THE IMPACT OF DEATH ANXIETY ON THERAPISTS’ PROFESSIONAL
CONFRONTATION WITH DEATH ISSUES

by

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Abstract

This quantitative research examined the relationship between death anxiety and professional death anxiety, as well as the influences that age, gender, and years of experience have on personal and professional death anxiety. This research was broken into two studies, one to validate a new scale designed to measure professional death anxiety via a field test and another to utilize the new scale to assess professional death anxiety of psychologists who treat patients with anxiety disorders. The Professional Death Anxiety Scale demonstrated moderate reliability in the first study. The scale did not produce reliable results for the sample of psychologists in the second study; therefore the hypotheses were neither accepted nor rejected. Even though the measuring instruments were found to be unreliable for the targeted population, the results of this research proved interesting and revealed several areas in need for further investigation.
Dedication

This effort is dedicated to the following people: in memory of my mother, Adah Ross, who instilled in me an unconditional positive regard for all people; to my husband and muse, Dan Carr, who supported me in my endeavor from the beginning; to my son, Jacob Richards, who encouraged me to pursue a college degree when I thought that I was too old; to my daughter, Sierra Richards, who comforted me when the work was overwhelming; to my step-children, D. Aaron Carr and Alicia Dearth, who understood the pressures of being a college student and empathized with my situation; to my sister, Kim, who let me vent about the frustrations of being a non-traditional student; and my sisters, Brenda and Sherry, who were my cheerleaders along the way.
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CHAPTER 1. INTRODUCTION

Introduction to the Problem

Cited as being the “most common of emotional disorders,” anxiety affects “more than 25 million Americans” (American Psychiatric Association, 2005, What Are Anxiety Disorders? Section, para. 1) for which the cost of treatment is $42 billion annually (Anxiety Disorders Association of America, n.d., Misdiagnosis section). Those suffering from anxiety disorders can spend years in continual treatment or may seek treatment repetitively for years. Why might this be so? One reason might be that the canned treatments of therapy that so many therapists prescribe do not fully address the underlying existential factor that lies at the core of emotional disorders, specifically anxiety.

According to Solomon, Greenberg, and Pyszczynski (1997), each individual strives to reduce anxiety from the time of birth, yet the individual’s concern of "death is the worm at the core" of anxiety (p. 61). Humans cannot escape their mortality and the awareness of this fact can debilitate many individuals to the point that they seek professional and non-professional help for alleviating their anxiety. Yet, the core problem of anxiety is not adequately addressed in therapy which may be the reason for repetitive treatments and high expenditures for treatment. Feinstein and Krippner asserted that the psychological profession was doing a huge disservice by not taking into consideration the importance of addressing existential concerns during treatment (1997).
If psychological treatment is a recommended treatment by the National Institute of Health (2000, Psychotherapy section), why are so many people stuck in therapy for years? This is a question that Walsh (2004) and others have contemplated for many years. Walsh claimed that the profession has lost something due to the templates of canned therapy treatments and implied rules of the profession which have entangled the mental health profession (p. 456) and thereby, stagnated the growth of psychotherapy. Furthermore, Walsh indicated that the empirically based “rules” of the profession is problematic, as the process of validation has removed therapist and patient perspectives from the equation. Science deals with tangible, rational, and measurable data, but chaotic situations cannot be rationalized or predicted by science, according to Weik (2001, Myth in Organization section, para. 1). Carl Jung asserted that mental health professionals need to look beyond knowledge and psychological assumptions and tend to their patients’ needs. "What counts, after all, is not whether a theory is corroborated, but whether the patient grasps himself as an individual" (Jung, 1961/1989, pp. 131-132). This is especially important when dealing with existential concerns, which are at the root of anxiety disorders.

Existential concerns are not always addressed during therapy. Frankl would have been very disappointed as his research (1967) demonstrated that existential concerns can be greatly reduced by addressing one’s own meaning of death and of life. Worden (2002) deduced that some therapists avoid the topic of death when treating their patients due to their own concerns. As it has been supported that therapist bias impacts treatment outcomes, it is only reasonable to assume that therapists’ own existential anxiety would impact the treatment provided to their patients.

Many studies have been conducted on bias in psychology (e.g., Gore-Felton et al., 2000; Murdock and Fremont, 1989; Roysircar, 2004) which suggests that a therapist’s personal views,
feelings, and beliefs have an impact on the outcome of psychotherapy. As such, one might question whether the therapist’s personal views, feelings, and beliefs about death impact the level of anxiety that therapists might experience when providing therapy to patients during treatment sessions. Such bias may impact the outcome of treatment, as existential issues are not handled properly, if at all, during psychotherapy sessions.

Finally, studies indicate that age (Neimeyer, Wittkowski, & Moser, 2004; Cicirelli, 2003; Keller, Sherry, & Piotrowski, 1984), experience (Kirchberg, Neimeyer, & James, 1998), and gender (DePaola, Griffin, Young, & Neimeyer, 2003) significantly impact an individual’s attitude toward death. Since the premise of this study is to determine how personal death anxiety affects a therapist’s death anxiety when discussing death related issues with patients, then the factors of age, gender, and years of experience would contribute to the anxiety that one has toward death personally and professionally. As such, these factors will also be examined in this study.

Background of the Study

From birth, humans strive for anxiety reducing measures, yet the root of anxiety – the fear of death (Solomon, Greenberg, & Pyszczynski, 1997, p. 61) – is not always acknowledged as the underlying factor. Worden (2002) indicated that therapists may feel uncomfortable addressing their own existential concerns and avoid topics related to existential concerns when treating their patients. During the course of treating patients, those therapists who experience death anxiety may avoid the issues of death that their patients present and need to process. If this is the case, it is no wonder that the cost of treating anxiety disorders is astronomical. If the intrinsic existential concerns of patients are not being considered during the course of therapy,
then the psychological profession is providing only a bandage for patients to get them over the
bumps in their current condition and that is not conducive to sound mental health for patients in
the long run.

Statement of the Problem

Relevant research (Gore-Felton et al., 2000; Murdock and Fremont, 1989; Roysircar,
2004) has supported that the views of therapists often influence the process of therapy treatment.
For instance, not all therapists fully address existential concerns, according to Worden (2002).
Worden claimed that a therapist might avoid his or her patient’s existential concerns in an
attempt to ward off his or her own existential anxiety.

Ordinarily, humans are able to find buffers for existential anxiety through various actions,
behaviors, and thoughts. However, those with maladaptive anxiety disorders are unable to find
relief through these methods and seek professional help. As the core issue of anxiety is not fully
addressed during the course of therapy, patients can be involved in treatment for years, which
can be quite costly in time and money.

Purpose of the Study

“Professional psychologists are increasingly likely to encounter opportunities to work
with patients and families facing end-of-life issues” (Haley, Larson, Kasl-Godley, Neimeyer, &
Kwilosz, 2003, abstract section). As the baby-boomer generation heads into their elder years, it
will be increasingly important for psychologists to be ready for the influx of death related
treatments. As it stands, classes for grief and bereavement for psychology students are often an
option for the student, yet in the students’ future practice, there will be a great need for the
psychologist to be able to treat those with issues related to death. To build a case that grief and bereavement courses should be a mandatory consideration, studies must be conducted to demonstrate the importance of the courses. Steps toward that goal would include research that supports a need for grief courses. Research would be needed to establish current views on death and dying issues, current treatment modalities, aspects of successful treatment modalities and finding out why these treatments are successful, and the creation of a successful treatment plan for grief and bereavement issues using modalities that have been deemed successful. This study is one step in that direction. The purpose of this study is to determine if a therapist’s personal death anxiety affects the level of anxiety that is generated during the treatment of patients as it relates to issues of death. Although this is a small step, it is a step in the right direction.

Rationale

Sigmund Freud (1930/1961) wrote "anxiety is always present somewhere or other behind every symptom; but at one time it takes noisy possession of the whole of consciousness, while at another it conceals itself so completely that we are obliged to speak of unconscious anxiety" (p. 139). Further developing Freud’s assertion, Becker posited that "the fear of death can be carefully ignored or actually absorbed in the life-expanding processes" (1973, p. 21). Greenberg, Pyszczynski, and Solomon (1986) expounded upon and conducted research on Becker’s ideas and developed the fundamental premise for their terror management theory which holds that people use anxiety buffering mechanisms (cultural worldviews and self-esteem enhancing mechanisms) to reduce the anxiety that arises from the intrinsic fear of death. Solomon, Greenberg, and Pyszczynski wrote that "no sensible person would deny that the inevitability of death poses a rather serious problem for humankind" (1997, Introduction, 1st para.).
When the individual lacks the ability to buffer death anxiety through their actions, behaviors, and thoughts, then the individual ultimately will suffer as a result of their existential anxiety. At this point, anxious individuals seek treatment from professional and nonprofessional sources. If these sources are unable to provide help that will address the underlying cause of the individual’s anxiety, then the individual will continue to suffer the often overwhelming symptoms of existential anxiety.

As most humans have an intrinsic fear of death, what happens when a therapist is presented with a patient who has issues related to death? This depends upon the therapist. Not all therapists experience a level of death anxiety that would interfere with their work. The reason for this may be the therapist’s age, gender, and experience.

Cicirelli (1998; 2003) found that individuals differ in their response to thoughts about death and dying depending upon their age and gender. Cicirelli found that young adults demonstrated higher levels of death anxiety, whereas older adults tend to view death differently, depending upon their transition stage. Even at that, the individual’s meaning of death was a huge element in the age and gender factor that produced the most significant differences.

Cicirelli also found that women demonstrated higher levels of death anxiety (1998, abstract) and that “women were more likely to see death as a form of continued existence” (p. 730). DePaola, Griffin, Young, and Neimeyer (2003) reported that females, without regard for race, demonstrate higher levels of death anxiety and that “women tend to view death in more emotional terms, whereas men tend to perceive death in more cognitive terms” (p. 338, para. 1). However, DePaola et al. found inconsistencies in previous research conducted on the topic of death anxiety and gender.
As psychology stretches to meet the needs in primary care needs, “end-of-life care will be an increasing area of practice” (Haley, Larson, Kasl-Godley, Neimeyer, & Kwilosz, 2003, p. 626). As such the training that psychology students receive on death and dying is extremely important, as knowing how to deal with patients who present with death related issues, as well as dealing with one’s own anxiety toward death, will aid the student transition into an effective therapist. Training aids students in knowledge, but the actual experience of treating patients with death related issues a big challenge for the beginning mental health professional. Kirchberg, Neimeyer, and James demonstrated that a lack of professional experience “presents unique challenges to beginning mental health providers, especially for those whose personal death anxieties leave them vulnerable to such work” (1998, abstract).

The rationale for this submission is to demonstrate that various factors exist that can inhibit a therapist’s ability to overcome his or her own death anxiety. The information that is generated from this research will aid in better training for students and professionals that will enable them to better understand and minister to their patients’ and their own anxieties toward death. While this submission does not provide an answer to the successful elimination of death anxiety, nor does it delve into the professional practice of therapists, it is a positive step in the right direction toward shedding a light on the importance of thorough training and education on death related issues.

Research Questions

The hypothesis of this study is that mental health professionals who have little difficulty with their own mortality are more apt to address death related topics during the course of their patients’ treatment. The study will answer the following questions: 1) is there a significant
relationship between a therapist’s own level of anxiety about death and his or her level of anxiety generated as a result of working with patients who present with symptoms of death anxiety; and 2) do therapists’ age, years of professional experience, or gender significantly affect personal and professional anxiety toward death?

Significance of the Study

The American Psychiatric Association (2005) described anxiety disorders as "the most common of emotional disorders" that "affect more than 25 million Americans" (What Are Anxiety Disorders? section, para. 1). Symptoms can interfere with the daily functioning of those who suffer with anxiety disorders. The treatment for anxiety disorders costs Americans $42 billion per year (Anxiety Disorders Association of America, n.d., Misdiagnosis section).

As cited previously, Freud (1930/1961) wrote "anxiety is always present somewhere or other behind every symptom; but at one time it takes noisy possession of the whole of consciousness, while at another it conceals itself so completely that we are obliged to speak of unconscious anxiety" (p. 139). If more insight was provided that supported the premise that existential anxiety is an important factor of anxiety disorders, then students may benefit with better training in the existential concerns of humans. Better training would provide psychology students the knowledge of how to deal with patients who present with death related issues, as well as dealing with their own anxiety toward death. This will aid the student in his or her transition into the professional world as an effective therapist.

Furthermore, this study is significant in that it is a step toward demonstrating that existential anxiety should be given more respect as a factor in mental health disorders. Worden (2002) indicated that the topic of death is often overlooked during the treatment of a patient and
suggested that it can be a challenging concept to tackle. It is not a new idea that therapists’
views, personal concerns, and beliefs can impact the outcome of psychotherapy. This particular
bias can be detrimental to the outcome of the patient’s treatment. If existential factors were given
more attention, then the cost for psychological therapeutic treatment could be reduced
significantly.

Definition of Terms

Bias. Bias is defined as a personal partiality that interferes with one’s thoughts, actions,
and behavior.

Canned treatments. Canned Treatments refer to rigid methods of treatment used by
therapists that do not allow for the individual differences of each patient.

Existential anxiety. Existential anxiety is defined as anxiety that is related to the

Fundamental Attribution Error. A fundamental attribution error is “the tendency to focus
on the role of personal causes and underestimate the impact of situations on other people’s
behavior” (Brehm, Kassin, & Fein, 2002, p. 107).

Mortality salience. Mortality salience is the realization and understanding of the reality of
one’s own mortality.

