RELIGIOUS ORIENTATION, DEATH ANXIETY, LOCUS OF CONTROL AND BELIEF IN PUNISHMENT AFTER DEATH

DISSERTATION

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Evidence is cited in this paper which suggests religion is gaining in influence on American life. Although interest in religiosity is increasing, mental health research into the area is meager. As psychological researchers grow cognizant of the impact of social systems on the individual, it becomes important to examine the impact of religion and religious belief on the emotional health of the individual. The literature also suggests that attitudes toward death and the individual's perception of power/helplessness, which are elements closely associated with religious belief, are also important factors in determining one's state of psychological well-being. This study is an attempt to look more closely at the role of religion, attitudes toward death, and perception of power/helplessness in a psychiatric population as compared to a nonpsychiatric population.

The major variable under consideration, religious orientation, was measured with the Intrinsic-Extrinsic Religious Orientation Inventory which measures the nature of one's involvement with religion. The individual with an intrinsic orientation toward religion is believed to exhibit
a healthier adjustment than the individual with an extrinsic orientation toward religion. It was hypothesized that healthier religious adjustment would be related to lower death anxiety, as measured by the Death Anxiety Scale, and lower locus of control scores, as measured by the Internal-External Locus of Control Scale. Further, it was assumed that whether or not one's religious belief system includes a belief in punishment after death would exert some influence on death anxiety.

The information obtained in this study suggests that the most important factor of concern to psychiatric patients in the area of religious orientation and death anxiety is belief in punishment after death and its relationship to locus of control. Death anxiety was greatest in psychiatric patients who believed in punishment after death. Overall subjects who believed in punishment after death tended to exhibit higher external locus of control scores. Implications of these findings are discussed.
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The resurgence of interest in religion in this country over the past ten years has been commented on in both popular and academic journals. On April 11, 1977, a U.S. News and World Report cover story bore the title "A Time of Renewal for U.S. Churches." The article reported statistics showing that the percentage of the nation's adult population which attended worship services during a typical week had steadily dropped from 49 percent in 1958 to 40 percent in 1972. During those 14 years, attendance had dropped at least one percent for every two year period. The decline was reported across the board among Protestants, Catholics, and Jews—the three major religious groups in this country. A summary article by Gallup (1977, as quoted in U.S. News and World Report) asserted the existence of mounting evidence that the U.S. was in the early stages of a profound religious revival. Having documented a steady decline in church attendance over the preceding 15 year period, Gallup noted an increase of two percent in the year 1976.

As further evidence of the increasing influence of religion, Gallup cited an increase from 14 percent in 1970 to 44 percent in 1976 of Americans who told the Gallup Poll that they believed religion was "increasing its influence on
American life" (p. 50). During the same time frame, a concern for the impact of religion on the individual can be noted in the psychological literature (e.g., Argyle & Beit-Hallahmi, 1975; Beit-Hallahmi & Argyle, 1977; Lovinger, 1979; Bergin, 1980; Ellis, 1980; Shaver, Lenauer, & Sadd, 1980; and Walls, 1980).

Despite growing interest in the concept, religiosity, it is noteworthy that mental health research into the variable is meager. Psychological researchers are becoming aware of the impact various social systems exert upon the individual. Families, schools, the judicial system, crowded cities, even organized sports have been targeted as social influences which affect our emotional health. The role religion plays in emotional health has been examined much less often than the other major components of our social structure.

With evidence that religion is gaining influence on American life, it is assumed that this influence spans the range of emotionally healthy and unhealthy individuals. If mental health professionals are to consider important social influences impacting on their clients, religious belief and its role in the lives of emotionally healthy and unhealthy individuals must be looked at more closely.

Shaver, Lenauer, and Sadd (1980) proposed two explanations for the renewed American interest in religious experience. The authors cited Berger's (1979) arguments that modern
society has greatly increased the range of life choices available to the average person. It was Berger's contention that expanded life choices are salient for religious belief systems. These belief systems increasingly become vulnerable to conflict, uncertainty, and doubt with the advent of increased choices. Shaver, Lenauer, and Sadd believed that increasing numbers of Americans are looking to firsthand religious experiences as a means to quell the conflict and doubt.

The second explanation offered by the authors for the rising interest in religion refers to William James' (1902) analysis of "healthy-minded" religion. According to James, healthy-minded religion is religion that emphasizes benefits to mental and physical health which can be derived from religious experience and belief. It was his contention that a lack of firm beliefs is associated with conflict and indecisiveness, which are incompatible with healthy-mindedness. Shaver, Lenauer, and Sadd contend that the ensuing cognitive dissonance instills a need for religious experience. Based on James' theory, these authors hypothesized that confidence and consistency of belief would be associated with health, happiness, and an absence of tension and conflict. Utilizing a sample of 2,500 women, they were able to confirm their hypothesis. "The slightly religious respondents were less happy than either the very religious or the antireligious ones" (p. 1567). Among those women who reported themselves as religious, greater religiosity was associated with greater self-reported health and happiness.
Is there such a thing as "healthy" religion? It is a question for which a quick and simple answer is not likely to be found, if for no other reason than the emotionally laden and experiential nature of the question. In defense of religion, Arlow (1961) has suggested that the richness of religious myth and ritual is important as communal experiences which support the ego in its struggle with id impulses and reality. It was his contention that religion provides an opportunity for identification with the central figures, thus bolstering social adaptation in much the same way that identification with parental figures bolsters the internalization of societal norms. Saffady (1976) contended that the accepted psychoanalytic view has typically been that religion represents a neurotic attempt to avoid frightening reality. Kaplan (1963, as cited in Saffady) has argued that neuroticism is no more prevalent in religion than in politics, art, or love. However, he made the distinction between infantile religion and mature religion. In his view, infantile religion insists on submission to authority as a condition of salvation, while mature religion emphasizes responsibility rather than dependency, anxiety and guilt.

Similar differentiations between religious belief systems have been made by other authors. Fromm (1960) distinguished between authoritarian and humanistic religions. He described authoritarian religions as involving the omnipotence of the
deity and the insignificance of the person, the use of ends (i.e., promise of life after death) to control the lives of people, and obedience as a virtue, and disobedience as a cardinal sin. In contrast, he saw humanistic religions as those which involve God as a symbol of the person's powers, self-actualization rather than the power of God, and worship out of love rather than fear.

Allen and Spilka (1967) suggested that the nature of personal religion could be structured into the dichotomy of committed versus consensual religion. They saw the differences in outlooks as differences in cognitive style. Committed religion was described as cognitively open, abstract, flexible and complex; while consensual religion was seen as closed, restrictive, rigid, detached, and concrete.

Allport and Ross (1967) devised the concept of intrinsic ends-oriented and extrinsic means-oriented religiousness. They described intrinsic orientation as an involvement centered on meaning and direction to one's life being provided by religion. Extrinsic orientation involves a focus on security, status, and the sociability of religious participation. These authors felt that mental health is facilitated by an intrinsic orientation but not by an extrinsic one.

The relationship between religiosity (or the absence of it) and the presence (or absence) of emotional maladjustment has been investigated by researchers with both "normal" and "psychiatric" populations. Wilson and Miller (1968) measured
anxiety, fear, and religiousness in 100 undergraduate students and found religiousness to correlate with both anxiety and fearfulness. The authors concluded that nonreligious persons tended to give "healthier" answers than religious persons. Cowen (1954) and Strunk (1958) reported negative correlations between "orthodox religiosity" and self-esteem scores.

Religious individuals also have been characterized as more suspicious and dependent in interpersonal relationships than nonreligious individuals (Broen, 1957; Dreger, 1952).

