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The relationship between religious orientation, coping style, and psychological health on death anxiety and life satisfaction

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The relationship between religious orientation, coping style, and psychological health on death anxiety and life satisfaction

Abstract:

The study was conducted to explore how religious orientation, gender, age, psychological health and coping style interact with levels of death anxiety and life satisfaction. Questionnaires were administered to a convenience sample of 100 undergraduate third year psychology students consisting of (n = 77) female and (n = 33) males. The study is a correlational cross-sectional design. Questionnaires included the Templer/McMordie death anxiety scale, the religious orientation scale, the Brief cope scale, the satisfaction with life scale, the general health questionnaire. No relationship found between any of the predictors and death anxiety, apart from gender. Females scored higher on death anxiety than males. Additional tests reported that life satisfaction, an altering consciousness coping style and avoidance coping had a significant relationship with being at risk of developing a stress related illness. As life satisfaction increased the risk of developing a stress related illness decreases.

Introduction:

This introduction will be divided into three main sections, death anxiety, religion and research and hypothesis. The first section will discuss possible historical evidence on death anxiety, contrasting theories and quantitative research into the topic in relation to different variables. The second section will discuss religious theories and research and associated variables. The third section will discuss possible research and hypothesis.

Section 1a: Death anxiety

At what point in human evolution did our ancestors develop a modern understanding and awareness of their own mortality? This will never be known for sure, but fossil and archaeological evidence suggests ritual symbolic behaviour emerged 40,000 years ago. Tis activity is thought to have its roots over 100,000 years ago where evidence of structured abandonment of Homo sapiens was found (Pettitt, 2011). Dead bodies were collected and divided into different areas from the living, most likely to protect the living from disease. This is the first sign of a formal division between the living and the dead. Occasions of these burials were very rare, and it was not until 14,000 years ago that people were buried in what we recognise as cemeteries (Pettitt, 2011). Among humans organised and cultural responses to death are universal, and there is vast archaeological evidence attesting to how differently humans deal with their dead across the world, from weeping to laughing to fighting and partying. But one thing they have in common is that it is always meaningful and expressive (Pettitt, 2011).

Theories of death anxiety

As mentioned, we have no idea what these proto-humans concept of death was, or their level of fear from it, but we do have an enormous range of studies and theories concerning death anxiety in the modern era. One of the earliest theorists on death anxiety was Sigmund Freud. He believed the unconscious had no concept of death, but the displayed anxiety was the repression of the libido or sex instincts. Perhaps an anxiety over the loss of a loved one. As Freud describes anxiety as "nothing other than an expression of the fact that, the person is feeling the loss of the person they love" (Freud, 1953, p289). Resulting in Thanatophobia (fear of death). Freud in his own words, "Our own death is indeed quite unimaginable, and whenever we make the attempt to imagine it we can perceive that we really survive as spectators. Hence the psychoanalytic school could venture on the assertion that at bottom nobody believes in his own death, or to put the same thing in a different way, "in the unconscious everyone is convinced of his own mortality" (Freud 1913/1915 p304-305). This view is consistent with Freud's overall concept of the unconscious system in which there is "no negation and no varying degree of certainty". Unconscious processes are not responsive to the passage of time. So death the end point of personal time would have no meaning to the unconscious (Kastenbaum, 2000, p102). Another argument Freud brought towards Thanatophobia was that if we have not experienced death how can we fear it? We must be projecting other anxieties to the blank screen known as death. Castration anxiety was thought to present a normative challenge in childhood development. The adult who is beset by death anxieties may be representing unresolved castration anxiety (Kastenbaum, 2000, p102/103).

Another leading theorist on death anxiety is (Ernest Becker, 1973) specifically in his book The Denial of Death (1973). “Ones whole life is a style or scenario with which one tries to deny oblivion and to extend oneself beyond death in symbolic ways, one is often untouched by the fact of his death because he has been able to surround it by larger meanings” (Becker, p104-105). This idea was contrary to Freud’s. Becker believes that all anxiety is rooted in the awareness of our mortality. The consequences of this are enormous, and reveal themselves in every aspect of individual and cultural life. It is the terror of death that drives both the person suffering from schizophrenia and psychotic depression to their extremes of escape (Kastenbaum, 2000, p104). Ordinary life in today’s society is marked by heavy repression of death-related anxiety, according to Becker, and this takes a toll on us. We become conformists, seeking security by tying into a system that will meet our dependency needs and help us deny our intrinsic vulnerability (Kastenbaum, 2000, p104). Individuals and society, he states, enter into collusion, and the dynamics of death anxiety and its denial keeps the collusion going. Traumatic experience can disrupt this system and we are then faced with the challenge of either restoring the tenuous system of mutual illusionary support or with confronting death as an aware individual (Kastenbaum, 2000, p104). A flourishing society requires active participants who work, breed, interact, and believe in shared values. Fear of death intensifies self preoccupation, reduces attention and energies necessary for group endeavours. If too many people become preoccupied and dysfunctional because of their indulgence in death anxiety, then the viability of the society may become imperilled. Becker believes we should acknowledge our anxieties and contemplate death if we intend to live as an enlightened and self-actualised person. The repression of death-related thoughts and feelings requires too much effort, drains too much energy. This is a similar interpretation of solving death anxiety to that of Freud’s. Both argue that the fate of civilisation as well as the maturation of the individual requires a greater willingness to contemplate death (Kastenbaum, 2000, p105).

Terror management theory, developed by (Greenberg, Pyszcynski & Solomen, 1986), was based on the work of Ernest Becker. The theory proposes that cultures humanely constructed beliefs about the nature of reality shared by individuals in groups serves to assuage the terror engendered by the uniquely human awareness of death, and in doing so preserve consciousness in its present form. Culture serves to reduce anxiety about death by providing the possibility for individuals to perceive themselves as persons of value in a world of meaning, and so qualify for immortality (Solomen et al, 2003). All cultures provide their constituents with a meaning to origin of the universe, an explanation of what happens people when they die that offers hope of immortality, symbolically through the performance of heroic deeds, creation of monuments or works of art, identification with enduring institutions and through various types of after lives promised by most organised religions (Solomen, et al 03). Immediately after explicit reminders of mortality individuals will trivialize extrinsic goals, but when a delay and distraction follow's an explicit mortality reminder, individuals will favourably evaluate extrinsic goals (Spee & Greenberg, 2009).

The majority of past literature has centred on negative post-trauma experiences in relation to death anxiety, however many survivors of life threatening events perceive positive changes attributable to the trauma (Bonanno, 2005). Post traumatic growth theory (PTG) occurs when a person witness's or was confronted with an event that involved actual, threatened death or serious injury, and the persons response involved intense fear , helplessness, or horror (APA,2000, p467). So a near death experience is an extremely distressing event and leads to a wide range or negative physical, psychological and social consequences (Tedeschi & Calhoun, 2005). However a large number report positive outcomes, and growth as a consequence of the experience (Bonanno, 2005). Negative effects must occur though before growth is possible. It is the devastation of loss that provides survivors with the opportunity and motivation to rebuild their life, the near death experience being a catalyst for change (Calhoun & Tedeschi, 2006).

