AN INVESTIGATION INTO ATTITUDES TOWARD
DEATH AND ATTEMPTED SUICIDE

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AN INVESTIGATION INTO ATTITUDES TOWARD
DEATH AND ATTEMPTED SUICIDE

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By

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CHAPTER I
INTRODUCTION

How an individual reacts to the thought of death is one of the basic psychological issues with which each person is involved, consciously or unconsciously. Perhaps behind a sense of discouragement and depression is found a basic fear of death or a wish to die. This fear or wish undergoes complex elaborations and manifestations which are directed in many ways (22).

Man uniquely has at his disposal a psychopathological means of escaping life. He attains this by being instrumental in his own death, literally an active death by suicide. The person who commits suicide or attempts suicide tries to meet death more abruptly and suddenly than most. Information about attitudes toward death could throw some light on understanding the psychology of suicide. (A discerning fifteenth century author remarked that, "As soon as a man comes to life he is immediately old enough to die." The ideas and attitudes that one holds concerning death are potential guiding forces of his behavior (7).

Death, whether considered to be traumatic, tragic, or happy; a return to the womb; or a contest between the will to live and the desire to return to the inorganic state, sometimes poses a severe problem for many people, if not all
human beings. Human responses to life and death have run
the gamut of emotional possibilities from total indifference
to total fear (16).

Historical and ethnological information reveals that
reflection concerning death extends back to earliest civil-
izations and exists among practically all people. Perhaps
from the first time man saw the lifeless form of his species
or enemy he began to reflect upon death, what, if anything,
happened after death, and how death might be related to him
(16). Many investigators hold that fear of death is a
universal reaction.

There are several theories about death and suicide
proposed by thinkers and scientists in the field of psycho-
logy. Freud, for instance, began with the concept he called
the pleasure-pain principle. He theorized that the indivi-
dual always sought to avoid pain because it signified
destruction of a part of the body and threatened the whole.
Therefore, it would seem that the organism would avoid pain
and death to seek life and pleasure. Originally then,
Freud viewed this theory from the biological point of view.
During the First World War, he began reviewing the pheno-
mena of war. He saw devastation everywhere and men following
the tragic round of history, once again bent on painful
experiences leading to self destruction. As a result he
postulated the so-called "death instinct." Thus Freud pro-
posed a new dichotomy of motivations into categories of Eros
and Thanatos, Eros being the self-preservation instincts, and Thanatos the self-destructive instincts or death (17).

Stekel (18) went so far as to express the hypothesis that every fear is ultimately a fear of death. Death themes and fantasies are prominent in psychopathology. Ideas of death have been recurrent in some neurotic patients and in the delusions and hallucinations of many psychotic patients. The stupor of the catatonic patient, for example, has sometimes been likened to a death state or even to a form of psychological suicide (3).

Assael (1) hypothesized that there was a particular personality with a particular life constellation aiming at death, through suicide, as the ultimate redemption from despair. This type of personality had a pathological dependency on death in its thinking and action. The idea of death gained the quality of an *überwertige idee*, or literally invaded the whole being of the person. Any emotional experience was related back to the idea of death and centered around conflicts of life instincts and death instincts. It thus became the core and sole motive of their life.

The question of the existence of death instincts invariably arose in relation to death and suicide. Suffice it to say that only a few mental scientists in the literature (5, 12) still hold to Freud's dualistic theory of instincts. The majority (2, 9, 16, 19) instead believe in the unitarian or life instinct theory. Their explanation of man's
aggressive internal destructive behavior is that it developed in response to environmental interference of the life instincts.

By further observation, death and suicide were considered to be goals of inevitable seeking or a kind of internal drive which some persons possessed. Initiative is equated with aggression, and hostility is elevated to the status of a primary life force. Then, if hostility is turned internally, it constitutes self-destruction or suicide (9).

Related Research

Few people realize that suicide is more frequent than murder and more easily predicted. The normal person views suicide as too dreadful and senseless to be conceivable. There almost seems to be a taboo on the discussion of it as there was a taboo on the topic of sex during the nineteenth century. There has never been a wide campaign against suicide as there have been against other less easily preventable forms of death (11).

Once every minute, or even more often, someone in the United States either kills himself or tries to kill himself with conscious intent. Sixty or seventy times every day these attempts succeed. In many instances these deaths could have been prevented (11).
While the contemplation of one's death may be almost a universal concern, Rhudick (15) felt that this area of psychology had received relatively little attention in terms of research. He aimed his investigation at the relationship of death concerns in a normal aged group to various sociological, psychological, and health variables. Specifically, the study was on the death concerns in an aged sample and whether it was related to personality factors rather than to demographic factors such as age, sex, and marital status. Each subject completed the Minnesota Multiphasic Personality Inventory (MMPI) and the Thematic Apperception Test and, as predicted, there was no relationship between high death concern and such demographic variables as age, sex, occupational status, or education. However, high death concerns were associated with high scores on the MMPI dimensions of hypochondriasis, hysteria, dependency, and impulsivity. This finding was interpreted to mean that high concern over death involved neurotic preoccupation, particularly in relation to bodily symptoms. The interpretation tended to be confirmed by the relationship of high death concern to high scores on the physical and the psychiatric disturbance section on the Cornell Medical Index (15).

In a pilot study by Christ (4), one hundred acute geriatric patients admitted to a general hospital were examined. The majority could give relevant answers to most of the questions on their attitudes toward death. Most of the
patients were found to be fearful of death, but as a whole were willing and in some cases relieved to discuss it. Even some terminally ill patients with severe psychiatric symptoms were able to discuss the topic, at times with evident relief. In this study it was speculated that at least some of the psychiatric symptoms which included somatic delusions and fears of being poisoned, killed, or thrown out of their homes could have been symptoms of marked denial of death. Christ felt that if marked denial of death was present, it became incumbent for the psychologist or psychiatrist to talk to the patient about his ideas of death.

It seemed strange to Middleton (13) that psychology had never developed what might be called a mental hygiene of death. It still remained for the modern clinical techniques of case histories, group studies, and documentary analysis to be applied to the study of attitudes toward death. Only upon such a basis, slowly to be accumulated, compared, and worked over, could a clinical psychology of death be built which could be of social value.

