

**DEATH ANXIETY AND RELIGIOUS BELIEF: A RESEARCH NOTE**

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**ABSTRACT**

This study assessed the contribution of religious beliefs in moderating the effect of death anxiety on forty-five (45) subjects who were diagnosed with Lou Gehrig's disease (ALS). Subjects were administered the Templer Death Anxiety Scale and the Shepherd Christianity Questionnaire. Results indicate an inverse relationship between religious beliefs and death anxiety. The age and gender of each respondent was also examined to see if there was a correlation with death anxiety. Neither of these variables produced statistically significant effects on death anxiety.

**INTRODUCTION**

This study examined the effects of religious beliefs in moderating death anxiety on forty-five (45) subjects who were diagnosed with Lou Gehrig's disease (ALS). The age and gender of the participants were also examined to see if there was a correlation between these variables and death anxiety. Amyotrophic Lateral Sclerosis (ALS) also commonly known as Lou Gehrig's disease is a fatal motor neuron disease in which there is a progressive degeneration of motor cells in the brain (upper motor neurons) and spinal cord (lower motor neurons). When the motor neurons can no longer send impulses to muscles, the muscles begin to waste away (atrophy) causing increased muscle weakness. ALS is often referred to as a syndrome because the disease itself becomes more apparent in various patterns. Patients will experience impaired use of limbs (hands and feet), thick or slurred speech eventually not being able to swallow at which time a feeding tube will be placed in the stomach. Finally, a person loses the ability to breath at which point a decision is made about death. ALS does not impair all the senses or intellectual reasoning. Most patients are diagnosed in their mid 50's, but ALS can also affect young adults or teenagers. However, onset of this disease is rare before the age of thirty. There is no effective treatment and the duration of life upon diagnosis is typically between two to five years. ALS involves a series of losses ultimately ending in the painful confrontation with death. Although this affliction may not be as common as other types of illnesses that are potentially terminal, such as cancer, it offers fertile ground for studying the fear of death among a group of individuals who are facing imminent death in the near future. Thus, the purpose of this research was to determine the relationship between death anxiety and strength of religious belief among a sample of

individuals with ALS.

**REVIEW OF LITERATURE**

Although researchers have long examined the issue of how religion influences levels of death anxiety, they have generally limited their focus to college populations or those afflicted with illnesses such as cancer. To our knowledge no studies have specifically examined the relationship between religious beliefs and death anxiety among ALS patients. The current study offers an opportunity to extend our knowledge of death anxiety among a population with the unique characteristic of imminent death approaching rapidly. Unlike cancer, ALS offers no potential hope of remission or recovery. Thus, we examine the relationship between death anxiety and prior knowledge of one's rapidly approaching death combined with the characteristic of no hope of recovery.

Previous studies concerning the relationship between death anxiety and religion or spirituality have produced inconsistent and often conflicting results (Rasmussen & Johnson 1994). Some researchers have found a strong negative correlation between death anxiety and intensity of religious devotion (Frank, Templer, Cappelletty, & Kauffman 1990-91; Gibbs & Achterberg-Lawlis 1978; Ita 1995-96). Frank et al. (1990-91) found that strong attachment to a belief system was the variable most predictive of lower death anxiety. Gibbs and Achterberg-Lawlis (1978) found that cancer patients with higher levels of religious beliefs had significantly lower death anxiety levels. They found a strong negative association between fear of death and self-rating of strength of religious beliefs, indicating less fear among strong believers. They also found a correlation between low levels of perceived physical pain and low levels of fear of death. Strong religious beliefs were associated with a denial of certain aspects of one's illness and death, resulting in

less fear of death. Ita (1995-96) studied the acceptance of death in hospice patients. Patients with higher spirituality had lower death anxiety. Gielen and Roche (1979-80) examined the death anxiety of Huntington's disease patients. They tried to isolate all the factors that are relevant to the determination of death anxiety in patients with this disease. They found a negative correlation between importance of religion and level of death anxiety but it was not significant.

Those studies that examined death anxiety among populations with illnesses that could potentially result in death have found negative relationships between religious beliefs and fear of death (Alexander & Alderstein 1958; Templer & Dotson 1970). On the other hand, those studies that examined college populations were less likely to report such relationships. For example, Templer and Dotson (1970) examined 213 college students and found no relationship between Death Anxiety Scale (DAS) scores and several variables of religious affiliation, belief, and activity. They suggested that religion had a limited effect upon the attitudes and behaviors of most college students in our society. Chaggaris and Lester (1989) found no association between fear of death and religious belief of 36 men and women enrolled in college courses. Thus, a review of many previously reported studies on death anxiety found conflicting results (Martin & Wrightsman 1964).

