescribes how individuals will define and redefine themselves as well as their relationship to one another during the dying process.

A closed awareness context, in which the patient is not informed or is not aware of a diagnosis of impending death, is often chosen by hospital staff. Pragmatic reasons for this preference include the prevention of hysterical responses from patients and families in order to maintain social order. The imprecision in

predicting the exact timing of death is a useful rationalization to continue the charade. Reassigning emotionally attached nurses to other wards, subjecting the patient to additional and perhaps unnecessary tests to induce a sense of optimism, maintaining a present-oriented conversation, and emphasizing to the patient the staff's confidence in medical knowledge and technology are some of the tactics that are informally learned and used for managing the situation. Because suspicious patients and relatives are sensitive to cues of terminality, the closed awareness context is unstable and usually breaks down quickly.

The suspected awareness context, in which the patient has a suspicion that the hospital personnel believes him to be dying, is described as a "contest for interactional control" (Glaser and Strauss, 1965: 47). The patient's task is to detect or elicit signs of terminality and the medical staff's task is to avoid disclosing a diagnosis. Responses to indirect queries can be interpreted by patients as "cues" signaling upcoming death. The context of mutual pretense refers to the situation in which both the staff and the patient recognize imminent death, but agree to maintain the charade that an illness is not terminal (1965: 64). Both the staff and the patient use "props" as well as behaviors to maintain the awareness context. For example, the dying

person can decorate his hospital room, carefully attend to dress and grooming and avoid discussing topics that are related to health and death. The staff uses the everyday hospital routine and the traditional hospital props to sustain the mutual pretense.

Couched in Hughes' conception of "dirty work" (1958) Glaser and Strauss explain why the nurse, rather than the physician, is often assigned the task of informing the patient of his fate. The doctor's superior status allows the delegation of this unpleasant duty to lower ranking staff members. Furthermore, when physicians fulfill their ethical obligations of disclosing a diagnosis, the use of technical language is common because it serves the purpose of allowing "gentle disclosure" as well as the function of permitting the doctor to maintain an emotional detachment or social distance necessary for his continuous encounters with death.

Through direct disclosure by the medical staff, the context shifts to one in which both the staff and the patient acknowledge imminent death through overt behaviors. In this open awareness context, a patient responds to his newly gained knowledge by either denying or accepting his death. Dimensions of the denial type response are variable. A patient can test the validity of information received by playing a "polarity game." That is, by "questioning a nurse about the most extreme

life-or-death implications of his illness, the patient forces her to give a normalizing answer, which usually locates him a safe distance from death" (Glaser and Strauss, 1965: 133). Engaging in solely future oriented conversations, comparing symptoms to those of people who appear more seriously ill, and employing selective comprehension of information are other examples of commonly used denial tactics.

Persons who accept upcoming death may actively prepare for the event by settling social and financial affairs, attempting to live a "full life" before death, or by committing suicide; also, a person can passively assent to the forthcoming event. The response of calm resignation is preferred by nurses, because it "relieves them of the responsibility for cheering up the patient and also improves their own morale" (Glaser and Strauss, 1965: 130).

The doctor must, to a certain degree, shift his attention away from the dying and toward those who benefit from his services. His specialized training includes the formal learning of skills necessary to save or preserve life; daily contact with the dying could encourage an awareness of futile efforts. Once he is convinced that activities directed toward healing or curing a patient are useless, the doctor's problem "becomes one of spending his time legitimately, according to professional values"

(Glaser and Strauss, 1965: 180). Researchers observed that the mechanisms doctors employ to handle the dilemma of coping with the dying include sending the patient home for the balance of his life, extending special privileges such as granting furloughs from hospital confinement, or treating the case as medically interesting or clinically valuable. These tactics are used because through informal learning, physicians adopt a medical philosophy that "perhaps includes even the moral, social or economic philosophy of the various specialities" (Hughes, 1958: 118). This philosophy implicates relations of physicians to each other, to their patients, and to members of the lay public.

The Glaser and Strauss typology is useful for explaining how an individual's definition of death emerges through interaction. Families, medical staff and characteristics of the setting influence behavioral responses of the terminally ill. Because the analysis is limited to observations of interactants in a coercive social setting, it fails to present an understanding of how the terminally ill define death in other settings. Furthermore, by solely focusing upon overt behaviors, Glaser and Strauss do not consider the individual's covert interpretations for the meaning of personal death.

Some hospital-based researchers find that dying is a process characterized by distinct stages. The

psychoanalytically oriented work by Kubler-Ross (1969) presents an example of a stage theory of dying. For two years, Kubler-Ross and hospital chaplains interviewed 200 terminally ill, hospitalized patients. Most patients defined themselves as religious, and all experienced ample time to work through stages. Kubler-Ross found that the first stage, denial, was initially embraced by almost all patients in order to allow the pursuit of life's activities, and only three individuals in the study maintained denial until death. Researchers found the most acute and expressive forms of denial among those whose terminal diagnosis arrived prematurely or abruptly. Denial, no matter what form it takes, is fragile. As it breaks down, it is often replaced by anger, characterized by rage, envy and resentment. The patient knows that his projects and goals can't be accomplished, that he will lose control over his activities and that he will be abandoned by many of his former role partners. Anger can be "irrational," for example, a resentment for young people because they have long-range plans, or it can be "rational," for example, a rage expressed for being confined to a hospital bed (1969: 54-70).

Bargaining is the third stage and usually represents a deal with God for postponing death. Self-imposed "deadlines" usually result in broken promises. Patients often find another occasion for bargaining. The fourth

stage, depression, represents a sense of hopelessness and sensing the loss of objects. Reactive depression refers to acknowledging the loss of objects such as "being a woman," a job, or companionship. It is different in nature than preparatory depression, or the depression that takes into account impending loss. Preparatory depression is used as a mechanism to accept the loss of all loved objects (Kubler-Ross, 1969: 87).

Acceptance is the final stage of dying. Kubler-Ross contends enough time as well as professional help are necessary for the patient to work through previous stages and finally accept death. Acceptance is not a happy or joyous sensation, nor is it a form of resignation. It is a time of passivity, of wanting to be alone, of wanting silence rather than conversations with visitors. Interests in worldly events diminish and the accepting patient feels "peaceful" while waiting for death. Hope can be maintained throughout all the stages. Early in the dying trajectory, patients can hope for cures. Later, they can hope that suffering and death have meaning for either the self or for others.

The Kubler-Ross thesis is somewhat limited by its approach to understand responses to personal death. A large component of both hope and the acceptance stage is religious conviction. Since all patients interviewed were either religious at the onset of illness or

discovered the comforts of religious beliefs once diagnosed terminal, the concerns and reactions of the non-religious dying individual are not discussed. Since all patients were hospitalized, it is possible to suggest that medical practitioners and the hospital setting are determinants of death acceptance. Although Kubler-Ross acknowledges that patients can sometimes shift from one stage to another, the model suggests that the sequence of stages is relatively fixed. For example, a patient progresses from depression to acceptance. This sequence might be affected by the sequence of medical treatments. Once a patient perceives that pallative care represents the nature of his medical treatment, it symbolizes that others acknowledge and accept imminent death, thereby encouraging the patient's acceptance of his fate. The model might, therefore, be applicable only to those dying in specialized settings and under specialized circumstances. Since the patient's reactions must also be shaped by the meanings of death and by its influences on surviving family or others who are intimately related, explanatory power of the Kubler-Ross model is further limited by its neglect of the more sociological process of dying. Empirical findings do indicate that between 60% and 75% of Americans die in hospitals or nursing homes (Simpson, 1979: 17). In 1978, 48% of deaths were due to cardiovascular-renal diseases and 22.4% resulted from

cancer (Chiappetta, 1979: 95). These two major causes can both account for prolonged illness. Thus, the Kubler-Ross model presents a limited understanding for the dying process of many individuals.

In summary, the abilities to reason and to symbolize allow the person to understand the meaning of the future and of personal death. Events causing widespread death result in psychological damage that includes an identification with death itself. They also permit description of possible reactions to the threat of death. Anxiety, alienation, guilt, fear and concern for health are some dimensions of death-related responses.

Settings designed to manage the dying and cope with death have goals of maintaining social order; participants employ mechanisms to remain detached from death while providing services necessary to cure the ill and quiet the dying. The dying process continues to be extended in duration. Contemporarily, more persons enact dying roles and more individuals interact with the dying than was the case in earlier times. These factors suggest that attitudes and behavioral responses toward personal death and toward the deaths of others are influenced by experiences and interaction; they are affected by characteristics of the social setting and can reflect personality characteristics of the individual.

CHAPTER II

CONCERN FOR PERSONAL DEATH

In order to focus upon the individual and to propose death related cognitions influence everyday behaviors and the self, it is necessary to demonstrate that certain characteristics of persons in the general population are related to concern for personal death. Robert Kastenbaum has researched the topic for over a decade and contends a "standard, easily identified response that can be classified unambiguously as fear of death has not yet been established" (1974). Fear of death takes many forms and researchers assume that it is related to many concerns. Denial of mortality, occupational choices, risk-taking behavior and phobic behaviors are some of the responses studied. Thoughts concerning nonexistence, the process of dying, pain, dependency and the mode of death are among the several negative responses expressed. Although death related cognitions and behaviors are complex, examining the construction of paper-and-pencil measures and empirical findings based on these and other projective instruments enables a definition of a population that is concerned with the prospects of death. Representatives from this

population are distinguishable from those who are not overly concerned with their mortal nature.

For the purposes of this project, one who consciously or nonconsciously responds to his own eventual death and evaluates inevitable fate negatively is defined as an individual who is concerned with death. This definition allows a discussion of findings that assess anxiety or tension that can motivate behavior and promotes an assessment of various degrees of death concern. Speculative or intuitive efforts to identify attitudes or behaviors that are not direct indicators of death concern do not meet the criteria imposed by the definition and are excluded from the compilation.

Sellitz et al. contend that in addition to its reliability and validity, a measuring instrument must have the ability to make "distinctions fine enough for the purpose it is to serve" (1962: 148). Results from administering a test should also enable an assessment of the degree to which respondents differ on a certain characteristic. Three instruments designed to measure death concern are particularly valuable because various indices of validity and reliability have been determined. These produce findings that identify those overly concerned with personal death, compared to others. Furthermore, researchers using these instruments suggest that the three measures examine the same construct.

Boyar's Fear of Death Scale consists of true-false statements. Templer's Death Anxiety Scale[1] contains fifteen true-false items and Dickstein's Death Concern Scale[2] contains thirty items, each with four response alternatives.

