THEORETICAL ORIENTATION

DEATH

Death is a highly personal issue with its meaning varying from individual to individual. Everyone at some point must see death as part of life. The concept has been variously defined and elaborated. Weissman (2000) integrated meanings of death into four categories, namely:

- Death is an exigency and defeat of life, a tragedy, negating life’s values, signifying failure and futility.
- Death is an illusion and an extension of life, a prologue to another form of life, death means transition not extinction.
- Death is an inevitable and inexorable fact of life, a confrontation with finitude; it is an end point in the “contract” between the living and life’s parameters.
- Death is an explanation and expiation of life, a final judgment on the life processes; it offers retribution or reward, a release from mortality’s constraints.

According to Kastenbaum (2006), the word death is used in at least three primary ways. The three primary ways are:

- **Death as an event:** Here death is something that happens. It happens at a particular time and place and in a particular way. Death is an event
that cuts off a life. In this context the time, place and cause of death can be recorded on a death certificate. This usage does not concern itself with mysteries or explanations.

- **Death as a condition:** It is viewed here as a non-reversible condition in which an organism is incapable of carrying out the vital functions of life. Here the main focus is on the specific signs that establish the termination of life, particularly bringing the medical context to it. It is a crucial area in biomedical and bioethical controversy. These signs or determinants of termination of life are often obvious to all observers but sometimes even the experts can disagree.

- **Death as a state of existence or non-existence:** In this sense, death is what becomes of a person after death. Here we are neither concerned with the event that ends life nor with the condition of the body at that time but the focus is on the form of existence that is thought to prevail when a temporal life has come to its end. The context of religion providing explanations of ‘life’ after death is symbolized here.

In the medical sense death is a condition. “Death is defined as the permanent cessation of all vital functions of the body including the heart beat, brain stem activity and breathing”. Whereas “Dying is considered as the process of losing these functions” (Kaplan & Sadok, 2000). Dying may also
be seen as a developmental concomitant of living, a part of the birth-to-death continuum.

According to Singh (2002), death represents only dissolution of bodily life, a time of rest and peace, a supreme refuge from the turmoil of life. Singh’s (2002) views on death are given below:

- **Death as a tool**: Here person attempts to achieve certain goals and satisfactions from the present context using death as a tool or mean.

- **Death as a Passage**: On persuasion of some religious beliefs and values, we can say that death not only terminates but also initiates a new phase, transcending life, only to lead a further role of being here.

- **Death as an end**: Here death is conceived strictly in biological terms as terminal event in life of the living creatures.

**STAGES OF DEATH AND DYING**

Dying is a process, the end point of which is death. In this sense dying is the terminal part of living. The coping responses during this particular segment of life are shaped by previous experiences with death, as well as by cultural attitudes and beliefs. Working with patients in terminal stage, Kubler-Ross (1969) postulates five stages that dying individuals pass through from the time they first become aware of their fatal prognosis, indicating the impending death to their actual death.
1. **Denial:** On being told that one is dying there is an initial reaction of shock. The individual may appear dazed at first and then refuses to believe the diagnosis or deny that anything is wrong. Some people never pass beyond this stage and may go from doctor to doctor until they find one who supports their position.

2. **Anger:** People become frustrated, irritable and angry that they are sick with multiple externalized attributions for the fatal verdict. In this second phase a common response is “Why me”? One may become angry at God, one’s fate, a friend or a family member. The anger may even be displaced to caregivers.

3. **Bargaining:** In this phase, the individual attempts to negotiate with physicians, friends or even God: in return for a cure, they will fulfill one or many promises like giving charity, attending prayer meetings regularly, visiting religious places and trying alternative ‘treatments’.

4. **Depression:** Clinical signs of depression, withdrawal, psychomotor retardation, sleep disturbances, hopelessness and possibly suicidal ideation are manifested in this stage. Depression is the reaction to the effects of illness on individual’s life. It may be in anticipation of the approaching death or the fears for life’s ‘unfinished’ tasks and responsibilities, or even despair for futile life that person has lead.

5. **Acceptance:** At this final stage, one realizes that death is inevitable and accepts the universality of the experience. Kubler-Ross considered acceptance
As last stage in the process of death and dying. The basis for considering acceptance as the last stage in the process of death and dying was her close observations of terminally ill patients. Under ideal circumstances the individual is courageous and is able to talk about his or her death as he or she faces the unknown. People with strong religious beliefs and those who are convinced of a life after death can find comfort in these beliefs (Zisook & Downs, 1989 & 2000). At this stage despair is replaced by acceptance.

**DIMENSIONS OF DEATH**

Death has been reported to have three dimensions (Singh, Singh, & Nizamie, 2003); and its study varies depending on the dimension that is being researched. **Impersonal dimension** of death considers it as an impersonal event, stripped of human element and dead are simply dead bodies classified as discarded according to various categories. It is death of an object that entails no personal grief or loss. For instance, the obituaries of strangers have impersonal significance because emotional loss is missing (Weissman, 1985).

**Interpersonal dimension** of death is concerned with the objective fact of death of others. It is a loss of a significant person that affects us. The typical response it produces is grief and bereavement. While impersonal death refers to “it is dead”; interpersonal death means “someone else is dead”. Interpersonal death changes the perceivers’ psychological field and, in turn, alters the interpersonal behaviour of those affected. **Intrapersonal**
death refers to the inner experience of personal mortality, which most people dread but find difficult to anticipate. It is believed to be the only dimension that matters i.e. it is the base to the other two dimensions too. The impact of the dead body or death of the other one is important only because of its importance for subjective death (Weissman & Haeckett, 1961).

DEVELOPMENT OF THE CONCEPT OF DEATH

The concept death is developed overtime, as the person grows, experiences various losses and thinks about concrete and abstract concepts (Kozier, Erb, Berman, & Snyder, 2004). In general human move from childhood belief in death as temporary state, to adulthood in which death is accepted as very real but also very frightening, to older adulthood in which death may be viewed as more desirable than living with a poor quality of life. Development of death concept in different age groups is given below:

- **Infancy to 5 years**: In this phase of development the child cannot understand the concept of death. Infant’s sense of separation forms the basis for later understanding of loss and death.

- **5 to 9 years**: At this stage one understands that death is final. But believes that own death can be avoided and associate death with aggression or violence.
• **9 to 12 years**: This age group starts understanding death as inevitable end of life. Concept of own mortality begins and expressed as interest in afterlife or as fear of death.

• **12 to 18 years**: In this phase of development one fears a lingering death. May fantasize that death can be defied, acting out defiance through reckless behaviours. This age group seldom thinks about death but view it in religious and philosophical terms. It seems like that they have reached to “adult” perception of death but are emotionally unable to accept it. May still hold the concepts from previous development stages.

• **18 to 45 years**: Here the attitude toward death is influenced by religious and cultural beliefs.

• **45 to 65 years**: Acceptance of own mortality comes in this phase of life cycle. Encounters with death of parents or peers take place. Experience peak of death anxiety and can only be diminished with emotional well-being.

• **65+ years**: In this part of life one fears prolonged illness. Start considering death as having multiple meanings (e.g. freedom from pain, reunion with already deceased family members).
Nagy (1948) has reported three stages of development of death related cognitions in children. In stage I: the children below 5 years lack appreciation of death as final and complete cessation. Stage II: children in this stage think of death as final and inevitable. A strong tendency to personify is noted here. Stage III: begins at the age of 10 years, marked by comprehension of death as both final and inevitable. The prospect of personal mortality seems to be accepted.

Many of us hesitate to talk about death, particularly with youngsters. But death is inescapable event in the life cycle, which must be dealt with. So by talking to children on this topic we can discover what they know and do not know. If they have worries, fears or misconceptions by providing information, comfort and understanding can be improved and they can be helped out.

ATTITUDE TOWARDS DEATH AND DYING

Attitude towards death became a topic of significance in the late 1950’s with Feifel’s research on geriatric and mentally ill populations (Feifel, 1955 & 1956). However a “publication explosion” in the literature did not occur until the mid-1970s ushered in by the development of the first widely available instrument designed specifically for the direct assessment of death fear, threat and anxiety. In late 1970s several review articles appeared to
integrate, criticize and give direction to the burgeoning literature in the said area.

Bagozzi and Burnkrant (1979) and McGuire (1985) have documented that attitudes have three components:

(i) A *cognitive* component, which refers to knowledge about the object, belief and ideas.

(ii) An *affective* component, meaning a feeling about the object, like or dislike.

(iii) A *behavioural* component, implying a tendency towards action related to the object component.

There is not much agreement concerning how attitudes and behaviours towards death and dying are formed and modified (Tomer, 1994). Research findings suggested that death attitude and death anxiety are not innate attitudes, but such attitudes are learned from social environment and cultural exposure (Kearl, 1995). Wong, Reker, and Gesser (1994) gave attention to multidimensionality of death attitudes both positive and negative attitudes.

Wong et al. (1994) have identified three different types of *positive death attitudes*. *Neutral acceptance*, where death is seen as an integral part of life. Death is neither feared nor welcomed. One simply accepts it as one of the unchangeable facts of life. An *escape acceptance* results from living
conditions that are felt unbearable by the individual and hence death seems like an attractive alternative to difficult life. The third is *approach acceptance*, which implicates the belief in a happy after life, and therefore is a transition to the next stage. Approach acceptance implies belief in a happy after life (Dixon & Kinlaw, 1983).

