THE EFFECT OF A SHORT COURSE OF DEATH EDUCATION ON ATTITUDE TOWARD DEATH AND SUICIDE ACCEPTABILITY: AN EXPERIMENTAL STUDY

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We hereby recommend that the dissertation prepared under our supervision by BERT WAYNE BOLAN entitled THE EFFECT OF A SHORT COURSE OF DEATH EDUCATION ON ATTITUDE TOWARD DEATH AND SUICIDE ACCEPTABILITY: AN EXPERIMENTAL STUDY

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DEDICATION

TO MY SWEET BABY DOLL

BETTY

. . . my friend, companion,

and lover . . .

ACKNOWLEDGEMENTS

The writer wishes to express his deepest gratitude to his dissertation director, Dr. Don Merki, for his time, support, guidance, knowledge, and interest that was freely given to the development of this study and the professional growth of the writer.

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CHAPTER I

ORIENTATION TO THE STUDY

Rationale for the Study

Thanatology, the study of death and the process of dying, has been a subject of man's concern since the beginning of his existence.[1] A new level of acceptance and interest in the study of death and dying began in the late 1960's with the publication of two books, one edited by Toynbee and another authored by Kubler-Ross.[2] These publications have drawn the attention of educators to the need for some type of instruction about the process of death.

Recently, there has been an impetus to include death education as a part of the health education

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[1]Lawrence A. Cappiello and Ronald E. Throyer, "A Study of the Role of Health Educators in Teaching About Death and Dying," The Journal of School Health 49 (September 1979): 397.

[2]A. Toynbee, ed., Man's Concern With Death (New York: McGraw-Hill Company, 1969); E. Kubler-Ross, On Death and Dying (New York: Macmillan Company, 1969).

curriculum.[1] Leviton stated that the need for formal and informal education enabling people of all ages to cope with death and suicide is becoming increasingly evident.[2] Leviton is convinced that death education is as much a health entity as sex education. Both, he explains, have as their goal the desire to help individuals to come to terms with their own feelings, attitudes, and body. In order to live a constructive life, man needs to be at peace with his own sexuality and with the fact of his own eventual death.[3]

It appears, then, that an understanding of death and suicide is being recognized as an area intimately related to man's ability to live a worthwhile, happy, and productive life. Weisman and Hackett have written that how one has lived can determine how one will die; conversely, how one views his imminent death can affect his style of living.[4]

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[1]Dale V. Hardt, "Development of an Investigatory Instrument to Measure Attitudes Toward Death," The Journal of School Health 5 (February 1975): 96.

[2]Dan Leviton, "The Need for Education on Death and Suicide", The Journal of School Health 39 (May 1969): 270.

[3]Ibid.

[4]A. D. Weisman and T. P. Hackett, "Predilection to Death," Psychosomatic Medicine 23 (June 1969): 232-256.

Attention continues to be focused on the recognition that death education can be a major resource for anxiety reduction. With the reduction of anxiety life can take on new meaning. Kastenbaum indicates that the new awareness of death and the availability of death education offers an opportunity to re-evaluate the meaning of life.[1] This concept awards the health educator with the golden teachable moment. Leviton suggests that legitimate health education concerns include the following: (1) the study of helping people come to terms with their eventual death, (2) helping them cope with the death of their loved ones, and (3) their own death fears, and (4) prevention of suicide.[2] There is strong evidence that courses in death education generally have a positive effect on participants with regard to attitudes about dying, death, and grief.[3]

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[1]Robert Kastenbaum, "We Covered Death Today," Death Education 1 (January-March 1977): 85-92.

[2]Dan Leviton, "Education for Death," Journal of Health, Physical Education, and Recreation 40 (September 1969): 46-47.

[3]Dan Leviton, "Death Education," ed. H. Feifel, New Meanings of Death (New York: McGraw-Hill, 1977), pp. 253-272.

Death education has the potential of stimulating individuals to develop priorities. It might stimulate persons to plan for life and appropriate death. It could stimulate a desire for a loving peaceful world for all people. It should stimulate individuals to communicate esteem, respect, and love to those dear before they die.[1]

Hardt suggests that if health educators are to be concerned with education about death, they must also be aware of attitudes toward death. He implies that education which concerns itself with attitudes is more likely to fulfill needs and interests.[2] Stagner writes that attitudes held by an individual not only determine the conclusions he will derive from a presentation of facts, but will also influence the very facts he is willing to accept.[3] Shaw and Wright have stated that attitudes significantly influence mans responses to cultural

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[1] Ibid., 41-54.

[2] Hardt, pp. 96-99.

[3] R. Stagner, Encyclopedia of Educational Research (New York: The Macmillan Company, 1950) p. 77.

products, to other persons, and to groups of persons.[1] While attitudes alone may not determine how one will respond, they do play an important part in this process.

At present, thanatalogists have conducted limited research into the effect of death education on attitudes and behavior. There comes a time when sound assessment techniques must be employed in order to determine the impact and effectiveness of instruction.[2] Knott and Prull have observed that few published reports exist that evaluate the effectiveness of death education courses on students.[3]

Leviton and Foreman found that death education helped students to discuss both personal death and death of others. The course appeared to help students consciously verbalize their thoughts concerning death and helped in developing a personal eschatology.[4]

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[1]M. Shaw and J. Wright, Scales for the Measurement of Attitudes (New York: McGraw-Hill Book Company, 1967), p. 559.

[2]Carrell Crase, "The Need to Assess the Impact of Death Education," Death Education 1 (January-March 1978): 423-431.

[3]J.E. Knott and R.W. Prull, "Death Education: Accountable to Whom? For What?" Omega 7 (February 1976): 177-181.

[4]D. Leviton and E. Foreman, "Death Education for Children and Youth," Journal of Clinical Child Psychology 3 (January-April 1974): 8-10.

In a later study, Leviton found similar results and suggested that conscious thoughts and verbalization about death may serve to reduce one's fear of death.[1] Leviton further states that the need for research to determine more fully the effects of death education courses is obvious. Most of the research accomplished thus far in the field of death education has been essentially descriptive, although a few investigators have used sophisticated experimental designs.

Hoelter reports that while there is little doubt that a course on death and dying can have a positive impact on the cognitive aspect of the student, one cannot conclude the same on an affective level. He stresses the need for death educators and researchers to continue to investigate the affective impact of the death education experience.[2]

In summary, (1) an increased knowledge and understanding about death could possibly contribute to the individual's increased awareness of the value of life; (2) death education can benefit from well-designed experimental research to determine the effectiveness of

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[1]Dan Leviton, "Education for Death or Death Becomes Less a Stranger," Omega 6 (February 1975): 183-191.

[2]Jon W. Hoelter and Rita J. Epley, "Death Education and Death-Related Attitudes," Death Education 3 (January-March 1979): 67-75.

the death education experience; (3) death education can benefit from research testing the affective level of death attitudes; (4) death education research can possibly contribute to the literature in the area of death education: and, (5) there is a need for formal approaches to the teaching of death education in America.

Purpose of the Study

The purpose of the study was to ascertain whether death education alters attitudes toward death and suicide acceptability. A secondary purpose was to determine if a relationship exists between death attitude and suicide acceptability. A third purpose was to access whether or not a time span makes a difference on the impact of death education.

Statement of the Problem

The general problem of the study was to examine the differences between attitude toward death and suicide acceptability of 100 individuals who attended an adult community death education course. Two sub-problems were examined:

1. The relationship between death attitude and suicide acceptability

2. An examination of the differences that time makes on the impact of death education

The investigation identified the responses of the subjects according to the death attitude scale and the suicide acceptability scale.[1]

For the purpose of this study 100 persons were randomly assigned into two groups:

1. The experimental group comprising 50 individuals
2. The control group comprising 50 individuals

Hypotheses for the Study

The following null hypotheses were tested at the .05 level of significance:

1. There is no significant difference in the attitude toward death at the time of posttest 1 between those individuals who had had death education and those individuals who had had no death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale

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[1]Hardt, pp. 96-99; Jon W. Hoelter, "Religiosity, Fear of Death and Suicide Acceptability," Suicide and Life-Threatening Behavior 9 (October-December 1979): 163-172.

2. There is no significant difference in suicide acceptability at the time of posttest 1, between those individuals who had had death education and those individuals who had had no death education as revealed by the data collected from the administration of the Hoelter Suicide Acceptability Scale
3. There is no significant difference in the attitude toward death between posttest 1 and posttest 2 among those individuals in the experimental group who had had death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale
4. There is no significant difference in suicide acceptability between posttest 1 and posttest 2 among those individuals in the experimental group who had had death education as revealed by the data collected from the administration of the Hoelter Suicide Acceptability Scale
5. There is no significant difference in the attitude toward death at the time of posttest 1 between those

individuals in the experimental group who had had death education and those individuals in the control group at the time of posttest 2 who had had death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale

6. There is no significant difference in suicide acceptability between those individuals in the experimental group at the time of posttest 1 who had had death education and those individuals in the control group at the time of posttest 2 who had had death education as revealed by the data collected from the administration of the Hoelter Suicide Acceptability Scale

7. There is no significant difference in the attitude toward death among those individuals in the control group between posttest 1 before death education and posttest 2 after they had had death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale

8. There is no significant difference in suicide acceptability among those individuals in the control group between posttest 1 before death education and posttest 2 after they had had

death education as revealed by the data collected from the administration of the Hoelter Suicide Acceptability Scale

9. There is no significant difference in the attitude toward death at the time of posttest 2 between those individuals in the experimental group who had had death education and those individuals in the control group who had had death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale

10. There is no significant difference in suicide acceptability at the time of posttest 2 between those individuals in the experimental group who had had death education and those individuals in the control group who had had death education as revealed by the data collected from the administration of the Hoelter Suicide Acceptability Scale

11. There is no difference in relationship between death attitude and suicide acceptability at the time of posttest 1 between those individuals who had had death education and those individuals who had had no death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale and the Hoelter Suicide Acceptability Scale

12. There is no relationship between death attitude and suicide acceptability between posttest 1 and posttest 2 among those individuals in the experimental group who had had death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale and the Hoelter Suicide Acceptability Scale

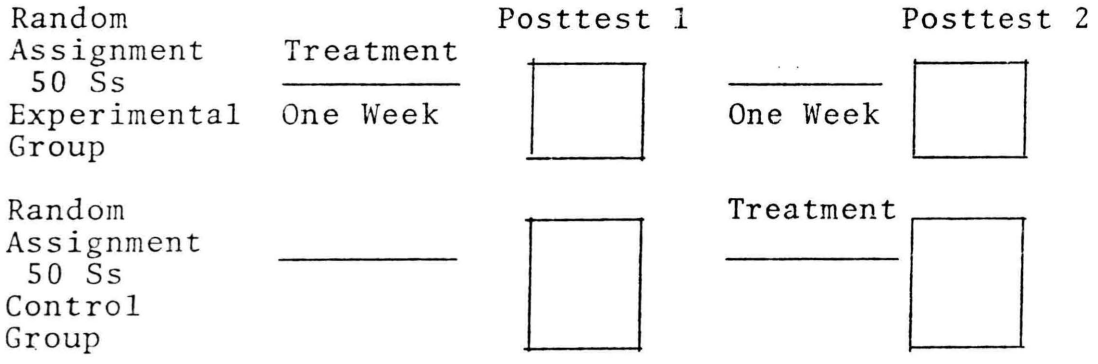
13. There is no difference in relationship between death attitude and suicide acceptability between those individuals in the experimental group at the time of posttest 1 who had had death education and those individuals in the control group at the time of posttest 2 who had had death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale and Hoelter Suicide Acceptability Scale

14. There is no relationship between death attitude and suicide acceptability between posstest 1 and posttest 2 among those individuals in the control group as revealed by data collected from the administration of the Hardt Death Attitude Scale and the Hoelter Suicide Acceptability Scale

15. There is no difference in relationship between death attitude and suicide acceptability at the time of posttest 2 between those individuals in the experimental group who had had death education and those individuals in the control group who had had death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale and the Hoelter Suicide Acceptability Scale

General Design of the Study

The basic research design was as follows:



During the months of August and September, media advertising was released to solicit volunteers to participate in the study. Media advertising included local newspapers and local radio stations. From this solicitation, individuals were randomly assigned to either the

experimental or control groups. Random assignment was attained by the drawing of numbers at the first session of the death education class. Both groups were given the Hardt Death Attitude Scale and the Hoelter Suicide Acceptability Scale as the dependent measures. (See Appendix A for the death attitude and suicide acceptability scale.) The tests were given to the groups at the designated posttest.

From the data collected, the researcher determined whether death education altered attitude toward death and suicide acceptability. The data were also examined to determine if a relationship existed between death attitude and suicide acceptability. Further, an examination was made of the differences that time makes on the impact of death education.

Definitions and/or Explanations of Terms

For the purpose of clarification, the following definitions or explanations of terms were used for the study:

1. Adult is defined as any person 18 years of age or above

2. Community is defined as a body of individuals with common interests interacting in a common location[1]

3. Death Attitude Favorability. Death attitude favorability is defined in terms of ability to adapt to the death of others and to accept the inevitability of one's own death[2]

4. Death Education. A developmental process that transmits to people and society valid death-related knowledge and implications resulting from that knowledge[3]

5. Dying. The onset of dying is discovered or certified when:

   a. The medical facts are recognized

   b. The facts are communicated to the patient

   c. Nothing more can be done to preserve life[4]

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[1]Woolf, Henry Bosley, ed., Webster's New Collegiate Dictionary (Springfield, Massachusetts: G. & C. Merriam Company, 1977), p. 228.

[2]Edward J. Hart, "Philosophical Views of Death," Health Education 8 (November/December 1977): 2-3.

[3]Dan Leviton, "The Scope of Death Education," Death Education 1 (January-March 1977): 41-56.

[4]Robert J. Kastenbaum, Death, Society, and Human Experience (St. Louis: The C. V. Mosby Company, 1977), pp. 231-235.

6. Euthanasia. The good death. The person's own natural death without prolonging the dying process unduly.[1] Euthanasia in this sense is not used to connote mercy killing

7. Grief. A deeply human emotional experience as the result of loss. A heavy distress caused by loss or sorrow[2]

8. Loss. Anything which disrupts the individual's security system. The removal of objects of security[3]

9. Stress. Stress is the nonspecific response of the body to any demand made upon it.[4] Stress is the common denominator of all adaptive reactions in the body

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[1]Elizabeth Kubler-Ross, Questions and Answers on Death and Dying (New York: Macmillan Publishing Company, Inc., 1974), pp. 78-81.

[2]Ibid.

[3]Hart, pp. 2-3.

[4]Hans Selye, Stress Without Distress (New York: The American Library, Inc., 1975), pp. 156-159.

10. Suicide. The act or an instance of taking one's own life voluntarily and intentionally[1]

11. Suicide Acceptability. The degree to which suicide offers an acceptable solution to one's problems[2]

12. Unfavorable Death Attitude. An unwillingness or inability to adapt to the death of others or to accept one's own death[3]

Delimitations of the Study

The study was subject to the following delimitations:

1. One hundred subjects who participated voluntarily in the death education course in September and October 1980
2. The reliability of the Hardt Death Attitude Scale administered to the subjects
3. The reliability of the Hoelter Suicide Acceptability Scale administered to the subjects

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[1]Corrine Loing Hatton, Sharon McBride Valente, and Alice Rink, Suicide Assessment and Intervention (New York: Appleton-Century-Crofts, 1977), pp. 114-124.

[2]Hoelter, Religiosity, pp. 163-165.

[3]Hart, p. 2-3.

4. The degree to which the subjects truthfully responded to the instruments
5. The degree to which the subjects were representative of the population from which they were drawn
6. The degree to which the death education course was objectively taught
7. The degree to which the classes taught were representative of death education

Assumptions of the Study

The following assumptions were made by the researcher:

1. It was assumed that the independent variable of death education accounted for any change in attitude, or if any other factor would change, it would be evenly distributed between the control and experimental groups
2. It was assumed that the subjects were equally exposed to influences other than death education that might account for a change in attitude
3. It was assumed that the influence of the instructors was the same for each subject
4. It was assumed that the dependent measures yielded parametric data[1]

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[1]Quinn McNemar. Psychological Statistics, (New York: John Wiley and Sons, 1949), pp. 78-105.

CHAPTER II

SURVEY OF SELECTED RELATED LITERATURE

A comprehensive review of the available literature relating to death attitudes and suicide acceptability, disclosed that the present investigation does not duplicate any previous study. For an organized presentation, the review of the literature is divided into three sections: (1) a brief history of death education, (2) studies and surveys about death attitudes, and (3) studies and surveys about suicide acceptability.

A Brief History of Death Education

Although death has been among man's greatest concerns from his beginning, only in the past ten years have researchers and educators made even sporadic attempts to describe attitudes toward this both abstract and concrete concept.[1] Researchers and educators now

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[1]Hardt, pp. 96-99.

realize that attitudes toward death comprise a complex area of concern with individual, subcultural, and cultural ramifications. This concern has prompted a more open, frank discussion of death.

