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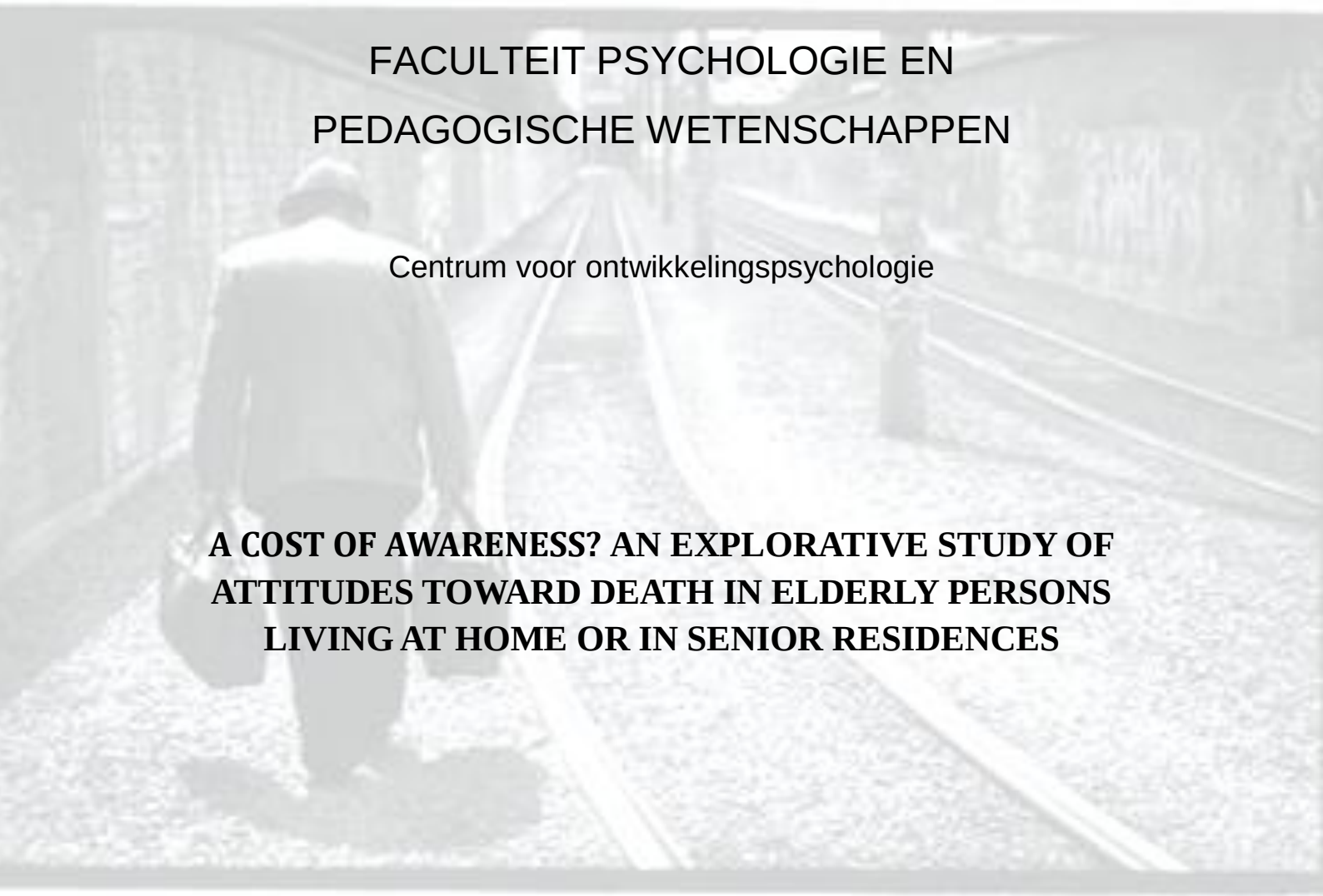

A COST OF AWARENESS? AN EXPLORATIVE STUDY OF ATTITUDES TOWARD DEATH IN ELDERLY PERSONS LIVING AT HOME OR IN SENIOR RESIDENCES

Licentiaatsverhandeling aangeboden tot
het verkrijgen van de graad van
Licentiaat in de Psychologie
door
Sofie Hermans
o.l.v. Prof. Dr. R. Krampe

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Sofie, Hermans, A cost of awareness? An explorative study of attitudes toward death in elderly persons living at home or in senior residences

Verhandeling aangeboden tot het verkrijgen van de graad van Licentiaat in de Psychologie, examenperiode: juni 2008, Leiding: Prof. Dr. R. Krampe (promotor)

Elderly not only live longer, this group also expands in our society as a result of the birth-wave that appeared after World War II. The majority of these old people now die in institutions rather than at home. To promote the provision of good care, research approaches are needed, which emphasize individual differences among people and which also take their views and perspectives onto their own situations into account.

This explorative study examines differences in death attitudes in elderly persons according to place of residence. Participants were 85 subjects either living at home or in an institution (age range 59-96 years). The questionnaire contained the Death Attitude Profile Revised, which measures five attitudes toward death: three positive attitudes (approach acceptance, neutral acceptance, escape acceptance), and two negative ones (death avoidance, and fear of death). Furthermore, demographic variables, social network variables and life-satisfaction were assessed and examined regarding their influence on differences in death attitudes between people living at home and people living in an institution. Results show that elderly living in an institution had significantly less fear of death and they see death more as a welcome escape of life compared with people who are living at home. Regarding neutral acceptance, the effect of place of living failed to reach significance only by a slight margin. Given overall differences between seniors living at home and in residences regarding mean age, marital status, loneliness, and intensity of social contact, data were also analyzed using mediation analysis. Reported group differences remain robust for fear of death after age and marital status were controlled for. Neutral acceptance is mediated by age. Although the effect of place of living and age doesn't reach significance for escape acceptance, results indicate a possible mediating effect of age. Regarding the social network variables, reported group differences between institutionalized and non-institutionalized elderly remain robust for fear of death and escape acceptance. Social network variables as well as place of living don't have a significant effect on neutral acceptance.

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Ouderen leven niet alleen langer, deze groep breidt zich ook uit in onze maatschappij als resultaat van de geboorte-golf die zich na Wereldoorlog II voordeed. De meerderheid van deze oude mensen sterft nu in instellingen eerder dan thuis. Om de voorziening van goede zorg te bevorderen, zijn onderzoekbenaderingen nodig, die individuele verschillen onder mensen benadrukken en die ook hun meningen en perspectieven op hun eigen situaties in overweging nemen.

Deze exploratieve studie onderzoekt verschillen in houdingen tegenover de dood van ouderen naargelang verblijfplaats. De deelnemers waren 85 ouderen die of thuis of in een instelling (leeftijdsgroep 59-96 jaar) leven. De vragenlijst bevatte de Death Attitude Profile Revised, dat vijf houdingen ten opzichte van dood meet: drie positieve houdingen (approach acceptance, neutral acceptance, escape acceptance), en twee negatieve degenen (death avoidance, and fear of death). Voorts werden demografische variabelen, sociale netwerk variabelen en levenstevredenheid onderzocht betreffende hun invloed op verschillen in attitudes tegenover de dood tussen mensen thuis en mensen die in een instelling leven. De resultaten tonen aan dat ouderen die in een instelling leven significant minder vrees hebben voor de dood en zij de dood meer als een welkome vlucht van het leven zien vergeleken met mensen die thuis leven. Voor neutral acceptance is het effect van woonplaats randsignificant. Gegeven dat er verschillen bestaan in gemiddelde leeftijd, huwelijksstaat, eenzaamheid, en intensiteit van sociaal contact tussen beide groepen, werden de gegevens ook geanalyseerd dmv. mediatie analyse. De groepsverschillen blijven robuust voor fear of death na controle voor leeftijd en huwelijksstaat. Neutral acceptance wordt gemediëerd door leeftijd. Hoewel het effect van woonplaats en leeftijd geen significantie bereikt voor escape acceptance, wijzen de resultaten op een mogelijk mediërend effect van leeftijd. Betreffende de sociale netwerkvariabelen, blijven de groepsverschillen tussen geïnstitutionaliseerde. en niet-geïnstitutionaliseerde ouderen robuust voor fear of death en escape acceptance. De sociale netwerkvariabelen evenals woonplaats hebben geen significant effect op neutral acceptance.

DANKWOORD

Een thesis is soms een eenzame bezigheid, maar ze wordt zeker niet alleen geschreven. In dit dankwoord wil ik degene bedanken die hebben bijgedragen tot het tot stand brengen van deze thesis. In de eerste plaats gaat mijn dank uit naar mijn promoter Pr. Krampe die mij de mogelijkheid en het vertrouwen heeft gegeven om dit vrij thesis onderwerp te realiseren. Het heeft ervoor gezorgd dat ik over de hele weg gemotiveerd ben gebleven, een ongelooflijk geschenk! Vervolgens wil ik hem ook bedanken voor het leiden van deze thesis en de feedback. Vele mensen hebben me bijgestaan bij concrete zaken en verdienen ook een plaats in dit dankwoord: Jan voor algemene computer ondersteuning, Igor Dubois voor het delen van excell kennis en zeker niet te vergeten Tom voor de raad bij de analyse van mijn resultaten. Voorts wordt een thesis op bepaalde plaatsen geschreven. Ik schrijf het liefst wanneer ik in een staat van 'peace of mind' ben, in een rustige en ondersteunende omgeving. De mensen die deze omgeving mee hebben gecreëerd draag ik een warm hart toe: in de eerste plaats mijn mama, Goedele Horemans. Mijn nicht Gitta Horemans en haar vriend Jo Franckx die mij een onderdak hebben verleend in hartje Leuven tijdens de meest cruciale maand voor een thesis: de laatste. Mijn kotgenoten in Valencia, die nooit hebben geklaagd over de terrorisatie van de living met artikels, laptop en koffie. Vele vrienden die mij hebben geholpen bij de dataverzameling en mijn gezaag hebben aanhoord tijdens de verschillende stappen van het onderzoeksproces. Bij voorbaat is mijn papa, Ludo Hermans bedankt voor het lezen van mijn thesis met veel interesse☺. Ten laatste zou ik het OCMW willen bedanken voor het openstellen van hun instellingen voor dit onderzoek.

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DAP	Death Attitude Profile
DAP-R	Death Attitude Profile Revised
DPS	Death Perspective Scale
MODDI-F	Multidimensional Orientation Toward Death and Death Inventory
MS	mortality salience
TMT	Terror Management Theory

CHAPTER 1

GENERAL INTRODUCTION

Death eventually comes to everyone -- rich and poor, saint and sinner, the wise and the foolish. Sooner or later, everyone must face his or her own vulnerability and the inevitability of death. Distraction and denial may postpone the realization and acceptance of the inevitable, but no matter how physically fit or informed one may be, that day will surely come. This fate is something that people do not only share with each other, but also with every living being. However, as far as we know, humans are presumably the only living creatures who realize that they will die some day. Because of this realization we create attitudes toward death and dying. This explorative study examines such attitudes toward death and whether these attitudes are affected by place of residence, life-satisfaction, and several demographic and social network variables .

Death has become associated with very old age, those who may be regarded as having little economic or social value to society and its continuing function (Glaser 1966, Turner 1995), as average life-span increased (Douglas, 2007). Not only do elderly live longer, there are also more old people. Namely, the birth-wave that appeared after the second World war has consequences for the compilation of the population today. In 1999, the amount of people over 60 of the total population in Europe ranged from 15% in Ireland to 24% in Italy. Italy contains the most old people of Europe, followed by Greece, Spain, Germany, Belgium and Sweden (De Jong Gierveld, 2001). In 2004, one of five persons in Belgium were retired. From this population, sort or less half of the retired persons are between 65 and 75 years old, 15% is younger than 65 and 40 % is 75 year or older (Berghman, Curvers, Palmans, & Peeters, 2007). Furthermore, 54% is female and 46 % is male. Women are, in comparison with the total amount of the population slightly overrepresented in the population of retired people. According to the authoritative Centers for Disease Control and Prevention and the Merck Company foundation's latest publication, the growth in the number and proportion of older adults is unprecedented in the history of the United States and Europe and the population of people aged 65 and older will double during the next 25 years (Armstrong, Conn, & Pinner, 1999).

Furthermore, this graying of the population goes hand in hand with a diminishing of the amount of young people as a consequence of a lower birth-rate. So, on a big scale, fewer young people need to take care of a growing group of elderly. This is one of the reasons that nursing homes are gaining importance as places where elderly live out their lives in modern Western societies (Bickel, 1998; Streckeisen, 2001). The majority of these old people currently die in institutions rather than at home. Since there is evidence that end-of-life care in nursing homes lacks quality (Maddocks & Parker, 2001), there is a growing discussion on

introducing care principles in nursing homes in order to improve end-of-life care in these institutions (Hockley & Clark, 2002; Heimerl, Heller & Kittelberger, 2005). Patients in nursing homes represent a particularly vulnerable group because they placed their dignity under the constraints of the need for help and care (Pleschberger, 2007). There is a demand for approaches which emphasize that 'people matter as individuals, for who they are and not what they can do'. So, in order to accomplish good end-of-life care, the views of those who are most affected is of utmost importance (Small & Rhodes, 2003; Heimerl, 2000). Older people rarely participate in end-of-life care research and may be most at risk of exclusion from choices such as the setting and type of care that they receive during dying. These tendencies are particularly marked among the very old and 'frail'. By examining possible differences in death attitudes in elderly who live in institutions (e.g. nursing homes),and at home, we hope to contribute to an understanding of people who are in the terminal period of their lives. This could help us define what good care means, because, good care for people in institutions does not begin when a person dies, but when a person enters a home and lays trust in the hand of others.