Among psychiatric populations, the presence of religious ideas and religious claims has been well documented. Farr and Howe (1932) examined 500 consecutive cases and found 13.5 percent to involve religious content. Sixty-four percent of those with religious symptoms were diagnosed manic or depressive. Oates (1949) reported that virtually half of his psychiatric cases presented with religious concerns and conflicts. He further reported that over 20 percent of his caseload involved religious content in psychotic ideation. Lowe (1955) concluded that the content of psychotic delusions tended to be taken from the dogmas of religions. Mailloux and Ancona (1960) reported finding religious content in patients diagnosed obsessive-compulsive, phobic, depressed, and paranoid. Gallenmore, Wilson and Roads (1969, as cited in Beit-Hallahmi and Argyle, 1977) found that 52 percent of their manic-depressive patients reported "conversion" or "salvation" experiences. The Group for the Advancement of
Psychiatry (1968, as cited in Beit-Hallahmi and Argyle, 1977) contended that religion was more likely to play a role in depression and schizophrenia than in other diagnostic categories. Boisen, Jenkins, and Lorr (1954) performed a factor analysis on the ideas expressed by 47 acute schizophrenics. The analysis demonstrated two factors: 1) the factor of seeking solution to inner conflict through religious surrender and 2) the factor of seeking solution to inner conflict through paranoid projection. The researchers proposed that the two factors are related to two solutions for inner conflict represented in the religious tradition: 1) surrendering to the will of God and 2) blaming the devil.

Bergin (1980) conceded that distortions of religion often are traceable to distortions of reality, but added an interesting qualifier:

Religion operates at several different levels. It has social system or social structure aspects that are basically sociological; it influences specific forms of small-scale interaction, such as child-rearing practices in families; it operates in the cognitive domain to provide interpretive schemas for life experience and values as regulators of conduct; and it provides unusual emotional experiences of ecstasy, oneness, insight, and conviction. This multiform phenomenon can therefore go awry in a variety of ways and places. Human history,
including contemporary life, is replete with instances of reality that have been perpetrated in the name of religion. The disgust and aversion some professionals express when religious issues are raised are therefore quite understandable. I empathize with them, but their interpretations are based on a lack of differentiation between benevolent and harmful "religious" events, just as therapy researchers for so long failed to differentiate valid from invalid interventions and thus obscured the evaluation of therapeutic outcomes (p. 643).

Bergin made the indisputable point that religion is often an influential and inseparable part of the socialization process. For mental health professionals to ignore and avoid religious issues with clients because of lack of understanding of religious concepts would be comparable to avoiding a client's history of child abuse because of a lack of understanding of abuse. Nevertheless, religious concepts and issues have been avoided with clients, just as these concepts have been avoided in research and in training.

Lovinger (1979) delineates three problem areas often encountered in therapy with people of strong religious orientation. The first problem area involves factors personal to the therapist such as therapist's attitudes toward religion, therapist's reluctance to intervene in religious matters, and
therapist's simplistic views of religions. The second problem area involves specific lacks in the therapist's knowledge. This includes a general lack of knowledge about religion and a more specific lack of knowledge about the role of religion in the individual patient's life. The third problem area outlined by Lovinger is lack of specific therapeutic strategies to meet "religious" resistances.

Lovinger (1979) addressed therapeutic antipathy toward religion by suggesting that "the failure to take cognizance of any significant aspects of a patient's life is very likely to significantly restrict what therapy has to offer" (p. 419). He contended that a patient's religious attitudes should be met with an attempt to understand their meanings to the patient. Through this understanding, the therapist can find nondestructive ways of loosening resistances and helping the patient resolve those problems which interfere with effective functioning. Lovinger cautioned that incorporating the patient's religious values into therapy might require an attempt to overcome severe informational deficiencies about religion on the part of the therapist. It should be added that it may require an attempt to distinguish between healthy and unhealthy religious attitudes.

Rationale for Study

In view of the momentous role assumed by religion in the socialization (and, sometimes, the pathological development) of mental health clients, the present study is an attempt to
augment the insufficient knowledge and understanding of religiosity and religious belief within a psychopathological population. One of the responsibilities of mental health professionals is to attempt to understand the important social influences impacting on their clients. Evidence cited here suggests religion is gaining in influence on American life. The literature also suggests that attitudes toward death and the individual's perception of power/helplessness, which are elements closely associated with religious belief, are also important factors in determining one's state of psychological well being. This study is an attempt to look more closely at the role of religion, attitudes toward death, and perception of power/helplessness in a psychiatric population as compared to a non-psychiatric population. Since the relationships under investigation have been little studied, this research is exploratory in nature rather than an attempt to confirm or expand existing theories.

A variable which is closely associated with religious belief is death and one's attitude toward it. In fact, it has been argued that death created religion. Becker (1973, as cited in Minton & Spilka, 1976) asserted that "Religion solves the problem of death" (p. 204). Weisman (1972, as cited in Minton & Spilka, 1976) further claimed that "Religion recognizes man's yearning for survival and depends upon man's inability to imagine anything else" (p. 101). Feifel and Nagy (1981) have suggested that most human behavior of any
consequence is in response to the problem of death. Leming (1979) has discussed this issue at length from a sociological perspective.

According to Leming, the discussion has been dominated by the theories of Malinowski (1965), Radcliffe-Brown (1965), and Homans (1965). It was Malinowski's contention that religion functions to relieve the anxiety caused by life's crises and that "death, which of all human events is the most upsetting and disorganizing to man's calculations, is perhaps the main source of religious belief" (p. 71). Radcliffe-Brown disagreed with Malinowski's contention that religion is an anxiety reliever and instead suggested that had it not been for religion, we would not have anxiety concerning death. It was his allegation that religion gave humankind fears and anxieties from which they would have been free, i.e., fear of spirits, God, the devil, hell. (It should be noted that Radcliffe-Brown fails to take into account those religions which do not advocate an afterlife or punishment, thus alleviating the introduction of such fears.) Homans declared that both theorizers were correct—that religion because of its emphasis on immortality and a coming judgement, increases death anxiety. However, once the religious individual has fulfilled the ceremonies required by that religion, he/she will experience a decrease in anxiety. Leming examined Homans' theory and discovered a curvilinear relationship between religiosity and death anxiety. He concluded that
the nonreligiously committed individual need not fear an afterlife or divine judgement but only the disruptive effects of death upon his social life. The moderate religionist fears both the afterlife as well as the secular crisis which death presents. Finally, the highly religious individual redefines the secular loss created by death as religious victory and looks forward to his rewards in the afterlife (p. 356).

It was Leming's final contention that religion serves the dual function "of afflicting the comforted and comforting the afflicted" (p. 358).

The concept of religion as a fear-inducer is validated in part by the presentation of 22 cases by Bromberg and Schilder (1936) in which severe death anxiety was linked to fear of punishment. The cases presented included patients diagnosed as anxious, obsessive, hysterical, depressed, schizophrenic, and epileptic. In each case recurring thoughts of death and dying were part of the symptom picture. In each example the authors linked recurring thoughts of death to specific fears of punishment in the individual.

Kastenbaum and Aisenberg (1972) note that fear of punishment is embodied in one of the three distinguishable death fears named by Philosopher Jacques Choron (1964). The three types of death fears included (a) what comes after death,
(b) the "event" of dying, and (c) "ceasing to be." The authors asserted:

Fears of what may happen after death often embody the threat of punishment. We will be made to pay for our personal sins and transgressions—perhaps even for the very fact that we are members of such a notorious species (p. 46).

It can be assumed that death anxiety is at least partially a function of whether or not an individual believes in punishment after death.

The role of death fears in psychopathology has been commented on by several investigators (Boisen, Jenkings, & Lorr, 1954; Feifel & Nagy, 1981; Minear & Brush, 1980). Rhudick and Dibner (1961, as cited in Apfeldorf, 1975) reported a positive relationship between death anxiety and neuroticism and depression. Minear and Brush (1980) examined the relationship between death anxiety, religiosity, and suicide potential. They contended that individuals with weak or nonexistent religious ties have the most potential for self-destructive behaviors. Feifel and Nagy (1980) investigated men who had been indulging in life-threatening behaviors. They found that those persons with a high degree of death anxiety (a) perceived death in more negative terms, (b) were more frequently preoccupied with thoughts about death, (c) reported an increase in personal fear of death as they advanced in years, and (d) were less religious (as measured by both
church attendance and reported beliefs) than those with low death anxiety.