Green and Irish note that the first conference on death education was held at Hamline University in 1970.[1] Speakers at that conference spoke of the need for and the potential of death education. At that time, there were no more than twenty death education courses in existence above the high school level. Most were offered at the college level, while a few medical schools allowed an elective which included thanatological materials to some extent.[2]

Over the past ten years, death education as a course of study has succeeded in working its way into numerous grade school, high school, and college offerings.[3]

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[1]B. Green and D. Irish, Death Education: Preparation for Living (Cambridge, Massachusetts: Schenkman, 1971), pp. 78-79.

[2]Leviton, Scope, pp. 41-56.

[3]Dale V. Hardt, "A Measurement of the Improvement of Attitudes Toward Death," The Journal of School Health 46 (May 1976): 269-270.

In 1974, Berg and Daugherty estimated that in just four years after the Hamline Conference over 1100 courses existed above the high school level.[1] While emphasis has been at the college level, formal death education also exists in high school, professional, and adult education curricula. Often death education is seen at the preschool and elementary level on an informal, teachable-moment basis.[2] At the university level, death education has been taught in marriage and family life classes, counselor education, and health education courses.[3] Death and dying is also being pursued in varying degrees by psychologists, psychiatrists, medical and paramedical technologists, policemen and life support personnel, legislators, and school educators ranging from kindergarten through university.[4]

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[1]D. Berg and G. Daugherty, Death Education: A Survey of Colleges and Universities (Dekalb, Illinois: Educational Perspectives, 1974), pp. 17-23.

[2]Leviton, Scope, pp. 41-56.

[3]Parris R. Watts, "Evaluation of Death Attitude Change Resulting from a Death Education Instructional Unit," Death Education 1 (January-March 1977): 187-193.

[4]Crase, pp. 423-431.

Even though many disciplines are involved in death education, Leviton states that it should have common systematic goals. He suggests that these goals and objectives should encompass the following:

1. Remove the taboo aspect of death language so students can read and talk about death rationally without becoming anxious
2. Promote comfortable and intelligent interactions with the dying as human beings who are living until they are dead
3. Educate children about death so they develop a minimum of death-related anxieties
4. Assist the individual in developing a personal eschatology by specifying the relationship between life and death
5. Assist the individual in understanding the concepts of appropriate, good, or healthy death
6. Perceive the doctor or counselor as a professional and human being, neither omnipotent nor omniscient, who has an obligation to give competent and humane service, attention, and information without mendacity, to the dying and their families

7. Understand the dynamics of grief and reactions of differing age groups to the death of a significant other
8. Understand and be able to interact with a suicidal person[1]
9. Understand the role of those involved in what Kastenbaum and Aisenberg call the "death system", and the assets and liabilities of that system[2]
10. Educate consumers to the commercial "death market"[3]
11. Recognize that war and other holocausts are related to feelings of personal immortality and omnipotence. War might be avoided if we realize that it may be ourselves or our children who would be killed or mutilated as well as the amorphous "enemy"
12. Recognize the variations involved in aspects of death both within and among cultures. Death means different things to different people

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[1]Leviton, Scope, pp. 41-56.

[2]Robert Kastenbaum and Ruth Aisenberg, The Psychology of Death (New York: Springer Publishing Company, 1976), pp. 17-47.

[3]Ibid.

There are many approaches and combinations of approaches which are used for subject presentation in death education. Harris suggests five major categories of approaches to death education: the philosophical, the sociological, the psychological, the medical-legal, and that of health education.[1]

The philosophical approach will frequently center on the meaning of life and death in both symbolic and human terms. The philosophical concept states that, until we learn to accept death, we are not really living.[2] Religion and death is another aspect of the philosophical approach.[3] Most religions accept the fact that people die. The Judeo-Christian concept is the most commonly held tradition about death in the United States. Its fundamental belief is that the body is only a temporary house for the soul. The body dies,

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[1]William H. Harris, "Some Reflections Concerning Approaches to Death Education," The Journal of School Health 48 (March 1978): 162-165.

[2]P. Insel and W. Roth, Health in a Changing Society (Palo Alto, California: Mayfield Publishing Company, 1976), pp. 124-125.

[3]E. Ziegler, Philosophical Foundations for Physical, Health, and Recreation Education, (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1964), pp. 25-217.

but the soul is immortal.[1] During a philosophical discussion, the student can develop a personal philosophy of death and dying. This can have an effect on the understanding of life and can serve as an experience in establishing individual values.[2]

The sociological approach defines death in terms of cultural and societal influences.[3] Topics include the study of the denial of death, death rates of different social classes, the aspects of the funeral and burial customs, wills, euthanasia, living wills, and insurance.[4]

The psychological approach deals with openness and awareness about death.[5] Awareness of impending death can give the individual an opportunity to close his

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[1]Insel and Roth, pp. 124-125.

[2]Harris, pp. 162-165.

[3]Kastenbaum and Aisenberg, pp. 5-20.

[4]Edwin Schneidman, Death: Current Perspectives (Palo Alto, California: Mayfield Publishing Company), pp. 201-321.

[5]B. Glaser and A. Strauss, Awareness of Dying (Chicago: Aldine Publishing Company, 1965), pp. 11-103.

life in accordance with his own ideas about proper dying. An important psychological aspect is the concept of grief and bereavement. Many psychiatrists consider the grief syndrome to be an illness.[1] It is important, then, that the individual develop an understanding of grief as a normal and essential process.

Kubler-Ross has given an in-depth psychological look at death as viewed from the standpoint of the dying person.[2] She has identified five stages in the process of dying which include: (1) denial and isolation, (2) anger, (3) bargaining, (4) depression, and (5) acceptance. Each of the five stages has a psychological place in the development of a preparation for death.[3]

The medical-legal approach attempts to deal with death by explaining the role of the health professional in the dying process. Schneidman suggests that the doctor, nurse, social worker, and chaplain can be of great help during the final moments of life if

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[1]E. Kubler-Ross, Death: The Final Stage of Growth (Englewood Cliffs, New Jersey: Prentice-Hall, 1975), pp. 10-164.

[2]E. Kubler-Ross, On Death and Dying (New York: Macmillan, 1969), pp. 34-100.

[3]Ibid.

they can understand the family's conflicts at this time and help select the one person who feels most comfortable staying with the dying person.[1] Those who have the strength and the love to sit with a dying person in the silence that goes beyond words will know that the moment of death is neither frightening nor painful but a peaceful cessation of the functioning of the body.[2]

Another major area of the medical-legal approach is the medical term for the definition of death. There is endless controversy over this topic because of the ramifications of determining the point at which the cessation of the brain's function is irreversible. The Harvard Ad Hoc Committee to examine the definition of brain death established the criteria for brain death as: (1) unreceptivity and unresponsibility, (2) no movement or breathing, (3) no reflexes, (4) flat electroencephalogram.[3] The committee could not establish, however, that irreversible coma is death; thus, the issue remains unresolved.

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[1]Schneidman, pp. 201-321

[2]Ibid.

[3]W. Shibles, Death, Interdisciplinary Analysis (Whitewater, Wisconsin: The Language Press, 1974), pp. 200-235.

The health education approach combines the aforementioned approaches on death education into a course with both depth and scope. Harris suggests two main areas of emphasis to be considered by the health educator which are: (1) the education or informational and (2) the development of mental health and values clarification.[1] In either of these areas, the health educator can combine several aspects of the more limited approaches and aim at the well being of the total person, physically, mentally, and spiritually.

The health education approach provides an opportunity to examine life goals, philosophy, environment, fears, attitudes, grief, values, and loss.[2] This examination can help the individual view life more clearly from the perspective of one's imagined death.

An advantage of the health education approach to the study of death is that an understanding of one's

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[1]Harris, pp. 162-165.

[2]Sidney Simon, Values Clarification (New York: Hart Publishing Company, 1972), pp. 308-313.

own life and death can be developed.[1] Kubler-Ross explains that death is the key to the door of life.[2] It is through accepting the finiteness of individual existence that enables one to find the strength and courage to reject those extrinsic roles and expectations to devote each day to growing as fully as possible.

By combining a variety of approaches, the health educator can attempt to guide the individual in making intelligent decisions and in a clarification of values and the development of self-awareness about death. This can provide an environment of growth for the individual and thus help the person to live life more fully.[3]

A review of the literature reveals that classroom presentations, discussion, and group activities

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[1]Kastenbaum and Aisenberg, pp. 252-274.

[2]Kubler-Ross, Final, pp. 10-164.

[3]Herman Feifel, New Meanings of Death (New York: McGraw-Hill Book Company, 1977), pp. 17-24.

are included under the following broad subject areas:

1. Attitudes Toward Death
2. The Dying Process
3. The Terminally Ill
4. Euthanasia and Suicide
5. Bereavement and Grief
6. Rebirth of the Human Spirit
7. Funerals, Customs, and Rituals
8. Death as Identified in Music, Literature, and the Arts
9. Alternatives to Immediate Death[1]

In summary, death education is a recent concept to be added to the curriculum of American schools and universities. The systematic study of death and dying is approximately ten to twelve years old. Within this period, educators have advanced the subject to one that now provides a wide-open forum at all levels of education. The need for formal and informal education

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[1]Hardt, Development, pp. 96-99.

enabling people of all ages to cope with death and suicide appears to be increasingly evident.

Studies and Surveys about Death Attitudes

In 1975, Hardt developed a valid and reliable attitude scale to measure attitudes toward the concept of death.[1] The scale developed was a Thurston Equal-Appearing Interval Attitude Scale. Using the statistical test of correlation, concurrent validity demonstrated a coefficient of .84 while construct validity produced a coefficient of .98. Utilizing the split-half method of reliability with the Spearman-Brown Prophecy formula serving as an adjustment formula, a reliability coefficient of .87 was produced for the form. The scale was readable by the fifth grade and up when judged by criteria set forth by Flesch and by Dale and Chall.[2]

The following list includes the death attitude form, representative scale values for each of the attitude statements, and directions for use: The following

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[1] Ibid.

[2] R. Flesch, The Art of Readable Writing (New York: Harper and Brother, 1949), pp. 35-60; E. Dale and J. Chall, "A Formula for Predicting Readibility," Education Resource Bulletin 27 (March 1948): 11-194.

items are not intended to test your knowledge. There are no right or wrong answers. Your responses are anonymous. Directions: Read each item carefully. Place a check mark next to each item with which you Agree. Make No Marks next to items with which you disagree.

249 _____ The thought of death is a glorious thought.

247 _____ When I think of death I am most satisfied.

245 _____ Thoughts of death are wonderful thoughts.

243 _____ The thought of death is very pleasant.

241 _____ The thought of death is comforting.

239 _____ I find it fairly easy to think of death.

237 _____ The thought of death isn't so bad.

235 _____ I do not mind thinking of death.

233 _____ I can accept the thought of death.

231 _____ To think of death is common.

229 _____ I don't fear thoughts of death, but I don't like them either.

227 _____ Thinking about death is over-valued by many.

225 _____ Thinking of death is not fundamental to me.

223 _____ I find it difficult to think of death.

221 _____ I regret the thought of death.

219 _____ The thought of death is an awful thought.

217 _____ The thought of death is dreadful.

215 _____ The thought of death is traumatic.

213 _____ I hate the sound of the word death.

211 _____ The thought of death is outrageous.

To score, simply disregard the first number (2), place a decimal point between the two remaining numbers, and average the responses. The average will fall either on an attitude statement or between two attitude statements. Example: An individual checks items 237 (3.7), 235 (3.5), and 227 (2.7). By adding these together and dividing by the total number of items checked, an average of 3.3 is found. Hence, we can say that this person's attitude toward death at the time he/she took the test, is best described by statement 233, e.e. "I can accept the thought of death." Statements from 1.1 to 3.0 on the scale are considered representative of death attitudes ranging from Unfavorable to Neither Favorable nor Unfavorable, respectively. Statements from 3.0 to 4.9 on the scale are considered representative of death attitudes ranging from Neither Favorable or Unfavorable to Favorable, respectively. Hardt used the scale to test 692 subjects between the ages of thirteen and twenty-six. Attitudes toward the

concept of death were assessed and compared in relation to sex, age, social position, church attendance, and recency of death experience of family or friends. Using multiple regression analysis (α = .05) results of the study indicated that age, sex, social position, church attendance, and recency of death experience have little effect on one's attitude toward death. The study implied that the ability to adapt to the death of others and to accept the inevitability of one's own death appears to be a positive component of emotional health.

Hardt used his death attitude scale to evaluate eighty-six students ranging in age from eighteen to twenty-seven. A pretest-posttest design was utilized. No mention was made of a control group. A directional t-test for dependent samples was employed to treat the data. The selected level of significance was .05. The results of the study indicated that there had been an improvement in death attitude. This implied that there was a greater acceptance of the inevitability of one's own death as well as the death of others among the subjects in the study.

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[1]Hardt, Measurement, pp. 269-270.

Watts conducted a study to evaluate death attitude change among university students involved in a death education instructional unit.[1] Experimental group subjects (N = 39) were drawn from two introductory health education classes, while control group participants (N = 40) were obtained from two sections of a different health education course. The Hardt Death Attitude Scale and the Watts-Andrews Death Attitude questionnaire were selected as the dependent measures. The research design was quasi-experimental wherein a non-equivalent control group was employed. A pretest, treatment application, and posttest format was utilized with the experimental group. A pretest, nontreatment, and posttest format was employed within the control group.

Statistically, an analysis of covariance utilizing the pretest scores as the covariate was selected as the appropriate procedure to compare posttest mean death attitude scores. Adjusted posttest means of the death attitude scale were found to be significantly

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[1]Watts, pp. 187-193.

different. Comparison of the adjusted posttest means of the death attitude questionnaire revealed a significant difference. Watt's findings indicated more favorable death attitudes among the death education groups.

Hoelter and Epley reported their assessment of the impact of a death and dying course and examined the unique death-related attitudes of students choosing to enroll in such a course.[1] Subjects included students enrolled in a course in the sociology of death and dying and a course in the sociology of the family, the latter serving as the control group. Anlysis included seventeen students in each class for whom matched pretests and posttests were available. The classes were taught by the same instructor. The instrument consisted of two twenty-item semantic differential scales that evaluated attitudes toward the terminally ill; a six-item attitude toward suicide scale developed by Hoelter, three controversial death-related attitude items including

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[1]Hoelter and Epley, Death Education, pp. 67-75.

abortion, and capital punishment; and a factor-analytic multidimensional fear of death scale.[1]

The assumption that death education courses serve to reduce fear of death and promote positive attitudes toward the terminally ill was not supported by the findings of this research. Pretest, posttest results for the control group also yielded no significant differences.

Examination of pretest means between experimental and control classes yielded significant differences on the controversial death-related attitude measures and the attitude-toward-suicide measure. The multivariate test between the two groups on attitudes toward abortion, euthanasia, and capital punishment yielded an overall significant mean difference. Examination of the univariate F ratios showed only attitudes toward abortion to be significant. Students enrolled in the death and dying class had more favorable attitudes

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[1]R. J. Epley and C. H. McCaghy, "The Stigma of Dying: Attitudes Toward the Terminally Ill," Omega 8 (August 1978): 389-393.

toward abortion than those in the control class. Analysis of pretest data also showed death education students to hold more favorable attitudes toward suicide than did the control group.

Wittmaier reported the attitudes toward death and dying of fourteen students who took a death education course.[1] The treatment group was compared with a group of students who requested the course but were not able to be accomodated. A posttest-only design was used. The posttest was given two weeks after the course ended and included the Templer Death Anxiety Scale.[2] A t-test was used to compare the means of the two groups. The results indicated that those completing the course had higher fear of death scores and rated death more potent on a semantic differential. The treatment group also indicated they would feel more comfortable talking with a dying person.

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[1]Bruce C. Wittmaier, "Some Unexpected Attitudinal Consequences of a Short Course on Death," Omega 10 (February 1980): 271-275.

[2]D. Templer, "The Construction and Validation of a Death Anxiety Scale," Journal of General Psychology 82 (May 1970): 165-177.

In 1975, Bell utilized an experimental format to examine the influence of a course on death and dying on death attitudes of college students in a mid-southern university.[1] The experimental group (N = 24) consisted of those who had pre-enrolled for the course. The control group (N = 50) was chosen at random from the student population. The experimental group was exposed to an eighteen-week course on the social aspects of death and dying. Pre and posttest measures of death attitude were obtained by a Likert-type instrument developed by the researcher. The data were treated with analysis of variance. The findings of the study indicated significant changes in the cognitive component of those in the experimental group. These individuals entertained more frequent thoughts of death and manifested a greater amount of interest in death-related discussions than were true of the control group. Items constituting the affective dimension were not appreciably changed by experimental procedures. Both groups indicated approximately the same degree of fear in relation to death

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[1]Bill D. Bell, "The Experimental Manipulation of Death Attitudes: A Preliminary Investigation," Omega 6 (May 1975): 199-205.

and expressed similar feelings toward discussing their own or a close friend's death with other persons.