Assumptions and Limitations

Assumptions

It was assumed that all participants provided truthful answers to the questionnaires.
Limitations

This study was limited by the sample of participants. The state from which the psychologists were chosen is a rural state with a limited amount of psychologists, therefore the results of this study is limited to similar populations and may not be a reliable indicator of the entire population of psychologists worldwide. Furthermore, this study was limited due to the amount of volunteers to participate in the study.

Nature of the Study, or Theoretical/Conceptual Framework

The theoretical approach to this study revolves around the existential approach to psychology specific to the inherent human concern of death. One specific idea of existential psychology used throughout this study is the terror management theory, developed by Greenberg, Solomon, and Pyszczynski (1986). In addition to the terror management theory, previous studies have shown that age, gender, and years of experience also affect one’s level of anxiety regarding death. As such, these factors have been examined to assess their impact on personal and professional death anxiety. Finally, the fundamental attribution error was used to explain why therapists might avoid topics of death during the treatment of their patients.

Regarding the terror management theory, the impact of existential concerns on society did not go unnoticed by Greenberg, Solomon, and Pyszczynski, who proposed their theory in 1986. Essentially, this theory holds that humans use certain mechanisms to alleviate the anxiety that occurs when they are faced with the reality of their own mortality (mortality salience). Solomon, Greenberg, and Pyszczynski (1998) found that individuals are able to alleviate their existential anxiety through “culturally shared illusions” (p. 19) that provides justification or meaning for life and also through the use of self-esteem enhancing thoughts, actions, and
behaviors. Individuals are usually able to buffer the anxiety of death with the use of these mechanisms, however, there are times that the reality of one’s own mortality is too apparent to avoid, as was the case after the September 11, 2001 terrorist attack on United States soil.

The reality of one’s mortality is largely influenced by an individual’s age, gender, and professional experience, as is the case with therapists. DePaola, Griffin, Young, and Neimeyer (2003) reported that levels of death anxiety was shown to be high in those young adults between the age of 18 to 26, higher in those adults who are 35-50 years old, and lowest in those whose ages are over 60 (p. 336). DePaola et al. also suggested that although most research indicates that women demonstrate higher levels of death anxiety, some studies report no difference between genders (p. 338).

While age and gender are being examined, one must not forget the impact of years of professional experience on one’s level of death anxiety. According to Kirchberg, Neimeyer, and James (1998) beginning counselors react differently to death related issues than do more experienced counselors (p.112). This study will examine the effects of experience on the level of death anxiety that professionals may exhibit.

The final concept that helps frame this study is the fundamental attribution error. A fundamental attribution error occurs when an individual inadvertently makes an erroneous judgment in the identification of a personal attribution of another and/or an erroneous adjustment of this perception based on the situation (Brehm, Kassin, & Fein, 2002, pp. 108-109). Some therapists avoid confronting their patients’ existential concerns because they have not come to grips with their own existential concerns. These therapists may make the erroneous assumption that the patient does not wish to discuss such issues. This demonstrates an attribution error and a serious bias that can impact the outcome of the patient’s treatment.
Organization of the Remainder of the Study

Chapter 2 introduces literature relevant to death anxiety, age, years of experience, and gender and how these affect individuals in their daily lives. As indicated previously, terror management theory states that people utilize defensive mechanisms to alleviate death anxiety (Greenberg, Solomon, & Pyszczynski, 1986). This particular chapter will discuss the concepts regarding an individual’s fear of death and his or her strivings to reduce this innate fear. Furthermore, the chapter will explore how death anxiety affects mental health and why these concepts are important for the psychological treatment of anxiety disorders. Finally, Chapter 2 will explore how a psychologist’s own feelings toward death anxiety may affect the outcome of the patients who present for treatment as a result of fundamental attribution error.

Chapter 3 restates the purpose of this study. The details of the research are submitted and examined as it pertains to the factors that determine the study’s validity. The target population and sampling procedures are detailed and examined. The survey instruments, data collection and analysis methods are identified, defined, and discussed. The field test will be discussed in this chapter. The hypotheses for this study are restated and the expectations of the researcher are discussed.

Chapters 4 and 5 provide the details of data collection, analysis, and the results of the study. Chapter 4 details the collection of data via survey questionnaires and details the scoring procedures of the questionnaires. The data will clarify the independent and dependent variables and the validity and reliability of the study will be examined. Finally, the summary of the analysis of the data is presented in Chapter 5. The results of the analysis, the conclusions drawn from the analysis, the implications of the study, and the recommendations for future research will be provided.
CHAPTER 2. LITERATURE REVIEW

The American Psychiatric Association (2005) described anxiety disorders as "the most common of emotional disorders" that "affect more than 25 million Americans" (What Are Anxiety Disorders? section). Symptoms can interfere with the daily functioning of those who suffer with anxiety disorders. The cost to treat anxiety disorders is listed as $42 billion per year (Anxiety Disorders Association of America, n.d., Misdiagnosis section).

The National Institute for Mental Health ([NIMH], 1994) prescribes a psychotherapeutic approach for treating anxiety disorders that encompasses cognitive-behavioral (CBT) and behavioral (BT) therapy techniques. NIMH contends that cognitive therapy "helps people change thinking patterns that keep them from overcoming their fears," while behavioral therapy "seeks to change people's reactions to anxiety" (p. 23). Although these treatment modalities can be effective for some, there are still many patients who require lengthy treatment or who have to return to therapy for booster sessions or for the treatment of new problems related to the old. The canned treatments of cognitive-behavioral therapy that so many therapists rigidly follow do not fully address the underlying anxiety that humans possess. Norcross (2005) asserted that the “professional training that addresses only or primarily the techniques of psychotherapy quickly becomes arid, disembodied, and decontextualized” (p. 840, para. 2). Norcross further suggested that this may result in neglecting the human aspect in treatment – the psychologist’s and the patient’s.
This current study was not designed to measure treatment success, but to shed light on an often neglected aspect of therapy, specifically in treating anxiety. Anxiety disorders have received significant attention from past and present sources. Sigmund Freud (1930/1961) wrote: anxiety is always present somewhere or other behind every symptom; but at one time it takes noisy possession of the whole of consciousness, while at another it conceals itself so completely that we are obliged to speak of unconscious anxiety (p. 139).

Rollo May, an existential psychology proponent, declared that "the distinctive quality of human anxiety arises from the fact that man is the valuing animal, the being who interprets his life and world in terms of symbols and meanings, and identifies these with his existence as a self" (1979, p. 72). Additionally, terror management theorists claim that from the time a human is born he or she strives for self-preservation and when threatened, the individual’s anxiety level elevates (Greenberg, Pyszczynski, & Solomon, 1986).

It is Becker’s idea that “life is never really ours,” that plants the seed for an underlying factor in anxiety – the fear of death (1973, p. 56). "No sensible person would deny that the inevitability of death poses a rather serious problem for humankind" (Solomon, Greenberg, & Pyszczynski, 1997, Introduction, para. 1). Solomon et al. found the fundamental basis of their terror management theory by studying the works of Ernest Becker, specifically Becker’s claim that the overt and covert fear of death faced by humans plays a motivational role in social life. Becker indicated that individuals need to ease the anxiety that comes with the awareness of one’s mortality. Terror management theorists, specifically Solomon, Greenberg, and Pyszczynski, have taken Becker’s ideas and expounded upon them. Terror management research has indicated that people use anxiety buffering mechanisms (cultural worldviews and self-esteem enhancing mechanisms) to reduce the anxiety that arises from the intrinsic fear of death.
Theoretical Framework

Existential Psychology

"Personal meaning is a complex achievement of the human spirit and is found in the individual's confrontation with the challenges of the world and one's own being" (Langle, 2004, Abstract). There are numerous aspects in life that can be challenging. For instance, it is not uncommon for some people in today’s world to feel as if their identity has been replaced by a number. Their lives are being overtaken by corporate protocols and some have lost touch with their own identities in the process.

Other challenges relate to the struggles that one has with everyday aspects of life. There are those who struggle with the death of loved ones due to natural or man-made disasters. Many struggle at the end of their lives trying to find an answer to the question of life. Others are faced with uncertainties related to the possible loss of employment or retirement without the financial ability to do so. With the employment situation as it is today, graduates are challenged with the uncertainty about future employment. Parents are faced with the situation where their sons and daughters are on a foreign soil fighting a war for a reason of which they are not sure. A final example of life’s challenges is that there are those who are prisoners of conflict, confined by bars or their own pathology. How are people able to cope with challenges such as these?

Existential psychology was developed as a response to the cries for answers to life’s challenges. The existential approach of psychology entails finding answers to issues pertaining to the concerns that all humans face in regards to life, death, suffering, and the reasons for these. As with any psychological approach, there are several theories that were formulated within the paradigm of existential psychology; however, this section will focus on logotherapy and terror management theory.
Logotherapy

Logotherapy is an approach that aids humans in realizing their freedom of choice to create meaning for their own lives. Logotherapy essentially stresses that each individual has the freedom and ability to choose how he or she will interpret and find meaning in life. Treatment involves assisting the individual in the creation of his or her own meaning.

Logotherapy was developed by Victor Frankl. Many of Frankl’s ideas were formulated during his detentions at three concentration camps in Auschwitz, Dachau, and Theresienstadt during World War II. During his imprisonment, Frankl covertly provided assistance to fellow prisoners. One particular experience that Frankl related after his release was his attempt to assist two prisoners who were contemplating suicide. As with many detainees, these individuals would rather have died at their own hands than face torture and an eventual, painful death. Frankl realized that these prisoners felt that there was nothing left for them in life and that they must be persuaded that there was a reason for the situation if only to provide something to the world. Frankl philosophized:

… for each of them, indeed for all, somebody or something was waiting, whether it was a piece of work to be done or another human being. But what if this waiting should prove to be without prospect of fulfillment? For there surely are situations in which it is certain that a man will never again return to a job or will never see a certain person again, and thus it is really true that nothing and no one is waiting for him any longer. But even then, it turned out, in the consciousness of every single being somebody was present, was invisibly there, perhaps not even living any longer but yet present and at hand, somehow "there" as the Thou of the most intimate dialogue. For many it was the first, last, and ultimate Thou: God… The important thing was to ask, What … is required of me (1967, p. 104)?

This excerpt encapsulates the basis of logotherapy – a theory of existentialism that evolved from ideas of philosophy, psychology, and spiritual ideas. Logotherapy encompasses three basic
assumptions that include "freedom of will, will to meaning, and meaning of life" (Frankl, 1967, p. 2).

Freedom of will is the assumption that one is free to choose how to react to the conditions of life despite the inability to change the circumstances. Each individual has the freedom to step back from a situation and apply his or her own perception of the circumstances in life. “Life has meaning under all circumstance, even the most miserable ones” (Logotherapy Institute, n.d., Tenets section).

According to Frankl, one's will to meaning meant that each individual was not a slave of defense mechanisms or drives, but have the free will to exact meaning in life. People often suffer in trying to find a meaning in life, as they are self-defined through self-actualizing experiences. It is, however, through life’s suffering that the individual is truly defined. Meaning is found through the struggles of life, not in the search for meaning. Frankl indicated that the real purpose in life is to lessen the tension between what the individual feels he or she is and what he or she ought to be.

The Logotherapy Institute defined meaning of life as the "freedom to find meaning in what we do, and what we experience, or a [sic] least in the stand we take when faced with a situation of unchangeable suffering" (n.d., Tenets section). Frankl stressed that people have to contend with pain, death, and guilt. These three circumstances were deemed by Frankl as the "tragic triad," from which meaning in life is also created. Frankl wrote "man is ready and willing to shoulder any suffering as soon and as long as he can see a meaning in it" (1967, p. 56).

So, in addition to the struggles that one suffers through, self-actualizing experiences help define the individual. This is an important concept in existential psychology. The following
section provides insight into the ways in which individuals are normally able to defend against existential anxiety and what happens when these defenses are rendered useless.

*Terror Management Theory*

Solomon, Greenberg, and Pyszczynski understood that humans strive, from the beginning of their lives, for self-preservation and felt that "death is the worm at the core of social motivation" (1997, p. 61). These authors continued that "no sensible person would deny that the inevitability of death poses a rather serious problem for humankind" (Introduction, 1st para.). These three social psychologists began their research in a quest to find out why people have difficulty existing without conflict and why self-esteem is so important to humans. Solomon, Greenberg, and Pyszczynski found, through studying the work of Ernest Becker, that the overt and covert fear of death faced by humans plays a motivational role in social life.

Becker (1973) wrote "the fear of death can be carefully ignored or actually absorbed in the life-expanding processes" (p. 21). Humans strive to be free of anxiety and "even in our flirtations with anxiety we are unconscious of our motives. We seek stress, we push our own limits, but we do it with our screen against despair and not with despair itself… It is fateful and ironic how the lie we need in order to live dooms us to a life that is never really ours" (p. 56). Humans intrinsically realize that there is no immunity from death. However, Jeff Greenberg, Sheldon Solomon, and Tom Pyszczynski found ways in which individuals strive to lessen the effects of their fear of death. This became the foundation of their terror management theory in 1986. According to the terror management theory, people use self-esteem elevating behaviors and their cultural worldviews as anxiety buffers against the thoughts of death that have the potential of terrorizing each individual.
According to their research, Solomon et al. concluded that social worldviews help to alleviate death anxiety. Those with different beliefs than one’s own threatens one’s constructs of reality. This results in the lessening of the anxiety buffering effects of worldviews and the lowering of one's self-esteem. The general reaction is for the in-group to respond negatively and sometimes violently toward the threatening out-group.

