DEATH CONCERN: A COMPARISON OF ATTITUDES TOWARDS DEATH HELD BY COUNSELLORS, TEACHERS, CLERGY, NURSES AND STUDENT NURSES IN NEWFOUNDLAND

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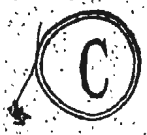
by



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Abstract

The present study compared the attitudes towards death held by counsellors, clergy, student nurses, teachers and nurses.

The sample (N=257) was drawn from five professional groups and consisted of 30 counsellors, 44 clergy, 76 student nurses, 54 teachers and 53 nurses. A general information questionnaire and the Death Concern Scale (Dickstein, 1972) were administered to all subjects.

There was a significant difference between the scores of the counsellors, clergy, student nurses, teachers and nurses on the Death Concern Scale at the .01 level of confidence. Further analysis showed that the score of the student nurses was significantly higher than the scores obtained by all the other groups.

Since the student nurses were on the whole a much younger group, further analysis was carried out on the basis of age and death concern. There was a statistically significant difference between the scores of those under thirty and those over thirty.

Other demographic characteristics of the population were also presented.

It was concluded that members of all these professions should be prepared to deal with the question of death as part of their work experience. Death education courses were suggested as one means of helping these professionals come to terms with death and dying.

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CHAPTER I

INTRODUCTION

Just as sex was a taboo topic to the Victorians, death has been a taboo topic in the twentieth century (Feifel, 1959; Toynbee, 1968). Through the use of euphemisms and elaborate rituals, society tries to protect itself from the reality and inevitability of death. Much of our energies go toward trying to foster the image that we are immune to change and death (Brown, 1970).

Yet the fear of death and the resultant underlying anxiety remain with us. Many writers in different fields have mentioned this fear of death. Freud referred to his Todesangst ("dread of death") in his writings. Paul Tillich's theory on anxiety is based on man's awareness of his finiteness (Feifel, 1969a). Ernest Becker (1975) aptly summed up the dilemma of humans as being driven in the struggle to perpetuate life, yet doomed to a state of dread by their unique fear of death. Obviously a person's attitude towards death affects attitude towards life. This was well illustrated by Abraham Maslow who wrote the following passage while living a post-mortem life after a severe heart attack:

> If you're reconciled with death or even if you are pretty well assured that you will have a good death, a dignified one, then every single moment of every single day is transformed because the pervasive undercurrent - the fear of death - is removed. (1970)

Today the topic of death has become more fashionable (Morgenson, 1973). Books such as Jessica Mitford's American Way of Death, David Hendin's Death as a Fact of Life and

Kubler-Ross's On Death and Dying are best-sellers. When Psychology Today published a questionnaire on attitudes towards death in August 1970 they received 30,000 replies, compared to 20,000 received on a similar survey regarding attitudes towards sex. Many universities now offer courses on attitudes towards death - courses which often fill to capacity (Schneidman, 1970). Efforts have also been made to develop curriculum on attitudes towards death suitable for each age level in the school system (Leviton and Forman, 1974). Radio and television programs on death and dying have become fairly common and many popular magazines feature articles concerning death and grief.

Various factors have been cited as explanations for this change in the attitude of North Americans towards death. The ever-present threat of nuclear war and total annihilation has greatly increased our awareness of the reality of death. The issues of abortion and euthanasia have caused people to question and re-examine their own attitudes towards death. Almost every evening television provides us with death experiences in our homes. Slowly but surely the taboo of the topic of death has begun to lift.

As will be seen in the next chapter, psychological research on death and dying has gradually increased (Lester, 1967). At present, wide discrepancies exist in the results obtained from the different studies. The elusiveness of the topic and the lack of sophisticated techniques for measuring attitudes towards death have contributed to these discrepancies. Obviously, these limitations will only be overcome with the

further development of research into all aspects of death.

The present study looked at the attitudes towards death held by members of certain helping professions. All of these people - school counsellors, teachers, clergy, nurses and student nurses -, should be prepared to help others come to terms with death and dying, since they will inevitably have to do this in their jobs. Their helpfulness in such situations may, in large measure, be determined by their own attitudes towards death. This study was undertaken to produce new findings which would encourage continued investigation into attitudes about death held by members of various professions.

Purpose of the Study

The purpose of this study was to investigate and compare the death concern of selected professional helpers and to examine its relationship to various sociological variables. Specifically, the death concerns of school counsellors, teachers, clergy, nurses and student nurses as measured by the Death Concern Scale were compared and analysed in relationship to their profession and their age.

The Hypothesis

The following null hypothesis was investigated in this study:

It was predicted there would be no significant difference between the mean group scores of the counsellors, teachers, clergy, nurses and student nurses on the Death

Concern Scale.

Definition of Terms

For the purposes of this study, the following definitions were used:

Death Concern: The score obtained on the Death Concern Scale (Dickstein, 1972).

Death Education Program: A program of at least one day's duration dealing with the topic of death and dying.

School Counsellors: Those counsellors listed by the Department of Education of Newfoundland as full-time counsellors.

Teachers: Those teachers in attendance at the summer school sessions of Memorial University of Newfoundland in 1974.

Nurses: All working registered nurses within the Province of Newfoundland as of June 1974.

Student Nurses: All members of the 1974 first year class of the General Hospital School of Nursing, St. John's, Newfoundland.

Clergy: All ministers and priests within the Anglican, United and Roman Catholic Churches in the Province of Newfoundland as of June 1974

Limitations

In interpreting the data of this study the following limitations should be borne in mind:

(1) The instrument used to collect the general

information was devised by the author and had a number of omissions of informational questions that, in restrospect, would have provided other valuable information. For example, no question was asked concerning the respondents' marital status.

(2) The Death Concern Scale requires further validity and reliability studies (see Chapter III).

(3) The teacher sample was restricted to those attending summer school sessions at Memorial University of Newfoundland in 1974. Therefore, this may not have been a representative sample of the teacher population of Newfoundland.

(4) Because of the type of listings kept by the Department of Education of Newfoundland, the school counsellor sample was not made up solely of full-time counsellors.

Significance of the Study

A discussion of the significance of this study will be summarized under the headings: historical basis; opinions about attitudes towards death; recent studies of attitudes towards death; and, present trends.

Historical Basis:

Death has always been an inescapable fact of life. Throughout the ages men have studied death from many view points - philosophical, religious, medical, artistic and so on. But, as will be shown in Chapter II, death has been a taboo topic for many years in the Western World.

Only within the past two decades have scientists from a variety of disciplines begun a systematic study of

death and dying. According to Feifel (1974), psychologists have apparently realized the close link between attitudes about death and behaviour. Many studies (Feifel, 1959; Lester, 1967; Templer, 1970; Dickstein, 1972) have been done on the topic of death. A growing number of studies suggest death has become the organizing principle of people's lives (Feifel, 1974).

Opinions about attitudes towards death:

For the purpose of this study, the author was primarily concerned with looking at the attitudes towards death held by members of particular helping professions.

Most authors on the topic of death stress the fact that unless one comes to terms with one's own fears and concerns about death, one cannot effectively help others deal with the issue (Feifel, 1974; Kubler-Ross, 1969). These writers suggest that in order to listen and empathize with somebody else's fears about death, the helping person must first feel secure within himself regarding this topic.

Members of the profession chosen for this study deal with death as part of their work. Obviously the clergy, nurses and student nurses have a more direct contact with death. Clergymen traditionally have been involved in working with the dying and the bereaved. Both nurses and student nurses work with the sick and sometimes with the dying, although, according to Quint (1967), nursing students often get little exposure to the dying during their training.

The connection between school counsellors, teachers and death is less obvious but just as important. At various

times in their careers, school personnel will probably be faced with the occurrence of death; for instance a student who looses a close relative, friend or pet through death; the death of a well-known public figure; even the death of a fellow student. At these times, counsellors and teachers can play a very important role in helping children come to grips with their grief.

As will be further outlined in Chapter II, children have many fears and fantasies about death. Often they are discouraged from asking questions about it. In the school setting, teachers and counsellors can do much to help children understand the concept of death at the level appropriate to their psychological and cognitive development. Like sex education, death education may soon become a regular part of the curriculum.

Members of all the helping professions in the present study (clergy, nurses, student nurses, teachers and counsellors) are in a position to help people come to terms with death - if they have been able to do so themselves.

Recent studies on attitudes towards death:

The results of research on attitudes toward death have often been inconclusive and contradictory (Lester, 1967; Feifel, 1974). This appeared to be due both to the elusiveness of the topic and the variety of methods used to collect the data. These problems are discussed further in Chapter II.

There have been very few studies concerning attitudes towards death held by the members of particular professions. Feifel (1967) found medical students and doctors have a

greater fear of death than the terminally-ill, the seriously-ill and healthy adults. He concluded people enter medicine in order to overcome their fear of death. With this conclusion in mind, Lester (1971a) studied attitudes towards death held by the staff of a suidice prevention centre. He found these workers had an acceptance of the reality of death, a result which differed from Feifel's findings.

It seems important more research be done in this area to determine if members of these helping professions have been prepared to help others come to terms with the reality of death; and, if they have not, to devise methods of preparing them to deal with this issue.

Present trends:

The amount of research on attitudes towards death has grown steadily. Two journals - Omega and the Journal of Thanatology - are devoted entirely to topics related with death. Books on death have been moved from the religious to the psychology section of bookstores and have begun to be widely read (Kron, 1974).

Within the medical world, there seems to be a growing awareness of the need for death education for those people who will be dealing with the dying. Dr. Kubler-Ross, through her seminars with dying people, attended by doctors, nurses, clergy and social workers, has led this movement. Her books (1969, 1975) describe the success of these seminars as a learning experience for both the living and the dying.

In Newfoundland, students within the Nursing Faculty of Memorial University organized a one-day seminar on death in March 1974. Other nursing schools have also had similar death education programs (Martin, 1975).

In the United States, some death education courses have been offered in college, high school, junior high and elementary schools (Zazzaro, 1973; Shrank, 1971; Schneidman, 1970). A Task Force connected with Ars Morienda has been set up to determine if a professional association of death education teachers, counsellors and researchers would be feasible (Schneidman, 1970). (Ars Moriendi - literally the art of dying - is an association of professionals concerned with how we deal with dying and grief). Recently in Halifax, Nova Scotia, Dr. D. Brundage from the Ontario Institute of Studies in Education said death education should become part of the family-life program within the schools (Moreira, 1975). Obviously death education courses will expand over the next few years.

A growing need has developed for people within these helping professions - clergy, nurses, student nurses, teachers and school counsellors - to be prepared to help others deal with death. Individuals within these professions should first be helped to come to terms with death themselves before they can be expected to help others.

Through comparing the attitudes toward death held by the members of these different professions, this study took a small first step in this area.

Summary

This chapter has presented an introduction to the study, the purposes of the research, and significance of the study. The next chapter will review in more detail the literature in the area.

CHAPTER II

REVIEW OF THE LITERATURE

Presented in this chapter is a short historical review of attitudes towards death throughout the ages; an examination of the Western attitudes towards death; a brief look at the attitudes towards death and dying in Newfoundland; and, a summary of the related research on attitudes towards death.

Historical Review of Attitudes Towards Death

In Ancient Greece, Sophocles claimed one thing in man's universe which has defeated him is death (Toynbee, 1968). Today, twenty-four centuries later, man remains in the same predicament: only the gods and amoeba are immortal, all other living creatures must die. However of all these mortal creatures, only man has to deal with his awareness of his inevitable death - hors incerta, mors certa (Feifel, 1959, xiii).