The second chapter is aimed at giving the reader an understanding of death and death attitudes by presenting different usages of the word death and the history of death attitudes to the creation of the model of Wong, Reker, and Gesser (1994), which is used in this study. The strength of this model is that it considers the multidimensionality of death attitudes by including positive attitudes toward death. Since the constellation of different death attitudes capture individual differences better than one single attitude, this model offers a useful framework to gain a better understanding of how elderly in an institution and at home differ in the way they approach death.

In chapter three, we will present this multidimensional model of Wong et al. (1994) in more depth. The different attitudes are discussed, along with their interrelation and correlates. The results of the few, old investigations that include place of living are inconsistent. At the end of this chapter, a rationale for the association between fear of death and death acceptance is given from an existential view.

In chapter four the methodology of this study is presented. Next, in chapter five, the results of the analysis of the data of this study are presented. First, an effect of place of living was examined for all five Death Attitude Profile-Revised (DAP-R) dimensions. In order to interpret this effect, demographic variables, social networks variables, and life-satisfaction were investigated according to the suggested steps of mediation-analyses. In the last chapter, the results are discussed and conclusions are put forward.

Algemene Inleiding

De dood komt uiteindelijk aan iedereen -- rijk en arm, heilige en zondaar, wijze en dwaas. Vroeg of laat, moet iedereen zijn of haar eigen kwetsbaarheid en de onvermijdelijkheid van de dood onder ogen zien. Afleiding en ontkenning kunnen de realisatie en de aanvaarding van dit feit uitstellen, maar hoe dan ook, die dag zal zeker komen. Dit lot is iets die de mensen niet alleen delen met elkaar, maar ook met elk levend wezen. Nochtans, voor zover we weten, zijn mensen vermoedelijk de enige levende schepselen die realiseren dat zij op één of andere dag zullen sterven. Door dit besef creëren wij houdingen ten opzichte van dood en het sterven. Deze exploratieve studie onderzoekt dergelijke houdingen ten opzichte van dood en of deze houdingen door verblijfplaats, levenstevredenheid, en verscheidene demografische en sociale netwerkvariabelen worden beïnvloed.

Met de verlenging van de levensduur, is de dood steeds meer geassocieerd met zeer oude leeftijd (Douglas, 2007) – zij die worden beschouwd als hebbende weinig economische of sociale waarde in de maatschappij en zijn voortgaande functie (Glaser 1966, Keerder 1995). Niet alleen leven ouderen langer, er zijn ook steeds meer oude mensen. De geboorte-golf van na de tweede oorlog heeft gevolgen voor de huidige samenstelling van de bevolking. In 1999, strekte de hoeveelheid mensen van 60 jaar of ouder van de totale bevolking in Europa zich uit van 15% in Ierland en 24% in Italië uit. Italië bevat de oudste inwoners van Europa, gevolgd door door Griekenland, Spanje, Duitsland, België en Zweden (De Jong Gierveld, 2001). In 2004, was één op vijf personen in België op pensioen. Van deze bevolking, is ongeveer de helft tussen 65 en 75 jaar oud, 15% is jonger dan 65 en maar liefst 40% is 75 jaar of ouder (Berghman, Curvers, Palmans, & Peeters, 2007). Voorts is 54% vrouwelijk en 46% mannelijk. Vrouwen zijn, in vergelijking met de totale bevolking, sterker vertegenwoordigt in de bevolking van gepensioneerden. Volgens de laatste publicatie van de authoritative Centers for Disease Control and Prevention and the Merck Company foundation, is de groei in het aantal en het aandeel oudere volwassenen ongekend in de geschiedenis van de Verenigde Staten en Europa en de bevolking van mensen op de leeftijd van 65 zal tijdens de volgende 25 jaar nog verdubbelen (Armstrong, Conn, & Pinner, 1999).

Voorts gaat deze vergrijzing van de bevolking hand in hand met een verminderen van het aandeel jonge mensen ten gevolge van een lager geboortencijfer. Dus, op grote schaal, staan minder jonge mensen in voor een groeiende groep bejaarden. Dit is één van de redenen waarom bejaardentehuizen aan belang winnen als plaatsen waar de bejaarden hun leven

'uitleven' in onze moderne westelijke maatschappij (Bickel, 1998; Streckeisen, 2001). De meerderheid van deze oude mensen sterft momenteel in instellingen eerder dan thuis. Aangezien het blijkt dat palliatieve zorg in verpleeghuizen kwaliteit mist (Maddocks & Parker, 2001), is er een toenemende discussie rond het introduceren van zorgprincipes in verpleeghuizen. Hierdoor wil men de zorg in deze instellingen te verbeteren (Hockley & Clark, 2002; Heimerl, Heller & Kittelberger, 2005). Patiënten in verpleeghuizen vertegenwoordigen een bijzonder kwetsbare groep. Wegens hulpbehoevendheid, plaatsen ze hun waardigheid in de handen van de zorginstelling (Pleschberger, 2007). Er is een vraag naar benaderingen die benadrukken dat mensen `als individuen, van belang zijn voor wie zij en niet zijn wat zij kunnen'. Dus, om kwaliteitsvolle zorg op het einde van het leven te verwezenlijken, zijn de meningen van degene die deze zorg ontvangen van uiterst belang (Kleine & Rhodos, 2003; Heimerl, 2000). Vermits oude mensen zelden deelnemen aan zorgonderzoek, bestaat het gevaar dat ze worden uitgesloten bij het kiezen van de plaats en het type zorg die zij tijdens het sterven ontvangen. Deze tendensen zijn bijzonder duidelijk onder de zeer oude mensen. Door mogelijke verschillen in houding tegenover de dood te onderzoeken tussen ouderen die in instellingen (verpleeghuizen) leven en thuis, hopen we ik bij te dragen tot het begrijpen van mensen die in de eindeperiode van hun leven zijn en wat goede zorg juist inhoudt.

In het tweede hoofdstuk trachten we de lezer een begrip mee te geven van dood en houdingen tegenover de dood door verschillend gebruik van de term dood voor te stellen en de geschiedenis van houdingen tegenover de dood te presenteren tot aan de verwezenlijking van het model van Wong, Reker, en Gesser (1994), dat in deze studie wordt gebruikt. De sterkte van dit model is dat het de multidimensionaliteit van houdingen tegenover de dood in rekening brengt door ook positieve houdingen ten opzichte van dood op te nemen. Aangezien de constellatie van verschillende doodshoudingen individuele verschillen beter vat dan beter één enkele houding, biedt dit model een nuttig kader aan om verschillen in hoe bejaarden thuis en in een instelling de dood benaderen, te achterhalen.

In hoofdstuk drie, gaan we dieper in op dit multidimensionele model van Wong et al. (1994) De verschillende houdingen tegenover de dood worden besproken, alsook hun onderlinge relatie en correlaten. De resultaten van de paar, oude onderzoeken die verblijfplaats als variabele opnemen zijn inconsistent. Aan het eind van dit hoofdstuk, wordt een reden gegeven voor de associatie tussen vrees voor dood en doodsgoedkeuring vanuit een existentiëel perspectief.

In hoofdstuk vier presenteren we de methodologie van deze studie. Vervolgens

worden in hoofdstuk vijf de resultaten van de analyse van de gegevens van deze studie voorgesteld. Eerst, werd een effect van woonplaats onderzocht voor alle vijf dimensies van de *Death Attitude Profile-Revised* (DAP-R). Teneinde dit effect te interpreteren, werden de demografische variabelen, de sociale netwerkenvariabelen, en de levenstevredenheid onderzocht volgens de voorgestelde stappen van mediator-analyse. In het laatste hoofdstuk, worden de resultaten besproken en de conclusies naar voren gebracht.

CHAPTER 2

DEATH ATTITUDES: CONCEPT AND HISTORY

As stated in the general introduction, this first chapter intends to provide the reader with notions of death and death attitudes. First we will present different usages of the word death. Second, we will sketch the history of death attitudes to the creation of the model of Wong et al. (1994). By including several positive attitudes toward death besides negative ones, this model offers a useful framework to examine differences in how people in a senior residence and at home approach death.

Death Definitions

The word *death* is used in at least three primary ways (Kastenbaum, 2006). The three primary usages are: death as an event; death as a condition; and death as a state of existence or nonexistence. In the first usage, death as an event, death is something that happens. It occurs at a particular time and place and in a particular way. In this sense of the term, death is a phenomenon that stays within the bounds of mainstream conception and observation. Time, place, and cause can be recorded on a death certificate. This usage does not concern itself with mysteries or explanations: death is an event that cuts off a life. The second usage, namely death as a condition, refers to the crucial area in biomedical and bioethical controversy. Death is the nonreversible condition in which an organism is incapable of carrying out the vital functions of life. It is related to, but not identical with death as an event because the focus here is on the specific signs that establish the termination of life. These signs or determinants are often obvious to all observers. Sometimes, though, even experts can disagree. In the last sense, death as a state of existence or nonexistence, it can almost be said that death is what becomes of a person after death. It refers not to the event that ends life nor the condition of the body at that time, but rather to whatever form of existence might be thought to prevail when a temporal life has come to its end. The context indicates the intended meaning in some instances, but it is not unusual for ambiguity or a shift in meanings to occur in the midst of a discussion. People fail to understand each other unless the specific usage of *death* is shared. The questionnaire that measures death attitudes in this study, refers to the first and the third meaning of death, in the sense that attitudes toward death are grounded in the knowledge that death ends life and the beliefs that people have about what happens after they die, the latter consistent with the cognitive component of an attitude, as we shall discuss in the next section.

History of Attitudes toward Death

Attitudes toward death became a topic in the late 1950s with Feifel's research on geriatric and mentally ill populations, although a handful of pioneering studies appeared before that time. By the mid-1960s, the volume of reports began to increase, coincident with the rising popular interest in the topic of death. However, a "publication explosion" in the literature did not occur until the mid-1970s, ushered in by the development of the first widely available instruments designed specifically for the direct assessment of death fear, threat and anxiety. At the high point of interest in the late 1970s, several review articles appeared to integrate, criticize and give direction to the burgeoning literature. The result was an improvement in the scientific quality of the literature in the field, yielding a growing body of findings. The dominant theme in these empirical studies has been death anxiety (Marchall, 1981).

Johnstone and Reid (1981) stated that there are perhaps too many definitions of an attitude. Allport (1935, p. 820) gave a definition which combines many early ideas when he talked about 'a mental and neural state of readiness to respond, organized through experience, putting forth a directive and/or dynamic influence on behavior'. His definition has stood the test of time and influenced many future thinkers and researchers. Later, in 1958, Rhine referred to an attitude as a concept with an evaluative dimension and this drew attention to an important insight. These contributions have stressed that attitudes involve more than the cognitive and, in particular, the evaluative dimension proposed by Rhine has assumed greater importance in later work. A person may know, may have feelings or may experience. However, it is possible that these may lead to evaluation and subsequent decisions. Many (Bagozzi & Burnkrant, 1979; McGuire, 1985) have noted that attitudes have three components: (1) a cognitive component which refers to knowledge about the object, the beliefs, and ideas; (2) an affective component, meaning a feeling about the object, like or dislike; and (3) a behaviourial component, implying a tendency-towards-action the object component. Overall, it has been established that attitudes tend to be consistent and stable with time. Nonetheless, despite this stability, they are open to some change and development, although deeply held attitudes are highly internalized and are resistant to modification. The investigation of Shiappa, Gregg, and Hewes (2004) showed significant differences on all five death attitude dimensions measured by the Death Attitude Profile–Revised (DAP-R) (Wong et al., 1994) after exposure to 10 episodes of the television series *Six Feet Under*, suggesting that our attitudes about death and dying are influenced by experiences we may have. We could

assume that our attitudes toward death change with growing older and seeing more friends and family members die.

Although the main focus of the literature has been on negative attitudes toward death, some investigators also examined positive attitudes. Most notably, Wong et al. (1994) gave attention to the multidimensionality of death attitudes as they distinguished two negative attitudes toward death, death avoidance and fear of death, as well introduced a three-component model of death acceptance, based on a conceptual analysis. The reason for the distinction between the two negative attitudes, is that the authors discovered in their study that some people would rather avoid the topic about death. They suggested that a difference should be made between fear of death, in which a person confronts death and the feelings it evokes and death avoidance, in which a person avoids thinking or talking about death in order to reduce death anxiety. This consideration led them to include a seven-item death avoidance subscale in their instrument to measure death attitudes, the DAP-R, which was also used to assess death attitudes in this study. Regarding the positive attitudes, the *Raj and Najman Death Acceptance Scale* (1974) has long been one of the few published death acceptance measures. Whereas death acceptance is treated unidimensionally by these authors and defined as feeling positive about death, Wong et al. (1994) considered the multidimensionality of death acceptance, as they identified three different types of death acceptance: neutral acceptance, approach acceptance and escape acceptance. Neutral acceptance is an attitude that regards death as an integral part of life. Death is neither feared nor welcomed. One simply accepts it as one of the unchangeable facts of life. Escape acceptance results from living conditions that are felt unbearable by the individual such that death seems an attractive alternative to it. Approach acceptance implies the belief in a happy afterlife. The positively perspective associated with it leads to a positive outlook on death. So the DAP-R consists of five dimensions that represent attitudes toward death.

When we use the word death, it should be clear which meaning we subscribe to it. Because death attitudes are grounded in the knowledge that death ends life and the beliefs that people have about what happens after they die, we could state that this study refers to these two usages of the word death. Research concerning death attitudes mainly focused on fear of death or death anxiety. Therefore, the model of Wong et al. (1994) which contains two negative attitudes as well as three acceptance attitudes toward death, offers a welcome approach. Since this multidimensional model is used throughout this study, the different

attitudes toward death are presented in more detail in chapter two, as well as their interrelation and correlates.

