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Senior outlook on death and dying: A comparative study of older volunteers serving older clients versus older volunteers serving younger clients

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A COMPARATIVE STUDY

OF

OLDER VOLUNTEERS SERVING OLDER CLIENTS

VERSUS

OLDER VOLUNTEERS SERVING YOUNGER CLIENTS

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ABSTRACT

This thesis examines the attitudes toward death and dying held by volunteers in the Senior Companion Program as compared with those in the Foster Grandparent Program. These programs represent two distinct environments, since volunteers in the former program interact only with other senior citizens while those in the latter program interact with children. In recent years volunteerism has been studied extensively relative to the positive effects that volunteer activities have on those performing them. However, there is a lack of research on the effects of the particular surroundings in which the volunteers operate. The comparison of two groups of volunteers who are approaching the final years, with one group serving clients who are even nearer the end of their lives, and the other group serving clients who are at the beginning of their lives, provides a singular opportunity to investigate attitudes relative to death and dying; in short: do volunteers who serve the elderly clients with physical ailments and who, in some cases, even watch their clients wither away toward death view death differently than those volunteers who interact with young and healthy children?

ACKNOWLEDGMENTS

DEDICATION

This Work is Dedicated to

My Parents

Orrie and Hazel Udstuen

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Chapter 1

Introduction

The focus of this study is on the attitudes of senior citizens on death and dying. In particular, the study concentrates on how older volunteers serving older clients compare with older volunteers serving younger clients. The specific groups studied are members of the Senior Companion Program (SCP), who serve other senior citizens in private homes, adult day-care settings and nursing homes; and members of the Foster Grandparent Program (FGP), who serve children in school and hospital settings. These two programs were chosen because they represent two distinct and contrasting environments, since volunteers in the SCP interact with other senior citizens, while those in the FGP interact with children. In both programs, volunteers must be at least sixty years old. Volunteers who wish to receive a stipend, which is currently $2.55 per hour, must be considered as having a modest income according to Federal guidelines which are updated annually and which vary from one location to another in the United States. While, in theory, individuals who do not meet such income guidelines could volunteer, in practice, there are no such individuals in these two programs in Eastern Nebraska. These two programs are funded by grants from the Corporation of National Community Services, formerly called ACTION. Recruitment of members occurs through contacting Churches and other Community Organizations. Often recruitment occurs by word of mouth, as volunteers tell others about their volunteer experiences. Before joining the program prospective volunteers in both the SCP and FGP programs are given physical examinations to assure they are able to perform their volunteer work. Each year

thereafter physical examinations are also provided at no cost to volunteers to ensure that they are physically able to continue with their volunteer work. In addition, a criminal background check is carried out to make sure that the programs are not sending known criminals into the clients' environments.

These two programs are examples of a trend which has emerged during the last twenty-five years to engage people in volunteer activities. Volunteerism has been studied both from the perspective of the effects that volunteer activities have on society and the effects that volunteer activities have on the volunteers. This study concentrates on the effect that a particular environment might have on volunteers. In fact, the two programs, SCP and FGP, provide quite different environments: the SCP volunteers work with older adults--often older than themselves--who are sometimes quite frail; the FGP volunteers work with children who are lively and energetic. SCP volunteers, who are in the later years of their lives, serve clients who are approaching the end of their lives; while FGP volunteers, who are also in the later years of their lives, serve children who are at the beginning of their lives. SCP volunteers witness their clients growing more and more frail, becoming less independent, losing cognitive functions, becoming institutionalized, and sometimes dying. Meanwhile FGP volunteers witness their clients growing more and more robust, becoming more independent, gaining cognitive skills, and preparing for their future lives. Such contrasting environments for volunteers provide a singular opportunity to study attitudes relative to death and dying. In response to such contrasts, it seems natural to ask the question: Do older volunteers who serve elderly and frail clients view death differently from older volunteers who serve young

and healthy clients? Thus, for the purposes of this investigation, the following hypothesis

is formulated: that SCP volunteers, who interact with elderly clients, will exhibit higher

death anxiety than FGP volunteers, who interact with children.

Chapter 2

Literature Review

Introduction

Attitudes on death have been measured in different ways. One reason for the multitude of measurements is that death brings into play the nebulous and debatable areas of religion and religious concepts or the lack of religious beliefs. Santrock (1992) presents different theories having to do with life-stages and life satisfaction, such as the Life's Stages of Erikson (1968; cited in Santrock, 1992) and the Hierarchy of Needs of Maslow (1954 & 1971; cited in Santrock, 1992) to help explain this phenomenon. In addition to the application of theories, a number of tools have been developed to measure death anxiety. It is important to note that such anxiety may on occasion subdivide into anxiety about death and anxiety about dying, that is, a fear of the result of the dying process and a fear of the process itself. It is also worth noting that death anxiety can also be viewed as anxiety about the concept of death and anxiety about one's own death. Finally it must be kept in mind that some degree of fear or anxiety about death is normal.

Returning to the idea of life-stages and life satisfaction, it has been hypothesized that certain features tend to mark the life of a person with successful aging. Fisher's (1995) theoretical presentation about life satisfaction and successful aging, enumerates some concrete characteristics of these concepts: good health, sufficient finances, owning a home, having autonomy, interactions with others, environmental mastery, personal growth, self-acceptance, a sense of purpose, making a contribution, learning new things

and helping others. Fisher studied Volunteers in an FGP and when asking these volunteers the question "Do you feel that being a Foster Grandparent has helped you age successfully?" (p. 247) found an agreement rate of 97%. As theoretical underpinning for his thoughts, Fisher uses Erikson (1968; cited in Fisher, 1995) on generativity versus stagnation and Maslow (1971; cited in Fisher, 1995) on self-actualizing individuals as dedicated people devoted to some task outside themselves and some vocation or duty or beloved job. Of course, what Fisher is alluding to here is volunteerism.

Volunteerism

Volunteerism has flourished in the United States since the 1960s with such federal programs as the Senior Companion Program (SCP), the Foster Grandparent Program (FGP), and the Retired Senior Volunteer Program among others. These programs encourage persons who are sixty years old and older to remain active in their communities. As mentioned, these programs fulfill a dual purpose: they benefit the volunteers by keeping them actively engaged in meaningful activity, and they benefit the clients and communities that are served by the volunteers. The volunteers in the SCP provide companionship and assistance with daily living activities to elderly clients--many of whom would otherwise live out isolated lives. The volunteers in the FGP provide warmth and love to neglected, developmentally delayed, and emotionally needy children in day-care programs, head start programs, hospitals, schools and even private homes. Arch (1978) called this program a "model for intervention for professional workers concerned with family welfare" (p. 605) in her study of the FGP in Pittsburgh. While Omaha has opted not to place FGP volunteers in private homes, home placement has

been a characteristic of the Pittsburgh version of the FGP. The home visitors' goals are to parent the parents, modeling appropriate parenting behavior and providing stimulation for the children. As to the effect of participation in the program by the volunteers, Arch quotes one volunteer who stated "Since I've been in the program, I'm not tired any more" (p. 605).

In discussing volunteer programs, it is important to note that in many cases stipends are offered to the volunteers, thus obscuring the lines between pure volunteerism and employment. While these stipends help older volunteers on whom volunteering would impose economic strain, it can come as a surprise to some who think of "volunteering" as work without any compensation. Haber (1982) notes that volunteerism could be an alternative source of personnel in the face of cutbacks implemented during the 1980s in the human services areas. In particular, he reports on an SCP sponsored by the Institute of Gerontology at the University of the District of Columbia in which the program was successful in recruiting older persons into training programs that lead to volunteer work or part-time work paying a stipend. There is, however, no discussion of how important this stipend might be, although he implies that the stipend might be necessary for a variety of reasons to encourage participation. Regardless of the issue of stipends, such activity is rewarding for those who volunteer. Those in need of help from an SCP are specifically described by the program of the District of Columbia as the psychologically impaired, the physically disabled, the frail, drug and alcohol abusers, the blind, the deaf and the terminally ill. The purposes of the District of Columbia program are to provide psychological services and a financial stipend to Senior Companions and

to provide social services to frail elders in need who live in the community. In accordance with general practice within the program, the SCP volunteers receive forty hours of training in offering emotional support, advice and referral information to frail elders who are contending with physical decline, impending death, or the death of significant others (Haber, 1982).

Every year millions of people volunteer time and energy to helping others by offering to provide companionship, to impart learning, or to render support to the sick. Snyder (1993) outlines some key factors of volunteerism: sustained helpfulness involving a continuing investment in the well-being of another person, pro-social action in which people actively seek out opportunities to help others, and commitment to an ongoing helping relationship often over a considerable period of time and involving personal sacrifice of time, energy and expense. In his study, Snyder describes the reasons for volunteering from a varied functional approach: different people may engage in the very same behaviors for quite different psychological reasons. Some potential motivations are: community concern, personal values, personal development, esteem enhancement, elimination of loneliness, feeling better about themselves, and coping with anxieties about personal mortality. Generally speaking, people will volunteer for activities which fulfill their motivations. One question that arises is retention of volunteers. In this case, it seems that people will ultimately remain with their chosen activities if these activities fulfill motivations that make them feel good rather than activities that are undertaken because of an abstract concern for others in the community (Snyder, 1993).