The two *negative attitudes* towards death are *death avoidance* and *fear of death*. *Death avoidance*, in which a person avoids thinking or talking about death in order to reduce death anxiety, and *fear of death*, in which a person confronts death and feelings it evokes. Here in this study the focus is on one of the negative attitudes towards death i.e. *fear of death*.

**FEAR OF DEATH AND DEATH ANXIETY**

Human beings have basic self-preservation drive. Combining this drive with the realization that death is inevitable that creates in them the paralyzing terror of death. In other words, all human drama is, to a great extent, a story of how human beings cope with terror of death and how they overcome death anxiety through a great variety of conscious and unconscious defense mechanisms (Wong, 2002).

Death is viewed as an event over which one generally has no control and thus generates anxiety amongst people (Schumaker, Barraclough, & Vagg, 1988). Death anxiety is defined as a negative and apprehensive feeling
that one has, when thinking about death and dying (Richardson, Berman, & Piwowarski, 1983).

Fear of death and death anxiety are the two terms which have been used interchangeably in literature (Fiefel & Nagy, 1981; Wink & Scott, 2005). The Death anxiety possesses four dimensions namely, fear of death itself, fear of dying of self, fear of death of others and fear of dying of others. Pollak (1980) pointed out that researchers often examine death anxiety on separate dimensions based on the assumption that death anxiety is a multi-dimensional construct. Collelt-Lester’s fear of death scale (1969) was developed to allow investigators to examine death anxiety along several dimensions. The significance of fear of death has been on the increase because of the contemporary mechanistic approach to life where the focus has moved away from humans and more towards technology, bringing with it alienation for dying individuals; i.e. the impersonal dimension is on the rise while interpersonal is markedly reduced. Hence, the intrapersonal needs to be explored.

The desire to cling to life and the fear of death have been held as vital principles of humanity: “The idea of death, the fear of it; haunts the human beings like anything else. It is a main spring of human activity - activity designed largely to avoid the fatality of death, to overcome it by denying in someway that it is final destiny of man”. It is this denial of death
which buys freedom from anxiety about death and defends against the fear of death (Becker, 1973; Davidson & Jackson, 1985).

**HISTORY OF FEAR OF DEATH/DEATH ANXIETY**

Death and dying has been a topic of question and concern throughout history, a topic many desperately try to avoid. Fear of death became a topic of psychological interest in the late 1950s. The study of death and associated factors has been issue of concern in Psychology, particularly over the last 50 years (Neimeyer, 1997). Sigmund Freud, the founder of psychoanalysis was the first person to recognize and state that people (particularly his patients) sometimes do express fears of death. Nevertheless, *thanatophobia*, as he called it, is merely a masquerade. He believed that there is a deeper source of concern, and the expressions of death are somewhat superficial because they only hint at what really troubles the person but thorough exploration of individual’s feelings and thoughts related to fear of death is required to deal with or to suggest strategies to manage these fears. Fiefel’s (1955 & 1956) research work, investigating attitudes of elderly and mentally ill patients towards death acted as the catalyst for promoting the work in this field. Fiefel’s research work is responsible to make death and dying a topic of psychological interest (Neimeyer, Wittowski, & Moser, 2004).

*Thanatology* is the study of death-related behaviours, thoughts and feelings. Psychology emerged from philosophical traditions in which the
problem of death was prominent with specific concern to ‘Thanatophobia’ around the mid-1950s; and consequently psychology and related fields also began to consider feelings about death and dying as a problem for scientific investigation (Kastenbaum & Costa, 1977; Kurlychek, 1976). In early 1960’s a few university texts on thanatology appeared and professional journal such as Omega began publishing articles on death, dying and bereavement. Largely due to Elizabeth Kubler Ross’s (1969) work on death and dying at University of Chicago, and to Hospice Movement, death education grew through 1970s. Further in 1970s Templer ignited the research arena of death anxiety by constructing the Death Anxiety Scale. Templer in 1970 suggested that death anxiety involves both uneasiness about personal extinction, and apprehension about dying process. In 1980s most of the medical school programmes incorporated the study of death and dying in curriculum. Tomer (1992) on the basis of Templer’s definition elaborated that death anxiety is caused by the anticipation of the state in which one is not alive, including aspects of fear of dying or the death of significant others.

Death anxiety is an emotional reaction provoked by the anticipation in which the self no longer exists (Tomer & Eliason, 1996). Neimeyer (1997) described death anxiety as a term encompassing a cluster of death attitudes, characterized by fear, threat, unease, discomfort and other negative emotional reactions, along with anxiety as a kind of diffused fear with no clear object
(anxiety in psychodynamic sense). Fear of death “includes measures of the extent to which one experiences angst in reference to death” (Fortner & Neimeyer, 1999). In the research, the terms “death anxiety” and “fear of death” are often used interchangeably although some research findings distinguish between “fear of death” and “fear of dying” (Dumont & Foss, 1972). Throughout the years a number of factors in maintenance of death anxiety have been identified. The most common factor is the fear of the unknown, “Death is perhaps the most mysterious and unknown of unknowns. No one can report what happens after death” (Dumont & Foss, 1972). Fear of hell, of separation, fear of what will become of family, fear of losing consciousness and fear of the dark can contribute for some adults in the maintenance of the fear of death (Dumont and Foss, 1972). Servaty and Hayslip (1996) suggested that death anxiety possesses different meanings for different people and death anxiety is multidimensional, not unidimensional construct. Death could occur at any point in the life cycle. In industrialized nations with modern and advanced medical facilities the death rates are higher for people beyond the age of 50. This means that the life expectancy has increased. People are living at least 20-30 years longer and have more time to ponder their demise. Progressive increase in the number of institutionalized deaths encouraged the researchers to study the various psychological aspects of the final stages of life and death itself (Gomez, Hidalgo, & Sabado, 2007).
Over time this approach has been consolidated and has found clinical and statistical verifications.

Templer (1970) suggested that “death anxiety involves both uneasiness about personal extinction and apprehension about the dying process”. Tomer (1992) expanded upon Templer’s definition referring to death anxiety as being caused by the anticipation of the state in which one is not alive, including aspects of fear of dying or the death of significant others. According to Fortner & Neimeyer (1999) Fear of death “includes measures of the extent to which one experiences angst in reference to death”. Whereas, Belsky (1999) defined “death anxiety” as the thoughts, fears and emotions about that final event of living that we experience under normal conditions of life”.

**RELIGIOUS ORIENTATION TOWARDS DEATH**

**Hinduism:** The Hindus believe that “Atman” is birth less and deathless. Death is only casting away of physical body. It is like the separation of soul from body. It is “Brahma” out of which the soul emerges as Brahma ordains. After casting of mortal body on completion of its earthly sojourn, it aspires to merge again with Brahma and if it is successful in this endeavor, it is liberated from the cycle of birth and rebirth and attains salvation or “moksha” failing which it takes another body and is reborn and the cycle continues endlessly.
The Vedas dearly show that the ancient Hindu believed in the immortality of the soul. In Bhagvad Gita it is said that: “The soul of man is indestructible, it can not be pierced by sword, fire cannot burn it, air can not dry it, and water cannot moisten it.”

In the great battle of Mahabharata when the warrior Arjun lost his equipoise and became indecisive, refusing to fight and kill his own kith and kin, then Lord Krishna imparted wisdom unto Arjun and revealed the greatest philosophy of life and death. The Lord said there was never a time when we did not exist, neither Arjun nor his kith and kin. That, which is non existent, can never come into being and which is, can never cease to be. The innermost reality is “Atman”, which is both changeless and eternal. How can it die with the death of body? (Mascaro, 1962).

In doctrine of Karma ones deeds play an important role. Gita says that actions performed, Nishkam, gradually lead people to a stage when they will not be born again but will be merged with “Brahma”, the Almighty and be freed from this world and finally attain Moksha/Nirvana, as pointed out by Lord Buddha.

Although Hindus believe in the continuity of life after death but still they are not able to overcome the fear of death. The possible reason for this may be their inability to see that continuity. Some of the Hindu sages and seers claim that by practicing Sadliana or Yoga one can acquire powers to see
one’s past and foresee one’s future, that one becomes “Trikaldarshi”. In order to acquire such powers one has to practice highest ideals of righteousness with complete devotion and dedication and surrender to “Brahma’ the mighty creator and protector of this universe. One’s ability to see the continuity of life will certainly lessen one’s fear of death.

**Sikhism:** According to Sikhism, human life is the most important gift given by God to unite with the ultimate reality. It is up to the mortal to end the continuing journey of births and deaths by meditating on the name of God. Guru Nanak Dev Ji says in Japji Sahib that, human beings do not have the strength to take birth and live as they decide and they do not hold the power to die. Birth and death is in the hands of almighty Lord. In Sri Guru Granth Sahib, P. 63 it is written that everyone asks for long life and no one wishes to die. Here are a few verses from Sri Guru Granth Sahib related to the philosophy of life and death.

