SUMMARY

Death is a universal and unavoidable phenomenon. It arouses strong feelings of dread and fear in dying individuals as well as their families and health care providers. It is an issue avoided by everyone in the modern society. Death is terrifying for everyone because it is omnipresent, omnipotent and brutally impartial. Death and taxes are two things; which are certain in life. One can escape paying taxes but death is certainty for all. Death is unknown and completely mysterious. Its’ invisible monstrous presence threaten to take away everything we care about in an instant.

Incidents of death surround us throughout our lifespan. Recent years have seen an increasing interest in the psychology of death and dying. The vicarious exposure of young and old alike to media depictions of violence and death is one of the factors responsible for promotion of interest in death and dying issues. While it has become common place to speak of death, it is paradoxical that there are not many individuals who can deal with most direct experiences of death without bearing a heavy and long-lasting psychological burden (Davidson & Jackson, 1985).

The term death and dying are not synonymous and have no unequivocal definitions. Death may be considered as absolute cessation of vital functions, while dying is the process of losing these functions. Advances in technology have changed the focus of death definitions from circulatory and respiratory...
functions to brain stem activity. Death is defined as the cessation of vital functions of the body including the heartbeat, brain stem activity and breathing (Kaplan & Sadock, 2000). 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 and dying, as well as by cultural attitudes and beliefs. Kubler-Ross (1969) postulated five stages that many dying individuals pass through from time they first become aware of their fatal prognosis to their actual death. The five stages of coping as given by Kubler–Ross are: denial, anger, bargaining, depression and acceptance.

Every fear is ultimately a disguised fear of death (Dumont & Foss, 1972). Fear of death and death anxiety are the two terms which have been used interchangeably in the literature. Pollak (1980) points out that researcher often examine death anxiety on separate dimensions based on the assumption that death anxiety is a multi-dimensional construct. The death anxiety possesses four dimensions specifically fear of death of self, fear of dying of self, fear of death of others and fear of dying of others. Collet-Lester’s fear of death scale (1969) was developed to allow investigators to examine death anxiety along several dimensions. Templer (1970) suggested death anxiety involves both uneasiness about personal extinction and apprehension about the dying process.
Today the significance of fear of death and dying has increased because of the technological developments and modernization of the society. Due to the advancement of society the experience with death and dying has changed dramatically. In the past all the family members used to witness the dying process and death of their loved ones in their homes. Presently as the institutionalized deaths are increasing in number there are very few possibilities for family members to view the reality of death (Dumont & Foss, 1972). This prevents their exposure to death and dying. Today the death is considered as a failure of medical sciences. Modern society is death denying and avoiding society. People die in the alien world of modern hospitals where they do not find somebody with whom they can discuss their fear of dying process and death. Many theoretical and empirical evidences have established that many nurses because of their fears and anxieties often avoid and isolate the dying patients (Kubler-Ross, 1969; Quint, 1967; Epstein, 1975; Folta, 1963; Glaser & Strauss, 1969).

The various correlates of death anxiety which are studied by the psychologists are age, gender, religion, spirituality, ethnicity, occupation, death education, ego integrity, environment, depression, a personal sense of fulfillment, health, exposure to death and dying. Present research work was planned to study all the four dimensions of death anxiety along with cognitive, emotional and behavioral correlates of fear of death. Under
cognitive, emotional and behavioural correlates, the variables hope, alienation, meaningfulness in life, intrinsic religious motivation and health promoting behaviours were incorporated.