Middleton (13) studied a large group of college students, and he found that sex differences were not sharply enough differentiated to be considered very significant. He did find that death in general seemed to depress both male and female groups. In fact, the great majority of the subjects reported that they thought of their own death very rarely or only occasionally. The special circumstances that caused
the subjects most often to entertain thoughts of their death were during depressed moods, after the death of relatives, misfortunes, disappointments, or failures, following an escape from an accident, before taking trips, after attending church, and during illness. Fifty-one per cent of the subjects reported that they were inclined to entertain thoughts of being killed in an accident. Eight per cent reported that they imagined that death would be horribly painful. Over eighty per cent reported that they never wished they were dead (13).

Another interesting point brought out by Middleton (13) was that sixty-four per cent of the subjects reported that even if they knew positively there was no future life there would still be absolutely no change in their present manner of living. Only three per cent reported there would be a radical change in their life.

Feifel (6) believed that dreams with death themes and death fantasies were especially prominent in psychopathology. In his study the subjects were comprised of two groups. Seventy-nine per cent of the patients in the closed ward group were diagnosed as schizophrenic reaction, paranoid type, and fourteen per cent as schizophrenic reaction, unclassified. The open ward group was comprised of twenty per cent who were classified by anxiety, fifteen per cent somatization, and fifteen per cent depressive reactions. Although most of the patients felt that old age was the
time of life when people most feared death, a substantial minority in both groups of patients ranked childhood as the time when people most feared death. It was thought that this might be related to experiences of severe emotional deprivation early in the life of some patients and possibly connected with childhood fears of castration.

Most of Feifel's (6) patients perceived death as the natural end of the life process. This was followed by the religious view that it was actually a preparatory stage for another life. Many depicted death as occurring through violent means, and the conjecture was that this was allied to intense aggressive impulses with which these patients were contending. When faced with hypothetical situations suggesting the imminence of death, the characteristic response tendencies of both groups of patients highlighted activities oriented toward benefiting others and stressing religious values. This was in contrast to the reported findings for normals whose activities in similar situations emphasized personal gratifications. It must be remembered, however, that these data were collected on a conscious level and not at the deeper unconscious level.

In a similar study Wolfe (21) attempted to measure various attitudes toward death of older patients who were assigned to diagnostic groups by employing psychological tests and psychiatric evaluation. All patients were in good contact at the time of the study. The passive-dependent
personalities became disturbed, agitated, and depressed when they thought of dying. However, they viewed death as unavoidable and as a relief from painful events. The schizoid personalities were harder to evaluate, but it was felt that most of them were moderately fearful underneath their outwardly unconcerned or aloof facade. The inadequate personalities, as they were called, suffered from great fear of death. Compulsive personalities viewed death as a great threat and generally feared the unknown, while the paranoid personalities were divided into two groups in terms of their attitudes toward death. One group looked upon death positively and welcomed it as a liberation. The other group was very much afraid of death and suspicious of what might happen after death. In summary Wolfe stated that people react differently to the problem of death, and when facing death, the person showed an accentuation of lifelong personality defenses.

In a second study Peifel (7) found that two major outlooks dominated the thinking of older persons: one group viewed death philosophically as the end, and the other viewed death in a religious vein as the doorway to a new life. When his older subjects were tested, he found that twenty percent of them had a negative attitude toward death, that is, the end of everything. Forty percent had a positive or religious attitude toward death. Twenty percent were evasive on the subject of death. He also found that most of
the subjects felt that old age was the time of life when people feared death most and childhood when people feared death least.

It was also reported that older persons who were religiously inclined gave more thought to concepts about death than those to whom death represented the inescapable end. Did the former master their anxiety about death by thinking of it as a precursor of a new life? Fiesel concluded his study by stating that too many people considered death as a purely biological event, but actually its meaning for the individual and to society served as an important organizing principle in determining how one conducted himself all through life (7).

In a study carried out by Fulton (8), it was found that respondents who were temporally oriented toward death tended to think of death primarily in terms of what happened to the body. Responses suggesting the finality of death were more numerous in this group. Also characteristic of this group was an emphasis upon the temporal life as having been a satisfying one and/or a full one. The respondents who were primarily spiritually oriented thought of death almost exclusively as a transition to another form of life. However, emotional responses suggesting either fear of death or the dead were more frequent among spiritually oriented than the temporally oriented. This finding was somewhat unexpected in
view of the belief that the conception of death as a transition to another form of life served to lessen the fear regarding death (8).

Pollack (14) did a study concerned with the problem of suicide in a general hospital. The purpose was to suggest possible clues which physicians in a general hospital could try to recognize in potential suicidal patients. In this study all the patients were male veterans with a wide age range (from twenty-six to sixty-five), different racial extractions, religious groups, marital status, and occupational status. A clinical analysis of eleven hospitalized patients who successfully committed suicide was used in Pollack's report (14).

A review of the eleven cases showed that depressed feelings, psychotic disturbances, increased pain, and fear of death increased, and the patient's state of consciousness became sufficiently clouded to impair his awareness and behavior. Although fear of death was present to a large degree and openly expressed by many of the patients, their agitation appeared more specifically related to their distressing physical disabilities than to the fear of death. The patient's fear of death was not viewed as a deterrent to the final suicide. The specific tension-producing quality of the severe dyspnea could have been of qualitative and quantitative importance to the suicidal patients (14).
Tabachnick's investigation represented an attempt to collect data from individuals in the community who had attempted suicide, as contrasted to the group who were more readily seen in the neuropsychiatric hospitals. The experimental group was composed of sixty individuals who had made suicidal attempts. The motives for the suicidal attempts seemed to be consistent with the dynamic diagnosis of a passive, orally oriented person. Elements of masochism, identification with feared objects, and subsequent attempts to hurt these feared objects symbolically by self destruction were common. Guilt and anxiety caused by possible ambivalence concerning death often seemed to be in extreme during the period immediately preceding the suicidal attempt. In regard to these points, it may be possible to apply Freud's theory of instincts in which he proposed that beyond all activity of living matter lies an attempt to return to the inorganic state. The cases presented by Tabachnick offered evidence that could easily fit into this theory.

It has often been asked if people fear death more when they feel that they have failed in life. Mauren (5), in a study involving 200 high school seniors, found that poor achievement was associated with a greater fear of death. He felt that this fear was often so pervasive that it could only be communicated indirectly. Mauren also found that high achievement was associated with a greater sophistication in acknowledging inevitability. He therefore
concluded that persons with high achievement in school, and to some degree achievement in life, enjoyed life and found satisfactions in helping others in planning a useful life. In essence, the person was mature and emotionally stable.