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CHAPTER 3

NEGATIVE AND POSITIVE DEATH ATTITUDES: INTERRELATION AND CORRELATES

In this chapter, we will present the multidimensional model of Wong et al. (1994) in more depth. The different attitudes are discussed, along with their interrelation and correlates. Regarding place of living, which is the most important variable of this study, previous research is scare and old. To our best knowledge, the meta-analysis of Fortner and Neimeyer (1999) offers the most recent and clear results about place of living, although this study is based on death anxiety. At the end of this chapter, a rationale for the association between fear of death and death acceptance is given from an existential view. This rationale forms the basis for including social network variables and life-satisfaction in this study.

Multidimensional Model of Death Attitudes by Wong and Colleagues

Three Component Model of Acceptance

Approach acceptance. The importance of approach acceptance was emphasized by Wong (2000) who related approach acceptance to positive meanings of life and described it "as an optimal way to approach death" (p.31). It is also the first factor to emerge in factor analyses of the DAP-R (Wong et al., 1994; Clements & Rooda, 2004). Kübler-Ross (1969) considered acceptance as the last stage of dying, as she worked with terminal ill patients in the hospital context. From the testimonies of these patients the author proposed the existence of five stages of psychological confrontation by persons to their own deaths: negation, anger, negotiation, depression, and at last acceptance. For her, this last stage was the acknowledgment to the inevitability of death. As Wong and colleagues (1994) state in their investigation, because her conception of acceptance was preliminary based on observation of the dying process of terminally ill patients, it is likely that those who have already come to terms with death prior to the diagnosis of terminal illness may bypass the stages of dying as described by Kübler-Ross.

The Three-Component Model of death acceptance of Wong and colleagues (1994). shares some common features with the approach of Klug and Sinha (1987-1988). These investigators differentiated between cognitive and affective death attitudes. In the view of Klug and Shinha, death acceptance is the conscious rational acknowledgement of the prospect of one's own inevitable death (confrontation with death, cognitive component) and at the same time the positive emotional appraisal of this realization (integration of death, affective

component). It must be stated that both models, Wong et al.'s Three-Component Model and Klug and Sinha's Two-Component Model, are not fully comprehensive. They both focus on the prospect of death (i.e. being death one day) only, but not on the dying process. Wittkowski's (2001) Multidimensional Orientation Toward Death and Death Inventory (MODDI-F) on the other hand, is based on a conception of acceptance that can refer to both the dying process and to death. In this view, acceptance delineates the tendency to regard the dying process on one hand and the prospect of (one's own) death (i.e. the loss of the world) on the other as natural parts of life, incorporating mortality into an overarching context of meaning (e.g. religious belief, justice). This conception of 'agreement' with death is similar to Wong et al.'s component of neutral acceptance. Also this model is therefore not fully comprehensive, because it focuses only on one attitude. Because this study follows the model of Wong et al. (1994), the focus is on the prospect of death and not on the process of dying.

As stated above, approach acceptance implies the belief in a happy afterlife. Thalbourne's research (1996) yielded that the pure desire or wish for there to be an afterlife is the most important process for belief in a life after death. In other words, an afterlife seems to be desirable. A relation has been found between belief in an afterlife and fear of death. For example, Osarchuk and Tatz (1973) induced fear of death in their subjects and observed an increase in belief in life after death. They concluded that one function of belief in an afterlife "might be to help the individual to deal with anxiety over death" (p.256). Thalbourne (1996) found a negative correlation between death anxiety and believers, as measured by the 7-item Death Acceptance Scale of Ray and Najman. This latter founding is consistent with the view that such belief lowers anxiety about death. Also Ray and Najman (1974) found that death acceptance is higher in subjects who have lower death anxiety. Since the development of other approach acceptance measures than the scale of Ray and Najman, there has been found an association between death acceptance and fear of death. More specifically, most studies found a negative correlation between approach acceptance and fear of death (Clements & Rooda, 2004; Klug & Boss, 1977; Klug, 1997; Rasmussen & Johnson, 1994; Ray & Najman, 1974; Thorson, 1991; Tomer & Eliason, 2000; Vandencreek, Franskowski, & Ayres, 1994; Wittkowski, 1996; Wong et al., 1994).

Regarding the main independent variable in this study, place of residence, findings of conducted studies are inconsistent. Whereas Swenson (1961) reports that persons residing in homes for the aged hold a more positive and accepting attitude toward death than those living in their own homes, Shrut (1958) concluded that those living under conditions approximating

a previous residence, i.e., in apartments, showed significantly less fear and preoccupation with death than those residing in the traditional facility. Kimsey, Roberts, Logan, Logsdon, and Holcomb (1970) report that neither institutionalized nor non-institutionalized aged report an accentuated fear of death or dying. Also Myska and Pasewark (1978) found no differences between institutionalized and non-institutionalized samples in anxiety toward death. In their meta-analysis of all published research on the population of older adults, Fortner and Neimeyer (1999) found that place of residence predicted death concerns: those living in institutions (e.g. nursing homes) were generally more fearful of death than those living independently. Therefore, it was predicted in this study that people living in an institution have less death acceptance than people living independently.

Regarding demographic variables, Keller, Sherry and Piotrowski (1984) found that older persons had more belief in the hereafter and that women expressed a significantly greater belief in the life hereafter than males. The attitude fear of death is proven to be lower among elderly (Bengston, Cuellar, & Ragan, 1977; De Vries, 1993; Gesser, Wong, & Reker, 1987-88; Kalish, 1976; Neimeyer, 1985; Robinson & Wood, 1984; Stevens, Cooper, & Thomas, 1980; Thorson & Powell, 1990; Wass, 1977) suggesting, consistent with the first finding of Keller and colleagues, that older persons have more death acceptance. Regarding the second finding of Keller and colleagues, other studies also show that women tend to have more belief in a afterlife (Klenow & Bolin, 1989). Wong et al. (1994) found in their study that women have more death acceptance. This finding seems somewhat contradictory with the finding that women tend to have more death anxiety (Immarino, 1975; Lonetto, Mercer, Fleming, Bunting & Clare, 1980, McMordie, 1978; Neimeyer, Bagley & Moore, 1986; Pollack, 1979; Wass & Meyers, 1982; Wong et al., 1994), but following Osarchuk and Tatz (1973), a belief in an afterlife could be seen as a defense mechanism against death anxiety. On the basis of these findings we expected age and gender to have an influence on the attitude death acceptance in this study.

Neutral acceptance. Feifel (1955) and Shneidman (1966) proposed a type of death acceptance that is labeled "Neutral Acceptance" by Gesser and colleagues (1987-88) when constructing the original Death Attitude Profile questionnaire (DAP). Some of Feifel's hospitalized patients, and Shneidman's "Psyde-Acceptors", accepted the inevitability of death: they neither looked forward to nor fear its occurrence. According to Wong et al. (1994) this attitude contains a view that death is an integral part of life. To be alive is to live with

death and dying (Armstrong, 1987; Kübler-Ross, 1981; Saunders & Baines, 1983; Morison, 1971). One neither fears death nor welcomes it, one simply accepts it as one of the unchangeable facts of life and tries to make the best of a finite life. Therefore, it implies an ambivalent or indifferent attitude, similar to that measured by the indifference Toward Death subscale of Hooper and Spilka's (1970) Death Perspective Scale (DPS). That this attitude does not imply a demotivation toward life is supported by the findings of Gesser et al. (1987-88) who reported that neutral acceptance was unrelated to hopelessness, but positively related to happiness. A basic tenet of humanistic or existential psychology is that self-actualization is possible only when the individual has come to terms with the fact of personal mortality (Bugental, 1965, Feifel, 1990; Maslow, 1968; May, Angel, Ellenberger, 1985). Therefore, an actualized person is not threatened by personal death. Frankl (1965) also believed that finding a meaning in life removes an individual's fear of death and increases his or her well-being. Alexander and Adlerstein (1959) reported that non-religious subjects who see death as the natural end of life may be plunge themselves into the rewards of living. Bregman (1989) remarked that if death is natural, as Kübler-Ross insisted that it is, then acceptance of death is a moral good, and denial is a violation of this good. This ethical naturalism is independent of particular beliefs in the afterlife.

Regarding age, several authors found a significant effect on neutral acceptance (Gesser et al., 1987; Wong et al., 1994). Older persons are more accepting of death as a reality compared with the young, but not middle-aged adults (Wong et al., 1994). No effect of gender has been found on this dimension (Wong et al., 1994). Neutral acceptance was also linked to other attitudes toward death. Studies using the DAP-R found a significant negative correlation between neutral acceptance and fear of death (Clements & Rooda, 2000, Wong et al., 1994) and death avoidance (Clements & Rooda, 2004). A positive correlation has been found with approach acceptance by Clements and Rooda (2004), and a zero correlation by Wong et al. (1994). Although no studies have been done concerning place of residence and a neutral attitude toward death, it was predicted that people living in an nursing homes have less neutral acceptance on the basis of two findings. Namely, Fortner and Neimeyer (1999) found in their meta-analysis that those living in institutions generate more fear of death than those living independently and there has been found a negative correlation of fear of death and neutral acceptance (Clements & Rooda, 2004, Wong et al., 1994). Concerning demographic variables, it was expected in this study that older persons should have more neutral acceptance and gender does not have an effect.

Escape acceptance. It was Shneidman who suggested another type of death acceptance (1966). "Psyde-Welcomers" welcome the end of life, and view death as an escape from pain and suffering. Also in Feifel's study (1956), 10% of the White male American veterans of World War II, saw death as a release of pain. Again, Gesser et al. (1987-88), renamed this attitude in their original study 'Escape-Oriented Death'. Vernon (1972) suggested that the fear of living under certain conditions may be stronger than the fear of death. When people are overwhelmed by suffering and pain, and there is little likelihood of relief, death seems to offer the only escape. Therefore, in escape acceptance the positive attitude toward death is based on the inherent "goodness" of death, but on the "badness" of living (Wong et al., 1994). Typically, people exhibit escape acceptance because they cannot longer effectively cope with the pain and problems of existence. In the original study of Gesser et al. (1987) this attitude was correlated with hopelessness. So, in contrast with neutral acceptance, this attitude does imply a negative view of life.

Wong and colleagues (1994) found a significant effect of age on the dimension escape acceptance. Older persons were significantly more likely to accept death as an escape of life than were both the middle-aged and the younger adults. According Wong et al. (1994), this finding is consistent with the notion that elderly individuals are willing to be freed from the infirmities of the body. They found indeed that escape acceptance was associated with reducing physical well-being, although this association was the strongest for young adults. Furthermore they suggest that decreased opportunities for engaging in meaningful activities and increased isolation may also contribute to the increase in escape acceptance with advancing age. Regarding gender, women were significantly more accepting of death as an escape than were men (Wong et al.., 1994). Reker and Wong (1984) found in their study of community and institutionalized elderly an inverse relationship between death acceptance (measured by a sub-scale of the Reker and Peacock Life Attitude Profile) and psychological well-being. Studies using the DAP-R have found a significant negative correlation of escape acceptance with fear of death and a positive correlation with approach acceptance (Clements & Rooda, 2004; Wong et al., 1994). Again, for this dimension no studies have been conducted with place of residence. So, for escape acceptance this study used the same rationale as for approach and neutral acceptance. Namely, Fortner and Neimeyer (1999) found in their meta-analysis that those living in institutions generate more fear of death than those living independently and a negative correlation has been found with fear of death (Clements &

Rooda, 2004; Wong et al., 1994). Therefore, it was predicted that people living in institutions score lower on escape acceptance than those living independently.

Negative Attitudes Toward Death

Fear of death. The dominant theme in empirical studies about death and dying has been death anxiety. To gain further insight in this attitude, we will first distinguish fear of death from death anxiety and then turn to a short overview of theories of this topic. In this short overview it becomes clear that this study follows life-span researchers who share the conception of fear of death as a state and not a trait.

The terms fear of death and death anxiety are used interchangeably in the literature, but it may be helpful to distinguish between the two terms. In general, a fear may be realistic or exaggerated but it can be specified or articulated. By contrast, anxiety is a generalized state of being. Anxiety is fatiguing because one cannot readily locate the threat. Accordingly, one could regard fear of death as specific and consciousness and death anxiety as more generalized and perhaps inaccessible of awareness. When using indirect techniques to measure death anxiety, one needs to be cautious in accepting at face value the degree of fear of death verbalized at the consciousness level (Feifel & Branscomb, 1973).

Two influential theories dominated thinking about death anxiety and fear until the late twentieth century. Sigmund Freud had the first say. The founder of psychoanalysis recognized that people sometimes do express fears of death. Nevertheless, thanatophobia, as he called it, is merely a masquerade for a deeper source of concern. Or in other words, these expressions of death are somewhat superficial because they only hint at what really troubles the person. According to Freud (1953), it is not death that people feared because: "Our own death is indeed quite unimaginable, and whenever we make the attempt to imagine it we . . . really survive as spectators. . . At bottom nobody believes in his own death, or to put the same thing in a different way, in the unconscious every one of us is convinced of his own immortality." (p. 304–305). The unconscious does not deal with the passage of time nor with negations. Furthermore, whatever one fears cannot be death because one has never died. People who express death-related fears, then, actually are trying to deal with unresolved childhood conflicts that they cannot bring themselves to acknowledge and discuss openly. So, Freud traced death fears to unresolved psychological conflicts whose roots are often to be found in

infancy and childhood.