The effects of death education on fear of death and attitudes toward death and life were measured by Leviton and Fretz.[1] Students in two death education classes were compared with students of sex education and introductory psychology. Both the experimental and control groups completed a variety of attitudinal, motivational, and demographic background measures before and at the end of their courses. A pretest, post-test 2 x 2 repeated measures design was utilized for the study.

Analysis of the various dependent measures yielded two main effects (group effect and change effect), and one interaction (group by change). The results indicated that initially the death education students did not differ greatly from students in the other two courses in their beliefs, attitudes, and backgrounds. At the end of the death education course the experimental group viewed death as more approachable.

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[1]Dan Leviton and Bruce Fretz, "Effects of Death Education on Fear of Death and Attitudes Towards Death and Life," Omega 9 (August 1978): 279-283.

Collett and Lester conducted a study to devise separate measures of death fears, attempting to distinguish between the fear of death and the fear of the process of dying and to differentiate between these fears, depending upon whether they are for onesself or for another.[1] The subjects formed an original sample and a replication sample each consisting of twenty-five female undergraduates. Thirty-eight statements were composed concerning four fears: fear of death of self; fear of death of others; fear of dying of self; and fear of dying of others. The subjects were required to indicate agreement or disagreement with each item on a six-point scale ranging from strong agreement (+3) to strong disagreement (-3).

The scores of the subjects in the original sample on each item were correlated with the total score to which each item belonged. All items whose correlations were not significant at the .10 level of significance were eliminated.

The intercorrelations between the four subscales were, in general low. A three-way analysis of

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[1]L. Collett and D. Lester, "The Fear of Death and the Fear of Dying," Journal of Psychology 72 (June 1969): 179-181.

variance with repeated measures was carried out on the data with the two samples treated as a replication factor. The terms of the analysis involving the replication factor were all nonsignificant. The subjects showed a significantly higher fear of death than of dying. The subjects also showed a significantly greater fear when the self was the referent than when another was the referent.

The low intercorrelations between the four fears indicated the potential usefulness of differentiating the four specific fears rather than indiscriminately grouping all items on the same scale. This could possibly lead to an improvement in available measures of the fear of death. The results further indicated that of the four fears, fear of dying of others was least feared. For this subscale the mean score was negative, indicating that, in general, the subjects faced this topic rather than avoiding it.

A quasi-experimental study was done by Knott and Prull to evaluate the effectiveness of a college death education course on attitudes toward death and dying.[1] Two groups (control and experimental total

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[1]Knott and Prull, pp. 177-181.

N = 70) were asked to complete a brief survey of attitude and demographic information related to death and dying. The attitudinal items, nine in number, were all Likert-scaled. This scale was given as a pretest at the beginning of the spring semester and then as a post-test at the end of the semester. The majority of both groups were female, white, in their early twenties and Catholic. Gain scores for the nine attitudinal items were computed for each group and t-tests were applied to the data comparing the two groups on the difference between gain scores. Statistical significance ($p < .01$) was found in only one case.

In comparison to the control, the experimental group showed a marked increase in thought about their own death. The data suggested further exploration of a few dimensions, such as attitudes concerning suicide and mourning and grief rituals. The researchers felt that the results were disappointing. The investigators concluded by calling more attention to the need of accountability in death education courses. Thanatologists of all persuasions need to put more into the evaluation of educating others for living by educating them about dying.

Hardt conducted an investigation of the stages of bereavement of a sample population of 692 individuals ages thirteen through twenty-six.[1] Bereavement may take many forms and affects not only the individual's concept of the world but one's self-concept as well. The loss of a loved person suddenly and violently alters one's view of the world and more importantly, provides drastic alterations in one's view of himself.[2] The purpose of the study was to determine how long one suffers after the death of a loved one.

The instrument used was the Hardt Death Attitude Scale.[3] A second instrument consisted of a questionnaire developed by the investigator and included six variables: age, sex, educational level of self, religious beliefs, and recency of death experience. Recency of death experience was defined as how long it

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[1]Dale V. Hardt, "An Investigation of the Stages of Bereavement," Omega 9 (August 1979): 277-285.

[2]J. P. Cattell, "Psychiatric Implications in Bereavement," in Death and Bereavement, ed. A. H. Kutscher (Springfield, Illinois: Charles C. Thomas, 1974):, p. 153.

[3]Hardt, Development, pp. 96-99.

had been since an emotionally close friend or relative died.

From the data provided it was hypothesized that the mourning process can be identified as being comprised of five phases or stages. It was concluded that it takes about eight months to pass through the stages before reorganization or acceptance of the death of a loved person can be identified.

The following are the stages that a person passes through with the loss of a loved one: Stage I--from the time of death up to, but not including one month; Denial; Stage II--one month to but not including, the second month; False acceptance; Stage III--two months to, but not including the third month; Pseudo-reorganization; Stage IV--three months to, but not including eight months; Depression; Stage V--eight months and longer; Reorganization and acceptance. The implications of the study were that the mourning process extends for at least eight months. According to the author, this process seems normal and should be considered so by therapists, counselors, and close friends or relatives of the mourner.

The impact of a death and dying workshop on individual attitudes toward life and death were examined by Durlak.[1] The workshop was a voluntary eight-hour, small group experience conducted for heterogeneous hospital staff of a large southeastern medical center. Pretest-posttest questionnaire data were collected from two groups of workshop participants (N = 51) and a matched control group (N = 19). The workshop group was divided into two experimental groups consisting of nineteen participants from two didactically-oriented workshops and thirty-two participants from three experientially-oriented programs. The total sample averaged thirty-two years of age and 67 percent were female. The dependent measures included Templer's Death Anxiety Scale, Lester's Fear of Death Scale, Crumbaugh and Maholick's Purpose in Life Test, and the Marlowe-Crowne Social Desirability Scale.[2]

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[1]Joseph A. Durlak, "Comparison Between Experiential and Didactic Methods of Death Education," Omega 9 (February 1978): 55-56.

[2]D. I. Templer, "The Construction and Validation of a Death Anxiety Scale," Journal of General Psychology 82 (January-October 1970): 165-177; D. Lester, "Fear of Death of Suicidal Persons," Psychological Reports 20 (February-June 1967): 1077-1078; J. C. Crumbaugh and L. T. Maholick, "An Experimental Study in Existentialism: The Psychometric Approach to Frankl's Concept

One of the workshop groups participated in an educational program emphasizing lecture presentations and small group discussion. In contrast, the second workshop group confronted, examined, and shared their own feelings and reactions to grief and death. Role Playing and death awareness and grief exercises were used for this purpose.

Correlational data indicated that social desirability response parameters were a relatively unimportant influence on questionnaire scores. Only the posttest relationship between the death anxiety and Marlowe-Crowne scales reached significance and this correlation was small in magnitude.

The purpose in life test was significantly and negatively correlated with both death scales. The significant pretest and posttest correlations between the two death scales indicated some, but not a major degree, of measurement overlap between these two instruments. One-way analysis of variance were performed on

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of Noogenic Neurosis," Journal of Clinical Psychology 20 (January-September 1964): 200-207; D. Marlowe and D. Crowne, "A New Scale of Social Desirability Independent of Psychopathology," Journal of Consulting Psychology 24 (February-December 1960): 349-354.

pretest questionnaire scores to assess initial comparability of groups. No significance between group differences were found.

All F tests were nonsignificant for scores on the purpose in life test. A significant main effect for time and a significant group by time interaction appeared in the analysis of scores on the Templar scale. Post hoc mean comparisons indicated the didactic group differed significantly from the experiential but not the control group. The latter two groups did not significantly differ from one another.

Analysis scores on the Lester Scale also yielded a significant main effect for time and a significant group by time interaction. Duncan tests indicated that the experiential group differed significantly from the other two groups who did not differ from one another. Results indicated that the experiential workshop decreased participants' fears and concerns about death while only slightly heightening their anxieties about death. In contrast, the didactic workshop apparently had negative effects since participants reported greater fears and anxieties about death at the end of the workshop than when they began it. Controls showed slight negative

changes in these death measures over time. No changes appeared in purpose in life scale scores for any of the groups. The author concluded than an emotional, personal approach to death is an important element in an effective death education program.

Dickstein investigated the relationships between existing death scales as they relate to measures of anxiety, social desirability and death attitude.[1] The subjects were thirty-four male and thirty-four female undergraduates of Harvard University. The mean age of the participants was 20.06 for females and 20.44 for males. All subjects completed six scales including: the Death Concern Scale, the Tolor and Reznikoff Death Anxiety Scale, the Templer Death Anxiety Scale, the Fear of Death and Dying Scale, the Marlowe-Crowne Social Desirability Scale, and the State-Trait Anxiety Inventory.[2] The

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[1]Louis S. Dickstein, "Attitudes Toward Death, Anxiety, and Social Desirability," Omega 8 (November 1977-1978): 369-378.

[2]L. Dickstein, "Death Concern: Measurement and Correlates," Psychological Reports 30 (February-June 1972): 563-571; A. Tolor and M. Reznikoff, "Relation Between Insight, Repression-Sensitization, Internal External Control and Death Anxiety," Journal of Abnormal Psychology 72 (October 1967): 426-430; D. Templer, "The Construction and Validation of a Death Anxiety Scale," Journal of General Psychology 82 (June-October 1970): 165-177; L. Collett and D. Lester, "The Fear of Death and the Fear of

scales were administered in random order with different subjects receiving different orderings. The volunteer participants were tested in groups.

The results indicated that the death scales showed moderate commonality reflecting 35 percent common variance for both males and females. Three of the scales showed significant ($p < .05$) negative correlations with social desirability. There were no significant sex differences on the death scales. The study provided support for the construct validity of the various death scales. The researcher concluded that the scales measuring attitudes toward death do appear to contain an element of social desirability. The relationships appear to support the contention that concern about death is not a socially desirable standard in American culture.

Similarities and dissimilarities in attitudes toward death in a population of older persons were

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Dying," Journal of Psychology 72 (July 1969): 179-181; D. Crowne and D. Marlowe, "A New Scale of Social Desirability Independent of Psychopathology," Journal of Consulting Psychology 24 (February-December 1960): 349-354; S. Spielberger, R. Gorsuch and R. Lushene, State-Trait Anxiety Inventory Manual (Palo Alto, California: Consulting Psychologists Press, 1970), PP 78-84.

evaluated by Wass, Christian, Myers, and Murphey.[1] The subjects were seventy-one persons age 65 or above, who were selected from three different types of residence communities. An abbreviated form of Shneidman's questionnaire was used to survey attitudes of older persons concerning death.[2] Responses for the total sample were tabulated. Responses were then tested for differences with respect to type of community in which participants resided, educational level, income, living arrangement, and sex. The McSweeny Formula was used to test for significance of differences between groups.[3] This formula is a modification of the chi-square allowing for multiple comparisons among proportions. The hypotheses that not only similarities but also significant differences exist among older persons in their attitudes and opinions concerning various aspects of death was supported by the data. Very few differences were found between men and

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[1]Hannelore Wass, Milton Christian, Jane Myers and Milledge Murphey, Jr., "Similarities and Dissimilarities in Attitudes Toward Death in a population of Older Persons," Omega 9 (November 1977): 337-354.

[2]E. S. Shneidman, "You and Death," Psychology Today 5 (June 1971): 43-45.

[3]M. McSweeny, A. C. Porter, and L. A. Mara-Seiulo "American Educational Research Association Pre-Session on Nonparametric Measures and Associated Post-hoc Procedures." Mimeographed Lecture Number 9, (1971): 7.

women and between subjects living with family and living alone. There was an apparent inverse relationship between influence of traditional religious beliefs on attitudes toward death, and educational level. Rural elderly persons exhibited a much higher degree of traditional religious influence than did the urban elderly.

From the data, the researchers implied that the general public needs to be educated in order to understand that old persons are not a homogeneous group. It was also clear that old persons have strong convictions and opinions concerning death and dying, and are willing to express them when given the opportunity. Findings of the study with respect to the timing of death have important implications for physicians and families. The data indicated the need for death and dying to be openly discussed. The data showed that the majority of the elderly want to be told if they are terminally ill and want to be allowed to die a natural death rather than have their lives prolonged by artificial means. The findings also indicated that most older persons do not become upset and anxious when the subject of death is discussed. It appears that the older subjects welcome the opportunity to voice their views and opinions.

Death attitudes and experiences of rehabilitation counselors were investigated by Bascue and Lawrence.[1] A ten-item biographical questionnaire developed by the researchers and a forty-five-item multiple-choice death attitude and experience inventory was administered to sixty-five rehabilitation counselors.[2] Statistical procedures were not mentioned.

There were fifty-four subjects for the study with 46 percent male and 54 percent female. The study showed the following results: (1) the majority of the counselors had a positive attitude about death, (2) the majority of the counselors wanted to be told by a physician if they were terminally ill, (3) 70 percent of the counselors felt that at least a few cases of potential suicide should not be prevented. (4) 13 percent of the subjects felt funeral practices were not very important for the survivors of dead individuals.

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[1]Loy O. Bascue, Richard E. Lawrence, and Jo Ann Sessions, "Death Attitudes and Experiences of Rehabilitation Counselors," Suicide and Life-Threatening Behavior 8 (April-June 1978): 14-17.

[2]E. S. Shneidman, "You and Death," Psychology Today 4 (August 1970): 67-72.

The question, "What motivates individuals to choose voluntarily to confront the subject of Death?" was evaluated by Bluestein.[1] The Psychology Today questionnaire was administered to eighty-two psychology of death students.[2] The responses of the thanatology class were compared to those of a national sample that utilized the same questionnaire.[3] The purpose of the comparison was to ascertain whether there were significant differences between the two groups' attitudes. Chi-squares were computed to test the hypotheses that the thanatology students would not differ significantly from the national sample. All questionnaires were filled out anonymously by the subjects in both groups (national sample N = 30,000). The subjects ranged in age from twenty to twenty-four years, were single, Caucasian and protestant. Males and females were equally divided into two groups. Subjects were upper classmen majoring in psychology, and came from a relatively small family.

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[1]Venus W. Bluestein, "Death-Related Experiences, Attitudes and Feelings Reported by Thanatology Students and a National Sample," Omega 6 (August 1975): 207-218.

[2]Shneidman (1970), pp. 67-72.

[3]Shneidman (1971), pp. 43-45.

On most of the items which were compared, the thanatology students did not differ significantly from the national sample. However, some significant trends did emerge. In general, the chi-square calculations showed the thanatology student to be more likely to remember childhood concepts of death and more likely to recall how death was spoken of in the family as a child. Similarly, death was more likely to have been discussed openly in the home of the thanatology students than was true in the national sample.

The thanatology students thought more frequently about their own death and were concerned more about the effects that one's death will have upon loved ones than about the loss of ego. The investigator concluded that thanatology students seem to be more sensitive to interpersonal relationships.

Kahana and Kahana investigated the attitudes of young men and women toward awareness of death.[1] Subjects were ninety college students at a major private university. There were thirty-eight men and fifty-two women in the

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[1]Boaz Kahana and Eva Kahana, "Attitudes of Young Men and Women Toward Awareness of Death," Omega 3 (February 1972): 37-44.

sample. Subjects ranged in age from nineteen to forty-three with a median age of twenty-four.

A questionnaire, especially developed for the study and pretested on a small group of college students was administered to the subjects. The questionnaire included information on age, sex, college major, and questions about attitudes toward awareness of impending death. Attention was focused on temporal death attitudes.

Results supported clinical observations indicating that, for many individuals, the perception of death from a temporal distance may be quite a different matter than when it is perceived as personally near.[1] Significantly more subjects wanted to be informed of impending rather than eventual death, than did not. Knowledge of impending death was seen by this group as a form of mastery over death in both practical and emotional terms. The study revealed two major reasons for desire to be informed of impending death: (1) pragmatic responses, and (2) subjective responses. Pragmatic responses almost always focused on the individual's responsibility for others who will remain living. Reasons which were termed as subjective focused on the intellectual and emotional needs

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[1]H. Feifel, "Death," ed. N. L. Farberow, Taboo Topics (New York: Atherton Press, 1963): pp. 8-21.

of the dying individual for such knowledge regardless of its practical usefulness.

Death was accepted by the subjects primarily as the inevitable end to a full life cycle. As indicated by the results, the majority of the respondents expressed little fear of awareness of death when it was impending. In contrast, the subjects portrayed strong and pervasive fears by their unwillingness to face knowledge of their life expectancy. These findings support Feifel's view that the unknown can be feared more than the most dreaded reality.[1]

Steininger and Colsher correlated attitudes about the right to die among 1973 and 1976 high school and college students.[2] The purpose of the study was to examine the issue of the individual's right to choose death.