- Guru Nanak Dev Ji says: “If I remember Him, I live, if I forget Him I die”.
- “Death is the great secret of life; do not cry for the dead, their agony is over”. Whosoever is born shall die and depart. All shall take their turn (474).
- Whosoever is born is destined to die (789).
• Whatever is seen, that all shall vanish like the shadow of cloud. O’ slave Nanak, he who knows the world to be unreal abides under Lord’s protection (219).

• With whom should I make friendship the whole world is to perish (468).

So it can be concluded that Sikhs believe that death is the name of forgetting God and death is terror for an ordinary person, but people who know true living, do not fear death as it would unite them with Supreme Being. It’s clear from Sikh history that the Sikhs felt pleasure in dying for a good cause. Death of a “Gurmukh” results in the union with God while the death of a “manmukh” puts him in the unending life cycle in the shape of different species. It has been stressed that the inevitable must happen. Why do you worry, fret and fume? Trust in God and be at ease (Sikh Missionary, 2004).

**Muslim/Islam** (Muhammad, 2004; Safi & Bigelow, 2008): The primary source of Islam is the sacred Quran, which, Muslims believe, is the literal and unaltered word of Allah, as revealed to the Prophet Mohammad by the Angel Jibril (Gabriel) during the seventh century. The second and much larger source of Islam is the Sunna, which is widely known as Hdith. The latter consists of various collections of sayings, deeds and decisions attributed to Muhammad. According to the Quran 45:26, “It is God who gives you life, then causes you to die, and then He gathers you all to the Day of Resurrection.
of which there is no doubt, though most people do not comprehend”. 

Muslims’ views of death begin with the premise that the eternal human soul is God-given and that after physical death there is an eventual resurrection (qiyamat) and day of judgment (yaum al din). Between death and that time, the soul remains in a state reflecting the life the person lived. The person’s eternal fate, either paradise or hell, is determined at the final judgment, when humanity will be sorted and God will determine their ultimate destiny. At that time those whose “good deeds are heavy on the scales will have a pleasant life, but the one whose good deeds are light will have the Bottomless pit for his home” (Quran 101 : 6-9).

Islamic tradition views fear as inherent in human nature, fear of anything other than Allah’s displeasure is discouraged on religious and moral grounds.

A few Quranic verses about fear are given below:

It is only “Satan” that suggests to you the fear of his votaries: Be not afraid of them, but fear Me if you have faith (3[AI IMRAN ];175)… fear not men but fear Me (5[Al-Ma’sida ]; 44). In remedies for fear and death, it is suggested for sick, troubled and apprehensive to repeat certain Quranic verses, hadiths and other sanctioned “magical” formulae (ruqua) once or several times in order to regain health and well-being, or to remove or alleviate fear.
Christianity: According to Christian philosophy, man was not originally created to die. When Adam and Eve were first placed in the Garden of Eden, they were in such a condition that they might have remained there for a myriad years if they have kept their integrity. There was no reason why unfallen man should die— but now that we have sinned, the seeds of corruption are in this flesh of ours and it is appointed unto men once to die. If any man resolves to follow Christ, he must not love his own life in comparison to his love to Jesus Christ, but he must be willing to lay down his life for the sake of God, who gave up his life upon cross for us. The fear of death is very dishonoring to God. Never forget what David said, “He that is our God is the God of salvation; and unto God the Lord belong the issues from death” (Supergeon, 1908; Sabom, 2003; Doug, 2005).

The verses from Bible make the Christianity’s point of view clear on life and death:

- If we live, we live to the Lord; and if we die, we die to the Lord. So, whether we live or die, we belong to the Lord (Romans 14:8).

- For we are God’s workmanship, created in Christ Jesus to do good works, which God prepared in advance for us to do (Ephesians 2:10).

- Now we know that if the earthly tent we live in is destroyed, we have a building from God, an eternal house in heaven, not built by human
hands. Meanwhile we groan, longing to be clothed with our heavenly dwelling (Corinthians 5:1-2).

- Jesus said to her, “I am the resurrection and the life. He who believes in me will live, even though he dies, and whoever lives and believes in me will never die. Do you believe this?” (John 11:25-26).

- Jesus came to reconcile us with God. How can we reconcile with God? Jesus said, “You must be born again” (John 3:7) and added, “I am the way, the truth and the life. No one comes to the father except through me” (John 14:6).

- When perishable has been clothed with the imperishable and the mortal with immortality, then the saying that is written will come true: “Death has been swallowed up in victory”. Where, O death is your victory? Where O death, is your sting? (Corinthians 15:54-55).

THEORES OF FEAR OF DEATH

The influential theories that dominated the thinking about death anxiety and fear related to it, until the late twentieth century, are Freud’s concept of death instincts and Becker’s existential view. Along with these the other approaches to understand fear of death/death anxiety were introduced in late twentieth century including the terror management theory,
regret theory and meaning management model (Encyclopedia of Death & Dying, 2006).

**Freud’s Concept of Death Instincts:** (Freud, 1953)

Freud juxtaposed life instincts with death instincts and two were referred as Eros and Thanatos. Freud saw all human behaviour as motivated by the drives or instincts, which in turn are the neurological representations of physical needs. At first, he referred to them as the life instincts. These instincts perpetuate the life of the individual, by motivating him or her to seek food and water. The motivational energy of these life instincts that powers our psyches, he called libido, from the Latin word for “I desire”. Later in his life, Freud began to believe that the life instincts did not tell the whole story. Libido or the pleasure principle keeps us in motion and the goal of all this motion is to be still, to be satisfied, to be at peace, to have no more needs. But the goal of life is death. Freud began to believe that “under” and “beside” the life instincts there was a death instinct. He began to believe that every person has an unconscious wish to die. He viewed it as tendency of all organisms and their component selves to return to an inanimate state. It was based on his experiences with patients where life can be a painful and exhausting process. Death promised release from the struggle. Freud is quoted as referring to the nirvana principle. Nirvana is a Buddhist idea, often translated as heaven, but actually meaning “blowing out”, as in the blowing out of a candle or as
seeking a state of rest (Gabbard, 2000). It refers to non existence, nothingness, the void, which is the goal of life in Buddhist philosophy. The day to day evidence of the death instincts and its nirvana principle is in our desire for peace, for escape from stimulation, our attraction to alcohol and narcotics, our penchant for escapist activity, such as losing ourselves in books or movies, our craving for rest and sleep. Sometimes it presents itself openly as suicide and suicidal wishes. And, as Freud theorized, sometimes we direct it out away from ourselves, in the form of aggression, cruelty, murder and destructiveness. Thus, for Freud, death as an instinct symbolized.

Becker’s Existential View of Death:

Becker (1973), in his book The Denial of Death, asserts that fear of death is natural and present in everyone no matter how disguised it may be. According to him the fear of death is an emotional manifestation of the self preservation instinct. Most people rarely think about death or their ultimate individual value. Rather, they think about their goals and aspirations relevant to their careers, relationships, hobbies and the means through which these goals are to be achieved. However, according to Becker much of people’s daily behaviour consists of attempts to deny death and there by keep death anxiety under control. This anxiety is so intense that it generates many, if not all, of the specific fears and phobias people experience in everyday life. The
fear of death is behind all normal functioning in order for people to aim towards self-preservation; but not constantly present in one’s conscious mental functions. When alarmong realities continue to intrude and if they were exposed to brutal reminders of their vulnerability, this anxiety becomes pronounced and may even hinder normal functioning. The fear thus must be repressed enough to allow us to live comfortably and normally, yet accessible enough to allow us to react appropriately to any threat to our continued existence.

Becker also suggested that this is where society plays its role. No function of society is more crucial than its strengthening of individual defenses against death anxiety. Becker’s analysis of society convinced him that many beliefs and practices are in service of death denial that is, reducing the experience of anxiety. Funeral homes with their flowers and the medical system with its evasions are only among the more obvious societal elements that join with individuals to maintain the fiction that there is nothing to fear. Thus Becker has emphasized the social aspect of death anxiety including the role society play in managing the death anxiety.

**Terror Management Theory:**

A more recent social psychological theory with many existential elements is that of terror management theory (TMT) (Greenberg, Solomon, & Pyszczynski, 1997). This theory proposes that fear of death underlies or
motivates much of what we do. This controversial and emerging theory combines psychological and sociocultural elements by suggesting that we manage our death related terror by immersing ourselves in arbitrarily constructed institutions like family, work, nationalism and religion. Terror management theory posits that people deal with the problem of death by employing two distinct modes of defense: the first is direct rational, threat focused defenses and second is symbolic cultural defenses.

Direct rational, threat focused defenses function to reduce the individual’s perception of his or her vulnerability to life threatening conditions, thus push the problem of death in to vague and distant future. Symbolic, cultural defenses embed the individual as a valuable part of an eternal conception of reality that is bigger, stronger and more enduring than an individual (Pyszczynski, Greenberg, & Solomon, 1998).

These defense mechanisms are manifested in the form of a dual-component, cultural-death anxiety buffer comprising of: i) a cultural worldview and ii) self esteem, which is acquired by believing that one is living up to the standards of values inherent in one’s cultural worldview.