Suggestions that death fears play an important role in psychological well-being are not new. Becker (1973) comments on the role of death fears in Freud's theory of the instincts. He asserts that Freud's original theory that repression was the result of man's instinct for pleasure and sexuality was wrong. It is Becker's contention that "consciousness of death is the primary repression, not sexuality" (p. 96). He further asserts that the most important idea to emerge in Freud's later writings was the "death instinct" which he theorizes:

was a device that enabled him to keep intact the earlier instinct theory, now by attributing human evil to a deeper organic substratum than merely ego conflict with sexuality. He now held that there was a built-in urge toward death as well as toward life; and thereby he could explain violent human aggression, hate, and evil in a new--yet still biological--way: Human aggressiveness comes about through a fusion of the life instinct and the death instinct. The death instinct represents the organism's desire to die, but the organism can save itself from its own impulsion toward death by redirecting it outward (p. 98).

It is Becker's view that Freud's theory of the "death instinct" circumvented the issue of death fears as a primary human
problem. He asserts that psychoanalytic literature continued to ignore fear of death until World War II.

Kastenbaum and Aisenberg (1972) point out our increasing awareness that thoughts, feelings, and behavior may be relevant to when and how we die. Yet the authors assert that "The rapid growth of the mental health movement in the United States was not accompanied by a parallel increase in attention to death and related topics" (p. 230). The authors accuse the mental health profession of scanty training and inadequate knowledge in the area of death. They recommend a stimulus-response approach to the study of death. The S-R approach assumes an association between "death" (the stimulus) and "fear" (the response).

Kastenbaum and Aisenberg also thought it helpful to make a distinction between fear, "the object of which can be located and described," and anxiety, "which encompasses a vague apprehension of impending disaster." Templer's Death Anxiety Scale (Templer, 1970), the instrument utilized in this exploration to assess levels of death anxiety, incorporates both items which fit the criteria for fear and items which fit the criteria for anxiety. "The sight of a dead body is horrifying to me" is an example of an easily identifiable and describable object of fear; while, "I am often distressed by the way time flies so very rapidly" is indicative of a vague apprehension of the end of time (or life).
Kastenbaum and Aisenberg proposed several reasons for the surge of interest in death related topics in the mental health field. Among these reasons are: (a) the growing influence of mass media which makes it difficult to isolate ourselves from violent death, (b) the prospect of massive annihilation through nuclear war, and (c) the increasing awareness of lethal components to our lives, i.e., pollution, drugs, alcohol, crime, and auto deaths. Certainly it is a rare mental health practitioner who has not encountered the frustrated client who throws up his hands in exclamation of "What's the use? We'll all die from the bomb or pollution anyway!" It is not at all unusual for the subsequent sequence of questions regarding the meaning of life to lead the client into an exploration of his views of religiosity.

Religiosity is defined here as the state of being religious and does not imply or incorporate any value regarding excessive religiousness. For purposes of this study, the major variable under consideration, religious orientation, was assessed with the Religious Orientation Inventory (Peagin, 1964; Allport & Ross, 1967; Robinson & Shaver, 1973). Allport (1957, 1965, 1968, as cited in McClain, 1978) has argued that the varying depth and breadth of religious sentiment renders its study as a unitary component much too vague and broad to be useful. It is his belief that the critical issue for study is the nature of one's involvement with religion. McClain (1978) stated that by focusing on the extrinsic-intrinsic continuum, Allport assumed:
that the extrinsic orientation characterizes the immature person who tends to use religion instrumentally, while intrinsic orientation is found in the more mature person, the one committed to religious values as ultimates. Persons who are religious out of extrinsic motivations may find their religion useful in a variety of ways, e.g. to provide security and comfort, sociability and distraction, or status and justification. These people may take their creeds lightly or else shape them to fit other needs. In contrast, those who are intrinsically motivated find their central motive in religion. However strong their other needs may be, they are perceived as having less significance than their need to live in faithfulness to their religious commitment. They seek to live their religion in that they endeavor to internalize religious values and to follow them fully. Allport believed that this kind of religious involvement serves as a uniter of personality, thus contributing to the well-being of the person (p. 159).

McClain cited several studies (Allport & Ross, 1967; Brannan, 1970; Feagin, 1964; Photiadis & Biggar, 1962; and Rice, 1971) which have found extrinsic orientation to be associated with the same negative characteristics found in
studies utilizing unitary measures of orthodoxy of beliefs. The studies also maintained the existence of an association between intrinsic orientation and so-called "healthy" personal characteristics.

The major benefit to be gained through the use of the Religious Orientation Inventory lies in its categorization system. Rather than classifying the individuals as either religious or nonreligious, it is possible to assign them to one of four classifications: intrinsically religious, extrinsically religious, indiscriminately proreligious, or nonreligious. The indiscriminately proreligious category includes those people who appear to contradict themselves by expressing blanket support for all religious statements. The categories are not discrete but representative of tendencies toward the different orientations. Allport saw intrinsically religious individuals as healthier and more well-integrated in their beliefs than either the extrinsically religious or the indiscriminately proreligious individuals. In terms of Leming's theory of the curvilinear relationship between religiosity and death anxiety, Allport's intrinsically religious individuals should exhibit less death anxiety than the extrinsically religious or indiscriminately proreligious individuals.

One area which seems relevant to any investigation of religious orientation and death anxiety is the role played by feelings of powerlessness. Seligman and Maier (1967) presented evidence that the belief that what one does will not
affect the course of negative events can result in lack of persistence toward a goal. Learned helplessness, as defined by Seligman and Maier, is the perception of independence between an individual's responses and the occurrence of aversive outcomes. There is reason to believe that death anxiety is a reflection of a fundamental sense of powerlessness/helplessness or the inability to control one's environment. It would seem at face value that all people recognize within themselves the inability to control their own deaths, except in the case of suicide. Yet, it is only in very rare instances that an individual gives up the struggle to avoid that most aversive of all outcomes, death.

Projector (1968, as cited by Kastenbaum and Aisenberg) argues that the American obsession with occurrence of accidental death serves to repress awareness of an inability to control one's own death. He believes people repress consciousness of mortality by concentrating on those who die in "unlucky" accidents and avoidable situations. Kastenbaum and Aisenberg suggest that the tendency to regard death as an external threat (rather than an indwelling threat) may be related to personality structure. They cite as an example the individual who characteristically projects anxieties and tensions upon the environment. Such an individual may perceive death as something "out there" to be anticipated vigilantly. The authors refer to the locus of death as either "out there" waiting on highways and other hazardous places or "inside me" in the form of genetic predispositions to disease and suicidal impulses.
The locus of death is closely related to Rotter's (1966) concept of internal-external locus of control. According to Rotter a belief in external control reflects a general orientation toward explaining events as the result of luck or the control of powerful others. Incorporating Kastenbaum and Aisenberg's arguments then it becomes feasible to speculate that an individual high in belief in external control projects his death anxieties outward and vigilantly looks around for death "out there" in the environment. In contrast to an external locus of control, a belief in internal control reflects a general orientation toward explaining events as the result of one's own behavior or characteristics. Such an individual might locate death inside, thus perceiving it as a somewhat more controllable phenomenon. Certainly such an individual can control suicidal impulses and can presumably even ward off genetic predispositions to disease through proper health and nutrition.