One of the purposes of volunteerism, as mentioned before, is for the benefit of the client. Skovholt (1974), in studying the FGP, among other programs, characterizes helping as therapeutic for the helper. In fact, all considered, the one to benefit most from some situations is the helper. He notes that the FGP program, since its inception in the 1960s, has had volunteers who exhibited significant positive changes over control groups in terms of mental health indices. Specific benefits are especially noted in feelings of self-competence among poor, indigenous, non-professional workers. One explanation offered by Skovholt is the idea of reciprocity: there is the general feeling that people who have helped should be helped and not hurt. Thus, there is a sort of self-serving interest in volunteering. This concept ties in well with issues of retention where inward-directed rather than out-ward motivators may enhance retention in activities (Snyder, 1993). Nevertheless, it is also suggested that both types of motivators should be addressed with proper supports (Nathanson & Eggleton, 1993). Since volunteering represents primarily a social exchange rather than an economic exchange, it is a sort of win-win situation, rather than a gain-lose situation, for both parties. Here the volunteers may gain esteem, affection, interpersonal competence, a sense of equality, valuable personal learning and social approval in return for their efforts. Since there is no money exchanging hands, a relationship more akin to friendship than that of a professional or commercial provider develops. Thus the quality of life is improved for both the volunteer and the client (Skovholt, 1974).

It is not enough to have theoretical and long-range benefits for attracting and retaining volunteers, especially as the need for volunteers becomes increasingly important

as a response to the need for community services. This is being fueled by a decline in taxpayer support for social services. Thus, both those interested in saving taxpayer dollars and those interested in seeing needs met in the community look to the pool of retired people as a resource to be tapped. The phenomenon of volunteering was highlighted by George Bush in his "thousand points of light" approach to solving problems which had for a number of years fallen within the purview of government programs. Nathanson and Eggleton (1993) give some reasons they found for volunteering: being asked to volunteer, a cure for a sense of incompleteness, giving back to the community, meeting new people and trying new skills. However, once people have decided to volunteer a number of areas need to be addressed in order to make the volunteering experience successful: providing ample support, holding award or recognition events, issuing news releases, having in-house newsletters, offering training programs, and providing support groups and supervision. Above all one must be practical and expedient in recruitment and retention efforts. In order to prevent wasted training, many programs, including FGP and SCP in Omaha, Nebraska, ask volunteers to sign up for at least one year of service.

One facet of FGP which differs from a number of other programs is that there is an inter-generational factor involved: young and old are brought together. The name itself evokes connotations of the usually favorable connections between grandparents and grandchildren. In fact, the explicit philosophy underlying the FGP is that older persons are a powerful human resource who have unique strengths which can be used in the care of special and exceptional children (Schirm, Ross-Alaolmolki & Conrad, 1995). The

dual goals of the FGP focus on: benefits to be realized by the volunteers, who are low-income persons sixty years of age and over, from participating in service to children; and benefits to be realized by the children with exceptional or special needs. Put simply, the FGP has positive benefits for both older adults and the children they serve. Some motivators for FGP participation are special: a love for children and a personal enjoyment from interacting with children, concern for children, and an interest in guiding children. Other motivating factors are similar to those for other types of volunteering: feeling useful, making friends and improved feelings of personal well-being.

Well-being

Well-being can be associated with health. According to Sabin (1993), a number of positive effects on health can accrue from particular activities: going to church or temple, seeing friends and neighbors, conversing on the phone, and volunteering. Sabin draws a correlation between health and a reduction in mortality over a given period. Social interaction is important, especially outside one's family, as a predictor of mortality. However, it is not clear that there is a definite cause-and-effect relationship at work here, since it is probable that those volunteering are more able-bodied and healthy than those not volunteering. Nevertheless, Sabin felt comfortable asserting that being socially active seems to reduce the risk of mortality.

Regardless of well-being, elders will inevitably experience certain declines: among these are decreased physical strength, diminished social support, loss of control over daily activities, increased feelings of death anxiety and hopelessness (Schorr, Farnham & Ervin, 1991). One way to counter such developments is to increase

perceived control over these conditions. In fact, in one study, individuals who perceived themselves as healthy, experienced less anxiety about death (Schorr, Farnham & Ervin, 1991). Being involved in a volunteer program is one way to remain active and remain within a social support system.

Death Anxiety

Of course, the experience toward which we are all moving and the ultimate source of death anxiety is death itself. While perceptions can be utilized to control an unhealthy outlook toward death, eventually everyone must confront the issue of death. As people age, in some ways death becomes less an issue of terror, but some degree of fear is inherent no matter what the age. As one ages, thoughts on death begin to turn from the idea of death in the abstract to concerns about the process of dying. A part of aging is people's recognizing that they are growing old, and death and dying develop into a more personal matter. More concrete fears begin to take hold, such as pain and grief. Even anxiety about death itself, as opposed to dying, can be broken down into subcategories: death avoidance, death fear, death denial and reluctance to interact with the dying, and their opposite, death acceptance, which is often overlooked, but which does not necessarily eliminate death anxiety (deVries, Bluck & Birren, 1993).

Charles Corr (1993) emphasizes that dying is a normal process in human life. He believes that coping with dying consists mainly in living as well as we can and in not feeling obliged to reach any particular goals. In his analysis of dying, he disputes some of Kübler-Ross's views on the topic, such as her stage-based model and her penchant for recommending psychological help for people dying. Instead, he emphasizes that dying

is a normal process and that most dying people have no need for psychotherapy. He concentrates on ways of coping, such as improving understanding, fostering empowerment and sharing in the process with the dying person.

Tomer and Eliason (1996) discuss a wide variety of issues surrounding death anxiety. They identify three immediate antecedents of death anxiety: past-related regret, future related regret and meaningfulness of death. They also report that there is no strong evidence of a relationship between age and death anxiety, although there is some evidence of less fear of death in older adults than middle-age or young adults. They relate death acceptance to wisdom and the eighth stage of Erikson's theory (1963; cited in Tomer & Eliason, 1996), which deals with integrity versus despair, covering such aspects as past-related regret, fulfillment, lack of fulfillment, guilt, fear of death, and being at peace with one's life. They also discuss the meaningfulness of death, noting that when death is viewed as meaningful (either because of a belief in an afterlife or because it is an alternative to suffering), it seems to cause less anxiety. They report that one's view of self can increase death anxiety when there is a large discrepancy between the actual self and the ideal self. Coping mechanisms which help to reduce death anxiety include: receiving positive feedback which enhances self esteem, engaging in life-review and reminiscence (so long as these do not turn out to be negative experiences), adopting realistic goals, renouncing impossible goals, concentrating on personal goals rather than societal goals, identifying with one's culture and living up to its standards of value, reducing past and future related regrets, adopting a positive view of death, and accepting death as a transcendence of self and liberating oneself to another reality. Finally, Tomer

and Eliason (1996) report that the importance of using coping mechanisms increases with age and that life review, reminiscing and life planning play an important role here.

Crase (1992) gives a good overview of the state of death studies in a reflection about the first fourteen years of the publication of the journal *Death Studies* (called *Death Education* for volumes one through eight). He notes that this field is expanding and refining its knowledge, exhibiting more collaborative studies, moving toward having more empirical characteristics, and attracting multi-disciplinary contributions from a mature group of scholars for whom this is a peripheral interest. While the field appears to be progressing and maturing, there are very few graduate programs leading to advanced study and degrees in thanatology.

Any developing discipline or organization eventually needs a set of guidelines or ethical standards with which consistency and fairness can be promoted. Attig (1995) discusses ethical questions surrounding the final stages of life. He discusses ways that theories, concepts, principles, rules, guidelines and other abstracts should be applied in contexts of individual and community life. He emphasizes that those who are ill should be active in defining their own care. A proper set of ethics needs to be developed to enhance the quality of both the person needing care and the persons providing care. A number of ethical considerations are mentioned: acknowledging human frailty, discerning procedures which respect persons, finding ways to support peoples' efforts to go on with their lives on their own terms, understanding what is at stake in the persons' lives, fulfilling responsibilities courageously, respectfully, decently and humanely, acknowledging other persons' subjectivity, promoting understanding of others'

perspectives, seeking common ground for viewing the world, remaining open to change, respecting those who can no longer speak for themselves, and treating others as equal partners. According to Attig, honest dialogue underpins all of these ethical considerations.

Knight and Elfenbein (1996) report that there is a relationship between involvement in one's health care and death anxiety, with those taking poorer care of their health having more anxiety. They come to this finding in a study of college students. Knight and Elfenbein also discover some differences between males and females: among subjects with high death anxiety, females are more likely to prefer health information than males; females are more likely to ask questions; and males are less likely than females to visit a physician for an annual examination. While this study focuses exclusively on a college-age population, it may be applicable to other age groups as well. In such a case, it might be worth encouraging people of any age group to engage in proper health care as a means of avoiding death anxiety.