Freud's reduction of death concern to a neurotic cover-up did not receive a strong challenge until Ernest Becker's 1973 book, *The Denial of Death*. In explaining his existential view, Becker argues that death anxiety is the most basic driving force for the individual and the society. Not only is death anxiety real, but it is people's most profound source of concern. This anxiety is so intense that it generates many if not all of the specific fears and phobias people experience in everyday life. Aware of our mortality, we must find a way to keep this awareness from coming too painful, too terrible. For this reason, according to Becker, much of people's daily behavior consists of attempts to deny death and thereby keep their basic anxiety under control. Becker also suggested that this is where society plays its role. He believes that no function of society is more crucial than its strengthening of individual defenses against death anxiety. According to Becker, the denial of death has become a popular and wide-spread characteristic of modern society. His analysis of society convinced him that many beliefs and practices are in the service of death denial, that is, reducing the experience of anxiety. Funeral homes with their flowers and homilies, 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. According to Becker, psychiatric disorders like depression and schizophrenia are possible consequences of the breakdown of death-denial when an individual comes face-to-face whit the reality of personal death. While Freud would seek the “real reasons” for manifest death anxiety, Becker would look for the ways in which death anxiety and its denial underlies many individual and sociocultural phenomena. His work, like that of Weisman (1972), calls valuable attention to the many ways in which we try to avoid acknowledging our own mortality. There are, however, two important similarities between these contrasting views: (1) both do suggest that we cannot become complete and mature adults unless we live with the full realization of our mortality, and (2) neither have been firmly supported by empirical research (Kastenbaum, 2000).

Other approaches to understanding death anxiety and fear were introduced in the late twentieth century. Terror Management Theory (TMT) as developed by Pyszczynski, Greenberg, and Solomon (1999) states that during evolution, cognitive abilities emerged that enabled people to understand our own mortality. This awareness was accompanied with terror and the need to manage this terror. So, in order to cope with this terror our ancestors developed a solution to the problem of death in the form of a dual-component cultural anxiety

buffer. This buffer consists of a cultural worldview and self-esteem. The cultural worldview can be described as a symbolic conception of reality that provides life order, permanence, and stability. It is a set of standards through which people can attain a sense of personal value; and some hope of either literally or symbolically transcending death. The self-esteem is obtained by believing that one is living up to the standards of value inherent in one's cultural worldview. Research based upon the TMT is based on two basic hypotheses and their consequences. The anxiety-buffer hypothesis states that, to the extent that self-esteem provides protection against anxiety, then strengthening self-esteem should make one less prone to anxiety and anxiety-related behavior, and weakening it should make one more prone to anxiety and anxiety-related behavior. The mortality salience (MS) hypothesis states that to the extent that a psychological structure provides protection against anxiety, then reminding people of the source of their anxiety should lead to an increased need for that structure and thus more positive reactions to things that support it and more negative reactions to things that threaten it. The results of studies testing the anxiety-buffer and MS hypotheses provide strong support for the TMT proposition that self-esteem and faith in the cultural worldview function, at least in part, provide protection from deeply rooted fears of death and vulnerability. However, neither the original formulation of TMT nor the results of these studies explain the cognitive processes through which thoughts of death produce such broad-ranging effects on human thought and behavior.

Another recent approach, regret theory, was proposed in 1996 by Adrian Tomer and Grafton Eliason. Regret theory focuses 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 cannot accomplish something good in life. People might torment themselves with regrets over past failures and missed opportunities or with thoughts of future accomplishments and experiences that will not be possible. Regret theory also has implications for anxiety reduction. People can reconsider their memories and expectations, for example, and also discover how to live more fully in the present moment. Tomer and Eliason recently (2005) expanded their model incorporating positive attitudes toward death into their model. The generalization of the model to approach acceptance was only partial successful.

Robert Kastenbaum (2000) suggests that people might not need a special theory for death anxiety and fear. Instead, they can make use of mainstream research in the field of life span development. Anxiety may have roots in people's physical being, but it is through personal experiences and social encounters that they learn what might harm them and,

therefore, what they should fear. These fears also bear the marks of sociohistorical circumstances. For example, fear of the dead was salient in many preliterate societies throughout the world, while fear of being buried alive became widespread in nineteenth-century Europe and America. In modern times many people express the somewhat related fear of being sustained in a persistent vegetative state between life and death. Death-related fears, then, develop within particular social contexts and particular individual experiences. People do not have to rely upon the untested and perhaps untestable opposing views of Freud and Becker—that they are either incapable of experiencing death anxiety, or that death anxiety is the source of all fears. It is more useful to observe how their fears as well as their joys and enthusiasms are influenced by the interaction between cognitive development and social learning experiences. In this way people will be in a better position to help the next generation learn to identify actual threats to their lives while not overreacting to all possible alarms all the time.

Kastenbaum's suggestion that fear develops through personal encounters and social experiences can be linked to research that tried to identify whether death anxiety is a "state" that reflects the press of physical or environmental conditions or a "trait" that represents a relatively enduring early learned fear (Pettigrew & Dawson, 1979). If death anxiety is a state phenomenon, it should fluctuate with consciousness-of-mortality enhancing experiences and experimental manipulations. Studies regarding this issue show different results depending on the kind of measure that was used for death anxiety. Indirect measures (projective and/or unobtrusive) have related death anxiety to old age and nearness to death, whereas direct measures fail to find more death anxiety in groups characterized by old age (Feifel & Branscomb, 1973). The findings of Pettigrew and Dawson (1979) suggest that death anxiety may represent a trait rather than state phenomenon, because both indirect and direct measures of death anxiety did not increase by experimental manipulation of the realization that death is inevitable. While research showing gender differences in fear of death can be explained on the basis of a trait-view, developmental research showing age differences in death attitudes suggests that fear of death fluctuates with life stages. Life span psychologists (Kastenbaum, 1979; Levinson, 1977; Neugarten, 1968) have postulated that different age groups vary in their attitudes toward death. Although some early studies found no significant correlation between age and death anxiety scores (Erlemeier, 1978; Lester, 1967; Pollack, 1979; Templer, 1971; Wittowski, 1978), later studies that have compared death attitudes of the elderly with those of other age groups have shown, with fair consistency, that the elderly think and talk

more about death, although death appears less frightening for them (Bengston, Cuellar, & Ragan, 1977; Kalish, 1976; Wass, 1977). This finding has generally been confirmed by more fine-grained research using many of the stronger death attitude measures with diverse samples (De Vries, 1993; Gesser et al., 1987-88; Neimeyer, 1985; Robinson & Wood, 1984; Stevens, Cooper, & Thomas, 1980; Thorson & Powell, 1989). Fear of death is greater in adolescence and young adults fear death whereas older adults worry more about the circumstances of their death (Kalish, 1976; Kastenbaum, 2000; Iammarino, 1975). Accordingly, Fry's study (1990) showed that a common theme in homebound elderly person's fear and concerns about death is the idea of dying alone. Wagner and Lorion (1984) found that death anxiety response patterns are a function of the population examined, namely whether people lived in an institution of at home. Again, the most important finding regarding place of residence stems from the meta-analysis of Fortner and Neimeyer (1999) that yielded more fear of death in people living in institutions compared with people who live independently. Therefore, it was predicted that people living in an institution are more fearful than people living at home. Regarding gender, the majority of research shows that women report more death fear than do men (Immarino, 1975; Lonetto et al., 1980, McMordie, 1978; Neimeyer et al., 1986; Pollack, 1979; Wass & Meyers, 1982; Wong et al., 1994). In fact, this difference has been found in other cultures (Lonetto et al., 1980; McMordie & Kumar, 1984). It must be noted however, that in the recent study of Fortner, Neimeyer, and Rybarczyk (2000), gender and age were unrelated to death concern within the group of older adults, suggesting that these demographic factors wane in importance as markers of death anxieties near the end of life.

Regarding other correlates of death anxiety in the elderly, Swenson (1961) reported that education and marital status were significantly related to death anxiety. Wagner and Lorion (1984) found that people who were still married showed significantly more death anxiety as people who were widowed, suggesting that the prospect of leaving a spouse behind after death creates anxiety for married persons. Although some studies found no direct relationship between levels of physical well-being and death threat or anxiety (Baum, 1983; Baum & Boxley, 1984; Robinson & Wood, 1984. Templer, 1971; Wagner & Lorion, 1984), others point to higher levels of death concern among the infirm elderly (Fortner & Neimeyer, 1999; Tate, 1982) or suggest that better health is associated with less fear of death (Christ, 1961). On the basis of this literature, it was expected that age, gender, education, marital status and health status have an influence on fear of death. More specifically it was expected that women, married people, and older individuals with less health, show more fear of death.

Death avoidance. As explained above, Wong et al. (1994) suggested that a distinction should be made between fear of death and death avoidance, in which a person avoids thinking or talking about death in order to reduce death anxiety. While Sigmund Freud first described 'defense mechanisms' for the ego's struggles against unendurable realities (Freud, 1953) and Anna Freud later delineated these defenses in her book *The Ego and the Mechanism of Defense* (1967). For Freud, however, it was not death but sexuality that constituted the basic repression and it was not until the late 1960s and 70s that a 'great deal of collective bustle' arose over death and its denial in the modern industrialized world (Lofland, 1978). Death avoidance or death denial was also defined as an individual coping mechanism by Zimmerman. She stated that death denial can be perceived as standing in the way of several components of palliative care (Zimmerman, 2007).

In one study death avoidance has been found to correlate negatively with neutral acceptance (Clements & Rooda, 2004), while in another study a zero-correlation has been found (Wong et al., 1994). Like Wong et al. (1994), Clements and Rooda (2004) found no correlation between death avoidance and two types of death acceptance, escape acceptance and approach acceptance. Most important is that in both studies, death avoidance correlated positively with fear of death (Clements & Rooda, 2004; Wong et al., 1994). Regarding other variables, Wong et al. (1994) found a significant effect of gender on death avoidance. Men tend to avoid death more than women. In the same study, no effect of age was found. Furthermore death avoidance was associated with psychological distress, only for the middle-aged and the older adults. For older adults, death avoidance was also related to depression. For the authors, this finding is evidence for the view of death denial as a defense mechanism. Death avoidance suppresses thoughts and feelings about death that exist in the unconsciousness, but nonetheless has an effect on behavior, creating psychological discomfort. On the basis of these findings, it was expected in this study that gender has an effect on death avoidance, while age does not. Concerning place of living, it was expected that people living in an institution exhibit more death avoidance than people living at home, because of the found association between death avoidance and fear of death (Clements & Rooda, 2004; Wong et al., 1994) and the finding of Fortner and Neimeyer (1999) that fear of death is more salient among residents than independent people.

Relation Approach Acceptance – Fear of Death: an Existential View

Following Ray and Najman (1974), Wong et al. (1994) stressed that fear of death and death acceptance should not be considered as two different poles of one dimension, although these two dimensions are intimately related, based on an existential view of death attitudes. This existential perspective posits that individuals are motivated to pursue personal meaning (Frankl, 1965; Reker, Peacock, & Wong, 1987; Reker & Wong, 1988; Wong, 1989) and is consistent with Erikson's psychosocial theory (1982) that individuals in their last stage of development come to terms with death by resolving the crisis of integrity versus despair. In the following paragraph, we will discuss the theory of Erikson.

Development, according to Erikson (1982), functions by the epigenetic principle. This principle comprises that we develop through a predetermined unfolding of our personalities in eight stages. Our progress through each stage is in part determined by our success, or lack of success, of psychosocial developmental tasks in all the previous stages. The tasks belong to a certain stage and thus, are appropriate for a certain age and time during the life course. Or put differently: each stage has a certain optimal time. Although he follows Freudian tradition by calling the stages crises, they are more drawn out and less specific than that term implies. Each of Erikson's stages of psychosocial development are marked by a conflict, for which successful resolution will result in a favorable outcome, for example trust vs. mistrust, and by an important event that this conflict resolves itself around, for example meaning of one's life. Favorable outcomes of each stage are sometimes known as "virtues", a term used, in the context of Eriksonian work, as it is applied to medicines, meaning "potencies". Erikson's research suggests that each individual must learn how to hold both extremes of each specific life-stage challenge in tension with one another, not rejecting one end of the tension or the other. Only when both extremes in a life-stage challenge are understood and accepted as both required and useful, can the optimal virtue for that stage surface. Thus, 'integrity' and 'despair' must both be understood and embraced, in order for actionable 'wisdom' to emerge as a viable solution at the last stage. The Erikson life-stage virtues, in the order of the stages in which they may be acquired, are:

1. hope- Basic Trust vs. Mistrust
2. will- Autonomy vs. Shame and Doubt
3. purpose- Initiative vs. Guilt
4. competence- Industry vs. Inferiority

5. fidelity- Identity vs. Role Confusion
6. love (in intimate relationships, work and family)- Intimacy vs. Isolation
7. caring- Generativity vs. Stagnation
8. wisdom- Ego Integrity vs. Despair