Subjects included 544 high school students and 274 college students. A questionnaire developed by the researchers, was administered to the study sample. Two hundred eighty-four subjects completed the questionnaire in 1973 while 260 responded in 1976.

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[1]Feifel, Death, pp. 8-21.

[2]Marion Stininger and Sandra Colsher, "Correlations of Attitudes about 'The Right to Die' Among 1973 and 1976 High School and College Students," Omega 9, (November 1978): 355-368.

The survey was designed to study the following attitudinal statements: (1) people have the right to decide whether they want to live or die, (2) doctors should go along with it when people dying of incurable diseases ask them to end their lives quickly and painlessly, (3) when people die, there is nothing left of them except in the memories of those who knew them. The research questions were: (1) how accepted were these three items, (2) to what degree were they intercorrelated, (3) to what degree were they correlated with liberalism-conservatism, dogmatism, and other items in the questionnaire? Chi-square and Pearson's product moment correlation were used to treat the data. The data were tested at the .05 level of significance.

The results of the study suggested that the attitudes explored change as a function both of personality and current social factors. Education was not always related to the attitude studied. The death attitude items were related to beliefs about religion, abortion, teenage birth control, and the worth of current ideas.

The right to die items were positively correlated in all groups; the more conservative the students, the

likelier they were to disagree with them. Agreement was related to belief in self-determination in moral and social matters. The item rejecting life after death was generally unrelated to the right to die items and to liberalism-conservatism, but its acceptance was greater among the more dogmatic college students.[1] A general item about the right to decide between life and death, and a specific one about that right for the terminally ill was accepted by more than half of the sample; both were more accepted than an item rejecting life after death.[2]

Studies and Surveys About Suicide Acceptability

In 1978, Hoelter did a study to test two hypotheses: (1) the acceptability of suicide is a decreasing function of religiosity; (2) the acceptability of suicide is a decreasing function of fear and death.[3] Questionnaire data were collected from 205 respondents

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[1]M. Stininger, and H. Lesser, "Dogmatism, Dogmatism Factors and Liberalism-Conservatism," Psychological Reports 35 (August-December 1974): 15-21.

[2]R. A. Kalish, "The Aged and the Dying Process: The Inevitable Decision," Journal of Social Issues 21 (January-October 1965): 87-96.

[3]Hoelter, Religiosity, pp. 163-172.

(146 female and 59 males) at a midwestern university. The questionnaire included Hoelter's six-item suicide acceptability scale, Putney and Middleton's Religious Orthodoxy Scale, self-reported religiosity and belief in a supreme being, childhood and current church attendance, and a factor analytic multidimensional fear of death scale.[1] Results of the study supported the first hypothesis that the five measures of religiosity are inversely related to suicide acceptability. The study also supported the second hypothesis that suicide acceptability is a decreasing function of fear of death. Based on the results of the multiple correlations, Hoelter concluded that fear of death is a slightly better predictor of the acceptability of suicide as compared to the religiosity measures.

Attitudes toward death and suicide in a non-disturbed population were evaluated by Lester in 1971.[2] Rather than focusing on those patients who had attempted

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[1]S. Putney and R. Middleton, "Dimensions of Religious Idealogy," Social Forces 39 (May 1961): 285-290.

[2]David Lester, "Attitudes Toward Death and Suicide in a Non-Disturbed Population," Psychological Reports 29 (August-December 1971): 386.

suicide, the purpose of his study was to examine attitudes among those who had not attempted suicide.

The subjects were forty-six students in a course of introductory psychology; twenty-three males and twenty-three females ranging in age from seventeen to fifty years with the median age being twenty-two and one-half years. Each subject completed two fear-of-death scales and rated the concept of suicide on the activity, potency, and evaluative scales of the semantic differential.[1]

The Pearson Product-moment correlations among the three semantic differential measures of attitudes toward suicide and six measures of death attitudes were computed. Lester reported three of the eighteen correlations were significant at the .10 level of significance and resulted from chance factors (a two-tailed test was utilized). There appeared to be no consistency in the direction of the association among the correlation coefficients.

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[1]Collett and Lester, pp. 179-181; Lester, pp. 1077-1078; C. Osgood, G. J. Suci, and P. H. Tannenbaum, The Measurement of Meaning (Urbana, Illinois: University of Illinois Press, 1957), pp. 104-113.

On the Lester Fear of Death Scale, there is an item "nothing can be so bad that a sane man would commit suicide."[1] Those agreeing with this item were compared with those disagreeing on the Collett and Lester Fear of Death Scale.[2] Because males and females differed in their fear of death, a two-way analysis of variance was computed for each subscale of the Collett-Lester Fear of Death Scale with the two variables being sex and agreement versus disagreement with the suicide item on the Lester Scale. The effect of agreement versus disagreement with the suicide item on the fear of death on the Collett-Lester Scale was not significant. Lester concluded that there appeared to be no association between attitudes toward suicide and attitudes toward death in a non-disturbed population.

Neuringer studied changes in attitudes toward life and death during recovery from a serious suicide

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[1]Lester, Fear, pp. 1077-1078.

[2]Collett and Lester, pp. 179-181.

attempt.[1] The purpose of the study was to assess the suicide attempter's attitudes toward life and death, and linking those attitudes to one's self-destructive behavior. The study also investigated the assumption that the life of an individual attempting suicide has to be experienced negatively and that death as an expectancy will bring about a neutral state or some positive existence in order for death to be chosen over life.[2]

A semantic differential scale was developed by the investigator.[3] The study utilized nine evaluative scales: good-bad; dirty-clean; nice-awful; unpleasant-pleasant; fair-unfair; worthless-valuable; happy-sad; dishonest-honest; and beautiful-ugly. The subjects were asked to rate what the concepts of life and death meant for them personally on the semantic differential. Half of the subjects (N = 5) received the test one and a half days after their suicide attempt, while the other subjects

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[1]Charles Neuringer, "Changes in Attitudes Toward Life and Death During Recovery from a Serious Suicide Attempt," Omega 1 (November 1970): 301-309.

[2]R. S. Cavan, Suicide (Chicago: University of Chicago Press, 1929), p. 56-80.

[3]Osgood, Suci, and Tannenbaum, pp. 18-21.

(N = 5) were evaluated two weeks after their suicide attempt.

The subjects were gathered from five Veterans Administration hospitals and one large metropolitan general hospital. All of the subjects were native born, Caucasian males between the ages of twenty-one and fifty-five. They were of average intelligence as defined by the Wechsler-Bellevue Intelligence Scale, Form I.[1] None of the subjects were psychotic and they were all in good enough mental and physical condition to participate in the research project. In order to compensate for the small sample, attention was given to subject selection procedures. The results of the study indicated the general assumption that the attitudes towards life and death must be negative and positive respectively, in order for suicide to occur, were not substantiated. Although the attitudes towards death were somewhat positive, it was found that the feelings about life were even more positive. The study of changes of these feelings over time indicated that the attitude toward death shifted from somewhat positive to clearly negative. But the attitude toward life remained stable.

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[1]D. Wechsler, The Measurement of Adult Intelligence (3rd ed.) (Baltimore, Maryland: Williams and Wilkins, 1944), pp. 118-122.

The data of the two groups were evaluated by the t-test. The t-test values associated with the differences between the activity and potency meaning factor scales for death made by the two groups of subjects were statistically significant. The investigator concluded that it appears that death grows more abhorrent to the suicide attempter as he begins to recover from a serious suicide attempt.

CHAPTER III

METHODOLOGY

Introduction

The purpose of this study was to determine whether death education alters attitudes toward death and suicide acceptability. In addition, the study was conducted to ascertain if a relationship exists between death attitude and suicide acceptability, and to determine if a time span makes a difference on the impact of death education. The study included 100 persons divided into two groups: fifty persons who served as the experimental group and fifty persons who participated in the control group. The study was conducted during September and October 1980, at Huguley Memorial Hospital, Fort Worth, Texas. The procedures followed in the development of the investigation are described under the following subheadings: (1) preliminary procedures; (2) selection and description of the instruments; (3) selection of the site; (4) selection of subjects; (5) procedures followed in assignment to groups; (6) collection of data; and (7) treatment of data.

Preliminary Procedures

At the beginning of this study all accessible literature pertaining to death education was collected and studied. From this material, course content was selected for the death education seminar. The following is an outline of the death education course which was used as the treatment for the study:

1. Theories of Death
   - A. The sociology of death and dying
   - B. Religious views
   - C. Language and definitions of death
2. Attitudinal Positions on Death and Dying
   - A. The fear of death and dying
   - B. Guilt reactions
   - C. Death and the quality of life
   - D. Coming to grips with one's own feelings
3. The Stages of Dying
   - A. The dying process
   - B. The grief process
   - C. The concept of human loss
4. Coping With the Stress of Death and Dying
   - A. Coping styles
   - B. Identifying the cause of stress
   - C. Coping mechanisms

5. Issues on Death and Dying

   A. The cost of dying--the consumer

   B. Euthanasia and suicide

   C. Murder and war

Based on a comprehensive review of the literature, appropriate criteria were established for: (1) the selection of the instruments to be used in the study, (2) the selection of the subjects to be tested, (3) the administration of the instruments, and (4) the selection of the site.

Personal interviews were conducted with the management of Huguley Memorial Hospital in Fort Worth, Texas, to determine the possibility of administering the instruments. The main reasons for selecting Huguley Memorial Hospital as the site for the study were: (1) the ability of Huguley Memorial Hospital to attract sufficient participants for the study, and (2) the receptive attitude toward academic research that was exhibited by the administration of the hospital.

Permission was granted by the vice-president of the hospital to conduct the study, with the understanding that the participants have the choice of whether or not to participate. It was further understood that the hospital would assume no liability as a result of the study.

Selection of the Instruments

Criteria were established for selection of the two instruments used in the study. The Hardt Death Attitude Scale was selected to determine the death attitude of the subjects. To evaluate suicide acceptability, the Hoelter Suicide Acceptability Scale was chosen for use in the study.

The Hardt Death Attitude Scale

The criteria established for the selection of an instrument to measure death attitude were:

1. The instrument must be able to measure attitudes toward the concept of death
2. The instrument must be considered adequate by the author with respect to reliability and validity
3. The instrument must be considered adequate by the investigator with respect to reliability and validity
4. The instrument must not cost more than 50¢ per copy
5. The instrument must not take more than thirty minutes to complete

The Hardt Death Attitude Scale was developed in 1975.[1] See Appendix A for copy. It was designed to

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[1]Hardt, Development, pp. 96-99.

measure attitudes toward the concept of death. Hardt utilized the Thurston Equal-appearing Interval Attitude Scale in the construction of the test. The form consisted of twenty odd-numbered attitude statements ranging from 1.1 to 4.9 in .2 intervals. Statements from 1.1 to 3.0 on the scale are considered representative of death attitudes ranging from unfavorable to neither favorable nor unfavorable, respectively. Statements from 3.0 to 4.9 on the scale are considered representative of death attitudes ranging from neither favorable nor unfavorable to favorable, respectively.

The twenty responses on the questionnaire are not intended to test knowledge. Since attitudes are being measured, there are no right or wrong answers. To determine attitude, the subject is instructed to place a check mark next to each item of agreement. No check marks are placed next to items of disagreement. The twenty responses range in number from 249-211. To score the form, the first number (2) is disregarded, a decimal point is placed between the two remaining numbers, and the responses are averaged. The average will fall either on an attitude statement or between two attitude statements.

Using the statistical test of correlation, concurrent validity demonstrated a coefficient of .84 while

construct validity produced a coefficient of .98.[1] Utilizing the split-half method of reliability with the Spearman-Brown prophecy formula serving as an adjustment formula, a reliability coefficient of .87 was produced for the form.[2]

The Hoelter Suicide Acceptability Scale

The criteria established for the selection of an instrument to measure acceptability were:

1. The instrument must be able to measure suicide acceptability. See Appendix A for copy
2. The instrument must be considered adequate by the author with respect to reliability and validity
3. The instrument must be considered adequate by the investigator with respect to reliability and validity
4. The instrument must not cost more than 50¢ per copy
5. The instrument must not take more than thirty minutes to complete

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[1]Hardt, Development, pp. 96-99.

[2]Ibid.

The Hoelter Suicide Acceptability Scale was developed in 1978.[1] It was designed to measure the degree to which suicide offers an acceptable solution to one's problems. The questionnaire developed was a Likert-type scale. The form consisted of six suicide statements. For each item the following choices were available: strongly disagree, disagree, neutral, agree and strongly agree. The value of each item ranged from one through five, with five indicating the strongest suicide acceptability. The total possible points a subject could obtain was thirty. The higher the score, the more suicide is viewed as an acceptable action. Hoelter believes that the scale can be an important tool in assessing the probability of suicide because it measures the degree to which suicide becomes an acceptable action for the individual.

Utilizing the Pearson Product Moment Correlation, a reliability coefficient of .78 was produced for the questionnaire. No validity coefficient was given for the form.

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[1]Hoelter, Religiosity, pp. 163-172.

The Selection of the Site

The criteria established for the selection of Huguley Memorial Hospital as the site for the study were:

1. The site must be within reasonable driving distance for the investigator
2. There must be no expense to the investigator for the use of the site to conduct the study
3. The administrators of the site must be willing to give permission for the study
4. There must be a method of advertising to solicit the participants for the study
5. There must be secretarial help available
6. There must be classroom space available
7. The site must have credibility within the community in order for subjects to be attracted to support the death education program
8. The administrators of the site must be free from any liability as a result of the study
9. The participants must be able to choose to participate in the study

After establishing criteria for the selection of the site the investigator conducted personal interviews with the administrators of Huguley Memorial Hospital. Upon completion of the interviews permission was granted by the vice-president of the hospital to conduct the study.

Selection of Subjects

The criteria established for the selection of subjects for the study were:

1. Subjects must be willing to participate in the study
2. Subjects must be willing and able to participate in the study during September and October 1980
3. Subjects must be 18 years of age or older
4. Subjects must be accessible for two posttests
5. Subjects must be willing to participate without compensation
6. Subjects must be willing to participate in ten hours of death education at the study site.

Procedures Followed In Assignment to Groups

During the months of August and September 1980, media advertising was released by the hospital's public relations department to solicit volunteers for the study. Media advertising included local newspapers and local radio stations. See Appendix B for the newspaper advertisement and radio public service announcement.

From this solicitation, 209 individuals were randomly assigned to either the experimental or control groups. Random assignment was attained by the drawing of

numbers at the first session of the death education class. Numbers ranged from 1-300. Every other number was on a colored paper. Those receiving the colored paper were assigned to the control group while those receiving non-colored paper were assigned to the experimental group. The control group consisted of 104 individuals and the experimental group had 105 participants. Upon completion of the oral presentation by the investigator, which explained the study to the subjects, the control group was dismissed while the experimental group began ten hours of death education in five consecutive sessions, September 22-26, 1980, from 7:00 p.m. to 9:00 p.m.

At the end of the death education class on September 26, the control group returned and with the experimental group took the first posttest. Beginning September 29, the control group returned and was given the identical death education course as the experimental group. During this time, the experimental group was not present. The seminar continued through October 3, 1980. At the end of the second death education class on October 3, the experimental group returned, and at the same time

as the control group, took posttest 2. At the time of posttest 2, there were fifty subjects in the experimental group and fifty subjects in the control group who met the criteria for inclusion in the study. The subjects consisted of both male and female adults of varying ages, educational background, marital status, religious beliefs, and with diverse reasons for attending the death education seminar.

Collection of the Data

The following areas were considered in the collection of the data: (1) the criteria for the administration of the instruments and (2) instructions for completing the death attitude scale and the suicide acceptability scale.

Criteria for the Administration of the Instruments

The criteria established for the administration of the instruments specified that:

1. The investigator must gain proper permission from the Human Subjects Review Committee to administer the selected tests to subjects. The approval letter is in Appendix C

2. The investigator must gain written permission from the study site to administer the selected tests to subjects. See Appendix C for the letter of approval
3. The questionnaires must be administered to the subjects during September and October 1980
4. The administration of the instruments must be limited to those who give signed consent. A copy of the form is in Appendix D
5. All directions for administering the tests must be identical

Instructions for Completing Tests

The instructions for administering the tests were the same for each group. The investigator administered the tests to both groups. Before the tests were given, the purpose of the study was explained to the subjects. The following procedures were followed for the completion of the tests:

1. Each posttest was administered to both groups at the same time
2. The instructions to both tests were read to each group with further explanation when needed

3. The subjects were encouraged to take as much time as was needed for the tests
4. Subjects were asked not to discuss items on the questionnaire with anyone else in the room
5. Subjects were instructed to take the death attitude questionnaire and then take the suicide acceptability scale. The death attitude scale was labeled as questionnaire one, while the suicide acceptability scale was marked as questionnaire two
6. Subjects returned all completed tests to the investigator

Treatment of Data

Death Attitude Scale

The statistical procedures involved with this scale focused on the following purposes: to ascertain whether death education alters attitudes toward death; to access whether time makes a difference on the impact of death education; and, to determine if a relationship exists between death attitude and suicide acceptability. To determine the significance of the differences between the two groups with respect to altering death attitudes and the impact of time on death attitudes, a two-way

analysis of variance with repeated measures was utilized.[1] To determine where the differences in the means existed, Tukey's subsequent test for comparison of means was applied to the data.[2] The hypotheses tested were numbers: 1, 3, 5, 7, and 9. (See Chapter I for hypotheses.)