Cultural views facilitate effective terror management by providing individuals a group with a vision of reality that supplies answers to universal cosmological questions i.e. “Who am I”, “where did I come from” & “what will happen to me when I die?” in a way that imbue the universe with
meaning, permanence and stability and convey hope of symbolic and/or literal immortality. Every culture, by upholding standards by which its people are supposed to abide, affords opportunities for individuals to live forever, either symbolically, by production of great works or amassing of great fortunes that extend beyond an individual’s life time and therefore serves as a testament to one’s existence and literally through religious beliefs of an after life through reincarnation or heaven (Solomon, Greenberg, & Pyszczynski, 1991). Self esteem is primary psychological mechanism by which culture serves its death-defying function. Self esteem can serve its anxiety-buffering function only to the extent that faith in the cultural worldview is sustained. Because faith in cultural worldview depends on consensual validation from others, those who question that worldview threaten an individual’s faith in their worldview. Faith in the cultural worldview is maintained through secular and religious teachings, associated cultural rituals, continual social validation in interpersonal and intergroup contexts and defensive reactions to those with alternative worldviews (Greenberg, Solomon, & Pyszczynski, 1997).

Self esteem acquires its anxiety buffering qualities in the context of the socialization process. Eligibility for immortality is limited to those who “do the right thing”. This entails adhering to the standards of appropriate conduct associated with the social roles that exist in a given culture. Ultimately self esteem is culturally constructed, in that there is no way to feel good about
oneself in the absence of socially prescribed standards of right and wrong. Obviously, what is considered right and wrong varies from culture to culture, no one cultural worldview is literally true. Consequently, individuals must rely on faith in order to preserve their belief in the particular culturally prescribed vision of reality that they subscribe to (Solomon, Greenberg, & Pyszczynski, 1991). Thus, the terror of death becomes the basic force behind the cultural norms/framework as well as the source of self esteem leading to the individual’s self concept.

**Regret Theory of Death:** (Tomer & Eliason, 1996)

Another recent approach, regret theory, was proposed in 1996 by Adrian Tomer and Grafton Eliason. This theory’s main focus is on the way in which people evaluate the quality or worth of their lives. The prospect of death is likely to make people more anxious if they feel that they have not and can not accomplish something good in life i.e. past related regret and future expected regret. Past related regret is, “the perception of not having fulfilled basic aspirations” in one’s life. Future expected regret is the “perceived inability to fulfill basic goals in future”, or the feeling that one does not have enough time to reach one’s goals before one dies. People might torment themselves with regrets over past failures and missed opportunities or with the thought of future accomplishments and experiences that will not be possible. Regret theory also has implications for anxiety reduction. People can
reconsider their memories and expectation and also discover how to live more fully the present moment. Tomer and Eliason recently (2005) expanded their model incorporating positive attitude towards death i.e. Meaningfulness of death. Meaningfulness of death is “the individual’s conceptualization of death as positive or negative, making sense or senseless”. A negative conceptualization of meaningfulness of death will cause death anxiety and positive beliefs about death, in other words the meaning of death for the individual is positive, and then this would cause its acceptance. Thus, the negative connotation attached to death was (for the first time) substituted by the bipolar aspects of the concept. Death acceptance could actually become a positive force for life achievements.

**Meaning Management Model:** (Wong, 2002)

This model fits under the umbrella of positive psychology which is about how to live well and die well. How we view death and how we cope with death anxiety can profoundly affect every aspect of life either positively or negatively. Death is the only certainty in life. All living beings die; there is no exception. However, human beings alone are burdened with the cognitive capacity to be aware of their own inevitable mortality and to fear what may come afterwards. Furthermore, their capacity to reflect on the meaning of life and death creates additional existential anxiety. This model proposes that
meaning management is required than terror management in dealing with death anxiety. The meaning management model posits the following:

(i) Human beings are born with the innate need for meaning, but it may lie dormant because of our preoccupation with the business of living.

(ii) Death and suffering awaken in us the urgent need to search for meaning and purpose for life and death.

(iii) One can discover and create meaning in every situation, even in the face of death.

(iv) Meaning management helps deepen one’s faith and spirituality, it also enables to achieve a better understanding of the meaning and purpose of life.

(v) Meaning management helps construct a useful psychological and spiritual mode that offers us the best protection against the fear of death and dying.

(vi) Meaning management motivates us to embrace life to engage in the business of living, regardless of one’s physical conditions and current circumstances.

(vii) Meaning management is not just rationalization or cognitive reframing but a reconstruction and transformation of our values, beliefs and meaning systems.
How one lives foreshadows how one dies, when one lives a meaningful life, one leaves a meaningful life. Such wisdom and courage can only be acquired through accepting death and understanding its meanings. Ultimately meaning management may be the only effective psychological model that protects us against loss and death.

Thus, providing a base to one’s very existence, it provides meaningfulness to all life concerns. The life tasks are means to a larger end of a meaningful death. As long as this existential goal exists, there are no fears; only a will to achieve meaningfulness.

HOPE

Hopefulness is the salient quality of a “survivor” attitude. Hope is an intrinsic component of life and allows the individual to use crisis as an opportunity for growth (Miller, 1985). The will to live and hope are closely linked to each other. Webster’s New International Dictionary (1976): uses ‘desire’, ‘trust’ and ‘expect’ as synonyms for hope as a verb and ‘trust’, ‘reliance’ and ‘promise’ in relation to hope as a noun. Snyder et al. (1991) have defined “hope as a cognitive set that is based on a reciprocally derived sense of successful (a) agency (goal–directed determination) and (b) pathways (planning of ways to meet goals)”. Hope is an anticipation of a future which is good, based on mutuality, a sense of personal competence,
coping ability, psychological well-being, purpose and meaning in life, and a sense of “the possible” (Marcel, 1962).

The current conceptualization of hope is phenomenological in nature and rests upon the cognitive appraisal of one’s goal-related capabilities. Although external forces affecting goal-related activities may influence a person’s cognitive analysis of agency and pathways, it posits that there should be an enduring, cross-situational subjective level of hope.

Thus hope in this context is a dispositional concept, although it is possible to change dispositional hope over time (e.g. through counseling).

**PRINCIPLES OPERATIONALIZING HOPE**

What causes hope to manifest is some goal, need or challenge in life. Prior to this situation, it exists as a sheer abstraction or as an idea without basis in reality. Hope is exercised on things out of one’s control and some type of sacrifice is required along with some dream or vision to sustain hope. It is through the process of hope whereby things are brought into materialization in the physical realm (Egelletion, 1997).

**SPHERES OF HOPE**

Hope is expressed across two spheres, namely generalized hope and particularized hope. Generalized hope has some future beneficial outcomes
but indeterminate developments. It is broad in scope and not linked to any particular object of hope. It protects against despair when person is deprived of particular hopes and preserves or restores the meaningfulness of life in all kind of circumstances. It imparts an overall motivation to carry on with life’s responsibilities and gives a broad perspective for life; and provides thought processes that include flexibility and openness to changing events. Particularized hope on the other hand is concerned with a particularly valued outcome, or state of being. In other words, it is a hope with an object. Particularized hope clarifies, prioritizes and affirms what a hoping person perceives is most important in life. It preserves and restores the meaning in life. Particular hopes encourage investment in and commitment to something specific that extends beyond the present moment and provides an object toward which a hoping person’s own energies and those of others can be directed. Hope in this sphere provides an incentive for constructive coping with obstacles and for devising alternative means to realize the object of hope (Dufault & Martocchio, 1985).

**DIMENSIONS OF HOPE**

The six dimensions of hope are affective, cognitive, behavioural, affiliative, temporal and contextual. i) **Affective dimension** focuses upon sensations and emotions that are part of hoping process. Components of affective dimension are: a) an attraction to desirable outcome, b) a sense of
personal significance of the outcome for the hoping person’s well-being, c) feelings of confidence about outcome, d) feelings related to some uncertainty about the outcome, e) a broad spectrum of feelings that may accompany hope. ii) Cognitive dimension stressed upon the processes by which individuals wish, imagine, wonder, perceive, think, remember, learn, generalize, interpret and judge in relation to hope. Components of this dimension are: a) identification of desired object, b) examination and assessment of reality in relation to hope, c) discrimination of actual and potential internal and external hope promoting factors from hope inhibiting factors, d) perception of desired future outcome as realistically possible though not certain and e) imaginative use of past and present facts that permits belief that the boundaries of favorable possibility are wider than they might seem and the boundaries of unfavorable possibility are narrower than they seem. Hope is reality based from the perspective of the hoping person and it depends upon hoping person’s perception of the situation, the timing of reality considerations and the extent in which, as well as manner in which, persons’ examine and assess reality in relation to the desired object. iii) Behavioral dimension focuses upon the action orientation of the hoping person in relation the hope. The actions taken to affect an outcome may fall into one or more of four realms: psychological, social, physical and religious. Actions in psychological realm are mental activities such as organizing ideas, planning strategies, making decisions and thinking about how a situation can
be resolved or how a climate can be created to fulfill hope. These actions also include determining appropriate actions for self and possible actions for others that might assist in hope fulfillment, actions in social realm are acts that involve others e.g. seeking help of others to achieve hopes not achievable alone, actions in physical realm are specific, visible; personal acts taken by the individual to achieve hoped object. The acts include physical activities, actions in religious realm are those related to a belief in a Higher Power or God. iv) **Affiliative dimension** focuses upon person’s sense of relatedness or involvement beyond self as it bears upon hope. It includes components of social interaction, mutuality, attachment and intimacy, other directedness and self-transcendence. It is not characterized only by relationship with people but also by relationship with God. v) **Temporal dimension** focuses upon hoping person’s experience of time (past, present and future) in relation to hope and hoping. Hope is directed towards a future good, but past and present are also involved in hoping process. Components are extent of inclusion of past, present and future in to the hoping process and the degree of time specificity or non specificity of hope. vi) **Contextual dimension** is focused on the life situations that surround, influence and are a part of person’s hope. In a sense, the contexts serve as the circumstances that occasion hope, the opportunity for the hoping process to be activated, or as a situation for testing hope. A frequent context with in which hope is experienced is the situation of actual or potential loss (Dufault & Martocchio, 1985).
THEORIES OF HOPE

Basic theories of Hope are of Stotland (1969) and Averill, Catlin, & Chon (1990). More recently Snyder (1994) has also developed a model of hope.