The literature suggests that the powerlessness an individual experiences may be an important mediating factor in terms of the anxiety with which he/she faces death. Menton and Spilka (1967) investigated the relationship between various religious orientations and perspectives on death. They reported that those people with closed, restrictive, rigid, detached, and concrete religious orientations had negative outlooks on death and saw it as the ultimate in frustration and helplessness. Steward (1975) found that individuals who were active
participants in religious activities and perceived themselves as high in internal control were less fearful of death than those low in beliefs of internal control. Taylor and Reznikoff (1967) reported finding significantly greater death anxiety among subjects with strong beliefs in an external locus of control than among those with strong beliefs in an internal locus of control. Returning to the assumption that death anxiety is partially a function of the individual's belief in punishment after death, it is likely that an individual with a belief in punishment after death will experience less death anxiety if he/she exhibits a belief in an internal locus of control. Such an individual would likely believe that his/her own behavior will determine whether he/she will be punished, thus allowing him/her ultimate control over that outcome. Inherent in the foregoing assumptions is the concept of responsibility taking.

One of the goals of psychotherapy has traditionally been the promotion of individual acceptance of responsibility. In fact many therapists link the goal of responsibility taking more specifically to the transformation from an external locus of control to an internal locus of control, which is seen as related to psychological well-being. Investigators have often demonstrated a relationship between internal-external control and psychological adjustment. Hersch and Scheibe (1967) reported that internally-oriented subjects were more likely to describe themselves as powerful, independent, and effective
on an adjective checklist. Feather (1967, as cited in Joe, 1971) described externals as possessing more debilitating anxiety and neurotic symptoms than internals. Williams and Vantress (1969) found externals to be significantly higher than internals on a hostility inventory. The authors contended that experiencing more feelings of powerlessness and more frustration through external forces increased the manifestation of hostility. In his comprehensive review article on the internal-external construct, Joe (1971) asserted that the "findings depict externals, in contrast to internals, as being relatively anxious, aggressive, dogmatic, and less trustful and more suspicious of others, (and) lacking in self-confidence and insight (p. 623).

Summary

To summarize, religious orientation, death anxiety, and locus of control have been suggested as concomitants of psychological well-being. Yet, the relationships between these variables and the roles they play in psychopathology have not been studied adequately.

Purpose and Hypotheses of This Study

The primary concern of this investigation is to shed more light on the role played by religious orientation and death anxiety in emotional maladjustment. The information obtained by this exploration may be useful to mental health professionals as an aid in isolating factors of concern to religion-preoccupied and death-anxious patients. Only after the present scanty knowledge of the interrelationship of religion and death anxiety
is augmented can the role it plays in psychopathology and the groups most affected by it begin to be clarified. The current study is an investigation of the relationships between religious orientation, death anxiety, locus of control, and belief in punishment after death in a psychopathological population. It is an assumption of this study that individuals from a non-psychiatric population will exhibit patterns more indicative of psychological well-being, i.e., higher incidence of intrinsically religious orientation, lower death anxiety, and lower locus of control scores. Emphasis is placed on the exploratory nature of this study in its attempt to explore statistical relationships between the hypothetically related variables: religiosity, death anxiety, locus of control, and belief in punishment after death. It is helpful to conceptualize the possible relationships with the following schema.

\[
\begin{align*}
R &= \text{Religious Orientation} \\
DA &= \text{Death Anxiety} \\
LOC &= \text{Locus of Control} \\
BIP &= \text{Belief in Punishment}
\end{align*}
\]

In accordance with Leming's theory of the curvilinear relationship between religiosity and death anxiety, it was hypothesized that individuals with an intrinsic religious orientation, as defined by Allport, would exhibit less death anxiety than participants with an extrinsic religious orientation or those with an indiscriminately pro-religious orientation.
Recall that the latter two types of orientation were considered by Allport to be indicative of less maturity, less integration of religious beliefs, and less "healthy" personality characteristics than the intrinsically religious category. In conjunction with the curvilinear theory and Allport's categorization scheme, it was also hypothesized that nonreligious individuals would exhibit less death anxiety than the extrinsically religious or the indiscriminately proreligious. It was further hypothesized that no significant difference in death anxiety would be found between the nonreligious and the intrinsically religious. This hypothesis was made based upon Leming's contention that the nonreligious individual need not fear afterlife and the religious individual with a mature, well-integrated belief system views death as a religious victory.

Another hypothesis revolved around the nature of the individual's belief system regarding punishment after death. It seems intuitively reasonable to expect that death anxiety would be tempered by whether or not an individual believes punishment after death is a viable possibility. Therefore, it was hypothesized across religious categories (extrinsic, intrinsic, nonreligious, and indiscriminately proreligious) that those subjects who do not believe in the possibility of punishment after death should exhibit less death anxiety than those subjects who do acknowledge the possibility of punishment.

It was hypothesized across religious categories that those individuals with higher beliefs in an external locus of control
would have greater death anxiety (due to a pervasive sense of powerlessness over future events) than those individuals with a stronger belief in internal locus of control, who presumably see their behavior as exerting more control over events.

Finally, it was hypothesized that the nonpsychiatric patients, relative to the psychiatric group, would exhibit a higher incidence of intrinsically religious orientation, lower death anxiety, and lower locus of control scores.

Method

Subjects

Volunteer subjects were recruited from the inpatient and outpatient services of James A. Haley Veteran's Hospital, Tampa, Florida. Acutely psychotic and suicidal "at risk" patients were excluded from this sample based on the judgments of personnel in charge. Most recent DSM III diagnoses were obtained from patient psychiatric records and utilized for classificatory purposes in the statistical analyses.

Patients were subdivided into the following categories: substance abuse disorders, affective disorders, schizophrenic disorders, and anxiety disorders. The primary rationale for concentration on these disorders was that the bulk of the mental health population tends to fall into one of these four categories. Twenty subjects were recruited for each diagnostic grouping; substance abuse disorders, affective disorders, schizophrenic disorders, and anxiety disorders. An additional forty subjects were recruited from the hospital medical wards
and served as the nonpsychiatric control group in the comparison. There were a total of 120 subjects who completed the study.

All subjects were male veterans ranging in age from 19 to 67. Mean age of the sample was 38. Nineteen of the subjects were Catholic, 53 were Protestant, and 48 claimed no religious affiliation. Fifty-seven subjects were married, 26 subjects were divorced, and 37 were never married. Only three subjects were college graduates; an additional 35 subjects had some college coursework, and the remainder had high school diplomas or equivalency degrees. Those veterans with occupations represented a broad spectrum of occupational fields; however, 63 subjects were either disabled or unemployed. This number represents more than one-half of the total subject population (see Table 1, Appendix F).

**Instruments**

Intrinsic-Extrinsic Religious Orientation Inventory. The Intrinsic-Extrinsic Religious Orientation Inventory (Feagin, 1964; Allport & Ross, 1976) was used to assess religious orientation. Robinson and Shaver (1973) report that the inventory has consistently demonstrated its construct validity in both published and unpublished studies. They cite as evidence of its reliability item-to-subscale correlations ranging from .18 to .58. The instrument is composed of 20 statements, with one of four choices ranging from strong agreement to strong disagreement. Items were scored from one
to five, with four and five indicative of extrinsic orientation, and three assigned to any omitted item. Depending on their tendency to agree or disagree with the two types of statements, subjects were assigned to one of four classifications: intrinsically religious (agreement with intrinsic and disagreement with extrinsic), extrinsically religious (agreement with extrinsic and disagreement with intrinsic), indiscriminately proreligious (agreement with both intrinsic and extrinsic), or nonreligious (disagreement with both intrinsic and extrinsic). The scale was self-administered.