_Terror Management Theory's Concept of Cultural Worldviews._ Cultural worldviews are "a set of beliefs about the nature of reality shared by groups of individuals that provides meaning, order, permanence, stability, and the promise of literal and/or symbolic immortality to those who live up to the standards of value set by the worldviews" (Harmon-Jones, Simon, Greenberg, Pyszczynski, Solomon, & McGregor, 1997, Introduction, para. 2). Many cultural worldviews originate from spiritual teachings and myths. The adherence to these help promote self-esteem.

_Terror Management Theory's Concept of Self-Esteem._ Harmon-Jones et al. defined self-esteem as "one's belief regarding how well one is living up to the standards of value prescribed by the worldview" (1997, Introduction, para. 2). Self-esteem “varies in response to success, failure, changes in fortune, social interactions, and other life experiences” (p. 68, Brehm et al.). One perception is that "a valuable member of a meaningful universe constitutes self-esteem; and self-esteem is the primary psychological mechanism by which culture serves its death-defying function" (Solomon, Greenberg, & Pyszczynski, 1998, p. 13, para. 2). Greenberg, Pyszczynski, and Solomon (1986) found that when the individual's worldviews are threatened certain reactions occur. These reactions include a lowered level of self-esteem, an elevation of death anxiety, and an attempt to reinstate personal worldviews, publicly and privately (p. 195), in order to restore a sense of normalcy to life.
It did not go unnoticed that there was the link between self-esteem, cultural worldviews, and death anxiety. Solomon, Greenberg, and Pyszczynski wanted to establish if "reminding people of their own mortality would be expected to activate the need for validation of their sense of self-worth and their faith in the cultural worldview" (1998, p. 20). Research studies that followed (e.g., Harmon-Jones et al., 1997; Greenberg, Pyszczynski, & Solomon, 1992; Dechesne, et al., 2003) supported the connection and contended that "the unique awareness of death and tragedy renders human beings prone to debilitating terror, and that this terror is managed by a dual-component anxiety buffer consisting of a cultural worldview and self-esteem.

Greenberg, Pyszczynski, and Solomon (1998) found that psychological defenses are rendered useless if one realizes that one’s personal worldviews are in error and that the resulting existential anxiety has the ability to debilitate an individual (p. 39, Summary section). From his observations in concentration camps, Frankl (1967) witnessed this type of suffering when the prisoners lost faith in their cultural worldviews and religious beliefs. Frankl explained that those who lose all meaning in life will go into "a cultural hibernation for self-preservation" (p. 95) and the "existential loss of structure" will result in an individual's physical-psychic collapse (p. 97). When one's awareness of death is so profound and the individual is no longer able to use defense mechanisms, including anxiety buffers, in the face of death, the individual is apt to suffer an "existential frustration" and eventually an “existential breakdown,” as indicated by Frankl.

As indicated previously, cultural worldviews originate from spiritual teachings and myths. The adherence to these help promote self-esteem and provide essential meaning to life which consequently prevents existential frustration from occurring. Becker (1973) observed that humans are obsessed with those mythical or religious heroes who have defeated death. Becker averred "we celebrate heroes because they bravely face death and we are unsure that we could do
the same. Certain cult members and religious people celebrate those who have defeated death and who have raised from the dead or never tasted death as these are a way that we obtain immunity from "death and the dread of it" (p. 12). Humans endeavor to maintain balance with their culturally specific values and react negatively toward those without similar goals. In essence, cultural worldviews provide a means to assuage existential human concerns related to one’s identity, human origin, life direction, and life after death (Greenberg, Pyszczynski, & Solomon, 1986, p. 13, para. 1).

Maintaining Worldviews. Could humans deal with the true meaning of existence? Are humans able to face the true meaning of life and death? There are some that might and those that might not, so this is where cultural worldview myths come in to play. Weik defined "two major conceptualizations of myth: a collective phenomenon underlying culture" and "myth as a fraud or lie designed to legitimate wrong or selfserving [sic] purposes" (2001, Myth in Organization section, para. 1). Weik continued that myths can be positive, as in culturally shared values, or negative, as in the lies that are told to distort reality. Positive myths provide relief during stressful times, as individuals believe that if their heroes can withstand insurmountable odds, so too can they. Weik studied historical "transformation processes" and found that these processes did affect various levels of society and did result in a partial or complete breakdown of structures, frames of reference, and value systems" (Particularities section, para. 1). According to Weik, after taking myths as pure fantasies for a quite a long time, historians now identify important historical periods underlying these "stories" and have found them to have been developed during “times of grim upheaval” (para. 1). The myths that were created during these times were instrumental in helping people overcome the chaotic period.
Cultural myths sustain humans even when faced with cold, hard truths. Terror management theory (Greenberg, Solomon, & Pyszczynski, 1986) suggests that in-groups fight against those who threaten their cultural worldviews – those who seek to change their myths. Wars are fought not for freedom or material possessions, worldly objects, fame, or substance. Wars are declared as a means for protecting cultural worldviews. Wars are fought to keep myths and cultures alive.

Weik (2001) stated that myths are used to maintain moral order and a number of political institutions (Theories section, para 2). After the 2001 terrorist attacks, George W. Bush declared war on an abstract entity – terrorism. Weik might reason that this was a myth suggested by Bush in order to distort the reality of the true situation. After the September 11, 2001 terrorist attacks on United States soil, the country was in chaos. In order to regain control of the situation, Bush made the declaration of war which successfully worked to restore the citizens’ sense of security.

When Americans were able to envision an enemy, they responded by touting the cultural myths on which the nation was founded – liberty, freedom, and justice. American flags were bought in record numbers and hung from houses where there were none prior to the attack. People volunteered from all over the country to help in the recovery effort. Those who were unable to provide physical assistance sent money to organizations that aided the survivors of the attack and the family members of those who died in the attack. There was little progress in the war against terrorism, but the posed endeavor did succeed in lessening the anxiety of the people who lived in the United States. The cultural myth of liberty, freedom, and justice that was put forth as the backbone of the United States two hundred years prior to the attacks was able to sustain the citizens despite the chaos of the situation. "For most people it means a great deal to
assume that their lives will have an indefinite continuity beyond their present existence. They live more sensibly, feel better, and are more at peace” (Jung, 1961/1989, p. 301).

According to Weik, science encompasses the study of tangible, rational, and measurable data, but in times of chaos, there is no rationality and science cannot predict with certainty the circumstances of any event. Cultural myths sustained individuals after the 2001 terrorist attack. Cultural myths help restore meaning to the circumstances of life and death.

The example of the aftermath of the terrorism attack on United States soil demonstrates the need for cultural myths or worldviews (war on terrorism and life, liberty, and justice) and self-esteem enhancing actions and behaviors (buying flags and helping others) that serve to alleviate death anxiety. This is an example of an overt action to alleviate death anxiety.

Covertly, however, humans rely on psychological mechanisms to alleviate death anxiety. One of the covert mechanisms is avoiding those who choose to discuss death. Adult children avoid discussing funeral arrangements that their parents wish to discuss with them. Adults avoid discussing the death of a family member with children or will sugar coat the details.

Another covert mechanism is demonstrated when an individual avoids thoughts and discussions of death and assumes that others do not wish to discuss the delicate issue of death either. A patient may hint that he or she is having an issue with death, but is afraid to fully address the topic. A therapist who tends to avoid the subject of death will not pick up on the hint. When a patient is more open about death related topics, the therapist might unintentionally skirt the issue and switch to another topic. A therapist’s bias on the subject of death would affect the patient’s striving to process his or her issues of death.
Review of Related Studies

*Therapists’ Bias*

Research has supported that the attitudes of therapists directly affect the outcome of patient treatment. Various studies have been conducted on bias in psychology and have supported the idea that the views of the therapist do impact patient treatment (Gore-Felton et al., 2000; Murdock and Fremont, 1989; Roysircar, 2004). In reference to terror management theory, the bias that has been observed may be due to the therapist’s protection of his or her own worldviews or their need to retain a high level of self-esteem. Roysircar suggested that “therapists might discover that negative reactions have occurred because of [their] fears…. Guilt can arouse avoidance of or pity for clients’ concerns. Anger can arise when therapists feel that clients are using issues of race to gain power in the relationship” (2004, Therapist Examination section, para. 2).

Roysircar found, from reading the work of Gatz and Pearson (1988), that misguided beliefs of the therapist hinder the treatment that is provided to patients. One belief, by some therapists, is that depression is common in the elderly, so the therapist is apt to disregard the treatment of this presenting problem. Roysircar also discussed therapist bias regarding socioeconomic status and children of single mothers where therapists assume that these factors are indicative of an elevated “risk for psychopathology or low achievement” (2004, Therapist Bias section).

Murdock and Fremont (1989) identified four attributional dimensions that therapists use as a basis for clinical judgments: locus of cause, stability of the cause, globality, and controllability. These authors assumed that “attributional dimensions may also be linked to more commonly assessed dimensions of clinical judgment as when internal problems are perceived as
relatively severe or problems attributed to stable causes are judged to be uncontrollable” (para. 5). Murdock and Fremont indicated that labels given to patients from other sources (e.g., intake specialists) will often result in the therapist designing a treatment plan base on the label and searching for confirmation of the label instead of treating the patient as an individual with unique presenting problems.

Label bias is not the only concern, as the therapist’s beliefs are also a factor in the treatment that he or she prescribes for patients. Gore-Felton, Koopman, Thoresen, Arnow, Bridges, and Spiegel (2000) conducted a study on the beliefs of psychologists who treated patients for a history of past childhood sexual abuse. These authors found that the judgments that therapists made were influenced by their own personal beliefs. If therapists believed that memories of childhood abuse were possible, then they assumed the stance that the patients were abused and then treated the patients for the abuse. If therapists did not believe that memories of childhood abuse were possible, then they did not treat for the alleged abuse. Gore-Felton, et al. suggested that “in processing large quantities of patient information, therapists tend to use judgmental heuristics, or cognitive simplification strategies, that deviate from normative principles of statistics and probability” (para. 7) and also suggested that “therapists’ assessment of the credibility of sexual abuse memories may profoundly affect the course of treatment” (para. 6). In essence, a therapist’s treatment plan for the patient is often based on the therapist’s belief of the patient’s suggestion of the presenting problem and the strategies by which the therapist makes the determination for the treatment. In other words, the therapist’s own beliefs biased the treatment.

The treatment provided to patients also depends upon the therapist’s own mental health. The personal distress of the therapist affects the therapist’s attitude toward the patient’s
presenting problem and treatment thereof. Guy, Poelstra, and Stark (1989) conducted a study on the effects of a therapist’s personal distress on the treatment that is provided to patients. The study supported their claim that a therapist’s personal distress does affect the quality of treatment that the therapist provides. Guy et al. found that “more than one third of [749] respondents reported that their personal problems decrease the quality of the care that they provided to their patients” (Discussion section, para. 2).

Attitudes of the therapist have been discussed as having an impact on the treatment that therapists provide their patients. There are other aspects of the therapist that may impact the therapist’s personal death anxiety. These are discussed in the following section.

*The Impact of Age, Gender, and Experience*

Norcross (2005) noted that the empirical advances have impacted mental health treatment, but not necessarily in the best way. Norcross wrote

The pursuit of technical competency has much to recommend it, but it may inadvertently subordinate the value of the personal formation and maturation of the psychologist. The ongoing march toward [empirically supported treatments] and [evidence-based practices] tends to neglect the human dimension of the psychologist and the psychotherapy (p. 840, para. 2).

Norcross supported the claim that canned therapies are not the best way to treat patients. The practices take away the human element of treatment. Patients come to therapists for help with their issues and some therapists will ignore the issues and treat the patient’s label instead.

Norcross felt that the human element enables the therapist to understand the problems that the patient presents with. The arguable factor is that these same elements can make a significant negative impact on treatment, as well, and that is why the empirical based treatments
were developed. Empirical based treatments were developed to guide therapists away from their bias in order for the therapist to tend to the patients need. While the human element is necessary for empathetic treatment, the affects of age, gender, and experience have the ability to hinder treatment, especially when it comes to the treatment of patients for their anxiety toward death.

Age Affects. Cicirelli (1998) found that individuals differ in their response to thoughts about death and dying depending upon their age and gender. Cicirelli found that young adults demonstrated higher levels of death anxiety, whereas older adults tend to view death differently, depending upon their transition stage. Even at that, the individual’s meaning of death was a huge element in the age factor that produced the most significant difference.

Cicirelli wrote “in the same way that death meanings are expected to change over the life span with changes in life’s experiences, death fears are also expected to change” (p. 717, para. 4). Cicirelli found that as people age, the dynamics of their thoughts about death change, as does the fear that is produced from thoughts about death. What was also found was that death defined as extinction produced significant effects for individuals on the intrapersonal, interpersonal, and transpersonal levels. Cicirelli defined intrapersonal meanings of death as the “annihilation of the body and fear of not fulfilling one’s goals.” The interpersonal aspect was defined as “the loss of social identity and the fear for the welfare of others.” Finally, Cicirelli defined the transpersonal aspect as “the fear of the unknown nature of death and fear of punishment in the afterlife.” Cicirelli found that death defined as extinction was more prevalent for younger adults than those adults who were older.

Cicirelli (2003) later found that older adults view death differently as their age progresses. Cicirelli wrote:
Those in their early seventies tend to be more concerned with living rather than death, those in their late seventies and early eighties are trying to cope and come to terms with their approaching death, and those in their nineties have accepted death and are concerned with just finishing their lives (p. 76, para. 4).

Although one would be hard pressed to find mental health practitioners in their nineties practicing psychology, the issue remains that death is viewed and feared differently depending on the individual’s age.