Hope is an important aspect in every individual’s life, especially in the context of fear of death as this creates feelings of hopelessness. It has been documented that witnessing death or exposure to death experiences creates feelings of hopelessness, helplessness and powerlessness. These feelings/emotions affect the sense of well-being among people (Meier et al., 2001). Various meanings are associated with alienation. All points towards a central theme that is lack of control an individual experiences over his environment which produces in him a sense of frustration and powerlessness. It becomes impossible for everyone to hear or say any last words. Man’s alienation becomes greater as he moves in to the modern world. In a highly advanced capitalist society of present time loneliness, alienation and fear of death become equivalent (Eid, 2001). Meaningfulness in life is one of the most influencing variables in relation to fear of death. Quinn and Rezinkoff (1985) concluded that people having high death anxiety/fear had lower purposefulness to their lives. Death to Frankl (1965) is a factor in the meaningfulness of life. The existentialists also believe that death to one who has found purpose in life has meaning because life has meaning; death to one who has discovered no purpose in life will become a very anxiety provoking
experience (Durlak, 1972). Religion is one expression of spirituality. Duff and Hong (1995) examined the effect of religiosity on death anxiety and proposed that death anxiety is lower in communities with higher rate of attendance to religious services. 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. Health promotion is an area which includes both the human environment and human behaviour. People are becoming increasingly aware of the relationship between lifestyle and illness therefore working towards promoting healthy habits. Human beings are conscious of the fact that they will inevitably die thus death and dying related thoughts regulate their behaviours. Thoughts of death remove an individual’s “protection” from mortality and make them seek ways to “save themselves” (Greenberg, Solomon & Pyszczynski, 1997). Death is more of a threat for which we do not have enough self control to resist. The importance of fear of death and death anxiety research rests on the premise that all humans will eventually die. Death is a real possibility to all at any time; therefore, how people deal with the recognition of their death is a subject of considerable relevance to everyone. Discussions on the issues related to death and dying are not welcomed or encouraged by everyone because we live in death denying society. But it is important to think and talk about death if we want to think significantly about life because by realizing that we are mortal beings every moment in life becomes important. The subject of fear of death or death
anxiety and how it is managed by individuals is worth serious investigation.
In Indian context there are few studies relating to various aspects of death and
dying and it was felt that this is the area which needs further exploration.

OBJECTIVES

The objectives of the study are as follows:

Primary Objective:

1. To study the relationship between fear of death and it’s cognitive,
emotional and behavioural correlates.

Secondary Objectives:

i. To assess the level of fear of death among study subjects.

ii. To compare the fear of death among two groups of females particularly;
females exposed to death/dying (group–I) and females not exposed to
death/dying in last two years (group–II).

iii. To compare fear of death of self with fear of death of others in females,
and among females exposed to death/dying (group–I) and females not
exposed to death/dying in last two years (group–II).

iv. To study the relationship of fear of death with hope, alienation,
meaningfulness in life (search), meaningfulness in life (presence),
intrinsic religious motivation, and health promoting behaviours in
females.
v. To explore the relationship of fear of death with hope, alienation, meaningfulness in life (search), meaningfulness in life (presence), intrinsic religious motivation, and health promoting behaviours in two groups of females i.e. females exposed to death/dying (group-I) and females not exposed to death/dying in last two years (group-II).

vi. To study the relative contribution of hope, alienation, meaningfulness in life (search), meaningfulness in life (presence), intrinsic religious motivation, and health promoting behaviours to fear of death in females.

**HYPOTHESES**

In light of the review of literature following hypotheses were framed:

1. Fear of death would be present in all the study subjects.

2. Fear of death would be more among females exposed to death/dying as compared to females not exposed to death/dying.

3. Fear of death of self would be more as compared to fear of death of others.

4. Fear of death would be negatively related to: hope, meaningfulness in life (presence) and intrinsic religious motivation.

5. Fear of death would be positively related to: alienation, meaningfulness in life (search), health promoting behaviours and age.
6. Hope, alienation, meaningfulness in life (search), meaningfulness in life (presence), intrinsic religious motivation and health promoting behaviours would be significantly contributing to fear of death.

SAMPLE

Purposive sampling method was used to select a sample size of 200 females comprised of 100 females professionally exposed to death/dying and 100 other females not exposed to death/dying from urban areas of Punjab and Chandigarh were in the age group of 25-45 years. All the subjects recruited for the study were married with at least one issue and minimum qualification up to graduation level.

Inclusion criteria: All married females with issue in the age group of 25-45 years with minimum qualification up to graduation level.

Exclusion criteria: Females who had witnessed the death of first degree relative or of a close significant member of family in last two years in both the study groups. Females suffering from any mental or chronic medical illness were also excluded.

TOOLS USED FOR THE PRESENT STUDY

Background Questionnaire:

Background questionnaire was developed to collect information about socio-demographic characteristics of the subjects and to ascertain the status of
exposure to death/dying in last two years. Questions about the health status of the subjects were also incorporated. The questionnaire comprised of total eight questions. Four questions were about socio–demographic profile and two about their exposure to death/dying in last two years. Two questions were added to explore the health status of the subjects.

**The Revised Collett-Lester Fear of Death and Dying scale (Lester, 1990):**

The Collett-Lester Fear Of Death and Dying Scale (1969) was devised to provide a measure of death anxiety that distinguished between the fear of death and fear of dying and which also measured both these fears for oneself and for others. The revised scale (1990) used in this study has four subscales i.e. Fear of death of self, Fear of dying of self, Fear of death of others and Fear of dying of others. Each subscale is comprises of 8 items and scoring is based on 5 point Likert scale ranging from not disturbed (1) to extremely disturbed (5). The test-retest reliability using Pearson correlations were 0.85 for death of self, 0.79 for dying of self, 0.86 for death of others, and 0.83 for dying of others.