Throughout the ages men have attempted to find different ways to reconcile themselves to their deaths. Hedonism - the attitude of eat, drink and be merry for tomorrow we die - provided an escape for some people. Yet the thought of death still lurked in the revellers' minds; in fact during Medieval feasts it was the custom to bring out statues of skeletons to remind people there was no escape from their ultimate fate (Morgenson, 1973).

Sophocles put forward a much more pessimistic view of life. He claimed:

> . . . it is best of all never to have been born and second-best - second by far - if one has made his appearance in this world, to go back again, as quickly as may be, thither whence he has come. (Toynbee, 1968, p. 70)

To the Greeks, death provided a release whereby the soul escaped from the prison of the body (Toynbee, 1968).

A good index of this attitude of pessimism towards life has been the degree of acceptance of suicide within a culture. In many societies (e.g. Greek, Roman, Japanese and Eskimo) suicide has been viewed as a basic human right. It was an honourable way to die. This is particularly evident when one looks at the attitude of the Japanese kamikaze pilots of World War II who crashed their planes directly into their target. "I have been given a splendid opportunity to die" wrote one pilot (Hinton, 1972, p. 47). Men were eager to give their lives this way.

However, most attempts to achieve a reconciliation with death have been connected with some form of immortality. Robert Lifton (1969) wrote:

> . . . man requires a sense of immortality in the face of inevitable biological death. This sense of immortality need not be merely a denial of the fact of his death, although man is prone to such denial. It also represents a compelling universal urge to maintain an inner sense of continuity, over time and space, with various elements of life. This sense of immortality is man's way of experiencing his connection with all of human history. (Lifton, 1969, p. 72)

This search for immortality has taken many forms. Some cultures, of which the Ancient Egyptians were a prime example, attempted to circumvent death through physical countermeasures. The Pharaohs not only provided an entire

household in their tombs but they also tried to counteract physical decay through embalming, a practice now common in North America.

Fame as a means of immortality has been popular throughout the ages. Leaders of the Ancient world had their deeds commemorated in verse; ironically, today, the recorder not the leader has become the best remembered. Today endowment funds for colleges, scholarships, and so on, serve as a means of preserving one's name for posterity, thereby hopefully avoiding the oblivion of death (Toynbee, 1968).

Many people hope to achieve immortality by producing future generations. Once again history bears witness to this fact with the heavy emphasis in most societies on producing sons to carry on the family name. Family wealth and heirlooms continue to be passed on through the generations as a form of memorial.

Indian philosophy for the past three thousand years has taken a completely different approach. Here, the quest has been to get in touch with the Ultimate Reality through spiritual communication. Only by overcoming all desires of the self - including a desire to live on - could this be accomplished (Long, 1975). If a person died after he had achieved a state of being one with the Ultimate Reality, he passed to Nirvana - "extinguishedness". Until a person achieved this he would continue to come back into this nightmare world as another human being. Thus, death was not to be feared, but rather rebirth. Within the Hindu and Buddhist philosophies, death should be accepted as "an ever-present

companion" to life (Long, 1975, p. 65).

Many cultures believe in the immortality of the soul. The body decays but the psyche stays on, usually to be assigned to some form of heaven or hell. No one has been able to satisfactorily describe the nature of this psyche. Unfortunately, for those who believe in the immortality of the soul as well as the final judgement, life will always be in a state of anxiety as the ever-present question of whether one will attain eternal bliss or eternal torment will exist.

Some religions, notably Christianity, have linked this belief in the immortality of the soul with a belief in the resurrection of the body. This, too, raised all sorts of questions as to what form the body would take; for example would it be that of the eighty year old man who died riddled with cancer or would he rise again as a virile young man of twenty? And where would all these resurrected bodies meet again? For some people, death has been perceived as only a temporary separation from loved ones.

Every form of religion has attempted to deal with the question of death to provide some measure of comfort for their followers regarding the meritability of death. As the world advances technologically and man's knowledge steadily increases, greater fear will probably surround the issue of death. Death will continue to defeat man.

Attitudes towards death in the Western World

Development of the death taboo:

No where has the fear of death remained more prevalent

than in the Western World where technological advances have been greatest.

Up until the seventeenth century, Christianity tended to comfort people. Everyone was promised an immortal soul and whether one ended up in heaven or hell, oblivion was avoided. However, in most of North America Christianity has declined. It appears to the writer that religion today has become a social convention not a source of comfort.

One of the main reasons for this change has been the growth of science. For many people, science replaced theology as a means of discovering the truth. The astronomers proved the earth was not the centre of the universe, Darwin traced our link with the apes, and the astronauts raised doubts about a heaven amongst the clouds. Although many theologians can reconcile the findings of science with belief in God, many people have lost their faith in Christianity and the Church. Fewer people believe they can look forward to a better life after death. With the loss of faith the fear of death has grown (Toynbee, 1968).

Less developed societies, for instance in Mexico and South America, have so far been largely spared from this disillusionment. Religion, with its promise of immortality, has remained strong. Moreover death has been regarded as a part of the natural process of life - just like birth. Most old people live with their children and grandchildren and eventually die in their home. They have time to prepare for death and they accept it. Father Murray Trelease (1975) recounts his experiences, with Indians from the interior of

Alaska, where the old people carefully plan their whole funeral in advance and the whole village takes part in the ceremony. Death is a part of life. No doubt over the years these societies will become more "developed" - and inherit the North American taboo of death (Toynbee, 1968).

Through the advancements of science, man's life expectancy has increased by thirty years since the beginning of the century (Toynbee, 1968). The fatal epidemics of diphtheria and smallpox, and the scourge of tuberculosis have been almost totally eliminated (Bell, 1970). From an early age we are vaccinated against all the common diseases. Science has gained some measure of control over death. But, people still die - from old age, fatal diseases, and accidents. Science cannot eliminate death.

Rather than attempt to deal with the inevitability of death, society has tried to pretend death does not exist. As Toynbee (1968, 131) says, "death is un-American" - to admit the reality of death is to imply America is not an earthy paradise. North Americans have gone to great lengths to hide this reality.

First, most people die in institutions or hospitals, not at home. Old people have become superfluous in North America today (Bell, 1970). They are placed in special homes in which they have little chance to feel needed in the world. They remain there until they die. Patients with fatal illnesses usually spend their last days in a hospital, away from family and friends. In most cases, visitors and children are rarely allowed to visit. It has become very easy

for people to grow to adulthood without any direct contact with the dying and the dead until faced with their own death.

Today's funeral practices epitomize the extremes society has reached in this effort to hide the reality of death. Obituaries state someone has "passed on" or "slipped away peacefully". (No one knows exactly where they have gone). Using new scientific devices and cosmetics, morticians work to make the body look more life-like. Jessica Mitford (1963) described the clothing industry which has developed to provide clothes to make the corpse beautiful. Cemeteries have been made to look like anything except what they are. The dead can leave tape recorded messages and films for the edification of any visitors to their resting place.

Evelyn Waugh's spoof on funeral practices, The Loved One, written in 1948, is uncomfortably like the situation in many parts of the United States and Canada today. He described the elaborate efforts to restore the body to look alive. Relatives choose which facial expression they would like "the loved one" to have - either "serene and philosophic" or "judicial and determined". All of the loved ones are housed in a large cemetery called "Whispering Glades". The phrase "many a true work spoken in jest" certainly applies to Waugh's early novel.

Those who subscribe to the science of cryonics argue that people need not even die. They subscribe to the freeze now, live later plan. Their frozen bodies have been stored in a mausoleum. Presumably as science produces cures for

various diseases and the ravages of old age, these people will be defrosted and cured. These "deep freeze societies" serve the need to deny the fact that people really die (Kubler-Ross, 1971, p. 54).

This denial of death has been particularly evident within the medical world (Feifel, 1962; Weisman, 1972). When Dr. Kubler-Ross (1969) made plans for her first seminar with a dying person, she found, according to the staff, none of the patients in the 600-bed hospital were dying. If the people were seriously ill they were considered "too weak" to be allowed to take part. But once Dr. Kubler-Ross got past this opposition, she discovered there were dying patients who were eager to talk about their condition.

Certainly in their training, hospital staff are not prepared to deal with the dying. Both doctors and nurses are taught to preserve life; consequently the death of a patient indicated failure on the part of the staff (Barton, 1972). According to Quint (1967), nursing textbooks might have one page out of a thousand on death and dying, and student nurses were rarely given the opportunity to work with a dying patient. The effects of this lack of preparation on the attitudes of the nurse is aptly illustrated in the following excerpt from an article written by a terminally-ill nursing student:

> But for me, fear is today and dying is now. You slip in and out of my room, give me medications and check my blood pressure. Is it because I am a student nurse, myself, or just a human being, that I sense your fright? And your fears enhance mine. Why are you afraid? I am the one who is dying. (Anonymous 1975, p. 26)

Most doctors can give many reasons for not telling

a person they are terminally-ill (Weisman, 1972). Yet Feifel (1959) found almost ninety percent of the patients he talked with wanted to be told the truth. Despite a conspiracy of silence maintained by family and hospital staff, many terminally-ill patients suspected their true condition but were denied the right to prepare themselves for death (Aries, 1974). They were forced to maintain the pretense that "everything is just fine".

From an early age, children learn death is a taboo topic. Their natural curiosity about dead insects or animals is curbed by phrases like "that's not nice to talk about". In studies done of children who had experienced the death of a parent, Furman (1974) found many young children were either not told about the death at all or else were told some fairy tale which the child did not believe. As other writers have shown (Nagy, 1948; Zeligs, 1967; Kastenbaum, 1974) this denial of reality on the part of adults has caused children to have many fears and fantasies which they rarely have an opportunity to express.

Ironically, through television, children have been constantly exposed to death - in cartoons, in the shows, and in the news. But it has an air of unreality, particularly as the cartoon characters and the actors come back to life in the next show. Children have little direct contact with death since generally it has occurred in hospital and they have rarely been allowed at funerals.

In this section the author has dealt with some of the most important causes and effects of the death taboo.

The advancement of science and the development of technology seem to be the basic factors causing the prevalent fear of death in the Western World. This fear has led society to take extreme measures to deny the reality of death. However these measures would appear to be doomed to failure since death is inevitable. Fortunately this attitude has been changing - the taboo of death has slowly lifted.

Lifting of the death taboo:

As mentioned briefly in the Introduction, death has become a fashionable topic. The taboo against it has begun to disappear. This section will deal more thoroughly with this changing attitude towards death within North American society, looking at both reasons for, and results of, this change.

Part of this change has been the result of the development of a whole new attitude towards life. There has been a general trend away from the materialism of our society today. This has become particularly evident through the back-to-the-land movement and the increasing popularity of the eastern religions amongst young people today. However, this search for a meaning in life has certainly not been restricted to the young. Without the traditional support of the Church many people have begun looking for their own answers to the question "what is life?" Inevitably any search for the meaning of life must include an understanding of the meaning of death (Gordon, 1972).

People have become more aware of the nearness of death. The development of nuclear weapons means one must

live with the threat of death and immediate annihilation (Feifel, 1974; Hendin, 1973). Bomb shelters have lost their popularity. People now seem to accept that if nuclear war breaks out death will be inevitable, even preferable. News reports of criminal violence and highway fatalities provide daily evidence of the constant danger of death to all of us.