In reviewing literature on death anxiety studies, Neimeyer, Wittkowski, and Moser (2004) found research that supports the contention that “death anxiety decreases from mid-life to old age” (p. 314, para. 1). Even though the level of death anxiety decreases in older adults, it was found that older adults who suffered health problems, psychological distress, weak religious beliefs, and low life satisfaction suffered higher levels of death anxiety for this age group.

Keller, Sherry, and Piotrowski (1984) found that death for young adults represented interference in their life. Young adults are just starting families and careers and may feel that death, at this age, would interfere in their dreams for the future. Middle-aged people, according to Keller et al., may use sublimating factors to “deny the threat of death” as they are “too busy with developing careers and achievements to be concerned about the threat of death” (p. 140, para. 4).

The debate on age effects on death anxiety is apparent in the research to date. Most agree that death anxiety cannot specifically be defined in such a way that would present a definitive answer. There are many variances as to how death is defined, presented, experienced, and assimilated. More research is needed in this area; however, most agree that general anxiety
toward death lessens as individuals grow older and that the concern for death transitions with age.

*Gender Affects.* Cicirelli (1998) found that women demonstrated higher levels of death anxiety and that “women were more likely to see death as a form of continued existence” (p. 730). DePaola, Griffin, Young, and Neimeyer (2003) reported that females, without regard for race, demonstrate higher levels of death anxiety and that “women tend to view death in more emotional terms, whereas men tend to perceive death in more cognitive terms” (p. 338, para. 1). Keller et al. questioned whether the findings of gender effects were valid as men were “more reluctant to admit vulnerability to death” and if “women [were] more insecure in controlling their destiny” (p. 141, para. 1).

*Experience Affects.* “Psychologists lag behind medicine and nursing in establishing relevant education curricula and clinical competencies,” according to Haley, Larson, Kasl-Godley, Neimeyer, and Kwilosz (2003). As it stands now, inadequately trained psychologists draw from the knowledge that they receive to treat issues of death and dying with techniques suitable for depression and anxiety symptoms. While these aid patients with those symptoms, the full prism of problems that patients experience due to death and dying are not comprehensive in nature.

Specialized training would enable therapists to fully treat patients with issues related to death and dying and also help therapists understand and deal with their own issues of the same nature. Kirchberg and Neimeyer (1991) found that issues related to patient death and loss intensifies the distress that is experienced by beginning counselors. Kirchberg, Neimeyer, and James demonstrated that a lack of professional experience “presents unique challenges to
beginning mental health providers, especially for those whose personal death anxieties leave them vulnerable to such work” (1998, abstract).

As discussed, various factors have been indicated as having an impact on death anxiety. Therapists’ personal thoughts and behaviors, along with their age, gender, and years of experience have the potential for influencing their professional reaction to patients death related issues. The purpose of this study was to determine if a therapist’s personal death anxiety affects the level of anxiety that is generated during the treatment of patients as it relates to issues of death. Is there a significant relationship between a therapist’s own level of anxiety about death and his or her level of anxiety generated as a result of working with patients who present with symptoms of anxiety? Do therapists’ age, years of professional experience, or gender significantly affect personal and professional anxiety toward death? These are questions that have been addressed in this current research.
CHAPTER 3. METHODOLOGY

Restatement of Purpose

There is little research on how therapists’ own reaction to personal existential anxiety affects the treatment outcome of their patients. As such, the basic purpose of this study was to determine if a therapist’s personal death anxiety affects the level of anxiety that is generated during the treatment of patients as it relates to issues of death. This is not the first study to imply that bias impacts the work of mental health professionals. Various studies (e.g., Gore-Felton et al., 2000; Murdock & Fremont, 1989; Roysircar, 2004) on bias in psychology suggest that a therapist’s personal views, feelings, and beliefs have an impact on the outcome of psychotherapy.

Secondary to that, this study examined the effects of age, gender, and years of experience on death anxiety levels of therapists, both personally and professionally. The effects of age, gender, and years of experience of the therapist have been researched for their impact on death anxiety. Previous research demonstrated a variance of effects; however, as issues related to death are multi-faceted, this current research examines the effects of personal death anxiety on therapists’ professional level of anxiety.

As indicated previously, “professional psychologists are increasingly likely to encounter opportunities to work with patients and families facing end-of-life issues” (Haley, Larson, Kasl-Godley, Neimeyer, & Kwilosz, 2003, abstract section). Future research will help determine the best practices that will provide successful treatment for patients with issues related to death.
Also, subsequent research may determine that more courses on death and grief should be made mandatory in graduate studies in psychology.

This current study is a first step action toward that goal. As previously suggested, the purpose of this study is to determine if a therapist’s personal death anxiety affects the level of anxiety that is generated during the treatment of patients as it relates to issues of death. Although this is a small step in the research necessary to determine the best practices for death anxiety treatments and treatments for death related issues, it is a step in the right direction.

In order to properly examine whether a therapist’s own death anxiety affects the level of anxiety experienced by the therapist during the treatment of patients with death related issues, a scale had to be developed to measure the level of professional death anxiety. The Professional Death Anxiety Scale was developed during this process for that reason. The Professional Death Anxiety Scale (PDAS) was examined for reliability to ensure a valid result for the original dissertation topic. As such, the remainder of this report will discuss two studies. The first study, Study 1, will detail the information regarding the field test that was performed to validate the PDAS. Study 2 will detail the information regarding the information regarding the actual topic of this dissertation.

Study 1

The Professional Death Anxiety Scale (PDAS) was developed to assess the level of death anxiety of professional therapists. The PDAS was designed using Templer’s Death Anxiety Scale (DAS) as a template. The DAS (Templer, 1970) is a validated instrument that is used to measure the therapist’s personal level of death anxiety. The scale is a 15 item, true or false self-
report questionnaire. Test-retest reliability was found to be .83, with an internal consistency of .76, according to Braunstein (n.d., Death Anxiety Scale section).

The PDAS uses the same 15-item, true/false self-report questionnaire design as the DAS. Items in the PDAS were patterned after the DAS in order to closely resemble the same concepts measured by the DAS. The first study in this series was conducted to determine the validity of the PDAS.

Research Design

A quantitative survey was used for this current study to obtain pertinent data for correlational analysis using nonprobability convenience sampling. The surveys, along with the participant’s demographic information, were used to examine the validity of the PDAS by taking measures similar to the DAS and making a comparison of the results.

Study 1 participants were given questionnaires to measure their personal level of death anxiety and their professional level of death anxiety. Demographic information was also solicited to further validate the PDAS.

Target Population

The target population consisted of graduate and undergraduate students, professional counselors, and student professionals.

Selection of Participants

Participants consisted of graduate students and graduate students who also were professionals in the mental health field (student professionals). Participants also included undergraduate students enrolled in an introductory psychology. Finally, mental health professionals who did not meet the criteria for the second study were invited to participate.
A list was generated from the doctoral psychology students enrolled at a major online university. Educational and Industrial/Organizational students were excluded from the proposed participant list as their chosen field would not involve treating individuals for anxiety issues. The remaining names on the list comprised of the pool of potential participants. These names were alphabetized and every fifth student was placed in a pool of potential participants. Until the list was pared down to 200 potential participants, the same selection cycle was continued. These 200 students were sent an e-mail of invitation to participate in the study.

Participants also consisted of students of one introductory psychology course. The researcher presented in front of the undergraduate students and solicited participation in the study. Those that wished to participate were included in the study.

Finally, 15 mental health professionals who were ineligible to participate in the second study were asked to participate in the first study. The individuals that agreed to participate were included in the study. These professionals included counselors, former psychologists, and nurses.

Variables

Independent Variables. The independent variables for Study 1 include the scores from the DAS and the PDAS. The age and gender of the therapist and the years of experience that the therapist has had in the psychological profession are also used as independent variables to determine the validity of the PDAS.

Dependent Variables. The dependent variable for this study is the coefficients of reliability for the two scales (PDAS and DAS).
**Measures**

*Demographic Questionnaire.* All participants completed a demographic section of the survey. Specific to this study, the participant’s age, years of experience, and gender were also requested.

*Templer Death Anxiety Scale (DAS).* The Templer Death Anxiety Scale or DAS (Templer, 1970) is a validated instrument that will be utilized to measure the therapist’s personal level of death anxiety. The DAS is a 15 item, true or false self-report questionnaire. Test-retest reliability was found to be .83, with an internal consistency of .76, according to Braunstein (n.d., Death Anxiety Scale section). Braunstein continued “psychiatric patients who spontaneously verbalize death anxiety had higher DAS scores than other psychiatric patients.” Validity of the DAS was also shown to have a high correlation (.74) to the Boyar’s Fear of Death Scale (FODS).

*Professional Death Anxiety Scale (PDAS).* The DAS was used as a template to create the Professional Death Anxiety Scale (PDAS). The PDAS is a newly constructed instrument that was used to measure the therapist’s level of anxiety that surfaces as a result of providing therapy to patients who have issues with death. The PDAS is a 15 item, true or false self-report questionnaire.

**Procedures**

Fifteen mental health professionals and 200 students (graduate student professionals and graduate students) were sent an e-mail invitation to participate in the study. Participants were asked to send a return e-mail indicating their consent to participate in the field test (Study 1). Of these, 67 students (17 males, 40 females) consented to participate. Forty-two of the 67 students worked in a mental health field and were designated as student professionals for the purpose of
this study. The remaining 15 participants were not employed in the mental health field and were labeled graduate students. 6 professionals (2 males, 4 females) also agreed to participate.

The professionals, student professionals, and graduate students who consented to participate in the study were sent an e-mail with the survey attached. The survey consisted of a demographic information page, the DAS, a page with four short scenarios, and the PDAS, respectively. The participants were asked to fill out the demographic information and also the survey by highlighting true or false answers. After the survey was complete they were asked to return the completed survey via e-mail attachment.

Undergraduate students enrolled in an introductory psychology course were also asked to consent to participate in the study. Thirty-eight students (13 males, 25 females) agreed to participate. The students were hand delivered the consent forms and survey. The students were told that their participation was not mandatory, nor did their decision to participate or not participate effect their grade in the course. They were instructed to read and follow the directions on the survey. Minimal conversation took place. After completion, the students brought the surveys and consent forms to the researcher. Those who did not wish to participate turned in their surveys and consent forms without completing them.

The researcher’s role was to produce questionnaires, test the new questionnaire for validity and reliability, revise the questionnaires as needed, present or e-mail the invitations and survey to the participants, collect and score the completed questionnaires, analyze data, and report the findings. Returned survey questionnaires were used for analysis. The returned questionnaires were individually scored, and these scores were entered into the SPSS 12.0 software program for analysis (SPSS, 2003). Each participant was assigned a number. Gender was coded (1 = male, 2 = female; 1 = true, 2 = false). Each score for each questionnaire was
entered into the program, as well as the participant’s age and years of experience as a psychologist. Data analyses were performed with the results posted later in this dissertation.

**Null Hypotheses**

The null hypothesis was that there would be no consistency between the scores of the DAS and the PDAS, regardless of age, gender, and years of experience. The PDAS would be shown to be an invalid and unreliable scale.

**Expected Findings**

It was expected that the PDAS would be deemed a good instrument to measure professional death anxiety and the results of the reliability and validity analyses would demonstrate that the PDAS was comparable at the professional level as DAS is on the personal level.

**Study 2**

**Research Design**

A quantitative survey was used for this current study to obtain pertinent data for correlational analysis using nonprobability convenience sampling. The surveys, along with the participant’s demographic information, were used to examine the relationship between a therapist’s own concern about mortality and his or her professional level of death anxiety. The raw data was also utilized to examine the relationship between therapists’ age, experience, and gender versus therapists’ personal and professional anxiety toward death.

The participants, psychologists who provide therapy to patients who present with anxiety disorders, were given questionnaires to determine their personal level of death anxiety and their
professional level of death anxiety. Demographic information – age, years of experience, and gender – was used to determine if these impact therapists’ death anxiety.

**Target Population**

The target population consisted of male and female psychologists who treat patients for anxiety related disorders.

**Selection of Participants**

A list was procured from one state Board of Examiners of Psychologists for active and non-active psychologists. The participants used in this study consisted of psychologists from the board’s list. Invitations to participate in the study were mailed to each psychologist on the list. Psychologists were asked to check a box declaring their willingness to participate. There was an area on the card for the psychologist to disclose the type of disorders that he or she treats. Those who replied and qualified, specifically those who treat patients with anxiety disorders, were sent a packet containing the questionnaires and consent form, along with a stamped and addressed envelope in which they could return the completed surveys. The population of licensed or licensed eligible psychologists in the specifically chosen state is 588; therefore, a sample size of 221 participants was required for a study with a 95% confidence level and a margin error of ± 5, according to Lenth (2005) and Raosoft (2004).

There are a total of 588 psychologists in the chosen state from which the participants were chosen. As there are a limited number of psychologists from the state whose practice involves the treatment of anxiety disorders and the expected return rate on mailed surveys was low, the participants were chosen in the order in which the surveys were returned (convenience sampling).
Variables

Independent Variables. The independent variables for this study include the therapist’s level of death anxiety, as measured by the Templer Death Anxiety Scale (1970); the age and gender of the therapist; and the years of experience that the therapist has had in the psychological profession.

Dependent Variables. Dependent variables for this study include the level of professional death anxiety, as indicated on the professional death anxiety scale and the personal level of death anxiety, as measured by the Templer Death Anxiety Scale (1970).

Measures

Demographic Questionnaire. All participants completed a demographic section of the survey. Specific to this study, the participant’s age, years of experience, and gender were also requested.