PTG refers to both a process where individuals grow beyond their pre-trauma level of functioning, and in many cases gain a better level of psychological adjustment (Tedeschi & Calhoun, 2004). In Tedeschi's and Calhoun's post traumatic growth inventory they measure five key elements in which growth is though to occur; shattering of fundamental assumptions of the world, leading to cognitive restructuring; Managing distress, relating to factors such as optimism and coping style; rumination, which may lead to cognitive restructuring of goals, through reflection and making meaning of the event; social support and continued distress (Tedeschi & Calhoun, 2004). The greater the difference between prior assumptions and event-related information the greater the chance of PTG occurring, certain types of deaths shatter specific assumptions (Matthews & Marwitt, 2003/2004). (Lykins et al, 2007) compared TMT and PTG and suggested how the theories may be reconciled. PTG proposes facing mortality can lead to intrinsic change. Whereas as TMT suggests facing mortality increases striving towards extrinsic goals that are personally and culturally valued.

Age, Gender, Coping and Death anxiety

Death is universal, permanent, definite and unknown. Death anxiety is a collection of death attitudes which are characterised by negative psychological reactions including fear, threat, discomfort, irritation, pain and other emotional responses (Naimeyer, Moser, & Wittkowski, 2003). Research has shown that higher death related anxiety is related to depression, general anxiety, distress, introversion, low self-esteem, low need for achievement and withdrawal from life (Gillard & Templer, 1985). Lower death anxiety is related to intrinsic life goals, such as personal development, society contribution and establishing meaningful relationships. Generally people with low death anxiety have better psychological health. Most research has found gender differences in levels of death anxiety. Females show higher death anxiety than

males (Power & Smith, 2008; Jackson, 2008; Suhail & Akram, 2002; Mahabeer & Bhana, 1984; McDonald, 1976). Consistently across studies there is an age effect on death anxiety.(Jackson, 2008) found that death anxiety is lowest in an older age group 60+, and highest in young adults between 20-30 years of age.(Thorson & Powell, 1988) also found that younger adults and women had higher levels of death anxiety, than older respondents and males. Women expressed more anxiety over loss of body integrity and pain associated with death than men, but this may be due to social desirability and men not expressing themselves. It was found that psychological maturity, not age, was in fact a better predictor of death anxiety (Rasmussen & Brems, 1996). (Pierce Jr et al, 2007) also found women to have higher levels of death anxiety, and also higher levels of extrinsic religious belief. They found that extrinsic religiosity promoted greater death anxiety in women, this may due to women using religion more for its social aspects and for the feeling of belonging to a group, rather than an intrinsic belief of religion which may suggest immortality in the form of an afterlife. Respondents of study by (Thorson & Powell, 1990) found that individuals who were older, female, had higher levels of intrinsic religiosity where lower in levels of death anxiety. Extrinsic religiosity was al related to higher levels of death anxiety (Nelson & Cantrell, 1980; Triplett et al, 1995). Cancer patients who were intrinsically orientated were found to have lower death anxiety and despair than patients who were extrinsically orientated (Acklin et al, 1983).Contrastingly, there was no significant relationship found between religiosity and death anxiety by (McDonald, 1976; Feifel, 1974; Ens & Bond, 2005) although females were found to have higher death anxiety than males. Only a modest relationship was found between religiosity and death anxiety in an overview and evaluation of the topic (Neimeyer et al, 2004).A higher level of death anxiety in people was found to in individuals who took part in more health promoting activities, especially in younger adults. This maybe, because older adults are less defensive against death as they are in more contact with death, as they get older death becomes a more normal concept

(Bozo et al, 2009). A social coping style was found in HIV+ gay men in relation to death anxiety. The men were more likely to turn to peers than to family for help in coping with death anxiety. Perceived positive support from family resulted in lower death anxiety than that of peers (Catania et al, 1992).

Measuring Death anxiety as a variable

One of the most widely used scale for measuring death anxiety, and the one I will be using in my research, is the Templer death anxiety scale, devised by Donald Templer in 1970. This scale was devised as at the time there was no instrument or procedure that could measure death anxiety in a valid or reliable way; apart form one, Boyer's fear of death scale (Templer, 1970). Mc Cully asked children to make up stories about death and Mauer asked high school students to write essays, both qualitative methods that were hard to measure to any degree of accuracy. The questionnaires and checklists of the time were short and brief (Templer, 1970). 15 items with significant item-totals score correlations constitute the Death anxiety scale. The validity was examined by two separate procedures; presumable high death anxiety patients in a psychiatric hospital scored high on death anxiety; and the Death anxiety scale correlated significantly with Boyar's fear of death scale, and with a sequential word association task (Templer, 1970)

Section 2b: Religion

In primitive cultures were man's knowledge is limited, the world may appear as fearful and hostile place. Cults, spells, and faith driven beliefs enable a certain semblance of control over the environment. As society becomes more complex these ideals become centred on groups and institutions. Scholars broadly agree that no convincing general theory of religion exists. Recently however new efforts at producing a general theory have appeared. Some theorists identify religion as symbolic, that is, religious ideas and symbols really are covert means of pursuing varying social purposes, especially social cohesion and order. If this is true, why does it so frequently work against its function, as in sectarian warfare (Guthrie, 1996).Cognitive theorists assert that the leading motivation for religious thought and action is to interpret or explain the world on one hand and to influence or control it on the other. In this view, religious thought may be mistaken, but it is neither irrational in context, nor implausible, nor does it differ from other kinds of thoughts or actions (Guthrie, 1996). Religion like secular thought and action anthropomorphize the world of phenomena. We rely on its humanlike beings to explain particular things and events. This anthropomorphizing is everywhere in our thoughts and effects our perception and responses throughout life, as when we speak to our computers, see faces in the clouds, and think natural disasters are punishment for wrong doing (Guthrie, 1996).

Theories on religion

One theorist on religion was Sigmund Freud. He drew comparisons between the obsessive actions of people suffering with nervous disorders and that of religious ceremonial practices. "People who carry out obsessive actions or ceremonials belong to the same class as those who suffer from obsessive thinking" (Freud, 1913-1914 p31). The obsessive neurotic enforces rules upon themselves in the form of compulsions to do some extra tasks, or prohibitions to not do a certain type of behaviour; this is likened to the sacred acts of religious ritual. There are differences though such as in the neurotic these traits are individual and held from public gaze, whereas religious ritual is stereotyped and of a public nature (Freud, 1913-1914 p33). These religious rituals are thought of as to be full of symbolic meaning and neurotic's behaviour is seen as foolish. When a neurotic is constructing their ceremony they do with a sense that if they don't they will be punished. This can be seen in religious people who believe they are sinners and so carry out rituals such as prayers as a defensive or protective measure against some sort of punishment (Freud, 1913-1914 p33). He believed that the formation of religion is based on the suppression of certain instinctual impulses. They are not exclusively sexual as in obsessional neuroses, but self-seeking or socially harmful impulses, but usually not without some sexual component. "A sense of guilt following upon continued temptation and an expectant anxiety in the form of fear of divine punishment" (Freud, 1913-1914 p39). In The future of an illusion Freud sees religion as a protective illusion against the harsh realities of nature, illness or death. He see's men as putting Gods in place of their father figure so as to carry out the tasks of " reconciling men to the cruelty of fate, compensate them for the sufferings and privations which civilised life has imposed on them, and to exorcise the terrors of nature"(Freud,1927, p18). It is when an individual realises that they will remain a child forever, and will always need protection from the father or in the case of religion a sublimated father figure, we create Gods from who he fears and at the same time seek protection.