Death Anxiety Scale. The instrument which was employed to assess death anxiety was Templer's Death Anxiety Scale (Templer, 1970). The scale consists of 15 true-false items, nine of which are keyed "true" and six of which are keyed "false" to avoid agreement response sets. A high score on the scale indicates a greater fear of dying. The instrument was self-administered. Templer (1970) cites a product-moment correlation coefficient of .83 as evidence of the scale's test-retest reliability and a Kuder-Richardson coefficient of .76 to demonstrate internal consistency. As evidence of the scale's validity, Templer reports that self-reported death anxious psychiatric patients have significantly higher scores than control patients and that the scale correlates significantly with two other death anxiety questionnaires and a sequential word association test.
The three methods of assessment which have typically been utilized in research on death anxiety have been interviews, projective techniques, and questionnaires. Interviews and projective techniques have not been shown to be reliable or valid. By contrast, Templer's scale has been investigated on both these dimensions. In addition, the Death Anxiety Scale was developed with a concern for construct validity, which was apparently overlooked in previous death scale construction (Templer, 1970).

**Internal-External Locus of Control Scale.** As a measure of subjects' perceptions of the contingency relationships between their own behavior and events which follow that behavior, Rotter's Internal-External Locus of Control Scale (Rotter, 1966) was utilized. The instrument is composed of 23 question pairs, using a forced-choice format, with an additional six filler questions. Internal and external statements are paired. The subject was given one point for each external statement selected. Scores may range from 0 (most internal) to 23 (most external). The scale was self-administered. Although the scale has been used most frequently with college students, Robinson and Shaver (1973) report the scale has successfully discriminated internals from externals among varying populations, including adolescents and elderly subjects. As a measure of generalized internal-external expectancy, the Rotter Scale's convergent validity cannot be easily disputed. Robinson and Shaver (1973) report that over 50 percent of internal-external locus of control studies have utilized Rotter's Scale. They cite as evidence
of instrument's reliability a Kuder-Richardson internal consistency coefficient of .70 and a test-retest reliability coefficient of .72.

**Personal Data Sheet.** A personal data sheet was administered to gather relevant demographic data for purposes of defining the parameters of the population. Among the items completed on this sheet were age, religious affiliation, marital status, occupation and educational level. An additional question concerning the subject's belief in punishment after death was included on this sheet and utilized in the analysis as a differential factor in death anxiety.

**Informed Consent Document.** The informed consent document described in general the procedures involved, assured the subjects they could withdraw at any time, and offered them the opportunity to be completely debriefed at the end of the procedure.

**Procedure**

The informed consent document, personal data sheet, Locus of Control Scale, Death Anxiety Scale, and Religious Orientation Inventory were administered to the subjects. All instruments were paper and pencil measures and were completed individually.

**Results**

**Preliminary Findings**

For purposes of analysis, subjects were categorized in one of the following four religious orientation groups:
(a) intrinsically religious, (b) extrinsically religious, 
(c) indiscriminately proreligious, or (d) nonreligious. The 
procedure outlined by Allport and Ross (1967) was used to 
categorize subjects based on median scores on the intrinsic 
and extrinsic subscales of the Religious Orientation Inven-
tory. Intrinsically religious respondents fall below the 
median scores on both subscales. Extrinsically religious 
respondents fall above the median scores on both subscales. 
Indiscriminately proreligious respondents score at least 
12 points less on the intrinsic subscale than on the extrinsic 
subscale. Median scores for this subject population are 34 
on the extrinsic subscale and 26 on the intrinsic subscale. 
Total number of subjects falling within the four religious 
orientation groups are as follows: intrinsically religious 
orientation, 21; extrinsically religious orientation, 20; 
indiscriminately proreligious orientation, 38; nonreligious 
orientation, 41. Frequency and percentages of participants 
falling into each of these religious orientation groups may 
be found in Table 2, Appendix G.

Since participants used in this study were drawn from 
potentially different populations, it is possible that the 
assumptions of some of the statistics used to analyze the 
data may have been violated. To explore this possibility, 
a one-way analysis of variance between the four diagnostic 
categories and their scores on the locus of control measure 
was computed. The analysis of variance demonstrated no
significant differences in mean locus of control scores between the diagnostic categories \( F(3, 79) = 0.275, p > .05 \). The means and standard deviations of scores on the locus of control scale may be found in Table 3, Appendix H.

**Relationship Between Religious Orientation and Death Anxiety**

It was hypothesized that those subjects with extrinsic religious orientation and indiscriminately proreligious orientation would have higher death anxiety than those subjects with intrinsic religious orientation and nonreligious orientation. The extrinsic religious orientation group obtained a mean death anxiety score of 7.56 (S.D. = 2.78); the intrinsic religious orientation group obtained a mean death anxiety score of 7.16 (S.D. = 3.52); the indiscriminately proreligious orientation group obtained a mean death anxiety score of 7.44 (S.D. = .68); and the nonreligious orientation group obtained a mean death anxiety score of 7.78 (S.D. = 2.50). In order to test the hypothesis, a one-way analysis of variance between the four types of religious orientation groups and their scores on the death anxiety measure was computed. For purposes of this analysis the independent variable was categorization in one of the four religious orientation groups. The dependent variable was death anxiety scores. The analysis of variance indicated no significant differences in mean death anxiety scores between the religious orientation groups \( F(3, 119) = 2.78, p > .05 \).
Correlation Between Belief in Punishment After Death and Death Anxiety

The hypothesis that belief in punishment after death would be positively correlated with death anxiety was tested by means of the point biserial correlation coefficient. A value of -.141, (p > .05) was obtained. No significant correlation was demonstrated between the two variables.

Correlation Between Death Anxiety and Locus of Control

As a test of the hypothesis that death anxiety would be positively correlated with locus of control scores, the Pearson product-moment correlation coefficient was utilized and a nonsignificant value of .164 (p > .05) was obtained.

Relationship Between Religious Orientation and Psychiatric Groups

It also was hypothesized that nonpsychiatric patients would demonstrate a greater frequency of intrinsic religious orientation than psychiatric patients. The frequencies and percentages may be found in Table 4, Appendix I. To examine this hypothesis, psychiatric patients, regardless of type of disorder, were collapsed into one group. Those psychiatric patients with an intrinsic religious orientation were separated from psychiatric patients with nonintrinsic orientations. Nonpsychiatric patients were next divided according to whether they held intrinsic or nonintrinsic religious beliefs. Differences in frequency between groups were then examined through computation of a 2 X 2 chi square. There were no
significant differences in the frequencies of nonpsychiatric and psychiatric patients in the intrinsic religious orientation group ($\chi^2 = .064, p > .05$).

**Relationship Between Death Anxiety and Psychiatric Groups**

It also was hypothesized that nonpsychiatric patients would exhibit lower death anxiety than psychiatric patients. Further, although no empirical evidence has been cited in previous research, it seems intuitively reasonable to predict that those individuals who believe in punishment after death would be more likely to have higher scores on the death anxiety measure than individuals who do not believe in punishment after death. To examine these hypotheses, differences in death anxiety scores were examined using a 2 X 2 (psychiatric versus nonpsychiatric X belief in punishment versus nonbelief in punishment) ANOVA. The psychiatric patients who believed in punishment after death obtained a mean death anxiety score of 8.56 (S.D. = 2.45); the psychiatric patients who did not believe in punishment obtained a mean death anxiety score of 5.82 (S.D. = 1.97); the nonpsychiatric patients who believed in punishment after death obtained a mean death anxiety score of 7.00 (S.D. = 1.45); and the nonpsychiatric patients who did not believe in punishment obtained a mean death anxiety score of 8.60 (S.D. = 2.90). No significant differences were found for the main effect of psychiatric population ($F(1, 119) = .472, p > .05$). However, a significant main effect of belief in punishment was found ($F(1, 119) = 5.14, p < .05$). Post-hoc
analysis utilizing the t-test procedure indicated that mean death anxiety scores were significantly higher for the belief in punishment group than the nonbelief in punishment group ($p < .05$). Further, a significant psychiatric group by belief in punishment interaction effect was found ($F(1, 119) = 10.09, p < .01$). Post-hoc analysis utilizing the t-test procedure showed that mean death anxiety scores were significantly higher for the psychiatric patients in the belief in punishment group than for the psychiatric patients in the nonbelief in punishment group ($p < .05$), as well as the nonpsychiatric patients in the belief in punishment group ($p < .05$). The nonpsychiatric patients in the nonbelief in punishment group did not differ significantly from the psychiatric patients in the belief in punishment group on death anxiety scores.