Templer Death Anxiety Scale (DAS). The Templer Death Anxiety Scale or DAS (Templer, 1970) is a validated instrument that will be utilized to measure the therapist’s personal level of death anxiety. The DAS is a 15 item, true or false self-report questionnaire. The level of personal death anxiety is directly related to the scores. A score of zero is indicative of no personal death anxiety, while a score of 15 would indicate severe personal death anxiety. Test-retest reliability was found to be .83, with an internal consistency of .76, according to Braunstein (n.d., Death Anxiety Scale section). Braunstein continued “psychiatric patients who spontaneously verbalize death anxiety had higher DAS scores than other psychiatric patients.” Validity of the DAS was also shown to have a high correlation (.74) to the Boyar’s Fear of Death Scale (FODS).
Professional Death Anxiety Scale (PDAS). The DAS was used as a template to create the Professional Death Anxiety Scale (PDAS). The PDAS is a newly constructed instrument that will be used to measure the therapist’s level of anxiety that surfaces as a result of providing therapy to patients who have issues with death. The PDAS is a 15 item, true or false self-report questionnaire. Internal consistency for the PDAS was 0.76. Similar to the DAS, the level of professional death anxiety is directly related to the scores. A score of zero is indicative of no professional death anxiety, while a score of 15 would indicate severe professional death anxiety.

Procedures

Data was collected via mail survey questionnaires. This researcher’s role was to produce questionnaires, test the questionnaires for validity and reliability, revise the questionnaires as needed, mail the invitations and survey to the participants, collect and score the completed questionnaires, analyze data, and report the findings. Returned survey questionnaires were used for analysis. The returned questionnaires were individually scored, and these scores were entered into the SPSS 12.0 software program for analysis (SPSS, 2003). Each participant was assigned a number and each participant’s data will be entered. Gender was coded (1 = male, 2 = female). Each coded score (1 = true, 2 = false) for each questionnaire was entered into the program, as well as the participant’s age and years of experience as a psychologist. Results were then analyzed and reported later in this report.

Null Hypotheses

1. There is no correlation between the therapist’s personal level of death anxiety and his or her level of anxiety generated as a result of working with patients who present with symptoms of death anxiety.
2. A therapist’s age, gender, and years of experience do not significantly affect the therapist’s personal or professional death anxiety.

*Expected Findings*

It was expected that therapists who demonstrate elevated levels of personal death anxiety on DAS scores would also have elevated levels of professional death anxiety, as indicated on PDAS scores. A positive correlation would be witnessed.

It was expected that age would affect therapists’ level of personal and professional death anxiety. There would be significantly higher mean scores on the DAS and PDAS of older therapists’ compared to younger therapists.

It was expected that gender would affect therapists’ level of personal and professional death anxiety. There would be significantly higher mean scores on the DAS and PDAS of female therapists compared to male therapists.

The results of this study have the potential of providing empirical support for the establishment of existential anxiety as being an important factor in the treatment of anxiety disorders, specifically those patients who exhibit anxiety related to death issues. Future insight will support the premise that existential anxiety is an important issue to address during therapy.

Most importantly, existential anxiety would gain more respect as a factor in mental health disorders and the treatment of these disorders. As such, professionals would be more adequately trained in addressing personal existential concerns, as well as the existential concerns of their patients. If existential factors were given more attention and acknowledged for their role in most anxiety disorders, then the cost for psychological therapeutic treatment could be reduced significantly.
CHAPTER 4. DATA COLLECTION AND ANALYSIS

As previously discussed, the basic purpose of this study was to determine if a therapist’s personal death anxiety affects the level of anxiety that is generated during the treatment of patients as it relates to issues of death. This study also examined the effects of age, gender, and years of experience on death anxiety levels of therapists, both personally and professionally. In order to examine these concepts, data had to be collected and analyzed.

There were two studies conducted to fulfill the requirements of this submission. The first study was a field test conducted to assess the reliability of the newly constructed Professional Death Anxiety Scale (PDAS). A second study was conducted to examine whether a therapist’s personal death anxiety affects the level of anxiety that is generated during the treatment of patients as it relates to issues of death. Psychologists’ age, years of experience as a psychologist, and gender were taken into consideration.

This chapter will discuss the data collection and analyses of the Study 1 and Study 2. There are two general sections of this chapter. The first section presents the data collection procedures for both studies. The second section provides the analyses and results of both studies.

Data Collection

Study 1

A total of 101 (32 males, 69 females) individuals consented to participate in this study. Fifty-seven doctoral level psychology students (17 males, 40 females) consented to participate.
Forty-two of the fifty-seven doctoral students worked in a mental health field and were designated as student professionals for the purpose of this study. The remaining fifteen graduate level participants were not employed in the mental health field and were labeled graduate students. Six mental health professionals (2 males, 4 females) also agreed to participate and were designated as professionals for the study. Also participating in Study 1 were thirty-eight (13 males, 25 females) undergraduate students enrolled in an introductory psychology.

The professionals, student professionals, and graduate students who consented to participate in the study were sent the survey via e-mail attachment. The survey consisted of a demographic information page, the Death Anxiety Scale (DAS), a page with four short scenarios (see Appendix B), and the Professional Death Anxiety Scale (PDAS), respectively. Appendix C provides the actual instrument. The participants were asked to fill out the demographic information and also the survey by highlighting true or false answers using a word processing program. The participants returned the completed survey via e-mail attachment, as directed.

Undergraduate students were given the survey as a group with the researcher present. Undergraduate students were instructed to read and follow the directions on the survey. After completion, the students brought the surveys and consent forms to the researcher. Those who did not wish to participate turned in their surveys and consent forms without completing them.

Following the example of Templer’s Death Anxiety Scale (1970), the directions for completing the Professional Death Anxiety Scale were as follows:

**DIRECTIONS:** Please answer the following 15 questions.
If a statement is true or mostly true as applied to you, circle “T.”
If a statement is false or mostly false as applied to you, circle “F.”

Each participant’s survey was individually scored using a key developed to measure the participant’s level of death anxiety. Templer (1970) developed his scale with 6 items keyed false
and 9 items keyed true. The same was done with the Professional Death Anxiety Scale. Items 2, 3, 5, 6, 7, and 15 were keyed as false and the remaining items were keyed true on both scales. Appendix D provides the key to the Professional Death Anxiety Scale developed for this study.

The demographic information of each participant was entered into the SPSS 12.0 (2003) program. Age and years of professional experience, as provided by the participants, were coded and entered into the program. The professional or academic status of the participant was also coded: 1 for graduate students; 2 for professionals (non-students); 3 for student professionals (those who are students and have a job in the mental health field); and 4 for undergraduate students. Finally, the raw individual item score and total score of each participant’s DAS and PDAS were entered into the program.

\textit{Study 2}

A list of 590 potential participants was provided by a state office of a Board of Examiners of Psychologists. This list was provided with a warning that it was overdue to be updated and that it was the only list available at the time. During the process of inviting psychologists to participate, it was found that four of the listed psychologists were deceased, eight had retired, fifty psychologists indicated that they did not treat anxiety disorders, sixty-five psychologists had moved out of state, 154 psychologists refused the invitation, 201 psychologists consented to be participants, and the remaining psychologists did not respond to the invitations.

There were two requirements for the study. The participants were deemed eligible if they were licensed or license-eligible in the chosen state and if they treated anxiety disorders. The original plan had been for 604 potential participants which meant that 235 were necessary for a valid study.
Due to the outdated list and the psychologists who were deemed ineligible, the numbers changed accordingly. Of the 590 psychologists, only 463 were eligible, given that those who did not respond to the invitations all provided treatment for patients with anxiety disorders and were still licensed in the chosen state. As a direct result of this, the number of participants needed to validate this study was determined to be 210. Of the 200 psychologists who consented to participate, only 178 individuals who met the requirements returned their completed surveys. It is unknown how many of the psychologists who did not respond to the invitation could have met the requirements.

As with the first study, the demographic information was entered into the statistical analyses program as given, specifically age, years of experience, and the average number of patients per week. The participants’ gender was coded (1 for males, 2 for females). The participants were then broken into smaller groups to examine whether particular age groups would display significant results as reported by Cicirelli (1998), Keller et al. (1984), and Neimeyer et al. (2004) as discussed in the literature review section of this report. The age groups were broken down in the following manner: 20 – 29, 30 – 39, 40 – 49, 50 – 59, 60 – 69, and 70 and over years of age.

Participants’ years of experience were broken into smaller groups to examine whether professional experience would make a difference in scores, as indicated by Kirchberg and Neimeyer (1991) and discussed in the literature review section. The groups were assembled with participants who had worked in the mental health field for one to five years, six to ten years, eleven to twenty years, twenty- one to thirty years, thirty-one to forty years, and forty-one to fifty years.
As with the first study, each participant’s survey was individually scored using the same key template as the one used for the first study. The raw individual item score and total score of each participant’s DAS and PDAS were entered into the statistical program for analyses. Overall scores were obtained by adding all answers to questions that were keyed as being related to death anxiety.

Analyses

Study 1

In order to examine the psychometric properties of the newly developed PDAS scale, the fifteen items were first subjected to a principal components analysis. The KMO test, used to determine whether this was a dataset appropriate for factor/principal components analysis, suggested that factor analysis was not ideal, KMO = .674. While principle components analysis is still possible, this original measure on which the PDAS was modeled, the DAS, is designed to be a single measure. In the one component solution, 24.5% of the variance was accounted for in the set of items. The 15 items of the DAS were subjected to a principal components analysis as well to compare the results to the PDAS. The results were highly similar. A KMO value greater than .80 would necessitate factoring the scale. This was not the case. The KMO = .673, and the amount of variance accounted for by the one component solution was equal to 23.5%.

In order to examine coefficient of reliability (Cronbach’s alpha) for both the 15 item PDAS and DAS scales, six items were reverse scored 2, 3, 5, 6, 7, and 15 on both measures. These six items were reverse scored (false answers on these items were recoded to true) so when the scores are added, a higher score would indicate higher levels of anxiety. Cronbach’s alpha measures unidimensional latent construct of a psychometric instrument and is a measure of
reliability of the instrument. Cronbach’s alpha for both measures was good; for the DAS, Cronbach’s $\alpha = .75$ and for the PDAS, Cronbach’s $\alpha = .76$.

An analysis of variance (ANOVA) is a technique to measure the differences of group means. An ANOVA was performed on the PDAS to examine if there was a difference by gender. First, Levene’s test of equality of error variances was performed to test for the assumption of homogeneity variances across groups. This test was not significant, $F(1, 99) = 0.14$, therefore the assumption was met and the variances are equivalent. The test for gender effects generated no significant difference on the PDAS, $(F(1,99) = 1.415, p > .05)$. For the DAS, the assumption of homogeneity was also met, $F (1, 99) = 0.03$. There was a significant difference by gender for the ANOVA $(F(1,99) = 8.60, p < .01)$, such that females reported higher DAS scores ($M = 6.10$, $SD = 2.90$) than males ($M = 4.34$, $SD = 2.57$).

An ANOVA was also performed on the PDAS to examine if there were group differences. The groups included students (graduate and undergraduate), student professionals, and professionals. The test for the assumption of homogeneity variances across groups was not significant, $F (3, 97) = 2.01, p > .05$, therefore the assumption was met and the variances are equivalent across the four groups. There was a significant difference by group for the PDAS, $(F(3,97) = 5.85, p < .05)$. The Bonferroni post hoc analyses demonstrated that undergraduates ($M = 5.66$, $SD = 3.03$) have higher scores than graduate students ($M = 3.00$, $SD = 1.77$) and student professionals ($M = 3.60$, $SD = 2.73$).
Table 1  
**PDAS Mean Scores per Group**

<table>
<thead>
<tr>
<th>Group</th>
<th>M</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduate Student</td>
<td>3.00</td>
<td>1.773</td>
<td>15</td>
</tr>
<tr>
<td>Professional</td>
<td>3.00</td>
<td>1.265</td>
<td>6</td>
</tr>
<tr>
<td>Student Professional</td>
<td>3.60</td>
<td>2.732</td>
<td>42</td>
</tr>
<tr>
<td>Undergraduate Student</td>
<td>5.66</td>
<td>3.025</td>
<td>38</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4.25</td>
<td>2.868</td>
<td>101</td>
</tr>
</tbody>
</table>

For the DAS, the assumption of homogeneity was also met, $F(3, 97) = 0.86, p > .05$.

There was also a significant difference for group, $F(3, 97) = 3.89, p < .05$. The Bonferroni post hoc analyses demonstrated that undergraduates ($M = 6.76, SD = 2.89$) have higher scores than student professionals ($M = 4.76, SD = 2.98$).

Table 2  
**DAS Mean Scores per Group**

<table>
<thead>
<tr>
<th>Group</th>
<th>M</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduate Student</td>
<td>4.93</td>
<td>1.981</td>
<td>15</td>
</tr>
<tr>
<td>Professional</td>
<td>4.83</td>
<td>2.317</td>
<td>6</td>
</tr>
<tr>
<td>Student Professional</td>
<td>4.76</td>
<td>2.978</td>
<td>42</td>
</tr>
<tr>
<td>Undergraduate Student</td>
<td>6.76</td>
<td>2.889</td>
<td>38</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5.54</td>
<td>2.907</td>
<td>101</td>
</tr>
</tbody>
</table>

The Pearson product-moment correlation coefficient measures the strength or weakness of a relationship between variables. The correlations between the PDAS, DAS, age, and years of
experience were examined using Pearson’s Product Moment Correlation. PDAS and DAS were positively correlated with each other $r = .670$ at the 0.05 level (2-tailed). The PDAS was negatively correlated with age, $r = -.346$ and years of experience, $r = -.229$ and these were significant at the 0.01 level (2-tailed).