From preliminary interviews, Boyar (1964) derived statements concerned with the act of dying, death's finality, corpses and burial practices. Judges rated items for face validity. Fear of death statements were embedded in filler items. Split-half, item-item and item-test correlations were calculated. An experimental design was used to test the scale's empirical validity. The Fear of Death Scale (FODS) was administered before and after a movie showing fatal traffic accidents that presumably increases death anxiety for an experimental group, and after a presumably innocuous movie showing traffic congestion for a matched control sample. Increases in FODS scores for the experimental group allowed Boyar to conclude that his scale is an empirically valid measure of death fear. He used no procedures to assess construct validity, but construct validity of this measure is explored by Templer.

Templer (1970) tried to reflect broad life

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[1]See appendix "A" for items of the Death Anxiety Scale.

[2]See appendix "B" for items of the Death Concern Scale.

experiences when composing the initial forty items for the Death Anxiety Scale (DAS).[3] A clinical psychologist, graduate students and chaplains rated the statements' face validity on a five-point relevance scale. Thirty-one items were retained and embedded in 200 Minnesota Multiphasic Personality Inventory (MMPI) items. Templer proposed that high death concern is not a variable that predicts specific, measurable, related phenomena, yet theoretically it is associated with emotional response, and a moderate degree of anxiety within the general population. Two separate projects were undertaken to assess construct validity, based on these assumptions.

The first involved administration of the DAS to 21 institutionalized psychiatric patients whose clinical records reported high death anxiety and to a control group of institutionalized subjects, matched for diagnosis, sex and age. High death anxiety subjects had a mean DAS score of 11.62 and control subjects' mean

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[3]Internal consistency of the Templer scale was determined by administering the instrument to three groups; two were undergraduates and a third ranged in age from 25 to 57. Fifteen statements that had point biserial coefficients significant at the 0.10 level in two out of three analyses were retained. To insure lack of redundancy, phi coefficients were computed. A product-moment correlation coefficient of 0.83 between two administrations of the DAS to one group was obtained. In addition to test-retest reliability, the author reports reasonable internal consistency of a homogeneous test; the Kuder-Richardson formula 20 produced a coefficient of 0.76.

score was 6.77. Difference between the means was significant at the 0.01 level. In the second project, the DAS, Boyar's FODS, a word association test and the MMPI were administered to 77 undergraduates following a pilot study that showed significant relationships between the use of emotional words in word association tests and DAS scores. The MMPI was included to identify associations between death concern and personality traits and to judge discriminant validity of DAS items. Intercorrelations among DAS scores and the three anxiety measures within the MMPI would suggest Templer's test identifies general anxiety rather than specific death anxiety. Reported high correlations between the DAS and Boyar's FODS invite the conclusion that both scales are valid instruments, and that neither is unique or superior to the other. Strong, positive correlations between the DAS and word association tests suggest projective techniques can measure death anxiety. Low to moderate relationships among DAS and the three anxiety measures within the MMPI support the contentions that DAS is a valid instrument and that individuals in a general population can experience death anxiety. Death anxiety is not necessarily a manifestation of general anxiety, nor a

certain syndrome of psychopathology.[4]

Dickstein (1972) composed 48 initial items, based on findings from previous research, to measure "conscious contemplation of the reality of death and negative evaluation of that reality." His scale is specifically designed to measure different degrees of death concern. The initial 48-item questionnaire was administered to 93 male and 67 female undergraduates.[5]

Dickstein approached the task of determining construct validity in a manner markedly different than Templer. Dickstein contends that death concern scores should be positively related to scores on general anxiety because "the person who is consciously concerned about death should be more anxious generally than the person who avoids thoughts of death." Additionally, he hypothesized that those concerned with death are sensitive

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[4]Thirty-two patients from an admissions ward of a psychiatric hospital were given the same battery of tests. DAS scores correlated positively with general anxiety and other types of psychopathology in this sample, suggesting schizophrenics, obsessive-compulsives and depressed persons experience high levels of death anxiety.

[5]Item analysis of the Dickstein DCS included examination of tests with the highest and lowest 27% of scores to eliminate 18 poor discriminators. The resulting 30-item scale and the Manifest Anxiety Scale were given to a group of students to determine internal consistency; measures were 0.85 and above. Two administrations of the DCS to female undergraduates from a different college produced a test-retest reliability correlation of 0.87.

to, and avoid threatening stimuli. They should also believe events that affect the individual are not subject to internal control. To examine these relationships, a battery of tests was given to female undergraduates.[6]

The possible range of DCS scores is 30-120. The ranges, means and standard deviations are similar for all administrations of the DCS; the distribution of scores from all tests is approximately normal. Test results indicate a significant, but moderate relationship between conscious death concern and anxiety[7] and between death concern and sensitization to threatening stimuli. Respondents with high scores on anxiety measures scored 85 or higher on the DCS while those low in anxiety scored 65 or lower on the DCS. Differences between the means of high, moderate and low DCS subjects are significant at the 0.01 level.

Klug and Boss (1977) administered the DCS to one group of church-attending Roman Catholics (n=157) and Templer's DAS with eight "Acceptance of Death" items

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[6]The Manifest Anxiety Scale, the State-Trait Anxiety Inventory, the Repression-Sensitization Scale, the Internal-External Scale and the Edwards Personal Preference Schedule were administered with the DCS to volunteers. The personality schedule was used to determine relationships between death concern and differentiating personality characteristics.

[7]These findings are similar to Templer's findings.

constructed by Klug[8] to another group from the same church (n=161). One purpose was to examine possible multi-dimensionality of the Dickstein construct; another was to test the validity of the instrument. Judges identified a "conscious contemplation" factor and a "negative evaluation" factor within the items. The two sets of data from the research project were factor analyzed, using a principal factor solution. Results suggest that the DCS is not measuring a unidimensional construct. Correlations computed on scores from both samples indicate a high degree of relationship between the negative evaluation component of the scale and Templer's DAS. The conscious contemplation component was similarly related to DAS items, but was not related to the eight Acceptance of Death items. These authors conclude that "the nature of conscious contemplation is not clear," and that the Templer DAS and Dickstein DCS are valid measures of the same, but complex concern for death.

Researchers continue to assess the validity of these and other death concern scales. Durlak (1972) administered four measures to 47 male and 47 female undergraduates with the Marlowe-Crowne Social Desirability Scale (1960). Boyar's FODS, Sarnoff and Corwin's Fear

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[8]See appendix "C" for the Acceptance of Death items.

of Death scale (1959), Lester's Attitudes Toward Death scale (1967), and the Lester-Collett Fear of Death and Dying Scale (1969) were presented in random order. Participants were told to complete questionnaires in the order of presentation. Correlations among death concern scales were moderate but significant; no general associations were found between any scale and social desirability indicators. Although higher intercorrelations among scales would account for more variance, Durlak concludes that each "lends support to the concurrent validity of the death measures." Moreover, he finds that responses to these tested items indicate attitudes toward personal death and dying rather than generalized fears of death.

In summary, it appears that researchers have constructed valid and reliable instruments that are capable of identifying various degrees of death concern. Some researchers use one or more of these scales when determining death concern and its possible antecedents or consequences among various populations. Others use projective techniques based on the assumption that an individual does not always say what is experienced when considering personal death. This argument fits the observed methodological constraints of the questionnaire format: "not only may people be reluctant to report openly their beliefs, feelings, motivations, plans and so on; they may be unable to do so . self-report

frequently requires self diagnosis" (Sellitiz et al., 1962: 237). Since death concern can operate at a conscious, imagery or nonconscious level of awareness findings derived from several methodological designs must be considered. Even a limited review of literature demonstrates that a considerable number of variables that relate to perceptions of finitude are examined through empirical research. For the purposes of this study, a limited presentation of research that examines (a) personality or personal characteristics of the individual, (b) demographic variables, and (c) particular roles enacted by the individual is utilized.

Thorson (1977) investigated the relationship between personality characteristics and death fears. He gave the Boyar Scale and the Edwards Personal Preference Schedule (EPPS) to 200 undergraduate and graduate students. He found that females scored higher than males on the FODS. Low scores were related to high aggression and endurance scores. Although his findings are also limited to students, Dickstein (1972) offers intriguing interpretations for associations among DCS scores and three personality traits measured by the EPPS. Death concern was correlated with heterosexuality, succorance and change. Succorance scores were virtually identical for high and medium DCS subjects while the low DCS subjects had markedly lower

succorance scores. Heterosexuality and resistance to change scores were similar for low and medium death concern subjects and different for high death concern subjects. The author posits "if the middle group is regarded as a normative group, it appears that the high death concern group is the discrepant group with regard to heterosexuality and change while the low death concern group is discrepant with regard to succorance." Succorance is defined as a desire to have others provide help when in trouble, to seek encouragement and to seek sympathy. Dickstein suggests that low death concern individuals are "reluctant to acknowledge any failing on self-sufficiency."

Heterosexuality is defined as endorsement of sexual pleasures. Dickstein's data that relate high DCS scores to high heterosexuality scores support earlier findings. Greenberger (1965) used Thematic Apperception Test materials and reports a higher frequency of story completions reflecting illicit sexual encounters among terminally ill adult females compared to control group subjects. Sarnoff and Corwin (1959) found sexual arousal among some males induced a temporary death anxiety. Paris and Goodstein (1966) report females experience a higher level of sexual arousal than males after reading death related materials.

Dickstein's finding that high DCS subjects tend to avoid novelty and experimentation, i.e., they resist change, is interpreted as a "defense against the passage of time leading to inevitable death." Dickstein and Blatt's earlier research (1966) supports this contention. High death concern among healthy young males was related to a foreshortened time perspective. Those preoccupied with death live more in the "present" and value the present compared to the "future." Feifel and Jones (1968) explored the same issue in their study comparing healthy, seriously ill, mentally ill and terminally ill older adults. Although the majority of subjects valued "time," a large proportion of the seriously and terminally ill defined time as meaningless.

Perceptions concerning locus of control is another personality characteristic examined in relation to death concern. Dickstein (1972) found no relationship between DCS scores and scores from the Rotter Internal-External Scale (I-E) among female students. This finding contradicts findings from earlier research by Tolor and Reznycoff (1967) who used a different death anxiety scale and found a strong association between death concern and perceptions of external control among male students. Patton and Freitag (1977) administered a death concern instrument, the I-E scale and a measure of general anxiety to a student sample of 111 males and

116 females ranging in age from 17 to 47. The Rotter Scale (1966) is based on social learning principles and hypothesizes behaviors are strengthened or weakened depending upon the individual's perceptions of his ability to cause desired behavioral outcomes. Patton and Freitag reasoned that those with an external locus of control feel helpless and unable to influence personal destiny. "Man's reaction to death points out how inadequate his coping mechanisms are in helping him deal with fear of death." Therefore, those scoring high on externality should score high on death anxiety. I-E scores among these subjects were inversely correlated with age; the older subjects were more likely to have an internal locus of control. I-E scores were moderately but significantly related to death anxiety, thereby supporting the research hypothesis. Those with an external locus of control showed higher death anxiety and were more anxious in general.