In order to test for possible differences in death anxiety scores between the psychiatric groups, a 4 (schizophrenic, substance abuse, affective, and anxiety diagnostic groups) by 2 (belief in punishment versus nonbelief in punishment) ANOVA was computed. The analysis resulted in a significant main effect of diagnostic groups ($F(3, 79) = 2.94, p < .05$), a significant main effect of belief in punishment after death ($F(3, 79) = 18.17, p < .01$), and a significant interaction effect ($F(3, 79) = 3.68, p < .05$). The group means and standard deviations may be found in Table 5, Appendix J. Since significant main effects were found, post-hoc analyses utilizing the t-test procedure were performed to identify
where the mean differences existed. Mean death anxiety scores were significantly greater for the belief in punishment group than the nonbelief in punishment group (p < .05). Also, mean death anxiety scores were significantly higher for the schizophrenic and substance abuse groups than for the affective group (p < .05). Mean death anxiety scores for the anxiety group were lower than the schizophrenic and substance abuse groups but were not statistically significant.

**Relationship Between Locus of Control and Psychiatric Groups**

Finally, as will be recalled, it was hypothesized that patients who were not being treated primarily for psychiatric disorders would exhibit lower locus of control scores than patients who were receiving treatment primarily for psychiatric disorders. It seems intuitively reasonable to predict that those individuals who believe in punishment after death would be more likely to have external locus of control scores than individuals who do not believe in punishment after death. To examine these hypotheses, a 2 X 2 (psychiatric versus nonpsychiatric X belief in punishment versus nonbelief in punishment) ANOVA of locus of control scores was computed. No significant difference was found for the main effect of psychiatric population (F(1, 119) = .115, p > .05) or for the main effect of belief in punishment after death (F(1, 119) = 3.52, p > .05). The psychiatric patients who believed in punishment after death obtained a mean locus of control score of 11.16 (S.D. = 1.84); the psychiatric patients who did not
believe in punishment obtained a mean locus of control score of 10.53 (S.D. = 2.59); the nonpsychiatric patients who believed in punishment after death obtained a mean locus of control score of 11.88 (S.D. = 4.39); and the nonpsychiatric patients who did not believe in punishment after death obtained a mean locus of control score of 9.35 (S.D. = 4.11). Computation of a point biserial correlation coefficient did indicate a significant inverse relationship between belief in punishment after death and locus of control scores across all groups, r = -.177, p < .05). This indicated that subjects who believed in punishment tended to exhibit higher locus of control scores than subjects who did not believe in punishment.

Discussion

The purpose of this study was to examine whether a relationship exists between religious orientation, death anxiety, locus of control, and belief in punishment after death among psychiatric and nonpsychiatric populations. To explore whether a relationship exists between these variables, participants were patients being treated in a hospital for either substance abuse, affective, schizophrenic or anxiety disorders. Additionally, a sample of participants who were hospitalized primarily for physical disorders was obtained. All participants were then given measures designed to assess their religious orientation, death anxiety, locus of control, and belief in punishment after death.
One hypothesis examined was whether a relationship exists between religious orientation and death anxiety. Contrary to predictions, no significant differences were found. Thus, results of this study are inconsistent with Leming's (1979) theory that the moderately religious individual should fear death more than the highly religious and nonreligious individual. These findings are also contradictory to those of other studies. Sociological theorists in the area (Malinowski, 1965; Radcliffe-Brown, 1965; Homans, 1965; and Leming, 1979) believe strongly that religion asserts an appreciable influence on death anxiety. There may be several reasons for the failure of this study to obtain findings consistent with what has been proposed by previous theorists. One possibility is that the instruments used to measure religious orientation and death anxiety were limited. The connections between the two concepts might have been more straightforward had the measurement of religious orientation included questions about the individual's belief system regarding afterlife. Perhaps the nature or healthiness of one's religious involvement, as measured by the Intrinsic-Extrinsic Religious Orientation Inventory, is not as important an issue as the depth or strength of one's belief system. Thus, it might be speculated that even in a bizarre delusional system, if one adheres strongly to a specific set of beliefs, he/she may experience less death anxiety regardless of the nature of that belief system. If in fact it is the strength of one's commitment to his/her belief system which is the differential
factor in death anxiety, it may be difficult to measure strength of commitment on any extant objective measure of religiosity. Perhaps a measure of religiosity which assesses differing degrees of commitment is needed in order to understand the relationship between religious involvement and death anxiety. At any rate, the Religious Orientation Inventory used in this investigation was not able to tap differences in religiosity which might account for differing levels of death anxiety.

The hypothesis that belief in punishment after death would be correlated with death anxiety also was examined. Contrary to expectations, no significant correlation was found. Although fear of punishment has been historically linked to death fears (Kastenbaum and Aisenberg, 1972; Choron, 1964) the concept of an anticipated reward after death has been overlooked. It is conceivable that an individual can believe in an everlasting punishment, yet be convinced that he/she can expect an everlasting reward. Certainly the anticipation of a reward may reduce death anxiety for that individual.

Another hypothesis which was examined was whether a correlation exists between death anxiety and external locus of control. Contrary to predictions which would replicate the results of Taylor and Reznikoff (1967) however, no significant differences were found. The failure of this study to replicate other findings may arise from the particular characteristics of this patient population. Certainly an argument can be made that veterans are accustomed to taking orders and thus as a
group are more external in orientation than the general population. Further, these veterans are hospitalized in a highly bureaucratic agency which may have increased their feelings of powerlessness. The high number of both psychiatric and nonpsychiatric disabled veterans also may complicate the analysis. Disabled individuals often feel isolated from the rest of society, which may in turn provoke feelings of powerlessness and anxiety. Measurement of the extent to which an individual feels isolated from the group may be an important variable for consideration in terms of death anxiety and locus of control.

The hypothesis that nonpsychiatric patients would exhibit a greater incidence of intrinsic religious orientation than psychiatric patients was not supported by this investigation. These results are inconsistent with Allport's (1965) contention that mental health is facilitated by an intrinsic religious orientation. The failure of this study to obtain findings consistent with Allport's theory may be related to the high number of unemployed and disabled veterans within the nonpsychiatric population, which might suggest a more dependent and less healthy adjustment to life than one would anticipate in the general population.

Another hypothesis which was examined was that nonpsychiatric patients would exhibit lower death anxiety than psychiatric patients. Contrary to expectation, no significant differences were found. A possible reason for the failure to find any
significant differences is that the nonpsychiatric patients may have been experiencing increased anxiety due to their medical problems. Kastenbaum and Aisenberg (1972) suggest that the disease process and its treatment may be a source of anxiety to medical patients which may in turn exert considerable influence on the measurement of death anxiety.

Although the investigation failed to support the assumption that nonpsychiatric patients would have lower death anxiety, results of this study suggest important differences between the nonpsychiatric and psychiatric patients with the addition of the belief in punishment variable. More specifically, death anxiety was significantly higher among psychiatric patients who believe in punishment than for psychiatric patients who do not believe in punishment or nonpsychiatric patients who believe in punishment. Bromberg and Schilder (1936) suggest that while psychopathology does not produce death anxiety that cannot be found in the normal population, the presence of pathology may bring such fears into the forefront. The presence of pathology also may act to bring any fear into the forefront, in this case fear of punishment. The information obtained in this study suggests that belief in punishment after death is related to greater death anxiety in a psychiatric population. This finding may have some clinical implications. One possibility is that in working with psychiatric patients, therapists should be cognizant of the potential for general anxieties to be linked to specific fears of punishment, which
in turn may be linked to specific guilt feelings. A possible implication of this finding for the clinical setting might be that in psychiatric populations therapy should address such issues as fear of punishment and fear of death. It may be useful for the therapist to explore with the individual specifically what behaviors are seen as punishable and the possibilities for changing these behaviors. It may also be necessary to help the patient work through guilt feelings about past "sinful" behaviors.