The distribution of PDAS scores was positively skewed, $\lambda_1 = 1.23$, $SE = .34$. The gender differences and group differences, as well as the associations between PDAS, DAS, age and years of experience were examine using non-parametric analyses to confirm the results of the previous analyses. The DAS was normally distributed so non-parametric analyses were not necessary.

The Mann-Whitney test is a non-parametric test for two independent samples that is used to compare central tendency and can be used when the distribution of the data is skewed, as was the case here. Two Mann-Whitney tests were examined to determine if there were significant differences by gender or by group. These tests replicated the original parametric tests. The test for gender was not significant, Mann-Whitney $U = 184.50$. The Mann-Whitney test for group was also not significant, Mann-Whitney $U = 125.5$. Spearman’s rho was examined to test the associations for the PDAS with DAS, age and years of experience. These tests also replicated the original correlations. Spearman’s rho was positive and significant for the relation between PDAS and DAS, $r_s = .46$, $p < .001$, while the associations with age and years of experience were not significant ($r_s = -.18$ and $r_s = -.08$, respectively).

A tetrachoric correlation analysis was considered for the validation of the PDAS. The analysis was intentionally bypassed for this study. The reason for this is that a tetrachoric correlation analysis artificially raises the reliability of the data. StatSoft, Inc. posited that “the tetrachoric correlation coefficient is larger than the standard correlation coefficient” and
discouraged its use (2006, Reliability and Item Analysis, last paragraph). Also, Gorsuch wrote that the results of a tetrachoric correlation provides only “estimates of Pearson product-moment coefficients” (1983, p. 296).

**Study 2**

In order to examine the coefficient of reliability (Cronbach’s alpha) for both the 15 item PDAS and DAS scales, six items were reverse scored 2, 3, 5, 6, 7, and 15 on both measures. Cronbach’s alpha for both measures was lower than acceptable; for the DAS, Cronbach’s $\alpha = .60$ and the PDAS Cronbach’s $\alpha = .55$. Both scales produced lower than acceptable coefficient of reliability. Regardless, the following discusses the results of the analyses.

Scale scores for the participants ($N = 178$) generated a mean of 5.35 ($SD = 2.46$) for the DAS and 2.81 ($SD = 1.87$) for the PDAS. Mean overall scale scores on the DAS for females ($N = 96$) was 5.59 with a standard deviation of 2.42, while males’ ($N=82$) mean overall score was 5.07 with a standard deviation of 2.48 on the DAS. PDAS overall scale scores were higher for females ($M=2.89$, $SD = 1.95$) than for males ($M = 2.73$, $SD = 1.79$). As displayed in Figure 1, the total overall results for the DAS generated a fairly normal distribution ($\lambda_1 = .291$, $SE = .182$), while the PDAS generated a positive skewness ($\lambda_1 = 1.207$, $SE = .182$).

![Figure 1. Overall results of the DAS and PDAS mean scores](attachment:image.png)
The mean overall scale scores on the DAS and the PDAS for each age group are represented in Table 3, while Table 5 displays the overall score results by group, given the group’s years of experience. The sixth experience group (41-50 years of professional experience) generated the highest mean score on the DAS, while the third group (11-20 years of professional experience) generated the highest mean score on the PDAS, as indicated in Table 4.

Table 3

*Overall Score Results by Age Group*

<table>
<thead>
<tr>
<th>DAS Score Overall</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1 (Age 20 – 29)</td>
<td>6</td>
<td>5.50</td>
<td>2.510</td>
</tr>
<tr>
<td>Group 2 (Age 30 – 39)</td>
<td>31</td>
<td>5.74</td>
<td>2.781</td>
</tr>
<tr>
<td>Group 3 (Age 40 – 49)</td>
<td>34</td>
<td>5.56</td>
<td>2.439</td>
</tr>
<tr>
<td>Group 4 (Age 50 – 59)</td>
<td>75</td>
<td>5.04</td>
<td>2.446</td>
</tr>
<tr>
<td>Group 5 (Age 60 – 69)</td>
<td>25</td>
<td>5.28</td>
<td>2.208</td>
</tr>
<tr>
<td>Group 6 (Age 70 +)</td>
<td>7</td>
<td>6.14</td>
<td>2.193</td>
</tr>
<tr>
<td>Total</td>
<td>178</td>
<td>5.35</td>
<td>2.455</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PDAS Score Overall</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1 (Age 20 – 29)</td>
<td>6</td>
<td>3.50</td>
<td>1.643</td>
</tr>
<tr>
<td>Group 2 (Age 30 – 39)</td>
<td>31</td>
<td>3.23</td>
<td>2.109</td>
</tr>
<tr>
<td>Group 3 (Age 40 – 49)</td>
<td>34</td>
<td>2.00</td>
<td>1.907</td>
</tr>
<tr>
<td>Group 4 (Age 50 – 59)</td>
<td>75</td>
<td>2.68</td>
<td>1.967</td>
</tr>
</tbody>
</table>

*(table continues)*
Table 3
(continued)

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 5 (Age 60 – 69)</td>
<td>25</td>
<td>2.40</td>
<td>1.291</td>
</tr>
<tr>
<td>Group 6 (Age 70 +)</td>
<td>7</td>
<td>2.43</td>
<td>1.397</td>
</tr>
<tr>
<td>Total</td>
<td>178</td>
<td>2.81</td>
<td>1.873</td>
</tr>
</tbody>
</table>

Table 4
Overall Score Results by Group - Years of Experience

<table>
<thead>
<tr>
<th>DAS Score Overall</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1 (1-5 yrs. exp.)</td>
<td>15</td>
<td>5.40</td>
<td>2.098</td>
</tr>
<tr>
<td>Group 2 (6-10 yrs. exp.)</td>
<td>33</td>
<td>5.42</td>
<td>2.550</td>
</tr>
<tr>
<td>Group 3 (11-20 yrs. exp.)</td>
<td>48</td>
<td>5.27</td>
<td>2.742</td>
</tr>
<tr>
<td>Group 4 (21-30 yrs. exp.)</td>
<td>57</td>
<td>5.12</td>
<td>2.323</td>
</tr>
<tr>
<td>Group 5 (31-40 yrs. exp.)</td>
<td>23</td>
<td>5.91</td>
<td>2.410</td>
</tr>
<tr>
<td>Group 6 (41-50 yrs. exp.)</td>
<td>2</td>
<td>6.00</td>
<td>2.414</td>
</tr>
<tr>
<td>Total</td>
<td>178</td>
<td>5.35</td>
<td>2.455</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PDAS Score Overall</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1 (1-5 yrs. exp.)</td>
<td>15</td>
<td>3.00</td>
<td>2.268</td>
</tr>
<tr>
<td>Group 2 (6-10 yrs. exp.)</td>
<td>33</td>
<td>3.09</td>
<td>2.283</td>
</tr>
<tr>
<td>Group 3 (11-20 yrs. exp.)</td>
<td>48</td>
<td>3.10</td>
<td>1.871</td>
</tr>
<tr>
<td>Group 4 (21-30 yrs. exp.)</td>
<td>57</td>
<td>2.44</td>
<td>1.452</td>
</tr>
<tr>
<td>Group 5 (31-40 yrs. exp.)</td>
<td>23</td>
<td>2.70</td>
<td>1.197</td>
</tr>
<tr>
<td>Group 6 (41-50 yrs. exp.)</td>
<td>2</td>
<td>2.00</td>
<td>1.414</td>
</tr>
<tr>
<td>Total</td>
<td>178</td>
<td>2.81</td>
<td>1.873</td>
</tr>
</tbody>
</table>
In order to examine the relationship between the DAS and the PDAS overall participant scores, a Pearson product-moment correlation was performed. The DAS and PDAS scores were positively correlated ($r = .422$) and significant at the 0.01 level.

In order to examine the relationship between the DAS, the PDAS, and gender, a Pearson product-moment correlation was performed. Again, apart from the previously mentioned relationship results between the DAS and PDAS, there was no significant relationship between the PDAS and gender, $r = .041$, or for the DAS and gender, $r = .106$, at the .05 level (2-tailed).

**Gender Affects**

There was no significant relationship between the PDAS scores and gender, but was there a significant difference due to gender effects? An analysis of variance (ANOVA) was performed on the PDAS to examine if there was a difference by gender. First, Levene’s test of equality of error variances was performed to test for the assumption of homogeneity variances across groups. This test was not significant, ($F (1, 176) = 0.263, p > .05$), therefore the assumption was met and the variances are equivalent. There was no significant difference by gender for the PDAS, $F(1,176) = 0.297$. For the DAS, the assumption of homogeneity was also met, ($F (1, 176) = 0.006, p > .05$). There was no significant difference by gender for the ANOVA ($F(1,176) = 2.00, p > .05$). This suggests that there were no significant difference of gender related to death anxiety, personal or professional.

**Age Differences**

An ANOVA was also performed to examine if there was an age group difference relative to death anxiety. The groups were broken down as follows: Group 1 = ages 20 – 29; Group 2 = ages 30 – 39; Group 3 = ages 40 – 49; Group 4 = ages 50 – 59; Group 5 = ages 60 - 69; and
Group 6 = age 70+. The test for the assumption of homogeneity variances across groups was not significant for the PDAS, \((F(5,172) = 1.119)\), therefore the assumption was met and the variances are equivalent across the groups. There was no significant difference by age group for the PDAS, \((F(5,172) = .906, p > .05)\). For the DAS, the assumption of homogeneity was also met, \((F(5,172) = .787)\). There was also no significant difference for age group on the DAS, \((F(5, 172) = .594, p > .05)\). This suggests that there were no significant age differences on death anxiety, personal or professional.

**Age and Years of Experience Relationship**

To examine the relationship between age (grouped and ungrouped) and years of experience (grouped and ungrouped) and the DAS and PDAS, a Pearson product-moment correlation was performed using the categorical (grouped) and continuous (ungrouped) data. There was a significant relationship shown for the PDAS and age, both grouped and ungrouped. Table 5 provides the results of this correlation.

<table>
<thead>
<tr>
<th>Age</th>
<th>Years of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grouped Ungrouped</td>
<td>Grouped Ungrouped</td>
</tr>
<tr>
<td>DAS - .049</td>
<td>-.066</td>
</tr>
<tr>
<td>PDAS -.157*</td>
<td>-.167*</td>
</tr>
</tbody>
</table>

*significant at the 0.05 level (2-tailed)

As indicated on the table above, there was a significant relationship between the PDAS and age, regardless of whether the participants were grouped by age or not. There were no relationships
between the PDAS and years of experience, grouped or not grouped; the DAS and age, grouped or not; or the DAS and years of experience, grouped or not.

**Years of Experience**

An ANOVA was also performed to examine if there was an experience group difference relative to death anxiety. The groups were broken down as follows: Group 1 = 1 – 5 years of experience; Group 2 = 6 – 10 years of experience; Group 3 = 11 – 20 years of experience; Group 4 = 21 – 30 years of experience; Group 5 = 31 – 40 years of experience; and Group 6 = 41 – 50 years of experience. The groups were selected according to previously mentioned research that indicated differences due to experience of mental health professionals. The test for the assumption of homogeneity variances across groups was not significant for the PDAS, \( F(5,172) = 1.378 \), therefore the assumption was met and the variances are equivalent across the four groups. There was no significant difference by experience group for the PDAS, \( F(5,172) = .995, p > .05 \). For the DAS, the assumption of homogeneity was also met, \( F(5,172) = .676 \). There was also no significant difference for experience group on the DAS, \( F(5, 172) = .378, p > .05 \). This suggests that there are no significant differences between death anxiety, personal or professional, and participant years of experience as a mental health professional.

**Interaction Affects**

In order to test interaction effects, a factorial analysis of variance was performed on the PDAS to examine if there was a difference due to age, gender, and years of experience. Age and years of experience were not grouped for the analysis. There was no significant difference due to age for the PDAS, \( F(5,172) = 1.017, p > .05 \), gender \( F(5,172) = .843, p > .05 \), or years of experience \( F(5,172) = 1.316, p > .05 \). There were no significant interaction effects witnessed. In order to test interaction effects, a factorial analysis of variance was performed on the DAS to
examine if there was a difference due to age, gender, and years of experience. There was no significant difference due to age for the DAS, \(F(5,172) = .954, p > .05\), gender \(F(5,172) = .135, p > .05\), or years of experience \(F(5,172) = 1.007, p > .05\). There were no significant interaction effects witnessed. The factors do not significantly influence others.

**Non-parametric Analyses**

The distribution of the PDAS overall scores was positively skewed, \(\lambda_i = 1.207, SE = .182\). The DAS was not examined with non-parametric statistics because it was normally distributed. The gender differences and group differences, as well as the associations between PDAS, DAS, age and years of experience were examined using non-parametric analyses to confirm the results of the previous analyses. Mann-Whitney tests were examined to determine if there were significant differences by gender, while a Kruskal-Wallis test – a non-parametric test similar to the parametric ANOVA - was run on Group Age and Group Years of Experience. These tests replicated the original parametric tests. The Mann-Whitney test for gender was not significant \((U = 3777.50)\). The Kruskal-Wallis test for Age Group was not significant, \(\chi^2(5) = 3.560\). The test for the Years of Experience Group was also not significant, \(\chi^2(5) = 3.709\).