The assasination of President Kennedy has also had an important influence (Feifel, 1969a). Most North Americans easily recall what they were doing and how they felt when they first heard the news on November 22, 1963. Everyone shared in the horror and the grief and no one could avoid the reality of his death. Each person worked through his grief and survived. It was a beginning step in dealing with the meaning of death for many people.

Technology has led to the need for a new definition of death. Death used to be clearcut. When a person's heart had stopped beating he was dead. Generally this was fairly easy to determine. However, Toynbee (1968) recounted how occasionally the corpse would come back to life during the funeral after having been in a comatose state for a few days. In order to prevent the burial of someone who was not truly dead, France, at one point, had a law saying a body had to be beheaded before burial. This effectively removed the danger of its revival!

With the advancement in medical technology people with heart failure have often been revived after they have "died". All bodily functions can be carried on effectively by machinery and the distinction between life and death has

become less clear. If a doctor cuts off the life-sustaining machinery has he committed a murder or allowed nature to take its course? Medical personnel and government legislators have attempted to redefine the term "death".

Today many parts of the body can be given to help someone else. This raises two important points. The first is connected with the above question of the definition of death. The organs to be transplanted are kept functioning by machinery - by removing them from the donor has the doctor in effect killed that person? The second point concerns the decision to donate parts of the body for future medical and scientific use. Anyone who has decided to do this must first have thought through their attitudes towards the meaning of death. As pressure has increased on society to make this type of donation, more people have begun to look closely at their feelings about death (Mitford, 1963).

The increased use of life-sustaining machinery in hospitals has led to the development of the right to die movement. Thousands of people have signed documents requesting their life not be prolonged by artificial means in the event of an incurable disease or irreversible injuries (Hendin, 1973). These living-wills have no legal validity. The patient must hope medical personnel and family members will carry out the will.

The question of euthanasia has become closely linked with the right to die issue. Mercy-killing involves a deliberate action on the part of one person to end the life of another. This issue often hits the news headlines as cases

have been brought to court where requests have been made to turn off life-support systems of people who have become human vegetables. The recent tragic case of Karen Quinlan has become the best-known (Kohl, 1976). Her parents sought the right to remove her life-sustaining machinery in order to allow her to die. At first this request was not granted, but now the machinery has been turned off and Karen remains in a comatose state.

At Robert Fulton (1974) indicated there can be dangers in the growing enthusiasm for euthanasia. Will the next step be a decision that the old, the crippled, and the mentally defective have become useless and therefore should be done away with? Thirty-five years ago Adolf Hitler used that rationale to end the life of seventy thousand such "worthless" people. Obviously society has to carefully study the whole issue of euthanasia.

People have begun to react against the elaborate preparations and unreality of funeral rituals. Books such as The Loved One and The American Way of Death have shown the ludicrous nature of some of these practices - as well as their enormous expense. Memorial societies have developed rapidly in many areas. They provide their members with simple and inexpensive funerals. Moreover the plans can be made in advance so the bereaved family will not be pressured into making quick funeral arrangements when death suddenly occurs (Mitford, 1963). People have begun preparing ahead of time for their inevitable death.

Within the medical world there has been a changing

attitude towards the treatment of the dying. Dr. Kubler-Ross has become a pioneer in the field of death education for medical personnel. Through her interviews with dying people she evolved her theory of the five stages of attitudes towards death; denial, anger, bargaining, depression and acceptance (Kubler-Ross, 1969). Her interviews also have shown the need for the dying to be given the opportunity to express their feelings and, most important, how much the listeners can benefit from these exchanges. Medical and nursing faculties have begun to provide seminars on the topic of death, often at the insistence of their students.

Within some hospitals there have also been important developments in this field. The Royal Victoria Hospital in Montreal, Quebec, has established the Palliative Care Unit solely for the treatment of the dying. The staff have been trained to meet the emotional as well as the physical needs of their patients. The ward has been open to visitors of all ages so all members of the family can come regularly. Unlike the attitude in other hospitals, the emphasis has been on helping the patients and their families to accept death (Bieler, 1976).

Some other hospitals provide programs for the families of dying children (Willis, 1974; Schnell, 1974; Wright, 1974). Doctors, nurses, social workers, clergymen and psychologists all help to provide support to the family. Often groups of these parents will meet together to give each other support and comfort. Medical personnel have begun to change their perception of their role. A growing realization of the need

to help patients to accept their inevitable death and to give aid to their families has developed. Doctors and nurses have begun to work more closely with members of other helping professions in order to meet the demands of this new role.

Death education has not been solely restricted to medical and nursing schools. Courses have been suggested for children at all ages in the school system (Ames, 1969; Schrank, 1971; McMahon, 1973; Zazzaro, 1973; Leviton and Furman, 1974). As discussed in a later section, studies have shown that the awareness of death as universal seems to be a function of age. Furthermore, the understanding of the irreversibility of death does not occur until age ten (Tallmer et al, 1974). Therefore death education for children must be based on an understanding of their psyshological, social and cognitive levels of development.

Within the elementary school, the emphasis should be on the teacher taking advantage of an opportune moment. For instance if a child starts to talk about a dead bird which she has found, the teacher can take this opportunity to let the children express some of their fears and curiosity about death. For junior high and high school students the death education program could be more formalized. Berg (1973) described the course he devised for grade seven children which covered such aspects of death as medical, financial, philosophical, religious and other factors. The topic of death had the three basic requisites for inclusion in the curriculum; universality; inherent interest; and, lack of knowledge. At the college level, courses in death education have become

extremely popular (Schneidman, 1970).

The question of death education in schools has raised similar reactions as has the question of sex education. Some people would argue such a program will intrude upon the rights of parents. Yet many parents continue to be very uncomfortable talking with their children about death (Moss, 1972). The issue of who should teach the courses has also been raised. Unless the teacher has come to terms with death, he will not be in a position to help others to do so (Ames, 1969). Few teacher training programs have offered their students courses in death education methods (Pincus, 1974). Perhaps death education will become part of the family life programs which have recently been developed.

An overall indication of the changing attitude towards death has been the tremendous outpouring of books and articles on the topic for both the lay person and the specialist. Popular magazines such as Quest (March/April 1975) and Time (July 1, 1974) have had articles on death. Books like Kubler-Ross's On Death and Dying have begun to be prominently displayed in the bookstores for general consumption. Professional journals in many fields include papers on different aspects of death. Sometimes a whole issue has been devoted to the topic, such as the summer 1974 volume of the Journal of Clinical Child Psychology which was entitled "Children and Death". The growth of interest in death in the psychological field will be more thoroughly discussed at the end of this chapter under the section headed "Summary of Related Research".

Attitudes towards death in North America appear to be in a transition stage. Society has reached the extremes of denial and begun to come to the realization death still exists. Moreover the great advancements in medical technology have begun to force people to personally face the questions of transplants, euthanasia, and the right to die. Obviously these changing attitudes are only a beginning as the taboo of death lifts.

Attitudes Towards Death in Newfoundland

As the previous section indicated, different cultures have different attitudes towards death. Since this research has a specific cultural context, the Province of Newfoundland, the following section will elaborate on Newfoundland culture and its possible shaping of attitudes towards death.

Newfoundland is an island in the Gulf of St. Lawrence. For hundreds of years it remained isolated from North American culture. Until twelve years ago, there was no road linking the east and west coasts, and many small rural communities were only accessible by sea (Noel, 1971). There were few industries, most communities being dependent upon the natural resources of the sea and the forest for their survival.

A typical outport community consisted of wharves, houses, fish flakes, a general store, a fishermen's lodge or hall, churches and schools built around the edge of a cove or bay. If there were churches of the Roman Catholic, Anglican and United faiths, then there were corresponding Roman Catholic, Anglican and United schools even though there might only be

fifty families in the area (Bradbrook, 1976). The church (or churches) played a central role in the community, taking a lead in all aspects of the spiritual, educational and social affairs of its members.

There were few telephones or radios, therefore little communication with the outside world. Many people spent their whole lives within one community, maintaining three, even four generation family homes. The older people continued to play an active role within their families and the community. Everyone in the household helped in the tasks of survival from chopping wood to fishing. From great-grandparents to young children, hardships were shared by all.

As recently as 1968, Mowat and de Visser were able to capture some of this old way of life in a remote outport on the south coast of Newfoundland. Their photographs show the harshness of the stark landscape and the wintry sea as well as the warmth and the courage of the people. Mowat (1968) described the atmosphere of the family home:

> The outport home rejects no man and no emotion. It accepts all there is of life and death. It provides a place where those who have outworn their flesh can wait the hours down. For them there is no banishment to a "room of one's own", or to an old folks sterile dying place where they must endure that pervading chill of death, preceding death, that freezes the spirit of the world's unwanted. Until their last breath fails, those whose present has become their past are nurtured within the haven of these walls. And at the going out at the end of it they pass in dignity and simplicity. And they are mourned. (Mowat, 1968, "And there is quiet at the close ...")

In his pictures, de Visser (1968) recorded the death of a very old lady. At her bedside with her family nearby she received her last communion from the minister. After her

death, her body is placed in the parlour of her home and people of all ages come to the house to give comfort to the family. Most of the community, including the children, join in the funeral. Children were not excluded from sharing this final stage of life. The old lady dies with simplicity and dignity "and there is quiet at the close" (Mowat, 1968).

Today this acceptance of death as part of the life process has become the exception rather than the rule in most Newfoundland outports. Great changes have occurred in the Province in the past twenty-five years. For one, the mortality rate has been reduced by twenty-five percent - and in the case of death through diphtheria and tuberculosis by ninety-five percent (Noel, 1971). Medical personnel and hospital facilities have more than doubled in this period. Obviously this improvement in health care has been one of the benefits of progress.

Technology has broken down the isolation of the communities. New roads enable people to move easily throughout most of the Province. In fact, over 150 communities have disappeared completely as their inhabitants were encouraged to move into central locations (Noel, 1971). These new central locations have become small towns thus losing the old intimate atmosphere of the traditional outport community. Mass communications link even the most remote places with the rest of the continent. Slowly the uniqueness of Newfoundland has been swallowed up into the homogenity of North America (Noel, 1971).

One of the effects of this enculturation has been the changing attitude towards death. Dying has changed from

an integral part of the life of the community to a more formalized process. Nursing homes have sprung up to look after 'old folks' who no longer have a role to play in their family or their community. Most people die in hospital rather than at home. Undertakers have a rapidly expanding business as people choose elaborate funerals including embalming and ornate caskets. People, especially children, have become insulated against the reality of death. Death has become a taboo topic.

Most of the subjects in this study have lived in Newfoundland during this time of cultural transition. Some have grown up in close-knit communities where death was accepted as an inevitable part of life, others have grown up in the age of hospitals and funeral parlours. One could speculate whether the older people in the sample were ever influenced by the taboo of death. It would seem to the author their early experiences with death and dying would still have a great influence on new attitudes towards death. The younger generation, those under thirty, have probably suffered the most from the taboo of death. They have been isolated from the reality of death. Presumably with the present change in attitudes towards death in North America where death has become more accepted as part of the natural process, the death taboo may again be lifted in Newfoundland society.