There have been many explanations for the ambiguity in the literature on death anxiety and religion. Fortner and Neimeyer (1999) in a review of research on death anxiety found that studies with younger samples suggest people who are more religious report lower levels of death anxiety, while those with elderly samples found no relationship. They suggest that these findings are the result of the elderly being relatively uniform on religious variables, which restricts variation of religiosity necessary to correlate with varying degrees of death anxiety. Templer and Dotson (1970) justified their lack of a relationship between death anxiety and religious variables by two reasons. First, they said that non-believers don't have a "hell" to fear but also they don't have a heaven to anticipate. Therefore, the non-believer is argued to have similar experiences with death anxiety as the person with strong religious beliefs. Heintz and Baruss (2001) attributed some of the inconsistency in findings to confusion in the use of the distinct terms spirituality and religious

behavior. While some religious behaviors are correlated with the dimensions of spirituality, many are independent of each other. Rasmussen and Johnson drew similar inferences.

One possible explanation for the conflicting results...may lie in the differentiation of spirituality and religiosity. Spirituality can be defined as high levels of satisfaction with life, strong feelings that life is meaningful, belief in an afterlife, and degree of certainty about life after death not tied to a particular religious denomination, while religiosity concerns itself more with practices and rituals...while there is some overlap, these two constructs are largely separate and independent. It may well be that prior research has inadvertently mixed the two... (1994:314)

Another important factor thought to influence death anxiety is age. There is evidence indicating that older adults typically have lower death anxiety scores (Fortner & Neimeyer 1999; Hintze, Templer, Cappelletty & Frederick 1993; Ita 1995-96; Stevens, Cooper, & Thomas 1980). Stevens et al. (1980) studied age norms for Templer's death anxiety scale and suggested that users of the Death Anxiety Scale should be aware that the age of the individual may be important in interpreting scores as the elderly typically have lower fear of death scores. However, others studies have reported no significant differences in levels of death anxiety based on age (Conte, Weiner, & Plutchik 1982; Templer, Ruff, & Franks 1971). Templer (1970) did suggest that retired adults possess less fear of death than younger age groups, which is similar to results of much of the other research. Ita (1995-96) found that age had an indirect effect on death anxiety through spirituality. Older persons had higher spirituality; higher spirituality predicted higher social support. This supports the theoretical view that spirituality develops through life as a dimension of human experience. Death anxiety was negatively correlated with age, which supports the proposed path from age to spirituality to death anxiety. Although most researchers have found a relationship between age and death anxiety, these findings have not been entirely conclusive. Some studies have reported no significant differences in levels of death anxiety based on age (Fortner & Neimeyer 1999; Templer et al. 1971).

Researchers have also examined the relationship between gender and death anxiety. In

general, such studies have also produced inconsistent findings. Gielen and Roche (1979-80) found no significant differences between male and female responses on death anxiety. Their sample consisted of 13 individuals with a terminal disease. All patients viewed death as relief. DaSilva and Schork (1984-85) found gender differences in perception of death among a sample of students. DaSilva and Schork (1984-85) found that half of the women they surveyed believed that religion played a very significant role in lowering death anxiety as compared to 21.6 percent of the men. Conversely, 16.2 percent of the men felt that religion had no role at all while 8.7 percent of the women felt that way. They concluded that women were more comfortable than men in dealing with death-related issues. Fortner and Neimeyer (1999) did not find gender to be a reliable predictor of death anxiety in elderly people.

Thus, both gender and age are factors that could potentially influence levels of death anxiety. There is also evidence the type of population sampled influences levels of death anxiety as well (Fortner & Neimeyer 1999; Heintz & Baruss 2001; Rasmussen & Johnson 1994). Consistent with the findings of earlier studies, one would theoretically expect those persons facing imminent death to differ from those who are not on levels of death anxiety.