Spearman’s rho was examined to test the associations for the PDAS with DAS, age and years of experience. These tests also replicated the original correlations. Spearman’s rho was positive and significant for the relation between PDAS and DAS, \((r_s = .422, p < .001)\). A negative, significant correlation was evidenced between the PDAS and age \((r_s = -.167, \ p < .05)\), while the associations with PDAS overall scores and years of experience were not significant \((r_s = -.100)\). As with the parametric correlations, age and years of experience were positively correlated \((r_s = .673, p < .001)\).
Comparison of Scores for Both Studies

In order to gain a perspective of the scores from both studies, Table 6 was provided to demonstrate the range of overall mean scores on the DAS and PDAS. The group of undergraduate students ranged in age from 18 to 37 years with no experience in the mental health field. The graduate student group ranged in age from 28 to 56 years with 0 - 2 years of prior work experience in the mental health field. Student professionals ranged in age from 27 to 61 years with 1 to 25 years of prior and current experience in the mental health field. The professional group consisted of six participants from 42 to 63 years of age with 3 to 25 years of experience in the mental health field. The group of psychologists range in age from 24 to 75

Table 6

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Range Of Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undergraduate Student</td>
<td>38</td>
<td>1 - 14</td>
</tr>
<tr>
<td>Graduate Student</td>
<td>15</td>
<td>2 - 9</td>
</tr>
<tr>
<td>Student Professional</td>
<td>42</td>
<td>0 - 13</td>
</tr>
<tr>
<td>Professional</td>
<td>6</td>
<td>2 - 9</td>
</tr>
<tr>
<td>Psychologist</td>
<td>178</td>
<td>0 - 12</td>
</tr>
<tr>
<td>PDAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undergraduate Student</td>
<td>38</td>
<td>0 - 14</td>
</tr>
<tr>
<td>Graduate Student</td>
<td>15</td>
<td>0 - 7</td>
</tr>
<tr>
<td>Student Professional</td>
<td>42</td>
<td>0 - 10</td>
</tr>
<tr>
<td>Professional</td>
<td>6</td>
<td>2 - 5</td>
</tr>
<tr>
<td>Psychologist</td>
<td>178</td>
<td>0 – 10</td>
</tr>
</tbody>
</table>
years with 0 to 45 years of experience (20 hours of patient contact per week). As the range of scores suggest, there was a restriction of range in scores evidenced (Appendix F provides a structured view of the data).
CHAPTER 5. RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

This quantitative research examined the relationship between death anxiety and professional death anxiety, as well as the influences that age, gender, and years of experience have on personal and professional death anxiety. This research was broken into two studies, one to validate a new scale designed to measure professional death anxiety via a field test and another to utilize the new scale to assess professional death anxiety of psychologists who treat patients with anxiety disorders. The remainder of the chapter will include the presentation of the results of the analyses, a discussion regarding the results of both studies, the conclusions made about the results, and the recommendations.

Previously, it was discussed that an individual’s feeling toward death can produce a great amount of anxiety that can significantly interfere with the individual’s life. As anxiety of any sort is no respecter of persons, it was important to determine if psychologists were affected by personal death anxiety. For the purpose of this study, it was also important to determine if a psychologist’s personal death anxiety affected professional anxiety related to the treatment of patients who have issues regarding death. As prior research is unclear regarding the effect of age, gender, and experience on death anxiety, this was also taken into account for this study.

The hypothesis of this study was that mental health professionals who have little difficulty with personal issues regarding death anxiety will demonstrate little difficulty with death related issues in their professional practice, while those with elevated death anxiety at the personal level will demonstrate elevated levels of death anxiety in their professional practice.
The study explored the following questions: (a) is there a significant relationship between a therapist’s own level of anxiety about death and his or her level of anxiety generated as a result of working with patients who present with symptoms of death anxiety and issues related to death; and (b) do therapists’ age, years of professional experience, or gender significantly affect personal and professional anxiety toward death?

In order to answer these questions, participants had to be solicited and a measurement of each participant’s level of death anxiety, personal and professional, had to be taken and analyzed. Although there are a handful of valid and reliable instruments that specifically measure for personal death anxiety, there were no instruments found that measured the level of death anxiety that might be found in those who practice psychology in the professional realm. As such, a professional death anxiety scale had to be developed and checked for reliability and validity during the course of this investigation.

The details of the analyses were presented in the previous chapter. The remainder of this chapter will include the presentation of the results of Study 1, a field test performed to validate the Professional Death Anxiety Scale (PDAS); the results of Study 2, the actual dissertation topic study which was performed to measure and analyze the effects of personal death anxiety on professional death anxiety, as well as the effects of age, experience, and gender on death anxiety; the discussion of the results of both studies; the conclusions of both studies; and the recommendations for future research.

Significance of Findings

Study 1

In order to examine the validity of the PDAS, Study 1 was conducted as a field test. Although the reliability of the instrument was found to be moderate ($\alpha = .76$), the PDAS
appeared to be a promising indicator of professional death anxiety, comparable to the reliability of the DAS (α = .75). An instrument with a coefficient of reliability within a range of .80 to 1.00 would be considered excellent. A coefficient of reliability range from .60 to .79 would be considered moderate. The coefficient of reliability for the DAS was .75 and the coefficient of reliability for the PDAS was .76. The PDAS and DAS were also positively correlated to one another (r = .682, p < .001).

The analysis for gender effects on death anxiety showed no significant difference, which suggested that gender does not affect the level of death anxiety, as measured by the PDAS (F(1,99) = 1.415, p > .05). This indicates that gender is not an issue with regards to the anxiety that might arise during the course of interactions with others who present with issues of death anxiety. In other words, males and females in this study are equally able to respond to issues related to death.

The DAS scores did show a significant difference due to gender (F(1,99) = 8.60, p < .01), with females displaying a higher level of personal death anxiety than males. This indicates that females do display a higher personal level of anxiety related to death and dying than do males.

The average age of the participants was 36.48 years and the range was from 18 to 63. The number of years of experience as a mental health professional ranged from 0 to 25 years. Fifty-two of the participants had no experience, while those with mental health experience (N = 49) had worked in the field from one to twenty-five years. Age and years of experience were examined to determine if there were any relationships with personal and professional death anxiety. The analyses did demonstrate a negative correlation between the PDAS overall scores and age, r = -.346, and years of experience, r = -.229, and these were significant at the 0.01 level (2-tailed).
The participants were categorized to examine group differences, since there were a small variety of groups represented in this study. There were 6 professionals, 42 graduate students working toward a doctorate degree who worked in the mental health field, 15 graduate students working toward a doctorate degree who were not employed in the mental health field, and 38 undergraduate students. These four groups were divided to examine the differences that experience might have on death anxiety, personally and professionally. There was a significant difference in scores for undergraduate students compared to graduate students and student professionals on the PDAS \( F(3, 97) = 5.85, p < .05 \). Undergraduate students also had higher scores on the DAS than compared to student professionals. The results indicate that experience (as a student of psychology or a mental health professional) and age do have an impact on death anxiety.

The null hypothesis was that there would be no consistency between the scores of the DAS and the PDAS, regardless of age, gender, and years of experience. Also, the PDAS would be shown to be an invalid and unreliable scale. The null hypothesis was rejected after Study 1 results supported that the PDAS was consistent to the DAS. The PDAS and DAS were positively correlated to one another \( r = .682, p < .001 \) and the reliability coefficient for the DAS was 0.75 and 0.76 for the PDAS, which indicated a moderate level of reliability for both instruments.

It was expected that the PDAS would be deemed a good instrument to measure professional death anxiety and the results of the reliability and validity analyses would demonstrate that the PDAS was comparable at the professional level as DAS is on the personal level. Study 1 supported these expectations.
Study 2

The second study conducted entailed measuring personal and professional death anxiety levels of eligible psychologists. Psychologists were considered eligible for this study if they were licensed or license eligible and if they treated individuals who presented with anxiety disorders. There were two null hypotheses for this study. The first null hypothesis was that there would no correlation between the therapist’s personal level of death anxiety and his or her level of anxiety generated as a result of working with patients who present with symptoms of death anxiety. The second null hypothesis was that a therapist’s age, gender, and years of experience do not significantly affect the therapist’s personal or professional death anxiety. It was expected that therapists who demonstrate elevated levels of personal death anxiety on DAS scores would also have elevated levels of professional death anxiety, as indicated on PDAS scores. A positive correlation would be witnessed.

It was expected that age would affect therapists’ level of personal and professional death anxiety. There would be significantly higher mean scores on the DAS and PDAS of older therapists’ compared to younger therapists. It was also expected that gender would affect therapists’ level of personal and professional death anxiety. There would be significantly higher mean scores on the DAS and PDAS of female therapists compared to male therapists.

Of the 201 eligible psychologists who consented to participate in this study, 178 individuals returned a completed survey. Ninety-six females and eighty-two males participated in the second study. These were psychologists who indicated that they were licensed or licensed eligible and who provided therapy to patients with anxiety disorders.

The DAS and the PDAS were not found to be valid or reliable measures for this particular sample. The coefficient of reliability was 0.60 (moderate reliability) for the DAS and
0.55 for the PDAS (highly questionable reliability). The DAS and PDAS scores were positively correlated \((r = .422)\) and significant at the 0.01 level, but these results were not as good as the results of Study 1. As the results of the analyses were not considered statistically reliable indicators for this sample and there were not enough participants for the results to be reliable, the results will not be presented.

Discussion of Findings

Reliability analyses from the first study’s data suggest that the DAS and PDAS demonstrated good reliability and that each of the 15 items contributed to the overall reliability. This was not the case in the second study where both the DAS and the PDAS measures failed the test for reliability. This indicates that these two instruments may be good measures of death anxiety for the general population, but they are not good measures of death anxiety for this study’s sample of professional psychologists.

One reason that the measures did not show great reliability with the professional therapists in Study 2 may be that, as professional psychological testers, the participants may be covertly or overtly analyzing the construction of the test and are answering the questions in ways that will not reflect badly on them. This may be a condition of the cohort effect, where the psychologists share a similar characteristic. This characteristic could be mental health experience, personality characteristics, or a number of other shared qualities.

Another reason might be that the psychologist was trying to present his or her self to another professional in a positive light. The fact that a doctoral student was conducting the study might have influenced the answers that were given by the psychologist, who wanted to exemplify a true, professional psychologist. Both reasons are examples of a bias effect.
Another reason that the measures did not show great reliability with the psychologists in Study 2 might be that they have had training and experience that has helped them overcome difficulties with death anxiety, but if this were the case, the scores would have been very low with a restriction of range in the scores. One might argue that professional psychologists would uphold the profession’s ethical guidelines to help promote research that is undertaken to better the population and bring about a better understanding of human nature; however, psychologists are human and humans tend to present themselves as desirable and respectable to others in society.

While these are good suppositions, it could be that the results of the actual study are an example of the anxiety buffering mechanisms described by the terror management theory. Jeff Greenberg, Sheldon Solomon, and Tom Pyszczynski found ways in which individuals strive to lessen the effects of their fear of death. This became the foundation of their terror management theory in 1986. According to the terror management theory, people use self-esteem elevating behaviors and their cultural worldviews as anxiety buffers to protect themselves against thoughts of death that have the potential of disrupting their lives due to the terror that thoughts of death can bring.

The first study indicated that the females produce statistically significant, higher scores on personal death anxiety measures than males. This was not the case for the measures for professional death anxiety in Study 1. It was also not the case for the results from Study 2. Apart from the Study 1, gender was not statistically significant factor for death anxiety, personally or professionally. DePaola, Griffin, Young, and Neimeyer (2003) stated that “women tend to view death in more emotional terms, whereas men tend to perceive death in more cognitive terms” (p. 338, para. 1). The reason for the disparity could be that assuming the role of a mental health
professional switches one’s consciousness from self to other mode. The procedures for Study 1 involved filling out the personal death anxiety scale, reading the professional therapist scenarios and then filling out professional death anxiety scale. There could have been a shift in mentality that allowed female participants to answer the final scale’s questions without the emotions discussed by DePaola et al., but with the assumption of the mindset of their perception of a professional therapist. This may have been the case in the first study. The female participants answered with all of their personal emotions in tact, but made a mental transition to therapist mode with the idea that therapists are trained to meet patients without personal influences infiltrating the therapy session. Males didn’t show a significant difference between the measures and this would support DePaola et al. claims that the perceptions of death are different due to gender.

On both measures (DAS and PDAS), the overall scores did not indicate a significant elevation, thus there was a positive skewness of the distribution of scores. As indicated by the terror management theory, self-esteem is elevated when a person takes a proactive step to positively change his or her life, such as going to college or working in a “helping” profession, as mental health professionals do. This factor could reduce one’s existential anxiety which would be demonstrated on measures that are taken to check for existential anxiety, specifically death anxiety. This would explain the positive skewness of the distribution of overall scores in both studies, Study 1 (the field study) and Study 2 (the original topic of this dissertation study).

Due to the fact that the overall distribution of scores did not produce a normal curve of distribution for the PDAS, nonparametric analyses were run. As with the parametric analyses of Study 1, it was determined that age and years of experience were not good indicators of professional death anxiety as the PDAS overall scores suggest, although those with experience in
the mental health profession, as opposed to non-professionals, seem to produce lower scores on the PDAS.

So the questions remain. Were the DAS and PDAS inadequate measures for the research presented? Did the second study’s participants misrepresent their true feelings toward the questions presented due to the cohort effect? There is no way of knowing the answer to these questions. The fact remains, however, that the reliability analyses conducted on the testing instruments in the second study indicate the scales’ inability to support the hypotheses presented for this particular sample population.