Summary of Related Research

Historically, there have been numerous reflection and writings concerning death and its meanings. However,

there were few attempts to carry out a systematic examination of the relevance of death concern to man. Middleton (1936) clearly stated the problem when he wrote:

> Great souls have, to be sure, always pondered the problem of the cessation of the self, and have written great words into the human record. They have done so, however, as seers, poets, philosophers, novelists, biographers, not as scientists. It remains to apply modern techniques of case histories, group studies and documentary analysis to the attitude and actual behaviour of people towards death. Only upon such a basis, slowly to be accumulated, compared and worked over, can a social psychology of death be built up which can be of social value. (Middleton, 1936, p. 165)

It has been only within the past twenty years that scientists from a variety of disciplines have begun a systematic study of death and dying for the purposes of determining the meaning of this final reality to individuals, and ascertaining individual and group reactions to death. These efforts have resulted in the development of tools for measurement, and attempts to formulate theories from empirical data (Feifel, 1959; Dickstein and Blatt, 1966). Because of the newness of this field of study researchers have stated many contradictory hypotheses and reported inconclusive findings (Lester, 1967). With time and continued research these problems should be overcome.

Following the example of Dickstein and Blatt (1966) and for the purposes of clarity, research on attitudes towards death has been divided into two areas. The author will first discuss the meaning of death to man. This will be followed by a discussion of the relationship between attitudes towards death and age, sex and occupation.

The Meaning of Death to Man:

In writing on the meaning of death, Freud (1957) claimed man could not conceive of his own death although he does have unconscious death wishes for others and for himself. Freud referred to his Todesangst or dread of death as a secondary phenomenon linked with castration and separation anxiety. Jung (1959) disagreed with his colleague, arguing the collective unconscious, as he conceptualized it, prepared us for death. The second half of life, Jung felt, was dominated by the fear of death.

Some writers have explained the meaning of death to man by referring to the experiences of childhood. In 1929 Chadwick stated death has been feared like the helplessness of childhood. Later, Bromberg and Schilder (1933) wrote that the meaning of death to an individual was dependent on childhood experiences. They stated death could mean an escape from an unpleasant situation, it could be used to demand the affection of a significant person, while to some people it was the equivalent of sexual intercourse and to others it satisfied masochistic tendencies. Wahl (1959) also based his theory of attitudes toward death on studies of children. He concluded the fear of death was linked to a child's hostile death wishes. Yet, like Freud, he felt the unconscious could not conceive of the death of the self.

Theories of anxiety have been linked to attitudes toward death by some writers. Melanie Klein (Feifel, 1969b) viewed the fear of death as the root of all anxiety. Likewise, Paul Tillich claimed most theories of anxiety have been

based on man's awareness of his finiteness and the feeling that someday man will be subject to non-existence (Feifel, 1969b).

Feifel (1969b) had a rather optimistic view of the effect of an individual's attitude toward death. He inferred death provided a challenge to man to accomplish things within a limited time span. He drew two basic conclusions from his study; death meant either an end or a beginning to people. Shrut (1958) had a somewhat similar interpretation. He concluded adults had three distinctive concepts of death - as a tool (for example, suicide), as a passage to another life, and as an end.

Two other interpretations of the meaning of death should be mentioned. Gardner Murphy (1959) linked the fear of death with fear of punishment, fear of the unknown and fear of losing consciousness. Two researchers, McClelland and Greenberger (Lester, 1967) both found death, to dying women, represented illicit sexual seduction, guilt and punishment.

Obviously these various perspectives on the meaning of death to man offer little consensus of opinion. But they do indicate death may mean different things to different people depending on many factors such as age, sex, health and so on. Furthermore, the meaning of death may change for each individual throughout the life-span. Consequently there can be no one unitary meaning of death to man.

Relationship between attitudes towards death and some specific variables

Many studies have been conducted in an attempt to determine the relationship between attitudes towards death and certain demographic variables. In this section, studies relating to age, sex and occupation will be discussed.

Age:

In 1948, Nagy published an extensive study on children's attitudes towards death. She concluded up to the age of five children have no conception of death; from age five to nine they personify death; and, after nine they have an idea of death's inevitability and reality.

However, Rochlin (1967) disagreed with Nagy's conclusion that children from three to five have no understanding of death. After studying children of this age group he reported they were capable of revealing organized thought through verbalization and play. Even at this early age these children had a conception of death.

Certainly most writers, such as Wolff (1966), Zeligs (1967), Tetrault (1974) and Mussen, Conger and Kazan (1974) have stressed the importance of the development of children's concepts of death through the age span of five to nine. During this period children become curious about death. They feel it is reversible and that people still live while buried. By age ten they have a fairly realistic idea of death.

Lester and Templer (1972b) looked at the relationship between death anxiety in children and the death anxiety of their parents. They administered the Death Anxiety Scale for

measuring death concern to high school students in three age groups (13-14 years, 15-17 years and 18-19 years). After analysing the results, they concluded sons resemble their parents more in their fear of death as they move through adolescence while daughters resemble their parents less as they grow older.

In his study of high school students, Kastenbaum (1959), concluded for eighty-five percent of them death was not part of their dominant view of life. He stated the other fifteen percent, who were more aware of death and had an understanding of its reality, would probably be less disorganized when they had to deal with death.

In a rather unique study, Cameron (1973) asked over four thousand people ages eight to ninety-nine what they were thinking about at that moment. He concluded young adults eighteen to twenty-five think less frequently about death than any other age group. Likewise, Middleton (1936) had earlier concluded college students were largely unconcerned about death.

In contrast, Alexander, Colby and Adlerstein (1957) reported death was an affect-laden concept for college students equal to concern about sex and school. Dickstein and Blatt (1966) found death concern in college students was related to a foreshortened time perspective.

Much of the research dealing with attitudes towards death and age has been directed at the elderly. Feifel (1956) interviewed elderly men in an institution. When asked the question "when are people most fearful of death?", 45 percent said when they reached their seventies, 15 percent said in their sixties, and 15 percent in their fifties.

In three quite thorough studies all carried out separately in 1961, Christ, Swenson, Rhudick and Dibner all concluded there was no significant relationship between age and fear of death. It should be pointed out all these studies were carried out with elderly subjects; therefore, the age range was restricted. Templer (1971a) also concluded there was no relationship between death anxiety and age in his studies on retired people.

In summary, most researchers concerned with children's attitudes towards death have stressed from ages five to nine children gradually develop a concept of death. By age ten they generally have a realistic view of the finality of death. A number of researchers reported high school and college students were largely unconcerned with death. However, other studies have indicated college students do have a concern with death. In looking at attitudes towards death and the elderly, the general conclusion was that no significant relationship exists between fear of death and age. These results illustrate the view that attitudes towards death may vary throughout the life-span.

Sex:

In a study done in 1936, Middleton concluded there was no significant difference between the attitudes of male and female college students towards death. On re-examination of Middleton's data through assessing those who omitted questions, Lester (1970) concluded there were significant differences between males' and females' attitudes towards

death. Females thought more about death and also showed a greater fear of death. Later in his own study, Lester (1972a) suggested females have a greater fear of death, specifically in terms of the effect of death on the body.

Feldman and Hersen (1967) looked at people who suffered from nightmares to see if they had high death anxiety. They found females who had nightmares had a significantly higher death concern than males who had nightmares.

However, most studies have found no significant difference between the attitudes towards death held by males and females. Christ (1961), Rhudick and Dibner (1961), Swenson (1961), Handal (1969), Dickstein (1972) and Templer (1974) all concluded sex was not a significant variable in looking at attitudes towards death.

Occupation:

Although Feifel, in The Meaning of Death (1959) suggested a need for studies into the relationship between attitudes towards death and occupation little has been done in this field.

Earlier Stacey and Martin (1952) conducted research looking at attitudes towards death of engineering, forestry and law students. They concluded engineering students were the least pre-occupied with death and law students the most concerned. There was no explanation of what these results might mean or why these three groups were chosen for study.

Feifel (1967) studied doctor's attitudes towards death. He compared doctors, medical students, the terminally-

ill, the seriously-ill and healthy adults. He found doctors had a greater fear of death although 63 percent said they were less fearful than when they were younger. Likewise, medical students had a high fear of death. Feifel concluded some people enter medicine in an effort to achieve control over death.

In the nursing field, Quint (1967) found nurses had little training or exposure to death. Often their instructors did not feel comfortable with the topic and this uneasiness was passed on to the students. Studies have shown nurses often respond more slowly to the call bells of terminally-ill patients (Bowers, 1964; Hendin, 1973). This also could suggest nurses continue to be uncomfortable with the dying.

In her book, Counseling the Dying, Bowers (1964) stated many men who join the clergy have suffered a traumatic death experience in their youth. She suggested they have turned to the ministry as an attempt to master death.

Lester et al (1971b) compared the death concern of those in a high risk occupation (patrolmen) to those in a low risk occupation (mailmen). Although there was no significant difference in their scores on the scale, he concluded those in a high risk occupation were less defensive and more willing to talk about death. Lester (1971a) also carried out a study looking at the attitudes towards death of the staff of a suicide prevention centre. Again there was no significant difference between their scores and those of the control group, yet the staff showed a more common sense approach to death. This finding obviously differs from the results of

Feifel's study on the attitudes towards death held by doctors.

In their studies with the elderly, Swenson (1961) and Rhudick and Dibner (1961) found there was no significant difference in the attitudes towards death held by those who were working and those who had retired.

In looking at the variables of age, sex and occupation and their relationship toward death, it is obvious the results are both contradictory and inconclusive. This is partially because so many different methods have been used to collect data. Moreover, the various measuring devices were not all based on the same criteria.

The next section will give a brief review of some of the methods of data collections used. Specifically, the writer will discuss scales, interviews, projective techniques and physiological measures which have been used by researchers in their studies of attitudes towards death and dying.

Methods used by researchers:

Research techniques have varied greatly in this field. Many studies have been based upon direct methods of investigation through the use of questionnaires (Middleton, 1936; Swenson, 1961). The greatest advantage of this method was it could be administered anonymously to a large number of people. But, of course, there always could be the possibility the responses were not representative of the true beliefs of the subjects. Different respondents may have answered the questions differently simply because they understand the question differently. The risk existed that each person used

their own subjective interpretation of what was being asked in the questions concerning attitude.

Often researchers develop their own particular scale for the collection of data. For example, Templer devised a Death Anxiety Scale (1970) and Collett and Lester developed a Fear of Death Scale (1969). Although some research has been done on the reliability and validity of these instruments by their authors, much more work needs to be carried out in this area.

Interviews, another direct method, have been used to gather data on attitudes towards death (Feifel, 1956). Christ (1961) used a questionnaire as the basis for his interviews with older people on their attitudes towards death. This avoided the difficulty of written responses to a questionnaire which might not reflect the subjects' beliefs owing to a misunderstanding of the meaning of the questions. Interviews have also been used with studies on children's attitudes towards death (Nagy, 1948; Koocher, 1974). In addition to oral responses, Nagy also asked children to write and to draw pictures concerning the subject of death.

Some researchers have used a more indirect method. Rhudick and Dibner (1961) used the Thematic Apperception Test in their study of death concern in aged individuals. Shrut (1958) devised a sentence completion test. As with other methods used, much more research needs to be done on the use of projective techniques as a means of collecting data on attitudes towards death.

A few researchers have relied on physiological methods

to collect data for their studies. Alexander and Adlerstein (1958) used the galvanic skin response (GSR) to study subjects' reactions to death-related words. Templer (1971b) also used the GSR in his study on verbalized and non-verbalized death anxiety. He found a modest but significant correlation between his Death Anxiety Scale and GSR.