A second study by Noppe and Noppe (1997) on an adolescent-through-college-age population, attempts to correlate the cognitive concept of death and anxiety about death with a number of circumstantial factors: number of death experiences, talking to friends about death, talking to parents about death, not talking to anyone about death, having a strong support system, and taking risks. They also study non-corporeal elements in thoughts of death: heaven, hell, reincarnation, afterlife in relation to the concept of death. A number of findings are presented: risk-taking correlates with having a close friend or relative commit suicide, adolescents associate death with a separation from

loved ones and the loss of current and future activities, having a strong support system offers an important coping mechanism, and death concepts are modified by experience.

Hintze, Templer and Cappelletty (1993) study death anxiety in a particular subgroup, gay men infected with HIV. Some conclusions are predictable: those whose medical condition are the worst exhibit the most death anxiety and death depression. Some conclusions run contrary to predictions and previous study: those whose loved ones know of their diagnosis have higher death anxiety and death depression; death anxiety and depression correlate to a higher degree than found elsewhere; death depression and death anxiety may be part of a global anxiety in this group; and there is a close relationship between physical and psychological well-being. A practical conclusion to be drawn from this study is that one should be cautious in encouraging those dying of AIDS to tell their loved ones about their condition, because of potential adverse reactions on the part of those so informed.

Therapeutic Approaches to Death Anxiety

While studies on theory and correlations among variables have their place in establishing an understanding of those who are facing death, there are a number of therapeutic endeavors that can be undertaken to reduce death anxiety and accompanying depression. Davis-Berman, Berman and Faris (1995) discuss one therapeutic possibility: life review and reminiscence as a tool for decreasing symptoms of depression, and increasing self-efficacy and activity. The format is a group setting with open and powerful dialogue about death and dying. The members of this group are identified as "people who had experienced a fair amount of death in their lives" and who "were

currently experiencing the death of friends and neighbors" (p. 61). This situation mirrors the work environment of the Senior Companion Program, where elderly clients often die while being served by volunteers. On the other hand, Foster Grandparents rarely experience the death of their young clients. On the positive side, the older members of the group studied by Davis-Berman, Berman and Faris (1995) show less anxiety about death, possibly because they feel they are living on borrowed time. As to benefit, such reminiscence groups appear to lower symptoms of depression and increase physical self-efficacy. This idea relates well to the socializing and energizing activities of volunteer programs.

Another therapeutic approach which ties in closely with the use of reminiscence is art therapy. The reason these mesh so well is that art can lead to reminiscence. Phillips (1981), the supervisor of an SCP in Oklahoma City, reports on the use of such therapy in working with the elderly. She bases herself on the model of Elizabeth Layton, an older woman who began painting at the age of 68 and who found that it relieved her long-time state of clinical depression. In this context Phillips discovers that art therapy, as a spontaneous and natural catalyst, can produce reminiscence which, as noted above, is a valuable therapeutic tool in sustaining health for elderly persons. One of the suggestions given to SCP and FGP volunteers is to use reminiscence to develop rapport with their clients. Phillips states that the use of art as a tool to promote reminiscing has been under-utilized with the elderly.

Yet another form of therapy lies somewhere between the abstract expression of art and the more factual expression of reminiscence. It is drama therapy, and it is

described by Worley and Henderson (1995). Discussions of death are difficult for any age group. Although elders engage in such discussions more often than younger people, there are not enough forums even for them to explore end-of-life issues seriously. One solution for exploring death issues in a non-threatening way, for breaking silence, for relieving emotional isolation, for imparting information, for offering support, and for facilitating an appreciation of the complexity of the issue of death is drama. Of course, drama is really another name for role-playing which has been a part of therapy for many years and which relies on dynamic dialogue and humor to bring situations to life. Such presentations, even though using a lighter format, can treat serious issues surrounding death, such as legal and medical concerns. While such dramatic representations may not solve problems, they allow the problems to be addressed, and Worley and Henderson find that, in fact, many participants are relieved in finding that they are not alone in their fears and concerns and that their involvement allows them to confront issues surrounding the ends of their own lives in a more thoughtful, deeply felt manner.

Therapy has also been directed toward particular subgroups of the dying. Smith (1994) outlines a six-session support group for people dying with HIV infection. His sessions center on the right of the dying to have control in making choices, which is consistent with the views of Schorr, Farnham and Ervin (1991); the right to reminisce, which allows disengagement from the past to allow an acceptance of what is to come; the right to laugh, which can liberate the dying person from the false solemnity that usually surrounds illness; the right to feel connected to family or friends, which needs broad definition with the special situations often found among those dying from AIDS; the right

to have a sense of purpose, which must be divorced from the traditional connection to one's work; and the right to be religious and/or spiritual, which may have to be reconstructed again because of the nature of this special group. It is important, however, not to impose any particular goals onto the dying, since such goals may constitute an additional burden. While these six areas covered by the sessions may help meet the psychological needs of the dying, one should especially avoid making a demand that one have a good death. Two of these topics have special meaning for volunteers: volunteers gain control of their lives by remaining active and socializing and the volunteers often use reminiscing when dealing with clients.

Spirituality

One of the key areas of influence as one approaches one's death is spirituality. It is very difficult to pinpoint the exact meanings and usages of words having to do with this area of the human condition. Nouns such as spirituality and religion, and the related adjectives: spiritual and religious are often used quite loosely and may mean very different things to different people. Nevertheless, it is difficult to imagine anything taking on more importance toward the end of one's life than questions that are addressed by these areas. Regardless of the particular outlook of individuals on these subjects, Smith (1993) contends that there is a need among the dying to explore religious-spiritual issues. These subjects, however, represent very sensitive areas for counselors to deal with. It is difficult to assess people's positions on religious-spiritual issues for a number of reasons: religious membership can be confused with religious involvement, religious membership or religious involvement can be mistaken for religiosity and spirituality, the

sheer number of belief systems today precludes comprehending the implications of each, it is imperative to remain non-judgmental about whatever the dying person's belief system might be, one must not impart theology to a client while still focusing sufficiently on the dying person's theology. One must be content with helping the client identify their resources and with helping them learn how to utilize those resources. Smith has designed seven questions to ask the person to help in evaluating the client's belief system. Smith outlines several tasks for clients to use in dealing with the religious-spiritual aspects of death: answering the seven questions he has designed; keeping a spiritual journal; drawing a picture representative of the divine or creative force--interesting in light of Phillips (1981) work on art therapy; and writing a healthy death story or drawing a healthy death scene. These assignments are used as points of departure in a following session. These tools are recommended since they allow clients to express thoughts and emotions while removing the fear of undue influence or proselytizing by the counselor.

Holden (1993) responds to Smith's (1993) thoughts on the religious-spiritual aspects of counseling the dying. While Smith stresses acceptance of the dying person's belief system whatever it might be, Holden feels that the person's spiritual belief must be evaluated on the basis of whether it seems to be yielding psychological benefit. When the belief system appears to be psychologically detrimental, the person should be invited to consider alternatives. Benefits from a belief system might include: a sense of clarity rather than confusion, emotional peace rather than terror or turmoil, meaningfulness rather than meaninglessness, closure rather than a sense of unfinished business, and social intimacy rather than isolation. Holden also believes that informed consent is

necessary before embarking on an exploration of a person's belief system and that Smith fails to take this into consideration adequately. SCP volunteers face a similar problem, as the religious-spiritual area of a person's life can be a very sensitive area. In fact, SCP explicitly instructs volunteers not to preach religion, although a general discussion about spirituality on a non-influential basis is permitted. Nevertheless, since SCP is a federally-funded program, it is necessary to balance the constitutional right of free speech with the constitutional ban on state-established religion. FGP, which deals with school-aged children, does not permit any discussion of religion. As the discussion in the Smith and Holden articles indicates--as well as on-going disputes at all levels of the courts--it is not easy to agree on exact rules here.

Assessment Tools

In assessing fear of death and anxiety about death a number of scales, tests and questionnaires has been used. Those assessment tools, discussed in the recent literature and potentially relevant for use with subjects such as volunteers in the SCP and FGP programs, are listed in Appendix A. While none of the assessment tools in the area of death is listed as commercially available within the print resources of the Buros Institute, forty-five of them are listed as available from Education Testing Service (ETS) in New Jersey. These were located in a search of the on-line database of the Library and Reference Services Division of ETS, using the keyword "death." Those scales listed in Appendix A which are found in the ETS database are so indicated. The discussion below is not exhaustive, but rather is limited to those mentioned in the current literature and to those which could be used with the target group. Some assessment tools are clearly

designed for other groups, such as children or the suicidal; and others, like the *Boyar Scale*, which is found in an unpublished dissertation (Boyar, 1964; cited in Thorson & Powell, 1988, 1990, 1992; Lester, 1991), have apparently been used mainly to correlate with and support other instruments (Lester, 1991; Thorson & Powell, 1988, 1990, 1992).

The *Threat Index* is one instrument which has received discussion in a number of investigations. Two investigations (Vandecreek, Frankowski & Ayres, 1994; Kirchberg & Neimeyer, 1991) find the *Threat Index* to be helpful, while a third (Chambers, Miller & Mueller, 1992) criticizes it and questions its validity. An additional study (deVries, Bluck & Birren, 1993) finds that the *Threat Index*--as well as the *Death Anxiety Scale* often fail to find gender differences with mature professional people. However, on the positive side, these researchers note that both *Threat Index* and the *Death Attitude Repertory Test* move from "expressive measures of anxieties and fear about death" to "cognitive assessment of the meaning underlying the construct 'death'" (deVries, Bluck & Birren, 1993, p. 367).