To determine the relation between the death attitude scores and the suicide acceptability scores, the Pearson Product Moment Correlation was utilized.[3] The hypotheses tested were numbers 12 and 14. (See Chapter I for hypotheses.)

Hypotheses numbered 11, 13, and 15 (see Chapter I for hypotheses) utilized the Pearson Product Moment Correlation to analyze the relationship between death attitude scores and suicide acceptability scores. Further, the independent samples t-test was utilized to determine the significance of the differences between the experimental and control groups.[4]

Suicide Acceptability

The statistical procedures involved with this scale centered on the following purposes: to ascertain

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[1] B. J. Winer, Statistical Principles in Experimental Design (New York: McGraw-Hill Book Comapny, 1962), pp. 514-559.

[2] Ibid. [3] Ibid., 58-76. [4] Ibid., 14-26.

whether death education alters suicide acceptability; to assess whether time makes a difference on suicide acceptability. To determine the significance of the differences between the two groups with respect to altering suicide acceptability, and the impact of time on suicide acceptability, a two-way analysis of variance with repeated measures was utilized.[1] To determine where the differences in the means existed, Tukey's subsequent test for comparison of means was applied to the data.[2] The hypotheses tested were numbers: 2, 4, 6, 8, and 10. (See Chapter I for hypotheses.) Demographic data were subjected to chi-square.

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[1]Winer, pp. 514-559.

[2]Ibid., 198-202.

CHAPTER IV

RESULTS OF THE STUDY

Introduction

The purpose of this chapter was to present a narrative and tabular form of the data collected in this study. The purposes of this investigation were threefold: (1) to ascertain whether death education alters attitudes toward death and suicide acceptability, (2) to determine if a relationship exists between death attitude and suicide acceptability and, (3) to determine whether or not a time span of seven days makes a difference on the impact of death education.

The study involved 100 subjects who volunteered to participate in a short course on death education. The findings of this study were based upon data collected from these subjects who lived in the Dallas-Fort Worth Metroplex during September and October 1980.

Two tests were administered to each individual: (1) the Hardt Death Attitude Scale which provided the individual with choices about death attitude, and (2) the

Hoelter Suicide Acceptability Scale which provided the individual with choices about the degree to which suicide offered an acceptable solution to one's problems. The data were treated statistically by the two-way analysis of variance with repeated measures, the Pearson Product Moment Correlation and Chi-square. Each analysis was presented in tabular form in this chapter. The .05 level of significance was used to determine if a significant difference existed between the two groups. In addition to these statistical analyses, the raw data on each of the variables is presented in Appendix F. This chapter is organized for the analysis and interpretation of data under the following subheadings: (1) description of the groups in the study, (2) performance of the groups on the tests and, (3) differences between the groups.

Description of the Groups in the Study

Tables 1 and 2 reveal the age distribution in years of both the experimental and control groups. The ranges, means, and standard deviations are presented.

The experimental group who chose to participate in the study ranged from twenty-seven to seventy-three years of age. A mean age of 47.56 years and a median of 47.5

years was obtained for the subjects. The standard deviation was 12.28 years. Eighteen percent of the participants (N = 9) consisted of males while 82 percent (N = 41) were females. The mean recency in months since a death experience was 19.72 with a standard deviation of 28.86.

The control group who chose to participate in the study ranged from nineteen to seventy-two years of age. A mean age of 44.2 years and a median of 44 years was obtained for the subjects. The standard deviation was 12.34 years. Twenty-six percent of the participants (N = 13) consisted of males while 74 percent (N = 37) were females. The mean recency in months since a death experience was 23.5 with a standard deviation of 24.17.

TABLE 1

Age Distribution in Years of the Experimental Group

N	Range	Mean	Median	Standard Deviation
50	46(73-27)	47.56	47.5	12.28

TABLE 2

Age Distribution in Years of the Control Group

N	Range	Mean	Median	Standard Deviation
50	53(72-19)	44.2	44	12.34

The following research design was utilized for the study:

		Posttest 1		Posttest 2
Random Assignment 50 Ss Experimental Group	Treatment / One Week	☐	/ One Week	☐
Random Assignment 50 Ss Control Group	/	☐	Treatment /	☐

To indicate the effectiveness of the death education course, a significant difference must exist between posttest 1 of the experimental group and posttest 1 of the control group. Further, the experimental group at posttest 2 must be significantly different than the control group at posttest 1. Also, a significant difference must exist between posttest 1 and 2 of the control group.

Performance of the Groups on the Tests

Death Attitude Scale

The scoring procedure for the Hardt Death Attitude Scale yielded a single score for each subject. Scoring procedures for this scale were presented in Chapter III.

Table 3 depicts the means of both the experimental and control groups at the time of posttest 1 and 2. Each group contained fifty subjects. A study of Table 3 reveals that the mean score for the experimental group of 3.4 was the same at both posttests. (There was one week between posttest 1 and 2.) This mean death attitude score was represented by the following statements: "I can accept the thought of death; I do not mind thinking of death." Further analysis of Table 3 shows that the mean score for the control group at posttest 1 was 2.6 while at posttest 2 it was 3.4

The mean death attitude score for the control group at posttest 1 was represented by the following statements: "Thinking of death is not fundamental to me; thinking about death is over-valued by many." This score was found to be significantly different from the control group at posttest 2 and the experimental group at both posttests.

TABLE 3

Death Attitude Mean Scores of the Experimental and Control Groups

	Posttest 1	Posttest 2
Experimental	3.4	3.4
Control	2.6	3.4

Suicide Acceptability Scale

The scoring procedure for the Hoelter Suicide Acceptability Scale yielded a single score for each subject. The score of the individual indicated the degree to which suicide offered an acceptable solution to one's problems. Scoring procedures were discussed in Chapter III.

Table 4 depicts the mean scores of both the experimental and control groups at the time of posttest 1 and 2. Each group contained fifty subjects. A study of the table reveals that the mean scores of the experimental group varied between posttest 1 and posttest 2. The scores at posttest 2 were lower than at posttest 1. Analysis of the table reveals that the mean scores for the control group also varied between posttest 1 and 2.

The scores at posttest 2 were lower than at posttest 1. Further study of Table 4 shows that the mean scores between the two groups varied with a significant difference existing between the experimental group at posttest 1 and the control group at posttest 2.

TABLE 4

Suicide Acceptability Mean Scores of the Experimental and Control Group

	Posttest 1	Posttest 2
Experimental	15.04	14.28
Control	14.20	13.16

One of the purposes of this investigation was to determine if one's suicide acceptability score would change in relationship to one's death attitude score. Table 5 portrays the Pearson Product Moment correlations between death attitude and suicide acceptability. The t-test was used to determine if the correlations were significantly different than zero.[1] A study of Table 5 reveals that the correlations were not significantly different than zero. Thus, the investigator did not test further for differences between groups. There was no relationship between death attitude and suicide acceptability.

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[1]Kenneth D. Hopkins and Gene V. Glass, Basic Statistics for the Behavioral Sciences (New Jersey: Prentice-Hall, Inc., 1978), pp. 283-286.

TABLE 5.

Pearson Product Moment Correlations Between Death Attitude and Suicide Acceptability of the Experimental and Control Groups

Correlation Tested	r	t-test*	P
**D.S E 1 and D.S C 1	.08	.52	> .05
D.S E 1 and D.S E 2	-.04	.27	> .05
D.S E 1 and D.S C 2	.02	.15	> .05
D.S C 1 and D.S C 2	.02	.15	> .05
D.S E 2 and D.S C 2	.02	.15	> .05
D.S E 1 and D.S E 1	-.15	1.04	> .05
D.S E 1 and D.S C 1	-.15	1.04	> .05
D.S E 1 and D.S E 2	-.15	1.04	> .05
D.S C 1 and D.S C 2	.08	.52	> .05
D.S E 2 and D.S C 2	-.04	.27	> .05

Key: *t = 2.02 (df = 48) α .05
**D = Death Attitude Scores N = 50
S = Suicide Acceptability Scores N = 50
E = Experimental Group
C = Control Group
1 = Posttest 1
2 = Posttest 2

Differences Between the Groups

Analysis of the data to determine the differences between the groups with respect to death attitude and suicide acceptability were accomplished by the two-way analysis of variance with repeated measures. Where significant *F* ratios were obtained, Tukey's subsequent test for comparing pairs of means was utilized.

A presentation of the ranges, means, standard deviations and standard errors of the mean of both the experimental and control groups is made in the following tables. Tabular data presented in this section are based on the hypotheses of the study. A study of Table 6 reveals the following facts about the experimental group on the death attitude scale.

1. The range of scores at the two posttests had a spread of .5. This means that little variability in scoring existed between posttest 1 and posttest 2 for the experimental group
2. The means for both posttests were identical. This result indicated that death attitude did not change among the experimental group during the seven days that followed the treatment

3. Posttest 1 yielded the smallest standard deviation but only .04 smaller than posttest 2. This result indicated that the experimental group tended to be similar in their response on the death attitude scale

TABLE 6

Performance Data of the Experimental Group on the Death Attitude Scale

	Posttest 1	Posttest 2
Range	1.5 (2.5-4.0)	2 (2-4)
Mean	3.4	3.4
Standard Deviation	.31	.36
Standard Error of the Mean	.044	.05

A study of Table 7 reveals the following facts about the control group on the death attitude scale:

1. There was a difference of .1 in the ranges. Posttest 1 had the larger range. This indicated more variability in scoring as compared to posttest 2.
2. Posttest 1 had the lowest mean with a score of 2.6. A spread of .8 between the highest and lowest mean

was present. This finding was significant which indicated that death attitude improved between posttest 1 and posttest 2. It also indicated that death education had a positive effect on the control group

3. Posttest 2 had the lower standard deviation. A difference of .10 was noted between posttest 1 and posttest 2. This indicated that more homogeneity in scoring occurred at posttest 2 than at posttest 1

TABLE 7

Performance Data of the Control Group on the Death Attitude Scale

	Posttest 1	Posttest 2
Range	1.9 (1.2-3.1)	1.8 (2.2-4.0)
Mean	2.6	3.4
Standard Deviation	.42	.32
Standard Error of the mean	.06	.05

Table 8 reveals the following about the experimental group at posttest 1 and the control group at posttest 2 on the death attitude scale:

1. The smaller range of scores occurred in the experimental group. Since there was just a .3 spread in

the two groups, it appeared that little variability existed between the experimental and control groups

2. Both groups had the same mean score. This indicated that after the treatment was given to both groups, attitude about death was the same for the control group as for the experimental group

3. The standard deviation for both groups was almost the same with only .01 difference between the two groups. This indicated that both groups showed similar homogeneity in scoring on the death attitude scale

TABLE 8

Performance Data of the Experimental Group at Posttest 1 and the Control Group at Posttest 2 on the Death Attitude Scale

	Experimental	Control
Range	1.5 (2.5-4.0)	1.8 (2.2-4.0)
Mean	3.4	3.4
Standard Deviation	.31	.32
Standard Error of the Mean	.044	.05

Table 9 reveals the following facts about the experimental and control groups at posttest 2 on the death attitude scale:

1. The range of scores indicated little variability between the groups. There was a .2 spread present
2. The means were identical indicating that the same death attitude occurred for both groups. Examination of the means revealed that there was no change in death attitude for the experimental group after seven days from the treatment
3. The control group had the lower standard deviation of the two groups. A difference of .04 existed. It appeared that the two groups were not significantly different in scoring on the death attitude scale at posttest 2.

TABLE 9

Performance Data of the Experimental and Control Groups at Posttest 2 on the Death Attitude Scale

	Experimental	Control
Range	2 (2-4)	1.8 (2.2-4.0)
Mean	3.4	3.4
Standard Deviation	.36	.32
Standard Error of the Mean	.05	.05

A study of Table 10 reveals the following facts relating to death attitude about the experimental and control groups at posttest 1:

1. The control group had a larger range of scores than did the experimental group. This indicated that the experimental group showed less variability in scoring than did the control group
2. The control group had the lowest mean score. This indicated that the experimental group had a more positive attitude (the willingness to accept one's own death and the death of significant others) about death than did the control group. The lower score of the control group indicated that the treatment of death education had a significant effect on the experimental group
3. The experimental group had the lowest standard deviation. A difference of .11 existed between the highest and lowest standard deviation. This indicated that the experimental group showed more homogeneity in scoring than did the control group

TABLE 10

Performance Data of the Experimental and Control Groups at Posttest 1 on the Death Attitude Scale

	Experimental	Control
Range	1.5 (2.5-4.0)	1.9 (1.2-3.1)
Mean	3.4	2.6
Standard Deviation	.31	.42
Standard Error of the Mean	.044	.06

A study of Table 11 reveals the following facts about the experimental group on the suicide acceptability scale:

1. The experimental group had identical ranges on both posttests. This means that the variability in scoring was the same at both posttests for the experimental group
2. The lower mean value was found at posttest 2. The spread was less than one point. This indicated that a non-significant change in suicide acceptability occurred during the week after the treatment

3. Posttest 2 had the lower standard deviation. A difference of .2 was noted between posttest 1 and 2. This indicated that there was more homogeneity in scoring at posttest 2 than at posttest 1

TABLE 11

Performance Data of the Experimental Group on the Suicide Acceptability Scale

	Posttest 1	Posttest 2
Range	19 (6-25)	19 (6-25)
Mean	15.04	14.28
Standard Deviation	4.5	4.3
Standard Error of the Mean	.64	.61

A study of Table 12 reveals the following facts about the control group on the suicide acceptability scale:

1. Posttest 2 had the lower range. A difference of six points existed between posttest 1 and 2. The variability in scoring was less at posttest 2
2. The lower mean occurred at posttest 2. The difference between the two means was 1.04. This indicated that suicide acceptability changed among the control group after the treatment was given; but not significantly

3. The lower standard deviation was found at posttest 2. A difference of .3 was noted. This indicated that less variability in scoring occurred at posttest 2 than did at posttest 1

TABLE 12

Performance Data of the Control Group on the Suicide Acceptability Scale

	Posttest 1	Posttest 2
Range	21 (6-27)	15 (6-21)
Mean	14.20	13.16
Standard Deviation	5.1	4.8
Standard Error of the Mean	.72	.68

A study of Table 13 reveals the following about the experimental group at posttest 1 and the control group at posttest 2 on the suicide acceptability scale:

1. A difference of four points in the range of scores was observed between posttest 1 and 2. A spread of fifteen points existed at posttest 2. This means that the variability in scoring at posttest 2 of the control group was less than for those subjects in the experimental group

2. Posttest 2 had the lowest mean score. A difference of 1.88 was noted between the two posttests. This indicated that the control group showed a significantly lower suicide acceptability than did the experimental group
3. The lower standard deviation was noted among the experimental group. A difference of .3 was observed between the two standard deviations. This indicated that the experimental group showed more homogeneity in scoring than did the control group

TABLE 13
Performance Data of the Experimental Group at Posttest 1 and the Control Group at Posttest 2 on the Suicide Acceptability Scale

	Experimental	Control
Range	19 (6-25)	15 (6-21)
Mean	15.04	13.16
Standard Deviation	4.5	4.8
Standard Error of the Mean	.64	.68

A study of Table 14 reveals the following facts about the experimental and control groups at posttest 2 on the suicide acceptability scale:

1. The control group had the smaller range of scores. A difference of six points was observed between the two groups. This indicated that the control group showed less variability in scoring on suicide acceptability than did the experimental group
2. The lower mean score was found in the control group. This indicated that death education had a greater, but not a significant effect in changing suicide acceptability for the control group than it did for the experimental group
3. The lowest standard deviation was noted for the experimental group. This indicated that the experimental group showed more homogeneity in scoring than did the control group

TABLE 14

Performance Data of the Experimental and Control Groups at Posttest 2 on the Suicide Acceptability Scale

	Experimental	Control
Range	19 (6-25)	15 (6-21)
Mean	14.28	13.16
Standard Deviation	4.3	4.8
Standard Error of the Mean	.61	.68

A study of Table 15 reveals the following about the experimental and control groups at posttest 1 on the suicide acceptability scale:

1. The experimental group had the smaller range of scores with a spread of nineteen points. This indicated that the experimental group showed less variability in scoring than did the control group
2. The control group had the lower mean of the two groups. A difference of .84 was noted between the two means. This indicated that the experimental group seemed more willing to accept suicide as an alternate to one's problems as compared to the control group. This result also seemed to indicate that death education changed suicide acceptability among the experimental group, but not significantly
3. The lower standard deviation was noted among the experimental group. A difference of .6 was observed between the two groups. This indicated that the experimental group showed more homogeneity in scoring on the suicide acceptability scale than did the control group

TABLE 15

Performance Data of the Experimental and Control Groups at Posttest 1 on the Suicide Acceptability Scale

	Experimental	Control
Range	19 (6-25)	21 (6-27)
Mean	15.04	14.20
Standard Deviation	4.5	5.1
Standard Error of the Mean	.64	.72

The statistical design used to test for differences in death attitude between the experimental and control groups was the two-way analysis of variance with repeated measures on one factor. The results of the analysis of variance is presented in Table 16. The results indicated a significant group effect ($F = 32.78$, $df = 1/98$, $p < .05$), a significant trials effect ($f = 97.58$, $df-1.98$, $p < .05$), and a significant trials by groups interaction ($F = 98.59$, $df = 1/98$, $p<.05$).