Most researchers, for instance Dickstein (1972), Templer (1970), Handal (1969) and Lester (1967) draw attention to the inadequate techniques used for the measurement of attitudes towards death. As Dickstein and Blatt (1966) stressed, the various methods assess different components as well as different levels of awareness of attitudes towards death. Only with continuous study and re-evaluation of tools of measurement will reliable data be accumulated on the relevance of death concern to man.

Summary

This chapter presented a short historical review of the attitudes towards death throughout the ages. People of all cultures have attempted to find different ways to reconcile themselves to death, yet despite man's advances in knowledge, fear still surrounds the issue of death.

As the discussion showed, fear of death has been most prevalent in the Western World where technological changes have been greatest. Unable to eliminate death, North Americans have attempted to deny its existence. The dying have been placed in hospitals and institutions, undertakers make the body look life-like and people speak of "passing on". But obviously death cannot be denied.

Recently changes have occurred in North America which show the taboo of death has begun to lift. The threat of nuclear war and the questions of euthanasia and abortion have forced people to think about the reality of death. Courses, books and articles concerning death have gained in popularity. Emphasis has been placed on death education for members of the helping professions. Attitudes towards death in North America appear to be going through a transition period.

This chapter also looked at attitudes towards death and dying in Newfoundland. It was shown that until recently death was accepted as part of the natural life process by most Newfoundlanders. Only in the past twenty years has Newfoundland society begun to be caught up in the North American denial of death.

Finally, the chapter concluded with a summary of related research on attitudes towards death. Writers have given many explanations of the meaning of death to man. The overall conclusion was there can be no one unitary meaning of death to man.

The research concerning the relationship between attitudes towards death and the variables of age, sex and occupation was contradictory and inconclusive. This was partially due to the variety of methods used to collect data in the studies. In summary, much work has to be done in the field of the attitudes toward death and dying.

The following chapter will discuss the sample, the instruments and the methodology used in the present study.

CHAPTER III

METHODOLOGY

This chapter contains a description of how the sample was selected, an outline of the procedure followed, a description of the instrument used in the study and an explanation of how the data was analyzed.

All the data was collected within the Province of Newfoundland, Canada during June, July and August 1974.

Selection of the Sample

The sample consisted of 34 counsellors, 61 teachers, 61 clergymen, 66 registered nurses, and 79 student nurses.

The 34 counsellors were those who responded from the list of 47 full-time school counsellors supplied by the Department of Education, Province of Newfoundland, St. John's, Newfoundland.

For the teacher group, subjects were obtained by selecting 61 teachers from those attending summer school classes in the Faculty of Education, Memorial University in St. John's, Newfoundland, July to August 1974.

The nursing group was randomly selected from the total population of registered nurses within the Province of Newfoundland. There were 66 questionnaires returned out of the total sample of 100.

The entire class of 79 first year student nurses from the General Hospital School of Nursing, St. John's, Newfoundland were administered the questionnaire.

The 61 clergymen who returned the questionnaire for

this study were selected from the three major denominations within the Province. Thirty clergymen were randomly selected from the total cleric population of each of these three groups -- Roman Catholic, Anglican and United.

A total of 301 questionnaires were returned. Forty-four of the respondents failed to fully answer the Death Concern Scale and therefore 257 completed questionnaires were used in the analysis.

Description of the Sample

The sample consisted of 257 people ranging in age from 17 to 66. There were 157 females and 100 males. They represented five professional groups: 30 school counsellors, 44 clergy, 76 student nurses, 54 teachers and 53 nurses. Further demographic characteristics of the sample can be found in Chapter IV.

Procedure

Two instruments were administered to all subjects, a questionnaire (see Appendix A) to obtain general information about the subjects and the Death Concern Scale (Dickstein, 1972) (see Appendix B).

The researcher personally administered the instruments to the teacher and student nurse groups. The following standardized instructions were used in each class:

Hello. My name is Janet Crosbie and I am a graduate student in guidance and counselling at Memorial University. For my thesis I am doing research on attitudes that various members of different professions have towards death. I need your help. I would like you to fill out this questionnaire - the first two pages solicit general information about yourself and then follows the Death Concern Scale. There are no right

and wrong answers on this scale - just answer each one quickly. As you can see there it no identification on the papers - all the data will be analysed on a group basis. If any of you would like some information on the results of the study please contact your instructor. Please raise your hand if you have any questions. Thank you very much for your help.

Sixty-one teachers filled out the questionnaire. Seven failed to fully complete the Death Concern Scale, therefore 54 or 89 percent were used in the analysis of the study. Three of the 79 student nurses returned incomplete Death Concern Scales. Analysis was done using 96 percent of the questionnaires from the class of student nurses.

The instruments along with covering letters (Appendices C and D) were mailed directly to the remaining three groups, i.e. the counsellors, the clergy and the nurses. Each envelope contained a stamped envelope addressed to the researcher. An identifying number in the left-hand corner of the envelope facilitated a follow-up mailing to those who failed to respond to the initial request (see Appendix E).

Follow-up mailings were carried out for these three groups. Of the 47 counsellors who received the questionnaire, 26 answered the initial request. A second questionnaire and a covering letter (see Appendix E) were sent to the remaining 21 subjects and another 8 replies were received. This gave a total of 34 replies. Four of these had incomplete Death Concern Scales therefore 30 responses were used in the study. This represents 64 percent of the total group who received the questionnaire.

In the nursing group, 47 nurses out of 100 answered

the initial request. After the follow-up mailing to the remaining 53 nurses, another 19 replies were received. Of the total of 66 responses received, 53 could be used in the final analysis.

Within the cleric group, the total number of replies can be looked at in terms of denominational affiliation. Of the 30 Roman Catholic priests who received the questionnaire, 11 answered the initial request. After sending out 19 follow-up questionnaires, 6 more replies were received. Sixteen out of 30 United Church ministers answered the first letter; another 7 replied from the 14 who received a second request. Eight Anglican ministers answered the first time (including one who sent back a blank questionnaire). Fourteen replies were returned from the 23 who received a second mailing. The total cleric sample of 61 represents 69 percent of those who were randomly selected to participate in the study. However, owing to incomplete Death Concern Scales, 44 (or 49 percent) of the returns were used in the analysis.

Instrument

The questionnaire used in this study was a two part instrument (Appendix A and B).

The general information questionnaire was devised by the author based on one used by Garlie (1971) in an unpublished doctoral thesis. This elicited certain demographic information necessary for the analysis of the data (see Appendix A).

The second section of the questionnaire was the Death Concern Scale developed by Dickstein in 1972 (see Appendix B).

This scale was based upon an earlier measure which had been devised by Dickstein and Blatt (1966). The Death Concern Scale claims to measure individual differences in the degree to which the individual consciously confronts death and is disturbed by its implications (Dickstein, 1972).

The scale consists of thirty items each of which contains four response alternatives. The first eleven items have the alternatives: often, sometimes, rarely, and never. The score for each item may vary from one to four with one always for a response of "never" and four always the score for a response of "often". The remaining nineteen items use a different set of four categories: I strongly disagree, I somewhat disagree, I somewhat agree, I strongly agree. These response alternatives were always presented in the same order. However, to control for acquiescence in response set, the items were arranged so agreement represents high death concern on eleven items and disagreement represents high death concern on eight items. The items for which disagreement represents high death concern are 12, 14, 15, 19, 23, 25, 26, and 28. Again, the score for each item may vary from one to four. The potential range of the scale is from 30 to 120 (Dickstein, 1972).

Dickstein (1972) made a study of the reliability and construct validity of the scale. Data on the test-retest reliability was obtained by administering the Death Concern Scale to a sample of 151 female college undergraduates twice within an intervening period of eight weeks. The test-retest reliability was .87.

He investigated the construct validity of the scale

by comparing its relationship with: the Manifest Anxiety Scale (MAS; Taylor, 1953); the State-Trait Anxiety Inventory (STAI; Levitt, 1967; Spielberger, Gorsuch, and Lushene, 1970); and the Repression-Sensitization Scale (R-S; Bryne, 1961; Byrne, Barry and Nelson, 1963). He postulated scores on the Death Concern Scale should be positively related to scores on measures of anxiety. These scores should also be positively related to scores on the R-S scale which claims to measure the tendency of the individual to avoid or acknowledge threatening stimuli.

The Death Concern Scale and the MAS were significantly correlated. The correlation was .34 ($p > .01$; two-tailed test) for the total sample. Subjects of high, middle and low death concern were compared by using analysis of variance. The high-scoring subjects all had mean scores of 85 or higher. The middle-scoring subjects ranged from 72.5 to 76.5 while the low-scoring subjects all had scores of 65.5 or lower. A comparison done using analysis of variance indicated a significant correlation between the scores on the Death Concern Scale and those on the STAI and R-S scales.

Dickstein suggested the Death Concern Scale would be a promising instrument for utilization in further research. It possessed a high level of reliability in terms of internal consistency for males and females. Death Concern was also positively related to manifest anxiety for both groups - and to state anxiety, trait anxiety and sensitization for females. More data needs to be obtained on males. Probably because of the scale's recent development, the author has been unable to

find any other reports of studies using the Death Concern Scale.

For this study the questionnaire method was chosen because it could be administered to a large number of people over a wide area. Furthermore, the respondents were assured of their anonymity and therefore may have been more willing to answer the questionnaire. Of course this method also has limitations which were discussed in Chapter II.

Analysis

The data collected in this study was numerically coded to maintain the anonymity of the respondents. It consisted of the subjects' replies to the items on the information questionnaire and the Death Concern Scale.

An analysis of variance was used to test the null hypothesis of no difference between mean Death Concern Scale scores of the five groups (see Table 9). Later, a t-test established which of the differences were significant (see Table 10). The null hypothesis was rejected at the .01 level of confidence for the two-tailed test. Additional analysis was then carried out on the data. Again comparison was considered significant at the .01 level of confidence.

The analysis which tested the hypothesis was carried out on an IBM 360/40 computer at Memorial University of Newfoundland using the SPSS and ANOVA programs.

Summary

This chapter has described the sample, the procedure, the instrument used and the data analysis. The following chapter will discuss the findings of the study.

CHAPTER IV

RESULTS OF INVESTIGATION

This chapter contains a presentation of the findings of the study. The first part of the chapter discusses some of the demographic characteristics of the sample. The second part deals with the testing of the hypothesis as established in Chapter I and the third section provides further analysis of the data prompted by some unexpected initial findings.

Demographic Characteristics

The data in this section were obtained from the demographic section of the questionnaire and are presented in tables to describe some characteristics of the sample.

Table 1 shows the ages of the participants in the different professional groups.

Table 1

Age of participants

	Below 30	Thirties	Forties	Fifties	Sixties
Counsellors	12	10	7	1	-
Clergy	7	19	10	4	4
Student Nurses	74	2	-	-	-
Teachers	35	13	4	2	-
Nurses	29	12	8	4	-

The student nurse group was obviously much younger than the other groups.

Table 2 indicates the sex of the members of each professional group.

Table 2

Sex of participants

	Male	Female
Counsellors	24	6
Clergy	44	-
Student Nurses	3	73
Teachers	28	26
Nurses	1	52
TOTAL	100	157

The sample was approximately 61 percent female and 39 percent male.

The religious affiliations of those who took part in the study are shown in Table 3. Thirty-eight percent of the group were Roman Catholic, 26 percent Anglican, 26 percent United Church and 10 percent were of other faiths.