**Hope Scale (Snyder et al., 1991):**

Total number of items in this scale is 12. This hope scale comprises of two sub scales namely the agency subscale and pathways subscale. The highest possible hope scale score is 32 and lowest score is 8. Author has documented that research on the hope scale indicates acceptable internal
reliability, the coefficient alpha is acceptable high (Cronbach’s alphas of 0.74 and 0.84).

**Alienation scale (Reddy, 1973):**

It is 14 item inventory developed on the basis of Melvin Seeman’s multidimensional framework for alienation. It is Likert type scale that gives five point summated ratings ranging from totally disagree (0) to totally agree (4). The test-retest reliability coefficient was found out to be 0.82. Concurrent validity as reported by author with Leo Srole’s scale for anomie was 0.43 (significant statistically). The relatively lower value is accounted for by the fact that Srole’s scale for anomie is concerned with only one of the five dimensions of alienation envisaged in Melvin Seeman’s multidimensional framework.

**The Meaning in Life Questionnaire (Steger et al., 2006):**

The MLQ consists of two subscales measuring the presence and the search for meaning in life, each containing 5 items and scoring is based on 7 point Likert scale ranging from 1 (Absolutely untrue) to 7 (Absolutely true). The MLQ has demonstrated good reliability and stability as well as robust structural validity (Steger et al., 2006). Each sub scale has shown convergent and discriminant validity as well as high test-retest reliability (Steger et al., 2006; Steger & Kashdan, 2007).
Intrinsic Religious Motivation Scale (Hoge, 1972):

This scale is used to measure the participants’ perceived internal relationship with God (Hoge, 1972). The scale is 10 items; 6 point Likert scale from strongly disagree (1) to strongly agree (6). A higher score denotes a stronger perceived internal relationship with God. Some items in this scale are reversed scored, these items are related to external motivators for religious convictions. The scale’s reliability is measured by the author using Kuder Richardson method and it is 0.901. In item to item scale correlations with total 10 items the alpha coefficients ranged from 0.60 to 0.85.

The Health Promoting Lifestyle Profile II (HPLP II) (Walker & Polerecky, 1996):

The 52 item HPLP II is composed of a total scale and six sub scales to measure behaviours in the theorized dimensions of health promoting lifestyle. The six sub scales measure behaviours in the theorized dimensions of health promoting lifestyle: namely spiritual growth, interpersonal relations, nutrition, physical activity, health responsibility and stress management. Content validity for the scale was established by literature review and content experts’ evaluation. Construct validity was supported by factor analysis that confirmed a six dimensional structure of health promoting lifestyle, by convergence with the personal lifestyle questionnaire (r=0.678). Criterion related validity was indicated by significant correlations with concurrent measures of perceived health status and quality of life (r=0.269 to 0.491). The alpha coefficient of
internal consistency for the total scale was 0.943; alpha coefficients for the subscales ranged from 0.793 to 0.872.

**STATISTICAL ANALYSIS**

Both the groups were compared for different dimensions of death anxiety using t-test (paired and unpaired). Intercorrelations between study variables were computed in total sample as well as in both the groups. Regression analysis was carried out to see the contribution of hope, alienation, meaningfulness in life, intrinsic religiosity and health promoting behaviours to fear of death.

**MAIN FINDINGS**

- All the study subjects were having varying degrees of death anxiety. Maximum subjects showed moderate fear of death and dying for self and fear of death and dying of others was high in maximum number of subjects.

- Fear of death and dying of self was significantly high in females professionally exposed to death and dying in group-I as compared to those females who were not exposed to death and dying in last two years in group-II.

- Significantly high fear of death of others as compared to fear of death of self was shown by all the study subjects in group-I, group-II and sample
as a whole. In total sample and in group-II the fear of dying process of others was also significantly high as compared to dying of self.

- Hope showed significant and positive relationship with fear of death and dying.
- Feelings of alienation increased with increase in fear of death and dying.
- Meaningfulness in life (presence) showed negative relationship with fear of death and dying whereas meaningfulness in life (search) found to be positively correlated with fear of death and dying.
- About the relationship of fear of death and dying with intrinsic religious motivation no conclusive comments can be made and this aspect needs further exploration.
- Health promoting behaviours were found to be positively correlated with fear of dying of self.
- For FDS, FDyS and FDO the overall contribution of all the variables was significant in total sample and among all the variables hope, alienation, health promoting behaviours and age were most influencing.