Vandecreek, Frankowski and Ayres (1994) use the *Threat Index* in a hospital setting to study the family members of a patient undergoing surgery in relation to their fear of death. While they focus their report on the *Threat Index*, they use several other tests (*Templer-McMordie Death Anxiety Scale*, a subsection of the *Collett-Lester Fear of Death Scale*, and the *Death Acceptance* sub-scale of the *Reker and Peacock Life Attitude Profile--Revised*) for the purpose of correlation. In their study they found that fear of death is higher among those who have never been hospitalized than among those who have been hospitalized before. There is, of course, some question as to whether age and

number of hospitalizations might also correlate. They conclude that the *Threat Index* is a useful instrument in studying death within the context of a hospital setting.

The *Threat Index* is also used in another study (Kirchberg & Neimeyer, 1991) which assesses fears of beginning counselors' discomfort in dealing with various stressful scenarios. They use this index to prioritize fifteen unpleasant situations which clients might present to them, such as impending death from AIDS, relationship counseling for homosexuals, terminal illness of a young woman, incest, suicide, loss of a child, date rape, deceased spouse, behavioral problems with children, and marital problems. They find that, with the exception of homosexual issues which emerge as the most stressful area of all, death issues prove to be the greatest source of stress. However, of the top two issues related with homosexual scenarios, the death of the homosexual is more stressful than the scenario of counseling a homosexual couple. Of the top eight issues, five are concerned with death. Thus death emerges as the greatest of threats.

However, one study (Chambers, Miller & Mueller, 1992) disputes the validity of the *Threat Index*. These authors find that the results of their investigation does not support the validity of the index. Their chief concern is based on an analysis of the items that occur in pairs, where a pair is a set of items to which adjectives are attached to describe self on the one hand and death on the other. Matches occur when one describes self and death with the same adjective, and splits occur when one uses not the same adjective but its opposite in describing self on the one hand and death on the other. The authors show how splits could occur in ways not related to fear: their most powerful example of a split which might not indicate fear is the situation of a person who

is faced with extreme suffering and emaciation who might view death as having an important meaning: freedom from further suffering. While such a person might still view himself or herself as having potential meaning, he or she can also see meaning in the relief of suffering that death might provide. The authors, after conducting experiments on forty-two students and fifteen HIV positive individuals, conclude that both splits and matches could be non-threatening. Chambers, Miller and Mueller conclude that it is the content behind the splits and matches rather than the fact of splits and matches which is the determining factor. Their conclusion is more boldly worded than one might normally expect: "the *Threat Index* is invalid and the findings provide no support for its continued use in therapy or classes on death education" (p. 490).

The *Lester Attitude Toward Death Scale* was published for the first time in an article by Lester (1991). One feature that distinguishes this from all other fear of death scales is that it has two parallel forms to permit "both a measure of the average attitude toward death and a measure of the range of attitudes agreed with" (p. 67). This allows an assessment of the "inconsistency of the respondent's attitude toward death" (p. 68). Lester correlates his results in testing this scale with the *Boyar Scale* and the *Collett-Lester Fear of Death Scale*, and concludes that the *Lester Attitude Toward Death Scale* primarily measures the fear of one's own death. Some of the determinations that Lester makes in using this instrument are: males have higher scores than females, religiosity is associated with more favorable attitudes toward death and with more consistent attitudes; no association is found as a result of being close to another's death and no association is found with dreams or nightmares. Lester (1991) concludes with some

thoughts on the use of fear of death scales in general: forced choice scales may disguise the focus of the scale, having a set of questions to check consistency of attitude is helpful, and many researchers use several scales to ensure that determinations are not a result of the scale chosen.

The *Twenty Statements Test* in its revised form is reported on by Durlak, Horn, and Kass (1990). The test is an open-ended type instrument which is subdivided into seven sub-categories. The respondents give twenty answers to a number of questions. The instrument's categories cover religious, personal and social reactions to death. Its advantage is that it takes a multidimensional perspective of attitude about death. It differs from other tests in that most are not open-ended but rather structured. Its disadvantage is its limited use and the fact that it has been used mainly on college-age subjects and a group of adults recruited by college-age students. The original test which was presented by M.H. Kuhn and T.S. McPartland in 1954 (cited in Durlak, Horn, & Kass, 1990), has been revised based on several issues: test-retest reliability studies, rendering the questions more personal, and revising the scoring procedures. While the authors report receiving a wealth of information on both cognitive and emotional reactions to death and also report good test-retest reliability, they conclude with a number of questions which still need work, which is not surprising for any open-ended type questionnaire. While open-ended questions might reveal a great deal of information, and while, as the authors suggest, more focus is needed on a positive view of the end of life than one finds in many studies and instruments, open-ended questions are, by nature,

difficult to manage. In corroborating their work they make use of the *Dickstein Negative Evaluation of Death Scale* and the *Collett-Lester Fear of Death of Others Scale*.

Durlak and Riesenberg (1991) assess various programs concerned with death education. They divide the types of education into experiential (dealing with feelings) and didactic (dealing with instruction) and consider the experiential as more successful. While covering a number of general areas in death education, such as a survey of other studies, characteristics of programs on death, studies of representative programs, treatment outcomes, and a statistical analysis of experiential versus didactic programs, they make positive recommendations on several fear of death scales: the *Negative Evaluation of Death sub-scale* of the *Death Concern Scale*, the *Collett-Lester Fear of Death of Others Scale*, and the *Nelson and Nelson Avoidance of Death Scale*. Actually fear of death is one of four areas whose outcomes are studied here: cognitive (issues such as euthanasia, abortion and suicide), affective (fear and anxiety about death), behavioral (changes in habits or lifestyle) and personality characteristics (reportedly rarely studied and no examples given). They conclude that death education programs generally have more success with the cognitive (issues surrounding death) than the affective (fear and anxiety). Thus, if one is interested in modifying the affective area (feelings about death), didactic programs are not very effective, and even experiential programs are only modestly successful. The authors note a lack of theory in death education and a lack of information on the reliability and validity of death scales. They also suggest that some degree of fear or anxiety about death is normal.

In another study dealing with the area of death and education, Knight and Elfenbein (1993) report seeing an increase in fear of death among subjects after their participation in death education programs. They also report on a number of studies that have concluded both an increase and a decrease in fear of death after an education program, and conclude that this might have been due to variations in the death education received. In their investigation, Knight and Elfenbein test both the didactic and experiential approaches to death anxiety. They also use multiple instruments to ensure that determinations are not a result of the scale chosen. The particular instruments used are the *Templer-McMordie Death Anxiety Scale*, a modification of the *Templer Death Anxiety Scale*, the *Death Anxiety Questionnaire*, the *Death Attitude Profile* and the *Semantic Differential Scale*. There are two goals here: to find out the effect of death education on death anxiety and to discover predictors of anxiety--in particular age, sex and religiosity. As noted above, overall death education has been shown to increase anxiety in students. Those who are religious report decreased death anxiety--possibly because death provides meaning rather than destruction; age and sex do not appear to emerge as significant predictors. Knight and Elfenbein also suggest that some degree of fear or anxiety about death may be not just normal, as Durlak and Riesenberg (1991) suggest, but even positive, since fear and anxiety may induce individuals to be more cautious in their daily lives and to appreciate their lives more.

Carr and Merriman, (1996) study health care workers and compare and contrast death attitudes of hospital-based health care professionals with hospice-based professionals. In a hospital-based setting one finds both curative and palliative settings.

In a hospice setting one finds only a palliative setting by definition. The authors note that no comparison has ever been made between those working in a hospice setting and those in a hospital setting. The authors use the *Templer Death Anxiety Scale* and the *Death Attitude Index*, a modification of *Hopping's Death Attitude Assessment Index*. Their study includes three groups: nurses, social workers and nurses' aides. They find that nurses have similar attitudes and beliefs regardless of setting with two significant exceptions: nurses in a hospital setting believe in prolonging life, while those in a hospice setting do not; and nurses in a hospice setting are more inclined to spend time with dying persons than those in a hospital setting. They find that social workers generally have similar attitudes and beliefs regardless of their setting. They report a greater disparity of attitudes and beliefs between nurses' aides in the two settings, with differences emerging in the level of comfort in being with dying persons. They find that nurses' aides in the hospital setting can progress to the point of avoiding being with the dying person. As to prolonging life, social workers in both settings believe in not prolonging life. This belief in not prolonging life is also the case with nurses in a hospice setting, while nurses in a hospital setting believe in prolonging life. Carr and Merriman find a good correlation between the *Templer Death Anxiety Scale* and the *Death Attitude Index*.