Table 3

Religious Affiliation

	Anglican	Roman Catholic	United Church	Other
Counsellors	6	12	6	6
Clergy	14	11	19	-
Student Nurses*	20	26	23	6
Teachers	13	30	7	4
Nurses	14	19	11	9
TOTAL	67	98	66	25

* 1 response missing.

Table 4 shows the size of the community in which the subjects spent the first sixteen years of their life. Thirty-two percent of the sample were brought up in a community of more than 22,500. It can be assumed the majority of the remaining 68 percent were brought up in rural communities in Newfoundland.

Table 4

Size of community of upbringing

	0-500	500-1500	1500-4500	4500-22,500	over 22,500
Counsellors	6	5	7	6	6
Clergy	9	14	3	6	12
Student Nurses*	7	9	15	9	35
Teachers	14	10	7	9	14
Nurses*	8	6	8	15	15
TOTAL	44	44	40	45	82

*1 response missing.

The data in Table 5 indicates the years of experience the professionals have had in their fields. It should be remembered all student nurses were in their first year of training. Sixty-one percent of the group had zero to five years work experience. Five teachers failed to answer this question.

Table 5

Number of years of experience

	0-5 years	6-10 years	11-15 years	16-20 years	Over 21 years
Counsellors*	18	8	2	-	1
Clergy*	11	12	7	4	9
Student Nurses	76	-	-	-	-
Teachers+	26	16	6	-	1
Nurses	26	13	7	5	2
TOTAL	157	49	22	9	13

* 1 response missing.
\+ 5 responses missing.

Table 6 indicates those participants who had to deal with death as part of their work within the past two years. It is interesting to note that 3 of the clergy and 4 of the nurses stated they had no recent situations of dealing with death in their jobs. Perhaps they were in teaching positions as opposed to dealing directly with members of the church or with patients.

Table 6

Dealing with death as part of work experience within past two years

	Yes	No
Counsellors	8	22
Clergy	41	3
Student Nurses	35	41
Teachers	7	47
Nurses	49	4
TOTAL	140	117

The data in Table 7 indicate those of the sample who had participated in some type of death education program. One of the clergy referred to his entire training as death education but obviously not all clerics felt this to be so. As a class, the student nurses had attended a one-day seminar on death education. It would appear that four of the group were absent on that day. The counsellor and teacher groups had by far the least exposure to death education programs.

Table 7

Participation in death education programs

	Yes	No
Counsellors	5	25
Clergy*	18	25
Student Nurses	72	4
Teachers	1	53
Nurses*	22	30
TOTAL	118	137

*1 response missing.

This part of the chapter has dealt with some of the demographic characteristics of the population. The significance of some of these results will be further discussed in Chapter V.

Results of Testing the Hypothesis

The null hypothesis stated there was no significant difference between the mean group scores of the counsellors, clergy, student nurses, teachers and nurses on the Death Concern Scale.

Table 8 shows the mean group scores of the counsellors, clergy, student nurses, teachers and nurses on the Death Concern Scale. The mean group scores ranged from a low of 66.89 for the clergy to a high of 78.69 for the student nurses. The other mean scores were 69.83 for the counsellors, 70.09 for the nurses and 71.93 for the teachers.

Table 8

The mean scores obtained on the Death Concern Scale by the five professional groups

	Total Numbers	Mean Score	Standard Deviation
Counsellors	30	69.83	12.08
Clergy	44	66.89	10.49
Student Nurses	76	78.69*	11.81
Teachers	54	71.93	14.03
Nurses	53	70.09	10.77

*significant at the .01 level of confidence

Using an analysis of variance and a .05 level of confidence, the results show there was a significant difference between the five professional groups (see Table 9).

Table 9

Analysis of variance of scores obtained by the five professional groups

	Sum of Squares	Degrees of Freedom	Mean Square
Between groups	4842.8750	(4)	1210.7188
Within groups	35893.1250	(252)	142.4330
TOTAL	40736.0000	(256)	
	F = 8.5003*		

*significant at the .05 level of confidence

Analysis was done to test the differences among the groups using t-tests with an .01 level of confidence. The level of confidence was placed at .01 in order to minimize the possibility of type I error in multiple comparisons. Table 10 presents the results of this testing. The mean group score of the student nurses was significantly higher than the mean group scores obtained by all the other professional groups on the Death Concern Scale.

Table 10

Probabilities of t-tests comparing the mean group scores of the five professional groups on the Death Concern Scale

	Clergy	Student Nurses	Teachers	Nurses
Counsellors	.268	.001*	.494	.919
Clergy		.000*	.051	.143
Student Nurses			.003*	.000*
Teachers				.451
Nurses				

*significant at the .01 level of confidence

The researcher decided to look for possible reasons for the significant difference between the mean group scores of the student nurses and those of the other groups. As mentioned in the beginning of this chapter, the student nurses were on the whole a much younger group. Seventy-four of the 76 student nurses were under 30 years of age. Therefore, it was decided to compare the mean group scores of those under 30 in each professional group.

Supplementary Analysis

In Table 11, the mean group scores of those under 30 in each professional group are shown. In all cases, except that of the student nurses the mean group score of those under 30 in each professional group was higher than the mean group score of the whole group. Since 97 percent of the student nurses were in the under 30 group, their mean group score is almost the same as for the whole group of student nurses.

Table 11

The mean group scores obtained on the Death Concern Scale by those under 30 in each professional group

	Number	Mean Score	Standard Deviation
Counsellors	12	72.50	12.54
Clergy	7	74.57	11.73
Student Nurses	74	78.50	11.84
Teachers	35	73.06	14.00
Nurses	29	73.07	9.57

Comparing the five professional groups by using analysis of variance and a .05 level of confidence, no significant differences were found between the scores obtained on the Death Concern Scale by those under 30 (see Table 12).

Table 12

Analysis of variance of scores obtained by those under 30 in the five professional groups

	Sum of Squares	Degrees of Freedom	Mean Square
Between groups	1156.7852	(4)	289.1963
Within groups	22013.0893	(152)	144.8230
TOTAL	23169.8750	(156)	
	F = 1.9969*		

*not significant

Analysis was then done of the mean scores on the Death Concern Scale obtained by those 30 years of age and older across all five professional groups. Table 13 gives these results. It should be noted although the mean score for the student nurses first appears quite high this was because only two questionnaires fitted into this older category.

Table 13

The mean group scores obtained on the Death Concern Scale by those 30 and older in the five professional groups

	Number	Mean Score	Standard Deviation
Counsellors	18	68.06	11.79
Clergy	37	65.43	9.74
Student Nurses	2	86.00	11.31
Teachers	19	69.84	14.23
Nurses	24	66.50	11.23

Again using an analysis of variance and a .05 level of confidence no significant differences were found between the scores of the older members of the five professional groups (see Table 14).

Table 14

Analysis of variance of scores obtained by those over 30 in the five professional groups

	Sum of Squares	Degrees of Freedom	Mean Square
Between groups	975.6250	(4)	243.9063
Within groups	12442.6875	(95)	130.9756
TOTAL	13418.3125	(99)	
	F = 1.8622*		

*not significant

The final step was to test for differences between those in the entire sample who were under 30 and those who were older. Table 15 shows those under 30 obtained a mean score of 75.65 on the Death Concern Scale, and those 30 and older obtained a mean score of 66.71.

Table 15

The mean group scores obtained by those under 30 and those 30 and older in the entire sample

	Total Number	Mean Score	Standard Deviation
Under Thirty	157	75.65*	12.19
Thirty and over	100	66.71	11.17

*significant at the .01 level of confidence

Using an analysis of variance and a .05 level of confidence there was a statistically significant difference between the scores obtained by the two groups at the .01 level of confidence (see Table 16).

Table 16

Analysis of variance of scores obtained by those under 30 and those 30 and older in the entire sample

	Sum of Squares	Degrees of Freedom	Mean Square
Between groups	4696.8750	(1)	4696.8750
Within groups	34775.1250	(249)	139.6591
TOTAL	39472.0000	(250)	
	F = 33.6310*		

*significant at the .01 level of confidence

Summary

This chapter contains an analysis of the data and the results of the study. Some demographic characteristics of the sample were presented in the first section. As outlined in Chapter I, the major purpose of the study was to compare the attitudes towards death held by the members of five different professional groups.

The mean group score of 78.69 obtained by the student nurses on the Death Concern Scale was significantly higher than the mean scores obtained by the other professional groups. These scores were 66.89 for the clergy, 69.83 for the counsellors, 70.09 for the nurses and 71.93 for the teachers.

Since the student nurse group was on the whole much younger than the other groups further analysis was carried out on the basis of age. It was found there was no significant difference between the scores of those under 30 in each professional group. However, on further testing, the results showed there was a significant difference between the scores of those in the entire sample under 30 and those who were 30 and older.

Implications arising from the findings will be discussed in the next chapter.

CHAPTER V

DISCUSSION, IMPLICATIONS, RECOMMENDATIONS AND SUMMARY

This chapter presents a discussion of the implications arising from the results, recommendations for further study, and a summary of the research.

Discussion and Implications of the Results

Before proceeding with a discussion of the findings, it is important to recall Dickstein's definition of death concern and the function of the Death Concern Scale:

> Death Concern is conceptualized as the conscious contemplation of the reality of death and negative evaluation of that reality. The scale purports to measure individual differences in the degree to which the individual consciously confronts death and is disturbed by its implications. (Dickstein, 1972, p. 564)

This contains two important and almost conflicting aspects. Each individual should consciously confront death but he should not be overly disturbed by its implications.

In his testing, Dickstein divided up his subjects into groups with high, middle and low death concern. Those in the high range with mean scores of 85 or higher were very anxious about death. Those in the middle range who had mean scores from 72.5 to 76.5 had an awareness and an acceptance of death. Those in the low range with mean scores 65.5 and below were unwilling to consciously confront death. These groupings should be kept in mind while looking at the findings of the present study.

As a result of the data analysis in this study, the following mean group scores were obtained on the Death Con-

cern Scale; 66.89 by the clergy, 69.83 by the counsellors, 70.09 by the nurses, 71.93 by the teachers and 78.69 by the student nurses. Except for the clergy group, the other groups had scores relatively close to the middle range as suggested by Dickstein.

The supplementary analysis carried out on the basis of age and death concern indicated that those under thirty had a higher level of death concern than the rest of the sample. As indicated in Chapter II, researchers have disagreed on whether young people are concerned about death (Cameron, 1973; Middleton, 1936; Dickstein and Blatt, 1966). These findings suggested they do have a concern with death.

In studies with older people, researchers have concluded there is no significant relationship between age and fear of death (Christ, 1961; Swenson, 1961; Rhudick and Dibner, 1961; Templer, 1971a). The present findings indicated older people were unwilling to consciously confront death thereby differing from earlier research results.

As Table 4 showed, 68 percent of the sample were brought up in rural Newfoundland communities. The literature suggested people from less sophisticated cultures have a greater acceptance of the reality of death (Toynbee, 1968; Mowat, 1968; Trelease, 1975). In this study, 73 percent of the clergy were brought up in rural communities. Since this group had a mean age in the late thirties, they were brought up while these outports were still relatively undeveloped. Yet, from the results of this study it might be inferred they showed an unwillingness to confront death. This finding does

not support the theory put forward in the literature.