Measuring Religion as a variable.

One quantitative way of measuring religious belief was developed by Allport and Ross in 1967, is the religious orientation scale (ROS). This scale measures levels of extrinsic or intrinsic religiosity. Extrinsic religiosity measures how the individual endorses religious beliefs and attitudes or engages in religious acts only to the extent that they might aid in achieving mundane goals, such as feeling comforted and protected or acquiring social status and approval. In contrast intrinsic religious orientation refers to motivation arising from goals set forth by the religious tradition itself and is assumed to have a motherly or mundane, even self-denying qualities. Religion is regarded as a master motive, whereas other needs strong as they may be are regarded as a less ultimate significance (Allport & Ross, 1967, p434). An earlier attempt to measure religiosity was conducted by Wilson in 1960 with assistance from Allport. It was a 15-item forced choice measure of extrinsic (not intrinsic) religious values (Burris, 1994, p145). Within the ROS itself, the extrinsic sub scale assesses an individual's degree of acknowledgment of the role religion plays in his or her life, as well as the degree to which he or she frankly admits to religious involvement in order to secure solace for social approval (Allport & Ross, 1967). A problematic issue with the ROS concerns conditioned items i.e. those containing a premise such as "although I believe in my religion" non religious respondents in particular have difficulty answering such questions because they disagree with the premise. Respondent's strategies for handling these items differ, such as skipping the item, or marking a strong disagreement (Burris, 1994, p147).

Religion, life satisfaction, general health and coping.

Research on the effects of religiosity in relation to coping styles, life satisfaction is comprehensive. People use religion as a type of coping mechanism and according to research indicates higher levels of life satisfaction and lower psychological distress. Using the general health questionnaire (GHQ) (Lewis et al, 2011) in a population from Northern Ireland, found regular church attendance lead to better psychological health, it was also found that females suffer from more psychological distress than males. (Theofilou 2012) found a high level of religious belief made patients undergoing dialysis less anxious and depressed, it is also suggested it can positively affect outcomes of medical procedures. Contrastingly, (O'Connor et al, 2003) found no relationship between religiosity and psychological distress, they found only social support significantly associated with psychological health. In a meta-analytic study of 147 studies looking at the relationship between psychological health and religiousness only a mild association was found, in the direction of religiousness reducing psychological distress (Smith et al, 2003). So there appears to be more evidence suggesting religiousness reduces psychological distress, but the results are far from conclusive, which is why this study is looking at the relationship between the two variables.

In relation to bereavement (Chapple et al, 2011) found that bereaved relatives use religion to make sense of the death of the loved one. Religious coping increases when the death is sudden or apparently senseless. Religion may help people reframe their loss, and find less threatening interpretations of events. (Park & Benore, 2004) argue that religion could be central to bereavement and coping, because what people believe about the possibility of an afterlife or continued attachment will inform the meaning of death for the bereaved. (Wortmann & Park, 2008) in a meta-analytic review of 73 articles involving religion and spirituality in the context of bereavement, results suggest that religion and spirituality has a general positive relationship

with adjustment to bereavement. Religious people are more satisfied with their lives because they regularly attend religious services and build social networks in their congregations. The effect of within-congregation friendship is contingent however on the presence of a strong religious identity. Praying together was found to be better for life satisfaction than bowling or praying alone (Lima & Putnamb, 2010). People who are high in religious collaborative coping showed less distress than other coping styles. Collaborative coping involves problem solving involving the individual and their perception that God is helping them with their problem. Deferring problem solving involves putting all the responsibility for the problem on God, and self-directed problem solving is when the individual takes personal responsibility and play an active role and God takes a passive role. In this study those high in collaborative coping were more satisfied with life and showed less distress than other coping styles (Pargament et al, 1988).(Mostafei, 2010) found a positive relationship between a problem focused coping style and an intrinsic religious belief, suggesting the idea of talking to a god may lead to people tackling their problems head on.

(Okuliez-Kozaryn, 2010) reported that it is the social aspect of religion that increases peoples life satisfaction. Social religion promotes life satisfaction whereas personal religion has in the majority no effect on life satisfaction and in some cases can increase misery. (Steinitiz, 1980; Markide, 1983) both reported that it was the social aspect of church attendance that increased life satisfaction. Those high in self-directed coping, and a high level of religious belief were the most distressed and least satisfied with life, possibly because they are excluding God from the coping process and this may cause cognitive dissonance (Keisla et al, 2009). Participation in religious services is where many older adults form friendships; this was looked at in the hospital setting of medically ill patients. In this study they found religious attendance was related to lower medical illness and better psychological health in later life (Koenig, 1998; Idler & Kasl, 1992). (Seybold & Hill, 2001) found religiosity can serve as a buffer against

psychological distress. (Maltby et al, 1999) suggests that the important mechanism moderating the relationship between religious orientation and psychological health is frequency of religious practice. They found the frequency of personal prayer and not orientation was the dominant measure explaining variances in psychological distress. In a comprehensive review of the relationship between life satisfaction and religion (Koenig, McCollough & Larson, 2001) found out of a 100 studies, there was no relationship in 13 of the studies.

Section 3b: Hypothesis

After examining the literature relating to death anxiety, religiosity, gender, age, coping style, life satisfaction and general, there appears to be a relationship, between type of religious belief, age, gender, and coping style and how they individually impact death anxiety, life satisfaction and psychological health. No one has looked in a single study, how each of these variables I have discussed interact with each other, so, there appears to be a gap in the literature and research should be conducted on these variables. There appears to be a re-occurring pattern in reducing death anxiety, psychological distress, coping styles and religious orientation. It appears that when social coping styles and more extrinsic religious orientation reduces anxiety and distress.

Hypothesis 1.Religiosity and death anxiety

It is hypothesized there will be a significant relationship between death anxiety and Intrinsic religious belief.

It is also hypothesized that the relationship between death anxiety and extrinsic religiosity will be significantly different than intrinsic religiosity.

Hypothesis 2.Death anxiety and gender.

It is hypothesized that death anxiety between male and females will be significantly different.

Hypothesis 3.Death anxiety and age.

It is hypothesized that older people will have lower levels of death anxiety than younger.

Hypothesis 4.Death anxiety and coping

It is hypothesized that a social coping style will lead to lower death anxiety.

Hypothesis 5.Religiosity and Life satisfaction

It is hypothesized that people will intrinsic religious belief will have higher levels of life satisfaction than those with extrinsic religious belief.

Hypothesis 6.Religiosity and General Health

It is hypothesized that people with intrinsic religious belief will have better psychological health than extrinsic religious belief.

Method Section:

Section 4d: Design

The study represented a quantitative cross-sectional design, involving the completion of a battery of questionnaires by participants. Predictor variables include age, gender, coping style, intrinsic religious orientation, extrinsic religious orientation and general health. The dependent include death anxiety and life satisfaction.

Section 5e: Participants

A convenience sample of 100 undergraduate full and part-time psychology students was used. There was (n = 23) males and (n = 77) females, 15 part-time and 75 full-time students. Participation was completely voluntary and students received no course credit or fee for taking part. All participants had the option of withdrawing from completing the questionnaires at any time.