The *Templer Death Anxiety Scale* is also used in a study by Henderson (1990). He is interested in reports of a high correlation between loss of control and increased anxiety. One of his specific interests is the idea that having more time to prepare for stressful events like death might impart a sense of control and consequently reduce

anxiety. The specific activities employed to instill this sense of control are drawing up a living will and assigning someone durable power of attorney. This is partially prompted by statements made by generally well-educated, middle class residents of a retirement community, which are the equivalent of: "I don't fear death. I fear dying." One of the aspects that makes dying stressful is a loss of control, and the activities listed above may contribute to increasing a sense of some control. Additionally, discussions about one's own death also can lead to a decrease in death anxiety by identifying and focusing on aspects of planning one's death. As a result of open discussions, a number of areas can be identified that allow the individuals to take part in planning their death and ultimately reduce anxiety: having the opportunity to clarify treatment options, sharing thoughts and ideas with children, making specific plans about their memorial service, contacting their minister about their plans, sharing concerns and wishes with their health care providers, feeling understood and cared about, and having time to reminisce and affirm beliefs. Individuals who want the least or no intervention during a terminal illness benefit the most from having this made known. The instrument used in reaching these conclusions is the *Templer Death Anxiety Scale*. B. deVries, S. Bluck, and J. E. Birren (1993) also use this instrument, and note that it has been the most commonly used instrument, although they remark that it has primarily been used in experiments with groups of college students, and that it--along with the *Threat Index*-- often fail to find gender differences with mature professional people.

In working with AIDS patients, Hintze, Templer and Cappelletty (1993) make use of the *Templer Death Anxiety Scale* and correlate it with the *Death Depression Scale*.

They find an extremely close correlation between these two scales when used with the population of their study. However, they point out that this may hold true only for this population, as they note that such a close correlation between depression and anxiety has not been reported in previous literature.

Finally, Thorson and Powell, in several studies (1988, 1990, 1992, 1993 & 1997) use a modification of the *Templer Death Anxiety Scale* (Templer, 1970) with modifications based on the work of Boyar (1964; cited in Thorson & Powell, 1988, 1990 & 1992) and Nehrke (1973; cited in Thorson & Powell, 1988, 1990 & 1992). One of these studies (1988) deals with death anxiety as a function of gender and age and also undertakes to "probe the meanings of death" (Thorson & Powell, 1988, p. 691). Several interesting conclusions are reached: women express more anxiety about death than men, and this is related to a fear of bodily decomposition and fear of pain; and older persons express less fear of death than younger persons, and this is related to thoughts on the afterlife and loss of personal control.

In a second study, Thorson and Powell (1990) investigate the relationship between fear of death and religiosity. In addition to the *Revised Death Anxiety Scale*, they also use the *Intrinsic Religious Motivation Scale* (Hoge, 1972). In addition to religion, age is also taken into consideration. They discover that those persons who are higher in religiosity are lower in fear of death. Some interesting findings are: both groups (high and low religiosity) express fears about pain, helplessness, cancer, lingering death and the process of dying; the high religiosity group is concerned about the existence of an afterlife while the low religiosity group is not greatly concerned about this; and both

groups express more fear about the process of dying than about being dead. In a third study, Thorson and Powell (1992) discuss their *Revised Death Anxiety Scale*. They tell of its development, analysis and functionality and report that the *Death Anxiety Scale*, developed by Donald Templer in 1970, is the most frequently used instrument used for death anxiety. This scale has undergone a number of revisions and Thorson and Powell call the version they developed the *Revised Death Anxiety Scale*. This scale can be used in either a true-false format or a Likert format. In addition to their findings mentioned above, they also note that White persons express slightly higher death anxiety than Black persons, and teenagers express higher death anxiety than those over age sixty.

In a fourth study, Thorson and Powell (1993) add the dimension of gender to correlations between personality and death anxiety. They find only one significant correlation for males: affiliation with death anxiety. On the other hand, they find several significant correlations for women both negative (deference, order, change and endurance to death anxiety) and positive (exhibition, heterosexuality, and aggression with death anxiety).

In a fifth study, Thorson and Powell (1997) investigate cultural differences and death anxiety. They use two scales for this purpose: the *Intrinsic Religious Motivation Scale* and the *Revised Death Anxiety Scale*. Subjects from two different cultures are compared: Americans and Kuwaitis. Kuwaitis express greater religiosity and greater death anxiety than Americans; furthermore, Kuwaiti women express significantly more religiosity and death anxiety than American women and the Kuwaiti women also express

significantly higher death anxiety than Kuwaiti males. The article ends with a long interpretive discussion of the reasons for such differences.

In a study on doctor-patient relationships, one of the areas covered by Twemlow, Bradshaw, Coyne and Lerma (1995) is fear of death. One finding which surfaces is a correlation of higher fear of death with loss of control--a finding that also has emerged from other previous studies (Henderson, 1990; Schorr, Farnham & Ervin, 1991; Smith, 1994). In the same vein, this investigation shows a correlation of lower fear of one's own death with a greater sense of responsibility for one's own health and treatment. This seems to be true for one's own health, and also extends to a concern about the death of others as well. This study uses a questionnaire called the *Profile of Attitudes to Medicine: Patients* of which the last part was the *Attitudes to Death Scale: Parts I & II*, which the authors claim yields satisfactory results.

Vandecreek and Nye (1993) report on testing the *Death Transcendence Scale*. This is a test which is based on the supposition that there is some phenomenon that is more enduring than self. It consists of twenty-three questions on five areas which can offer a sense of living on: religious, mystical, creative, bio-social and nature. There are some limitations to this test: it has only been used with a few groups--a group of college students, a group of hospital patients and their family members, and one community group; and a fair number of respondents have left questions unanswered in the mystical section, claiming that they are difficult to understand. Nevertheless, the authors report overall satisfaction with the instrument. They especially note that, in spite of the apparent difficulty with questions on the mystical section, it is apparent that for those

who respond by saying that they have undergone a mystical experience, the effect was a strong sense of death transcendence. The authors believe that there is a desire to transcend death and in some way or other to achieve some sense of immortality--whether it is in a literal way, in a belief in a full existence in an afterlife; or in a figurative way, in the memories of others or in the effects of their deeds. Vandecreek and Nye also believe that the *Death Transcendence Scale* is a reasonable tool for assessing this phenomenon.

Chapter 3

Methodology

Introduction

The purpose of this study is to examine the attitudes of senior citizens toward death and dying. In particular, this study concentrates on how the attitudes of older volunteers serving older clients compare with the attitudes of older volunteers serving younger clients. After a review of various instruments for measuring attitudes on death, the *Revised Death Anxiety Scale (RDAS)*, was chosen for several reasons: this instrument has the advantage of convenience of administration with large samples and of providing a means of assessing differences and making comparisons between and within groups; and the scale has shown acceptable levels of reliability among several large and diverse samples and it has been shown to be age-sensitive (Thorson & Powell, 1992). The subject population consists of volunteers of two programs (SCP and FGP), whose clients provide the contrasting conditions necessary for this study. The fact that both groups of the subject population meet on a monthly basis for an in-service meeting further facilitated the administration of the instrument.

Survey Instrument

The survey instrument used in this study is the *RDAS*. The *Death Anxiety Scale (DAS)* was originally developed by Donald Templer in 1970 and has subsequently undergone a number of revisions. The particular revision used in this study is the version published by Thorson and Powell (1992). The instrument contains twenty-five items and has been used with a five-point Likert response format, while previous versions

of the *DAS* and even earlier versions of the *RDAS* have been used with a true-false format. Using the Likert scale is consistent with its use elsewhere for measuring of agreement with a statement on attitudes, values and interests (McMillan, 1992). Additionally, Lester (1991) endorsed the use of the Likert scale, since forced-choice scales--such as true and false--may disguise the focus of the scale, while, at the other extreme, open-ended instruments can be difficult to evaluate. Of the twenty-five statements in the *RDAS*, seventeen are phrased positively and eight are phrased negatively. The respondents are asked to agree or disagree with these twenty-five statements using a five-point Likert scale. The five possible answers are: *strongly agree, agree, neutral, disagree,* and *strongly disagree*. Items are scored by assigning a value of 0 for the least level of death anxiety and a value of 4 for the highest level of death anxiety. Compensation for the fact that some items are worded affirmatively and some are worded negatively is achieved by reversing the values (0 becomes 4, 1 becomes 3, 2 remains the same, 3 becomes 1 and 4 becomes 0) assigned to the responses, such that the greater degree of anxiety will always have a higher numeric value independent of the negative or affirmative wording of an item. The range of the scores is then calculated by adding the scores for each response. Thus, the final score for each participant can range from a low of 0 to a high of 100.

Sample

The eighty-three participants in this study were volunteers in two programs under the auspices of the Eastern Nebraska Office on Aging: forty-six participants were from the Senior Companion Program, whose volunteers serve older adults, and thirty-seven

participants were from the Foster Grandparent Program, whose volunteers serve children.

All eighty-three participants were at least sixty years of age and lived in the area covered

by Dodge, Douglas and Sarpy Counties in Eastern Nebraska.