Tolor (1978) used the Health Locus of Control Scale (Wallston et al., 1976) that intends to measure a specific area of external control, an inventory of personal illness and accident, and a death concern measure in his study of white adults. Eighty-six men and women from diverse occupational and educational backgrounds volunteered for the project. Mean ages were 34.2 for men and 38.5 for women. Males reported a greater

frequency and seriousness of accident and illness but these data do not correlate with health locus of control scores. Women scored significantly higher than men on death anxiety but no relationships were found between locus of control and death concern within the research sample.

Nehrke et al. (1977-78) were interested in how different living arrangements affect the elderly's attitudes toward death. They administered the Boyar FODS, the Templer DAS, a Life Satisfaction Index and the I-E scale to 120 adults, all over the age of 60. An equal number of participants lived in private nursing homes, in public housing units and independently in the community. Findings show that the community sample was most satisfied with life, was almost internally controlled and scored highest on death anxiety. Those in nursing homes scored lowest on life satisfaction, highest on externality and lowest on death anxiety. The authors suggest that a sharing of thoughts about death among nursing home residents might ameliorate death concern; no similar opportunity to work through anxiety exists for those who live independently.

Research on locus of control and death concern presents contradictory findings and interpretations. This is a pervasive problem of dying and death literature that is partially explained by the populations studied,

by different conceptualizations of a construct, by the use of different instruments and by the lack of controls for variables that affect relationships. Rather than conclude that empirical evidence negates a possible linkage between perceptions of externality and death concern, analysts must recognize age, sex, place of residence and other variables influence self-perceptions that, in turn, affect death related cognitions.

Sadowski et al. (1979-80) attempt to unravel the nonconclusiveness resulting from locus of control research. Based on earlier findings questioning the unidimensionality of Rotter's construct, they administered the Reid-Ware Three Factor Locus of Control Scale (Reid and Ware, 1973) and Templer's DAS to 164 males and 211 females. The Reid-Ware scale contains 45 items in a forced-choice format and measures Fatalism, Self-Control and Social System Control. Analysis of all responses shows that women score significantly higher on the DAS compared to men. Analysis of male responses via a multiple regression model shows that 33% of the variance in death anxiety is explained by age, and the Fatalism and Self-Control factors of the Reid-Ware measure. No significant relationship was found between the Social System Control factor and the male DAS scores. The same amount of variance in DAS scores for females was explained. However, age was not a determinant of death

concern. Only the Social System Control and Self-Control factors account for variance in death anxiety among women.

The authors suggest that their findings reflect traditional sex role distinctions. The Social System Control factor measures a belief that powerful others influence one's behaviors; the "feminine role has traditionally implied accepting a subordinate social position." The Fatalism factor measures a belief that luck or fate controls behavior and is congruent with "the traditional masculine role of . being able to cope with an adverse and abstract environment." The Self-Control factor measures the extent to which the person believes behavior is determined by immediate impulses. Because it is a predictor of death concern for both sexes, Sadowski et al. conclude that death anxiety reflects concern over "inability to determine one's own behavior rather than beliefs about whether or not events in the environment occur as a consequence of one's behavior."

A limited amount of research on the relationship between self-esteem and death concern has been attempted. Davis et al. (1978) replicated a study by Moses (1973) that found an inverse relationship between self-esteem and death anxiety among college students. Templer's DAS and the Texas Social Behavior Inventory were given to 383 undergraduates (36 black males, 56 black females,

129 white males and 162 white females). Analyses of data indicate that males and blacks scored significantly higher on self-esteem than females and whites. A significant interaction between race and sex was found; black males scored higher compared to all other groups. Female DAS scores were higher than male scores, but no significant differences were found among other groups. The four sets of data were divided into subgroups of high and low self-esteem scores. Low self-esteem respondents (mostly white females) had significantly higher death anxiety scores than others. Black males manifest the least death anxiety. The authors compared mean DAS scores with those reported by Templer and Ruff (1971) on various populations and found that only psychiatric patients scored higher than white females with low self-esteem scores. They conclude that "the cause of this high death anxiety . is not readily apparent but suggests that additional research with such a group is warranted."

Some researchers probe the question of whether or not an individual's occupation affects or is influenced by death concern. After observing physicians who confront a daily threat of death, Hughes wrote "the layman has to learn to live with the uncertainty if not of ignorance, at least of lack of technical knowledge the physician has to live with and act in spite of the more closely

calculated uncertainty that comes with knowing the limits of medical knowledge and his own skills" (Hughes, 1958: 120). Feifel et al. (1967) found that a sample of physicians displayed higher death anxiety than a control group. They reasoned that occupational choice might be affected by a need to master a disproportionately high fear of death. Ford et al. (1971) administered the Collett-Lester and Lester death attitude measures to a group of Buffalo police and to a group of mailmen. Police, like physicians, choose an occupation that cannot avoid the deaths of others. Moreover, police work involves an acknowledged threat of personal death (Rubinstein, 1973). Police and mail carriers did not differ on death fears. The only significant difference between groups was that more mailmen refused to take the test compared to police. Since police death anxiety scores were similar to college student scores, researchers conclude "by being patrolmen they may have worked through their death anxiety" (Ford et al., 1971: 502).

Koob and Davis (1977) investigated death concern among military officers and their wives. The research hypothesis, "a lengthy commitment to a high-risk occupation and the necessary time to work through death anxieties will result in scores for military officers that are similar to those of nonrisk subjects" was confirmed. Templer's DAS was given to 72 active duty

officers and their wives. Women scored significantly higher than men and spouses' scores were moderately but significantly related.

Rather than focus upon specific occupations, Diggory and Rothman (1961) propose a role perspective of death concern, resulting from research on students and older adults. The authors review literature that shows "other things are more feared than [one's own] death." Idleness, being alone, pain, the death of a significant other and cancer are commonly expressed fears. Also, some individuals choose death rather than endure its alternatives. Diggory and Rothman attempt to comprehend the nature of death fears by testing the proposition: "to the extent that the goals a person values highly depend on his social status, his fear of various consequences of his own death should vary with his status or role, whether defined by age, sex, social class, religion or marital condition." Participants (n=563) rank ordered a list of seven consequences of death.[9] No systematic sampling procedures were used but respondents were classified by age, sex, marital status, religious affiliation and a crude measure of social class based on education and family income.

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[9]See appendix "D" for items of the Consequences of One's Own Death instrument.

Frequency distribution tables were constructed showing the number of respondents who assigned a given rank to particular items. Findings indicate that women fear dissolution of the body significantly more than men. Married persons rank inability to care for dependents a critical result of death while single or career oriented persons are more likely to be concerned with the termination of experience and the inability to complete projects. The researchers contend that "actively getting experiences and executing plans are values the loss of which by death would be keenly felt because of their importance to self-esteem."[10]

Empirical studies often report higher death anxiety among women compared to men (Middleton, 1936; Dickstein, 1972; Thornson, 1977; Koob and Davis, 1977). Analysts do not always interpret this finding. Some note that females score lower on self-esteem (Davis et al., 1978), others allude that sex roles might influence the degree or nature of death concern (Diggory and Rothman, 1961), while some explicitly contend that sex roles determine death anxiety (Sadowski et al., 1979-80). McDonald (1976) suggests that death fears are learned

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[10]Diggory and Rothman conceptualize "self-esteem" differently than Davis et al. who found an inverse relationship between self-esteem and death anxiety scores. Findings from these two studies are not necessarily contradictory.

responses. His research found females scored higher than males on the Templer DAS and he concludes "the significance of sex differences and death anxiety is consistent with previous research. The indication that females have a propensity toward higher levels of death anxiety than males could be explained generally as a function of the differential socialization of males and females in our society."

Rheingold (1967) discusses how motherhood affects death fears, based on psychoanalytic case studies. He posits that the symbiosis of child rearing provokes generally intense perceptions of death among women, perceptions that vary with age. Kimball's (1971) interpretations of responses toward death consider the interaction of age with sex and are partly based on observations and interviews with male and female patients, who at various ages faced threatening or terminal illness. He finds that women in their early thirties experience the highest degree of death concern. "Her success in these years seems to be how much she is able to accept her lost youth and simultaneously separate herself from her children." He concludes that some anxieties can result from dependencies and an identity based on a procreative role. Others can result from social expectations for females.

Since sex differences seem to be the most

conclusive findings of death concern research, controlling for gender enables exploration of the many contradictions found when studying specific populations or relationships between death fear and other factors. One area of non-conclusive research is the affect of religion on death attitudes. Generally, researchers study homogeneous populations, consider isolated aspects of the multi-dimensional concept of "religion" and neglect to impose controls for variables capable of determining relationships.

Religious affiliation is one variable that has been examined. Martin and Wrightsman (1965) examined death attitudes among members from three different churches and found no significant differences. Vernon (1970) surveyed college students throughout the United States and found some differences in death attitudes based on religious affiliation. Mormons feared death less than other groups, while Jews reported religious beliefs increase death anxiety. Jepson (1967) studied high school students and adult evening school students to examine Protestant-Catholic differences in attitudes. In this sample, he found that more Catholics define death in negative terms and more Catholics said they fear death.

Other researchers try to determine relationships between religious commitment or degree of religiosity

and death anxiety. Swenson's research (1959) had the purpose of obtaining an objective measure of death attitudes among the aged. Three categories of attitudes--positive or forward looking, evasive, and fearful--emerged from essays written on the topic of personal death. The resulting checklist of attitudes was administered to 200 individuals from nursing homes, golden-age clubs and business organizations. Participation in religiously oriented activities was used to define religiosity. Those who reported frequent religious activities were likely to express positive or forward looking attitudes toward death. Nonreligious individuals were more likely to express evasive or fearful attitudes.

In an early study, Feifel (1959) defined religious individuals as those who believe in God, in a "divine purpose" for the universe, in life after death, and in the bible as the revealer of "God's truth." Others were defined as nonreligious. The research sample consisted of 50 young people, 40 elderly individuals, 35 professionals and 85 mentally ill individuals. Feifel reports religious subjects were more fearful of death and that death fears increase with age. Religious people said that they were aware of death at an earlier age and had a more negative orientation to the later years of life, compared to nonreligious respondents.

In a later study, Feifel (1973) included a

measure of religious creed, a religious self-rating and a measure of religious behavior to distinguish between religious and nonreligious individuals. To assess death anxiety, instruments measuring conscious, imagery and nonconscious awareness of death concern were used. Subjects were 95 healthy and 92 terminally ill persons, ranging in age from 10 to 89 (M=40). No significant differences were found between religious and nonreligious subjects when measuring the three levels of death concern. The only difference found was that at a nonconscious level, the terminally ill expressed more anxiety toward death. Feifel concludes "the characteristic set for most subjects is a kind of coexisting acceptance-avoidance equilibrium toward fear of death" that is not influenced by religiosity.