In summary it may be said that the state of the research is somewhat contradictory. Several studies (4, 15, 21) tried to associate emotional difficulties and attitudes toward death. They reported that death concerns did seem to be expressed indirectly via somatic symptoms and withdrawal tendencies rather than outward anxiety, and that psychiatric symptoms may be the road taken by some persons to consciously deny concern about death. However, another study (6) compared attitudes toward death of mentally ill patients and normal individuals and found that the degree of mental disturbance exerted little effect on thoughts about death.

Two other articles (7, 8) reported that emotional responses suggesting either preoccupation about death or fear of death were found more frequently among the spiritually oriented than the temporally oriented. This finding was also unexpected, due to the belief that religion tended to lessen the anxiety regarding death.
Purpose of the Study

While the history of literature and mythology is abundant concerning writings on death, its sorrow and its happy or unhappy life beyond, there is a comparative lack of scientific writings on this subject (16). One of the major reasons that death is so inaccessible to scientific investigation is that there are too many negative attitudes centered around death. There is also a lack of objective instruments with which to work. It was the purpose of this investigation to add to the scientific knowledge of death and suicide and to present an exploratory investigation into the possibility of developing an attitudinal technique or scale for measuring responsiveness toward death. Responsiveness toward death has to do with how a person responds to his own death and the "death-instincts" and are explained later.

Since the types and purposes of tests used to detect suicidal intent are many and varied, ranging from the Rorschach, Thematic Apperception Test, Minnesota Multiphasic Personality Inventory, and the Sentence Completion test, it could be asked, why develop another? In this case the answer was to add a measurement which could be scored quantitatively, and one which dealt directly with death and the feelings surrounding death. It was also felt that a quantitative score would decrease the subjectivity and increase the accuracy of the instrument used for prediction.
In addition, it was felt that there was a need for greater exploration of the emotional processes that precede death by suicide and that death should not be thought of as a totally postmortem experience. The emotional processes concerning suicide often began long before the death and continued until some resolution had been achieved either by death or by the death of someone else. The psychologist in a relationship with a patient should know or be aware of his patient's possible wish to die or to commit suicide and/or the potential activation of self-destructive forces.

The review of the literature showed an increased interest by psychologists, in the last decade, in problems and potential research pertaining to death. Until recently most of the writings found on death were theoretical in nature, and there was a deficit of actual related scientific research. Further refinement of psychological techniques and more precise specifications of the conditions under which research on death could be carried out have broadened the psychologist's knowledge concerning death. At times there was a marked difference between much of the theory concerning death and the research findings. In formulating hypotheses centered around predicted findings concerning death and suicide, a choice had to be made between the writings that were theoretical and the findings of research which were supposedly carried out scientifically. The hypothesis may therefore contradict the theoretical approach at one time and accept
the research findings, and at other times reject the research findings and support the theoretical beliefs.

Hypothesis

The ambivalence or conflict built up between the positive concept of death as a new life and the negative or fearful concept that death is the biological end should be measurable by the use of a questionnaire containing both positive and negative attitudes toward death. It was hypothesized in this study that

1. If an individual is contemplating suicide, then he is vacillating between the death impulse and the wish to live, and this may be detected by an evasive attitude toward death.

2. The distribution will be significantly different between the suicidal and clinical portion of the sample in relation to their attitude toward death. That is, the suicidal sample will tend to have an evasive attitude toward death while the clinical group will have either a positive or negative attitude toward death.

3. The distributions will be significantly different between the suicidal and normal portions of the sample in relation to their attitude toward death. The suicidal patients will have an evasive trend while the normal portion of the sample will have either a positive or negative attitude toward death.
4. There will be no significant difference in distribution between the clinical portion of the sample and the normal subjects in terms of their attitude toward death. That is, both groups will tend to respond either positively or negatively toward death rather than evasively.
CHAPTER BIBLIOGRAPHY


CHAPTER II

METHOD

Subjects

There was a total of eighty subjects in the investigation, and all the subjects used were volunteers. If the patient used in the study was under the care of a psychiatrist or psychologist, that subject's doctor or psychologist was consulted prior to administering the questionnaire. All the subjects belonged in one of three categories.

Category A consisted of twenty adult and adolescent subjects who had engaged in at least one suicidal attempt, either mild or severe, which did not result in death. The subjects were either patients hospitalized in a neuropsychiatric hospital or clients seen on an out-patient basis at a county guidance center in Oklahoma. All the subjects in the category were under the care of a psychiatrist or psychologist at the time of testing.

Category B contained twenty subjects who were also either hospitalized or out-patients at the above mentioned institutions. These subjects had no expressed suicidal tendencies or past suicidal attempts, but they were considered to have an emotional disturbance severe enough to warrant psychiatric treatment. The large majority of the subjects in categories A and B were hospitalized patients.
The subjects in category C consisted of forty adult college students in a summer class of an upper division or advanced university psychology class. From observation and information offered by the class instructor, these subjects could all be described as belonging to the normal adult population with no known emotional disturbance severe enough for psychiatric help and no known suicidal tendencies or past suicidal attempts.

All the subjects were grouped according to religious preference into four groups: protestant, episcopal, catholic, and none. The subjects were then classified under one of the above four categories, and a summary by percentages is presented in Table I.

<table>
<thead>
<tr>
<th>TABLE I</th>
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<tr>
<td>PERCENTAGES OF EIGHTY SUBJECTS CLASSIFIED ACCORDING TO RELIGIOUS PREFERENCE</td>
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<table>
<thead>
<tr>
<th>Category</th>
<th>Protestant</th>
<th>Catholic</th>
<th>Episcopal</th>
<th>None</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>65%</td>
<td>15%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>B</td>
<td>70%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>C</td>
<td>80%</td>
<td>10%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Each subject was also classified according to age, sex, and marital status. The age characteristic was broken
TABLE II

DISTRIBUTION BY PERCENTAGES OF ALL SUBJECTS ACCORDING TO AGE RANGE AND CLASSIFICATION

<table>
<thead>
<tr>
<th>Category</th>
<th>Adolescent 13-19</th>
<th>Young Adult 20-39</th>
<th>Middle Aged 40-59</th>
<th>Older 60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>20%</td>
<td>75%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>B</td>
<td>10%</td>
<td>65%</td>
<td>25%</td>
<td>0%</td>
</tr>
<tr>
<td>C</td>
<td>0%</td>
<td>75%</td>
<td>25%</td>
<td>0%</td>
</tr>
</tbody>
</table>

into four distinct categories and labeled adolescent, young adult, middle aged, and older. The result of this description may be found in Table II. All of the subjects tested were classified into two marital categories only, married or single. The data are placed in Table III.