Erza Stotland’s Theory of Hope:

Stotland, in *The Psychology of Hope* (1969), focused his analysis on the expectancies that people hold regarding their goals. His theory operates out of a framework of socialpsychological theory on cognitive schemas. From this perspective hope is seen as related to an interaction between the subjective importance of a goal and the perceived probability of attaining it. According to his interpretation of an array of clinical and experimental research, a goal perceived to be highly important and likely to be attained stimulates selective attention, thoughts, and actions which enhance the actual likelihood of attaining that goal. This condition is characteristic of hope.

Stotland suggested that the core of hope was “an expectation greater than zero of achieving a goal”. Elevated hope in this context reflects a high perceived probability of attaining a goal. He also assumed that some minimum level of goal importance was necessary for hope to be operative. Although Stotland reasoned that it may be feasible to ask a person what his or her expectation of goal achievement may be, he noted that this is rarely done. Rather information about his expectation is obtained by observing how a
person reacts to the conditions of antecedent in terms of subsequent behavioural outcomes. This theory emphasized the person’s cognitive analysis of goal-related outcomes. Conversely, a goal which is seen as important, though remotely attainable, leads to increased anxiety and diminished purposeful activity. In this case, people tend to devalue the subjective importance of the goal in an attempt to relieve the anxiety. A goal-attainment expectancy of low importance and low probability is said to be characteristic of hopelessness. Stotland argued that the psychiatric pathology is associated with hopelessness and effective treatment must involve enhancing the patient’s perception that his goals are attainable. Thus, hope here conceived as the relationship between the subjective importance of a goal for a particular individual and his or her perception about the probability of attaining it.

**Averill, Catlin and Chon’s Theory of Hope:**

Averill, Catlin, and Chon (1990) suggested that hope is an emotion that has cognitive rules governing it. In particular, emotion of hope is seen as being appropriate when (a) a goal is important (b) is under some control (c) is at mid range in terms of probability of attainment and (d) is socially acceptable. Averill bases his conclusion that subjects rated anger, love and hope as all having the same five features. (1) all are difficult to control (2) all affect the way you think or perceive the event (3) all affect the way you
behave (4) all motivate behaviour, increase persistence, enable me to go on even in face of adversity and (5) all are common universal experiences.

James Averill states that “hope is not associated with any specific physiological responses or reflex like action” (Averill et al., 1990). In a series of studies done by Averill et al. (1990), he and his colleagues came to the conclusion that hope includes learned behaviours and thought processes that are acquired through the socialization process. This approach obviously rests upon a social constructionist underpinning in which the focus is on the norms or guidelines that are established in a given societal context. This theory is more complex than hope theory, but it has the ecological validity of being based on how people perceive it. Relative to hope theory this emotion and rule based definition does not lend itself easily to measurement. Yet it adds richness to concept of hope by emphasizing the importance of social norms associated with hoped for object or goal but it becomes difficult to measure this concept of hope in this sense.

**Snyder’s Model of Hope:**

More recently Snyder (1994 & 2000) developed a model of hope that built upon and expanded Stotland’s definition. In addition to defining hope as the positive expectation of goal attainment, Snyder et al. expanded the definition of hope to include two interrelated cognitive dimensions, namely, *Agency and Pathways* (Snyder, 1994 & Snyder et al., 1991). Agency refers to
the determination and commitment that helps one to move in the direction of a goal, and is considered the driving force of hope. Agency is considered to be a cognitive act consisting of having both important goals and believing that one can initiate and sustain action toward goal attainment. Pathways refer to an individual’s perceived ability to find one or more effective ways to reach his or her goals, as well as perceived ability to formulate alternative plans when obstacles get in the way of goal attainment. Snyder noted that the two dimensions of hope, commonly although not always co-occur, indicate that both agency and pathways are necessary for the operation of hope. The current conceptualization of hope is phenomenological in nature and rests upon the cognitive appraisal of one’s goals related capabilities. Although external forces affecting goal related activities may influence a person’s cognitive analysis of agency and pathways, but it is posited that there should be an enduring cross-situational subjective level of hope. Thus hope in this context is a dispositional concept, although it is possible to change dispositional hope overtime (Snyder, 1995).

This model is clearly cognitive in its emphasis, but it does not imply that emotions are irrelevant. ‘Higher hope persons’ with their elevated sense of agency and pathways for situations in general, approach a given goal with a positive emotional state. They take it as a challenge and the focus is on success rather than failure. ‘Low hope persons’ on the other hand with their
enduring perceptions of deficient agency and pathways in general, probably approach a given goal with a negative emotional state. A sense of ambivalence is there and the focus is on failure rather than success. This model gives more comprehensive view of the concept.

ALIENATION

One of the major problems facing the age of technological development is that of alienation. ‘A new kind of pessimism’ (Reston, 1967) seems to have emerged from the optimistic illusions of the ‘man achieving’. In mechanomorphic technocrat age, human life seems to have lost its significance. In rat-race for more achievement, mankind seems to be getting into the trap of self-annihilation. The increasing sense of estrangement from self and the environment is symptom of serious psychological malady—the feeling of alienation (Basu, 1989). Alienation is a powerful feeling of isolation and loneliness and stems from variety of causes. But feeling like a fish out of water expresses the feeling quiet well.

Despite its widespread usage across a number of disciplines, there has been failure to reach a consensus on even its most basic aspects. Due to the complexity of the concept of alienation and variety of meanings attached to it, it becomes difficult to derive one basic meaning. It is necessary to recognize the etymological roots of the word alienation. “Aliene” in French and “aliendo” in Spanish refer to mental disorder, particularly psychosis (it must
be recalled that psychiatrists used to be referred to as the “alienists” in old English). The concept of alienation, as it stands today, seems to have derived from the Latin verb “alienare”, meaning to estrange and noun “alienation” meaning separation, aversion or aberration of mind. It is interesting to note this connotation with psyche in the etymological roots of the word. From modern viewpoint alienation may be defined as the subjective experiencing state of detachment or estrangement of one’s self from its surroundings (Basu, 1989).

The philosophical seed of alienation were mainly sowed by Hegel in 1899. According to him, the history of man was at the same time the history of his alienation. Even though alienation came in to prominence in the early writings of Karl Marx, the concept of alienation finds, wide range of references across a broad range of subjects such as theology, philosophy, sociology, psychology and psychiatry (Johnson, 1973). Emile Durkheim’s (1897) gave important focus to alienation. Durkheim’s deep concern with modern man’s isolation from traditional society, and the resultant state of what he terms ‘anomie’, hovers overall his work and gives theme to his analysis of division of labour and his study on suicide. In his classic study on suicide, Durkheim argues that in contemporary civilization the exceptionally high number of voluntary deaths manifest the state of deep disturbance from which civilized societies are suffering.
Gradually, the emphasis shifted from sociological perspective to socio–psychological perspective of alienation. Socio–psychological perspective of alienation appears in literature by the middle of 20th century. Seeman (1959) in his important article on the “meaning of alienation”, proposed to treat alienation from personal standpoint of actor – which indicated the socio-psychological perspective of alienation.

“Alienation is the state of being emotionally separated from others and from one’s own feelings” (Encyclopedia of psychology/Alienation, 2008). Fromm (1955) defined alienation as the “mode of experience in which a person experiences himself as an alien or estranged from himself”. Seeman (1963) suggested that the degree of alienation reflects partly one’s own sensitivity to environmental cues, based on the perception of what effect one can have on the environment. Mohan and Joginder (1986) described “alienation as a situation where the framework in which one grows is shattered and this shattering brings about a breakdown of human form and disillusion of coherence and structure”. In a Dictionary of philosophy we find alienation as “ (a) a process of estrangement or isolation from a natural or social context; (b) the condition arising as a result of such a process; and (c) the subjective experience of being in such an experience”. Whereas Seeman (1959 & 1975) described alienation in terms of powerlessness, meaninglessness, normlessness, social isolation and self estrangement. The
detailed explanation of these different dimensions of alienation is given below:

**Powerlessness:** “The expectancy or probability held by the individual that his own behavior can not determine the occurrence of the outcomes or reinforcements, he seeks”. **Meaninglessness:** Seeman (1959) describes it as “when the individual, is unclear as to what he ought to believe when the individual’s minimal standards for clarity in decision making are not met”. **Normlessness:** is derived from Durkheim’s (1947) concept of anomie, used to denote the social situation in which social norms regulating individual conduct have broken down or are no longer effective (Dean, 1961). **Isolation:** as a variant of alienation is thought to be linked to people who assign low reward value to goals or beliefs that are typically highly valued in a given society (Seeman, 1959). **Self estrangement:** is the form of alienation which refer to the state where the person experiences himself as alien or becomes estranged from self (Fromm, 1955).