Chasin (1971) controlled for sex, education, family income and size of home town when analyzing responses from 324 questionnaires received from church members of one area in Iowa. A measure of religious orthodoxy constructed by Browne and Lowe (1951) and the Swenson checklist to measure death concern were used. Chasin finds that "women may be more homogeneous in their conceptions of death than are men." Most females, regardless of religiosity, conceptualize death as "sadness." Male fundamentalists are more likely to see death as "peaceful bliss" compared to less orthodox

males. When controlling for income or education, religious orthodoxy is related to evasive attitudes toward death among men. Males with higher incomes or higher education are less evasive than those with lower incomes or less years of formal education. Considering the importance of controlling for key variables when looking for attitude linkages, Chasin asks "what is it in the lives of women . which causes them to look at death in ways which are not affected by religious beliefs?"

La Piere and Farnsworth (1949) posit an association between age and death attitudes. They contend that a lack of indoctrination into a system of beliefs for the elderly is one reason for a reluctance to accept old age. Being "old" is viewed simply as a preface to death for many, and no adequate preparation exists for assuming an aged role. Consequently, the elderly should be anxious concerning upcoming death. Although empirical studies produce conclusive evidence for the relationship between age and death anxiety, it is not in the direction predicted by La Piere and Farnsworth. Martin and Wrightsman (1965) found older church-going respondents expressed less fear of death than younger individuals. Similarly, Swenson (1959) reported about half of his elderly subjects expressed positive attitudes toward death; some in poor health looked forward to

death. Riley's (1970) interviews with 1,482 adults from urban households show that age is one of the best predictors of death awareness and death attitudes. Older, compared to younger, respondents plan for death and discuss death with friends. They are not likely to express fears about death or dying.

To test the hypothesis that an individual's awareness of time remaining in his life is an inverse function of age, fifty healthy, retired individuals were asked four questions concerning time perspectives (Marshall, 1975). Researchers found that awareness of impending death was strongly related to age; older respondents expected to die in the near future. Moreover, awareness was related to whether or not the respondent had outlived his parents, siblings or friends. Younger individuals who had outlived their parents were most aware of limited time. Researchers explain why age is not the key determinant of death awareness. Experiencing the deaths of others and comparing self to others appear to initiate awareness of the upcoming event.

Nehrke (1974) administered the Boyar FODS and a 21-item semantic differential rating of self-concept to 25 three-generational female family units in order to assess actual and perceived death anxiety. Subjects completed measures in regard to self (actual) and in regard to perceived attitudes of the other two female

members. Findings indicate that each generation rated self lowest in death anxiety. Grandmothers accurately predicted higher death anxiety for their daughters and granddaughters. The youngest generation significantly misperceived the older generations as being more anxious concerning personal death. Nehrke concludes that a grandmother can accurately predict death anxiety of others because she has experienced various degrees of it throughout her life, whereas the more anxious and younger generations "assume" the elderly fear death.

Generally, researchers use college students or the elderly for examining the relationship of death awareness or death anxiety to age. Children and adolescents have received limited attention. For example, Alexander and Adlerstein (1958) administered a word association test to individuals ranging in age from 5 to 16. They found that all age groups in the sample responded similarly to death words. As measured by galvanic skin responses and response time, death words evoked more intense reactions compared to basal words.

Few studies, other than broad surveys that avoid the nature or degree of death concern, attempt to identify the effects of age on death attitudes in a population ranging from childhood through the aged. Although adulthood represents a neglected area of

exploration for those interested in the relationship between age and death anxiety in the general population, findings from specific populations do, however, allow inferences. Since the procreative role is related to high death anxiety, a large proportion of adult women should manifest high death anxiety. Since age is related to locus of control scores, and locus of control to death attitudes, younger compared to older adults should express more concern for personal death. If socialization practices and sex roles explain learned death fears, an interaction among age, sex and sex role expectations might predict high death anxiety exists for younger adult women.

A limited review of studies, that in most cases treat death anxiety as a dependent variable, suggest a summary of characteristics for those who are overly concerned with death. Contrary to many researchers' intuitions, evidence suggests that the elderly are not overly concerned with upcoming death. Perhaps they have had ample time to consider death's finality or perhaps problems faced by the elderly outweigh concern for inevitable death. It can also be suggested that the elderly fear an unknown dying process more than they fear inevitable death. These thoughts are congruent with findings indicating those committed to risky occupations show only low to moderate death anxiety. Those facing

death obviously use whatever mechanisms are necessary to prevent the threat of death from interfering with life's tasks, or they have accepted death as an integral part of life.

High death anxiety is found among some college aged and adult individuals. Heterosexuality, resistance to change, a "present time" orientation, low self-esteem and perceptions of an external locus of control are some indicators of a high degree of concern among college students.

Sex is a major predictor of high death anxiety for adults and college students. Overall, males are less concerned with death than are women. The observed interactions between sex and self-esteem and between sex and locus of control factors suggest that females scoring low on self-esteem or high on externality are concerned with personal death. Introducing a procreative role for these females that includes a high degree of concern for life and death, based on the concepts of separation and loss, invites inference that low self-esteem or externally controlled mothers are individuals who manifest the highest possible degree of death anxiety. If "birth" and "death" are considered opposite ends on a continuum of something called "life," a biological-destiny argument might explain death anxiety among women, as well as the relationship found between endorsement of sexual

pleasures (heterosexuality on the EPPS) and death concern among women. Although it is beyond the scope of this study to explore the question, analysis of the contents of sex roles might provide the most effective means for understanding the emergence of high death concern among women.

The preceding discussions focus upon death anxiety or death fears because most researchers dichotomize responses--an individual either fears death or is unafraid of it; people either accept or deny finitude. Responses are either passionate or apathetic. These simplistic conceptualizations present a major problem for those attempting to understand the nature and degree of death concern. Because researchers can evoke contrived responses toward personal death when administering paper-and-pencil tests, and can impose invalid inferences and interpretations on projective test findings (Sellitiz et al., 1962), the problems of understanding death related responses are compounded.

A few contributors suggest that most individuals acknowledge and react to thoughts about their own death. For example, Alexander et al. (1957) studied death cognitions among male college students and concluded "the concern with death would appear to be a force that has a continuing effect and is not confined . to instances of childhood, old age and psychopathology."

Within his sample, Feifel (1973) found subjects indicated little conscious concern for death. However, at the imagery level, the same subjects perceived death ambivalently. Death was described as "clean" and "gentle" but also as "dark" and "solitary." A word association test showed that the same individuals reacted anxiously to death stimuli.

Diggory and Rothman (1961) posit that the nature of death concern is related to social roles. Although it escapes the attention of these researchers, their analysis suggests why enactment of several and possibly conflicting roles evokes paradoxical responses toward death. It also suggests that researchers falsely dichotomize death attitudes.

In order to comprehend its nature, it appears that researchers must find some means to tap the meanings individuals assign to the consequences of personal death. Understanding contradiction and paradox is necessary. An isolated example of this type of approach is offered by Bakshis et al. (1974) who used a Twenty Statements Test format to operationalize attitudes toward personal death. Seventy-nine nurses answered the question "what is death?" Through content analysis, 17 categories of responses were identified. Two judges coded responses; reliability indices ranged from 0.80 to 0.96. One purpose of the research was to focus upon

"the saliency and the complexity of the symbolic and social context in which death is perceived." Perhaps the most important finding is that death was perceived in a variety of ways by most respondents. The majority viewed death both favorably and unfavorably. Termination of social activities, relationships and conditions were often mentioned responses and these consequences were described in both negative and positive terms. Although a TST approach does not measure specific attitudes, it promotes an understanding of perceived consequences of death. If used in conjunction with other measures, it could ameliorate some of the conceptual problems of dying and death research that have been discussed within this study. Because contradictory definitions emerged from a homogeneous population of white, married nurses and from individual respondents, Bakshis concludes that "one may surmise that these meanings are essentially a reflection of the actor's experience, that they are situationally generated, and selectively expressed."

Although a compilation of empirical studies suggests some possible identifiable characteristics of the individual, the elusive and multidimensional meanings of death pose an unsolved dilemma for researchers and for those who attempt definitively to describe a conceptual population of persons concerned with death. However, research findings do allow conclusions that

individuals respond to perceptions of death. Contradictory responses, affected by the contents of enacted or imagined social roles, are typical. One approach to understand the consequences of death for the person is to explore how and why the self, or an identity, emerges that defines the meanings of personal death.

CHAPTER III

THE ROLE IDENTITY MODEL

Preceding discussions show that concern for death is related to personal and social characteristics of the person. Thus, a framework that considers these factors in its explanation of the self is necessary to explore how perceptions of death and the self are interrelated. McCall and Simmons describe a processual self that determines behavior and influences ongoing relationships based on enacted and idealized roles. In the Meadian tradition, they are interested in what goes on "inside" the person as well as in what goes on "between" people. The authors label the approach to describe and explain who comes together to engage in what activities, where and how as "simply interactionist" (McCall and Simmons, 1978: 10). The focus is upon the individual and his everyday behaviors; the model is theoretically developed by exploring how and why individuals interact. Components of several perspectives (e.g., social exchange, reference group theory, structural role theory) are subsumed by this framework in order to augment the limited explanatory power of any particular theory of human behavior.

G. H. Mead's "self" is treated as an intervening variable between antecedents of the social world and an actor's behaviors. Consequently, the image of man is dialectical. He is portrayed as "dwelling in two distinct 'worlds,' the physicalistic world of animals and the idealistic world of mind and culture." A person is considered a rational thinker, yet "many of the complex decisions with which we credit him should not be interpreted as necessarily the results of deliberate reasoning." Identities are acquired and altered through role partnerships; moreover, relationships "contain the seeds of their own destruction, they cause members to change, and changed members entail altered relationships." This image of the symbol using person who constructs and defines a reality that is "fragile and adjudicated--a thing to be debated, compromised and legislated" presents a unifying, symbolic interactionist theme to the role identity model that invites further exploration based on a dialectical perspective of social behavior.