Further analyses were performed to examine the relationship between belief in punishment and death anxiety among the separate psychiatric categories. It was found that patients with affective disorders exhibited significantly less death anxiety than patients with schizophrenic and substance abuse disorders. Patients with anxiety disorders demonstrated less death anxiety than patients with schizophrenic and substance abuse disorders, but the difference was not statistically significant. This finding does suggest that death anxiety is a very real concern for many patients with schizophrenic and substance abuse disorders and to a lesser degree for many patients exhibiting anxiety disorders. A possible implication of this finding for the clinical setting might be that in these three diagnostic categories, therapists should be cognizant of the possibility of a relationship between death fears and the overt manifestations of the particular disorder. An example might be a substance abuser who is using alcohol or drugs to reduce awareness of death anxieties.
Finally, the hypothesis that nonpsychiatric patients would exhibit lower locus of control scores than psychiatric patients was examined. Contrary to predictions, no significant differences were found. These results are inconsistent with studies which reported a relationship between internal locus of control and psychological adjustment (Hersch and Scheibe, 1967; Feather, 1967; Williams and Vantress, 1969). The failure of this study to replicate these findings again may be related to the characteristics of this patient population, i.e., high number of unemployed and disabled veterans which may be indicative of a more dependent and less healthy lifestyle than might be found in the general population.

Although the hypothetical relationship between locus of control and death anxiety was not supported by this investigation, belief in punishment after death again emerged as an important variable. Those subjects who believe in punishment after death tended to exhibit higher external locus of control scores. What seems important is the connection between this finding that belief in punishment after death is related to external locus of control and the previously stated relationship between belief in punishment after death and high death anxiety. One can speculate that belief in punishment after death increases death anxiety because those who hold such a belief also hold the belief that events are controlled by luck or the control of powerful others (external locus of control). Such an individual may fail to see the relationship between his/her
behavior and punishment after death. He/she has ultimately given up control of that decision to a higher power. By failing to accept responsibility for the possible outcome (punishment) the individual seemingly opts for higher anxiety about the outcome.

The results of this study provide some insight into the relationships between religious orientation, death anxiety, locus of control and belief in punishment after death. Although the assumption that nonpsychiatric patients would exhibit patterns of more healthy adjustment than psychiatric patients was not borne out by this investigation, evidence does suggest important differences between the nonpsychiatric and psychiatric patients. The results of this exploration suggest that the single most important factor of concern to psychiatric patients in the area of religious orientation and death anxiety is belief in punishment after death and its relationship to locus of control.

Recognizing the exploratory nature of this study, it becomes important to note the limitations inherent in its design. By definition, an exploratory study involves speculation as to what variables may be validly included. Important and influential factors may have been excluded because the theoretical stance on the relationship between religious orientation, attitudes toward death, and perceptions of powerlessness did not lead to their recognition or inclusion. Certain characteristics of the patient sample utilized in this investigation call for cautious generalizations; i.e., the
sample is exclusively male, represents a relatively young population, and includes a high percentage of unemployed and disabled veterans. The instruments used to measure religiosity and death anxiety also introduce possible limitations. The connections between the two concepts might have been more straightforward had the measurement of religiosity included questions about the individual's belief system regarding afterlife. Perhaps the most serious limitation of this study involves the statistical methodology. Although the use of straight correlations allows for testing of the hypothesized relationships between variables, it does not allow for speculation as to cause and effect or the interpretation of complex interrelationships. It is suggested that future studies use different samples as well as the measures of religious orientation, death attitudes, and feelings of powerlessness.

The major finding of this exploration—that belief in punishment after death is related to greater death anxiety in a psychiatric population—has important implications for the mental health practitioner and raises many questions. The clear implication of this finding is the need to explore such concerns in therapy. The still unanswered questions are "how?" and "to what end?" How do we address religiously induced fears? What is our goal? It is often the case that our clients come to us with fears and anxieties which seem to be based in reality but have taken on an obsessional quality.
Should we respond any differently toward religiously induced fears than we do toward fear of heights? Should an atheist therapist deal with a fundamentalist client's religious concerns or refer to a Christian counselor? Do "we," "the professionals," have the right to challenge beliefs which to us appear to promote fear and anxiety? Or, does ethical psychotherapy demand a respect for individual belief systems? The questions raised point to the need for mental health professionals to establish ethical guidelines for the handling of religious issues in therapy.

If we agree that one of the goals of therapy is greater responsibility-taking by the client, perhaps the goal for a death anxious patient who believes he/she will be punished for transgressions should be for him/her to take responsibility for altering sinful behavior. Perhaps rather than challenge the belief in punishment, we should encourage accepting responsibility for one's behavior and modifying unacceptable behaviors. Perhaps, rather than attempting to alleviate guilt feelings in our clients, we should encourage them to respect, attend to, and learn from their guilt. The information gained from and questions raised by this study reemphasize the need for greater understanding of the role religiosity and attitudes toward death play in the lives of our clients.
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These consist of pages:

Appendix A, pages 46-49 (Intrinsic-Extrinsic Religious Orientation Inventory Inquiry Concerning Social and Religious Views)

Appendix B, page 50 (Death Anxiety Scale)

Appendix C, pages 51-54 (Internal-External Locus of Control Scale)

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Appendix A

Intrinsic-Extrinsic Religious Orientation Inventory
Inquiry Concerning Social and Religious Views

The following items deal with various types of religious ideas and social opinions. We should like to find out how common they are.

Please indicate the response you prefer, or most closely agree with, by writing the letter corresponding to your choice in the right margin.

If none of the choices expresses exactly how you feel, then indicate the one which is closest to your own views. If no choice is possible you may omit the item.

There are no "right" or "wrong" choices. There will be many religious people who will agree with all the possible alternative answers.

1. What religion offers me most is comfort when sorrows and misfortune strike.
   a. I definitely disagree.
   b. I tend to disagree.
   c. I tend to agree.
   d. I definitely agree.

2. I try hard to carry my religion over into all my other dealings in life.
   a. I definitely disagree.
   b. I tend to disagree.
   c. I tend to agree.
   d. I definitely agree.

3. One reason for my being a church member is that such membership helps to establish a person in the community.
   a. Definitely not true.
   b. Tends not to be true.
   c. Tends to be true.
   d. Definitely true.
4. Quite often I have been keenly aware of the presence of God or the Divine Being.
   a. Definitely not true.
   b. Tends not to be true.
   c. Tends to be true.
   d. Definitely true.

5. The purpose of prayer is to secure a happy and peaceful life.
   a. I definitely disagree.
   b. I tend to disagree.
   c. I tend to agree.
   d. I definitely agree.

6. My religious beliefs are what really lie behind my whole approach to life.
   a. This is definitely not so.
   b. Probably not so.
   c. Probably so.
   d. Definitely so.

7. It doesn't matter so much what I believe so long as I lead a moral life.
   a. I definitely disagree.
   b. I tend to disagree.
   c. I tend to agree.
   d. I definitely agree.

8. The prayers I say when I am alone carry as much meaning and personal emotion as those said by me during services.
   a. Almost never.
   b. Sometimes.
   c. Usually.
   d. Almost always.

9. Although I am a religious person I refuse to let religious considerations influence my everyday affairs.
   a. Definitely not true of me.
   b. Tends not to be true.
   c. Tends to be true.
   d. Clearly true in my case.
10. If not prevented by unavoidable circumstances, I attend church:
   a. more than once a week.
   b. about once a week.
   c. two or three times a month
   d. less than once a month.

