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The fear of death and the fear of dying: Possible barriers to altruistic behavior

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THE FEAR OF DEATH AND THE FEAR OF DYING:
POSSIBLE BARRIERS TO ALTRUISTIC BEHAVIOR

By

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Thesis

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MASTER OF ARTS

In

Sociology

Thesis Committee:

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March 15, 2005

Ypsilanti, Michigan

DEDICATION

I dedicate this work to my family, for without the support of my partner, Chadd, and my children, James, Daphne, and Ava, I could have never persevered through the rough spots. I also want to thank my friends, colleagues, and loved ones who helped make this research possible.

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Both individuals have not only been supportive of me through my journey and served as my mentors, but have become my lifelong friends in the process. Thank you both.

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ABSTRACT

Research in the study of the fear of death and dying and the study of altruism implies that there is a dynamic relationship between the two fields. Rarely, if ever, has a direct connection been made. This study is an effort to further explore the relationship that exists between the fear of death and dying, altruistic behavior, self-esteem, and perceptions of a common humanity. Through the synthesis of these four key social psychological concepts, a theoretical model was developed and tested.

Through the examination and statistical analysis of quantitative data and the systematic evaluation of interview data, several connections between our measures were made. The fear of death and dying is causally related to some degree to self-esteem and perceptions of a common humanity. Data failed to show a direct relationship between the fear of death and dying and altruistic behavior.

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CHAPTER 1: INTRODUCTION

Background and Significance

This study explores the relationship between two central social-psychological phenomena: altruism and the fear of death and dying. These two topics have received considerable attention as separate factors in human relationships, but research that treats the two as variables in a single theoretical model has rarely, if ever, been conducted.

The fear of death and dying has been studied extensively. It is best understood, however, within the field of psychology in psychoanalytic terms. Although Freud was no stranger to the discussion of death and dying, it is Ernest Becker who challenged the field of psychoanalysis and claimed that it is perhaps the fear of death, rather than the libido, that drives our behavior.

The topic of altruism, too, has been of interest to researchers and laypersons alike for many years. The term *altruism* is credited to nineteenth-century scholar August Comte. And although no approach to altruism has come to be accepted by all, many have continued the quest for a greater understanding of this phenomenon.

Current research in the study of altruism and the study of the fear of death and dying *implies* that a relationship exists between the two fields, but rarely has an explicit connection been made. Although abundant, the literature on the two subjects leaves at least one significant question unanswered: What factor or factors are responsible for inhibiting some people from acting altruistically while allowing others to participate in altruistic behavior?

The implied connection between altruistic behavior and the fear of death and dying is such that the two are inversely related, dynamic, and mediated by two key

concepts: self-esteem and perception of a common humanity.¹ This dynamic relationship exists such that when we display a high fear of death and dying, we close ourselves off from common humanity. This separateness feeds into a low self-esteem, giving us ultimately a barrier to altruistic behavior. The following statement can also be stated in the reverse: by behaving altruistically, we naturally feel good about ourselves, perceive a common humanity, and will have a healthier-minded attitude toward death and dying, therefore fearing it less. This study is designed to explore the dynamic cumulative and cyclical² model as outlined in Figure 1.1:

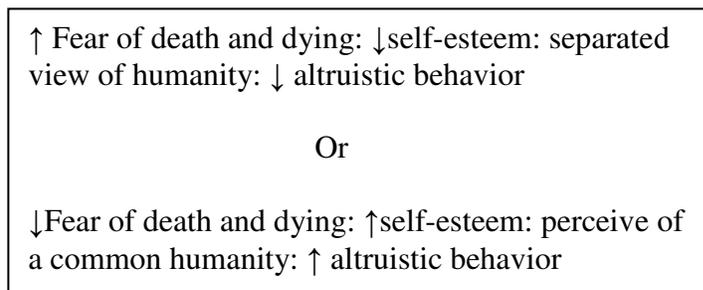


Figure 1.1: The creation of an exploratory model.

The aim of the field of sociology is to enhance our understanding of human interactions and to apply our knowledge in order to improve the world. It follows then that the study of what underlies (1) the predisposition to behave (or not to behave) altruistically and (2) the tendency to fear the natural process of death and dying is essential. When we can understand the barriers to such helping behavior and other manifestations of altruism, and to a more accepting view of death and dying, perhaps we can also begin to prescribe means by which such barriers might be overcome.

¹ The concept *perception of a common humanity* is credited to Kristen Renwick Monroe (1996).

² The concept *cumulative and cyclical* is credited to Gunnar Myrdal (1944).

The semantics of altruistic *attitudes* and altruistic *behavior* can be overcome by simply clarifying that altruistic behavior is the physical manifestation of an altruistic attitude.

Purpose of the Study

We live in a society that is generally motivated by fear. For example, from a very young age we are taught to fear strangers, the bogeyman, and evil stepmothers. Reinforcing our fears as we come into adulthood, the media inundate us with stories and images of atrocities including natural disasters, car crashes, robberies, muggings, and rapes. Rarely, if ever, are we told that we live in a safe place, free from harm.

What are the effects of these messages? Do they shape our perceptions of the world and of humanity? Could they reinforce our death anxiety and thus serve as a barrier to altruistic behavior? These questions lead to the suggestion that the messages that we receive from our environment fuel our natural fear of death and dying. That is, the forces that exacerbate our natural fear of death and dying also alter our capacity to perceive a common humanity and therefore inhibit altruistic behavior.