The two groups which had the greatest opportunity to deal with death in their work were the clergy and the nurses (see Table 6). Bowers (1964) and Quint (1967) have suggested members of these professional groups were uncomfortable with the topic of death and dying. The findings of this study support the theory that these groups are more defensive when faced with questions involving death.

One possible indication of this defensiveness was the failure on the part of a number of clergymen and nurses to fully complete the Death Concern Scale. Table 13 shows the number in each group who omitted items on the questionnaire.

Table 17

The number of incomplete questionnaires returned from each professional group and the reasons given for not answering items.

	Incomplete Returns	Explanation Given		
		Wording	Undecided	No Reason
Counsellors	4	1	1	2
Clergy	17*	10	-	6
Student Nurses	3	-	-	3
Teachers	7	4	-	3
Nurses	13	4	2	7

* The first return was from a clergyman who sent back a blank questionnaire with a letter explaining that "death cannot be looked at in the abstract."

A number of the respondents, especially within the clergy group, questioned the wording of some of the state-

ments. These items in particular seemed to cause doubts for respondents because of the wording. These were: number 15 "My general outlook 'just' does not allow for morbid thoughts"; number 28 "The death of the individual is ultimately beneficial because it facilities change in society"; and, number 29 "I have a desire to live on after death". Respondents commented that these statements were unclear. In three instances the respondents said they were undecided about the thought expressed in the statement.

It is impossible to know why twenty-one respondents left out questions without giving some explanation. Certainly the author can speculate that in some cases the omissions were accidental owing to a lack of concentration and haste. There does not seem to be any particular pattern in these unexplained unanswered questions.

It would seem the method of collecting data had some effect on the number of incomplete questionnaires since the greatest number of incomplete returns came from those who received the questionnaire by mail. Perhaps this group had more time for reflection as well.

It was also possible the groups, particularly the clergy and the nursing groups, were not representative because of a bias in the return. This was a limitation in the selection of the sample.

Both the counsellors and teachers claimed they had little experience with death as part of their work in the past two years (see Table 6). It was surprising to the author so few people working in schools had not been put in a position

where they needed to help pupils deal with bereavement. Perhaps there were many opportunities to do so but they failed to see that as part of their role. Since a child's anxieties often stem from fears about death (Furman, 1974; Kastenbaum, 1974), it would be especially important for counsellors and teachers to come to terms with their attitudes towards death and thus be ready to help others to do so (Pincus, 1974; Clay, 1974).

Most of the student nurses had participated in some type of death education program (see Table 7). Teachers and counsellors had by far the least exposure to this type of program. Much of the literature suggested members of the helping professions - counsellors, teachers, clergy and nurses - would benefit from death counselling and death education courses as part of their training (Kubler-Ross, 1969; Parkes, 1972). The findings of this study show members of these groups have not had the benefit of attending death education programs.

Recommendations

1. There is a need for further refinement of the scales used for measuring attitudes towards death. For example, it is possible the scale used in this study did not adequately measure the attitudes of those who accept death as part of life.

2. A larger number of subjects from each professional group would have widened the scope of the study.

3. The rate of completed returns would be increased if administered in person rather than through the mails.

4. Further study could be carried out on the attitudes of older people towards death to see why death concern seems to decrease with age.

5. The research could be more closely tied in with a specific death education program in order to evaluate the program as a preparation for dealing with death and dying.

Summary

This study was designed in order to compare the attitudes towards death held by counsellors, clergy, student nurses, teachers and nurses. Members of all these professions should be prepared to deal with the question of death as part of their work experience. At present there seems to be little opportunity for these people to participate in death counselling and death education courses. It is the opinion of the author each individual should begin their own death education program through introspection, discussion with relatives and friends, and reading the many excellent books available on the topic.

References

Alexander, I. E., Colley, R.S. and Adlerstein, A. M. "Is death a matter of indifference?" Journal of Psychology, 1957, 43, 277-283.

Alexander, I. E., and Adlerstein, A. M. "Affective responses to the concept of death in a population of children and early adolescents. Journal of Genetic Psychology, 1958, 93, 167-177.

Ames, L. B. "Death" Instructor, 1969, 78, 59.

Anonymous. "Death in the first person". In E. Kubler-Ross (Ed.) Death: The Final Stage of Growth, Englewood Cliffs, N. J.: Prentice-Hall, 1975.

Aries, P. Western Attitudes Toward Death Baltimore: John Hopkins University Press, 1974.

Barton, D. "The need for including instruction on death and dying in the medical curriculum". Journal of Medical Education, 1972, 47, 169-175.

Becker, E. Escape from Evil. New York: Free Press, 1975.

Bell, L. V. "Death in the technocracy". Journal of Human Relations, 1970, 18, 833-839.

Berg, D. W. and Daugherty, G. G. "Teaching about death", Today's Education, 1973, March.

Bieler, Z. "Special Unit aims to comfort dying not to prolong life", Montreal Star December 16, 1976, c.i.

Bowers, C. Counselling the Dying. New York: Thomas Nelson, 1964

Bradbrook, K. "Ars Moriendi in Newfoundland" Unpublished paper, Mount St. Vincent University, 1976.

Bromberg, W. and Schilder, P. "Death and Dying", Psychoanalytic Review, 1933, 20, 133-185.

Brown, N. "Norman O. Brown's Body" Psychology Today, 1970, August, 43-47.

Byrne, D. "The Repression - Sensitization Scale: rationale, reliability and validity, Journal of Personality, 1961, 29, 334-349.

Byrne, D., Barry, J., and Nelson, D." Relation of the revised Repression-Sensitization Scale to measures of self-description. Psychological Reports, 1963, 13, 323-334.

Cameron, P., Stewart, L. and Biber, H. "Consciousness of death across the life-span", Journal of Gerontology, 1973, 28, 92-95.

Chadwick, M. "Notes upon the fear of death". International Journal of Psychoanalysis, 1929, 10, 321-334.

Christ, P. E. I. "Attitudes towards death among a group of acute geriatric psychiatric patients". Journal of Gerontology, 1961, 16, 56-59.

Clay, V. S. "Children deal with death", School Counsellor, 1976, January, 1975-185.

Collett, L. and Lester, D. "The fear of death and fear of dying", Journal of Psychology, 1969, 72, 179-181.

Dickstein, L. "Death Concern: Measurement and Psychological Reports, 1972, 30, 563-571.

_____ and Blatt, S. "Death Concern, futurity, and anticipation. Journal of Counsulting Psychology, 1966, 30, 11-17.

Feifel, H. "Older persons look at death", Geriatrics, 1956, 11, 127-130.

_____ The Meaning of Death, New York: McGraw-Hill, 1959.

_____ "The function of attitudes toward death", Group for the Advancement of Psychiatry, 1965, 5, 632-641.

_____ "Attitudes towards death: a psychological perspective", Journal of Consulting and Clinical Psychology, 1969a; 33, 292-295.

_____ "Death - relevant variable in psychology". In R. May (Ed.) Existential Psychology, Toronto: Random House, 1969b.

_____ "Psychology and the death-awareness movement", Journal of Clinical Child Psychology, 1974. Summer, 6-7.

_____, Hanson, S; Jones, R; and Edwards, L. "Physicians consider death", Proceedings of the American Psychological Association, 1967, 2, 201-202.

Feldman, M. and Hersen, M. "Attitudes towards death in nightmare subjects" Journal of Abnormal Psychology, 1967, 72, 421-425.

Freud, S. Thoughts for the times on war and death. London: Hogarth 1957, 14, 273-302.

Fulton, R. "Coming to terms with death", Omega 1974, 5, 1-4.

Furman, E. A Child's Parent Dies. New Haven: Yale University Press, 1974.

Garlie, N. "Characteristics of Teenagers with Alcohol Related Problems'. Unpublished Doctor's dissertation, University of Utah, 1971.

Gordon, D. C. Overcoming the Fear of Death. Baltimore: Penquin Books Inc. 1972.

Grollman, E. Explaining Death to Children. Boston: Beacon Press, 1967.

Handal, P. "The relationship between subjective life expectancy, death anxiety, and general anxiety". Journal of Clinical Psychology, 1969, 25, 39-42.

Hendin, D. Death as a Fact of Life. New York: Warner Paperback Library, 1973.

Hinton, J. Dying. Hammondsworth: Penquin Books, 1972.

Jung, C. "The soul and death", In H. Feifel (Ed.) The Meaning of Death. New York: McGraw-Hill, 1959.

Kastenbaum, R. "Time and death in adolescence". In H. Feifel (Ed.) The Meaning of Death. New York: McGraw-Hill, 1959.

Kastenbaum, R. "Childhood: the kingdom where creatures die", Journal of Clinical Child Psychology, 1974, Summer, 11-13.

Kohl, M. "On death, dying and the Karen Ann Quinlan case", The Humanist, 1976, January/February, 16.

Koocher, G. "Conversations with children about death-ethical considerations in research", Journal of Clinical Child Psychology, 1974, Summer, 19-21.

Kron, J. "Learning to live with death", Omega, 1974, 5, 5-23.

Kubler-Ross, E. On Death and Dying. New York: Macmillan, 1969

_____ "What is it like to be dying?" American Journal of Nursing, 1971, January, 54-62.

_____ "The languages of dying", Journal of Clinical Child Psychology, 1974, Summer, 22-24.

_____ Death: the Final Stage of Growth. Englewood Cliffs, N. J: Prentice-Hall, 1975.

Lester, D. "Experimental and correlational studies of the fear of death. Psychological Bulletin, 1967, 67, 27-36.

_____ "Re-examination of Middleton Data: Sex Differences in Death Attitudes:, Psychological Reports, 1970, 27, 136.

_____ "Attitudes towards death held by the staff of suicide prevention centre". Psychological Reports, 1971a, 28, 650.

Lester, D. "Studies in death attitudes: part two", Psychological Reports, 1972a, 30, 440.

_____, Ford, R. E. and Alexander, M. "Fear of death of those in a high-stress occupation", Psychological Reports, 1971b, 29, 502.

_____ and Templer, D. "Resemblance of parent-child death anxiety as a function of age and sex of child", Psychological Reports, 1972b, 31, 750.

Leviton, D. and Furman, E. C. "Death Education for children and youth", Journal of Clinical Child Psychology, 1974, Summer, 8-10.

Levitt, E. The Psychology of Anxiety. Indianapolis: Bobbs-Merrill, 1967.

Lifton, R. Death in Life: Survivors of Hiroshima. New York: Random House, 1969.

Long, J. B. "The death that ends death in Hinduism and Buddhism". In E. Kubler-Ross (Ed.) Death: The Final Stage of Growth. Englewood Cliffs, N. J: Prentice-Hall, 1975.

Martin, L. and Collier, P. "A survey of nursing students", Journal of Nursing Education, 1975, 14, 30-35.

Maslow, A. "Editorial", Psychology Today, 1970, August, 16.

McMahon, J. D. "Death Education: an independent study unit", Journal of School Health, 1973, 8, 526-527.

Middleton, W. C. "Some reactions towards death among college students", Journal of Abnormal and Social Psychology, 1936, 31, 165-173.

Mitford, J. American Way of Death, New York: Simon and Shuster, 1963.

Moreira, W. "Doctors must accept facts of life - Brundage", Mail-Star(Halifax) July 19, 1975, 25.

Morgenson, D. F. "Death and interpersonal failure", Canada's Mental Health, 1973, 21, 3-4.

Moss, J. P. "Death in Children's Literature", Elementary English, 1972, 49, 530-533.

Mowat, F. and de Visser, J. This Rock within the Sea. Toronto: Little, Brown, 1968.