Section 6f: Procedure

Permission was first obtained from lecturer's within Dublin business school, to enter their classrooms and administer a paper and pen questionnaire. A brief outline of the research question was explained to the students, and at this stage they were told that their participation was voluntary and their identity would be anonymous. There was also an information sheet explaining this, and also a consent form (see appendix). The questionnaire took 10-15 minutes to complete. Pens were provided when necessary. The final page consisted of contact details of counseling and psychotherapy services, in case any of the participants were affected by anything within the questionnaire. My own email address was also on this page, for any students who wanted to contact me about the research.

The first page of the questionnaire consisted of brief demographic questions of age and gender. The following questionnaires were the Brief cope scale (Carver, 1978), the Templer/Mc Mordie death anxiety scale (Mc Mordie, 1978), the Religious orientation scale (Allport and Ross), the life satisfaction scale, and the general health questionnaire (Goldberg). When all data was collected it was entered into SPSS 18 to be analyzed.

Section 7g: Materials

Death anxiety was measured using the Templer/Mc Mordie death anxiety scale. It consists of a 15-item, 7 point likert scale used to assess the subjects level of death anxiety. It is a modification of Templer's original death anxiety scale which was a true/false questionnaire. Participants were asked to read each of the 15 questions carefully and indicate how they felt about the statement and respond with answers from 1-7 from "very strongly disagree" to "very strongly agree". Scoring proceeds from left to right with the first scale option valued at 1, the second scale answer valued at 2, etc. Responses marked "undecided" are a given a value equal to the mean of the rated answers rounded to the nearest whole number. The higher the total score the greater the level of death anxiety. Examples of items include the following, "I am not at all afraid to die" and "I am very much afraid to die". Scoring should be continuous with a maximum score of 79 and a minimum score of 21.Internal consistency and test re-test reliability for the modified death anxiety scale are .84 and .83 for a Cronbach's alpha (McMordie, 1979).

Satisfaction with life scale (SWLS) was developed by (Diener et al, 1985). It is designed to assess the participant's life satisfaction, by their own conscious judgment of their own life. The (SWLS) is a five-item questionnaire with statements such as "In most ways my life is close to ideal" and "I am satisfied with my life" each answer can be answered on a likert scale ranging from 1-7 from "strongly disagree" to "strongly agree". The original questionnaire had 48 items; this was reduced to 10 and then 5 to eliminate redundancies of wording and with minimal costs in terms of alpha reliability (Diener and Pavot, 1993). There is a reliability of .83 with a Cronbachs alpha and test-retest reliability of .69 (Bayoni et al, 2007). Scoring should be continuous with a maximum score of 35 (extremely satisfied) and a minimum score of 5 (extremely dissatisfied). Participants were asked to indicate their agreement with the statement by placing the appropriate number beside it.

The General health questionnaire (GHQ) was developed by Goldberg in 1978 (Goldberg & Wilson, 1988). There are four versions of the GHQ, the 60, 30, 28 and 12 item. The 12 item was administered for the purpose of this study. Examples of the items include "lost much sleep over worry" and "felt that you are playing a useful part in things?" Each statement is answered by four possible responses, e.g. "Better than usual" or "Not at all". The scoring is (0011) in a likert scale with scoring from left to right. There is a validity of .76 when tested with a cronbachs alpha (De Pilar, 2008). A mean score of 3 or higher indicates casesness or significant distress, and the participant is at risk of a stress related illness.

The Religious orientation scale (ROS) was developed by (Allport and Ross, 1967). It is a 20-item scale divided into two subscales that measure intrinsic and extrinsic religious orientation. It is a 5 point likert scale scored from 1-5 from left to right with answers such as "strongly disagree" and "strongly agree". The 11-item extrinsic subscale assesses an individual's acknowledgment of how religion plays a peripheral in their life. Does an individual use religion only to secure solace or social approval? Examples of items include "Although I believe in my religion I feel there are many more important things in my life" and "I pray chiefly because I have been taught to pray". The 9-item intrinsic subscale measures how much religion is a master motive in the individual's life, with items such as "If not prevented by unavoidable circumstances I attend church" and "My religious beliefs are what lie behind my whole approach to life". The two subscales should be seen as two separate scales, with extrinsic scores ranging from 11-55, and an intrinsic score range from 9-45. A Cronbachs alpha of .85 was reported for the intrinsic subscale, and a Cronbachs alpha of .70 was reported for the extrinsic subscale, with a test re-test reliability of .84 and .78 (Batson et al, 1993).

The Brief cope scale was developed by (Carver, 1997). It is a 28-item scale originally divided by Carver into 14 subscales; participants answer one of four choices for each question such as "I haven't being doing this at all" or "I've been doing this a lot". The scale assesses the individuals coping style in relation to stress. For the purpose of my thesis only four subscales of different coping types, developed by (Gibbons, 2010), was used for the purpose of this thesis. They were used as having fewer factors when running a multiple regression, makes the regression more manageable. The four types of coping subscales were approach coping, avoidance coping, altering consciousness and seeking support. The Cronbachs alpha for each factor was .8 and they each had face validity (Gibbons, 2010).

Results

Section 8h: Descriptive statistics

There is a total of 100 participants used in this study, broken up into (n=23) males and (n=77) females. The average age of the participants is 27, and the age range is from 18-55.

Table 1: *Descriptive statistics for all non-demographic variables.*

Variable	Mean	Standard deviation	Mode	Minimum	Maximum
Life satisfaction	22.23	7.44	30	5	35
General health	3.67	3.60	0	0	12
Intrinsic religion	17.45	7.53	8	8	36
Extrinsic religion	29.26	8.31	33	11	48
Approach coping	22.22	5.75	23	9	34
Avoidance coping	15.64	5.15	12	8	26
Alter consciousness	6.51	2.59	4	4	16
Seeking support	11.76	3.84	10	5	20
Death anxiety	57.38	9.29	57	21	79

The descriptive results show that the overall mean for death anxiety for all participants is 57.38 out of a maximum 79, and a minimum of 21. When participants are broken down into gender, females reported a mean score of 58.34 whereas males had a mean score of 54.17. These results suggest that females have higher levels of death anxiety than males.

The overall mean score for all participants for life satisfaction is 22.23 out of a maximum of 35 and a minimum of 5. When the participants are broken down into gender, females reported a mean score of 23 and males reported a mean score of 20.19. These results suggest a slight significant difference between males and females.

The overall mean score for all participants for the general health questionnaire (GHQ) is 3.70 out of a maximum score of 12, and a minimum score of 0. When the participants are broken down into gender, males reported a mean score of 3.30, females reported a mean score of 3.80. These results suggest no significant difference between males and females.

The overall mean score for intrinsic religious orientation is 17.45 out of a maximum score of 36, and a minimum score of 8. When participants are broken down into gender, males reported a mean score of 15.43, females reported a mean score of 18.07. These results suggest that there is a significant difference between males and females, with females having a stronger intrinsic religious orientation than males.

The overall mean score for extrinsic religious orientation is 29.30 out of a maximum score of 48, and a minimum score of 11. When participants are broken down into gender, males reported a mean score of 29, females reported a mean score of 29.40. There is no significant difference between males and females and extrinsic religious belief.

The overall mean score for approach coping style is 22.22 out of maximum score of 34, and a minimum score of 9.When participants are broken down into gender, males reported a mean score of 22.60, females reported a mean score 22.10. This suggests no significant between males and females in their use of an approach coping style.