Sharma and Rai (1976) expressed that alienation is the major modern malady and presents a current crisis in human life owing to maladjustment and dis–contentment with rapidly changing society.

It can be summarized that the various meanings associated with alienation point towards a central theme that is the lack of control an individual experience over his environment which produces in him a sense of
frustration and powerlessness. This ultimately leads to negation of the environment and most likely possible withdrawal from environment. There can be any force individual/social or economic against which one feels himself helpless/powerless and can do nothing to change it according to one’s desire. But becomes a helpless victim and thus an alienating situation arises.

Today, technological development has brought dehumanization and alienation to the dying person. Now people die in the alien world of the modern medical hospitals. One dies among strangers in a nursing home, who are dealing with the fear of death themselves. Man’s alienation becomes greater as he moves into the modern world. Here it unfolds in numerous varieties affecting both individual psyche and social fabric at large. The mechanical approach to life and death can not but lead to alienation. In a highly advanced capitalist society loneliness/alienation and fear of death become equivalent (Eid, 2001).

Alienation may occur in response to certain events or situations in society or in one’s personal life. Examples of events which can be held responsible for alienation are loss of a charismatic personality, or the discovery that a person who served as a role model has serious shortcomings. Personal events include death of a family member, a job change, divorce, leaving home for first time. Although most people may find that such occurrences trigger temporary feelings of disillusionment or loneliness, a
small percentage will be unable to overcome these events and will feel hopelessly drift and alone. An increase in this feeling of alienation among young people has been observed since the 1960s, attributing this alienation to variety of societal conditions; such as rapid socio-economic changes, violence in the media or lack of communal values in culture at large (Encyclopedia of psychology/Alienation, 2008).

Alienation is expressed differently by different people. Some become withdrawn and lethargic; others may react with hostility and violence; still others may become disoriented, rejecting traditional values and behaviour by adopting an erratic behaviour patterns. As society undergoes rapid changes, traditional values and behavioural standards are challenged. Some people find little they can believe in and so have difficulty in constructing a reality in which they can find a place for themselves. Here the social and cultural beliefs play an important role in bringing about or averting a feeling of alienation. Alienation appears to be a necessary accompaniment of development of personality, its management and control in proper manner is necessary for warmth, pleasure and exuberance in human life. Fear, anxiety and conflicts can lead to the feelings of alienation.

MEANINGFULNESS IN LIFE

In the modern world where the stress is increasing in human lives it has become important to understand the factors which can make life
significant or meaningful because life without meaning is just like a string of events that fail to coalesce in to a unified whole. We as human beings have developed profound abilities to harvest meaning from the world around us. All human beings strive to understand the meaning of their own lives. Meaning thus enables people to interpret and organize their experiences, achieve a sense of their own worth and place, identifying things that matter to them and effectively direct their energies.

After World War II, some thinkers stressed that life is meaningless, believed that there was no higher purpose to the universe and therefore people were all alone in trying to figure out what their individual lives were all about. However people will go to great extent to defend their ideas of what life is really all about. In other words it can be said that they firmly hold on to their life meanings. From this observation several psychologists proposed that people must be motivated to find meaning in their lives. Erik Erikson proposed the need for self integration in later life. Whereas Abraham Maslow proposed that meaning would arise from ‘self actualization’ or achieving one’s full potential. Fromm (1900-1980) stressed the importance of meaning in human life and posited that feeling alienated from others and mindlessly feeling, thinking and acting during daily work activities reduced our ability to find life meaningful. Fromm’s ideas about alienation and automatization in modern times echo work by Victor Farnkl. Victor’s experiences as a survivor
of Germany’s World War II concentration camps convinced him of the importance of finding a purpose for living. He felt that the biggest difference between those who did or did not survived the horrific camps was not how much they were forced to work, how little they had to eat or how exposed to the elements (Frankl, 1963). Frankl believed that all people must find their “why” i.e. their purpose in life. He wrote that people who found some meaning were more likely to survive and those who had lost their meaning/purpose were almost certainly doomed. Following Frankl’s writings and his founding of “logotherapy”, as a part of psychological work on the importance of searching for meaning accelerated dramatically.

**Definition:** Despite consensus regarding the importance of meaning in life, definitions and operationalization of meaning in life have varied across theoretical and empirical works generally defining meaning in terms of purpose, significance or as a multifaceted construct. Meaningfulness in life as a purpose: Frankl’s (1963 & 1965) theory of meaning was heavily focused on the idea that each person has some unique purpose in life. Here meaning is experienced as what people are trying to do to enact their values. Meaningfulness in life as significance: Semantic approach to define meaning focuses on lives from an informational significance point of view. Baumeister, (1991); Crumbaugh and Maholick (1964) & Yalom (1980) under this “existential theory of mind”, stated that meaning in life is created through
people’s effort to interpret their experiences in terms of life’s “intentions and significance”, whether “Life” has inherent meaning or not.

**Multifaceted Definitions:** The two major one-dimensional approaches to define meaning in life have been primarily motivational (purpose–centered) or cognitive (significance–centered). Multidimensional definitions of meaning in life often combine these two dimensions with an affective dimension referencing people’s fulfillment in their lives.

Reker and Wong (1988) defined meaning in terms of ability to perceive order and coherence in one’s existence, along with pursuit and achievement of goals and feelings of affective fulfillment arising from such coherence and pursuits.

It is surmised that depending upon the definitions, meaning in life should arise from: Comprehending one’s existence, identifying and achieving valued goals, feeling fulfilled by life and combination of above three.

According to Frankl (1963) essential elements to find meaningfulness in life include: finding meaning by engaging in creative endeavors; through elevating experiences; through an individual’s ability to reflect upon life experiences; and then to grow from the negative experiences and sufferings.

Baumeister (1991) stated four domains that give rise to this meaning namely; feeling a sense of purpose, having a basis for self worth, clarifying
values system by which one judge what is right and wrong and developing a sense of efficacy in the world around.

On similar lines Emmons (2003) gave four parts “taxonomy” of meaning or purpose in life consisting of evaluations related to: work/achievement, intimacy/relationships, spirituality and self transcendence or generativity.

It is said that it is important to maintain distinction between having meaning and searching for meaning (Steger, Frazier, Oishi, & Valler, 2006). The search for meaning in life refers to people’s desire and efforts to establish and/or augment their understanding of the meaning, significance and purpose of their lives. Some who are searching for are struggling to establish some minimal level of meaning in their lives, whereas others might consider themselves to be engaged in a life-long search for meaning, constantly striving to deepen their comprehension of the sense and significance of themselves and their lives (Steger & Kashdan, 2007).

THEORIES OF MEANINGFULNESS IN LIFE

Only a few theorists have addressed the issue of clinical and phenomenological aspects of meaning in life. Among the limited number of theories which have addressed the issue of life’s meaning are Victor Frankl’s (1963 & 1975); Abraham Maslow’s (1968 & 1971); and Irvin Yalom’s (1980). These most influential theories are described below:
Victor Frankl’s (1963) Theory:

Frankl has conceived meaning in life as a process of discovery with in a world that is intrinsically meaningful. Frankl’s theory postulates (Frankl, 1963 & 1975) that “meaning must be found and can not be given”. It is something to discover rather than to invent. It is, he says, a “perceptual phenomenon”. He conceived meaning in life as a process of discovery with in a world that is intrinsically meaningful. This search for a personal idiosyncratic meaning is a primary human motive. Further, fulfillment of meaning always implies decision making and individual is free to choose one’s attitude in any given circumstances. The meaning can be attained through creative, experiential and attitudinal values. Creative values inspire individuals to produce, create and achieve, usually through some form of work. Experiential values include positive human experiences such as love. Attitudinal values bring persons to choose their stance toward unavoidable negative conditions such as facing injustice with dignity. These three aspects will lead to the final goal of meaningfulness in life.

He also emphasized that meanings are not arbitrary human creations, but possess an objective reality of their own. There is only one meaning to each situation and this is its true meaning. Individuals are guided by their conscience to intuitively find this true meaning. Although circumstances exert
a powerful influence on the making and fulfilling of this meaning, yet it is largely dependent on person’s attitude towards the circumstances.