11. The church is most important as a place to formulate good social relationships.
   a. I definitely disagree.
   b. I tend to disagree.
   c. I tend to agree.
   d. I definitely agree.

12. If I were to join a church group I would prefer to join (1) a Bible Study group, or (2) a social fellowship.
   a. I would prefer to join (1).
   b. I probably would prefer (1).
   c. I probably would prefer (2).
   d. I would prefer to join (2).

13. Although I believe in my religion, I feel there are many more important things in my life.
   a. I definitely disagree.
   b. I tend to disagree.
   c. I tend to agree.
   d. I definitely agree.

14. Religion is especially important to me because it answers many questions about the meaning of life.
   a. Definitely disagree.
   b. Tend to disagree.
   c. Tend to agree.
   d. Definitely agree.

15. I pray chiefly because I have been taught to pray.
   a. Definitely true of me.
   b. Tends to be true.
   c. Tends not to be true.
   d. Definitely not true of me.
16. I read literature about my faith (or church).
   a. Frequently.
   b. Occasionally.
   c. Rarely.
   d. Never.

17. A primary reason for my interest in religion is that my church is a congenial social activity.
   a. Definitely not true of me.
   b. Tends not to be true.
   c. Tends to be true.
   d. Definitely true of me.

18. It is important to me to spend periods of time in private religious thought and meditation.
   a. Frequently true.
   b. Occasionally true.
   c. Rarely true.
   d. Never true.

19. Occasionally I find it necessary to compromise my religious beliefs in order to protect my social and economic well-being.
   a. Definitely disagree.
   b. Tend to disagree.
   c. Tend to agree.
   d. Definitely agree.

20. The primary purpose of prayer is to gain relief and protection.
   a. I definitely agree.
   b. I tend to agree.
   c. I tend to disagree.
   d. I definitely disagree.
Appendix B

Death Anxiety Scale

Please circle true or false for each of the following:

TRUE FALSE 1. I am very much afraid to die.
TRUE FALSE 2. The thought of death seldom enters my mind.
TRUE FALSE 3. It doesn't make me nervous when people talk about death.
TRUE FALSE 4. I dread to think about having to have an operation.
TRUE FALSE 5. I am not at all afraid to die.
TRUE FALSE 6. I am not particularly afraid of getting cancer.
TRUE FALSE 7. The thought of death never bothers me.
TRUE FALSE 8. I am often distressed by the way time flies so rapidly.
TRUE FALSE 9. I fear dying a painful death.
TRUE FALSE 10. The subject of life after death troubles me greatly.
TRUE FALSE 11. I am really scared of having a heart attack.
TRUE FALSE 12. I often think about how short life really is.
TRUE FALSE 13. I shudder when I hear people talking about a World War III.
TRUE FALSE 14. The sight of a dead body is horrifying to me.
TRUE FALSE 15. I feel that the future holds nothing for me to fear.
Appendix C

Internal-External Locus of Control Scale

Please underline the letter (a or b) of the statement which most closely represents your thinking for each pair of statements.

1. a. Children get into trouble because their parents punish them too much.
   b. The trouble with most children nowadays is that their parents are too easy with them.

2. a. Many of the unhappy things in people's lives are partly due to bad luck.
   b. People's misfortunes result from the mistakes they make.

3. a. One of the major reasons why we have wars is because people don't take enough interest in politics.
   b. There will always be wars, no matter how hard people try to prevent them.

4. a. In the long run people get the respect they deserve in this world.
   b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. a. The idea that teachers are unfair to students is nonsense.
   b. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6. a. Without the right breaks one cannot be an effective leader.
   b. Capable people who fail to become leaders have not taken advantage of their opportunities.

7. a. No matter how hard you try some people just don't like you.
   b. People who can't get others to like them don't understand how to get along with others.
8. a. Heredity plays the major role in determining one's personality.

b. It is one's experiences in life which determine what one is like.

9. a. I have often found that what is going to happen will happen.

b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10. a. In the case of the well prepared student there is rarely if ever such a thing as an unfair test.

b. Many times exam questions tend to be so unrelated to course work that studying is really useless.

11. a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.

b. Getting a good job depends mainly on being in the right place at the right time.

12. a. The average citizen can have an influence in government decisions.

b. This world is run by the few people in power, and there is not much the little guy can do about it.

13. a. When I make plans, I am almost certain that I can make them work.

b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14. a. There are certain people who are just no good.

b. There is some good in everybody.

15. a. In my case getting what I want has little or nothing to do with luck.

b. Many times we might just as well decide what to do by flipping a coin.
16. a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
   b. Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.

17. a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.
   b. By taking an active part in political and social affairs the people can control world events.

18. a. Most people don't realize the extent to which their lives are controlled by accidental happenings.
   b. There really is no such thing as "luck".

19. a. One should always be willing to admit mistakes.
   b. It is usually best to cover up one's mistakes.

20. a. It is hard to know whether or not a person really likes you.
   b. How many friends you have depends on how nice a person you are.

21. a. In the long run the bad things that happen to us are balanced by the good ones.
   b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. a. With enough effort we can wipe out political corruption.
   b. It is difficult for people to have much control over the things politicians do in office.

23. a. Sometimes I can't understand how teachers arrive at the grades they give.
   b. There is a direct connection between how hard I study and the grades I get.

24. a. A good leader expects people to decide for themselves what they should do.
   b. A good leader makes it clear to everybody what their jobs are.
25. a. Many times I feel that I have little influence over the things that happen to me.

    b. It is impossible for me to believe that chance or luck plays an important role in my life.

26. a. People are lonely because they don't try to be friendly.

    b. There's not much use in trying too hard to please people, if they like you, they like you.

27. a. There is too much emphasis on athletics in high school.

    b. Team sports are an excellent way to build character.

28. a. What happens to me is my own doing.

    b. Sometimes I feel that I don't have enough control over the direction my life is taking.

29. a. Most of the time I can't understand why politicians behave the way they do.

    b. In the long run the people are responsible for bad government on a national as well as on a local level.
Appendix D

Personal Data Sheet

AGE

MARITAL STATUS (check one)

- single ___
- married ___
- divorced ___
- widowed ___

OCCUPATION ________________________________

HIGHEST GRADE COMPLETED (check one)

- some high school ___
- high school graduate ___
- some college ___
- college graduate ___

RELIGION (check one)

- Catholic ___
- Protestant ___
- Jewish ___
- Other (please specify) _________________

Do you believe that if you do not live according to your belief that you will be punished when you die? YES ___ NO ___
Appendix E

Informed Consent Document

Recently this country has seen an increase in church attendance which suggests religion is becoming a more important influence on all of us. This study is designed to more closely look at some of the influences religion has had. The results will be used to increase our understanding of both the positive and negative effects of religion. If you agree to participate you will be asked to complete 3 forms regarding your views on several social and religious issues. It should take you approximately 1/2 hour to fill out the forms. If you choose to withdraw your participation, you may do so at any time without any prejudice. After you have completed the forms, I will be happy to answer your questions and more fully explain the study.

Debra Lofton

Agreement to Participate ______________________
Appendix F

Table 1

Demographic Variables by Category

<table>
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<tr>
<th></th>
<th>Nonpsychiatric</th>
<th>Substance Abuse</th>
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<th>Schizophrenic</th>
<th>Anxiety</th>
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Appendix G

Table 2
Frequency and Percentages of Subjects in Each Religious Orientation Category

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<th>Extrinsic n</th>
<th>Extrinsic %</th>
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Appendix H

Table 3

Means and Standard Deviations of Locus of Control Scores

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Appendix I

Table 4

Frequencies and Percentages of Intrinsic Religious Orientation in Psychiatric and Nonpsychiatric Groups

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Appendix J

Table 5

Means and Standard Deviations of Death Anxiety Scores As a Function of Group and Belief in Punishment After Death

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References