The overall mean score for avoidance coping style is 15.64 out of a maximum score of 26, and a minimum score of 8. When participants are broken down into gender, males reported a mean score of 16.34, females reported a mean score of 15.43. This suggests a slight significant difference between males and females in their use of an avoidance coping style.

The overall mean score for altering consciousness as a coping style is 7 out of a maximum 16, and a minimum score of 4. When participants are broken down into gender, males reported a mean score of 7.21, females reported a mean score of 6.30. This suggests a slight significant difference between males and females in the use of altering consciousness as a coping style.

The overall mean score for seeking support as a coping style is 12 out of a maximum 20, and a minimum of 5. When participants are broken down into gender, males reported a mean score 11.43, females reported a mean score of 12. This suggests no significant difference between males and females in seeking support as a coping style.

Section 9i: Inferential statistics

A Pearsons product-moment correlation coefficient was run to assess the relationship between death anxiety and all other predictor variables. There was found to be no correlation between death anxiety and any of the predictor variables.

A second Pearson correlation was run, omitting the variable of death anxiety. The relationship between life satisfaction and all other predictor variables was tested. There was significant negative relationship between life satisfaction and the general health questionnaire. ($r = -.506$, $n = 100$, $p < .005$) this indicates that a higher score on the GHQ leads to lower life satisfaction. The more a person is stressed the lower their satisfaction with life. See table 2.

Table 2: Pearsons correlation table

Variables	General health	Intrinsi religion	Extrinsic religion	Approach coping	Avoidance coping	Alter consciousness	Seeking support	Life satisfaction
General health	1							
Intrinsic religion	.100	1						
Extrinsic religion	.176	.638**	1					
Approach coping	.040	.165	.125	1				
Avoidance coping	.502**	.094	.114	.316**	1			
Alter consciousness	.191	.392**	.167	.272**	.291**	1		
Seeking support	-.011	.085	-.015	.569**	.312**	.320**	1	
Life satisfaction	-.506**	.024	-.030	.033	-.258**	-.222*	.022	1

* p is significant at .05 level.
**p is significant at .01 level.

A significant negative relationship between life satisfaction and the use of avoidance coping. ($r = -.258$, $n = 99$, $p < .005$) this indicates that the more a person uses an avoidance coping style the less satisfied they are with life.

A significant negative relationship between life satisfaction and altering consciousness as form of coping was found. ($r = -.222$, $n = 100$, $p < .005$) this indicates that the more a person uses the coping style of altering consciousness, the less satisfied they are with life.

The was no significant relationship between age of participants and death ($r = -.069$, $n = 100$, $p > .005$), or satisfaction with life ($r = -.008$, $n = 100$, $p > .005$).

An independent samples t-test was run to find if there is a relationship between gender and all predictor variables. There was a significant difference reported between males (M = 54.17, SD = 9.40) and females (M = 58.33, SD = 9.10) in relation to death anxiety (t(98) = -1.91, p = .059). This result suggests females have a higher level of death anxiety than males. See table 3.

Table 3: *An independents sample t-test table displaying the differences between males and females for the various variable*

Variables	Gender	Mean	SD	t	df	p
Death anxiety	Male	54.17	9.40	-1.91	98	.059
	Female	58.33	9.10			
Life satisfaction	Male	20.08	7.36	-1.58	98	.116
	Female	22.87	7.39			
Intrinsic religion	Male	15.43	6.25	-1.47	97	.143
	Female	18.06	7.81			
Extrinsic religion	Male	28.95	9.94	-.203	96	.840
	Female	29.36	7.82			
Approach coping	Male	22.60	4.76	.366	97	.715
	Female	22.10	6.05			
Avoidance coping	Male	16.34	4.98	.743	97	.459
	Female	15.43	5.21			
Altering consciousness	Male	7.21	2.64	1.49	98	.137
	Female	6.29	2.56			
Seeking support	Male	11.43	3.70	-.460	98	.647
	Female	11.85	3.90			
General Health	Male	3.60	3.75	-.618	98	.538
	Female	3.79	3.57			

An independent t-test between at risk groups of a stress related illness and not at risk groups of a stress related illness and key predictor variables. 51% of the sample was found to be at risk of a stress related illness. There was a significant difference in the scores of the at risk group (M = 18.75, SD = 7.56) and the not at risk group (M = 25.86, SD = 5.34) in relation to levels of life satisfaction (t(98) = 5.41, p = .000). This result suggests that people with higher life satisfaction are at less risk of a stress related illness. See table 4.

Table 4: *An independent sample t-test table displaying the differences between participants at risk of a stress related illness and the not at risk group for the various variables.*

Variables	GHQ casesness	Mean	SD	t	df	p
Death anxiety	At risk	57.90	7.72	-.571	98	.569
	Not at risk	56.83	10.73			
Life satisfaction	At risk	18.74	7.55	5.41	98	.000
	Not at risk	25.85	5.34			
Intrinsic religion	At risk	17.78	7.36	-.432	97	.666
	Not at risk	17.12	7.76			
Extrinsic religion	At risk	30.50	7.54	-1.51	96	.134
	Not at risk	27.97	8.95			
Approach coping	At risk	22.66	5.01	-.790	97	.432
	Not at risk	21.75	6.47			
Avoidance coping	At risk	17.33	5.17	-3.54	97	.001
	Not at risk	13.85	4.53			
Altering consciousness	At risk	6.94	2.74	-1.71	98	.090
	Not at risk	6.06	2.37			
Seeking support	At risk	11.88	3.62	-.323	98	.747
	Not at risk	11.63	4.10			

Note: p is significant at .05 level

There was a significant difference in the scores of the at risk group (M = 17.33, SD = 5.17) and the not at risk group (M = 13.85, SD = 4.53) in relation to avoidance coping (t(97) = -3.55, p = .001). Results suggest the use of avoidance as a coping style can be a risk in developing a stress related illness.

There was a significant difference in the scores of the at risk group (M = 6.94, SD = 2.74) and the not at risk group (M = 6.06, SD = 2.37) in relation to altering consciousness coping (t(98) = -1.711, p = .090). Results suggest the use of an altering consciousness coping style can be a slight risk in developing a stress related illness.

A multiple regression was run with the dependent variable of life satisfaction and the predictor variables of gender, general health, altering consciousness and avoidance coping. It was found 30% of the variance explained by the predictor variables. See table 5.

(R^2 = .298 (4.94) = 9.98, p < .001).

GHQ (B = -.518, p < .001, 95% CI = -1.479, -.654)

Gender (B = .176, p < .001, 95% CI = .017, 6.153)

Altering consciousness (B = -.107, p > .001, 95% CI = -.825, .214)

Avoidance (B = .047, p > .001, 95% CI = -.229, .363)

These results suggest that GHQ and gender are predictors of life satisfaction.

Table 5: *Multiple regression analysis of life satisfaction with GHQ, avoidance coping, altering consciousness and gender as predictor variables.*

Model	Unstandardized coefficients		Standardized coefficients	t	Sig
	B	Std error	Beta		
Constant	21.58	3.88		5.55	.000
General Health	-1.06	.208	-.518	-5.13	.000
Avoidance	.067	.149	.047	.451	.653
Alter consciousness	-.306	.262	-.107	-1.16	.246
Gender	3.08	1.54	.176	1.99	.049

Dependent variable: Life satisfaction
R^2 = .298, Adjusted R^2 = .268

A second multiple regression was run omitting the least significant variable of avoidance coping. It was found 30% of the variance was explained by the predictor variables. See table 6.