TABLE 16

Death Attitude
Summary Table

Source	df	SS	MS	F	P
Between					
Groups	1	5.81	5.81	32.78	.000
Error	98	17.38	.178		
Within					
Trials	1	7.49	7.49	97.58	.000
Trials by Groups	1	7.57	7.57	98.59	.000
Error	98	7.52	.077		

F.95(1,98) = 4.00

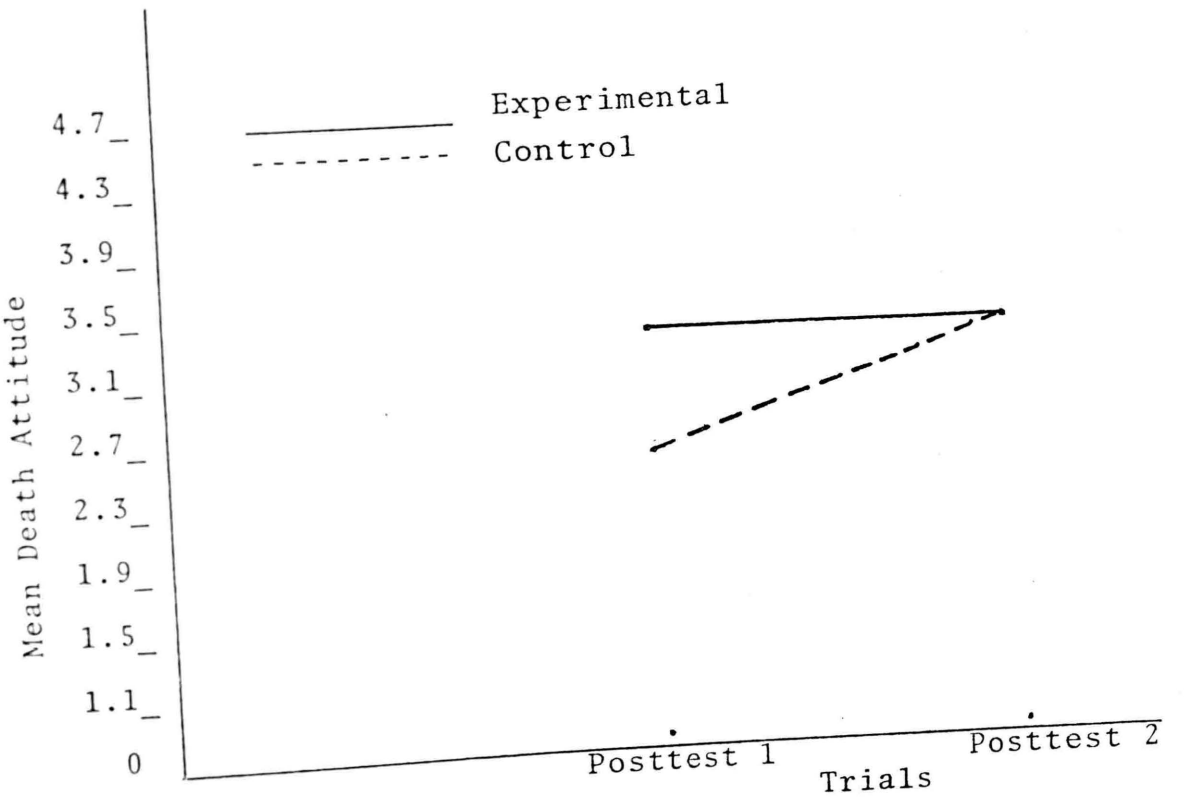
The performance curves for both the experimental and control groups are presented in Table 17. A study of Table 17 reveals a significant trials by groups interaction. This finding indicated that the death attitude of those in the experimental group was significantly different from the death attitude of those in the control group. This means that the treatment of death education had a significant effect on the experimental group at posttest 1. Further analysis reveals the following facts:

1. The score for the experimental group was the same at both posttests. This indicated the trials had no effect on the treatment. Time made no significant difference on death attitude

2. At posttest 2 the mean score of both groups was the same. This result indicated that the treatment had a significant effect on the control group. The death attitude of both groups was the same at posttest 2

TABLE 17

Interaction Graph of the Mean Death Attitude Score
Posttest 1 - Posttest 2



To locate the significant differences, Tukey's subsequent test was applied to the mean differences. A study of Table 18 reveals the following information:

1. At posttest 1 the experimental group scored significantly higher than did the control group. This finding means that the death attitude of those in the experimental group was more positive than the control group. Further, this result indicated that the treatment of death education had a significant impact on the experimental group. Death education significantly altered the death attitude of the experimental group
2. At posttest 2 the experimental group had a significantly higher score than did the control group at posttest 1. This indicated that the effect of the treatment irrespective of the trial, yielded a significantly different death attitude for the experimental group at the time of posttest 2 than it did for the control group at posttest 1
3. The control group scored significantly higher at posttest 2 than at posttest 1. This result indicated that the treatment of death education had a significant impact on the death attitude of the control group

TABLE 18

Matrix of Mean Differences Tukey's Subsequent Test for Death Attitude

		Experimental Posttest 1	Experimental Posttest 2	Control Posttest 1	Control Posttest 2
Means		$\bar{X}_1$ 3.4	$\bar{X}_2$ 3.4	$\bar{X}_3$ 2.6	$\bar{X}_4$ 3.4
$\bar{X}$	1	---	0	.8*	0
$\bar{X}$	2		------	.8*	0
$\bar{X}$	3				.8*

$c\pm$ .14 at q = .05

* Indicates significant differences between group means. $p < .05$

The statistical design used to test for differences in suicide acceptability between the experimental and control group was the two-way analysis of variance with repeated measures on one factor. The results of the analysis of variance is presented in Table 19. The results indicated a non-significant group effect ($f = 1.24$, df-1/98, $p > .05$), a significant trials effect ($F = 8.01$, df = 1/98, $p < .05$), and a

non-significant trials by groups interaction ($F = .19$, $df = 1/98$, $p > .05$). The trial effect indicated that there was a significant difference in the way the subjects performed on the suicide acceptability scale within all subjects.

TABLE 19

Suicide Acceptability
Summary Table

Source	df	SS	MS	F	P
Between					
Groups	1	48.02	48.02	1.24	.27
Error	98	3787.20	38.64		
Within					
Trials	1	40.50	40.50	8.01	.006
Trials by Groups	1	.98	.98	.19	.661
Error	98	495.52	5.06		

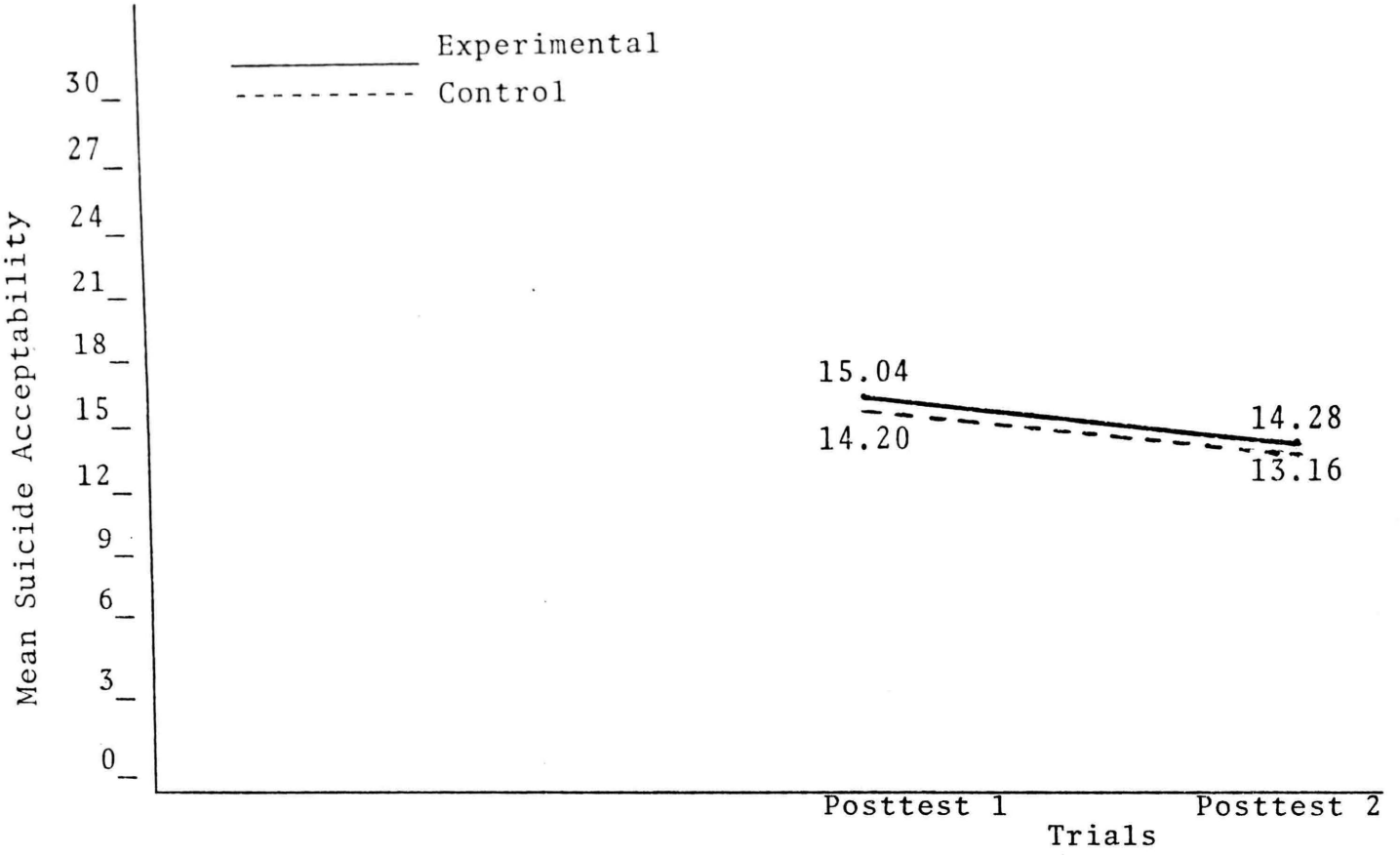
F.95 (1,98) = 4.00

The performance curves for both the experimental and control groups are presented in Table 20. A study of Table 20 reveals parallel lines which indicates a non-significant trials by groups interaction.

TABLE 20

Interaction Graph of the Mean Suicide Acceptability

Posttest 1 - Posttest 2



To locate the significant differences, Tukey's subsequent test was applied to the mean differences. A study of Table 21 reveals the following facts:

1. At posttest 2 the control group scored significantly lower than did the experimental group at posttest 1
2. The results indicated that the control group at posttest 2 was significantly different from the experimental group at posttest 1
3. The treatment of death education did not have a significant effect on either the experimental or control groups
4. Further analysis indicated that death education appeared to increase the suicide acceptability for the experimental group while it seemed to decrease it for the control group

TABLE 21

Matrix of Mean Differences
Tukey's Subsequent Test for
Suicide Acceptability

	Experimental Posttest 1	Experimental Posttest 2	Control Posttest 1	Control Posttest 2
Means	$\bar{X}_1$ 15.04	$\bar{X}_2$ 14.28	$\bar{X}_3$ 14.20	$\bar{X}_4$ 13.16
$\bar{X}_1$	---	.76	.84	1.88*
$\bar{X}_2$		----	.08	1.12
$\bar{X}_3$			---	1.04

$\underline{c}$+ 1.17 at α = .05

* Indicates significant differences between group means. $P < .05$

Table 22 is a presentation of the Chi-square values of both the experimental and control groups on the death attitude scale. The findings of the Chi-square test of independence revealed that for both groups at posttest 1 and 2 marital status was independent of death attitude. This result indicated that death attitude was not related to marital status.

TABLE 22

Chi-square Values for the Experimental and Control Groups at Posttests 1 and 2 Regarding Marital Status on the Death Attitude Scale

Experimental Posttest 1

	Married	Not Married	Total
Above $\bar{X}$	15	5	20
Below $\bar{X}$	12	10	22
Total	27	15	42
Chi-square	1.12		

Experimental Posttest 2

	Married	Not Married	Total
Above $\bar{X}$	16	5	21
Below $\bar{X}$	15	9	24
Total	31	14	45
Chi-square	.43		

Control Posttest 1

	Married	Not Married	Total
Above $\bar{X}$	25	6	31
Below $\bar{X}$	8	7	15
Total	33	13	46
Chi-square	2.48		

Control Posttest 2

	Married	Not Married	Total
Above $\bar{X}$	20	7	27
Below $\bar{X}$	10	6	16
Total	30	13	43
Chi-square	.25		

X^2 .95(1df) - 3.84

Table 23 presents the Chi-square values of both the experimental and control groups on the suicide acceptability scale. The results of the Chi-square test of independence revealed that for both groups at postest 1 and 2 marital status was independent of suicide acceptability. This indicated that suicide acceptability was not related to marital status.

TABLE 23

Chi-square Values for the Experimental and Control Groups at Posttests 1 and 2 Regarding Marital Status on the Suicide Acceptability Scale

Experimental Posttest 1

	Married	Not Married	Total
Above $\bar{X}$	19	7	26
Below $\bar{X}$	16	8	24
Total	35	15	50
Chi-square	.03		

Experimental Posttest 2

	Married	Not Married	Total
Above $\bar{X}$	16	6	22
Below $\bar{X}$	19	9	28
Total	35	15	50
Chi-square	.004		

Control Posttest 1

	Married	Not Married	Total
Above $\bar{X}$	18	7	25
Below $\bar{X}$	17	8	25
Total	35	15	50
Chi-square	.19		

Control Posttest 2

	Married	Not Married	Total
Above $\bar{X}$	15	7	22
Below $\bar{X}$	20	8	28
Total	35	15	50
Chi-square	.004		

X^2 .95 (1df) = 3.84

Table 24 is a presentation of the Chi-square values of both the experimental and control groups on the death attitude scale. The findings of the Chi-square test of independence revealed that for both groups at posttest 1 and 2 one's level of education was not related to death attitude.

TABLE 24

Chi-square Value for the Experimental and Control Groups at Posttest 1 and 2 Regarding Level of Education on the Death Attitude Scale

Experimental Posttest 1

	High School	College	Total
Above $\bar{X}$	11	8	19
Below $\bar{X}$	11	10	21
Total	22	18	40
Chi-square	.001		

Experimental Posttest 2

	High School	College	Total
Above $\bar{X}$	10	11	21
Below $\bar{X}$	13	10	23
Total	23	21	44
Chi-sqaure	.08		

Control Posttest 1

	High School	College	Total
Above $\bar{X}$	12	19	31
Below $\bar{X}$	6	9	15
Total	18	28	46
Chi-square	.047		

Control Posttest 2

	High School	College	Total
Above $\bar{X}$	11	16	27
Below $\bar{X}$	5	11	16
Total	16	27	43
Chi-square	.086		

X^2 .95 (1df) = 3.84

Table 25 represents the Chi-square values of both the experimental and control groups on the suicide acceptability scale. The results of the Chi-square test of independence revealed that for both groups at posttest 1 and 2 one's level of education was independent of suicide acceptability. This finding indicated that suicide acceptability was not related to one's level of education.

TABLE 25

Chi-square Values for the Experimental and Control Groups at Posttest 1 and 2 Regarding Level of Education on the Suicide Acceptability Scale

Experimental Posttest 1

	High School	College	Total
Above $\bar{X}$	12	14	26
Below $\bar{X}$	12	12	24
Total	24	26	50
Chi-square	.0016		

Experimental Posttest 2

	High School	College	Total
Above $\bar{X}$	12	10	22
Below $\bar{X}$	12	16	28
Total	24	26	50
Chi-square	.29		

Control Posttest 1

	High School	College	Total
Above $\bar{X}$	8	17	25
Below $\bar{X}$	11	14	25
Total	19	31	50
Chi-square	.32		

Control Posttest 2

	High School	College	Total
Above $\bar{X}$	6	15	21
Below $\bar{X}$	13	16	29
Total	19	31	50
Chi-square	.75		

X^2 .95 (1df) = 3.84

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS FOR FUTURE STUDY

This chapter includes a summary of the study and of the findings, with conclusions based on the analysis of the data. Recommendations for future research are based on the findings and conclusions.