Theory postulates that if individuals do not pursue meaning they may experience an existential vacuum or meaninglessness. This experience of vacuum for prolonged period can lead to a “noogenic neurosis”, a condition typified by boredom and apathy. When meaning is pursued people experience self transcendence and profit from its concomitant sense of life satisfaction and fulfillment. Hence, this theory concludes that meaning in life has to be discovered by the individual and here one’s attitude towards the given circumstances plays an important role.

**Abraham Maslow’s Theory:**

Maslow (1968 &1971) in contrast to Frankl has thought of meaning as an intrinsic emergent property within the person. His theory posits the following notions: The main focus is on gratification of needs. He states that until the lower needs are satisfied, values and meaning in life have little impact on human motivation. When lower needs are satisfied, values become motivational forces in individuals thus, dedicating themselves to some goal. Meaning in life is a “meta–motive”, a “meta need” which operates according to different rule than a “deficit need” or “lower need”. Meta motives require fulfillment for healthy functioning and produce illness when unfulfilled. Meta needs do not refer to internal deficit because tensions they create are often
pleasurable. Gratification of meta-needs adds to motivational power, their satisfaction creates growth rather than merely averting illness.

Meta needs can not be fully satisfied. Total fulfillment of one’s meaning or purpose in life is not possible because meaning in life is found in ideals such as non violence or beauty which cannot be perfected. Individuals are free to choose meanings, but they will be healthier if they choose meanings that help them to fulfill their inner nature. The healthiest out come occurs if chosen activities match the intrinsic values as closely as possible. Thus, Maslow’s theory (1968) holds that without the fulfillment of values, individuals in higher stages become ill: “The state of being without a system of values is psycho pathogenic. The human beings need a framework of values, a philosophy of life, a religion or religion surrogate to live by and understand by, in the same sense that they need sunlight, calcium or love”.

**Irvin Yalom’s Theory:**

Yalom (1980) has addressed the phenomenon of meaning in life from an existential stance. Yalom’s approach starts with the basic existential conflict that flows from the individual’s confrontation with four central givens of existence or ultimate concerns i.e. death, freedom, isolation and meaninglessness. Meaning in life is considered an individual’s creative response to the world’s absolute meaninglessness.
Humans essentially choose and create their own circumstances. Meaning does not exist outside the individuals, who fully create it of their own. As there is no ultimate design of or purpose to this universe, so personal meaning is required to survive in a meaningless universe. Various ways to achieve meaning are altruism, dedication to a cause, creativity or hedonism. Most of the individuals are aware of the self created nature of their personal meanings, a second action is required i.e. commitment. People need to commit themselves whole heartedly to their chosen meaning and purpose if they wish to avoid the anxiety of nihilism.

The human beings seem to require meaning. To live without meaning, goals, values or ideals seem to provoke considerable distress. In severe form it may lead to the decision to end one’s life. We apparently need absolutes, firm ideals to which we can aspire and guidelines by which to steer our lives (Yalom, 1980). So it is concluded that according to Yalom’s theory attributing meaning and purpose to external events provides a considerable amount of security and stability to human life. The world does not possess meaning can be very disappointing and may result in an overwhelming sense of irresponsibility and despair.

**Battista and Almond’s Theory:**

Battista and Almond (1973) after thorough review of the existing theories on meaning in life concluded that despite their profound differences
regarding the nature of meaning they essentially concur on some important issues. Taking a meta-perspective towards the various theories on meaning in life Battista and Almond discovered that there are four basic underlying conceptions about meaning in life which are common to each theoretical approach. These can be described as follows: When individuals state that their lives are meaningful this implies that (a) they are positively committed to some concept of the meaning of life; (b) they have a framework or have derived a set of life goals, purpose in life or life view from these; (c) they see themselves as having fulfilled or as being in the process of fulfilling their framework or life goals; (d) they experience this fulfillment as a feeling of significance. Battista and Almond’s approach involves a relativistic perspective on meaning in life. It holds that there is no “true” or “ultimate” meaning in life which is identical for everyone and acknowledges divergent ways of reaching a sense of meaningfulness to exist. In contrast to other theories, this theory emphasizes the critical role of individuals’ process of believing rather than the content of their beliefs.

The more philosophically oriented models have postulated that meaning in life develops only from the commitment to and fulfillment of the intrinsic meaning of life i.e. God (religious models); being (existential models), or man (humanistic models). The present relativistic model states that commitment to any system of beliefs can serve as a life framework for
the development of meaning in life. This model encourages scientific study of the various clinical and phenomenological aspects of meaning in life. This scientific stance promotes tolerance towards a wide variety of belief systems from which individuals have derived a deep sense of meaning in life. It acknowledges that there are many divergent (e.g. theistic, atheistic, humanistic) ways of deriving meaning in life which do not appear to be reducible to one ultimate, ‘true’ or fundamental meaning system.

**INTRINSIC RELIGIOUS MOTIVATION**

Religion is an important dimension of people’s lives around the world. 98 percent of the population in India, 88 percent in Italy, 72 percent in France and 63 percent in Scandinavia say that they believe in God (Gallup, 1985). In Indian society religion influences the cognitions/thinking pattern of people in relation to fear of death. An individual’s religion has the potential to contribute to cognitive and behavioural manifestations that in turn might influence many psychological, social and physical variables (Adrdelt & Koenig, 2007). William James, professor of psychology at Harvard University in early 1900s and a pioneer in the psychological study of religious behaviour, was the first to make the social science distinction between the two forms of religious practice i.e. intrinsic and extrinsic. Gordon Allport, his successor at Harvard in the late 1960s, concluded “I feel equally sure that mental health is facilitated by an intrinsic, but not an extrinsic religious orientation.
One of the most important concepts that guided the psychology of religion since 1960s is the concept of intrinsic religious motives (motives within the person) and extrinsic religious motives (using religion for non-religious ends) (Santrock, 2009). Allport and Ross (1967); best contrast extrinsic and intrinsic religious orientations by saying that “the extrinsically motivated person uses his religion, whereas the intrinsically motivated lives his religion”.

Intrinsic religious orientation involves religious motives that lie within the person, the person lives the religion. By contrast extrinsic practice is self-oriented and characterized by outward observance, not internalized as a guide to behaviour or attitude. Extrinsic religious orientation involves personal motives that lie outside the religion itself, using the religion for some non-religious ends. The distinction between intrinsic and extrinsic ways of being religious was initially seen as a way of describing genuine (intrinsic) and in genuine (extrinsic) religiousness. The notion also included the idea that religion is a master motive in life for intrinsically religious individuals (Allport, 1966; Donahue, 1985).

The evidence suggests that extrinsic form of religious practice is actually more harmful than no religion. Religion directed toward some other end than God, or the transcendent typically degenerates into a rationalization for the pursuit of other ends such as status, personal security, self-justification or sociability.
THEORETICAL PERSPECTIVE

In the psychology of religion the concept of intrinsic religious motives and extrinsic religious motives are most important. The notion is that intrinsically religious individuals live their religion while their extrinsic counterparts use it. Religion is a master motive in the lives of those who are intrinsically motivated. The distinction between intrinsic and extrinsic religious orientation is intellectually related to the distinction between intrinsic and extrinsic motivation in general motivation theory (Deci, 1975).

Self–Determination theory:

Self–Determination theory (SDT) is one of the most widely used theories of intrinsic motivation and was developed by Edward Deci and Richard Ryan in 1975. SDT states that humans have three innate psychological needs: a need to feel competent, a need to feel related and a need to feel autonomous. Intrinsic motivation develops out of the support of these needs. It has been documented by the theorists that when people feel competent, autonomous and self-determined, they will freely seek what interests them.

Theorists said that individuals can perceive specific events as informational (preserving a sense of competence and freedom), controlling (conveying a pressure to think, feel or behave a certain way), or amotivating (conveying personal incompetence and a sense that particular outcomes are
impossible to achieve). The role of environment has also been focused to be significant. Environment in general contains any mix of elements that could be defined as autonomous, supportive, controlling or amotivating. If a person perceives his environment as informational and feels competent and autonomous, intrinsic motivation can be sustained and/or enhanced. Self determination theory is specifically framed in terms of social and environmental factors that facilitate or undermine intrinsic motivation. This reflects the assumption that intrinsic motivation, being an inherent organismic propensity, is catalyzed (rather than caused) when individuals are in condition that conduce towards its expression.

**Cognitive Evaluation Theory: (CET)**

CET was presented by Deci and Ryan (1985) and then by Ryan and Deci (2000) to specify the factors in social contexts that produce variability in intrinsic motivation. CET is considered as a sub theory of self determination theory; argues that interpersonal events and structures (rewards, communication, feedback) that conduce towards feelings of competence during action can enhance intrinsic motivation for that action, because they allow satisfaction of the basic psychological need for competence. CET further specifies that feelings of competence will not enhance intrinsic motivation unless they are accompanied by a sense of autonomy or, in attribution terms, by an internal perceived locus of causality (de charms,
1968). Thus, people must not only experience perceived competence (or self-efficacy), they must also experience their behaviour to be self-determined if intrinsic motivation is to be maintained or enhanced. In other words, this theory highlights that for high level of intrinsic motivation, people must experience satisfaction of needs both for competence and autonomy.

