Knowledge and Attitudes of Residence Hall Students Toward Dying and Death

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Article:

Background: Avoiding The Issue

As human beings, we all must live with our mortality. However, in our society, it seems that avoidance and denial are the preferred methods for dealing with death.[1,13] College and university students, as a subgroup, naturally reflect this attitude. Willmer[25] observes, "Generally, [college and university students] do not plan for death and prefer not to consider it" (p, 2). Combs[4] supports this notion. After studying the effects of a death education program on college students, he concluded that the denial of death prevented participants from experiencing death fear or anxiety.

This overt denial of death has been a relatively recent phenomenon. Historical scrutiny of societal trends yields a partial explanation. Today's family structure is different than it was a century or so ago with fewer "extended" families (i.e., those including uncles, aunts, cousins, and grandparents). The average life span is also much greater. Therefore, exposure to death is less likely as a developmental influence.

Over the years, we have become increasingly tentative about addressing death-related issues. Even our language is reflective of this fact. Corr[6] refers to the "euphemisms" existing in our vocabulary which "employ indirection and camouflage to soften direct references to death." He continues:

> Thus, people rarely ‘die; ‘they ‘pass away,’ ‘expire,’ ‘kick the bucket,’ ‘pass on’, ‘go to meet their maker,’ or ‘go to receive their reward,’ Familiar metaphors of ‘laying someone to rest’ or ‘sleeping in heaven’ invoke soporific concepts that children often use for death (p. 47).

There are many other examples, but these euphemisms point to the notion that our society fasters a climate that is conducive to the denial and avoidance of dying and death. Wass[24] believes that the death awareness movement has become more influential in recent years, but admits that the conflict between death denial and conscious death awareness is not resolved. Americans try to prolong life at almost any cost. It can be deduced that most Americans fear death. Coping mechanisms, including the tendency to repress thoughts of death, are apparent. Several other authors address the issue of denial, but caution about hasty and simplistic uses of the term.[5,6,11,16,22]

Although such scholarly analyses must be acknowledged for their epistemological value, they are of only minimal utility to those of us functioning at the operational level. What is important at this level is the notion that denial, whatever its form, manifests itself in such a way as to impact greatly, and often negatively, on our society and people.[13,21.] Further, it is especially influential in college students, since they are statistically less likely than most to have to face dying and death anyway, particularly in peace time. If one is not confronted with such issues, it is easy to evade them. Literature[8,11,24] indicates that the overt denial of death leads to a variety of problems including inability to explain death to children, avoidance of death rituals, and failure to properly plan for one’s own death. Health education programs of a comprehensive nature need to address these problems and concerns.

The college or university environment does not aid matters. Students live in a closed atmosphere where interaction with the larger society is often minimal. In addition, they are removed from the family structure and hometown culture. Initially, this separation may stimulate introspection and death awareness. However, after becoming integrated into a college or university lifestyle, the relative lack of opportunity for students to confront death may allow avoidance behavior to perpetuate and ultimately deter awareness and introspection.

Denial of death may have various implications. Most significant, denial may not allow suitable preparation for death at several levels including intellectual, emotional and even in regard to consumer aspects. It necessitates dealing with death only as an intrusion due to its untimeliness. The emotional or psychological wound may be deeper and slower to heal than if there has been shown to be lower in students who had confronted the issue.[4] Similarly, "death-threat" is lower in students who take preparatory measure in planning for their own death .[20] In terms of financial ill-preparedness, Milford" and another more recent Federal Trade Commission report" have shown that unscrupulous funeral directors may take advantage of the emotional trauma of survivors after the death of a loved one by steering them toward more costly products and services. Effective educational programming in this area can enhance the students ability to address dying and death related issues and concerns, and subsequently enhance the ability to cope.[4,5,15]

Addressing The Issue

Any movement toward change must begin with the pro-motion of awareness. Death awareness can be achieved through death education. Formal death education experiences are already available on most college campuses. "Recent surveys and informed estimates have indicated that over a thousand courses with death themes currently exist at the postsecondary level nationally . . "[18] The number is likely to be even higher today. Yet death education must occur informally as well. It must be personalized, and it must address the problems, needs and interests of the target group. One such effort was reported by Engelman and Smith.[9] Dying and death-related issues were addressed systematically on a university campus. The authors suggest that the impact of their three-day symposium was generally positive, not only on students, but on others in the academic community as well. Indeed, it served to dissolve the role requirements of various groups. In the author's words, "the awesome topic reduced us to our common humanity, which we experienced in a university setting" (p. 56). In essence, Engelman and Smith found that awareness related to dying and death issues can have a significant impact in a college community.