Summary of the Study

It appears that an understanding of death is being recognized as an area related to man's ability to live a worthwhile, happy, and productive life. Increased knowledge and understanding about death could possibly contribute to the individual's increased awareness of the value of life and thus live life more fully.

The main purpose of this study was to ascertain whether death education alters attitudes toward death and suicide acceptability. A second purpose was to determine if a relationship exists between death attitude and suicide acceptability. A third purpose was to determine whether or not a period of seven days makes a difference on the impact of death education. The design of the study

was concerned with the death attitude and suicide acceptability of one hundred individuals who volunteered to participate in a short course on death education. The subjects were solicited through advertising in local newspapers and radio stations. The subjects lived in the Dallas/Fort Worth Metroplex and consisted of both male and female adults of varying ages, educational backgrounds, marital status, religious beliefs and with diverse reasons for attending the death education seminar.

For the purpose of this study the one hundred persons were randomly assigned to two groups: (1) the experimental group comprised of fifty individuals, and (2) the control group comprised of fifty individuals.

Two instruments were administered to obtain the data needed for the study: (1) the Hardt Death Attitude Scale was selected to determine the individuals' attitude about death and, (2) the Hoelter Suicide Acceptability Scale was utilized to determine the degree to which suicide offered an acceptable solution to one's problems. The death attitude scale and suicide acceptability scale were administered to all of the subjects during September and October 1980.

In Chapter I the rationale and purposes of the study were explained. This chapter contained the definitions and explanations of terminology utilized in the study. The statement of the problem, hypotheses, delimitations and assumptions were also set forth.

Chapter II presented a review of related literature. The review of literature was divided into: (1) a brief history of death education: (2) studies and surveys about death attitudes; and (3) studies and surveys about suicide acceptability. The review of literature revealed that death education is a recent subject which has been added to the curriculum of American schools and universities. The systematic study of death and dying is approximately ten to twelve years old. Within this period, educators have appeared to advance the subject to a wide-open forum at all levels of education. The review of literature also revealed that death education could benefit from well-designed experimental research to determine the effectiveness of the death education experience.

Chapter III contained a description of the procedures followed in the development of the investigation. These procedures were described under the following headings: (1) preliminary procedures; (2) selection and description of the instruments; (3) selection of the site;

(4) selection of subjects; (5) procedures followed in assignment to groups; (6) collection of data; and (7) treatment of data.

Chapter IV contained the results of the study. The chapter presented the analysis and interpretation of data under the following headings: (1) description of the groups in the study; (2) performance of the groups on the tests; and (3) differences between the groups.

Tests of Hypotheses

The summary of findings was based on the hypotheses of the study. The null hypotheses that follow were subjected to statistical analysis at the .05 level of significance.

Hypothesis One: There is no significant difference in the attitude toward death at the time of posttest 1 between those individuals who had death education and those individuals who had had no death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale.

Rejected

The significant difference found in death attitude between the experimental and control groups at posttest 1 implies that the treatment of death education had a significant effect on the experimental group. It can be

deduced that the experimental group had a significantly more positive attitude about death than did the control group.

Hypothesis Two: There is no significant difference in suicide acceptability at the time of posttest 1, between those individuals who had had death education and those individuals who had had no death education as revealed by the data collected from the administration of the Hoelter Suicide Acceptability Scale.

Accepted

This hypothesis was accepted because the results of this study showed that no significant difference occurred between the two groups with regard to suicide acceptability. Thus death education did not have a significant effect on the experimental group's attitude toward suicide acceptability.

Hypothesis Three: There is no significant difference in the attitude toward death between posttest 1 and posttest 2 among those individuals in the experimental group who had

had death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale.

Accepted

The death attitude of those subjects in the experimental group at posttest 2 was not significantly different than at posttest 1. This finding indicated that the effect of the death education course was not altered by a span of seven days time.

Hypothesis Four: There is no significant difference in suicide acceptability between posttest 1 and posttest 2 among those individuals in the experimental group who had had death education as revealed by the data collected from the administration of the Hoelter Suicide Acceptability Scale.

Accepted

Death education did not significantly change the suicide acceptability of the subjects in the experimental group between posttest 1 and 2.

Hypothesis Five: There is no significant difference in the attitude toward death at the time of posttest 1 between those individuals in the experimental group who had

had death education and those individuals in the control group at the time of posttest 2 who had had death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale.

Accepted

The death attitude of those subjects in the experimental group at posttest 1 was not significantly different from the death attitude of those individuals in the control group at posttest 2. After the treatment of death education, the same death attitude existed for both groups.

Hypothesis Six: There is no significant difference in suicide acceptability between those individuals in the experimental group at the time of posttest 1 who had had death education and those individuals in the control group at the time of posttest 2 who had had death education as revealed by the data collected from the administration of the Hoelter Suicide Acceptability Scale.

Rejected

This finding indicated that there was a significant difference in suicide acceptability between the control group at posttest 2 and the experimental group at posttest 1. The mean of the control group was significantly lower than the mean of the experimental group. Lower means that the control group was less willing to accept suicide as a solution to one's problems than was the experimental group. Death education may have affected the control groups attitude toward suicide acceptability.

Hypothesis Seven: There is no significant difference in the attitude toward death among those individuals in the control group between posttest 1 before death education and posttest 2 after they had had death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale

Rejected

This hypothesis was rejected because the death attitude of the control group at posttest 2 was significantly different from their death attitude at posttest 1. Death education seemed to have made a difference in death attitude for the control group. Their attitude was more positive after the course.

Hypothesis Eight: There is no significant difference in suicide acceptability among those individuals in the control group between posttest 1 before death education and posttest 2 after they had had death education as revealed by the data collected from the administration of the Hoelter Suicide Acceptability Scale

Accepted

This hypothesis was accepted on the basis that the results of the study revealed that no significant difference occurred between posttest 1 and 2 when the means of the two tests were compared.

Hypothesis Nine: There is no significant difference in the attitude toward death at the time of posttest 2 between those individuals in the experimental group who had had death education and those individuals in the control group who had had death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale

Accepted

There was no significant difference in death attitude at posttest 2 between the experimental and control groups. The study showed that death education had the same impact for both groups, irrespective of a time span for the experimental group.

Hypothesis Ten: There is no significant difference in suicide acceptability at the time of posttest 2 between those individuals in the experimental group who had had death education and those individuals in the control group who had had death education as revealed by the data collected from the administration of the Hoelter Suicide Acceptability Scale

Accepted

The study showed that no significant difference occurred between the experimental and control groups at posttest 2. Death education did not significantly change the suicide acceptability in the subjects of both groups at posttest 2, irrespective of a time span.

Hypothesis Eleven: There is no difference in relationship between death attitude and suicide acceptability at the time of posttest 1 between those individuals who had had

death education and those individuals who had had no death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale and the Hoelter Suicide Acceptability Scale

Accepted

The Pearson Product Moment Correlations were not significantly different than zero. There was no relationship between death attitude and suicide acceptability at the time of posttest 1 for both the experimental and control groups.

Hypothesis Twelve: There is no relationship between death attitude and suicide acceptability between posttest 1 and posttest 2 among those individuals in the experimental group who had had death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale and the Hoelter Suicide Acceptability Scale

Accepted

This hypothesis was accepted because the Pearson Product Moment Correlations were not significantly different than zero. The results of the study showed that there was

no relationship between death attitude and suicide acceptability in the experimental group between posttests 1 and 2.

Hypothesis Thirteen: There is no difference in relationship between death attitude and suicide acceptability between those individuals in the experimental group at the time of posttest 1 who had had death education and those individuals in the control group at the time of posttest 2 who had had death education as revealed by the data collected from the administration of the Hardt Death Attitude Scale and Hoelter Suicide Acceptability Scale

Accepted

The results of the study showed that the Pearson Product Moment Correlations were not significantly different than zero. There was no relationship between death attitude and suicide acceptability for the experimental group at posttest 1 and in the control group at posttest 2.

Hypothesis Fourteen: There is no relationship between death attitude and suicide acceptability between posttest 1 and posttest 2 among those individuals in the control group as revealed by data collected from the administration of the Hardt Death Attitude Scale and the Hoelter Suicide Acceptability Scale.

Accepted

This hypothesis was accepted on the basis that the Pearson Product Moment Correlations were not significantly different than zero. There was no relationship between death attitude and suicide acceptability for those subjects in the control group at posttests 1 and 2.

Hypothesis Fifteen: There is no difference in relationship between death attitude and suicide acceptability at the time of posttest 2 between those individuals in the experimental group who had had death education and those individuals in the control group who had had death education as revealed by the data collected from

the administration of the
Hardt Death Attitude
Scale and the Hoelter Suicide Accept-
ability Scale.

Accepted

The results of the study showed that the Pearson Product Moment Correlations were not significantly different than zero. There was no relationship between death attitude and suicide acceptability for both the experimental and control groups at posttest 2.

The following results of the study show that the Chi-square tests of independence were not significant at the .95 level of confidence:

1. Death attitude was not related to marital status for either the experimental or control group at posttests 1 and 2
2. Suicide acceptability was not related to marital status for either the experimental or control group at posttests 1 and 2
3. Death attitude was not related to one's level of education for either the experimental or control groups at posttests 1 and 2

4. Suicide acceptability was not related to one's level of education for either the experimental or control group at posttests 1 and 2

Discussion

The statistical treatment of the data from the death attitude scale and suicide acceptability scale provided information about the similarities and differences between the experimental and control groups. In this study, the death education course was effective in positively changing the death attitude of both the experimental and control groups. After the death education course, both groups were able to accept the thought of personal death and the death of significant others, while before the course was taught, the control group did not perceive death as a common or acceptable thought. This investigator deduced that the death education course was effective in changing the death attitude of the subjects in the study.

Further, the time span of seven days, did not alter the positive death attitude of the experimental group. This lack of change was another assurance that the impact of the death education course, irrespective of the time

span, was effective in maintaining the subjects' existing death attitude. Thus, death education was effective in changing death attitude for the subjects in this study.

A significant difference occurred between the two groups with respect to suicide acceptability. However, death education was not effective in changing the suicide acceptability for the subjects in this study. The significant difference existed between the experimental group at posttest 1 and the control group at posttest 2. The investigator cannot fully explain why this occurred while no significant differences were found between the two groups at posttest 1 or for the control group between posttest 1 and 2. Based on the results of this study it appeared that the control group was less willing to accept suicide as an alternative to one's problems than was the experimental group.

Death attitude and suicide acceptability were not related to marital status or one's level of education. It was the investigator's opinion that a relationship between these variables would exist. This opinion was based on the investigator's professional observations in the helping professions, that people happily married seemed to

cope more effectively with loss than single individuals. Likewise, those with more education appeared to cope with stress better than those individuals with less education.

Hardt suggested that suicide acceptability might be positively related to death attitude.[1] The investigator found that for the subjects in this study there was no relationship between death attitude and suicide acceptability.

Conclusions

The investigator was limited in the conclusions which were drawn since only one source was used to identify death attitude, and one source to identify suicide acceptability. Therefore, generalizations about death attitude and suicide acceptability affecting individuals other than those in this study were not attempted.

Based on the results of this study, the following conclusions were drawn:

1. A short course on death education appears to affect death attitude positively
2. The impact of a short period of time does not appear to change positive death attitude

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[1] Hardt, Measurement, pp. 269-270.

3. Death attitude and suicide acceptability are not related to marital status or one's level of education for the subjects in this study
4. A short course on death education does not appear to change suicide acceptability
5. Since death education did not have a significant impact on suicide acceptability, it is not possible to make a conclusion about the effect of time on suicide acceptability
6. There is no relationship between death attitude and willingness to accept suicide as a solution to one's problems

Implications

The following implications appear to be justified based on the findings of this study and the investigator's interpretation of these findings:

1. This study suggests that teachers of community health education should be encouraged to include death education as a part of the teaching curriculum. This study found that ten hours of death education positively changed death attitude
2. A significant difference in suicide acceptabiltiy was found between groups immediately after the death education course but no significant

differences were found between groups when only one group had had death education or after both groups had had death education and one group had had a time span. Thus it is possible that the Hoelter Suicide Acceptability Scale did not fully identify the suicide acceptability of the two groups the way it was intended, therefore, the true attitudes of the two groups were not obtained

3. This study suggests that death attitude and suicide acceptability are not related; or more specifically, an individual could manifest a positive death attitude and show no significant change in suicide acceptability. Even though suicide acceptability expresses an attitude toward a particular aspect of death it may be too specific to show any relationship to death attitudes in general

Recommendations

As a result of the present study, the investigator recommends the following for continued research:

1. A continuation of a study of this nature to determine if death attitude changes occur six months or perhaps one year after the death education course

2. A continuation of a study of this nature to determine if a longer course of death education of perhaps forty-five hours would alter suicide acceptability. Apparently ten hours of death education does not alter suicide acceptability
3. Further use of the Hardt Death Attitude Scale in studies involving death attitude to strengthen content validity
4. Further use of the Hoelter Suicide Acceptability Scale in studies involving suicide acceptability to strengthen content validity
5. A replication of the procedures followed in this study with respect to other health related attitudes
6. A continuation of this study to include equal numbers of men and women as subjects. Since this study included more women, a study that would include more men might yield different results
7. A study to construct and validate a suicide acceptability scale. Perhaps a Thurston equal-appearing-interval scale would be appropriate

A P P E N D I X

APPENDIX A

Tests Utilized

Part I: The Hardt Death Attitude Scale

Part II: Scoring Procedure for the Death Attitude Scale

Part III: The Hoelter Suicide Acceptability Scale

Part IV: Scoring Procedure for the Suicide Acceptability Scale

APPENDIX A. PART I

THE HARDT DEATH ATTITUDE SCALE

QUESTIONNAIRE ONE

The following items are not intended to test your knowledge. There are no right or wrong answers. Your responses are anonymous.

DIRECTIONS: Read each item carefully. Place a check mark next to each item with which you AGREE. Make NO MARKS next to items with which you disagree.

249 ___ The thought of death is a glorious thought.

247 ___ When I think of death I am most satisfied.

245 ___ Thoughts of death are wonderful thoughts.

243 ___ The thought of death is very pleasant.

241 ___ The thought of death is comforting.

239 ___ I find it fairly easy to think of death.

237 ___ The thought of death isn't so bad.

235 ___ I do not mind thinking of death.

233 ___ I can accept the thought of death.

231 ___ To think of death is common.

229 ___ I don't fear thoughts of death, but I don't like them either.

227 ___ Thinking about death is over-valued by many.

225 ___ Thinking of death is not fundamental to me.

223 ___ I find it difficult to think of death.

221 ___ I regret the thought of death.

219 ___ The thought of death is an awful thought.

217 ___ The thought of death is dreadful.

215 ___ The thought of death is traumatic.

213 ___ I hate the sound of the word death.

211 ___ The thought of death is outrageous.

APPENDIX A, PART II

SCORING PROCEDURE FOR THE HARDT DEATH ATTITUDE SCALE

The form consists of twenty odd-numbered attitude statements ranging from 1.1 to 4.9 in .2 intervals. Statements from 1.1 to 3.0 on the scale are considered representative of death attitudes ranging from unfavorable to neither favorable nor unfavorable respectively. Statements from 3.0 to 4.9 on the scale are considered representative of death attitudes ranging from neither favorable nor unfavorable to favorable, respectively.

The twenty responses on the questionnaire are not intended to test knowledge. Since attitudes are being measured, there are no right or wrong answers. To determine attitude, the subject is instructed to place a check mark next to each item of agreement. No check marks are placed next to items of disagreement. The twenty responses range in number from 249-211. To score the form the first number (2) is disregarded, a decimal point is placed between the two remaining numbers, and the responses are averaged. The average will fall either on an attitude statement or between two attitude statements. The scale yields a single score for each subject.

APPENDIX A, PART III

THE HOELTER SUICIDE ACCEPTABILITY SCALE

QUESTIONNAIRE TWO

The following items are not intended to test your knowledge. There are no right or wrong answers. Your responses are anonymous.

DIRECTIONS: Read each item carefully. Circle ONE number in each line across that best describes how you feel right now.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Suicide is immoral	5	4	3	2	1
2. If my personal problems became worse, I may decide to take my life	1	2	3	4	5
3. I would never under any conditions, kill myself.	5	4	3	2	1
4. If I were suffering from a terminal illness I might kill myself.	1	2	3	4	5
5. People who kill themselves may be better off now than when they were alive.	1	2	3	4	5
6. If everyone I loved were gone, I would consider killing myself.	1	2	3	4	5

APPENDIX A, PART IV

SCORING PROCEDURE FOR THE HOELTER SUICIDE ACCEPTABILITY SCALE

The Hoelter Suicide Acceptability Scale was designed to measure the degree to which suicide offers an acceptable solution to one's problems. The questionnaire developed was a Likert-type scale. The form consists of six suicide statements. For each item the following choices are available: strongly disagree, disagree, neutral, agree, and strongly agree. The value of each item ranges from 1 through 5, with 5 indicating the strongest suicide acceptability. The total possible points a subject could obtain is 30. The higher the score the more suicide is viewed as an acceptable action. The scale yields a single score for each subject.