TABLE III

SUMMARY OF PERCENTAGES OF THE SUBJECTS CLASSIFIED ACCORDING TO SEX AND MARITAL STATUS

<table>
<thead>
<tr>
<th>Category</th>
<th>Male</th>
<th>Female</th>
<th>Married</th>
<th>Single</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>30%</td>
<td>70%</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>B</td>
<td>30%</td>
<td>70%</td>
<td>85%</td>
<td>15%</td>
</tr>
<tr>
<td>C</td>
<td>38%</td>
<td>62%</td>
<td>68%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Categories A and B were also matched according to psychiatric diagnosis as closely as possible. The subjects were grouped in the following five broad classifications:
psychotic depression, character disorder, incipient schizophrenia, schizophrenia, neurotic reaction. A report of the matching is shown in Table IV.

**SUMMARY OF PERCENTAGES OF CATEGORIES A AND B CLASSIFIED ACCORDING TO PSYCHIATRIC DIAGNOSIS**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Category A</th>
<th>Category B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic Depression</td>
<td>15%</td>
<td>25%</td>
</tr>
<tr>
<td>Character Disorder</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>Neurotic Reaction</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>Incipient Schizophrenia</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Schizophrenic Reaction</td>
<td>25%</td>
<td>20%</td>
</tr>
</tbody>
</table>

In summation, the comparisons between the suicidal group or category A and the clinical group or category B were roughly comparable except for the attempt at suicide. The normal group or category C was roughly comparable to categories A and B except for emotional disturbances and an attempt at suicide.

To obtain the subjects listed in categories A, B, and C, as well as the cooperation needed for testing these
subjects, complete anonymity of the subjects had to be gaur-
anteed in several situations. This provision is complied
with throughout the three categories.

Description of the Instrument

The "Questionnaire Inventory of Past, Present, and
Future" (Appendix I) was especially developed for this study.
The questionnaire contains a total of one hundred twenty-
three items, of which forty are on attitudes toward death.
All of the phrases were designed to reflect a person's
attitude toward the events of the past, present, and the
future. It was expected that attitude toward death would
be associated with possible conflicts centered around sui-
cide. The forty items on death were regarded as crucial
to the present study; however, the remaining eighty-three
items were considered inconsequential to the results and
were not actually used as such in producing a quantitative
score. Therefore, only the forty items concerning death
were used in evaluating the subject's attitude toward death
or possible suicidal tendencies. All forty items concerning
death were revised from a list of attitudes toward death
assembled by Swenson (5) at the Mayo Clinic in 1961.
Swenson's items were obtained by asking subjects to write
essays describing their attitudes toward death, and then
having investigators select descriptive phrases pertaining
to death attitudes.
Originally the questionnaire contained only the forty phrases related to death. However, in reviewing the list of positive and negative attitudes toward death, the psychiatrist and psychologist at the neuropsychiatric hospital felt the questionnaire would produce a negative or depressive feeling among the patients used in the study. Although this belief did not seem to be substantiated in the available literature on the topic (1, 3, 4, 5), an attempt was made to add items to the original questionnaire which would tend to produce a more positive or neutral emotional tone during and after the questionnaire. The other eighty-three items not concerned with death were assimilated and constructed for this study. They included items concerning childhood, adolescence, sex, marriage, and religion.

Procedure

The following basic procedures were used in administering the "Questionnaire Inventory of Past, Present, and Future." Each subject was instructed individually in categories A and B. The subject was given a questionnaire face down and a sharpened pencil. The following instruction were then read to the subject.

On the back of each test put your age, sex, marital status and religious preference. This is a questionnaire of the past, present, and the future. There are several questions dealing with each main period. There are also several items concerning death and the afterlife. Do not be alarmed for
death in this questionnaire only represents another dimension of the future. Many people think of the future as being tomorrow, a year, or ten years from now. However, there is also a future that centers around death or the afterlife. Answer all questions and try to answer them honestly. You are now requested to read the instructions printed on each questionnaire. You may now turn your questionnaire over, read the instructions, and begin working. There is no time limit.

The following instructions were printed on the questionnaire.

We all think of the past, present, and future sometime or another. Below are a number of phrases that can be used to describe your attitudes and feelings as you think of the past, the present, and the future. Go through quickly and circle true (T) or false (F) before the phrase that describes your feelings about your life. You can be most helpful by being as frank and honest as possible.

For the group administration of the questionnaire to category C, the procedure was the same except that the instructions were given to the entire group. The subjects were spread out to the extent that they could not discuss their responses.

Design

The research design of the study consisted of comparing three groups by means of a psychological test questionnaire titled "Questionnaire Inventory of the Past, Present, and Future." The 123 items were arranged in an arbitrary manner in order to reduce the occurrence of items of attitudes toward death from clustering together and thus prevent negative
effects which the items on death might pose for the subjects.

The subjects were assigned to one of three categories. The first group was assigned to category A or the attempted suicide category. Attempted suicide was operationally defined as an attempt or gesture to consciously or unconsciously take one's own life in any manner and in any variety of ways that could result in death (3, 7, 8). No attempt was made to control the method or seriousness of the suicidal gesture.

The second group was designated as category B and consisted of emotionally disturbed patients. This category had no known or expressed suicidal tendencies or past suicidal attempts. However, they were severely disturbed enough to be either hospitalized in a neuropsychiatric hospital or to be under the care of a psychiatrist and/or psychologist on an out-patient basis.

The age groups mentioned earlier were arranged in four categories to indicate how closely the subjects were matched on this variable. Subjects thirteen to nineteen years were defined as "adolescent;" twenty to thirty-nine years of age was "young adult;" forty to fifty-nine years of age was "middle-aged;" and subjects sixty years or over made up the "older" group.

The attitudes toward death in the questionnaire were of two different categories, positive and negative. The
terms positive and negative assigned to the various items or attitudes toward death were assigned by Swenson (6) when he formulated his original list of attitudes toward death. Using Swenson as a guide, the attitudes were categorized as either positive or negative. That is, if a subject answered to an attitude designated as a positive item, then he received credit for answering positively to a positive attitude toward death, and he received one plus (+) credit toward the total score possible. The definition of positive was taken one step further than Swenson, however, and it was reasoned that if a negative attitude toward death was answered negatively (false), then that subject's attitude toward that particular negative item should be positive also and was scored plus (+). In essence then all positive items toward death answered "true" were given one plus (+) credit, and all negative items answered "false" were also given one plus (+) credit.