#### **METHODOLOGY**

The participants were forty-five (45) men and women who have been diagnosed with ALS. The prognosis given to all patients is between two to five years to live. The participants were recruited through a support group that meets via the Internet called PALS (Persons with ALS). Membership in the support group ranges from 40 to 75. First, permission was granted by the website coordinator and then on an individual basis if they were willing to participate. The subjects ranged in age from 32 to 76 years of age with a mean of 52.4 years. All the respondents were white. There were 27 males and 18 females in the sample. All subjects were administered the Templer Death Anxiety Scale (Templer 1970) and the Shepherd Christianity Questionnaire (Basset, Sadler, Kobischen, Skiff, Merrill, Atwater & Livermore 1981). Copies of the questions used in this research are available from the authors upon request. The Templer Death Anxiety Scale is a 15 item true/false questionnaire used to measure the level of affective arousal associated with death. Awareness of how an individual deals with im-

pending death can be studied by evaluating the level of death anxiety. The Templer Death Anxiety Scale was designed to measure this variable (Templer 1970). The Shepherd Christianity Questionnaire has 8 questions that examine a person's involvement with, commitment to and knowledge of Christianity. The questionnaire's reliability/validity are reported by Basset et al. (1981) and Pecnik and Epperson (1985).

The dependent variable, Death Anxiety Scale (DAS) score, is measured by a 15-item measure. The possible range of scores was 0-15 with actual scores ranging from 0-11. These raw scores were used in the analysis. The lower the number, the lower the death anxiety a person experiences; and the higher the number, the higher the death anxiety a person experiences. The 45 participants obtained a mean DAS score of 5.2.

Scores on the Shepherd Christianity Questionnaire, were derived from a combination of answers on two items designed to tap firmness of belief: How strong is your attachment to your belief system? and How is the strength of your religious conviction when compared to those of others? Alexander and Alderstein (1958) argued that degree of certainty rather than the nature of one's conviction is a more crucial variable for the Shepherd Christianity Questionnaire with respect to death anxiety. The responses were coded as follows: Strong (4), Strong-Moderate (3), Moderate (2), Weak-Moderate (1), and Weak (0). Of the 45 subjects, there were 18 Strong, 5 Strong-Moderate, 12 Moderate, 4 Weak-Moderate, and 6 weak. Another variable examined was the gender of the subjects. On this variable males were coded zero and females were coded one. The last independent variable analyzed was the subject's age. This was measured as the actual age of the participant in years. The analysis of the data was limited to measuring bivariate correlations between death anxiety and the 3 independent variables, due to the small sample size.

#### **FINDINGS AND DISCUSSION**

Using SPSS bivariate correlation coefficients were examined in order to determine the effects of religious beliefs, age and gender on death anxiety. These findings offer a conservative estimate of statistical association between the independent and dependent variables due to the small sample size. A significant negative correlation of ( $r = -.341$ ) was found at .05 level

(2-tailed) between DAS and the Shepherd Christianity Questionnaire. Death anxiety was positively related to age ( $r = .150$ ). Women had lower levels of death anxiety than men ( $r = -.024$ ), although the association was very low. Neither age nor sex were significantly related to death anxiety.

The present study found that a stronger Christian belief system diminishes death anxiety. These results are similar to the results of previous research done with terminally ill patients. Gibbs and Achterberg-Lawlis (1978) have suggested that strong belief in the strength and support of one's religion concomitant entails a denial of certain aspects of one's illness and impending death resulting in less expression of fear of death. When addressing the importance of these results in terms of their practical use one notes the importance of addressing spiritual issues to help manage death anxiety in terminally ill patients. Religious belief provides a prism through which one views death as well as providing a community of support and shared ideals that help cushion the sense of loneliness and helplessness that occurs when faced with imminent death (Austin & Lennings 1993). Sociological research has long offered support for the view that social support allows individuals to cope with stressful situations.

Our findings on gender and age reflect the ambiguity in the literature. Our insignificant finding that women had lower levels of death anxiety than men is similar to the findings of Gielen and Roche (1979-80) and Fortner and Neimeyer (1999) who found no significant correlation between gender and death anxiety, but in agreement with DaSilva and Schork (1984-85) who found that males tended to have higher death anxiety scores than females. The findings that older individuals had higher levels of death anxiety is in contrast to most other research. It may be that death anxiety does not continue decreasing with age. Further research should continue to examine these relationships, particularly within certain elderly age cohorts.

Much of the inconsistency in the research regarding gender, age, religiosity, and death anxiety is due to sampling and conceptualization/measurement issues (Fortner & Neimeyer 1999; Heintz & Baruss 2001). As discussed previously this is a particularly salient issue in any discussion of the various tools used to measure religious factors (Rasmussen & Johnson 1994).