Its authors contend that the framework is best suited to explain self and interaction among young and relatively independent persons who have the resources to seek rewards from various settings while recognizing opportunities are limited by man's finite nature. Delineating the processual nature of self and interaction

is a critical goal of the role identity model. McCall and Simmons suggest that the intuitive charm of unilinear causation precludes investigation of the interdependence of variables in most social scientific efforts. Thus, to introduce their perspective, the concept of interaction is defined. "Whenever a relationship of deterministic influence between two events cannot be resolved into a simple function of one but must instead be treated as a joint function, as a mutual or reciprocal influence, we have a case of interaction" (1978: 46). Through interaction, the planning, sometimes rational, individual assigns and interprets arbitrary but shared meanings to stimuli; resulting social objects enable appropriate plans of action to achieve desired goals. A person's enduring and situationally specific selves are seminal social objects that implicate expressive and cognitive activities for all interactants.

McCall and Simmons posit that the person's conception of self is likely to be role specific. Rather than limit their analysis to structurally prescribed and conceptually static "social roles," they synthesize personal characteristics with social characteristics of the individual by using the concept "interactive role," a line of action that considers both conventional expectations and idiosyncratic perceptions of a position. Whereas interactive roles are expressively enacted, "role

identities" are cognitively enacted. The content of a role identity is an "imaginative view of [the person] as he likes to think of himself being and acting as an occupant of [a specific] position" (1978: 65). A person has role identities for each status he assumes and for each he plans to occupy; identities may cluster, based on shared skills, audiences or institutional context. These idealized roles are somewhat determined by other persons; thus the content of role identities includes others, and is emergent since individuals have several interaction partners.

Role identities do not simply form a set of disunited parts. Rather the parts "exist in relation to one another and . . . the relationships may be those of conflict as easily as those of compatibility" (1978: 74). Identities are woven into an interrelated whole, representing a somewhat stable idealized self, and into fluid situational selves. A prominence hierarchy defines the holistic self. It is determined by the degree to which a person supports his own view of role identities, the degree to which identities receive support from significant others, and the commitment to, or investment in certain roles. It is therefore influenced by an interaction exchange of rewards. Rewards can be extrinsic, intrinsic, take the form of role support or be a combination of any forms. Intrinsic rewards, the

gratification received from performance itself, is viewed as a link between "animal" and "idealistic" worlds of humans. Role support is defined as a "set of reactions and performances by others the expressive implications of which tend to confirm one's detailed and imaginative view of himself as an occupant of a position" (1978: 71). Since role support confirms the content of role identities, a reciprocal process of defining and interpreting each other's performances is a mechanism for legitimating role identities. Audiences vary in their relevance for role support and a person's self is among his most important critics.

McCall and Simmons link the self to behavior by positing that role identities suggest plans of action. An individual is continually motivated to legitimate idealized versions of self since discrepancies always exist between the content of role identities and support gained through interactive role performances. Obtaining intrinsic and extrinsic rewards through performances shifts the need state of the individual in readily predictable patterns. The rewards of role support, however, affect role identities differently. Receiving slightly more or slightly less than the desired amount increases the need for additional role support. Extreme discrepancies evoke different responses. Receiving significantly more than desired can increase an appetite

for additional role support. Receiving extremely less than anticipated amounts discourages the individual from seeking further support for that specific identity (1978: 86 and 98).

A salience hierarchy of role identities represents the means for managing situational selves. It is the person's preferences for enacting a subset of interactive roles. A finite person realizes that each role represents a different line of action, that role identities are not equal in importance and that enactment opportunities are limited. Additionally, the performance of any given role is multiply relevant; it involves and affects numerous identities. An individual arranges a salience hierarchy to represent a relative order of priority of identities as possible sources of performance in a specific situation. This hierarchy is determined by the prominence of various role identities and by perceived opportunity structures. It is also determined by situationally specific needs.

Through interacting with others, a person seeks role identity support. "Undoubtedly man's most distinctive type of gratification is support for his various role identities" (1978: 148). Meanings attached to all social objects, including alter's responses, are created and defined through perceiving implications for cognitive and expressive activities. McCall and Simmons

consider the premise that perceptions are arbitrary, incomplete and not always accurate. Past training and experiences, a person's hierarchies of role identities, sensory limits, personal perspectives and selective attention are factors that influence the active process of directly perceiving role partners.

When interpreting a message from alter, ego recodes empirical information via abstracting and assigning messages to symbolic categories. In order to identify potential role support opportunities, one actor can categorize another's social identity by stereotyping and can assess his personal identity through the indirect knowledge of his personal reputation. Although both types of impressions often contain bits of misinformation, they enable initial encounters. A person, compared to other social objects, has the unique ability to "purposefully and differentially conceal or reveal certain of its characteristics" in order to maintain control over the self being presented (1978: 115). Thus, the information exchanges between actors are continually calculated with the goals of obtaining role support and other rewards. Since unconscious gestures and attitudes affect "expressions given off" (Goffman, 1959: 2) and since alter imputes characteristics to ego that will benefit his line of action, expressive control of the self is never total.

Socialization outcomes usually help the person understand the context of structured situations, thereby giving him cues to the meanings of alter's behavior. In unstructured situations, those that are somewhat ambiguous and those that represent most encounters, alternative interpretations of events and identities are possible. A working agreement, or mutual negotiation of identities in order to receive at least partial recognition for idealized roles, is necessary (McCall and Simmons, 1978: 139). Cognitive and expressive processes explain how a working agreement emerges.

Role taking is a cognitive activity that allows the actor to perceive opportunity structures from which to gain support for salience hierarchy identities. The purpose of role taking is not to see a "true self" but to judge, through alter's behaviors, his line of action that gives coherence, direction and meaning to his interactive role in a specific situation. Inferring identity is a mutual process between actors. Role taking ability is affected by the conventionality of settings and performances, by familiarity with alter and by subjective or objective experiences with similar roles. Finally, role taking is a metaphor. "When we 'project' ourselves into [alter's] situation and imagine how we would feel, we are sometimes impressed by the intensity and realism of our own feeling, but these

feelings are ours, not his, and the accuracy of our role taking remains uncertain" (1978: 131). In addition to role taking, an actor cognitively improvises an interactive role, in terms of how alter's behaviors can be used as an opportunity to gain rewards.

Role taking and devising appropriate interactive roles are seminal components of interaction, yet they cannot be witnessed by others. The expressive processes of presentation of self and altercasting explain how actors overtly communicate perceptions. Goffman's (1959) presentation of self describes how actors control expressive behaviors in order to communicate the character assumed in a particular situation. A skillful actor claims an identity that is difficult for others to deny. He constrains alter to act in accordance with his interactive role. In a sense, presentation of self becomes a self-fulfilling image because alter's responses reflect ego's performances of a certain character. Tactics used to present the optimal self are influenced by the audience and by personality characteristics of the actor (Weinstein and Beckhouse, 1969). Altercasting is analogous to presentation of self, in that one actor attempts to control the expressive behavior of another and the imputed role tends to be self-fulfilling. Its point of application, however, differs. Altercasting is the process whereby ego imputes to alter a particular

role and acts toward him as if he were that particular character (Weinstein and Deutschberger, 1963).

All actors engage in cognitive and expressive processes of interaction, thereby producing a complex intertwining of social and personal identities among interactants. Factors such as status differentiations and structural expectations constrain the individual's behaviors, yet McCall and Simmons posit that most circumstances allow for the negotiation of social identities. Both social and interactive roles are compromised by actors through bargaining. Negotiations of social identities are motivated by considerations of potential profit. Each change, or refusal to change, in both altercasting and presentation of self is acknowledged by expressive behaviors. Interactants seek support for role identities that are highest in the salience hierarchy and are thus willing to cede dimensions of self in order to reach perceived goals (Blumstein, 1975). When actors' identities in an encounter are reasonably negotiated, a "working agreement" exists that allows interaction to continue. Working agreements do not usually represent the goals of interaction, nor are they necessarily stable agreements. Actors continue to struggle over the character they wish to portray (McCall and Simmons, 1978: 139). However, the working agreement is a component of defining the situation and enables the beginning of

interaction tasks that are aimed at achieving certain goals.

McCall and Simmons posit "our actions are tailored to convey, through expressive implications, hints of what we are willing to do, if only alter will accept certain detailed contents of our altercasting and presentation of self" (1978: 147). Weinstein and Deutschberger (1964) extend this analysis by focusing upon the function, rather than the content of activities. Actors bargain, adapting to goals and circumstances of specific encounters, so that the task response for ego becomes the line of action for alter. Negotiated social and personal identities enable the person to seek extrinsic and intrinsic rewards for role performances. More importantly, the person seeks support for role identities, or the self. "Men seek to live and act in the manner in which they like to imagine themselves living and acting or, failing that in some degree, at least to be able to continue thinking of themselves in that same manner" (McCall and Simmons, 1978: 148). Individuals seek role identity support through the merits of performances, or more deviously through "outright bartering." Usually, encounters involve a combination of tactics and have the purpose of achieving a mixture of rewards.

Identities must continually be legitimated because discrepancies always exist between idealized selves and

role support received. "Woman's work is never done, nor is that of maintaining the self." Sustained relationships provide a somewhat routinized means for obtaining necessary role identity support. Relationships can be categorized by the basis for interaction, e.g., institutional, legal. McCall and Simmons posit that the nature of a relationship is based on reward dependability, ascription, commitment, investment, or attachment. Often, these factors blend together in relationships, yet they remain at least analytically distinct from one another. Individuals tend to become preoccupied with attachment as the basis for continued interaction but "the societies they live in are most concerned with their ascriptions and commitments" (1978: 171).

Ascription provides the individual with some of his first role identities. A child's sex, socioeconomic, religious and family roles form the basis for later identities. Cognitively learning social roles through anticipatory socialization, that is, "learning something of the shape and content of many roles that he will not be allowed really to perform for many years, if indeed ever," is a neutral process that can prepare a person for future roles as well as provide unrealistic expectations for the individual. For some roles, including a dying role, anticipatory socialization is impossible. A young person fantasizes enactment of

future roles and thus begins to attach the ideal standards for roles that will become the content of role identities. First audiences are critical for the person's decision to embrace or abandon certain identities; later experiences teach him to accommodate to a conventionalized world. Most importantly, idealisms do not easily disappear. "Unfulfilled components of role identities have a way of being visited upon the heads of succeeding generations" (McCall and Simmons, 1978: 215).

Role identity hierarchies emerge once the person perceives rewards for interactive roles. As audiences and experiences become diverse, the clustering of identities begins. Unfitting roles are abandoned and those congruent with opportunities enter the hierarchy. Skills and role partners are factors that affect the process that continues throughout a person's life. Adults "outgrow" identities, but identities once legitimated are difficult to discard, "especially those associated with great vigor, athletic skill, beauty, occupational horizons, mobility and freedom." Nonetheless, as audiences change, the self changes. A continual process of accommodation appears to represent the person's self. Allocating resources, while considering the demands of relationships based on ascription and commitment is necessary. Since the person shapes, and is shaped by his opportunity structures,

managing them is a seminal life task; logistical problems result from man's human nature. "Although man's opportunities are thus limited, as by the laws of physics and physiology, his aspirations are not" (1978: 232). Since the calculations of costs and rewards from relationships are subjective, and interpreting alter's behaviors is to a degree egocentric, misperceiving opportunity structures is common, or as McCall and Simmons write, "love is blind."