There was a total of twenty positive attitudes toward death and twenty negative attitudes toward death. Theoretically then, if a person answered all the positive attitudes positively (true) and all the negative attitudes negatively (false), then he could receive a total score of forty plus (+) credits. However, if the subject responded just the opposite as above he could receive a score of zero (0). In computing the subject's quantitative score, all the plus (+) responses were counted to get one total score. The scoring key can be found in Appendix II.
The response styles were assigned to three different categories. Category I consisted of a response style defined as "positive" in attitude toward death. Category II contained a response style defined as a "negative" attitude toward death. The last category or category III consisted of responses defined as "evasive" in attitude toward death.

The subject's response style was operationally defined as "positive" when his total positive responses fell between the scores of forty and twenty-six, "evasive" when his total score fell between twenty-five and sixteen, and "negative" when his score fell between the scores of fifteen and zero. These score ranges were arbitrarily set after administering the "Questionnaire Inventory of Past, Present, and Future" to category C, that group designated as normal.

The questionnaire was standardized on category C, and a split-half test of reliability was obtained. The results of this statistical evaluation are given and discussed at length in Chapter III.
CHAPTER BIBLIOGRAPHY


CHAPTER III

RESULTS

A reliability estimate was deemed important in this study since this was the first time the instrument, titled "Questionnaire Inventory of Past, Present, and Future," had ever been used in research. This instrument existed in only one form, and the labor involved in constructing an equivalent form would have made it virtually impracticable to do so simply for the sake of computing a reliability coefficient. However, it was felt that an approximation to its true reliability could be obtained by splitting the single questionnaire by chance into halves, assuming these halves to be equivalent to one another, and scoring each half separately for the individuals in the given group. The chance half was obtained by letting the odd items concerned about death constitute one half, and the even items the other.

The reliability test was run on the normal population as defined in Chapter II. The group was comprised of forty male and female subjects. The estimation of the reliability coefficient of the whole test was obtained by means of the Spearman Brown Prophecy Formula, which indicates the estimated reliability of the whole test. The corrected correlation coefficient was estimated to be 0.91. The coefficient was felt to indicate adequate reliability.
The data in this study were expressed in terms of classified frequencies. This means that in this research the data were recorded in terms of the number of subjects who fell into each of three categories. The question to be answered was whether the frequencies observed in the experimental samples deviated significantly from some theoretical or expected population frequencies. In all of the hypotheses it was attempted to determine whether the deviation of observed values from expected values could be attributed to sampling errors, or whether it would be concluded at a certain level of probability that a non-chance factor was operating.

A Chi Square goodness of fit test, using the 0.05 level of significance, was employed for hypothesis one. Yate's correction was employed where the expected frequency was less than ten.

The first specific hypothesis was that a greater proportion of the suicidal subjects would have an evasive rather than a positive or negative attitude toward death. The number and proportion of subjects classified according to attitude toward death are given in Table V. A considerably larger proportion of subjects in the suicidal group were found to be evasive in their attitude toward death. A Chi Square was also calculated for the suicidal group and a score above the critical value of 7.82 was required for
significance at the 0.05 level. The data employed in the computation are presented in the first row of Table V.

TABLE V

NUMBER AND PERCENTAGES OF SUBJECTS IN THREE CATEGORIES CLASSIFIED ACCORDING TO ATTITUDE TOWARD DEATH

<table>
<thead>
<tr>
<th>Categories</th>
<th>I (Positive)</th>
<th>II (Negative)</th>
<th>III (Evasive)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>A (Suicidal)</td>
<td>3</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>B (Clinical)</td>
<td>12</td>
<td>60</td>
<td>6</td>
</tr>
<tr>
<td>C (Normal)</td>
<td>9</td>
<td>22.5</td>
<td>10</td>
</tr>
</tbody>
</table>

For hypotheses two, three, and four a Chi Square test of independence of categorical variables was employed to determine if the frequency distributions of the various categories were significantly different from one another. In all the Chi Squares where the expected frequency was less than ten, Yate's correction was employed, involving diminishing the difference between the observed frequencies and the expected frequencies by 0.50. The 0.05 level was originally used to establish the significance of Chi Square. The Chi Square test was used to support or reject all the stated hypotheses.

Before a comparison between any of the groups could be made it was necessary to calculate the overall Chi Square
for the three subject groups. A Chi Square above the critical value of 9.49 was required for significance at the 0.05 level. These data are presented in Table VI.

TABLE VI
CHI SQUARE TEST FOR INDEPENDENCE OF CATEGORICAL VARIABLES

<table>
<thead>
<tr>
<th>Category</th>
<th>Critical Value</th>
<th>$X^2$</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>A, B, and C</td>
<td>9.49</td>
<td>22.08*</td>
<td>4</td>
</tr>
<tr>
<td>A and B</td>
<td>5.99</td>
<td>18.74*</td>
<td>2</td>
</tr>
<tr>
<td>A and C</td>
<td>5.99</td>
<td>26.02*</td>
<td>2</td>
</tr>
<tr>
<td>B and C</td>
<td>5.99</td>
<td>14.93*</td>
<td>2</td>
</tr>
<tr>
<td>A</td>
<td>7.82</td>
<td>23.19*</td>
<td>2</td>
</tr>
</tbody>
</table>

*Significant at .001 level.

The second specific hypothesis was that a significant difference in the frequency distributions of categories A and B would be found, and that the suicidal group, or category A, would tend to respond evasively toward death, and that the clinical group would tend to cluster around the positive or negative attitudes toward death. A Chi Square score of 5.99 was required for significance at the 0.05 level. The frequency data are presented in Table V.

A significant difference was found between the frequency distributions of categories A and B. Therefore, specific hypothesis two was supported and tended to be in the hypothesized direction mentioned above.
For specific hypothesis three it was hypothesized that a significant difference would exist between the frequency distributions of the suicidal and normal portions of the sample in terms of their attitude toward death. It was originally predicted that the suicidal group would tend to respond evasively while the normal group would respond either positively or negatively toward death. Although the frequency distributions differed significantly from each other, they were not in the predicted direction. The suicidal category responded as predicted, but the normal group did not. The majority of the normal group had an evasive attitude toward death, and the remaining subjects responded either positively or negatively toward death.