APPENDIX B

Media Advertising

Part I: Newspaper Release

Part II: Newspaper Display Advertisement

Part III: Radio Public Service Announcement

APPENDIX B, PART I

NEWSPAPER RELEASE

Doctors, health professionals, and ministers may all benefit from the new health seminar "Coping With Death and Dying", according to Wayne Bolan, M.P.H., Huguley Hospital Health Educator, and coordinator of the program.

The five-night seminar will be held September 22, through the 26th, beginning at 7:00 p.m. each evening in the hospital's cafeteria. For more information or to register for the seminar, call the Huguley Health Education Department at 293-9111, Extension 240.

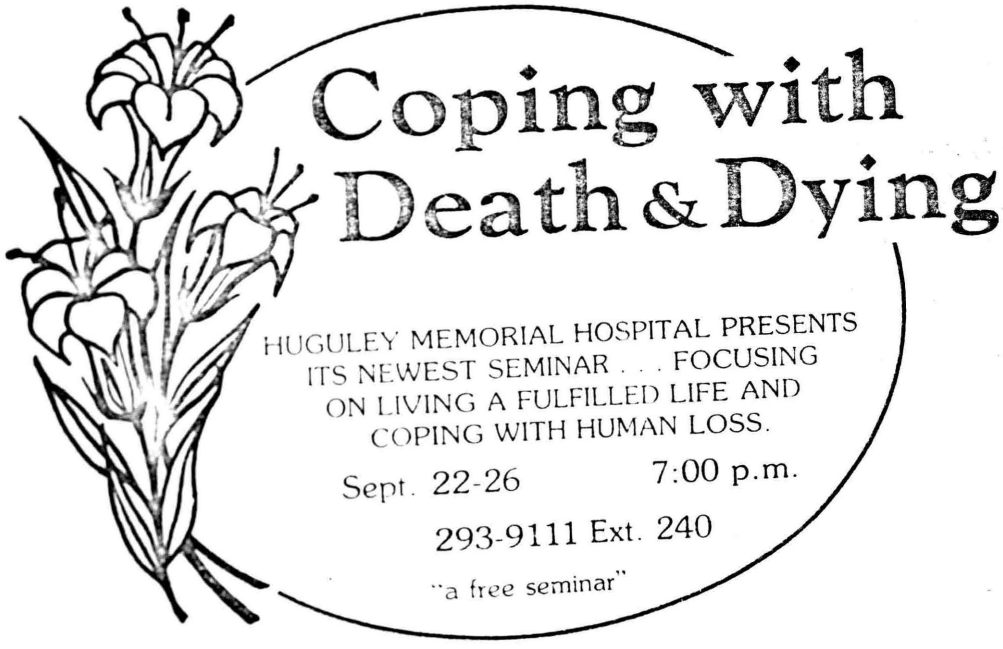
"Professionals commonly involved with people in life threatening situations have to maintain a professional distance. They may not understand death and coping with human loss any better than a non-professional," said Bolan.

Lectures and discussions at the seminar will be given by professionals including Bolan, Pastor Marvin Moore, and David Engleking, M.D.

The seminar will help participants learn how to lead a more fulfilled life, and help them to structure priorities, which may be particularly useful for busy professional people, according to Bolan.

APPENDIX B, PART II

NEWSPAPER DISPLAY ADVERTISEMENT



APPENDIX B, PART III

RADIO PUBLIC SERVICE ANNOUNCEMENT

DISCOVER THE MEANING OF LIFE. ATTEND "COPING WITH DEATH AND DYING," A SENSITIVE LOOK AT THE ISSUES OF DEATH AND DYING. BEGINS SEPTEMBER 22, 7:00 P.M., AT HUGULEY HOSPITAL IN FORT WORTH. CALL 293-9111, EXTENTION 240 FOR RESERVATIONS AND INFORMATION. THAT'S 293-9111, EXTENTION 240.

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APPENDIX C

Letters of Approval

Part I: Letter Approving Research from the Human Subjects Review Committee

Part II: Letter Approving Research Project from Huguley Memorial Hospital

TEXAS WOMAN'S UNIVERSITY
Box 23717 TWU Station
Denton, Texas 76204

HUMAN SUBJECTS REVIEW COMMITTEE

Name of Investigator: Wayne Bolan Center: Denton

Address: Route 1 - Box 210-B-3 Date: September 17, 1980

Alvarado, Texas 76009

Dear Mr. Bolan

Your study entitled The Effect of a Short Course of Death Education on Attitude Toward Death and Suicide Acceptability: An Experimental Study

has been reviewed by a committee of the Human Subjects Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education, and Welfare regulations typically require that signatures indicating informed consent be obtained from all human subjects in your studies. These are to be filed with the Human Subjects Review Committee. Any exception to this requirement is noted below. Furthermore, according to DHEW regulations, another review by the Committee is required if your project changes.

Any special provisions pertaining to your study are noted below:

____ Add to informed consent form: No medical service or compensation is provided to subjects by the University as a result of injury from participation in research.

____ Add to informed consent form: I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

HUGULEY
MEMORIAL
HOSPITAL

September 8, 1980

Wayne Bolan, M.P.H.
Director, Health Education Department
Huguley Memorial Hospital
P.O. Box 6337
Fort Worth, Texas 76115

Dear Mr. Bolan:

Permission is hereby granted to conduct your study: The Effect of a Short Course of Death Education on Attitude Toward Death and Suicide Acceptability: An Experimental Study.

It is my understanding that this study is being done for your dissertation to complete the requirements of the Ph.D. degree at Texas Woman's University.

It is also my understanding that the hospital will assume no liability whatsoever.

Very cordially,

Ken Dupper, Vice President
Huguley Memorial Hospital

df

___ The filing of signatures of subjects with the Human Subjects Review Committee is not required.

___ Other:

__X__ No special provisions apply.

cc: Graduate School
Project Director
Director of School or
Chairman of Department

Sincerely,

Chairman, Human
Subjects Review
Committee

at Denton

APPENDIX D

Signed Consent Form

Consent Form
TEXAS WOMAN'S UNIVERSITY
HUMAN SUBJECTS REVIEW COMMITTEE

(Form B)

Title of Project: The Effect of a Short Course of Death Education on Attitude Toward Death and Suicide Acceptability: An Experimental Study

Consent to Act as a Subject for Research and Investigation:

I have received an oral description of this study, including a fair explanation of the procedures and their purpose, any associated discomforts or risks, and a description of the possible benefits. An offer has been made to me to answer all questions about the study. I understand that my name will not be used in any release of the data and that I am free to withdraw at any time. I further understand that no medical service or compensation is provided to subjects by the university as a result of injury from participation in research.

Signature _____ Date _____

Witness _____ Date _____

Certification by Person Explaining the Study:

This is to certify that I have fully informed and explained to the above named person a description of the listed elements of informed consent.

Signature _____ Date _____

Position _____

Witness _____ Date _____

One copy of this form, signed and witnessed, must be given to each subject. A second copy must be retained by the investigator for filing with the Chairman of the Human Subjects Review Committee. A third copy may be made for the investigator's files.

APPENDIX E

Death and Dying Seminar Forms

Part I: Registration Form

Part II: Recency of Death Form

APPENDIX E, PART I

COPING WITH DEATH AND DYING REGISTRATION FORM

1. NAME_____AGE_____PHONE_____
2. ADDRESS_____
   Street City Zip
3. OCCUPATION_____
4. Marital Status: Single___ Married___ Divorced____
   Separated____ Widowed____
5. Has there been a change in marital status in past year?
   _____Yes _____No
6. Do you have children? ___Yes ___No If yes, how many?_____
7. Do you live alone?_____ With spouse_____family or relatives_____ with friends_____, in nursing home or boarding home in last 6 months_____ other_____
8. Are you presently employed?___Yes ___No
9. Do you have a religious faith? ___Yes ___No. If yes, what denomination?_____
10. What yearly income range are you? $12,000 or less____ $13-18,000_____ $19-24,000 ____ $25,000 or above____
11. Have you ever experienced the death of someone close? _____Yes _____No If yes, please check the appropriate blank. _____death of a child, _____death of a spouse, _____death of a parent, _____death of a brother/sister, _____death of grandparent/relative, ____death of close friend.
12. Do you attend church? _____Yes _____No
13. What is your educational background? ___elementary, ___high school, ___college, _____graduate, ___other Did you graduate? ___Yes ___No
14. How did you learn of this program?_____

APPENDIX E, PART II

COPING WITH DEATH AND DYING

When did you last experience the death of someone close to you?

Within the last 6 months? _____

Within the last 12 months? _____

Within the last 18 months? _____

Within the last 24 months? _____

Other _____

My number is _____

APPENDIX F

Raw Data Collected as a Result of Testing

Part I: Raw Data from the Hardt Death Attitude Scale for the Experimental Group

Part II: Raw Data from the Hardt Death Attitude Scale for the Control Group

Part III: Raw Data from the Hoelter Suicide Acceptability Scale for the Experimental Group

Part IV: Raw Data from the Hoelter Suicide Acceptability Scale for the Control Group

APPENDIX F, PART I

RAW DATA FROM THE HARDT DEATH ATTITUDE SCALE FOR THE EXPERIMENTAL GROUP

Subject Number	Posttest 1	Posttest 2
1	3.2	3.2
2	3.4	3.5
3	3.4	3.4
4	3.4	3.4
5	3.3	3.6
6	3.6	2.9
7	3.4	3.2
8	3.3	3.4
9	3.4	3.7
10	4.0	4.0
11	3.7	3.3
12	3.4	3.4
13	3.8	3.9
14	3.3	3.5
15	3.2	3.2
16	3.2	3.2
17	3.1	3.1
18	3.5	3.6
19	2.9	2.9
20	3.7	3.6
21	3.8	3.7
22	3.7	3.5
23	2.7	3.2
24	3.2	3.6
25	3.4	3.2
26	3.4	3.4
27	3.1	2.5
28	3.5	3.3
29	3.5	3.5
30	3.6	2.0
31	3.2	3.3
32	3.4	3.9
33	3.3	3.2
34	3.1	3.9
35	2.5	3.0
36	3.1	3.1
37	3.1	3.1
38	3.6	3.3
39	3.4	3.6
40	3.3	3.3
41	3.0	3.1

APPENDIX F, PART I

RAW DATA FROM THE HARDT DEATH ATTITUDE SCALE FOR THE EXPERIMENTAL GROUP

Page 2

Subject Number	Posttest 1	Posttest 2
42	3.9	4.0
43	3.5	3.5
44	3.5	3.7
45	3.5	3.5
46	3.6	3.6
47	3.9	4.0
48	2.7	3.4
49	3.8	3.7
50	3.1	3.2

APPENDIX F, PART II

RAW DATA FROM THE HARDT DEATH ATTITUDE SCALE FOR THE CONTROL GROUP

Subject Number	Posttest 1	Posttest 2
51	2.9	3.5
52	2.7	3.8
53	3.1	3.4
54	2.1	3.3
55	2.0	3.7
56	2.9	3.5
57	2.8	3.4
58	2.3	3.4
59	2.7	3.5
60	2.1	3.5
61	3.0	3.3
62	2.8	3.3
63	2.0	3.7
64	2.3	2.2
65	3.0	3.2
66	2.7	3.6
67	2.8	2.3
68	2.0	3.3
69	2.9	3.6
70	2.0	3.1
71	3.1	3.7
72	3.0	3.6
73	2.8	3.6
74	3.1	3.5
75	1.8	4.0
76	3.1	3.5
77	2.9	3.7
78	2.4	3.4
79	2.7	3.7
80	2.6	3.6
81	3.0	3.5
82	2.6	3.3
83	2.5	3.1
84	2.9	3.5
85	1.9	2.5

APPENDIX F, PART II

RAW DATA FROM THE HARDT DEATH ATTITUDE SCALE FOR THE CONTROL GROUP

Page 2

Subject Number	Posttest 1	Posttest 2
86	1.2	3.1
87	2.9	3.7
88	3.0	3.5
89	3.1	3.4
90	2.6	3.1
91	2.2	3.7
92	3.1	3.7
93	2.2	2.6
94	2.7	3.4
95	2.8	3.4
96	2.3	3.2
97	2.7	3.3
98	2.3	3.8
99	2.6	3.7
100	2.9	3.3

APPENDIX F, PART III

RAW DATA FROM THE HOELTER SUICIDE ACCEPTABILITY SCALE FOR THE EXPERIMENTAL GROUP

Subject Number	Posttest 1	Posttest 2
1	14	7
2	12	12
3	17	17
4	18	16
5	18	14
6	8	6
7	16	13
8	18	15
9	25	25
10	6	10
11	12	9
12	16	16
13	11	11
14	13	15
15	20	21
16	18	14
17	17	18
18	20	11
19	12	12
20	17	17
21	16	12
22	12	12
23	9	8
24	15	14
25	18	14
26	16	15
27	15	21
28	22	18
29	16	12
30	19	12
31	15	17
32	8	11
33	14	16
34	18	13
35	19	21
36	11	9
37	13	12
38	10	12

APPENDIX F, PART III

RAW DATA FROM THE HOELTER SUICIDE ACCEPTABILITY SCALE FOR THE EXPERIMENTAL GROUP

Page 2

Subject	Posttest 1	Posttest 2
39	20	12
40	20	21
41	13	13
42	17	15
43	7	10
44	12	11
45	20	17
46	23	22
47	10	9
48	19	22
49	10	10
50	6	17

APPENDIX F, PART IV

RAW DATA FROM THE HOELTER SUICIDE ACCEPTABILITY SCALE FOR THE CONTROL GROUP

Subject Number	Posttest 1	Posttest 2
51	18	21
52	10	8
53	14	19
54	15	9
55	22	19
56	19	19
57	14	6
58	12	9
59	7	6
60	9	9
61	15	10
62	21	21
63	8	8
64	14	13
65	13	9
66	15	11
67	18	19
68	11	10
69	11	11
70	6	6
71	19	18
72	17	18
73	27	19
74	22	20
75	7	11
76	12	13
77	13	12
78	21	15
79	13	16
80	11	15
81	6	6
82	10	10
83	18	20
84	7	6
85	19	18
86	16	12

APPENDIX F, PART IV

RAW DATA FROM THE HOELTER SUICIDE ACCEPTABILITY SCALE FOR THE CONTROL GROUP

Page 2

Subject Number	Posttest 1	Posttest 2
87	6	7
88	18	15
89	19	21
90	9	10
91	11	10
92	22	16
93	15	16
94	9	12
95	17	17
96	8	6
97	15	14
98	20	19
99	16	11
100	15	12

APPENDIX G

Raw Data Collected from the Recency of Death Form. The Data Presented are in Months

Part I: Raw Data From the Experimental Group

Part II: Raw Data From the Control Group

APPENDIX G, PART I

RAW DATA FOR THE EXPERIMENTAL GROUP FROM THE RECENCY OF DEATH FORM

Subject Number	Raw Data in Months
1	8
2	39
3	6
4	20
5	2
6	6
7	48
8	48
9	30
10	96
11	4
12	6
13	6
14	12
15	12
16	18
17	180
18	6
19	18
20	24
21	12
22	6
23	18
24	18
25	36
26	48
27	6
28	6
29	0
30	1
31	1
32	12
33	12
34	6
35	18
36	35
37	12
38	6
39	36

APPENDIX G, PART I

RAW DATA FOR THE EXPERIMENTAL GROUP FROM THE RECENCY OF DEATH FORM

Page 2

Subject Number	Raw Data in Months
	6
40	6
41	24
42	6
43	12
44	6
45	24
46	6
47	6
48	6
49	6
50	

APPENDIX G, PART 2

RAW DATA FOR THE CONTROL GROUP FROM THE RECENCY OF DEATH FORM

Subject Number	Raw Data in Months
51	12
52	6
53	24
54	6
55	120
56	6
57	6
58	36
59	36
60	36
61	24
62	6
63	6
64	12
65	12
66	96
67	6
68	12
69	24
70	24
71	12
72	12
73	12
74	18
75	24
76	18
77	18
78	12
79	12
80	6
81	6
82	6
83	6
84	12
85	18

APPENDIX G, PART 2

RAW DATA FOR THE CONTROL GROUP FROM THE RECENCY OF DEATH FORM

Page 2

Subject Number	Raw Data in Months
	29
86	24
87	36
88	36
89	84
90	60
91	18
92	18
93	12
94	12
95	6
96	6
97	24
98	72
99	36
100	

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