Scheduling time and investment for performances in order to maximize profits is managed through agenda construction. Short term agendas are determined by the person's salience hierarchy, or situational selves. They represent preferred alters and situations that encourage multiply relevant role enactment. Short term agendas are nested in long term agendas. The later are abstract plans or goals that indirectly influence activities. The relationship between short and long term agendas is somewhat problematic, as each can disrupt the other. "Prime encounters," those that involve high levels of emotional intensity, can upset commitment to short term agendas. Long term plans can be revised due to life crises or other extraordinary events. McCall and Simmons conclude their analysis by observing that the usual patterning of a person's activities represents an accommodation to the limitations of the empirical world.

But, "we are only partly bound by physical events and only tenuously bound to the present. Our symbolic proclivities allow us to people the empirical world with characters, events, and objects that no positivist could hope to detect."

Propositions delineated by McCall and Simmons can be integrated with generalizations derived from dying and death studies in order to suggest reciprocal relationships between death and the self. The following case study[11] shows how acknowledging death influences the everyday behaviors for one person, and illustrates the interrelationships among hierarchies of role identities, agenda construction, perceptions of opportunities and means for accommodating to eventual death.

Richard and Jane are married to each other. They are both in their mid-30s and they both acknowledge that their maximum life span is approximately 50 years. Richard endures a terminal kidney condition; one that isn't popular and one that is not being researched. Physicians informed him of his terminal condition during the seventh year of his marriage to Marie and during the last year of his graduate course work. Investment in academic roles and commitments to the marital relationship

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[11]This information was obtained through informal, unstructured interviews, conducted in the Fall of 1979.

ceased. Role identity hierarchies seem to have been drastically rearranged. It was no longer possible to receive role identity support for a husband and future father role, since Marie decided that a terminal spouse who shouldn't procreate wasn't part of the marriage arrangement. Marriage with Marie ended and began with Jane. The costs of a several year competition for a respectable position teaching medieval literature no longer appeared to be balanced with its potential rewards. Thus, academia was put aside in order to seek employment with immediate income rewards.

In one sense, Richard accommodates to his terminal world. His plans concern a foreshortened future. His activities are directed toward receiving rewards from delimited opportunity structures, and he has ceded several dimensions of self that were, at another time, important. In another sense, he doesn't accommodate to the limiting world of others. For example, he isn't concerned with the economic status of the U.S. when his children mature, he doesn't plan to compete for professional opportunities, he spends money on unplanned, spontaneous vacations and adventures rather than saving for the future. He claims he is not restricted to living his life in the manner expected for most adults. He senses a large degree of freedom to select role partners and interaction settings. In summary, Richard's

acknowledged mortal nature affects the content of role identities, the hierarchies of role identities, the encounters and relationships from which to gain rewards, and long term and short term agendas. Although his life is unusual in that he has a crystallized perception of when existence will end, some of his responses to finitude should be similar to those of individuals who are concerned with eventual death. Integrating role identity model propositions with dying and death literature is one way to generalize how perceptions of death affect the self.

The major concepts used by McCall and Simmons to explain self and everyday behavior are role identities, interactive roles, hierarchies of role identities, negotiation of the self and opportunities for rewards. Several definitions and propositions of the role identity model are particularly useful for this study. The following components will be used to propose relationships between an observable self and perceptions of death.

1) The content of a role identity is an idealized version of the person as an occupant of a specific position. The person defines content, and it is shaped by alter's responses to role performances.

2) An interactive role is a synthesis of a socially prescribed role performance with a person's idiosyncratic perceptions of a social position. Thus,

the person constructs and devises interactive roles.

3) A prominence hierarchy of role identities defines the enduring, holistic self. A salience hierarchy defines situational selves and represents preferences for interactive roles or subsets of roles in specific situations. Hierarchies can reflect conflicting arrangements of identities; they are largely determined by the rewards and costs of interaction.

4) The cognitive processes of role taking and improvising interactive roles, and the expressive processes of presentation of self and altercasting are means for reaching a working agreement of negotiated identities that enables pursuit of interaction tasks. Actors control each other's behaviors and are constrained by each other's behaviors.

5) Perceptions of opportunities, i.e., of rewarding interactions, are arbitrary, incomplete and not necessarily accurate. They are based on the person's process of giving symbolic meaning to stimuli of the empirical world.

6) Opportunities to receive extrinsic rewards, intrinsic rewards and role identity support are limited. Actors receive rewards through encounters and sustained relationships. Managing opportunity structures and managing investments of identities are means for maximizing interaction profits in a finite world.

Research findings generally show that concern for personal death is based on enacted and imagined social and personal roles. Since the person embraces multiple roles, perceived consequences of death are contradictory; overall, they appear to be ambivalent. Ambivalence toward death is found by those using different methodological designs and by those studying different populations.[12] More specifically, a foreshortened time perspective and perceptions of limited opportunities for experiences and role enactment are usually found to be related to contemplating death. General anxiety, concern for health, being female, motherhood, a high degree of succorance, endorsement of sexual pleasures, resistance to change, an external locus of control and low self-esteem are additional factors relating to a death concern that is intense enough to suggest how it motivates behavior. These findings invite propositions regarding how perceptions of finitude affect the self for those overly concerned with death.

In summary, the role identity model presents an

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[12]Ambivalence, as a typical response, is discussed by researchers who examine various units of analysis when exploring death concern. For example, H. Feifel (1959) and I. E. Alexander and A. M. Adlerstein (1958) focus upon the individual's ambivalent responses. Sociologists also research and analyze "American" ambivalence; e.g., see Parsons et al. (1973) and Dumont and Foss (1972).

explanation for an emergent self that seeks rewards for idealized roles through interaction. The model suggests a reciprocal relationship between perceptions of death and the self that is observable through empirical research. Since death is a personal event that terminates the self, and it affects intimate others, the model appears ideal for explaining how actors construct meanings for the self in a finite world. Although the authors consider ways in which actors constrain each other's overt and covert behaviors, they adopt a voluntaristic postulate that can limit the model's explanatory power. They acknowledge mechanisms of social control are "regrettably omitted" by their framework. Because death can represent the ultimate form of social control, research on dying and death that is amenable to conformity and cognitive dissonance analysis enables generalizations that explain how social control affects the self and definitions of personal death. Comparing these analyses to those implied by the McCall and Simmons framework is a means for examining the adequacy of different perspectives.

CHAPTER IV

CONFORMITY AND COGNITIVE DISSONANCE

Social control refers to mechanisms that interactants use to reduce or eliminate deviance (Crosbie, 1975: 510). Since it can be achieved through rewarding conformity or through the redefinition of constructs, exploring dying and death literature with theories of conformity and cognitive dissonance is worthwhile.

Kiesler and Kiesler define conformity as a "change in behavior or belief toward a group as a result of real or imagined group pressure" (1969: 2). Researchers disect the concept into two dimensions for the purposes of observation. Informational conformity, private acceptance of group norms and conviction are terms used to describe acquiescence to the standards and beliefs of others when no external pressures for conformity exist. Normative conformity or compliance is a response to at least an imagined pressure to conform. Meeting others' expectations brings approval and fulfills informational needs; neglecting expectations evokes rejection and disapproval.

The conformity process is complex, often includes combinations of the above dimensions, and is explained

by several social psychological theories. Festinger's social comparison theory (1954) offers an explanation for informational conformity and is the basis for several research efforts. The model posits that individuals attempt to establish social support for beliefs in order to avoid anxiety and uncertainty. A drive for "social reality" encourages a change in opinions or beliefs in order to receive rewarding support from others. Festinger contends that individuals compare themselves to similar others (1954: 123) thereby suggesting that informational conformity has a greater influence on the opinions of disagreeing but not extremely different others. Role theories which posit that behavior is governed by the expectations for an incumbent role, to gain rewards and avoid negative sanctions from a role partner, are used to explain situationally specific normative conformity (Turner, 1968). Exchange theories that focus upon rewards for acquiescence also predict compliance (Homans, 1961).

When conformity is treated as an independent variable, the above perspectives suggest that the process affects ongoing interaction, group stabilization, group structure and cohesion, social control of members and the distribution of resources (Crosbie, 1975: 431-442). These effects are found within dying and death literature. Glaser and Strauss (1965) and Gubrium

(1975) find that nonconformity to behavioral expectations of a hospital or nursing home invites avoidance by staff members, and tactics to encourage conformity. "Herding" patients to day rooms in nursing homes and reassigning terminal, disruptive patients within a hospital are mechanisms for social control.

Research on terminally ill patients demonstrates that persons who accept upcoming death conform not only to behavioral expectations, but also to the beliefs of others concerning imminent demise. The Glaser and Strauss "open awareness" context suggests that all interactants are aware that death is unavoidable. This belief, that a life will soon end, affects expectations of staff, families and patients. In this situation, a patient cannot check information received against known facts, since death is literally unknowable and the exact time and circumstances of the event are unknowable. The individual must accept the standards and beliefs of others as evidence for reality. Acquiescence to beliefs concerning death allows interaction with family members in preparation for death. Arrangements for funerals and the disposition of goods upon death, requests for spiritual guidance in preparation for an afterlife, and discussions concerning life's experiences are common for the accepting patient. Denial of death can remove the patient from others' preparation for his death, thus

encouraging a premature separation.[13]

Lofland (1978) examines case studies to explore how individuals construct dying roles and how others respond to emergent roles. She finds the dying, to a certain degree, sense freedom from many social expectations and often perceive option in shaping a unique dying role. However, role partners impose sanctions for what they consider inappropriate behaviors. Lofland concludes "undoubtedly, for most who confront the dying role . . the problem of construction is control" (1978: 19).

Because the dying find themselves in settings that cannot tolerate deviance or in circumstances that restrict behaviors, it is not surprising to discover a large degree of conformity among the terminally ill. The Kubler-Ross (1969) thesis that suggests individuals generally "accept" death is explained by conformity. The dying accept others' beliefs concerning mortality. Acceptance brings continued interaction with nursing staff

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[13]Spiegel's (1977) study on grief and anticipatory grief is based on interviews with mourners and a review of related literature. He concludes that anticipatory grief, or preparing for death by grieving before the event, includes rehearsals for loss by gradual and progressive separation from the individual before death. The patient influences the process. He can either continue to make decisions as long as he is conscious, or can allow others to respond to him as if he were absent from the group.

and family (Glaser and Strauss, 1965). The dying can continue to be integral group members and maintain approval, status and other group issued rewards. Since conformity can describe and predict the content of a dying role it appears to provide a limited understanding of how interaction shapes behavior among those encountering death. However, it does not enhance an understanding of how the healthy, including those concerned with future death, conform to a finite nature.