The specific hypothesis four stated that no significant difference in the frequency distributions between the clinical and normal portions of the sample would exist. That is, it was expected that both groups would respond either negatively or positively toward death and that few would obtain an evasive attitude. It was found that only the clinical group responded in the predicted direction. A Chi Square score below the critical value of 5.99 was required to accept hypothesis four. The frequency data are presented in Table V. A significant difference was found between the frequency distributions of categories B and C. Therefore, since the Chi Square was significant and the responses were not in the predicted direction, hypothesis four was not accepted.
CHAPTER BIBLIOGRAPHY


CHAPTER IV

DISCUSSION

✓ This study was not intended as a definitive investigation of attitudes toward death and attempted suicide, but only as a pilot study to explore the possibility set forth by Weisman (5) that differential death attitudes have clinical value. It was the thesis here that different attitudes toward death and dying may have different behavioral effects.

Before generalizing the findings widely, however, it is essential to remember that the response styles obtained may not be general phenomena. This was and must be considered only as a relatively small sample of clinical and suicidal patients under psychiatric treatment. Other sample groups may show different attitude patterns.

Despite these qualifications, it is possible to make some limited interpretations from these findings. The interlocking series of results presented in Chapter III indicates that a rather substantive degree of predictive ability has been demonstrated by the "Questionnaire Inventory of Past, Present, and Future," with a high degree of reliability. It is further felt that some progress toward achieving the goal of devising a relatively brief, easily administered, easily scored questionnaire, that could
possibly differentiate between patients with suicidal tendencies and clinical patients under psychiatric treatment, has been attained.

The theory upon which the research was originally founded was presented in hypothesis one, in which it was stated that a greater proportion of suicidal subjects would have an evasive rather than a positive or negative attitude toward death. The proportion of subjects in the suicidal classification with an evasive reaction was exceptionally larger than the other two attitudes; in fact, eighty-five per cent of that group were evasive. It is also interesting to note that of the three patients responding positively toward death rather than evasively, two were adolescent (fourteen and fifteen years of age). Thus, the Questionnaire may have been intellectually above their level, and they could not comprehend the items meaningfully. If only the adult patients in the suicidal group are used, it is found that more than ninety-four per cent of the subjects fall within the evasive category. Therefore, it can safely be interpreted that if a patient was contemplating suicide or had suicidal tendencies, then he was actively ambivalent concerning death. He was either consciously or unconsciously vacillating between the death impulses and the wish to live, and the vacillation could be detected by an evasive attitude toward death.
The statistical analysis of the suicidal group and clinical subjects indicate suicidal patients can be sensitively differentiated from the usual clinical patient under psychiatric care. It is further suggested that attitude toward death, by itself, may be potentially a powerful basis for prediction of future suicidal attempts.

In relation to hypothesis two, it was also noted that both the subjects in the clinical category who responded evasively toward death were diagnosed as psychotic depressive. A diagnosis of this type often leads one to suspect suicidal ideations. However, the other three remaining subjects in the clinical group classified as psychotic depressive did not fall within the evasive category. Therefore, three out of five patients classified as psychotic depressive were differentiated in terms of their attitude toward death. This finding raises many implications for the clinical psychologist who must deal with the suicidal patient, for it is very important that the psychologist know which patient in a therapy situation is suicidal. It is also a meaningful finding that the patients' attitudes toward death did not seem to vary within the same diagnostic category. That is, attitude toward death does not appear to be affected by psychiatric diagnosis. This finding is contrary to the findings presented by Wolfe (6), who stated that individuals with various personality types did seem to react differently toward death.
It is felt that the discrepancy in the findings was due to the criteria used for defining attitudes toward death.

Another one of the interesting findings that was not predicted in the original hypothesis is that none of the subjects in category A or the suicidal group obtained a negative attitude toward death. This is interpreted as meaning that those subjects who had attempted suicide looked upon death as a means of accomplishing some goal, or as a way to relieve their hardships.

In summary, the suicidal respondents appeared to be disposed toward the position of an evasive attitude toward death, whereas the clinical respondents were disposed toward the two opposite ends of the scale composed of positive and negative attitudes toward death.

In considering hypothesis three, it appears safe to say that normal persons do differ markedly from suicidal patients in relation to their attitude toward death. Although the results were significant, there was a noticeably large proportion of the normal sample who responded evasively toward death. In fact it was shown in Table V that more than fifty per cent of the normal subjects responded evasively. As stated in hypothesis three, it was originally predicted that the normal subjects would respond with either a positive or a negative attitude toward death. However, this evasiveness by normal subjects should perhaps have been expected, for the majority of people do not give much thought to death
throughout the major portion of their lives (4). Without awareness of being preoccupied with death, it would seem that a person's activities do draw attention to the existence of death. Activities such as avoiding a path through a cemetery, being held up due to a funeral procession, hearing of a friend's death, and not taking risks are signs that people do not like to think of death and give very little thought to it; thus, this is evasion (7). However, the evasiveness of the average person with no suicidal tendencies may actually be different from the evasion of a suicidal patient. In essence, a normal person is believed to be evasive about death by means of avoidance of the topic; whereas to the suicidal person, death is an active, personal, and persistent conflict in which thoughts of dying are ever present and conspicuous. He has thoughts of wanting to live and yet is too miserable to live, and wanting to die, yet he is too afraid of what death really holds for him (1).

In terms of prediction, it does not seem that one can safely detect possible suicidal tendencies when working with individuals outside of the clinical setting.

The data in Table VI lend support to the belief that an emotionally disturbed person's attitudes toward death are significantly different from those of the normal person with no serious emotional disturbance. The emotionally disturbed
person usually responded either positively or negatively toward death, with only a few patients responding evasively, whereas the majority of the normal group responded evasively toward death, and the remaining per cent of the normal subjects reacted either positively or negatively toward death. For a complete report of the direction of response between the clinical and normal group, refer to Table VI. These findings also agree with previous formulations and theories held by Feifel (2). He believed that clinical and normal persons did differ significantly in their attitude toward death.

Feifel (3) also found that twenty per cent of his sample of older persons had a negative attitude toward death, forty per cent had a positive attitude, and twenty per cent had an evasive attitude on the subject. In the normal group of this study, twenty-five per cent were negatively oriented toward death, twenty-two and one-half per cent were positive, and fifty-two and one-half per cent were evasive. These findings suggest that as the subject grows older he forms a more definite opinion toward death because he is forced to take the matter more seriously than the younger person.

There were obviously several limitations to the present findings. One of the major ones was that the sample of suicidal subjects were patients who had already attempted suicide, and they were not selected by the researcher as
suicidal prior to the actual suicidal attempt. However, all the suicidal patients tested did verbally confirm that they still wanted to die.

A second weakness in the above interpretations is that one does not know how much a person's attitude toward death may change after he has attempted to take his own life, in some cases nearly with success. It may be that by attempting suicide or making a suicidal gesture a person will for a short period satisfy his wish to die.