The groups are similar in several respects. Both groups are similar in economic

status because national guidelines exclude persons from middle and upper income groups

from receiving stipends. While volunteers may, in theory, serve without stipends; none,

in fact, have done so in the Eastern Nebraska area. Accordingly, both groups (FGP and

SCP) consist of individuals who wish to volunteer in the type of community program

which offers a stipend to offset expenses which they might incur as a result of their

volunteering efforts. Women outnumber men in both samples: 10 males (21.7%) and

36 females (78.3%) in SCP versus 2 males (5.4%) and 35 females (94.6%) in FGP. It

is interesting that the number of females from each program is almost identical (36 for

SCP versus 35 for FGP). In both the FGP and SCP group, federal guidelines mandate

a minimum age of 60. While mean and median for age cannot be computed because

exact ages were not asked, it is apparent from the percentages in each age group that the

FGP volunteers are slightly older than SCP volunteers. While 86.5% of FGP volunteers

and 82.7% of SCP volunteers are below the age of 80, 59.5% of the FGP volunteers fall

into the 70-79 age group and 45.7% of SCP volunteers fall into the 60-69 age group.

Both programs are similar in racial mix: African Americans represent the majority

population in both groups, constituting 65.2% of the volunteers in SCP and 56.8% of the

volunteers in FGP; Caucasians represent the second largest population, constituting

19.6% of the volunteers in SCP and 29.7% of the volunteers in FGP. Volunteers self-

select for either the FGP or SCP program, mainly based on their interest in working with children or the elderly.

Procedures

The instrument was administered at an in-service meeting of each of the two programs involved. These meetings are held on a monthly basis at a local church hall. The researcher invited volunteers in each program to participate in the study, stressing that the survey was absolutely voluntary, completely anonymous and strictly confidential. The wording of the invitation to participate and the instructions for filling out the surveys is contained in Appendix B. Each volunteer who agreed to participate in the program was given an Informed Consent Form. A copy of the Informed Consent Form is found in Appendix C. This form was then verbally reviewed by the researcher to ensure that each participant understood the purpose, procedures, risks and benefits of the study. Those who were still interested in participating, after having read the form and after having been given the opportunity to ask questions, were asked to sign the form. Those volunteers who elected to participate were then given a copy of the *RDAS* in exchange for the signed Informed Consent Form. A copy of the *RDAS* is contained in Appendix D. A different shade of paper was used for each group to preclude the responses from the volunteers of one program being inadvertently mixed in with the responses from volunteers of the other program. To help ensure that each question was understood and that each question was answered, to help prevent haste in responding to the items on the form, and to help meet the vision needs of the older volunteers, the researcher read each statement and then allowed sufficient time for the participants to respond to each

statement. Additionally, the survey form was printed in a large (14 pt.) type font in order to facilitate its reading by the older volunteers. When the surveys were completed, the participants were asked to drop their completed forms into a box. After the responses were collected, the researcher read the poem, "The Horizon," from *Chicken Soup for the Soul* (Canfield & Hansen, 1998) to the participants, in order to soften and lighten the mood from that of the statements in the survey instrument. Finally, the participants were told that they would receive a copy of their signed informed consent forms at the next monthly in-service meeting.

Chapter 4

Analysis of Data

Introduction

The focus of this study is on the attitude of senior citizens on death and dying. In particular, the study concentrates on how the older volunteers serving elderly clients in the SCP compare with the older volunteers serving children in the FGP. On July 8, 1998, the *RDAS* was administered to the SCP volunteers; and on July 17, 1998, it was administered to the FGP volunteers. There were 46 SCP and 37 FGP participants in the study. The responses from the participants were analyzed using an SPSS (Statistical Package for the Social Sciences) program manipulated to the purposes of this study by F.C. Powell.

Demographics

Of the 83 participants in the study, 46 were volunteers from the SCP and 37 were volunteers from the FGP. There were 46 signed consent forms from volunteers in the SCP and 46 surveys turned back in. There were 38 signed consent forms from volunteers in the FGP and 37 surveys turned back in, since one FGP participant had to leave before finishing the survey due to the early arrival of that person's transportation home. The partially finished survey was not counted.

The survey queried about the age, sex and ethnicity of the participants. The population of the SCP volunteers participating in the survey consisted of 36 females and 10 males. There were 21 participants between the ages of 60 and 69, 17 participants between the ages of 70 and 79, and 8 participants between the ages of 80 and 89. The

ethnic backgrounds were described by 30 participants as Afro-American, by 9 participants as Caucasian, by 0 participants as Asian, by 1 participant as Hispanic, by 5 as "other," and by 1 with no response. The population of the FGP volunteers participating in the study consisted of 35 females and 2 males. There were 10 participants between the ages of 60 and 69, 22 participants between the ages of 70 and 79, 4 participants between the ages of 80 and 89 and 1 participant between the ages of 90 and 99. The ethnic backgrounds were described by 21 participants as Afro-American, by 11 participants as Caucasian, by 0 participants as Asian or Hispanic, by 4 participants as "other," and by 1 with no response. One participant from FGP left blank the item for indicating sex. It could be determined from the consent forms that the response in this case had to be female, and the item was coded as such. Two participants--one from SCP and one from FGP--left blank the item for indicating ethnicity, and these responses were coded as "other." It is unclear exactly why 11 individuals checked the "other" designation: it may have been either because they considered themselves to be of mixed ethnic background or because they did not wish to give information on their ethnic background.

Analysis

The responses were analyzed using an SPSS program manipulated to the needs of this study by F.C. Powell. Of the 25 statements on the *RDAS*, 13 are worded affirmatively (1, 2, 3, 5, 6, 7, 8, 9, 12, 14, 15, 16, 18, 19, 20, 22, 24) and 8 are worded negatively (4, 10, 11, 13, 17, 21, 23, and 25). There were five possible degrees of agreement with a particular statement: *strongly agree, agree, neutral, disagree and*

strongly disagree, and the five responses were assigned values from 0 to 4 points respectively. The program was given instructions to compensate for the difference between affirmatively and negatively worded items in the following way. The negatively worded items (4, 10, 11, 13, 17, 21, 23 and 25) were left as is; while the affirmatively worded items were reversed from the entered values with 0 becoming 4, 1 becoming 3, 2 remaining the same, 3 becoming 1 and 4 becoming 0. The result of this reversing operation was a parallel progression of numbering for increasing levels of death anxiety, regardless of the negative or affirmative wording of a particular item on the *RDAS*. Several decisions were necessary in order to code the answers for irregularities in the responses to items. For any item to which no response was given, there was an assumption of a neutral response, and a value of 2 was assigned. For one item to which one participant from FGP marked both extremes (item #3), a value of 2 or neutral was assigned. For three items to which three participants from SCP marked two contiguous responses, the value was skewed from neutral, as it was thought that the intention was to indicate a response between the two marked choices.

The range of scores on the 100 point scale for all participants ran from a low of 13 to a high of 85. The mean was 45.181 (SD=13.237) and the median was 45.000. The range of scores for the FGP participants ran from a low of 22 to a high of 85. The mean was 47.568 (SD=15.163) and the median was 48.000. The range of scores on this scale for the SCP participants ran from a low of 13 to a high of 73. The mean was 43.261 (SD=11.265) and the median was 44. For a more complete overview of the scores, see Tables 1, 2 and 3.

A t-test was used to compare the responses of the SCP and FGP participants, using a .05 level for significance. Four items exhibited this level of significance: numbers 3, 17, 20, 22. For item 3 (*The idea of never thinking again after I die frightens me*), FGP had a mean of 1.7568, while SCP had a mean of 1.1739 with a significance of .028. For item 17 (*I am not worried about ever being helpless*), FGP had a mean of 2.4054, while SCP had a mean of 1.5217 with a significance of .003. For item 20 (*I am worried about what happens to us after we die*), FGP had a mean of 1.8649, while SCP had a mean of 1.2174, with a significance of .007. For item 22 (*The total isolation of death is frightening to me*), FGP had a mean of 1.9189, while SCP had a mean of 1.3478, with a significance of .022. No other items showed significance at the .05 level when responses of FGP and SCP participants were compared. It should be noted that two of the above items, 17 and 20, showed significance at the .01 level. Three (3, 20 and 22) and possibly all four of these items which showed significance point to concerns about life after death. This concern with death itself among FGP participants is accentuated by the fact that items concerning the pain and process of death showed no significant difference between FGP and SCP. In all significant instances, FGP participants scored higher in death anxiety than SCP participants. In addition, the mean score for FGP (47.568) was 4.307 points higher than the mean total score for SCP (43.261). In view of the above, it seems clear that FGP respondents appeared more anxious about death than their SCP counterparts. For a more detailed presentation of the mean and significance for each response, aligned with the wording of each item on the *RDAS*, see Table 4.

A similar t-test was run to compare the responses of all male participants with all female participants. In doing so, no significant differences appeared between these two groups. It is worth noting that there was a considerable difference in numbers between males (12) and females (71).