Murphy, G. "Discussion" In H. Feifel (Ed.) The Meaning of Death. New York: McGraw-Hill, 1959.

Munsen, P. H., Congo, J. J. and Kagan, J. Child Development and Personality. (4th ed.) New York: Harper and Row, 1974.

Nagy, M. "The child's theories concerning death", Journal of Genetic Psychology, 1948, 73, 3-27.

Noel, S. J. R. Politics in Newfoundland. Toronto: University of Toronto Press, 1971.

Parkes, C. M. Bereavement. London: Tavistock Publications, 1972.

Pincus, L. Death and the Family. New York: Pantheon Books, 1974.

Quint, J. C. The Nurse and the Dying Patient. New York: Macmillan, 1967.

Rhudick, P. J. and Dibner, A. S. "Age, personality and health correlates of death concern in normal aged individuals", Journal of Gerontology, 1961, 16, 44-49.

Rochlin, G. "How younger children view death and themselves" In E. Grollman (Ed.) Explaining Death to Children. Boston: Beacon Press, 1967.

Schneidman, E. S. "The Enemy", Psychology Today 1970, 4, 37-41, 62-66.

Schnell, R. "Helping parents cope with the dying child with a genetic disorder", Journal of Clinical Child Psychology, 1974, Summer, 34-35.

Shrank, J. "Death" Media and Methods, 1971, February, 32.

Shrut, S. D. "Attitudes towards old age and death, Mental Hygiene, 1958, 40, 259-266.

Spielberger, S., Gorsuch, R. and Lushere, R. State-Trait Anxiety Inventory Manual. Palo Alto: Consulting Psychologists Press, 1970.

Stacey, C. L. and Markin, K. "The attitudes of college students and penitentiary inmates toward death and a future life", Psychiatric Quarterly Supplement, 1952, 26.

Swenson, W. M. "Attitudes towards death in an aged population", Journal of Gerontology, 1961, 16, 49-52.

Tallmer, M., Formanek, R. and Tallmer, J. "Factors influencing children's concepts of death" Journal of Clinical Child Psychology, 1974, Summer, 17-19.

Taylor, J. "A personality scale of manifest anxiety", Journal of Abnormal and Social Psychology, 1953, 48, 285-290.

Templer, D. I. "The construction and validation of a Death Anxiety Scale." Journal of General Psychology, 1970, 82, 165-177.

_____ "Death anxiety as related to depression and health of retired persons", Journal of Gerontology, 1971a, 26, 521-523.

_____ "The relationship between verbalized and nonverbalized death anxiety", Journal of Genetic Psychology, 1971b, 119, 211-214.

_____ Tarter, R. E. and Ruff, C. "Death Anxiety in Suicide Attempters", Psychological Reports, 1974, 34, 895-897.

Tetrault, S. "Children and Death". Paper presented at the American Personnel and Guidance Association National Convention, April 10, 1974, New Orleans, Louisiana.

Toynbee, A. Man's Concern with Death. London: Hodder and Stoughton, 1968.

Trelease, M. "Dying among Alaskan Indians: a matter of choice". In E. Kubler-Ross (Ed.) Death: The Final Stage of Growth. Englewood-Cliffs, N. J: Prentice-Hall, 1975.

Wahl, C. "The fear of death". In H. Feifel (Ed.) The Meaning of Death. New York: McGraw-Hill, 1959.

Waugh, E. The Loved One. Boston: Little, Brown and Co. 1950.

Weisman, A. On Dying and Denying. New York: Behavioral Publications, 1972.

Willis, D. J. "The families of terminally-ill children: symptomatology and management", Journal of Clinical Child Psychology, 1974, Summer, 32-33.

Wolff, S. Children Under Stress. London: Penguin Press, 1966.

Wright, L. "An emotional support program for parents of dying children", Journal of Clinical Child Psychology, 1974, Summer, 37-38.

Zazzaro, J. "Death be not disturbed", Nation's Schools, 1973, 91, 39-42.

Zeligs, R. "Children's attitudes towards death", Mental Hygiene, 1967, 51, 393-396.

Appendices

APPENDIX A

General Information

In analyzing the results of the Death Concern Scale, it is necessary to obtain some general information about you as as individual. These questions are not intended to be "snoopy". Rather, the intent is to gain additional information which will aid in analyzing data about people from various backgrounds. All the data will be used for group analysis only.

Please answer each question to the best of your knowledge.

1. Title of position (Check appropriate category).

   a. ____ classroom teacher

   b. ____ special teacher

   c. ____ vice-principal

   d. ____ principal

   e. ____ school counsellor

   f. ____ clergyman

   g. ____ student nurse

   h. ____ staff nurse

   i. ____ supervisor

   j. ____ nursing instructor

   k. ____ other (please specify) _____.

2. Sex

   a. ____ male

   b. ____ female

3. Age of last birthday _____.

APPENDIX A
(continued)

4. Level of education: (check more than one if applicable).

a. ____ B.A. or B.Sc.

b. ____ B.A.Ed.

c. ____ M.A., M.Sc. or M.Ed.

d. ____ Ph.D.

e. ____ B.D.

f. ____ B.N.

g. ____ R.N.

h. ____ other (please specify) _____.

5. Years of experience in present profession ____.

6. Religious affiliation:

a. ____ Anglican

b. ____ Pentecostal

c. ____ Presbyterian

d. ____ Roman Catholic

e. ____ Salvation Army

f. ____ Seventh Day Adventist

g. ____ United Church

h. ____ Other

7. Size of community where you spent most of your youth (0 to 16 years).

a. ____ 0 - 500

b. ____ 500 - 1500

c. ____ 1500- 4500

d. ____ 4500 - 22,500

e. ____ 22,500 - 112,500

f. ____ 112,500 plus.

APPENDIX A

(continued)

8. Have you been involved in any type of death education program?

a. ____ yes

b. ____ no

9. If yes, how long a period was this for?

a. ____ one day

b. ____ two to five days

c. ____ longer than five days (please specify length ____ _____

10. Have you had any person experience with death within the past two years?

a. ____ yes

b. ____ no

11. If yes, how was this person (or persons) related to you? (Check more than one if appropriate).

a. ____ parent

b. ____ grandparent

c. ____ brother or sister

d. ____ relative

e. ____ close friend

f. ____ acquaintance

g. ____ other

12. Have you had any professional experience with death within the past two years?

a. ____ yes

b. ____ no

APPENDIX B

DEATH CONCERN SCALE

1. I think about my own death.
   1. _____Often
   2. _____Sometimes
   3. _____Rarely
   4. _____Never
2. I think about the death of loved ones.
   1. _____Often
   2. _____Sometimes
   3. _____Rarely
   4. _____Never
3. I think about dying young.
   1. _____Often
   2. _____Sometimes
   3. _____Rarely
   4. _____Never
4. I think about the possibility of being killed on a city street.
   1. _____Often
   2. _____Sometimes
   3. _____Rarely
   4. _____Never
5. I have fantasies of my own death.
   1. _____Often
   2. _____Sometimes
   3. _____Rarely
   4. _____Never

APPENDIX B

(Continued)

6. I think about death just before I go to sleep.

1. _____Often
2. _____Sometimes
3. _____Rarely
4. _____Never

7. I think of how I would act if I knew I were to die within a given period of time.

1. _____Often
2. _____Sometimes
3. _____Rarely
4. _____Never

8. I think about how my relatives would act and feel upon my death.

1. _____Often
2. _____Sometimes
3. _____Rarely
4. _____Never

9. When I am sick I think about death.

1. _____Often
2. _____Sometimes
3. _____Rarely
4. _____Never

10. When I am outside during a lightning storm I think about the possibility of being struck by lightning.

1. _____Often
2. _____Sometimes
3. _____Rarely
4. _____Never

APPENDIX B

(Continued)

11. When I am in an automobile I think about the high incidence of traffic fatalities.

1. _____ Often
2. _____ Sometimes
3. _____ Rarely
4. _____ Never

12. I think people should first become concerned about death when they are old.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

13. I am much more concerned about death than those around.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

14. Death hardly concerns me.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

15. My general outlook "just" doesn't allow for morbid thoughts.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

APPENDIX B

(Continued)

16. The prospect of my death arouses anxiety in me.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

17. The prospect of my own death depresses me.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

18. The prospect of the death of my loved one arouses anxiety in me.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

19. The knowledge that I will surely die does not in any way affect the conduct of my life.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

20. I envision my own death as a painful, nightmarish experience.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

APPENDIX B

(Continued)

21. I am afraid of dying.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

22. I am afraid of being dead.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

23. Many people become disturbed at the sight of a new grave but it does not bother me.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

24. I am disturbed when I think about the shortness of life.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

25. Thinking about death is a waste of time.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

APPENDIX B

(Continued)

26. Death should not be regarded as a tragedy if it occurs after a productive life.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

27. The inevitable death of man poses a serious challenge to the meaningfulness of human existence.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

28. The death of the individual is ultimately beneficial because it facilitates change in society.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

29. I have a desire to live on after death.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

30. The question of whether or not there is a future life worries me considerably.

1. _____ I strongly disagree
2. _____ I somewhat disagree
3. _____ I somewhat agree
4. _____ I strongly agree

APPENDIX C

P. O. Box 15,
Education Building,
Memorial University,
St. John's.

14 June 1974.

Dear Counsellor,

I realize this is a very inconvenient request but it will only take fifteen minutes of your time.

I am a graduate student in guidance and counselling at Memorial University. For my thesis I am doing research on attitudes towards death held by counsellors, teachers, clergy and nurses. In order to collect the necessary information I would like you to fill out the enclosed brief questionnaire. Since there are so few full-time counsellors in the province, a hundred percent return is desirable.

All the information will be strictly confidential. The data will be analyzed on a group basis only. If you would like any further information or copies of the results do not hesitate to contact me at the above address or at the following telephone numbers: 753-1200 ext. 3221 or 726-6945.

Thanking you in advance for your help. Happy holidays.

Yours sincerely,

Janet Crosbie

Dr. Norman-Garlie.
Supervisor.

APPENDIX D

P. O. Box 15,
Education Building,
Memorial University,
St. John's, Newfoundland,

June 26, 1974.

Dear Sir/Madam:

I am a graduate student in guidance and counseling at Memorial University. For my thesis I am doing research on attitudes towards death held by counselors, teachers, clergy and nurses. In order to collect the necessary information I would like you to fill out the enclosed questionnaire. A hundred per cent return would be desirable.

All the information will be strictly confidential. The data will be analyzed on a group basis only. The identifying number at the left hand corner of the envelope will be used if no reply is received from the initial questionnaire. If you would like any further information or copies of the results, do not hesitate to contact me at the above address or at the following telephone numbers: 753-1200 ext. 3221 or 726-6945.

Thanking you in advance for your help.

Yours sincerely,

Janet Crosbie.

Dr. Norman Garlie
Supervisor.

APPENDIX E

P. O. Box 15,
Education Building,
Memorial University,
St. John's, Newfoundland

27 August, 1974

Dear

Owing perhaps to the mails and the summer holidays, I have not yet received your reply to my initial questionnaire concerning attitudes towards death.

For the purposes of my research it is necessary that I have as many completed questionnaires as possible. I would really appreciate it if you would take the time (no more than ten minutes) to answer this.

Once again thanking you in anticipation.

Yours sincerely,

Janet Crosbie.

Dr. Norman Garlie