On the other hand the persons in the suicidal sample may have been evasive toward death because they came so close to death and could realize the consequences of death more realistically. That is, the suicidal subject may have been more evasive toward death due to his suicidal attempt or close call with death rather than any hypothesized theory of ambivalent conflicts concerning death.

In any case, the use of attitudes toward death may be potentially superior to any other method of differentiating subjects who have serious suicidal tendencies from a clinical population. This actually only seems reasonable if one realizes what suicide means. Suicide means death, and the implications of suicide to the patient are death. Therefore, it would only seem natural that suicide and death are directly related to each other, much more so than such variables as age, sex, and diagnosis. In summary it can be concluded that
differential death attitudes may have clinical value to the psychologist and/or psychiatrist.

It is also felt that there is a meaningful relationship between attitude toward death and suicide, and that this area of research holds many promises for broadening the psychologist's ability to predict suicide. He can thereby offer earlier support to those involved in suicidal conflicts before they become too ingrained in the person's being. Better instruments can be formulated and devised by clinicians to predict potential suicidal persons, and it is believed that attitude toward death offers a clue to this improvement in predictive instruments.
CHAPTER BIBLIOGRAPHY


CHAPTER V

SUMMARY AND CONCLUSIONS

The purpose of the present study was to investigate the relationship between attempted suicide and attitudinal responses concerning death. Two subsidiary purposes of this research were to compare the attitude toward death of the various subject groups and to demonstrate the use of the "Questionnaire Inventory of Past, Present, and Future" as an easily scored, quantitative method for determining attitude toward death.

Examination of the background material reveals somewhat contradictory results. This is felt to be due to a lack of objective criteria for judging attitude toward death. It was reported in several studies (1, 5, 6) that emotional difficulties did seem to be associated with attitudes toward death. The researchers stated that death concerns seemed to be expressed indirectly via somatic symptoms and withdrawal tendencies rather than by over anxiety. In some cases psychiatric symptoms may be the road taken by some persons to consciously deny concern about death. In contradiction to the above three studies, Piefel (2) found that the degree of mental disturbance exerted little effect on thoughts about death.
Two other researchers (3, 4) reported that emotional responses suggesting either preoccupation about death or fear of death were found more often among the spiritually oriented than among the temporally oriented. This finding was also unexpected due to the long-held belief that religion tended to lessen the anxiety regarding death. Although theology and philosophy have dealt with the problem of death and its meaning, and psychology has contributed much to the study of suicide, it was found that there were no specific studies in the literature concerning their relationship.

The subjects were divided into three groups. The suicidal group consisted of adult and adolescent patients admitted to a psychiatric hospital or out-patient guidance center as a result of an attempt at suicide. The clinical group was made up of emotionally disturbed patients who had no known suicidal attempts. The third group, designated as normal, consisted of students enrolled in an advanced psychology class in a Texas university.

The material for this study was a list of one hundred twenty-three phrases that reflected a person's attitude toward the past, present, and the future. However, only the forty items concerning death, specifically, were used to determine the subject's attitude toward death. The remaining items were used to offset any negative feelings that could result from thinking about death. The instrument used was titled
the "Questionnaire Inventory of Past, present, and Future."

All three of the groups mentioned above were matched as closely as possible on the following variables: age, sex, marital status, psychiatric diagnosis, and religion. There was no attempt to control the seriousness of the suicidal attempt.

Positive, negative, and evasive attitudes toward death were operationally defined. If a subject's total positive responses fell between the scores of forty and twenty-six he was considered to have a "positive" attitude toward death. An "evasive" score fell between twenty-five and sixteen, and a "negative" response was a score which fell between fifteen and zero. These scores were arbitrarily set after administering the test to a group designated as normal.

Data concerning the reliability of the "Questionnaire Inventory of Past, Present, and Future" were collected by means of the Spearman Brown Prophecy Formula for split half statistical technique. The reliability was found to be 0.91. A Chi Square formula was first computed for all three groups combined in order to obtain an overall Chi Square. A Chi Square was then computed for all possible pairs of groups, and one Chi Square was run between the response categories in the suicidal subject group. The 0.05 statistical level of significance was adopted.
Four specific hypotheses were presented. Hypothesis one stated that if an individual is contemplating suicide, then he is vacillating between the death impulse and the wish to live, and this may be detected by an avasive attitude toward death. A total of eighty-five per cent of the suicidal group were evasive toward death, which was significantly more than fell in the other categories.

Hypothesis two stated that a significant difference in the frequency distributions of categories A and B would be found, and that the suicidal group would tend to respond evasively toward death while the clinical group would tend to respond either positively or negatively. A significant difference was found, and the subjects responded in the above predicted pattern.

It was predicted in hypothesis three that there would be a significant difference between the suicidal and normal portions of the sample in relation to their attitude toward death. It was further felt that the majority of the suicidal group would have an evasive attitude toward death while the normal group would respond either positively or negatively. Although a significant difference between the response styles of the above groups did exist, the predicted direction did not hold true. A majority of the normal group responded evasively.

Hypothesis four stated that there would be no significant difference between the clinical and normal subjects in
terms of their attitude toward death, and that both groups would tend to respond either positively or negatively with few responding evasively. A significant difference was found between the frequency distributions of the two groups, and the normal group did not respond in the predicted direction.

It was concluded that predicting, with a reasonably adequate degree of accuracy, the direction of attitude response in relation to death was possible when the subjects were classified into the operationally defined groups termed clinical and suicidal. It was further suggested that attitudes toward death might be helpful in predicting future attempts at suicide, especially in terms of hospitalized, adult mental patients, and that differential death attitudes have clinical value to the psychologist and the psychiatrist.

Implications for future research are numerous. The adolescents in the sample who had attempted suicide did not tend to respond toward death in the same manner as the adult suicidal subjects. Additional research in this aspect of the problem should prove to be interesting. It is further suggested that future researchers attempt to study the suicidal patient's attitude toward death and attempt to control the seriousness of the suicidal attempt. It is felt that seriousness of the suicidal attempt will effect attitude toward death.
CHAPTER BIBLIOGRAPHY


BIBLIOGRAPHY

Books


Articles


Fiefel, Herman, "Older Persons Look at Death," Geriatrics, XI (February, 1956), 127-130.


Masserman, Jules, "Emotional Reactions to Death and Suicide," American Practitioner and Digest of Treatment, V (November, 1934), 41-46.


Shrut, Samuel D., "Attitudes Toward Death and Old Age," Mental Hygiene, XLII (April, 1958), 259-266.