(R^2 = .302, f(3,96) = 13.85, p < .001)

GHQ (B = -.498, p < .001, 95% CI = -1.385, -.670)

Gender (B = .174, p < .001, 95% CI = .035, 6.089)

Altering consciousness (B = -.101, p > .001, 95% CI = -.793, 210)

Table 6: *Multiple regression analysis of life satisfaction with GHQ, altering consciousness and gender as predictor variables.*

Model	Unstandardized coefficients		Standardized coefficients	t	Sig
	B	Std error	Beta		
Constant	22.47	3.39		6.62	.000
General health	-1.02	.180	-.498	-5.70	.000
Alter consciousness	-.291	.253	-.101	-1.15	.252
Gender	3.06	1.52	.174	2.00	.047

Dependent variable: Life satisfaction
R^2 = .302, Adjusted R^2 = .280

Discussion:

This study set out to investigate five separate hypotheses. The first was to find if there was a relationship between extrinsic and intrinsic religious orientation. The second hypothesis was to investigate a relationship between death anxiety and gender. The third hypothesis set out to investigate the relationship between death anxiety and age. The fourth hypothesis suggested there would be a relationship between death anxiety and coping styles, specifically a social coping style. The fifth was to find a relationship between participants with an intrinsic religious orientation and the level of their life satisfaction. The final hypothesis suggested that participants with an intrinsic religious orientation will have better psychological health than participants with an extrinsic religious orientation.

100 participants of various ages completed a booklet that required the participants to identify their gender and age. In addition they were requested to complete the Templer/McMordie death anxiety scale, the religious orientation scale, the brief cope scale, the satisfaction with life scale and the general health questionnaire. Using SPSS descriptive and inferential statistics were run, such as Pearsons correlation coefficient, and Independent samples t-test, and multiple regressions.

Hypothesis one predicted that people with intrinsic religious orientation would have lower death anxiety than people with an extrinsic religious orientation. Pearsons r correlation was used to test death anxiety and intrinsic and extrinsic religious orientation, so see if a statistically significant relationship existed. The results showed no significant relationship between death anxiety and intrinsic and extrinsic religious orientation. Therefore the hypothesis was not supported.

Hypothesis two predicted that females would have higher levels of death anxiety than males. The mean score for death anxiety for males is 54.17, and for females the mean score for death anxiety is 58.33. An independent samples t-test yielded results showing a significant difference between the sexes. It was found females did have higher levels of death anxiety than males. Consequently the hypothesis was supported.

Hypothesis three predicted that there would be a statistically significant difference among different age groups in relation to death anxiety. Participant's ages were divided into four groups. A Pearsons r correlation concluded that there was no significant relationship between age and death anxiety. Therefore the hypothesis was not supported.

Hypothesis four predicted that a social coping style, such as seeking support, would result in lower death anxiety. A Pearsons r correlation was run to test four coping styles, approach coping, avoidance coping, altering consciousness and seeking support and death anxiety. The results showed no significant relationship between death anxiety and any of the four coping styles. Therefore the hypothesis was not supported.

Hypothesis five predicted that participants with intrinsic religious orientation will have higher life satisfaction than participants with extrinsic religious orientation. A Pearsons r correlation was run to test life satisfaction and intrinsic and extrinsic religious orientation. The results showed no significant relationship between life satisfaction and intrinsic and extrinsic religious orientation. Therefore the hypothesis was not supported.

Hypothesis six predicted that participants with intrinsic religious orientation will have lower psychological distress than participants with extrinsic orientation. A Pearsons r correlation was used to test psychological health and intrinsic and extrinsic religious orientation. The results showed no significant relationship between psychological health and intrinsic and extrinsic religious orientation. Therefore the hypothesis was not supported.

In addition to the six hypothesis tested, more statistics were run. A Pearsons r correlation to test if there was a relationship between life satisfaction and all other predictors, omitting death anxiety and demographic variables. The results showed a significant negative relationship between life satisfaction and psychological health
($r = -.506$, $p < .005$). This indicates the more a person is under psychological distress the lower their satisfaction with life. Results also showed a significant negative relationship between life satisfaction and the use of an avoidance coping style ($r = -.258$, $p < .005$). This indicates that the more a person uses an avoidance coping style the less satisfied they are with life. A significant negative relationship between life satisfaction and altering consciousness as a coping style was found ($r = -.222$, $p < .005$).This indicates that the more a person uses the coping style of altering consciousness the less satisfied they are with life. In addition to the Pearsons r coefficient, using the results from the GHQ, participants were put into at risk of a stress related illness group, and not at risk of a stress related illness group. An independent samples t-test was run to test between at risk and not a risk groups and all other key predictors. Results showed 51% of the sample was at risk of a stress related illness. It was found people with higher life satisfaction are less at risk of a stress related illness ($t(98), = 5.41$, $p = .000$). A significant difference between at risk group and not at risk group was found in relation to avoidance coping ($t(97), = -3.55$, $p = .001$). This indicates that the participants that use an avoidance coping style can be at more risk of developing a stress related illness. There was also

a significant difference between the at risk group and not at risk group and altering consciousness as a coping style ($t(98) = -1.71$, $p = .090$). This indicates the use of the coping style of altering consciousness can be a slight risk in developing a stress related illness. A multiple regression was also run using the dependent variable of life satisfaction and the predictors of gender, psychological health (GHQ), and altering consciousness. The results indicate that psychological health and gender are predictors of life satisfaction.

In order to understand the results it is important to look at the methodological issues within the study. The Templer/McMordie death anxiety scale is a revision of the original (Templer, 1970) death anxiety scale. The original is a 15-item scale used in 60% of all studies published about death anxiety (Niemeyer &Van Brunt, 1995). Its primary weakness is related to the true-false format, the internal consistency is only fair, the response bias has not been determined and the discrimitive power is weak (McMordie, 1978). To improve these weaknesses the scale was converted to likert format. Likert scoring of a scale will produce higher reliability. The second method used to improve reliability was changing the wording of the item stems to a greater intensity e.g. “not particularly afraid” could be changed to “ scares me greatly” some item stems could also be changed to be made more personal “ thought of death” to “thought of my death”. This can give the scale greater intensity and so better accuracy. This study did not include the change in item stem intensity, if so; it may have had more accuracy in measuring death anxiety.

These results support other research results from (Ens & Bond 2007; McDonald, 1976) were they found no significant relationship between religiosity and death anxiety. It was found in these studies that females have higher death anxiety than males which was also confirmed by this study. No significant relationship between religious orientation and death anxiety was found by (Feifel, 1976; Sullivan, 1977), and only a modest relationship was found between the death anxiety scale and the religious orientation scale by (Neimeyer et al, 2004). As shown in review of death anxiety literature, the trend is that there is at best a modest relationship between religious orientation scales and death anxiety (Neimeyer, Wittowski, & Moser, 2004).