Residence Halls, College Students, and Dying and Death

In the college or university setting, the student spends approximately twenty hours per week in the classroom, and four to five times that at "home."[12] Typically, "home" for many college and university students, especially those at lower levels, is the residence hall. Therefore, it follows that an ideal setting for nonclassroom (informal) education is the residence hall. DeCoster and Mable[7] among others, provides a solid framework for this premise. It may be part of the overall developmental advantage to which Chickering[2] refers when comparing resident students to commuting students.

Overall development (i.e., development of the "whole" student) suggests an attention to a variety of common concerns including dying and death related issues. Residence hall professionals and paraprofessionals are responsible for facilitating the development of residence hall students. Therefore, it is incumbent upon them to provide educational experiences which help students cope with dying and death situations. In this milieu, the health educator can help train residence hall staff to address these concerns when appropriate, and to use appropriate referral mechanisms as warranted.

The purpose of this study was to assess the cognitive and effective status of residence hall students on dying and death related issues in order to draw implications for both educational interventions and further research.

The Sample

The participants for this study were students living in the North Halls section of the University Park campus of the Pennsylvania State University (N = 209).

The sample included 124 females (59 %) and 85 males (41 %). Nearly all were white (97%). There were 39 freshmen (19%), 66 sophomores (32 %), 71 juniors (34 %), and 30 seniors (14%). Religious backgrounds represented were Protestant (45%), Catholic (34 %), and Jewish (3%), as well as several other single representations totaling 10 % . Also, 7% were agnostic and 1 % were atheist. Most participants were from hometowns of less than 50,000 (79%). Only 7 % came from hometowns of over 500,000.

Instrumentation

A questionnaire composed of five sections was utilized. Part I assessed the demographic and experiential data. Part II was the Hardt Death Attitude Scale, a twenty item agree-disagree scale in which averaging yields a final death attitude statement. Part III was the Templer Death Anxiety Scale (DAS), a fifteen item true-false (agree-disagree) scale in which a high score means high death anxiety. Part IV was the Collett Lester Fear-of-Death Scale. This likert-type scale is divided into four subscales: fear of self-death, fear of self-dying, fear of others' death, and fear of others' dying. The last part was the Eddy[8] Knowledge Test of Death and Dying (KTDD) a fifty-two item multiple choice instrument. Each of the four instruments measuring affect and knowledge regarding dying and death have been demonstrated to be reliable and valid.

In addition to the demographic data, three experiential variables and four cognitive and affective variables were examined. The experiential variables were frequence of church attendance, experience with a significant other dying, and experience with the death of a significant other. The cognitive and affective variables were death and dying knowledge, death attitude, death anxiety, and death fears.

The questionnaires were distributed through student mailboxes. Students were asked to respond within one week. After one week, reminders were placed in mailboxes asking students to return their questionnaires within three days. Questionnaires were deposited by respondents into a locked receptacle in the area residence hall coordinators' office.

Results and Discussion

With regard to the knowledge level of the students surveyed, Table 1 identifies the mean score for the residence hall students surveyed and compares it with other subsets of college students who have completed the knowledge test. The mean for the residence hall students surveyed was 26.88. This indicates that these students, on the average, answered approximately fifty percent of the items correctly. Adjusting for the fact that students could guess, this mean score indicates a relatively low knowledge of dying and death related concepts. These mean data were compared with other student populations.

TABLE 1
Test of Significance for Residence Hall Sample (X = 26.88, N = 209) with other Independent Samples on the KTDD

Student Sample	Mean	S	F
Health Education Course (College A)	27.19	7.351	1.40
Health Education Course (College B)	31.50	6.78	11.2*
Sociology Course	33.71	5.92	18.9*
Nursing Course	34.47	6.17	22.9*

* Significant at < .01

These other groups represent students enrolled in dying and death classes where the KTDD was administered as a pretest. In three of the four comparison groups, there was a statistically significant difference in pretest scores with the student population which was beginning a death education course scoring higher. It seems that the

residence hall students did not score well on the knowledge test, especially when compared to other undergraduates who enroll in dying and death related courses in a variety of disciplines. Perhaps this reflects the notion that those students who choose to enroll in a dying and death course are more willing to confront the topic (and less prone to denial) and therefore may have willingly sought out information on this topic.

With regard to the affective measure, Table 2 presents the mean scores for death attitudes, death anxiety, and death fears.