Encyclopedia Articles

APPENDIX I

QUESTIONNAIRE INVENTORY OF PAST,
PRESENT, AND FUTURE

We all think about the past, present, and the future sometime or other. Below are a number of words or phrases that can be used to describe your attitudes or feelings as you think of the past, the present, and the future. Go through quickly and circle true (T) or false (F) before the phrase that describes your feelings about life. You can be most helpful by being as frank and honest as possible.

1. As a child I enjoyed science. T
2. I presently feel that most people are sincere. F
3. Life as a whole has been good to me. F
4. My hardest battle will be departing from life. T
5. I used to ask people for advice frequently. T
6. I find sex enjoyable. F
7. Death is something to be feared. F
8. Throughout my life people have treated me courteously. T
9. Today life is full of love and enjoyment. F
10. Life is too important to think about death. T
11. In these times an honest man is a happy man. F
12. As a child I remember being happy. T
13. I often change my mind about the afterlife. F
14. I think my life will be even happier in the future. F
15. Life will be happy no matter what happens in the future. T
16. Passing away will be peaceful bliss. T
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>17.</td>
<td>Right now I am chiefly interested in money.</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Eternal life will be happiness.</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>I like to make most of the family decisions now.</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>In the past I lived far beyond my means.</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Surrendering one's life will no doubt be a grim experience.</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>I like to spend too much money for pleasure these days.</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>I used to do many foolish things.</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>Lifelessness is very difficult to accept.</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Now that I'm an adult I can use my own judgement.</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>I won friends easily in the past.</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>Death is the end of everything.</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Earlier in life I was afraid of responsibility, especially marriage.</td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>I look forward to the ultimate end.</td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>I am too careful about my manner of dress these days.</td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>In the future I hope that the opposite sex is still attracted to me.</td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>The only thing I fear about eternity is that I will have to leave my loved ones.</td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>In this day and time one must have strong beliefs.</td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>I have always loved to dance and have fun.</td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>Only through cessation will we be delivered from all this difficulty.</td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>I think I loved my mother most when I was a child.</td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>In the past funny jokes used to be of a sexual content.</td>
<td></td>
</tr>
<tr>
<td>38.</td>
<td>Heaven and death offer a promise of a better life.</td>
<td></td>
</tr>
</tbody>
</table>
39. We face death every day.

40. Since I can remember I have always had enough money.

41. You have to have pull to get places these days.

42. When I perish I will be a better human being.

43. I am happy most of the time now.

44. Right now I think life treats us about as fair as we deserve to be treated.

45. One good thing about being extinct is that all your troubles will be over.

46. Now that I have more money I don't feel left out of things.

47. I once thought that marriage would solve most of my problems.

48. As I grow older I can show my real feelings more.

49. When I imagine myself being lifeless, terror overcomes me.

50. When the time comes, death will be easy.

51. I am ahead in life today because I tried hard.

52. I was always happy because I was the only child.

53. I have a very high opinion of religion.

54. I become nervous at the thought of no longer living.

55. My future has always been bright.

56. I love to dream of the future.

57. I dread the thought of being numbered with the deceased.

58. I think I can better myself in the future.

59. I hope I don't have to die soon.

60. These days it is easy to spend much of your time at parties and with friends.
61. I don't like to think about my last days on earth.
62. No matter how old I get in the future I will still like pretty women (or men).
63. Right now I feel very happy.
64. I love to think about death.
65. I didn't in the past, but now I know what life is all about.
66. Going to a new life will be wonderful.
67. As an adolescent I drank a great deal of milk.
68. I am sure that I will always be married.
69. Sometime in the near future I will marry.
70. Life will always go on as always.
71. I get the blues thinking of death.
72. Most of the time I am happy.
73. Spring has always made me feel good.
74. Leaving this life will be a beautiful experience.
75. In the future people will be happier.
76. I'm the type who will not need much care when I get older.
77. Passing away disturbs me.
78. Death will be a beautiful experience.
79. I want to have many children when I am married.
80. I used to be very overweight.
81. It is easy to make my wife (husband) happy.
82. I do more with my husband (wife) than I used to.
83. I fear the end of life.
84. I feel that it is important to have a happy outlook on the future.
T F 85. It is easy now to make a marriage work.
T F 86. Only through dying can I have a glorioustly peaceful and happy life.
T F 87. I think my marriage has been a happy one.
T F 88. My wife (husband) used to have habits that disturbed me.
T F 89. My husband (wife) never disturbs me when I try to sleep.
T F 90. I don't dwell on death at my age.
T F 91. I remember my father as strong and masculine.
T F 92. I have been able to learn from my experiences.
F 93. I can be content dreaming about death.
T F 94. I have always been a good worker.
T F 95. I care for my children now more than I used to.
T F 96. I am more of a companion to my mate than a lover.
T F 97. Unfortunately, loss of life means sadness.
T F 98. I have always and will always earn the living of the family.
T F 99. These days a man should help his wife around the house.
T F 100. I never want to be on my deathbed.
T F 101. I think that one should represent his or her family in the community, especially today.
F 102. My hardest battles are facing the ultimate end of life.
T F 103. I never have lost my temper and never will.
T F 104. I tried to support too many people in the past.
T F 105. I used to like to make fun of other people.
T F 106. I think of hell's torment when I think of dying.
T 107. All my life, even as an adolescent, my sex life was clean and fun.

T F 108. I can't understand why people can't be happy with all the conveniences we have these days.

T F 109. I believe life is better after death.

T F 110. Carnivals were fun for me as a child.

T F 111. School was easy for me.

T F 112. School was hard for me.

T 113. I have periods of such great restlessness that that I wish I weren't alive.

T F 114. Life, now, is full of excitement.

T F 115. In this day and time, religion is a great comfort.

T 116. In death we will be atoned for our sins.

T F 117. All my teachers in the past were funny.

T F 118. I can easily remember the good times I had when I was very young.

T 119. I can't stand to think about leaving this life like others can.

T F 120. I eat breakfast very seldom anymore.

T F 121. I have always been able to laugh at my troubles.

T F 122. I don't like to make excuses for my faults or failures because I am now an adult.

T F 123. Life is good to me now and always has been good to me.
APPENDIX II

SCORING KEY FOR THE "QUESTIONNAIRE INVENTORY OF PAST, PRESENT, AND FUTURE"

Positive Death Attitudes:

Note: Score one plus (+) point for each item listed below answered true (T).

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Negative Death Attitudes:

Note: Score one plus (+) point for each item listed below answered false (F).

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