The last stage, referred to as late adulthood or maturity, contains the task to develop ego integrity with a minimal amount of despair. This stage, especially from the perspective of youth, seems like the most difficult of all. It is characterized by a detachment from society, as people retire and no longer are needed as a parent, and a biological diminishing. Aware of this new fragility, there come fears about things that one was never afraid of before - the flu, for example, or just falling down. Along with the illnesses and watching friends and family die, come thoughts of one's own death. They may fear death as they struggle to find a purpose to their lives, wondering "Was the trip worth it?". A feeling of despair is accompanied with a preoccupation of the failures and the bad decisions they made in the past, and regret that (unlike some in the previous stage) they really don't have the time or energy to reverse them. Ego integrity means coming to terms with your life, and thereby coming to terms with the end of life. If you are able to look back and accept the course of events, the choices made, your life as you lived it, as being necessary, you don't need to fear death. Integrity is a state of mind: the conviction that life has been worthwhile and meaningful and the reconciliation of the discrepancy between reality and ideal. The maladaptive tendency in this last stage is called presumption. This is what happens when a person "presumes" ego integrity without actually facing the difficulties of old age. The malignant tendency is called disdain, by which Erikson means a contempt of life, one's own or anyone's. Someone who approaches death without fear has the strength Erikson calls wisdom. He states that if elders have integrity enough not to fear death, their children will not fear life. Therefore, Erikson calls integrity a gift to children. Butler (1963, 1975) promoted a similar view. He proposed that people are more afraid of a meaningless existence than of death. Individuals who see their life as fulfilling and meaningful should show less death anxiety and more death acceptance (Lewis & Butler, 1974). For example, Georgemiller and Malony (1984) reported that life review participants showed a decrease in death denial compared with the alternative-activity control group. Flint, Gayton, and Ozmon (1983) found a significant relationship between subjective satisfaction with one's past life and death acceptance. More recently, Wong and Watt (1991) reported that seniors who revealed integrity in their reminiscence were more likely to be healthier and

happier than those who did not. Referring to the relationship between acceptance of death and intrinsic religiosity (which aims to reflect the centrality of faith to one's life) Klug (1997) reported a low and Wittkowski (1990) a moderate positive correlation. The majority of research suggest that more genuine religious commitment ameliorates conscious fear of death (Bivens, Neimeyer, Kirchberg, & Moore, 1994; Rigdon & Epting, 1985; Thorson & Powell, 1990; Suhail & Akram, 2002), perhaps by giving meaning to one afterlife (Neimeyer, Wittkowski, & Moser, 2004). So, an attitude of acceptance toward death seems to be associated with more life satisfaction and a stronger religious belief. A number of investigators also found a relationship between death anxiety and lack of meaning in life. Durlack (1972) reported that subjects who had a purpose and meaning in their lives tended also to have less fear of death and more positive and accepting attitudes toward death. Quinn and Renikoff (1985) found that subjects who lacked a sense of purpose and direction in their lives reported high levels of death anxiety. In sum, there is sufficient evidence supporting the existential view that whether one fears or accepts death depends on whether one has found meaning in life and achieved integrity. So, following Feifel (1990), it is more likely that fear and acceptance coexist in an uneasy truce. Although people accept the inevitability of their own mortality, they can still be not at ease with their personal death. As Simpson (1980) has suggested: "Death acceptance is not necessarily the opposite of death anxiety and the two can correlate positively and be distinguished from death denial" (p. 143). So, from an existential perspective, a relationship between approach acceptance and fear of death is been found. Therefore, it is important to examine variables in this study that relate to the personal meaning people pursue in their lives, namely social contact, life-satisfaction and loneliness. Possible differences in attitudes toward death between institutionalized and non-institutionalized persons can be drawn back to these variables. Maybe the lack of variables relate to the personal meaning people pursue in their lives in previous studies who examined differences in attitudes between institutionalized and non-institutionalized elderly, is the reason for the contradictory findings.

Outline of the Study and Hypotheses

To promote the provision of good care in institutions, research approaches are needed which emphasize individual differences among people and which also take their views and perspectives onto their own situations into account. By examining possible differences in death attitudes in elderly who live in institutions (e.g. nursing homes) and at home, we hope to contribute to an understanding of people who are in the terminal period of their lives, and of what good care means. So, place of living is the most important independent variable in this study. To date, there is not much research that investigated the influence of place of residence on death attitudes. The few existing studies mainly focused on death anxiety or fear of death and are quit old (Shrut, 1958; Kimsey et al., 1970; Myska & Pasewark, 1978). Moreover, these few studies report inconsistent findings. More recent research focused mainly on residence staff and not on residents (Pleschberger, 2007). To our best knowledge, the meta-analysis of Fortner and Neimeyer (1999) offers the most recent and clear results about place of living, although this study is also based on death anxiety. They found that people in an institution have more fear of death than people living at home. So, recent research comprising place of residence is needed, whereby positive and negative views of the residents toward death are central. Since the pattern of death attitudes best captures individual differences, the multidimensionality of death attitudes was respected in this study by following the model of Wong et al. (1994). Therefore, our questionnaire contains the DAP-R, which measures five attitudes toward death: three positive attitudes (approach acceptance, neutral acceptance, escape acceptance), and two negative ones (death avoidance, and fear of death), which were used as dependent variables in this study.

Regarding these five attitudes, several relations with demographic variables are reported in the literature. Older people seem to have more positive attitudes toward death and less fear (Bengston, Cuellar, & Ragan, 1977; De Vries, 1993; Gesser et al., 1987; Gesser, Wong, & Reker, 1987-88; Kalish, 1976; Keller, Sherry and Piotrowski, 1984; Neimeyer, 1985; Robinson & Wood, 1984; Stevens, Cooper, & Thomas, 1980; Thorson & Powell, 1990; Wass, 1977; Wong et al. 1994). Only for death acceptance, no age differences were found. Whereas women typically showed more approach acceptance (Klenow & Bolin, 1989; Wong et al., 1994), escape acceptance (Wong et al., 1994) and fear of death (Immarino, 1975; Lonetto et al., 1980; McMordie, 1978; Neimeyer et al., 1986; Pollack, 1979; Wass & Meyers, 1982; Wong et al., 1994), than men, men were found to show more death avoidance than

women (Wong et al., 1994). Only for neutral acceptance no influence of gender has been found (Wong et al., 1994). Regarding marital status, a difference has been found for fear of death: married people tend to have more fear of death (Wagner & Lorion, 1984). Because of these influences of demographic variables on the five death attitudes, their mediating effects are investigated in this study.

From an existential perspective, a relationship between approach acceptance and fear of death has been proposed. Subjects who have a purpose and meaning in their lives tend to have less fear of death and more positive and accepting attitudes toward death (Durlack, 1972; Flint et al., 1983; Georgemiller & Malony, 1984; Lewis & Butler, 1974; Wong and Watt, 1991). This finding is consistent with the theory of Erikson (1982) that individuals in their last stage of development come to terms with death by resolving the crisis of integrity versus despair. Also Butler (1963, 1975) promoted a similar view. Therefore, it is important to examine variables in this study that relate to the personal meaning people pursue in their lives, namely social contact, life-satisfaction and loneliness. Possible differences in attitudes toward death between institutionalized and non-institutionalized persons can be traced back to these variables. One possible explanation is that the lack of variables relate to the personal meaning people pursue in their lives in previous studies who examined differences in attitudes between institutionalized and non-institutionalized elderly, is the reason for the contradictory findings. For this reasons, we also included measures of life-satisfaction and social networks into this study.

On the basis of the study of Fortner and Neimeyer (1999) and the reported interrelations between the five death attitudes, hypotheses were formulated for each death dimension. The acceptance attitudes have been found to correlate negatively with fear of death, whereas a positive association has been found between death avoidance and fear of death (Clements & Rooda, 2004; Wong et al., 1994). In general, it was expected that people living in an institution score higher on the negative attitudes fear of death and death avoidance than people who are living at home.

- Hypothesis 1: people living in an institution have lower scores on the dimension approach acceptance than old people living independently

- Hypothesis 2: people living in an institution have lower scores on the dimension neutral acceptance than people living independently

- Hypothesis 3: people living in institutions score lower on escape acceptance than those living independently

- Hypothesis 4: people living in an institution have higher scores on the dimension fear of death than people living independently

- Hypothesis 5: people living in an institution exhibit more death avoidance than people living independently

CHAPTER 4

METHODOLOGY

Participants

The people who are living at home were recruited in Antwerpen, Belgium, between June 2007 and September 2007. They were recruited from the community by asking them to participate face to face on the market, the street, a senior centre and through word of mouth. They were also recruited by their grandchildren, who are people I know. Several senior residences were asked to participate by random picking out their numbers from the phonebook. Eventually, the OCMW, which is an organization that contains 18 senior residences in Antwerpen, gave permission to interrogate their residents, who were willing to engage in the study. A fourth of the participants derive from two different private homes and the rest of the subjects stem of five different OCMW institutions. The OCMW organization is a general institution that pays special attention to certain groups of people, like seniors. When their supportive services for deprived elderly who are living it home, aren't sufficient anymore, it is possible for them to move to one of the OCMW residences. The organization uses special criteria for this take-in (see Appendix 1), like the ADL questionnaire. The criteria are important because they determine the type of participants who are living in their institutions and who are the majority of subjects in my study. The residences of the OCMW were asked to select all the people who are still capable to fill in a questionnaire or would be able to answer the questions. The questionnaire is slightly different for people living at home and people living in an institution (see Appendix 2). All the participants were tasked to fill in the questionnaire, which took approximately 60 minutes. Two people of one private home refused to further cooperate while I was questioning them. In the other private home, the people were filling in the forms in the main area. Three of them didn't fill in the questionnaire. I didn't had enough time in that institution to help all the participants. The overall responsrate of people in an institution was 68%. For people who are living at home, the responsrate is 82%.

When looking at the barcharts of the missing items per attitude (see Figure 1, Appendix 3), it is clear that in general, people in an institution leave more items open than people who are living at home. There are 7 subjects who not filled in more than 50% of the items of the DAP-R (see figure 1, Appendix 1). They are eliminated from the definitive dataset. The definitive dataset contains 85 Belgian older adults. 46 (54%) of them are living at home and 39 (46%) subjects are living in an institution for elderly.

A description of the dataset by demographic characteristics is presented in Table 1. On average, people who are living at home are younger than people who are living in an

Table 1

Summary statistics of demographic variables of the definitive dataset

	home			institution			Total
Variables	N	M	SD	N	M	SD	
Age***	45	72.49	12.17	39	84.51	6.82	84
School	45	16.09	2.15	39	15.50	2.20	84
Gender							
Men	11			16			27
Women	32			23			55
Missing	3			0			3
Status**							
Married	22			6			28
Widowed	15			27			42
Divorced	3			2			5
Separated	5			4			9
Missing	1			0			1
Children							
0	5			6			11
+0	40			33			73
Missing	1			0			1
Grandchildren							
0	12			8			20
+0	33			31			64
Missing	1			0			1

*p<.05. **p<.01.***p<.001

institution, with a range of 59 years to 90 years for people living at home and from 66 to 96 years for people in an institution. People who are living at home left school when they were older than people who are living at home, with a range of 12 years to 21 years in both groups. Most participants were 18 years old when they left school (31%) or 14 (29%). For both groups, the study contains less male participants than female participants. For three persons living at home, no information was available of their gender. The biggest difference in marital status between people who are living at home and people who are living in an institution is the amount of participants who are married. For both groups, the frequency for being single or divorced is the lowest. Most of the people who are living in an institution are widowed. For subjects living at home is this marital status most common after being married. In both groups are 6 participants without children (15% for institution and 13% for people living home). So 33 subjects in an institution (84%) and 40 subjects living at home do have children (87%).

Measures

Attitudes toward death. Attitudes toward death were measured by the Death Attitudes Profile –Revised, which is a revision of the DAP (Death Attitude Profile), a multidimensional measure of attitudes toward death developed by Gesser et al. (1987-88). The DAP consisted of four factorially derived dimensions: (a) Fear of Death/Dying (negative thoughts and feelings about the state of death and process of dying), (b) Approach Acceptance (the view of death as a gateway to a happy afterlife), (c) Escape Acceptance (the view of death as a escape from a painful existence), and (d) Neutral Acceptance (the view of death as a reality that is neither feared nor welcomed). As mentioned above, Wong et al. (1994) suggested that a distinction should be made between fear of death and death avoidance. This consideration led them to include a seven-item Death Avoidance subscale in the DAP-R. So the DAP-R consists of five dimensions that represent attitudes toward death. They also adjusted the Fear of Death and Dying scale by removing the items that refer to dying and adding new fear of death items. They changed the name of the dimension in Fear of Death. For this study the DAP-R is translated into Dutch. Therefore, I used for some items the previous translation of Nancy Van Ranst (1995) (see Appendix 4).

We conducted a conformity factor analysis on the 32-items of the Dutch version of the Death Attitude Profile-Revised questionnaire. We seek to determine if the number of factors and the loadings of measured variables (the items) on them conform the expected five factors

on the basis of the proposed theory of Wong et al. (1994). Consistent with the theoretical formulation, five components were extracted and rotated to an orthogonal (varimax) solution. These produced a structure consistent in general with Wong et al..'s (1994) original structure. The five components accounted for 59.72% of the variance. All 32 items loaded .40 or greater on at least one component, with the exception of item 17 (see Table 2, Appendix 5). This difficult item, originally belonging to the Neutral Acceptance scale, loaded in this solution heavily on the second component and positively on both the first and the last component. The five components clearly represent the Approach Acceptance, Fear of death, Death Avoidance, Escape Acceptance and Neutral Acceptance theoretical scales. The first component contained all 10 of the items from the Approach Acceptance scale (22% of the variance). The second component contained all of the 7 items from the Fear of Death scale plus 1 negatively loading item from the neutral acceptance scale (16.4% of the variance). The third component was represented by 5 of the 5 Death Avoidance items (8.3% of the variance). The fourth component contained all 5 of the Escape Acceptance items (7% of the variance) and the fifth component contained all of the 5 items of Neutral Acceptance (6.1% of the variance). The factor analysis makes it quite clear that the five dimensions are relatively independent and the high loading of each item on the theoretically appropriate factor demonstrate that the factors are pure and internally consistent. So, this solution is equal to the solution of Wong et al. (1994) and yields an extremely good fit to the theoretically derived DAP-R scales.