This research has examined some of the factors that influence death anxiety among individuals facing imminent death. Future research should further examine the potential differences in the effects of various illnesses on levels of death anxiety. Also potential interactions between age, gender, religious beliefs and death anxiety among persons facing imminent death as opposed to the general population should be explored.

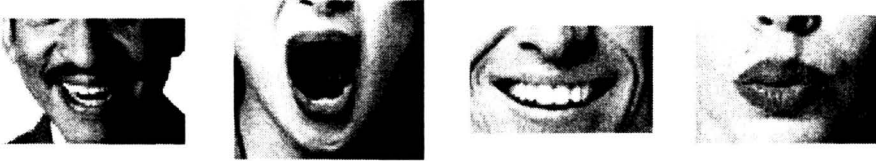
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## DISABILITIES MISCONCEPTIONS AND EMPLOYMENT: INTEGRATING ADVOCACY PERSPECTIVE AND REHABILITATION

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### ABSTRACT

This article reviews the literature on misconceptions held by employers and businesses about people with disabilities, which constitutes barriers to their full workplace participation. Designed to provide for the elimination of discrimination against individuals with disabilities, the Americans with Disabilities Act (ADA) more significantly provided for improving their employment opportunities. Enacted a decade ago in 1990, the ADA, however, has not moved fast enough in increasing employment opportunities for many of its intended populations. This article discusses demography of people with disabilities, employment issues, and misconceptions associated with disabilities. It discusses integrating an advocacy perspective in rehabilitation counseling.

### INTRODUCTION

During the past 30 years the United States has advocated on behalf of people with disabilities through a series of congressional actions and public policy initiatives. The enactment of the Americans with Disabilities Act (ADA) of 1990, signed a decade ago, signaled monumental federal legislation mandating action to eliminate discrimination against individuals with disabilities (Asch & Mudrick 1995; Henderson 1994; Orlin 1995). By prohibiting discrimination in employment, public accommodations, transportation and telecommunications, the ADA empowered people with disabilities to venture into the community, to seek employment and to lead active and productive lives.

The ADA focus is in breaking down barriers that prevent the millions of Americans who have physical or mental impairments from living up to their fullest potential. Previous legislative efforts aimed at improving conditions and opportunity for this population has culminated in the ADA passage. The Rehabilitation Act of 1973 and the subsequent Rehabilitation Act Amendments of 1974 were the first to prohibit discrimination against anyone who currently had or had in the past "a physical or mental impairment which substantially limits one or more of such person's major life activities" (Henderson 1994 104).

Expediencies of the ADA include the following paramount considerations: 1) gainful employment increases the person's earning and sense of independence, 2) the person is viewed by family and society as a more productive and integrated member of community, 3) expenditures for care or treatment programs decline, and 4) integration of those with disabilities into work environment has the potential to increase social comfort and

acceptance of people with special needs (Beck & Gray 1995; Chima 1998; Means, Stewart & Dowler 1997; Roessler & Sumner 1997; Stennett-Brewer 1997). It broadened prohibitions on employment discrimination for businesses with fifteen or more employees and banned discrimination in hiring, firing, compensation, advancement, and training. The ADA also requires employers to make "reasonable accommodations" for those with disabilities unless this would cause "undue hardship" (DiNitto 2000; Orlin 1995; Salsgiver 1998).

The literature on the implementation of the ADA, nonetheless, reveals that it has not moved fast enough during the ten years since its enactment for many people with disabilities, particularly in the area of employment (Hofius 2000; Salsgiver 1998). Large numbers of people with disabilities remained unemployed (Kirkpatrick 1994; Kopels 1995; Smolowe 1995). Reasons for the limited success of the ADA in moving more people with disabilities into the workplace include: 1) employers fear of lawsuits, 2) persistent misconceptions and stereotypes about disabilities, 3) the vagueness in ADA terminology, and 4) lack of specification regarding how changes must be implemented (Salsgiver 1998). While access to elevators, public facilities and transportation has improved, more people with disabilities are graduating from high schools and colleges posing a new challenge for employers in their employment decisions.

There is a need for more literature on employers' actions and attitudes toward those with disabilities. The purpose of this article is to acquaint the reader, potential employers, and rehabilitation practitioners with vital information on barriers that are limiting people with disabilities from entering the work