In order to gain some idea of a reasonable mean total score for the *RDAS*, a comparison of the mean scores from the present study was made with those scores reported by Thorson and Powell (1990, 1992 & 1993) in their use of the *RDAS*, reported on a scale of 100. Although the ages of the population of the present study (60 and over) do not allow for a perfect match by age with the studies of Thorson and Powell, the works listed above offer enough similarity--use of the Likert scale and sufficient sample in the same age group--to permit a comparison of mean total scores to reach an approximation of what might be plausible results for this study. In their 1990 study, Thorson and Powell compare intrinsic religiosity and death anxiety and report a mean total score of 39.79 (SD=14.57) for subjects aged 37-67 and a mean total of 41.22 (SD=14.78) for subjects aged 68-88. This information is reiterated in their 1992 study on the *RDAS*. In their 1993 study on personality, death anxiety and gender, Thorson and Powell report a mean total score of 44.5 (SD=14.8) for men aged 18-90; and a mean total score of 45.7 (SD=18.7) for women aged 18-90. In the present study, the mean total score for all was 45.181 (SD=13.237), for FGP 47.568 (SD=15.163), and for SCP 43.261 (SD=11.265). Thus, the mean total scores in the present study for all participants and for SCP participants fall within the ranges reported by Thorson and Powell, while the sores in the present study for FGP participants are 1.8 points above

the scores reported by Thorson and Powell. It is interesting to note that the score for all participants in the present study (45.181) corresponds closely to the score reported by Thorson (1993) for women (45.7).

The hypothesis was that SCP volunteers, who interact with elderly clients, would exhibit higher death anxiety than FGP volunteers, who interact with children. In fact, SCP volunteers did not exhibit higher death anxiety than FGP volunteers. Thus the hypothesis must be rejected.

Table 1

Frequency of Scores on the 100 Point Scale for all respondents

Value	Frequency	Valid Percent	Cumulative Percent
13	1	1.2	1.2
22	1	1.2	2.4
24	2	2.4	4.8
25	3	3.6	8.4
27	1	1.2	9.6
28	1	1.2	10.8
29	2	2.4	13.3
31	3	3.6	16.9
33	2	2.4	19.3
35	2	2.4	21.7
36	2	2.4	24.1
37	3	3.6	27.7
39	2	2.4	30.1
40	1	1.2	31.3
41	5	6.0	37.3
42	3	3.6	41.0
43	4	4.8	45.8
44	2	2.4	48.2
45	3	3.7	51.8
47	5	6.0	57.8
48	5	6.0	63.9
49	3	3.6	67.5
50	2	2.4	69.9
51	3	3.6	73.5
52	1	1.2	74.7
53	1	1.2	75.9
54	4	4.8	80.7
55	4	4.8	85.5
56	2	2.4	88.0
57	1	1.2	89.2
61	1	1.2	90.4
63	1	1.2	91.6
65	1	1.2	92.8
70	1	1.2	94.0
71	1	1.2	95.2
73	1	1.2	96.4
75	2	2.4	98.8
85	1	1.2	100.

N= 37

Mean: 45.181
Median: 45
Standard Deviation 13.237

Table 2

Frequency of Scores on the 100 Point Scale for FGP

Value	Frequency	Valid Percent	Cumulative Percent
22	1	2.7	2.7
24	1	2.7	5.4
29	2	5.4	10.8
31	2	5.4	16.2
33	1	2.7	18.9
35	1	2.7	21.6
36	2	5.4	27.0
37	2	5.4	32.4
39	1	2.7	35.1
41	1	2.7	37.8
43	1	2.7	40.5
44	2	5.4	45.9
45	1	2.7	48.6
48	2	5.4	54.1
49	1	2.7	56.8
50	2	5.4	62.2
51	2	5.4	67.6
52	1	2.7	70.3
54	1	2.7	73.0
55	2	5.4	78.4
57	1	2.7	81.1
63	1	2.7	83.8
65	1	2.7	86.5
70	1	2.7	89.2
71	1	2.7	91.9
75	2	5.4	97.3
85	1	2.7	100.

N= 37

Mean: 47.568
Median: 48
Standard Deviation 15.163

Table 3

Frequency of Scores on the 100 Point Scale for SCP

Value	Frequency	Valid Percent	Cumulative Percent
13	1	2.2	2.2
24	1	2.2	4.3
25	3	6.5	10.9
27	1	2.2	13.0
28	1	2.2	15.2
31	1	2.2	17.4
33	1	2.2	19.6
35	1	2.2	21.7
37	1	2.2	23.9
39	1	2.2	26.1
40	1	2.2	28.3
41	4	8.7	37.0
42	3	6.5	43.5
43	3	6.5	50.0
45	2	4.3	54.3
47	5	10.9	65.2
48	3	6.5	71.7
49	2	4.3	76.1
51	1	2.2	78.3
53	1	2.2	80.4
54	3	6.5	87.0
55	2	4.3	91.3
56	2	4.3	95.7
61	1	2.2	97.8
73	1	2.2	100.0

N= 46

Mean   43.261
Median   44.0
Standard Deviation 11.265

Table 4

Means and Significance of Responses
In order of question number

Item	FGP (N=37)	SCP (N=46)	Significance (Two-tailed)	Contents of Item
1	2.2703	2.2174	.841	*I fear dying a painful death.*
2	1.7027	1.3913	.237	*Not knowing what the next world is like troubles me.*
3	1.7568	1.1739	.028*	*The idea of never thinking again after I die frightens me.*
4	1.6216	1.8696	.378	*I am not at all anxious about what happens to the body after burial.*
5	1.5946	1.4783	.652	*Coffins make me anxious.*
6	0.9730	1.3261	.144	*I hate to think about losing control over my affairs after I am gone.*
7	1.4595	1.2609	.407	*Being totally immobile after death bothers me.*
8	2.0541	2.1087	.846	*I dread to think about having an operation.*
9	1.7838	1.3043	.059	*The subject of life after death troubles me greatly.*
10	2.3243	2.1522	.532	*I am not afraid of a long slow dying.*
11	1.9459	1.8696	.770	*I do not mind the idea of being shut into a coffin when I die.*
12	1.5405	1.3261	.399	*I hate the idea that I will be helpless after I die.*
13	2.5405	2.5217	.948	*I am not at all concerned over whether or not there is an afterlife.*
14	1.6216	1.4348	.477	*Never feeling anything again after I die upsets me.*
15	2.1351	1.8696	.309	*The pain involved in dying frightens me.*
16	2.9730	3.1759	.411	*I am looking forward to new life after I die.*
17	2.4054	1.5217	.003**	*I am not worried about ever being helpless.*
18	1.6757	1.3696	.241	*I am troubled by the thought that my body will decompose in the grave.*
19	1.5946	1.2391	.177	*The feeling that I will be missing out on so much after I die disturbs me.*
20	1.8649	1.2174	.007**	*I am worried about what happens to us after we die.*
21	1.3784	1.5435	.446	*I am not at all concerned with being in control of things.*
22	1.9189	1.3478	.022*	*The total isolation of death is frightening to me.*
23	2.2973	2.1957	.701	*I am not particularly afraid of getting cancer.*
24	2.5946	2.9130	.178	*I will leave careful instructions about how things should be done after I am gone.*
25	1.5405	1.4348	.665	*What happens to my body after I die does not bother me.*

Totals: 47.5703 43.2630

* significance at the .05 level
** significance at the .01 level

Chapter 5

Conclusion

This investigation into the differences between the two groups studied, FGP and SCP, is not only revealing, but also potentially helpful to these programs. Occasionally someone wonders if close proximity to those approaching death might exert a negative influence in creating anxiety among those working in this environment. On the basis of the outcome of this study, it would appear that such an environment is not conducive to increasing death anxiety, and actually appears to be less conducive to such an increase than a contrasting environment, working with children. As noted above, the SCP and FGP programs are composed of volunteers who are similar in age, race and income. The results of this study reveal that SCP volunteers do not exhibit more death anxiety than FGP volunteers. In fact, FGP volunteers exhibit significantly more death anxiety on four of the twenty-five items of the *RDAS* than their SCP counterparts; and FGP volunteers scored 4.307 points higher than SCP volunteers on the 100-point scale. The results of this study should help diminish fears that having elderly persons serve elderly and frail people might lead to increased death anxiety. While this finding can have a very direct application on other SCP and FGP programs, with some further study, it might also be extended to other similar settings, such as nursing homes, hospital and hospice settings.

Although it is beyond the scope of this investigation, one might design further studies to discover the reasons for the apparent differences between the two groups included in this investigation. Some areas to consider might be whether working with

the elderly may provide opportunities to discuss and to work through death issues on a more frequent basis than working with children, whether reminiscing with other senior citizens might have a therapeutic effect on volunteers, whether dealing with the loss of clients helps volunteers in coping with issues of the loss experienced in death, and whether engaging in activities with children who are theoretically looking forward to the future leads to a denial of mortality.

Death anxiety is experienced to some extent by all people, and a certain amount of death anxiety is normal. The results of this study indicate that programs, such as SCP, need not be alarmed that older volunteers witnessing the aging and loss of their clients to death will undergo an increase in the death anxiety of their volunteers. In fact, the current study indicates that such an experience may have a positive effect on volunteers coming to accept their own mortality. It would be very helpful if similar studies could be carried out at other FGP and SCP sites in the country where their volunteers are working to serve their respective clients.