Correlational analyses were also conducted. The intercorrelation matrix for the DAP-R dimensions is presented in Table 3 and Table 4 and Table5 (see Appendix 5) present the intercorrelationmatrix for both groups, people living at home and people living in an institution. Notable is the significant positive correlation between the two negative death attitudes, Death Avoidance and Fear of death, at the level of .45. This result is similar as the results found in previous studies (Wong et al., 1994; Tomer & Eliason, 2005). The same result is found in both groups, although the correlation for people living in an institution is not significant. On the other hand, the negative death attitudes are not correlated with two forms of acceptance, approach acceptance and escape acceptance. Previous studies either found significant negative correlations (Wong et al., 1994) or low correlations, a result that is found for both groups, with the exception of the marginally significant, positive correlation between fear and escape acceptance for people living in an institution. The negative death attitudes are negatively associated with neutral acceptance, a result that is similar to that of previous studies (Wong et al., 1994; Tomer & Eliason, 2005) and the same for both groups.

Previous studies have shown good psychometrical characteristics of the DAP-R. The alpha coefficients of internal consistency are represented in Table 6 (see Appendix 5). Alpha coefficients ranged from a low of .55 (neutral acceptance) to a high of .92 (approach acceptance). These results of internal consistency were also found in the study of Wong, et al.., 1994) and Tomer and Eliason (2005). Taken together, the Dutch DAP-R scales have a good to very good reliability. If we look at the alpha coefficients of the DAP-R subscales per group (see Table 7, Appendix 5), we can see that every subscale of the DAP-R has good results of internal consistency in both groups, except the scale neutral acceptance. This scale has a really low reliability coefficient in the institution group (alpha coefficient = .11).

Hobbies, activities of daily living and health status: To measure the extent participants are enrolled in activities and are still capable of carrying out these activities, three types of questions were created. Firstly, people were asked about their hobbies. I asked whether they are committed to certain hobbies and how frequent they practices this hobby. This questionnaire shows good reliability (Alpha coefficient = .6). The next questionnaire participants had to fill in, was the Acitivities of Daily Living. ADLs were assessed with a Dutch and modified version of the Spector-Katz Index. The ADL represent the ability of someone to take care of him- or herself. It is the most appropriate instrument to assess functional status as a measurement of the client's ability to perform activities of daily living independently. This ADL scale contains a total of 13 questions, each asking whether the subject is severely restrained (score = 1), a little bit restrained (score=2) or not restrained (score = 3) by doing a particular activity. The 13 activities are bathing, walking up and down stairs, making a walk, dressing, using a toilet, transferring from a bed to a chair, washing or shaving, eating, doing groceries, moving outside the house, doing heavy housework and driving a car. This instrument has a very good reliabilty (Alpha = .91). Finally, questions were asked to measure how participants experience their health status. Subjects had to report how healthy they feel themselves and the amount of conditions they have that are impeding.

Social relationships: To find out about the participants' social relationships, subjects were asked to categorize the type of people they know and interact with into four groups. The four groups vary in emotional closeness to the participants. I based the definition of the different groups on the 'method of three concentric circles' developed by Lang and Carstensen (1994). Participants were told that the first group represented members to whom the subject "feels very close, so close that it would be hard to imagine life without them." The second group refers to those network members to whom the subject does "not feel quite so

close compared to those in the first group, but who are still very important". The third group list those network partners to whom the subject "feels less close, but are still important". The last group represented people who are "in the lives of the participants, but are not emotionally important". The different type of people were the following: partner; brother/sister; children; family but no children or brother(s)/sister(s); friends; neighbors; nurses; others. When subjects selected 'others', they had to specify which type of people they mean. The subjects had to declare whether a certain type of people in their lives belong to one of the groups and how often they are in contact with them.

Loneliness and life satisfaction: Regarding loneliness, a 5-item self-report scale measure feelings of loneliness experienced in interpersonal relationships. Each item represent a statement and the subjects were asked to rate to which end they agreed with the statement. Scores ranged from 1 (I strongly disagree) till 5 (I strongly agree). The alpha coefficient indicates a normal reliability (= .58). Overall life satisfaction was measured with a 6-item self report scale. More precisely the scale measures to which extend people are happy with their past life and the present circumstances. This questionnaire has a very good reliability (alpha coefficient = .86).

CHAPTER 4

RESULTS

In this section, the analysis of the definitive dataset is presented. First, an effect of place of living was examined for all five DAP-R dimensions. In order to interpret this effect, demographic variables, social networks variables, and life-satisfaction were investigated according to the suggested steps of mediation-analyses by Baron and Kenny (1986). These authors propose three steps in order to investigate a mediating effect. In a first step, it should be shown that the initial variable is correlated with the outcome, in order to find an effect that can be mediated. In a second step, it should be examined whether the initial variable is correlated with the mediator. This step involves treating the mediator as if it were an outcome variable. Finally, it is investigated whether the mediator affects the outcome variable. These steps were performed on the data of this study. In what follows, we will discuss them in more detail.

Comparison of Group Means of Death Attitudes

To determine whether place of living had an influence on death orientations, one-way ANOVA was conducted for each of the dimensions. The means and confidence intervals for each dimension by place of living are presented in Figure 2. Regarding Fear of death, the average for people who are living at home and in an institution is 3.92 (*SD* = 1.43) and 2.81 (*SD* = 1.09), respectively. ANOVA results show a significant effect of place of living, $F(1,82)= 15.24$, $p = .0002$. The participants who are living at home had an average score on the death avoidance dimension of 4.37 (*SD* = 1.63) and the participants in an institution had an average score on this dimension of 4.23 (*SD* = 1.62). The effect of place of living was not significant, $F(1,82)= 0.03$, $p = .8562$. Regarding the third dimension, approach acceptance, the average for people who are living at home is 3.32 (*SD* = 1.65) and 3.74 (*SD* = 1.48) for people living in a senior residence. The effect of place of living was not significant, $F(1,82)= 1.80$, $p = .1836$. The participants who are living at home had an average score on the neutral acceptance dimension of 5.37 (*SD* = 1.05) and the participants in an institution had an average score on this dimension of 5.75 (*SD* = 0.64). The effect of place of living on neutral acceptance failed to find significance by a slight margin, $F(1,82)= 3.90$, $p = .0516$. Subjects living at home had an average score of 3.91 (*SD* = 1.52) on the escape acceptance scale, compared to an average score of 4.96 (*SD* = 1.37) for people living in an institution. ANOVA results show a significant difference between these groups, $F(1,82)= 12,45$, $p = .0007$. So, results show that people who are living at home have significantly more fear of death and less escape acceptance than people who are living in an institution. An almost significant

difference has been found for neutral acceptance: people in an institution have more neutral acceptance than people living at home. No effect of place of living was found for the dimensions approach acceptance and death avoidance.

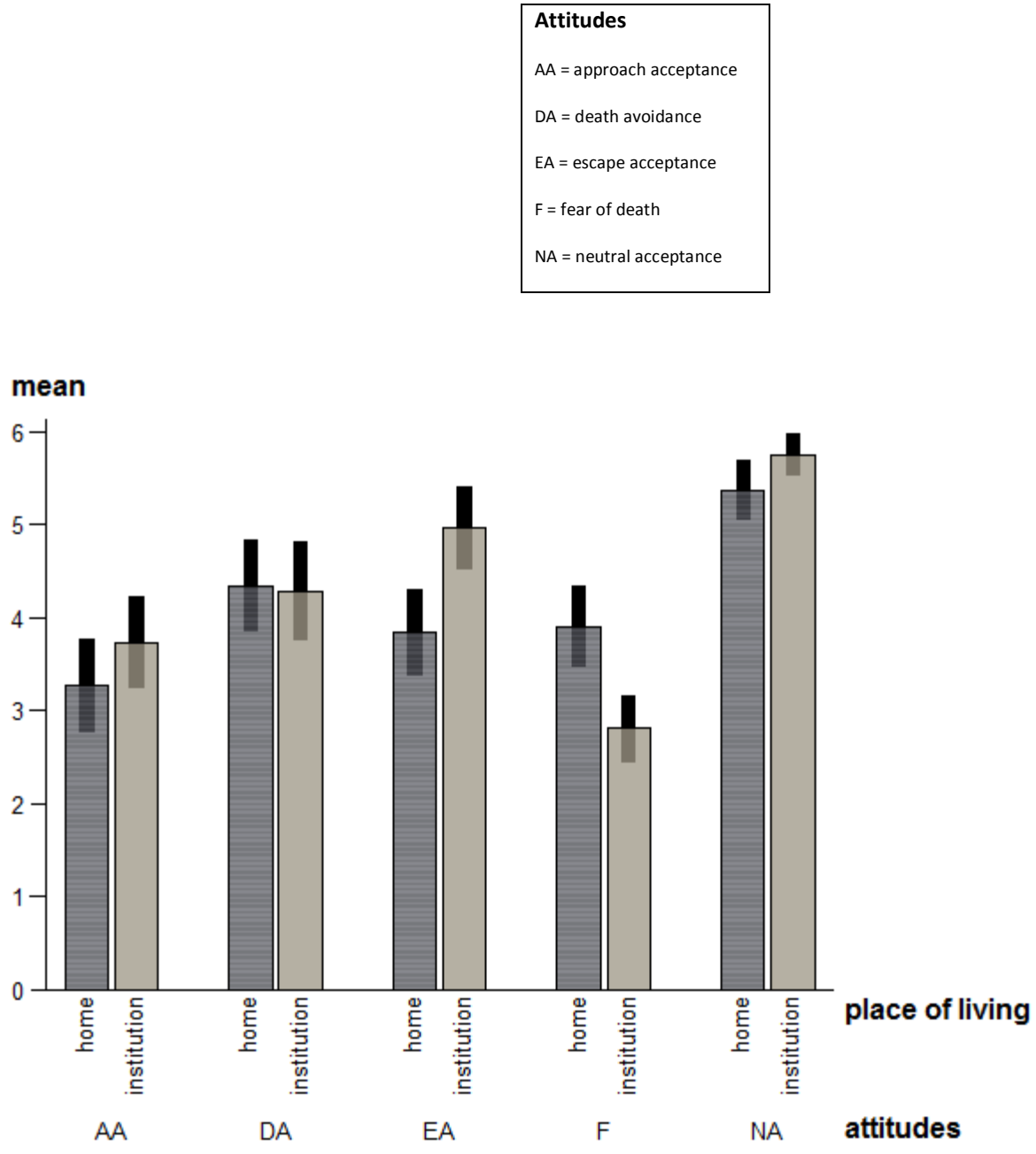

Figure 2. Means and confidence intervals of attitudes toward death by place of living.

Mediation Analysis

Demographic variables. Next, consistent with the second step in a mediator analysis, we examined the effect of place of living for the variables, age, school, gender, marital status, and the amount of children and grandchildren. The cell sizes, means, and standard deviations for these variables are presented in Table 1. To examine the relationship of age, children, and grandchildren with place of living, an ANOVA was conducted. In each ANOVA, place of living functioned as the factor and age, children, and grandchildren as the dependent variables. The results show a highly significant effect of place of living on age, $F(1,82)= 29.90$, $p = .0001$. Regarding school, ANOVA results show no significant difference of place of living, $F(1,82)= 1.53$, $p = .2190$. For the categorical variable gender, children and grandchildren, a chi-square test is used to determine the effect of place of living. These results indicate that there is no statistically significant relationship between participants' place of living and gender ($X^2(1) = 2.1819$, 0.1396), children ($X^2(1) = 0.028$, 0.8672), and grandchildren ($X^2(1) = 0.0458$, 0.8306). For marital status, the Fisher's exact test was used to determine an effect of place of living, because some of the cells have an expected frequency of five or less. The results suggest that there is a statistically significant relationship between place of living and marital status, $p = 0.0031$. So, regarding these demographic variables, results yield a significant relationship of place of living with age and marital status.

Further analyses were conducted to examine whether the demographic variables age and marital status mediate the found significant relationship between place of living and the attitudes fear, escape acceptance. Since the effect of place of living on neutral acceptance failed to reach significance only by a slight margin, we also conducted a mediation analysis for neutral acceptance. In particular, an analysis of covariance was conducted for each of the attitudes fear, escape acceptance, and neutral acceptance, with age as covariate and marital status and place of living as factors. Results are presented in Table 8. Regarding the dimension fear ANCOVA results show a significant effect of participants place of living, after age and status are controlled ($F(1,82) = 3.75$, $p = 0.0564$), namely people who live in an institution have less fear of death than people who live at home. The ANCOVA for neutral acceptance demonstrates no significant effect of place of living, after controlling for age and marital status ($F(1, 82) = 0.07$, $p = 0.7898$. The effect of place of living on neutral acceptance is mediated by age. Finally, place of living has a marginally significant effect on escape acceptance, after controlling for marital status and age ($F(1, 82) = 3.58$, $p = 0.0623$). People

who are living in an institution see death more as a welcome escape from life than people who are living at home.