No reliable conclusions can be made using the results from the second study. The fact that stood out in both studies was that low scores were found from both samples. One could surmise that the anxiety buffering mechanisms that were discussed in the terror management theory were a factor that influenced the low scores for the DAS, which is an often used and valid instrument, and the PDAS, which was validated only for a general population sample made up of students and student mental health professionals and not the targeted professional psychologists for the second study who provide therapy for patients with anxiety disorders.

Limitations

As with any study conducted, no matter what the results are, the researcher may find that the more that is learned, the more that is needed to be learned. The hypothesis of the first study was that there would be consistency between the scores of the DAS and the PDAS, regardless of age, gender, and years of experience. The PDAS would be shown to be valid and reliable scale. The hypothesis of the second study was that mental health professionals who have little difficulty with personal issues regarding death anxiety will demonstrate little difficulty with death related
issues in their professional practice, while those with elevated death anxiety at the personal level will demonstrate elevated levels of death anxiety in their professional practice.

It was found that the DAS and the newly developed PDAS were moderately reliable instruments to measure death anxiety for the sample population in the first study made up of undergraduate students, doctoral students of psychology, doctoral students who also held jobs in the mental health field, and a limited number of mental health professionals. Both instruments were found not to be reliable indicators of death anxiety for the sample of professional psychologists who treat patients for anxiety disorders. In both studies, the overall mean scores were low, suggesting that the participants overall did not demonstrate issues related to death anxiety that would interfere with their professional judgment as mental health professionals. The only significant result from the death anxiety analyses was the relationship between age and death anxiety scores which indicated that as one ages, death anxiety levels lessen.

The terror management theory suggests that self-esteem and cultural worldviews help buffer the effects of death anxiety, thereby lessening the anxiety that develops when one is reminded that life is finite. Neither of the sample participant groups produced high overall mean scores on the DAS or PDAS, which may mean that their involvement in academia and the helping profession helps lessen the effects of death anxiety. This might be the case, however this cannot be supported with the current study’s results.

On the other hand, it might be that participants did not reveal the true level of their death anxiety as they did not wish to appear unfavorable to the researcher. Professional psychologists may not have wanted a cohort to see them in bad light, so to speak, so they used their training in test construction and analysis to help them choose their answers accordingly. This would be an example of bias.
The fact remains that neither of these contentions could be supported in this study. More in depth analyses are necessary, using instruments designed to measure these instances. Thus, the more one learns, the more one learns that more is needed to be learned.

Finally, the second study was marred by complications. First, the list generated by the state’s Board of Examiners of Psychologists was outdated. There were those who were deemed ineligible due to retirement, not treating patients with anxiety disorders, death, and moving out of state. The list also did not include newly licensed or licensed eligible psychologists. Much of this was found during the course of the participant invitation process. There was also a lack of response from many psychologists, despite multiple attempts to contact them. As such, it is not known the true amount of psychologists who treat patients for anxiety disorders, those who have retired or are deceased, or otherwise eligible or ineligible to participate in this study. Although the response rate was adequate, according to a publication from the University of Texas (n.d.), there were not enough surveys returned to ensure valid results. 201 individuals consented to participate of the 590 mailed. Of these, only 178 individuals returned a completed survey, which was short of the 210 participants needed for a valid study.

Conclusions

There were two studies undertaken for the purpose of this dissertation. Study 1 was designed to establish the reliability and validity of the Professional Death Anxiety Scale, which was designed using the Templer Death Anxiety Scale (1970) as a template. The results of the first study indicated that the scales used to measure personal and professional death anxiety were valid and reliable for the participants of that study. The participants included undergraduate students, graduate students working toward a doctorate in psychology who did not work in the
mental health field, graduate students working toward a doctorate in psychology who did work in the mental health field, and a limited number of professionals who did work in the mental health field.

The results of the second study determined that the instruments of measurement were found to be unreliable for licensed and license-eligible psychologists that were targeted for the study. There were several null hypotheses suggested at the beginning of the research for the second study which included: 1) there is no correlation between the therapist’s personal level of death anxiety and his or her level of anxiety generated as a result of working with patients who present with symptoms of death anxiety, 2) a therapist’s age does not significantly affect personal or professional death anxiety, 3) a therapist’s gender does not significantly affect personal or professional death anxiety, 4) therapist’s years of experience as a mental health professional do not significantly affect the therapist’s personal or professional death anxiety, 5) therapists who demonstrate elevated levels of personal death anxiety on DAS scores would also have elevated levels of professional death anxiety, as indicated on PDAS scores, 6) age would affect therapists’ level of personal and professional death anxiety, and 7) gender would affect therapists’ level of personal and professional death anxiety, that years of professional experience would affect therapists’ level of personal and professional death anxiety. These hypotheses could not be supported or refuted due to the questionable reliability of the instruments for this sample for Study 2. Another set of instruments must be found that would provide reliable measures to test these hypotheses for the given sample.
Recommendations for Future Study

The general premise of this research was to explore the idea that more courses in death and grief were necessary for students of psychology. With the baby-boomer population beginning their turn into the elder stage of life, there will be a significantly elevated need for younger professionals to be able to meet the needs of patients who present with issues related to death and dying. Is it a worthwhile effort to continue to examine whether or not more courses in death anxiety are a good idea? One can never have enough training to understand the complexities regarding death and dying. There are various studies that support different ideas and concepts which indicate that thoughts on death and dying change as we grow older. Perhaps harnessing these ideas into a simpler theory would enable psychologists and other mental health professionals to adequately treat their patients for anxiety related to death instead of relying on “canned” treatments for all age groups.

The main purpose of this current study was to determine whether personal death anxiety affects professional death anxiety. Specific to this, do psychologists with elevated personal levels of death anxiety demonstrate a similar elevation of anxiety associated to their professional treatment of patients who present with issues related to death? Since death anxiety was described earlier in this report as an underlying concern of all humans and sometimes inescapable, does personal death anxiety of psychologists affect the level of anxiety that can arise when exposed to reminders of death when they are treating patients who present with issues related to death? In order to measure the level of professional death anxiety of psychologists, a new instrument was developed, the Professional Death Anxiety Scale, based on the Templer Death Anxiety Scale, a previously validated instrument.
Although the instruments used to measure levels of death anxiety were moderately reliable, as indicated by the reliability analyses in the first study, the same instruments were not found to be reliable indicators for the sample of participants in the second study. As such, there can be no reliable conclusion derived from the second study – the main topic of this dissertation. It is recommended that future research of this type rely on instruments other than the DAS and the PDAS.

Another topic that was addressed was the issue of bias. Psychologists are supposed to be trained to not let personal concerns interfere in the treatment that they provide to their patients or the research that is being conducted. Bias was an issue discussed in this report and the question of whether or not it was an underlying factor in the low scores of both studies in this report was not answered. One way to control for this would be to revise the questionnaire so that the first question is: I believe that psychological tests are for the advancement of valid research and for the well-being of the society. This would be a way to instill in the psychologist the purpose of the test and the research being conducted. It might serve the purpose of suggesting to the psychologist that the test should not be analyzed for construct and meaning and that the psychologist should answer the questionnaire as truthfully and unbiased as possible. It would also remind the psychologist of the integrity and ethics of providing true and unbiased answers to the remaining questions. It could not be supported, in this study that such was the case, but there was no control for bias in this study. Subsequent studies related to this topic would do well to incorporate a control for cohort bias and a way to determine if psychologists might have deviated from their true feelings when answering questions that might make them feel as if they were going to be judged as incompetent or unprofessional.
REFERENCES


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APPENDIX A. DEMOGRAPHIC INFORMATION PAGE FROM SURVEY

Please provide the following demographic information and answer the following survey, which is made up of 4 short questionnaires. Complete each questionnaire as they are presented before continuing on to the next.

- Age in years
- Gender (circle one)
- Years of experience working full time as a therapist (20 hours of patient contact per week)

Average number of patients seen per week
APPENDIX B. SCENARIO PAGE FROM SURVEY

Read the following scenarios and then continue to the next questionnaire.

- On a typical day at work, you look out toward the waiting area and see your next patient, Jan. Jan is HIV positive. Her appointment is today and she has a sinus cold. You see her sneezing and coughing in the waiting room. Jan needed to see you because her best friend died after suffering with AIDS.

- John is a 45 year old father of two who presents with a generalized anxiety disorder. During the session, John tells you that his father died of a heart attack when he was 45. John is afraid that the same will happen to him. He doesn’t want to leave a mortgage and other bills for his wife after he dies. He is upset that he won’t see his teenage son graduate in two years or dance at his daughter’s wedding.

- Mary is a 25 year old patient. At the last session, you discussed termination of therapy with her and Mary was glad that the time had come, but also sad to say goodbye to you. Your receptionist stops you at lunch to tell you that Mary had died in a car accident that morning.

- George is a 60 year old male patient who began therapy after his wife of 42 years died of cancer. George discusses, among other things, how life passes by so quickly.
APPENDIX C. PROFESSIONAL DEATH ANXIETY SCALE

**DIRECTIONS:** Please answer the following 15 questions.  
If a statement is true or mostly true as applied to you, circle “T.”  
If a statement is false or mostly false as applied to you, circle “F.”

<table>
<thead>
<tr>
<th></th>
<th>QUESTION</th>
<th>T</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I am not afraid to treat a patient who I know is HIV positive.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>2</td>
<td>Helping my patients work through their death issues seldom bothers me.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>3</td>
<td>It makes me nervous when patients talk about death or dying.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>4</td>
<td>I am uncomfortable when my patients discuss upcoming operations.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>5</td>
<td>Discussing death with my patients does not bother me.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>6</td>
<td>I am not uncomfortable when my patients discuss illness.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>7</td>
<td>The thought of my patients dying from physical illness or by accident never bothers me.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>8</td>
<td>I am distressed when my patients come to therapy with the flu or infectious illness.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>9</td>
<td>I will refer a regular patient to another therapist if there has been a death in his or her family.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>10</td>
<td>I am troubled when my patients discuss life after death.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>11</td>
<td>I do not like treating patients who are physically ill (non-contagious).</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>12</td>
<td>I shudder when my patients discuss the war in Iraq.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>13</td>
<td>The thought of my patient dying of natural causes during treatment is horrifying.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>14</td>
<td>I like it when my patients discuss the future.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>15</td>
<td>I do not like treating patients who are over 55 years old.</td>
<td>T</td>
<td>F</td>
</tr>
</tbody>
</table>

APPENDIX D. SCORE KEY FOR THE PDAS

DIRECTIONS: Please answer the following 15 questions.
If a statement is true or mostly true as applied to you, circle “T.”
If a statement is false or mostly false as applied to you, circle “F.”

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I am not afraid to treat a patient who I know is HIV positive.</td>
<td>T</td>
</tr>
<tr>
<td>2</td>
<td>Helping my patients work through their death issues seldom bothers me.</td>
<td>F</td>
</tr>
<tr>
<td>3</td>
<td>It makes me nervous when patients talk about death or dying.</td>
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<td>5</td>
<td>Discussing death with my patients does not bother me.</td>
<td>F</td>
</tr>
<tr>
<td>6</td>
<td>I am not uncomfortable when my patients discuss illness.</td>
<td>F</td>
</tr>
<tr>
<td>7</td>
<td>The thought of my patients dying from physical illness or by accident never bothers me.</td>
<td>F</td>
</tr>
<tr>
<td>8</td>
<td>I am distressed when my patients come to therapy with the flu or infectious illness.</td>
<td>T</td>
</tr>
<tr>
<td>9</td>
<td>I will refer a regular patient to another therapist if there has been a death in his or her family.</td>
<td>T</td>
</tr>
<tr>
<td>10</td>
<td>I am troubled when my patients discuss life after death.</td>
<td>T</td>
</tr>
<tr>
<td>11</td>
<td>I do not like treating patients who are physically ill (non-contagious).</td>
<td>T</td>
</tr>
<tr>
<td>12</td>
<td>I shudder when my patients discuss the war in Iraq.</td>
<td>T</td>
</tr>
<tr>
<td>13</td>
<td>The thought of my patient dying of natural causes during treatment is horrifying.</td>
<td>T</td>
</tr>
<tr>
<td>14</td>
<td>I like it when my patients discuss the future.</td>
<td>T</td>
</tr>
<tr>
<td>15</td>
<td>I do not like treating patients who are over 55 years old.</td>
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APPENDIX E. LIST OF OVERALL MEAN SCORES ON THE DAS AND PDAS

<table>
<thead>
<tr>
<th>Study 1</th>
<th>N</th>
<th>DAS Score Overall Mean</th>
<th>PDAS Score Overall Mean</th>
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<tr>
<td>Undergraduates</td>
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<td>6.76</td>
<td>5.66</td>
</tr>
<tr>
<td>Graduate Students</td>
<td>15</td>
<td>4.93</td>
<td>3.00</td>
</tr>
<tr>
<td>Student Professionals</td>
<td>42</td>
<td>4.76</td>
<td>3.60</td>
</tr>
<tr>
<td>Professionals</td>
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<table>
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<tr>
<th>Study 2</th>
<th>Group by Years of Experience</th>
<th>N</th>
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<th>PDAS Score Overall Mean</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>1 (1 – 5 years)</td>
<td>15</td>
<td>5.40</td>
<td>3.00</td>
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</tr>
<tr>
<td>2 (6 – 10 years)</td>
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<td>5.42</td>
<td>3.09</td>
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<tr>
<td>3 (11-20 years)</td>
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<td>3.10</td>
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<tr>
<td>4 (21-30 years)</td>
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### APPENDIX F. COMPARISON OF STUDIES PER SCORE, AGE, AND EXPERIENCE

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<tr>
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