Kiesler and Kiesler identify group pressure as the mechanism that explains effectiveness of conformity. "Group pressure is a psychological force operating upon a person to fulfill others' expectations . . especially those expectations of others relating to the person's 'roles' or to behaviors specified or implied by the 'norms' of the group to which he belongs" (1969: 31). The McCall and Simmons model posits that the "personal" roles, or those factors that uniquely shape one's interactive roles, are components of the self that extend the boundaries of norms and social roles. Rather than enact a mechanistic script applicable to mortal people, the individual gives meaning to life plans and projects that often transcend his finitude. There are no "group pressures" to live a mortal, limiting life for those who can symbolize the event of personal death.

Among theories of cognitive inconsistency,

Festinger's theory of cognitive dissonance is most useful for exploring how perceptions of death can operate as mechanisms of social control. Generally, congruity theories posit that rational man has a need for homeostasis. Heider's (1958) classical Gestalt stance contends that inconsistencies concerning the person and his environment exist within the phenomenological stimulus field. For Heider, needs represent stimulus field dynamics rather than specialized motivational states. Osgood (1960) and Festinger (1957) are among those who conceptualize inconsistencies as drives, similar in nature to physiological drives.

The conceptual unit of dissonance theory is the cognitive element, or a knowledge, opinion, or belief about the environment, oneself, or one's attitudes. Relations between cognitions can be consonant, irrelevant, or dissonant. If one cognition (or set of cognitions) psychologically implies the other, the relationship is consonant. If one implies the opposite of the other, the relationship is dissonant. Relationships are based on the individual's perceptions, and do not necessarily represent logical relationships. Experiencing dissonance is a motivational state for the person. The amount, or magnitude, depends on perceptions of relevance. A seminal component of Festinger's theory is its predictions for changing cognitions. The

resistance to change cognitive elements is determined by the clarity of "reality" and by the difficulty of changing cognitions. Ambiguous or abstract elements have a relatively low resistance to change (Wicklund and Brehm, 1976). Personal death, especially for the nondying individual, represents an abstract, seemingly unknowable event. Thus, responses to thoughts about death should not be resistant to change.

Dissonance is created by decision making, forced compliance, or by the exposure to information. It cannot be eliminated but it can be reduced to a manageable level. Eliminating cognitions, reducing their importance, adding new cognitive elements or increasing their importance reduce dissonance. The resistance to change of the most relevant cognitions determines which method is used.

Wicklund and Brehm (1976) outline the implications of the three distinct paradigms of the Festinger theory.

> 1) When a person chooses between attractive alternatives he experiences dissonance that can be reduced by magnifying the attractiveness of the chosen alternative and by reducing the attractiveness of the rejected alternative;
>
> 2) When a person is "forced" to engage in behavior that he would normally avoid, he experiences dissonance that can be reduced by coming to favor the behavior in which he has engaged;
>
> 3) When a person is experiencing dissonance with regard to some issue, he will tend to seek dissonance-reducing information, and

correspondingly, he will tend to avoid dissonance-increasing information.

In order to interpret dying and death studies with the principles of cognitive dissonance, it is necessary to demonstrate an unfitting relation between cognitive elements. The cognition "I am mortal" can obviously conflict with many attitudes, intentions and behaviors of the individual. Furthermore, since anxiety is a tension state and since dissonance is a tension state, it is likely that some dimensions of death anxiety can be discerned as dissonance.

Disaster studies demonstrate that clear, concrete facts show man his mortal nature; facts that are highly resistent to change. Survivors of the Buffalo Creek flood dream of drowning, feel guilt for living and generally find resolution for the trauma to be problematic. Hiroshima victims respond similarly and acknowledge membership in a stigmatizing group that is defined by death. Both groups of survivors manifest anxieties and phobia that disrupt previously routinized interaction patterns. Buffalo Creek survivors became alienated from each other (Erikson, 1976), and Hiroshima survivors report marriage and employment restrictions (Lifton, 1976). For these individuals, managing the large degree of dissonance aroused by death confrontation is difficult, if not impossible.

When death concern is conceptualized as a source of dissonance, those with high death anxiety can be compared to those with low death anxiety to explore mechanisms for managing dissonance. Among other characteristics, high death anxiety is related to an external locus of control (Sadowski et al., 1979-80), a present time orientation (Dickstein and Blatt, 1976), resistance to change (Dickstein, 1972) and low self-esteem (Davis et al., 1978). Perceiving that external events shape behavior is analogous to forced compliance. Dissonance theory would predict a high degree of death concern for those with high externality since the person acknowledges the impossibility of avoiding death. Preferring the present, avoiding thoughts about the future and resisting change are congruent with anxiety about nonexistence. A person with low self-esteem senses little efficacy and might therefore not sense capability to control life's tasks before death. Thus, dissonance theory appears capable of explaining the relationships between fear of death and perceptions of present experiences for some individuals.

Researchers often find that the elderly and the terminally ill manifest low death anxiety compared to other groups, although they often acknowledge death is imminent (Nerke, 1974; Swenson, 1959). Since there is no choice in selecting age or one's health, perhaps these

people reduce death related dissonance by rejecting the negative aspects of terminality. This inference is supported by the Swenson (1959) and Fiefel (1973) studies that suggest some terminally ill or elderly people look forward to personal death.

Some psychoanalytically oriented researchers posit denial alleviates tension or anxiety experienced from thoughts about death. Weisman's (1972) findings, based on clinical case studies, fit dissonance theory predictions. He writes, "only the fact of death is final; everything else is uncertain and inconclusive" (Weisman, 1972: xvi). Death can be postponed and postulating nonexistence is an illogical exercise. Weisman posits that three types of denial are commonly found among those who sense a threat of death. First order denial is based upon perceptions of the preliminary facts of an illness, second order denial refers to perceived implications of a terminal illness and third order denial is concerned with "the image of death itself: denial of extinction." This research interprets denial as a mechanism that helps nullify the constant threat of nonexistence while encouraging individuals to participate in a limiting and limited world. The terminally ill often engage in what Weisman labels middle knowledge regarding death:

> Patients seem to know and want to know, yet they often talk as if they did not know and did not want to be reminded of what they have been told.

> Many patients rebuke their doctors for not having warned them about complications in treatment or the course of an illness, even though the doctors may have been scrupulous about keeping them informed.

To deny the upcoming event, patients or those threatened with death seek information consonant with a desire for life, even if it involves misperceiving critical information.

The most obvious group of individuals who attempt to reduce dissonance concerning death awareness through denial are members of "immortalist" organizations. Over one million Americans pay membership dues in order to attend meetings and to receive newsletters containing information on the latest procedures to forestall death (Simpson, 1979: 23). Such thoughts as "it is not essential that we die . . . the only reason we do is that we don't know any better. We agree that physical immortality is the intended goal of human evolution" are dispersed throughout immortalist literature (Otto, 1979: 4). Denial of death is an apparent dissonance reducer for those who are dying as well as for those whose death is an unforeseeable future event. Selective interaction and seeking selective information are mechanisms that individuals use to deny eventual death.

Although some circumstances absolutely prevent denial, dissonance theory should predict behaviors or attitudes that demonstrate attempts to manage the

tensions associated with acknowledged mortality. Psychological closure, the inability to "feel," found among disaster survivors (Lifton, 1976; Erikson, 1976) is one observed response that verifies the dissonance model. Frankl's (1963) reflections on experiences in a concentration camp suggest apathy, or the inability to "care," is another. As a camp physician, he constantly witnessed death, while realizing that his own life was threatened. He writes, "the corpse which had just been removed stared in at me with glazed eyes. Two hours before I had spoken to that man. Now I continued sipping my soup" (1963: 35). To survive, Frankl espoused his "human freedom--to choose one's attitude in any given set of circumstances, to choose one's own way." He concludes that the camp restricted life, but the person's inner decisions shaped identity as it emerged under death awareness conditions.

The dissonance model appears useful for explaining variance in ways individuals cope with death concern. Life, compared to death, is attractive for most people. Those who have opportunities can engage in selective interaction or seek selective information to reduce death concern. Those with seemingly little or no choice can enhance beliefs that dying and death have meaning and that a degree of personal freedom exists when confronting personal death.

Since the reduction of dissonance often involves redefinition of important cognitions or clusters of cognitions, it is possible that it operates as a mechanism for social control that affects the emergent self and the individual's perceptions of personal death. However, research on dissonance invariably occurs in the laboratory (Wicklund and Brehm, 1976); this places a considerable restriction on exploring the question. Only post hoc inferences allow the analyst to posit reciprocal relationships between death and the self when relying solely upon the dissonance model. Theoretically, it appears more suitable than conformity processes for explaining and predicting how death concern influences the self. In its extreme form, dissonance represents a discrepancy between an idealized and actual self. An examination of how symbolizing individuals cope with limited worlds could be a salient issue for those who adopt a cognitive dissonance perspective.

CHAPTER V

A SYNTHESIS

The McCall and Simmons role identity model and Festinger's cognitive dissonance theory can both explain and predict relationships between death and the self. Comparing the utility of models with an appropriate "critical experiment" design is impossible because of the substantive area of research. Each approach has obvious advantages and disadvantages; each can explain some of the unknown amount of variance in responses to thoughts about personal death.

The role identity model specifies possible cognitive and expressive behaviors of adults who are concerned with terminality. It produces testable propositions, but it is somewhat restricted by its neglect of social control which affects a processual self. The dissonance model directly assesses the tension generated by a consciousness of finitude and generally suggests means for managing tension. It doesn't specify how or why dissonance is aroused when an individual considers future death and it doesn't necessarily identify specific ways to reduce death related dissonance. Only inferences allow predictions

based on one of the three major components of the model because most propositions of the theory are amendable only to experimental designs. Since active, creating man is inevitably constrained by his limited nature, it appears the models complement each other. Their integration should produce a powerful device for explaining variance in cognitive and expressive responses to thoughts about personal death. Moreover, both processual models examine the individual's interpretations of reality. Observing the emergent self who defines and responds to perceptions of future death would enable the refinement of theories that explain motivated behavior.

Glaser and Strauss (1971) discuss "substantive theory" as a link between empirical data and formal theory. Formal theory can be generated by either "rewriting" substantive theory in order to extend its generalizability, or by comparing substantive theories to locate common explanatory elements. The relevance of constructing substantive theory on dying and death perceptions concerns its ability to contribute to a cumulative body of knowledge that enables development of empirically based formal theory. For example, theory and research on dying can be compared to theory and research on separation or loss that has similar implications to death. Substantive theory on responses to imagined consequences of death could provide direction

for developing conceptual categories, properties of categories, and hypotheses to test conceptual links. In the particular instance of death research, the use of broad theoretical frameworks that consider the individual's ability to construct reality is necessary for initial conceptualization because personal death is objectively an unknown. This direction suggests an approach to explaining behavior that gives the individual credit for defining his social reality can benefit from substantive theory on dying and death.