Table 8

Results of ANCOVA for the different attitudes with age as covariate and place of living and status as independent variable

Source	df	SS	MS	F
Fear				
Age	1	7.71	7.71	4.37*
Status	3	2.96	0.99	0.61
Place of living	1	6.12	6.12	3.75*
Escape acceptance				
Age	1	6.68	6.68	3.39
Status	3	5.96	1.99	1.01
Place of living	1	7.05	7.05	3.58
Neutral acceptance				
Age	1	7.04	7.04	9.45**
status	3	3.70	1.23	1.66
Place of living	1	0.05	0.05	0.07

*p<.05, **p<.01

Social network variables and life-satisfaction. To further explore the found difference for fear of death, neutral acceptance, and escape acceptance according by place of residence, social network variables like loneliness and intensity of social contact per year with people who vary in emotional closeness and life-satisfaction, were examined by an ANOVA. The cell sizes, means and standard deviations are presented in Table 9. For each of the meaning variables an ANOVA was conducted with the particular social network variable or life-satisfaction as dependent variable and place of living as factor. Results are presented in Table

4. First of all, people living in a senior residence feel significantly more lonely than people who are living at home, $F(1,74) = 3.81$, p = 0.0546. For life satisfaction, results show no significant difference, $F(1,72) = 0.11$, .7373. Regarding overall intensity of social contact,

Table 9

Summary statistics of social network variables and life satisfaction of the definitive dataset

	home			institution			Total
Variables	N	M	SD	N	M	SD	
Loneliness*	40	2.09	0.71	36	2.38	0.58	76
Life satisfaction	40	3.6	0.9	36	3.67	0.58	76
Intensity social contact	42	683.5	323.75	38	748.47	443.87	80
Group 1*	43	481.91	294.49	39	331.44	340.9	82
Group 2	44	181.14	194.42	39	179.08	218.01	83
Group 3**	42	28.95	66.02	39	141.1	214.91	81
Group 4 *	41	24.68	69.56	38	85.23	150.53	80

*p<.05. **p<.01

results show no significant difference of place of living, $F(1,78) = 0.57$, $p = .4537$. Nevertheless, if we look at the intensity of social contact in different groups of emotional closeness, ANOVA results show a significant difference of intensity of social contact with people who are very important in their lives (group 1) according to place of living, $F(1,80) = 4.6$, $p = 0.0351$. People living at home have more social contact with people who are most important to them as elderly who are living in a senior residence. No significant difference was found for intensity of social contact with people who are very important in the lives of the participants, but not that emotional close as people from the first group, $F(1,81) = 0.00$, p .9638. For intensity of social contact with people who are emotionally important (group 3) and people who are merely present in the participants' lives (group 4) a significant difference was found between people living at home and in an institution, $F(1,79) = 10.39$, $p = 0.0018$, $F(1,77) = 5,4$, $p = 0.0228$, respectively.

Additional analyses were conducted to investigate a possible mediator effect of social

network variables on the found significant relationship between place of living and the attitudes fear, escape acceptance, and neutral acceptance. In particular, intensity of the first, third, and fourth group, loneliness, and place of living were submitted as factors in an

Table 10

Results of ANOVA for the different attitudes with social network variables and place of living as factors

Source	Df	SS	MS	F
Fear				
loneliness	1, 65	3.76	3.76	2.17
Intensity social contact 1	1, 65	0.29	0.29	0.17
Intensity social contact 3	1, 65	0.78	0.78	0.45
Intensity social contact 4	1, 65	0.03	0.03	0.02
Place of living	1, 65	14.62	14.62	8.43**
Escape acceptance				
loneliness	1, 65	7.42	7.42	3.82*
Intensity social contact 1	1, 65	0.00	0.00	0.00
Intensity social contact 3	1, 65	4.1	4.1	2.11
Intensity social contact 4	1, 65	1.79	1.79	0.92
Place of living	1, 65	14.54	14.54	7.49**
Neutral acceptance				
loneliness	1, 65	0.81	0.81	1.01
Intensity social contact 1	1, 65	1.98	1.98	1.48
Intensity social contact 3	1, 65	0.01	0.01	0.01
Intensity social contact 4	1, 65	0.13	0.13	0.16
Place of living	1, 65	1.38	1.38	1.7

*p<.05, **p<.01

ANOVA for fear of death, escape acceptance, and neutral acceptance. The results are presented in Table 10. For fear of death, results show a significant effect of participants place of living, after controlling for this social network variables, $F(1,65) = 8.43$, $p = 0.005$, namely people who live in an institution have less fear of death than people who live at home. Results of the ANOVA for escape acceptance yield a significant difference for place of living after controlling for the meaning variables, $F(1,65) = 7.49$, $p = 0.008$. Also loneliness seems to remain significant, $F(1,65) = 3.82$, $p = 0.0549$. The ANOVA for neutral acceptance demonstrates no significant effect of place of living, as well as for the other variables in the model.

So, results show that elderly living in an institution had significantly less fear of death and they see death more as a welcome escape of life compared with people who are living at home. Regarding neutral acceptance, the effect of place of living failed to reach significance only by a slight margin. These findings contradict our hypotheses. Regarding approach acceptance and death avoidance, no group differences were found which does not confirm our expectations. Given overall differences between seniors living at home and in residences regarding mean age, marital status, loneliness, and intensity of social contact, data were also analyzed using mediation analysis. Mediation analysis for the demographic variables show that reported group differences remain robust for fear of death after age and marital status were controlled for. Neutral acceptance is mediated by age. Although the effect of place of living and age doesn't reach significance for escape acceptance, results indicate a possible mediating effect of age. Regarding the social network variables, reported group differences between institutionalized and non-institutionalized elderly remain robust for fear of death and escape acceptance. Social network variables as well as place of living don't have a significant effect on neutral acceptance.

CHAPTER 5

DISCUSSION

Goal of the Present Study

The goal of this study was to contribute to an understanding of how elderly in an institution and at home approach death. Therefore, possible differences in death attitudes in elderly by place of living were examined. Five death attitudes were measured with the DAP-R, two negative ones (fear of death and death avoidance) and three positive ones (neutral acceptance, escape acceptance, and approach acceptance). Furthermore, demographic variables, life-satisfaction, and social network variables were analyzed regarding their influence on differences in death attitudes between people living at home and people living in an institution. This analysis was conducted to further investigate possible mechanisms of differences in death attitudes between groups.

Summary of Findings

The results of this explorative study are noteworthy in several respects. First of all, we provided evidence that place of living has a significant effect on two death attitudes, namely fear of death and escape acceptance. People in an institution have less fear of death and more escape acceptance than elderly living at home. For neutral acceptance, the effect of place of living failed to reach significance only by a slight margin. People in an institution tend to see death more as an integral part of life than people living at home. These findings contradict our hypotheses regarding these dimensions. Regarding approach acceptance and death avoidance our hypotheses could not be confirmed. Apparently, believe in a happy hereafter and death avoidance are not influenced by place of living.

Secondly, mediator analyses were conducted to investigate whether demographic variables, social network variables, and life-satisfaction have an effect on the relationship of death attitudes and place of living. Since we found a significant effect of place of living for escape acceptance and fear of death and an almost significant effect for neutral acceptance, mediator analyses were only conducted for these three death dimensions. In a first step, a possible effect of place of living was investigated for the mediator variables. Regarding the demographic variables, results show mean differences between groups for age and marital status. Concerning the social network variables and life-satisfaction, results indicated that institutionalized elderly feel themselves significantly more lonely and have less contact with people who are most important to them than non-institutionalized elderly. They do have significantly more contact with people who they mark as emotionally important and just present in their lives than non-institutionalized elderly. No difference between groups was

found for intensity of social contact with people who are very important in the lives of the participants, but not that emotional close as people from the first group. In a second step, we examined whether these possible mediator variables affect fear of death, escape acceptance, and neutral acceptance. For the demographic variables results show that reported group differences remain robust for fear of death after age and marital status were controlled for. Neutral acceptance is mediated by age. So, people in a senior residence are older and people who are older see death more as an unchangeable fact of life. Although the effect of place of living and age does not reach significance for escape acceptance, results indicate a possible partial mediating effect of age. Probably, older people see death more as a welcome escape of life than their younger counterparts. However, the fact that the effect of place of living remains marginally significant after submitting age into the model suggests that there is something to place of living that is associated with escape acceptance. Regarding the social network variables, reported group differences between institutionalized and non-institutionalized elderly remain robust for fear of death and escape acceptance. Social network variables as well as place of living don't have a significant effect on neutral acceptance.

Relation with Previous Studies

Results of the present study show that place of living has a significant effect on fear of death, after age, marital status, and social network variables are controlled for. People in an institution have less fear of death than elderly living at home. This finding is inconsistent with previous research (Fortner & Neimeyer, 1999; Shrut, 1958). It should be noted that the subjects in the research of Shrut (1958) were only unmarried white Jewish women. Fortner and Neimeyer (1999) state that their results regarding institutionalization are limited by the low number of relevant studies available. Since we found a significant difference in fear of death between groups, the finding does not collaborate with the results of Kimsey et al. (1970) and Myska and Pasewark (1978) who found no difference between institutionalized and non-institutionalized elderly. These few studies which include institutionalization are also hard to compare since they use different questionnaires to measure fear of death or death anxiety. Regarding approach acceptance and death avoidance the present study did not find a difference between groups, although previous research reported a significant difference between institutionalized and non-institutionalized elderly for approach acceptance (Swenson, 1961).

It should be noted that previous studies which included place of living as a factor are

quit old and therefore possibly influenced by historical circumstances. The form of elder care provided is changing rapidly. Traditionally, elder care has been the responsibility of family members and was provided within the extended family home. Increasingly in modern societies elder care is now being provided by state or charitable institutions. The reasons for this change include decreasing family size, the greater life-expectancy of elderly people, the geographical dispersion of families, and the tendency for women to be educated and participate on the labour-market. This also means that institutionalized elderly 40 years ago formed an exceptionally group of people, indicating that caution must be maintained when comparing these older investigations with the present study.

Mediation analysis of the present study shows that neutral acceptance is mediated by age. So, people in a senior residence are older and people who are older see death more as an unchangeable fact of life. This finding is consistent with previous research which found a significant effect of age on neutral acceptance (Gesser et al., 1987; Wong et al., 1994). Regarding the mediation analysis of escape acceptance, we found that the results indicate a partial mediating effect of age. Probably, older people see death more as a welcome escape of life than their younger counterparts, like previous research suggested (Wong et. al, 1994).

According to the existential view described in chapter two, people accept death more and have less fear of death when they experience a sense of meaning in their lives. A lot of research has given support to this perspective (Durlack, 1972; Flint et al., 1983; Georgemiller & Malony, 1984; Lewis & Butler, 1974; Renikoff, 1985; Wong and Watt, 1991). Given that the present study found that people in an institution have less fear and more escape acceptance, these elderly should see their lives as more fulfilling and meaningful than people living at home. A lot of authors posit interpersonal relations among the dimensions that provide meaning in one's life (De Vogler & Eversole, 1980; Fiske and Chiriboga, 1991; Hedlund & Birren, 1984; Klinger, 1977; Reker, 1988; Thurner, 1975). It is even been proven to be the most important source of meaning (Prager, 1997). However, the results of the present study indicate that intensity of social contact does not mediate the association between place of living and escape acceptance and fear of death. Moreover, our results report that people in an institution feel more lonely and have less social contact with people they find most important in their lives, indicating that people in an institution experience their lives less meaningful than people living at home.

Limitations of the Current Study

Several limitations of this study are acknowledged. First of all, most subjects stem of OCMW institutions. This organization is a general institution that pays special attention to certain groups of people, like seniors. It is less expensive to stay in an OCMW institution than a private home. Therefore it is possible that people with lower social economic status are investigated in this study. Second, due to constraints of some people in an institution they needed help with filling in the questionnaire. This means that some people were interviewed and some weren't. The measures used are self-report, so respons bias might affect the validity. It would be desirable, therefore, in future research to obtain additional data. Third, it should be noted that people voluntarily enrolled in the investigation and were informed about the goal of the study. So, it is likely that people who score high on the death avoidance dimension evade to fill in the questionnaire. Finally, we used a cross-sectional design. Therefore, caution about making causal inferences from the results should be maintained. Further clarification of the found relationships would require a longitudenal study.

A Tentative Account of the Present Study

As stated above, the results of the present study indicate an effect of place of living on fear of death, after age, marital status, and social network variables are controlled for. This finding is can be linked to research that tried to identify whether death anxiety is a "state" that reflects the press of physical or environmental conditions or a "trait" that represents a relatively enduring early learned fear (Pettigrew & Dawson, 1979). If death anxiety is a state phenomenon, it should fluctuate with consciousness-of-mortality enhancing experiences and experimental manipulations, consistent with the thoughts of life-span psychologists. They have postulated that fear of death fluctuates with experiences throughout the lifespan and develops within particular social contexts and particular individual experiences (Kastenbaum, 2000). Developmental research showing age differences in death attitudes supports that fear of death fluctuates with life stages (Kastenbaum, 1979; Levinson, 1977; Neugarten, 1968). Since place of living has an effect on fear of death in the present study, this finding supports as well the notion of fear of death as a state and not a trait phenomenon. People in institutions have encountered different experiences than people living at home. They are faced with other tasks and living conditions, which may influence their fear toward death.

An experience that varies between people living at home and in an institution is the experience of *being taken care of*. Elderly who are living in an institution are care-recipients.

They are there because they weren't able to live alone anymore. There is a growing interest within palliative care into the effects of care giving on both the individuals who provide care and those who receive the care. Although there is now a well-developed literature in the area of caregiver burden, the significance of being on the other side, as a care recipient, is just beginning to emerge. Importantly, it appears that for some care-recipients there is a general sense that they have become a burden to others, defined as 'empathic concern engendered from the impact on others of one's illness and care needs, resulting in guilt, distress, feelings of responsibility, and diminished sense of self (McPherson, Wilson, & Murray, 2007). Conceptually, this feeling like a burden to others can be understood from the social psychological perspective of equity theory (Walster, Berscheid, & Walster, 1973). Equity theory posits that individuals strive to maintain balance between benefits (receiving help and support) and contributions (giving help and support) within their relationships. Inequity arises when individuals give more than they receive or vice versa. When inequity transpires, it produces affective distress, which motivates the individual to restore equity through altering the contributions given and received, or altering their perception of the situation to restore psychological equity. Unfortunately, institutionalization reduces to reciprocate and restore equity; a consequence may be that they perceive themselves as having become a burden. This could lead to seeing death as a welcome escape of life and having less fear of death.