A limitation of this research is that in the religious orientation scale there is no option for non-religious groups, which may have forced non-religious participants to disagree with all questions on the religious orientation scale, this would lead to a possible third group that was neither intrinsically or extrinsically religious, but not non-religious either. A simple question asking, whether a participant was religious or not could rectify this problem. This is important as (McMordie, 1981) found that individuals with very high or very low religiosity have low death anxiety, meaning that a non-religious group that could potentially have a significant relationship with death anxiety was not included in this study. Another critique of the religious orientation scale is that using and living one's religion is very important, and separating the two aspects into intrinsic and extrinsic is contrived, and perhaps the most religiously developed integrate both aspects (Pargament, 1992). It was hypothesized that a strong belief system for against religious belief increases perception of control and predictability and decreases death anxiety. So people with no religious belief could not be measured in this study. The absence of any relationship between religious orientation and death anxiety could also be explained in terms of religion having a limited effect upon the attitudes and behaviour of most undergraduate students in our society (Templer & Dotson, 1981). Further research could rectify this if the sample was taken directly from a religious congregation were there would be

large amounts of participants who have extrinsic and intrinsic religious orientation.

The second hypothesis was supported as females were found to have higher death anxiety than males. This finding is consistent with previous research conducted (Noppek, 1999; McDonald, 1976; Power & Smith, 2008; Niemeyer & Von Brunt, 1995; Jackson, 2008; Suhail & Akram, 2002; Mahabeer & Bhana, 1984). This is valid information but knowledge on why this is so is limited. Further research could attempt to understand males have less anxiety than females. Attempts to understand this have been made by (Mahabeer & Bhana, 1984). They attribute the difference to sex-role expectancies which require males to be free from anxiety and fear, even though they have similar death anxiety to females but will not admit it. (Holcombe et al, 1993) have also addressed this issue and conclude that females construe death more in terms of negative emotions, and also relative to males viewed death as something having greater personal impact, despite their more frequent tendency to see it as a continued form of existence.

The third hypothesis was not supported, no significance difference was found among the four age groups in relation to death anxiety. This supports results from (Templer et al, 1971), they found no relationship between age and death anxiety. It rejects (Jackson, 2008; Thorson and Powell, 1988) who yielded results showing older adults reporting to have lower death anxiety than younger adults. (Rasmussen & Brems, 1996) found that psychological maturity was a better predictor of death anxiety than age. Further research on the topic may include the Constantinople inventory of psychosocial development, which would measure psychological development. A limitation of this study is that over half the participants were between the ages 18-26, leading to the other groups producing mean scores from a smaller sample. The oldest participant was only 55. Further studies could ensure that each group was equally weighted, and a more equal male to female ratio, as females made up 77% of the sample. Instead of using

a cross sectional study, the implementation of a longitudinal study may reveal results of death anxiety levels over an individual's lifetime.

The fourth hypothesis was not supported, there was no relationship found between death anxiety and coping. There is no previous research regarding the Brief cope subscales devised by (Gibbons, 2008), which was a motivation for this research. Results from this study reject results from (Florian, Mikulincer & Hirschberger, 2002) they found close social relationships can act as an inoculating power against existential threats. These results also reject results from (Catania et al, 1992) they found social support especially from family members significantly reduced death anxiety in HIV+ gay men.

Hypothesis 5 was not supported, there was no relationship found between religious orientation and life satisfaction. This supports results from (Steinitz 1980; Markide 1983) were no relationship between religious orientation and life satisfaction was found. (Okuliez- Kozovyh, 2010) reported that religious belief itself was not a predictor of life satisfaction, but the social aspect of religion can increase life satisfaction. In a comprehensive review of 100 studies on the relationship between life satisfaction and religiosity, 13 were found to have no relationship (Koenig, McCullough & Larson, 2001). No relationship between religiosity and life satisfaction could be seen as an indicator that religion plays a limited role in the lives of undergraduate students as it affects their life satisfaction in a neither positive nor negative way. (Hunsberger, 1985) reported that religiosity increases with age in relation to life satisfaction in a study of 65-88 year olds. The reason for this study finding no significant relationship between religious orientation and life satisfaction, maybe due to the fact that over 50% of the sample age are below 27, religion is less likely to have an impact on the lives of younger participants. The extended satisfaction with life scale could have been used in this study to give more

accurate readings of life satisfaction, this is a 50-item self-report scale, divided into nine subscales, general life, social life, sex life, relationship, self, physical appearance, family life, school life and job satisfaction. This was not implemented in this study due to time constraints in collecting data, as the extended satisfaction with life scale takes 20 minutes to complete (Alfonso, Allison & Rader, 1996). Further research using the extended satisfaction with life scale may find a relationship between one of the subscales and religious orientation.

Hypothesis six was not supported. There was no relationship between religious orientation and psychological health. This supports research by (O'Connor et al, 2001), they found no relationship between psychological health and religiosity in a sample of undergraduate students, and (Pokorski & Warzecha, 2011) found no relationship in a sample of a population. Some data suggest there is a relationship between religiosity and psychological health (Seybold & Hill, 2001) found religiosity can serve as a buffer against psychological distress. (Maltby et al, 1999) suggests that the important mechanism moderating the relationship between religious orientation and psychological health is frequency of religious practice. They found the frequency of personal prayer and not orientation was the dominant measure explaining variances in psychological distress. A study by (Hyman, 2005) found that scores were significantly higher on the GHQ-12 among the religious participants, which suggests religious belief increases psychological distress.

All data was collected using self-report questionnaires, the problem with self-report questionnaires is that students may not wish to report factors that they may be ashamed off, such as not being able to deal with stress or using a more negatively perceived coping style. Religious participants may not report being so, as religious belief in Ireland is becoming less especially among the younger population (O'Mahony, 2008), a religious participant may not

admit to be so, for the reason of social desirability.

Another limitation of self-report measures participants are asked to respond in a generalized and after the experience or feeling has happened; this leads us to think that responses may have a limited accuracy. Also the participants were final year psychology students who themselves were carrying out their own data collection and perhaps using some of the same scales as used in this study, which may have affected their appraisals and responses. There was a limited sample of only 100 participants, which may not be representative of the population as a whole.

Additional results

After running Independent t-tests, and multiple regressions not including any of the hypotheses, some significant results were found. 51% of the participants were at risk of a stress-related illness. This supports research by (Muhamed Saiful Bahri et al, 2011) when using the GHQ-12 found 50% of first year medical students were at risk of a stress-related illness.(Guthrie et al, 2009) found similar results, 36% of a medical student sample were at risk of a stress-related illness.

It was found also that the coping styles of altering consciousness, which includes drug, alcohol use, religious practices and meditation, and the coping style of avoidance which a similar coping style to the one previously mentioned, had a greater risk of incurring a stress related illness (Gibbons et al, 2010). The results also indicate that those with greater higher life satisfaction are at less risk of developing a stress related illness.

The results suggest that the participants are using coping styles that are causing psychological stress. Psychological stress is a relationship between the person and the environment that is appraised by the person as either exceeding his or her own resources, causing potential harm to their well-being. Coping can be seen as how the individual manages the person environment relationship, which is seen as stressful to them. Primary appraisal of a situation is the initial

perception about a stressor and whether it is positive eustress or negative distress. Secondary coping deals with how the person copes with the stressor (Lazarus & Folkman, 1984). A study by (Goldring, 2012) looked into stress in university students and found some evidence toward the subjectivity of stress. It was found the structure of the university can lead to increased levels of stress. The design of the intense schedule of study may represent a goal to difficult to reach for some students, whereas on the other hand the schedule can be seen as an achievable challenge. They also found time requirements, extra-curricular activity, major assignment deadline, where all additional stressors leading to mental health issues. These stressors combined with the coping styles of altering consciousness and avoidance could be a possible reason why over half of the participants are at risk of a stress-related illness.