It is beyond the scope of this project to empirically investigate the utility of theory on death and the self. However, hypothesis construction is possible. The balance of this effort summarizes thoughts that emerged from considering dying and death studies within the boundaries of cognitive dissonance and role identity frameworks. The summary is presented to outline components of a causal process format of substantive theory (Turner, 1978). Abstract and concrete concepts are defined and operationalized. Existence statements describe situations in which relational statements apply.

Death refers to the termination of human experience. It represents the ultimate limit imposed upon the self, behavior, plans, and abstract goals. The self is a social object that emerges through interaction. It is composed of idealized social and personal roles, or role

identities, that motivate behavior.

The content of role identities is affected by perceptions of death. Idealisms are shaped by acknowledged and personally defined limits. As interaction partners exit through death, the content of role identities reflects the loss of social objects as well as an awareness of future loss.

A person constructs interactive roles that reflect his concern with death. The idiosyncratic portion of an interactive role includes personality characteristics that are related to high death concern. Thus, attributes such as succorance, heterosexuality, external control and low self-esteem can potentially affect the interactive role in any situation. When an individual selects an interactive role, based on these characteristics, he will magnify the attractiveness of its components while reducing the attractiveness of alternative lines of action.

Since hierarchies of prominence and salience are largely determined by perceived opportunity for rewards, a person concerned with personal death should place identities that can gain immediate rewards in more prominent positions than those relying upon the future. This factor should therefore affect both the person's situational selves as well as his holistic self.

Since perceiving opportunities is based on

symbolizing the empirical world, a person concerned with his death will sense contradictory opportunity structures. Perceiving limits and constraints rather than broad opportunities for some role performances should be typical. Simultaneously, the high death concern individual will seek opportunities that enhance his perceived freedom from the constraints of some social expectations. This implies that opportunity structures will psychologically fit the person's perceptions of his limiting world.

Audiences chosen by the death concerned person can reflect self-imposed temporal boundaries. Relationships based on attachment or dependability of rewards might be sought more often than those based on commitment. Logistical management should reflect these choices and short term agendas should dominate the interaction time budget. Audiences chosen will provide the person with information congruent with perceptions of a limited world.

When negotiating identities, processes of altercasting and the presentation of self will reflect death concern. Although audiences demand various interactive roles, ego can cast alter with a character that fulfills needs such as succorance, heterosexuality, and immediacy for rewards. A high death concerned ego should present the self in a manner that displays factors

such as anxiety, resistance to change and concern with the present.

These propositions suggest interrelated role identities, interactive roles, hierarchies and perceived opportunity structures, of which all determine the self, can be affected by concern for death. The role identity model also suggests how the individual actively defines his reality, and therefore attaches meaning to death. The process of interpretation implies the person doesn't respond to a physical, objective reality; rather he responds to a social definition of reality. Death is symbolic. "What is essential is that the symbol should arouse in one's self what it arouses in the other individual" (Mead, 1934: 149). Interactants give meaning to death and act upon it as a social object. Interaction partners, content of communication with others, content of mind activity and interpreting empirically observed events of the actor's world are among factors that contribute to the individual's definition of personal death. All these factors arise in everyday behavior with others that is motivated by a need to receive support for prominent identities and constrained by self defined limits. The person with several enacted and imagined roles interacts with countless others in numerous settings. The content of each role identity implies a consequence of death.

Therefore, the overall meanings of death are inherently complex and probably contradictory for most individuals.

McCall and Simmons suggest procedures for identifying and measuring role identity hierarchies and their reciprocal relationship with perceptions of death. A Twenty Statements Test (TST)[14] that intends to assess self-conceptions of social roles, combined with semi-structured interviews to explore categories of social roles can be used to specify identities. The question "How do you like to think of yourself being or acting as a(n) _____?" enables descriptions of the content of various idealized roles (McCall and Simmons, 1978: 254).

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[14]Spitzer et al. (1971) discuss several advantages of the TST, an instrument designed to measure the self. It involves a social psychological conception of self; i.e., the person relates himself to his social context. It assumes the self consists of complex meanings, actors interpret and define social reality and meanings, and social objects cluster. Responding to "Who Am I?" elicits conscious, salient attitudes about the self, i.e., about the person as a social object. Theoretical and methodological assumptions of the TST are empirically verifiable. Researchers use this measure more frequently than any others to measure the self. Validity information available is at least equal to that available on other instruments that measure self concept. Numerous scoring procedures can be used and the instrument allows reliable coding. Variables operationalized by the measure are found to be correlated with several behaviors (pp. 73-111). Finally, the format can be used to measure other social objects. Cottrell (1971) is among those who discuss disadvantages of the TST approach. He finds the instrument assumes a "static" self. Researchers can intrude interpretations during administration of the test and can make invalid inferences when interpreting results.

Relating six factors: self-support, social support, intrinsic gratification, extrinsic gratification, degree of commitment and degree of investment for each role identity and specifying the relative importance of each factor, allows determination of a role identity prominence hierarchy, or idealized self. The order of responses on a TST infers salience of identities. Respondents can also rate specific interactive roles according to perceived utility (McCall and Simmons, 1978: 260-264). The TST format for measuring death concern (Bakshis et al., 1974) complemented by the Dickstein Death Concern Scale (1972) enable and understanding of the perceived consequences of death, as well as a reasonable assessment of anxiety or dissonance created by death awareness. Direct observations of altercasting and presentation of self allow for an examination of the negotiation of identities (Weinstein and Deutschberger, 1963) that are affected by death concern. Since a considerable amount of literature suggests characteristics of those overly concerned with personal death, identifying participants for this form of research--one that seeks an understanding for the nature of concern--would not be problematic. Although this design is applicable only to an intensive study of a small number of individuals, it ameliorates some of the restrictions of purely

quantitative studies[15] that usually rely upon narrow conceptualizations of death concern and produce dead level abstraction type findings.

The preceding pages demonstrate that some individuals experience a high degree of death concern, some manifest contradictory responses to thoughts about personal death and some respond ambivalently to death. Considering social roles and personality characteristics is necessary in order to understand the source and nature of death concern. Although psychologists have explored the relationships between death anxiety and personality, there is an apparent lack of sociological investigation in the general area. Since research designs are capable of examining and measuring the self, as well as thoughts about personal death, integrating the concepts appears essential in order to understand how the person defines and is constrained by his mortal nature. Although the products of this effort are limited to statements, they emerged from empirical research findings and theoretical propositions

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[15]"Quantitative" studies refer to those discussed in chapter two that often involve administration of a single instrument to one population in order to examine correlations between measures of death concern and a narrowly defined set of personality traits, attitudes or behaviors. Although a compilation of studies identifies key characteristics of the death concerned person, individual efforts do not often permit generalizations.

on purposeful behavior. Perhaps they suggest a beginning for understanding thoughts expressed by those who try to communicate an ambivalence toward life and death. "The memory came faint and cold of the story I might have told, a story in the likeness of my life, I mean without the courage to end or the strength to go on" (Beckett).

APPENDIX A

DEATH ANXIETY SCALE

Donald I. Templer
The Journal of General Psychology 82:167 (1970)

(Key)

T I am very much afraid to die.

F The thought of death seldom enters my mind.

F It doesn't make me nervous when people talk about death.

T I dread to think about having to have an operation.

F I am not at all afraid to die.

F I am not particularly afraid of getting cancer.

F The thought of death never bothers me.

T I am often distressed by the way time flies so very rapidly.

T I fear dying a painful death.

T The subject of life after death troubles me greatly.

T I am really scared of having a heart attack.

T I often think about how short life really is.

T I shudder when I hear people talking about a World War III.

T The sight of a dead body is horrifying to me.

F I feel that the future holds nothing for me to fear.

APPENDIX B

DEATH CONCERN SCALE

Louis S. Dickstein
Psychological Reports 30:565 (1972)

1. I think about my own death.
2. I think about the death of loved ones.
3. I think about dying young.
4. I think about the possibility of being killed on a city street.
5. I have fantasies of my own death.
6. I think about death just before going to sleep.
7. I think of how I would act if I knew I were to die within a given period of time.
8. I think about how my relatives would act and feel upon my death.
9. When I am sick I think about death.
10. When I am outside during a lightning storm I think about the possibility of being struck by lightning.
11. When I am in an automobile I think about the high incidence of traffic accidents.
12. I think people should first become concerned about death when they are old.

13. I am much more concerned about my death than those around me.
14. Death hardly concerns me.
15. My general outlook just doesn't allow for morbid thoughts.
16. The prospect of my own death arouses anxiety in me.
17. The prospect of my own death depresses me.
18. The prospect of the death of my loved ones arouses anxiety in me.
19. The knowledge that I will surely die does not in any way affect the conduct of my life.
20. I envision my own death as a painful, nightmarish experience.
21. I am afraid of dying.
22. I am afraid of being dead.
23. Many people become disturbed at the sight of a new grave but it doesn't bother me.
24. I am disturbed when I think about the shortness of life.
25. Thinking about death is a waste of time.
26. Death should not be regarded as a tragedy if it occurs after a productive life.
27. The inevitable death of man poses a serious challenge to the meaningfulness of human existence.
28. The death of the individual is ultimately beneficial because it facilitates change in society.

29. I have a desire to live on after death.
30. The question of whether or not there is a future life worries me considerably.

APPENDIX C

ACCEPTANCE OF DEATH ITEMS

Leo Klug and Marvin Ross
Psychological Reports 40:910 (1977)

1. I accept the fact of my inevitable death.
2. Reflecting on death helps me appreciate life more.
3. I discuss death when the occasion presents itself.
4. I have reconciled myself to the reality of my own inevitable death.
5. I have consciously contemplated the fact that one day I will die.
6. In my own life I have come to grips with the fact of my inevitable death.
7. When death comes I'll be ready.
8. I am quite conscious of the fact that one day I will die.

APPENDIX D

CONSEQUENCES OF ONE'S OWN DEATH

James C. Diggory and Doreen Z. Rothman
Journal of Abnormal and Social Psychology 63:205 (1961)

A. I could no longer have any experiences.

B. I am uncertain as to what might happen to me if there is a life after death.

C. I am afraid of what might happen to my body after death.

D. I could no longer care for my dependents.

E. My death would cause grief for my relatives and friends.

F. All my plans and projects would come to an end.

G. The process of dying might be painful.

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