Future Perspectives

The social perspective of equity theory, as described above, offers a useful framework for further research. Since institutionalization reduces to reciprocate and restore equity in social relationships, this could lead to the perception of having become a burden to others. This feeling could affect the way people approach death. Further research examining differences in death attitudes by place of living, should include this variable as a possible mediator. Furthermore, it could be useful to examine other dimensions of social relationships, like the quality of social contacts.

Conclusion

Whit the present study we hope to contribute to more effective care-giving by gaining further understanding of how elderly approach death and how these death attitudes are influenced by living circumstances. The results of this study clearly show that place of living has an impact on death attitudes. Particularly the effect of place of living on fear of death

remains robust after controlling for mediators. To comprehend how people in an institution differ in the way they approach death from people living at home, it is important to give attention to the constellation of death attitudes. Since the DAP-R measures a broad spectrum of death attitudes, implementing positive attitudes as well, this instrument should be used in future research. Since there is so little and recent research that includes place of living and the present study did not find any mediators that could explain the shown differences in death attitudes, future research is necessary. Especially by further investigating possible mechanisms that underlie differences in death attitudes between people living at home and in an institution, we could gain insight in providing the best care for people who are in the terminal period of their lives.

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APPENDICES

APPENDIX 1 Ocmw. criteria for transfer to a home

APPENDIX 2 Questionnaire for people living at home and for people living in an institution

APPENDIX 3 Description of the dataset

APPENDIX 4 Dutch translation of the Death Attitude Profile-Revised

APPENDIX 5 Quality of DAP-R

APPENDIX 6 Results of analyses

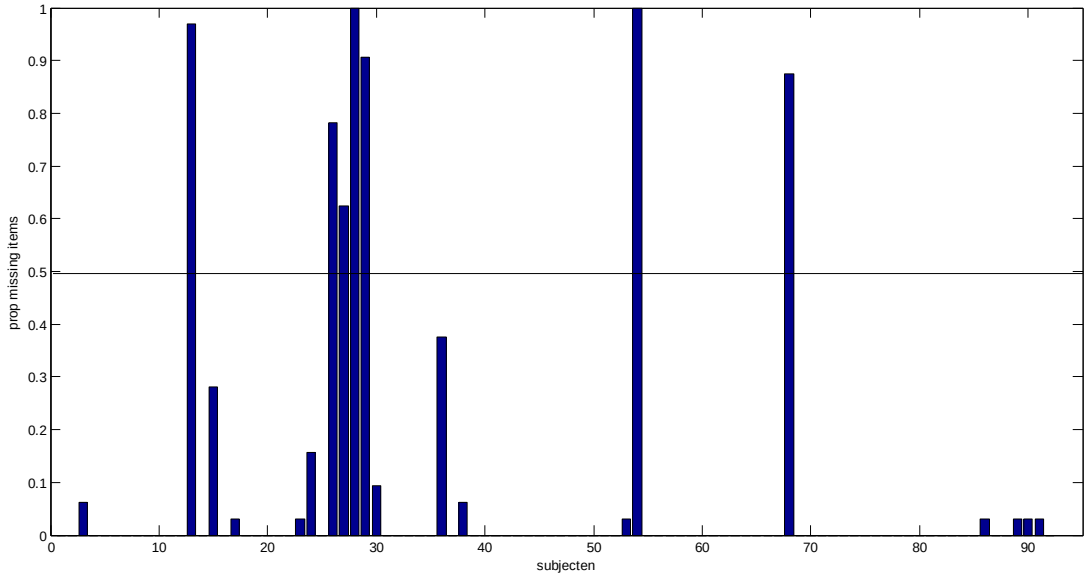

Figure 1. Missing items per subject.

HOUDING TEN OPZICHTE VAN DE DOOD

(Wong & Reker)

Deze vragenlijst bevat een aantal uitspraken over hoe mensen staan ten opzichte van de dood. Lees elke uitspraak zorgvuldig en duid dan aan in welke mate u er mee instemt of niet mee instemt. U kunt dit aanduiden door één van de volgende antwoordcategorieën te gebruiken:

HA: Helemaal Akkoord	HNA: Helemaal Niet Akkoord
A: Akkoord	NA: Niet Akkoord
EA: Enigszins Akkoord	ENA: Enigszins Niet Akkoord
OB: Onbeslist	OB: Onbeslist
ENA: Enigszins Niet Akkoord	EA: Enigszins Akkoord
NA: Niet Akkoord	A: Akkoord
HNA: Helemaal Niet Akkoord	HA: Helemaal Akkoord

Bv. de uitspraak: “de dood is een vriend”. Als u helemaal akkoord gaat met deze uitspraak, omcirkel dan HA (HELEMAAL AKKOORD). Als u helemaal niet akkoord gaat met deze uitspraak, omcirkel dan HNA (HELEMAAL NIET AKKOORD). Houd er rekening mee dat de volgorde van de antwoordalternatieven niet steeds dezelfde is. Wanneer u niet kunt beslissen, omcirkel dan OB (ONBESLIST). Maar tracht zo weinig mogelijk de categorie onbeslist te gebruiken.

Het is belangrijk dat u een antwoord geeft op alle uitspraken. Veel van de uitspraken zullen op elkaar lijken maar ze zijn noodzakelijk om kleine verschillen in houding aan te tonen.

HA: Helemaal Akkoord	HNA: Helemaal Niet Akkoord
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OB: Onbeslist	OB: Onbeslist
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NA: Niet Akkoord	A: Akkoord
HNA: Helemaal Niet Akkoord	HA: Helemaal Akkoord

1)	De dood is zonder twijfel een grimmige ervaring.	HA A EA OB ENA NA HNA
2)	Het vooruitzicht van mijn eigen dood maakt mij angstig.	HNA NA ENA OB EA A HA
3)	Ik vermijd ten alle prijze van aan de dood te denken.	HA A EA OB ENA NA HNA
4)	Ik geloof dat ik nadat ik gestorven ben in de hemel zal zijn.	HNA NA ENA OB EA A HA
5)	De dood zal een einde maken aan al mijn zorgen.	HNA NA ENA OB EA A HA
6)	De dood moet beschouwd worden als een natuurlijke, onbetwistbare en onontkoombare gebeurtenis.	HA A EA OB ENA NA HNA
7)	Ik word verontrust door het feit dat de dood het einde is van alles.	HA A EA OB ENA NA HNA
8)	De dood is een toegangsweg tot een plaats van ultiem welzijn.	HNA NA ENA OB EA A HA
9)	De dood betekent een verlossing uit deze verschrikkelijke wereld.	HA A EA OB ENA NA HNA
10)	Zodra de gedachte aan de dood bij mij opkomt, probeer ik deze weg te duwen.	HNA NA ENA OB EA A HA
11)	De dood is een bevrijding van pijn en lijden.	HNA NA ENA OB EA A HA
12)	Ik probeer steeds om niet aan de dood te denken.	HA A EA OB ENA NA HNA
13)	Ik geloof dat de hemel een veel betere plaats zal zijn dan deze wereld.	HA A EA OB ENA NA HNA

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NA: Niet Akkoord	A: Akkoord
HNA: Helemaal Niet Akkoord	HA: Helemaal Akkoord

14)	De dood is een natuurlijk aspect van het leven.	HA A EA OB ENA NA HNA
15)	De dood is een vereniging met God en een eeuwig geluk.	HNA NA ENA OB EA A HA
16)	De dood houdt een belofte in van een nieuw en heerlijk leven.	HA A EA OB ENA NA HNA
17)	Ik ben niet bang voor de dood maar ik zit er ook niet op te wachten.	HA A EA OB ENA NA HNA
18)	Ik ben zeer bang voor de dood.	HNA NA ENA OB EA A HA
19)	Al bij al vermijd ik toch van aan de dood te denken.	HNA NA ENA OB EA A HA
20)	De vraag of er leven is na de dood, houdt me erg bezig.	HA A EA OB ENA NA HNA
21)	Het feit dat de dood het einde zal betekenen van alles wat ik ken, maakt me bang.	HA A EA OB ENA NA HNA
22)	Ik kijk uit naar een hereniging na mijn dood met al diegenen die mij dierbaar waren.	HNA NA ENA OB EA A HA
23)	Ik beschouw de dood als een bevrijding van het lijden op aarde.	HA A EA OB ENA NA HNA
24)	De dood is gewoonweg een deel van het proces van het leven.	HA A EA OB ENA NA HNA
25)	Ik zie de dood als een overtocht naar een eeuwige en gelukzalige plek.	HA A EA OB ENA NA HNA
26)	Ik probeer om niets te maken te hebben met het onderwerp van de dood.	HNA NA ENA OB EA A HA
27)	Door de dood wordt een wondervolle bevrijding van de ziel mogelijk.	HNA NA ENA OB EA A HA

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HNA: Helemaal Niet Akkoord	HA: Helemaal Akkoord

28)	Eén ding is er dat mij in het aanschijn van de dood een gerust gevoel geeft, namelijk mijn geloof in een leven na de dood.	HNA N ENA OB EA A HA
29)	Ik zie de dood als een bevrijding van de last van dit leven.	HNA NA ENA OB EA A HA
30)	De dood is goed noch slecht.	HA A EA OB ENA NA HNA
31)	Ik kijk uit naar een leven na de dood.	HA A EA OB ENA NA HNA
32)	De onzekerheid van niet te weten wat er gebeurt na de dood kwelt mij.	HNA NA ENA OB EA A HA

Table 2

Rotated factorloadings of conformity factor analysis on the 32-items of the Dutch version of the DAP-R

	Components				
	1	2	3	4	5
F1	-,163	,651	,097	,068	-,102
F2	-,201	,649	,337	-,124	-,138
F3	-,056	,161	,788	-,065	-,068
F4	,741	,034	,086	-,058	,143
F5	-,018	-,116	-,022	,702	,172
F6	,019	-,123	-,131	,061	,651
F7	-,028	,667	,065	,047	,276
F8	,627	,001	-,035	,062	,295
F9	,090	-,009	,243	,747	-,195
F10	-,092	,307	,796	-,088	-,165
F11	,050	,018	,049	,524	-,067
F12	,052	,105	,817	,127	-,089
F13	,739	-,104	,148	,058	-,156
F14	,162	-,192	,030	-,125	,599
F15	,895	-,152	,030	,042	,028
F16	,846	-,114	-,012	,066	-,162
F17	,290	-,646	-,078	,095	,280
F18	-,003	,772	,204	-,155	-,153
F19	,073	,225	,798	,012	,024
F20	,245	,589	,288	,181	-,141
F21	-,062	,807	,125	-,168	-,026
F22	,537	,005	-,051	,141	-,059
F23	,227	,055	-,119	,786	,046
F24	-,009	-,098	,088	-,018	,710
F25	,874	-,028	,001	,098	,086
F26	-,080	,083	,594	,045	,079
F27	,662	-,104	-,105	,313	,263
F28	,871	-,001	-,125	,033	-,067
F29	,269	,008	-,080	,854	,114
F30	-,149	,128	-,119	,091	,497
F31	,699	,117	-,203	,296	-,224
F32	,271	,661	,081	,301	,024

Table 3

Pearson Correlation Coefficients between the DAP-R subscales

	Fear	death avoid	Approach Accept	Neutral Accept	Escape Accept
Fear	1.00000				
Death_avoid	.45***	1.00000			
Approach_Accept	-.03	-.05	1.00000		
Neutral_Accept	-0.38***	-.2*	.17	1.00000	
Escape_accept	.03	.01	.30**	.11	1.00000

p<.001=***; p<.01=**; p<=.05*

Table 4

Pearson Correlation Coefficients between the DAP-R subscales for people living at home

	Fear	death avoid	Approach Accept	Neutral Accept	Escape Accept
Fear	1				
Death_avoid	0.63***	1			
Approach_Accept	-0.02	-0.09	1		
Neutral_Accept	-0.33**	-0.16	0.11	1	
Escape_accept	0.11	0.12	0.45**	0.09	1

p<.001=***; p<.01=**; p<=.05*

Table 5

Pearson Correlation Coefficients between the DAP-R subscales for people living in an institution

	Fear	death avoid	Approach Accept	Neutral Accept	Escape Accept
Fear	1				
Death_avoid	.24	1			
Approach_Accept	.08	-.01	1		
Neutral_Accept	-.34*	-.29	.23	1	
Escape_accept	.3	-.15	-.03	-.06	1

p<.001=***; p<.01=**; p<=.05*

Table 6

Alpha coefficients for the DAP-R subscales

Subscales	
Approach Acceptance	.919
Fear	.839
Death Avoidance	.850
Escape acceptance	.806
Neutral acceptance	.547
Total	.813

Table 7

Alpha coefficients for the DAP-R subscales by group

	Place of living	
	home	institution
Subscales		
Fear	.85	.77
Death_avoid	.88	.83
Approach_accept	.93	.91
Neutral_accept	.69	.11
Escape_accept	.79	.76

Table 8

Correlations of death attitudes and age by place of living

	Place of living		
attitudes	home	institution	total
Fear	- 0,20	- 0,19	- 0,38***
Neutral Accept	0,16	0,43*	0,32**
Escape Accept	0,35*	0,05	0,39***

***p<.0001, **p<.005, *p<.05

Table 9

Fisher exact tests for relation dimensions and status by place of living

	Place of living	
	home	institution
Dimensions		
Fear	.71	.85
Escape	.28	.99
Neutral	.27	.91