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Appendix A

Annotated List of Cited Assessment Tools

Boyar Scale for the Measurement of Fear and Death

Lester (1991)

Thorson & Powell (1988)

Thorson & Powell (1990)

Thorson & Powell (1992)

Collett-Lester Fear of Death of Others Scale

Durlak, Horn & Kass (1990)

Durlak & Riesenberg (1991)

Collett-Lester Fear of Death Scale (ETS)

Lester (1991)

Vandecreek, Frankowski & Ayres (1994)

Death Acceptance sub-scale of the *Reker and Peacock Life Attitude Profile--Revised)*

Vandecreek, Frankowski & Ayres (1994)

Death Anxiety Questionnaire (ETS)

Knight & Elfenbein (1993)

Knight & Elfenbein (1996)

Death Attitude Index (a modification of *Hopping's Death Attitude Assessment Instrument*)

Carr & Merriman (1996)

Death Attitudes Repertory Test

deVries, Bluck & Birren (1993)

Thorson & Powell (1992)

Death Attitude Profile (ETS)

    Knight & Elfenbein (1993)

    Knight & Elfenbein (1996)

Death Concern Scale (ETS)

    Durlak & Riesenberg (1991)

Death Depression Scale (ETS)

    Hintze, Templer & Cappelletty (1993)

Death Transcendence Scale

    Vandecreek & Nye (1993)

Dickstein Negative Evaluation of Death Scale

    Durlak, Horn & Kass (1990)

Durlak and Kass Attitudes to Death Scale

    [made into section five of the *Profile of Attitudes to Medicine: Patients*

    scale]

    Twemlow, Bradshaw, Coyne & Lerma (1995)

Hopping's Death Attitude Assessment Instrument

    Carr & Merriman (1996)

Intrinsic Religious Motivation Scale

    Thorson & Powell (1990)

    Thorson & Powell (1997)

Lester Attitude Toward Death Scale (ETS)

    Lester (1991)

Negative Evaluation of Death sub-scale of the Death Concern Scale,

Durlak & Riesenberg (1991)

Nelson and Nelson Avoidance of Death Scale

Durlak & Riesenberg (1991)

Profile of Attitudes to Medicine: Patients

Twemlow, Bradshaw, Coyne & Lerma (1995)

Reker and Peacock Life Attitude Profile--Revised (ETS)

Vandecreek, Frankowski & Ayres (1994)

Revised Death Anxiety Scale (Nehrke-Templer-Boyar Scale)

Thorson & Powell (1988)

Thorson & Powell (1990)

Thorson & Powell (1992)

Thorson & Powell (1993)

Thorson & Powell (1997)

Semantic Differentiation Scale

Knight & Elfenbein (1993)

Templer Death Anxiety Scale (ETS)

Carr & Merriman (1996)

deVries, Bluck & Birren (1993)

Henderson, M. (1990)

Hintze, Templer & Cappelletty (1993)

Knight & Elfenbein (1996)

Thorson & Powell (1988)

Thorson & Powell (1990)

Thorson & Powell (1992)

Vandecreek, Frankowski & Ayres (1994)

Templer-McMordie Death Anxiety Scale (ETS)

Knight & Elfenbein (1993)

Knight & Elfenbein (1996)

Vandecreek, Frankowski & Ayres (1994)

Threat Index (ETS)

Chambers, Miller & Mueller (1992)

deVries, Bluck & Birren (1993)

Kirchberg & Neimeyer (1991)

Vandecreek, Frankowski & Ayres (1994)

Twenty Statements Test (revised)

Durlak, Horn & Kass (1990)

Appendix B

Instructions Given to Subjects

Good Afternoon.

A couple of months ago, Mary Parker told you that I am working on a Master's Degree in Guidance and Counseling and that I would be asking you if you could help me in my research by filling out a survey.

The area I am working on deals with attitudes about death and dying. The survey form that I am using has been in existence with different revisions since about 1970. It asks you for your reactions to statements about death.

There are twenty-five statements in the survey. These statements are written out and each is followed by five possible reactions, which are: *strongly agree, agree, neutral, disagree* and *strongly disagree*. Here is an example which has nothing to do with the topic I am working on. You see the statement *I enjoy chocolate ice cream.* This statement is followed by the five possible reactions I just mentioned. You now respond by circling either *strongly agree, agree, neutral, disagree,* or *strongly disagree,* depending on how much you agree with the statement about enjoying chocolate ice cream. There are no right or wrong answers. This survey should take about twenty minutes. I will read each statement twice. This will help us keep together in filling out the survey.

Before we begin, I will pass out consent forms and will go over them with you. If you wish to participate, you can sign and date the form. If you don't wish to participate, you can simply not sign the form. For those of you who choose to participate, please sign and date the consent form and I will give you a survey form when

you hand in your signed consent form. After the surveys are filled out, a box will be passed around. Please place your forms into the box. The questions about age, sex and ethnicity will only be used for statistical analysis. There will be no attempt to identify you with your responses.

Appendix C

Informed Consent Form

Study of Volunteer Attitudes Toward Death
Using *The Revised Death Anxiety Scale.*

You are invited to participate in this research study. Your responses will be anonymous and the forms you fill out will be kept confidential.

The following information is provided in order to help you to make an informed decision whether or not to participate. If you have any questions, please do not hesitate to ask.

You were selected as a potential subject because you are a volunteer in either the Foster Grandparent Program or the Senior Companion Program.

Participation in the study will require approximately 25 minutes of your time, and it is not considered to be a part of your volunteer effort. In this study you will be asked to react to statements on the *Revised Death Anxiety Scale* about what you think about death. There is no correct or incorrect response to any of the statements. It is just a set of statements to which you give your personal response.

There are no risks or discomforts associated with this research.

The information gained from this study may help us to understand how certain volunteer activities relate to particular groups' attitudes on death.

This study is being conducted anonymously. There will be no attempt to match the forms or the answers with particular individuals. The information obtained from this study may be used later for publication, but your own responses and your own forms will not be identifiable.

Participation is voluntary. If you decide not to participate, you are free to withdraw from the study at any time without consequences.

If you have any questions, please do not hesitate to ask the investigator now or later at 444-6558 ext. 247.

You are voluntarily making a decision whether or not to participate in this research study. Your signature certifies that you have decided to participate, having read and understood the information presented. You will be given a copy of this consent form to keep at the next in-service meeting.

_____   _____

    Signature of Subject   Date

Principal Investigator:
Charles O. Udstuen   Office: 444-6558 ext. 247

Appendix D

Survey Instrument

Please circle your age group:

Age: 60-69

70-79

80-89

90-99

Please circle your sex:

Female

Male

Please circle the word that best describes your ethnicity:

Afro-American

Asian

Caucasian

Hispanic

Other

Please circle the name of the group in which you volunteer:

Foster Grandparent Program

Senior Companion Program

Please circle response which best describes your reaction to each statement.

1. *I fear dying a painful death.*

   strongly agree   agree   neutral   disagree   strongly disagree

2. *Not knowing what the next world is like troubles me.*

   strongly agree   agree   neutral   disagree   strongly disagree

3. *The idea of never thinking again after I die frightens me.*

   strongly agree   agree   neutral   disagree   strongly disagree

4. *I am not at all anxious about what happens to the body after burial.*

   strongly agree   agree   neutral   disagree   strongly disagree

5. *Coffins make me anxious.*

   strongly agree   agree   neutral   disagree   strongly disagree

6. *I hate to think about losing control over my affairs after I am gone.*

   strongly agree   agree   neutral   disagree   strongly disagree

7. *Being totally immobile after death bothers me.*

        strongly agree   agree   neutral   disagree   strongly disagree

8. *I dread to think about having an operation.*

        strongly agree   agree   neutral   disagree   strongly disagree

9. *The subject of life after death troubles me greatly.*

        strongly agree   agree   neutral   disagree   strongly disagree

10. *I am not afraid of a long slow dying.*

        strongly agree   agree   neutral   disagree   strongly disagree

11. *I do not mind the idea of being shut into a coffin when I die.*

        strongly agree   agree   neutral   disagree   strongly disagree

12. *I hate the idea that I will be helpless after I die.*

        strongly agree   agree   neutral   disagree   strongly disagree

13. *I am not at all concerned over whether or not there is an afterlife.*

        strongly agree   agree   neutral   disagree   strongly disagree

14. *Never feeling anything again after I die upsets me.*

       strongly agree   agree   neutral   disagree   strongly disagree

15. *The pain involved in dying frightens me.*

       strongly agree   agree   neutral   disagree   strongly disagree

16. *I am looking forward to new life after I die.*

       strongly agree   agree   neutral   disagree   strongly disagree

17. *I am not worried about ever being helpless.*

       strongly agree   agree   neutral   disagree   strongly disagree

18. *I am troubled by the thought that my body will decompose in the grave.*

       strongly agree   agree   neutral   disagree   strongly disagree

19. *The feeling that I will be missing out on so much after I die disturbs me.*

       strongly agree   agree   neutral   disagree   strongly disagree

20. *I am worried about what happens to us after we die.*

       strongly agree   agree   neutral   disagree   strongly disagree

21. *I am not at all concerned with being in control of things.*

        strongly agree   agree   neutral   disagree   strongly disagree

22. *The total isolation of death is frightening to me.*

        strongly agree   agree   neutral   disagree   strongly disagree

23. *I am not particularly afraid of getting cancer.*

        strongly agree   agree   neutral   disagree   strongly disagree

24. *I will leave careful instructions about how things should be done after I am gone.*

        strongly agree   agree   neutral   disagree   strongly disagree

25. *What happens to my body after I die does not bother me.*

        strongly agree   agree   neutral   disagree   strongly disagree