Table 2
Mean Scores for Affective Death Measures (N = 209)

Affective Measure	Mean Score
Death Attitude	31.12
Death Anxiety	6.65
Fear of Death (self)	35.25
Fear of Death (others)	35.04
Fear of Dying (self)	33.72
Fear of Dying (others)	44.04

To measure death attitudes, the Hardt Death Attitude Scale was used. Scores on this scale can range from 11-49 with the higher score representing more appropriate attitude toward death. The scores of the residence hall students surveyed shows that on the average their attitudes are at the approximate midpoint on this death attitude scale.

The Templer Death Anxiety Scale was used to measure death anxiety. The scores on this instrument can range from 0-15. A mean score of 6.65 indicates that the subjects studied scored slightly less than the midpoint. In other words, the population studied tended toward a negative direction on this death attitude measure.

The Collett-Lester Fear of Death Scale is divided into four subscales; fear of death self, fear of death of others, fear of dying self, fear of dying others. Each of these subscales consisted of nine items and each item was rated according to a six response likert scale ranging from 1 (strong disagreement) to 6 (strong agreement). Therefore, the score for any one subscale could range from 9-54 with 31.5 serving as the midpoint. The results of this study indicate that the subjects scored just slightly above the midpoint on each of the four subscales. This does not indicate that the sample population has slightly better than average fear of death, but that, the response tended toward slight agreement on a six response likert scale which ranges from strong disagreement to strong agreement.

Overall, on the attitude measures, the data indicate that this population does not differ significantly from the population in general with regard to attitudes toward death. Their scores indicate that as a group the residence hall students attitudes toward dying and death support the often held notion that death is a taboo topic.

Three experiential variables were also examined. These variables were included to determine possible relationships with death knowledge or affect. For example, frequency of church attendance was examined by Kalish[14] and found to be related inversely to fear of death. Others report similar findings under the rubric of religiosity.[15,17] However, Simpson[22] believes that there are conflicting findings in the literature on the relationship between religion and attitude toward death.

With regard to the relationship of dying and death experiences on death attituded, Kastenbaum[14] believes: "If we ourselves have lived in a close relationship to a terminally ill person, this singular experience may have exerted a strong influence on our general thoughts and feelings about death" (p. 55).

The analysis of these variables yielded three statistically significant relationships. These were church attendance and fear of self-death, class standing and fear of self-dying and experience with dying and fear of self-dying.

The relationship between church attendance and fear of self-death found that those attending church regularly had a lower fear of their own death ($p. < .001$). This may be indicative of a tendency for those individuals to be in touch with, and perhaps to some degree at peace with, the idea of their own death. One possible reason for this may be that many religions provide for and confront death regularly, openly, and willingly. Church services are likely to be occasions at which death is discussed more commonly, possibly resulting in a more positive personal outlook. Also, religions that promote the concept of a pleasant and rewarding afterlife may provide one factor which could reduce the fear of self-death.

The relationship between class standing and fear of self-dying indicated juniors had a much lower fear of their own dying than undergraduate classes ($p. < .05$). The greatest difference was between juniors and seniors. Perhaps this is indicative of a general state of fear (e.g., fear of the unknown) that a senior contemplating his or her future may have. One study has reported such a relationship.[23]

Lastly, experience with dying and fear of self-dying were significantly related ($p. < .05$). Subjects having a recent or present experience with dying indicated a lower fear of their own dying than those with no such experience. This would support the notion that experiencing, and hence confronting, a situation of this nature may lead an individual to contemplate and prepare for his or her own dying. This is noteworthy in terms of its implications for residence halls, as well as for students in general. Often students are confronted with the fact that an individual on the residence hall floor has a parent or some significant other who is terminally ill.

The common avoidance reaction is the posture chosen by many, if not most, students. It usually would be wiser for all involved to confront and deal with the issue. Moreover, educational programs centered on understanding dying friends and relatives may ease the potential need to cope by avoiding.

In summary, several points merit attention. First, college and university students reflect societal attitudes of denial and avoidance toward dying and death. These attitudes hold implications for health educators serving residence hall staff and student services personnel. These implications include the need to provide students with the skills to cope with dying and death situations, and to train residence hall staff to effectively confront dying and death problems. Health education programming designed to emanate from practical goals of death education is an appropriate and necessary means of addressing this issue. The authors believe that health educators skilled in the area of death education should begin to work in concert with residence hall staff to develop a comprehensive effort to raise student awareness of dying and death related issues, and to help students cope more effectively with related life events.

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