**HEALTH PROMOTING BEHAVIOURS**

Health promotion is an important component of health practice. It is a way of thinking that revolves around a philosophy of wholeness, wellness and well being. In the past two decades, the public has become increasingly aware of and interested in health promotion. Many people are aware of the relationship between lifestyle and illness and are developing health promoting habits, such as getting adequate exercise, rest and relaxation, maintain good nutrition and controlling the use of tobacco, alcohol and other drugs (Kozier et al., 2004).

The vision of health promotion was expressed in 1979 with the Surgeon General’s report *Healthy People*, which emphasized health promotion and disease prevention. *Healthy People 2000* followed in 1990 and provided a framework for national health promotion, health protection and preventive service strategy (U.S. Department of Health and Human Service) [USDHHS], 1990).
Healthy people 2010: Understanding and Improving Health (USDHHS, 2000), presents a comprehensive 10-year strategy for promoting health and preventing illness, disability and premature death.

Health promotion thus includes programmes that modify both the environment and the behaviour of individuals. It involves education in lifestyle and behavioural change, community development, organizational change, and at the political level-legislation.

**Definition:** Pender, Murdaugh and Parsons (2002) consider health promotion to be different from health protection or illness prevention. They defined *health promotion* as “behaviour motivated by the desire to increase well-being and actualize human health potential” and *health protection* or illness prevention as “behaviour motivated by a desire to actively avoid illness, detect it early or maintain functioning within the constraints of illness”.

An overview of the differences between health promotion and health protection is given below (Pender et al., 2002).

<table>
<thead>
<tr>
<th>Health Promotion</th>
<th>Health Protection</th>
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<tbody>
<tr>
<td>• Not disease oriented</td>
<td>• Illness or injury specific</td>
</tr>
<tr>
<td>• Motivated by personal, positive “approach” to wellness</td>
<td>• Motivated by “avoidance” of illness</td>
</tr>
<tr>
<td>• Seeks to expand positive potential for health</td>
<td>• Seeks to thwart the occurrence of insult to health and well-being.</td>
</tr>
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Some models specifically describing the health promoting behaviour are described below:

**Health Belief Model:** (Rosenstoch’s, 1974)

Rosenstoch’s (1974) assumed that good health is an objective common to all people. Becker added “positive health motivation” as a consideration. Rosenstoch’s (1974) and Becker and Maiman’s (1975) health belief model (fig.1) addresses the relationship between a person’s belief and behaviour. It provides way of understanding and predicting how clients will behave in relation to their health and how they will comply with health care therapies. This model comprises of three components i.e. individual perceptions, modifying factors and likelihood of action.

In the first component of this model; the individual perceptions involve the perceived susceptibility to an illness and the individual’s perception of the seriousness of the illness. Perceived susceptibility and perceived seriousness together; determine the total perceived threat of an illness to a specific individual. The second component is modifying factors; include the factors that modify individual perceptions. Demographic, sociopsychological and structural variables along with cues to action come under this component of the health belief model. The third component is the likelihood that a person will take recommended preventive actions. Depends on person’s perception of the benefits and barriers of taking action. Preventive actions
may include lifestyle changes, increased adherence to medical therapies or a search for medical advice or treatment.

Thus it can be said that health belief model stipulates that a person’s health related behaviour depends on the person’s perception of four critical areas i.e. the severity of potential illness, the person’s susceptibility to that illness, the benefits of taking a preventive action, and the barriers to take that action. Model also incorporate cues to action as important element in eliciting or maintaining patterns of behaviour.

**Figure-1 Health Belief Model**
Health Promotion Model:

Pender et al. (2002) have modified the health belief model to develop a health promotion model. According to Pender health belief model explains only health protecting or preventive behaviours but does not emphasize health promoting behaviours. The initial version of the Health Promotion Model (HPM) focused on health-promoting behaviours rather than health protection or illness prevention behaviours. The initial model has recently been replaced by the Health Promotion Model (Revised) as shown in the figure-2 (Pender et al., 2002). The HPM is a competence or approach-oriented model that depicts the multidimensional nature of persons interacting with their interpersonal and physical environments as they pursue health (Pender et al., 2002).

The assumptions of the HPM are: Persons seek to create conditions of living through which they can express their unique human health potentials.

1. Person has the capacity for reflective self-awareness including assessment of their own competencies.
2. Person value growth in direction viewed as positive and attempts to achieve a personally acceptable balance between change and stability.
3. Individuals seek to actively regulate their own behaviour.
4. Individuals in all their biopsychosocial complexity interact with the environment and being transformed overtime.
5. Health professionals constitute a part of the interpersonal environment, which exerts influence on persons throughout their life span.

6. Self-initiated reconfiguration of person-environment interactive patterns is essential to behavior change.
The variables in the revised HPM and their interrelationships are described below: (Pender et al., 2002).

**Individual Characteristics and Experiences:** The importance of individual characteristics and experiences will depend on the target behaviour for health promotion. *Personal factors* are categorized as biological, psychological, and sociocultural. Some personal factors can influence health behaviours while others cannot be changed. *Prior related behaviour* includes previous experiences, knowledge of and skills in health-promoting actions also influence the behaviour.

**Behaviour–Specific cognitions and affect**- This set of variables is considered to be of major motivational significance for acquiring and maintaining health-promoting behaviours.

- **Perceived benefits of action**- Anticipated positive outcomes that will occur from health behavior affect the person’s plan to participate in health promoting behaviours and may facilitate continued practice. Prior positive experience with the behaviour or observation of others engaged in behavior is a motivational factor.

- **Perceived barriers to action**- Anticipated imagined or real blocks and personal costs of understanding a given behaviour.
• **Perceived self-efficacy**- Judgment of personal capability to organize and execute a health promoting behaviour. Perceived self efficacy influences perceived barriers to action so higher efficacy results in lowered perception of barriers to the performance of the behaviour.

• **Activity–related affect**- The subjective feelings that occur before, during and following an activity can influence whether a person will repeat the behaviour again or maintain the behaviour. A positive affect or emotional response to a behavior is likely to be repeated and behaviours associated with a negative affect are usually avoided.

• **Interpersonal influences**- Interpersonal influences are person’s perceptions concerning the behaviour, beliefs or attitudes of others. Family, peers or health professionals are sources of interpersonal influences. Interpersonal influences also include expectation of significant others, social support and learning by observing others.

• **Situational Influences**- These are direct and indirect influences on health promoting behaviour include perceptions of available options, demand characteristics and the aesthetic features of the environment. Demand characteristics can directly affect healthy behaviours through policies such as company regulations to establish “no smoking” environment. People in comfortable environment will be more willing to practice healthy behaviours rather than those feeling alienated.
**Behavioural Outcome:**

- **Commitment to a plan of action** - Commitment to a plan of action involves two processes: Commitment and identifying specific strategies for carrying out and reinforcing the behaviour. The concept of intention and identification of a planned strategy leads to implementation of health behaviour. Strategies are important because commitment alone often results in “good intentions” and actual performance of behaviour.

- **Immediate competing demands and preferences** - Competing demands are those behaviours over which an individual has a low level of control. Competing preferences are behaviours over which an individual has a high level of control; this control depends on the individual’s ability to be self-regulated or to not “give in”.

- **Health promoting behaviour** - Endpoint or action outcome directed toward attaining positive health outcome such as optimal well-being, personal fulfillment, and productive living. Health promoting behaviours should result in improved health, enhanced functional ability and better quality of life at all stages of development.

**STAGES OF HEALTH BEHAVIOUR CHANGE**

Health behaviour change is a cyclic phenomenon in which people progress through several stages. In **figure-3** the stages of health behaviour change are shown (a) precontemplation, (b) contemplation, (c) preparation,
(d) action, (e) maintenance, and (f) termination. If a person does not succeed in changing behaviour, relapse occurs.

**Termination:** Copes without fear of relapse.

**Maintenance:** Integrates new behaviour in to lifestyle.

**Action:** Modifies behaviour and surroundings.

**Preparation:** Plans to take action, makes final adjustments before beginning behaviour change.

**Contemplation:** Acknowledges having a problem and researches causes and possible solutions. Not ready to commit to action.

**Precontemplation:** Denies having a problem, may feel situation is hopeless.

**Relapse or Recycle:** An opportunity to learn from the experience and renew efforts to change.

**Figure-3 Stage Model**
**Precontemplation stage:** Person typically denies having a problem, views others as having a problem, and therefore wants to change their behaviour. They do not think about changing their own behaviour.

**Contemplation stage:** Person acknowledges having a problem, seriously considers changing a specific behaviour, actively gathers information and verbalizes plans to change the behaviour in near future.

**Preparation stage:** Occurs when the person undertakes cognitive and behavioural activities that prepare the person for change. Final specific plans are made.

**Action stage:** Occurs when the person actively implements behavioural and cognitive strategies to interrupt previous behaviour patterns and adopt new ones. Greatest commitment of time and energy is required.

**Maintenance stage:** Here person integrates newly adopted behaviour patterns into his or her lifestyle.

**Termination stage:** This stage is the ultimate goal where the individual has complete confidence that the problem is no longer a temptation or threat.

These six stages are cyclical; people generally move through one stage before progressing to the next (Prochaska, Norcross, & DiClemente, 1994).