Conclusion:

These findings suggest that the only predictor of death anxiety is gender, with females having significantly higher levels than males. Additionally this study found that the undergraduate psychology student sample is at high risk of developing a stress related illness, perhaps of the coping styles these individuals are using or the extra stress involved in the final year of a psychology degree. These findings are quite important in relation to interventions for at risk students.

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Appendix:

Participant Information sheet

Hi,

My name is Gavin Moore, I am a third year psychology student and for my thesis I am conducting research on how death anxiety and life satisfaction is affected by religious belief, social support, coping style, age and gender. I will be asking you to complete the Templer death anxiety questionnaire, the general health questionnaire, the brief cope questionnaire and religious orientation scale.

Completion of the questionnaire is entirely voluntary and responses will be kept anonymous. The questionnaire will take approximately 10-15mins to complete. Previous research using questionnaires has found participants do not find it distressing. Once the results have been analysed for the purpose of this study they will be destroyed. Participation in the survey can be withdrawn at any time.

Please tick box

☐ I am over 18 and wish to take part

Please ask if there is anything that is not clear or if you would like more information and take time whether or not you decide to take part. If you wish to contact me [redacted] or my supervisor is Dr Chris Gibbons [redacted]

Participant Consent Form

Title: Religiosity as a coping mechanism for death anxiety.

Name of Researcher:.....

Please put an X besides each point

1. I confirm that I have read and understood the Participant information sheet dated.....for the above study. I have had the opportunity to consider the information and, if questions were asked have had these answered satisfactorily.....

2. I understand that the information I contribute in completing the memory recall task may be looked at and analysed by the researchers.....

3. I agree to take part in this research.....

4. This agreement is of my own free will.....

5. I realise that I may withdraw from the study at any time without giving a reason and without any effect on my education.....

6. I have been given full information regarding the aims of the research and have been given information with the researchers' names on and a contact number and address if I require further information.....

7. I recognise that all personal information provided by myself will remain confidential and no information that identifies me will be made publicly available.....

Signed:..... Date:.....

(By researcher)

Print name:.....

Please answer the following:

Age: ☐

Male: ☐ Female: ☐

This form contains a series of statements. Read each one, carefully and decide how you feel about it and then use the coding categories 1-4 to answer the question. Make your answers as true FOR YOU as you can. Place your answer at the end of each sentence.

Coding categories:

1 = I haven't been doing this at all

2 = I've been doing this a little bit

3 = I've been doing this a medium amount

4 = I've been doing this a lot

1. I've been turning to work or other activities to take my mind off things.
2. I've been concentrating my efforts on doing something about the situation I'm in.
3. I've been saying to myself "this isn't real."
4. I've been using alcohol or other drugs to make myself feel better.
5. I've been getting emotional support from others.
6. I've been giving up trying to deal with it.
7. I've been taking action to try to make the situation better.
8. I've been refusing to believe that it has happened.
9. I've been saying things to let my unpleasant feelings escape.
10. I've been getting help and advice from other people.
11. I've been using alcohol or other drugs to help me get through it.
12. I've been trying to see it in a different light, to make it seem more positive.
13. I've been criticizing myself.

14. I've been trying to come up with a strategy about what to do.
15. I've been getting comfort and understanding from someone.
16. I've been giving up the attempt to cope.
17. I've been looking for something good in what is happening.
18. I've been making jokes about it.
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
20. I've been accepting the reality of the fact that it has happened.
21. I've been expressing my negative feelings.
22. I've been trying to find comfort in my religion or spiritual beliefs.
23. I've been trying to get advice or help from other people about what to do.
24. I've been learning to live with it.
25. I've been thinking hard about what steps to take.
26. I've been blaming myself for things that happened.
27. I've been praying or meditating.
28. I've been making fun of the situation.

This form contains a series of statements. Read each one, carefully and decide how you feel about it and put a corresponding number that closely relates to how you feel at the end of each statement. Try to use the undecided and neutral ratings as little as possible. Please answer all items.

.

Very strongly disagree =1 strongly Disagree = 2 Disagree = 3 Neutral = 4

Agree = 5 strongly agree = 6 Very strongly agree = 7 Undecided = 8

29. I am very much afraid to die.

30. The thought of death seldom enters my mind.

31. It doesn't make me nervous when people talk about death.

32. I dread to think about having to have an operation.

33. I am not at all afraid to die

34. I' m not particularly afraid of getting cancer.

35. The thought of death never bothers me.

36. I am often distressed by the way time flies so rapidly.

37. I fear dying a painful death.

38. The subjects of life after death troubles me greatly.

39. I am really scared of having a heart attack.

40. I often think about how short life really is.

41. I shudder when I hear people talking about World War III.

42. The sight of a dead body is horrifying to me.

43. I feel the future holds nothing for me, to fear.

Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

- 7 - Strongly agree
- 6 - Agree
- 5 - Slightly agree
- 4 - Neither agree nor disagree
- 3 - Slightly disagree
- 2 - Disagree
- 1 - Strongly disagree

44.____ In most ways my life is close to my ideal.

45.____ The conditions of my life are excellent.

46.____ I am satisfied with my life.

47.____ So far I have gotten the important things I want in life.

48.____ If I could live my life over, I would change almost nothing.

Please indicate the extent in which you agree or disagree with each item below by using the following rating scale.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

49. Although I believe in my religion, I feel there are many more important things in my life.

50. It doesn't matter so much what I believe so long as I lead a moral life.

51. It is important for me to spend periods of time in private religious thought and meditation.

52. The primary purpose of prayer is to gain relief and protection.
53. If not prevented by unavoidable circumstances, I attend church.
54. I try hard to carry my religion over into all my other dealings in life
55. The church is most important as a place to formulate good social relationships.
56. The prayers I say when I am alone carry so much meaning and personal emotion as those said by me during services.
57. What religion offers me most is comfort when sorrows and misfortune strike.
58. I pray chiefly because I have been thought to pray.
59. Although I am a religious person I refuse to let religious considerations influence my everyday affairs.
60. A primary reason for my interest in religion is that my church is a congenial social activity.
61. Quite often I have been keenly aware of the presence of god or the divine being.
62. Occasionally I find it necessary to compromise my religious beliefs in order to protect my social and economic well-being.
63. I read literature about my faith (or church).
64. If I were to join a church group I would prefer to join a bible study group rather than a social fellowship.
65. One reason for my being a church member is that such memberships help establish a person in the community.
66. The purpose of prayer is to secure a happy and peaceful life.
67. My religious beliefs are really what lie behind my whole approach to life.
68. Religion is especially important because it answers many questions about the meaning of life.

Please answer all the questions simply by circling or emboldening the answer that you think most nearly applies to you. Remember that we want to know about your present and recent complaints, not those you had in the past. It is important that you try to answer all the questions.

Have you recently:

1. been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2. lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3. felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4. felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
5. felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6. felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7. been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8. been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
9. been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10. been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11. been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12. been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual

Thank you for your participation in this study. Your time is greatly appreciated.

If you have any questions or issues and wish to talk to someone the following organisations provide support: The Samaritans is a confidential 24 hour support service, LoCall: 1850 60 90 90, email: jo@samaritans.org.Councellingdirectory.ie is Ireland's largest independent directory of accredited counsellors and psychotherapists with over 1200 listings.