This study is an effort to further explore the relationship that exists among the fear of death and dying, altruistic behavior, self-esteem, and perception of common humanity.

Research Questions and Hypotheses

This study stems primarily from an interest in altruism. More specifically, what makes one person act altruistically, whereas another may act in a manner that purely reflects self-involvement? Based on this interest, this study explores the following research questions:

- Does the fear of death and dying have a negative effect on altruistic behavior?

- What role does self-esteem play in relation to the fear of death and dying and altruistic behavior?
- What role does perception of common humanity play in relation to self-esteem, the fear of death and dying, and altruistic behavior?
- Are there significant gender differences in altruistic behavior, perception of common humanity, self-esteem, and/or fear of death and dying?
- Do those personally affected by cancer differ in their perception of common humanity, behavior, and/or fear of death and dying?

From the above research questions, the following null and research hypotheses were derived:

Null Hypotheses

- The fear of death and dying has no effect on altruistic behavior.
- There is no relationship between self-esteem and altruistic behavior.
- There is no relationship between perception of a common humanity, self-esteem, fear of death and dying, and altruistic behavior.

Research Hypotheses

- The fear of death and dying has a negative effect on altruistic behavior.
- There is a relationship between self-esteem and altruistic behavior.
- There is an inverse, dynamic relationship between perception of common humanity, self-esteem, the fear of death and dying, and altruistic behavior.

Central concepts to the aforementioned hypotheses include altruistic behavior, self-esteem, fear of death and dying, and a perception of common humanity. We can draw several assumptions from these hypotheses as well; for example, by fearing

death/dying, we separate ourselves from fellow humanity, thus making it psychologically easier to not help someone else in need. This isolation can therefore serve to lower one's self-esteem and even further justify selfishness.

Theoretical Framework

Key to the integrity of this project is the creation of a theoretical synthesis. The fields of social psychology, philosophy, historical sociology, and political psychology have been invaluable sources of information and research.

The creation of a non-recursive, causal model illustrating this theoretical synthesis is made possible through the application of the cognitive orientation *perception of a common humanity* as outlined by Monroe, Sorokin's definition of *altruism*, Becker's existential evaluation of *the fear of death*, and Oliner's historical review of moral exemplars. Equally key to the development of the aforementioned model is the supportive research by Hessing and Elffers, and Midlarsky and Kahana.

The explicit link between the fear of death and dying and altruistic behavior is a rare find. A study by Hessing and Elffers (1985) examined the relationship between self-esteem and altruistic behavior and found the fear of death to be an intervening variable. "There is evidence of a difference in motivations for altruistic behaviors between persons with positive self-esteem or positive mood and persons with negative self-esteem or negative mood" (p. 930).

Through the examination of the self-esteem of organ donors (organ donation being the altruistic behavior), Hessing and Elffers found no relationship between donating behavior and self-esteem. However, it was noted that the fear of death *did not* have an effect on the behavior for those with positive self-esteem. Conversely, it did for

those with low self-esteem. What this indicates is that the fear of death/dying does indeed influence our behavior and that it can serve as a barrier for altruistic behavior. It also indicates that positive self-esteem may in turn influence our fear of death and dying.

Additional significant, supportive research comes from Midlarsky's and Kahana's (1994) test of the theoretical model of "faith development" introduced by Fowler (1981). According to this theory, as one ages, he/she progresses through developmental stages to a point at which self-needs have been met and one can act selflessly. Self-preservation is no longer a concern: the self is ready to encompass universal love or, in Monroe's terms, the perception of a common humanity. When this stage is reached, the individual has come to terms with mortality, fears death less, and is thus more likely to behave altruistically.

According to Midlarsky's and Kahana's interpretation of the theory of faith development, one attains universal love, or faith, only later in life, if at all. Because of a lack of time and relevant experience, they argue, only rarely can younger people reach the highest developmental level. However, the model presented here and the intent of the proposed research is to test the model with a focus on people who, through whatever means (this research examines those who have encountered a situation in which their death is imminent), have come to accept death as a healthy part of life. They are therefore capable of *universal love* or perceiving a common humanity and will have thus reached the final stage developmental stage without necessarily achieving old age.

On the basis of on the observations outlined in the literature, most notably the research supporting the synthesis of the fear of death and dying and altruistic behavior, it

can be deduced that the fear of death and dying and altruism are causally related. To be more specific, the relationship is

1. **Inverse:** A low degree of altruism is associated with a high level of the fear of death and dying. A high degree of altruism is associated with a low level of the fear of death and dying.
2. **Dynamic:** Change in the degree of the fear of death and dying is associated with a change in altruism.
3. **Mediated:** The relationship is not necessarily a direct one and includes other variables, most assuredly, self-esteem and perception of a common humanity.

The following path diagram summarizes the model as it has developed to this point. We see that it is non-recursive such that, reading from left to right, the variable *fear of death and dying* (F) is exogenous and *altruistic behavior* (A) is the final dependent variable. Reading from right to left, these roles are reversed, with altruistic behavior as exogenous and fear of death and dying as the final dependent variable.

Path Model

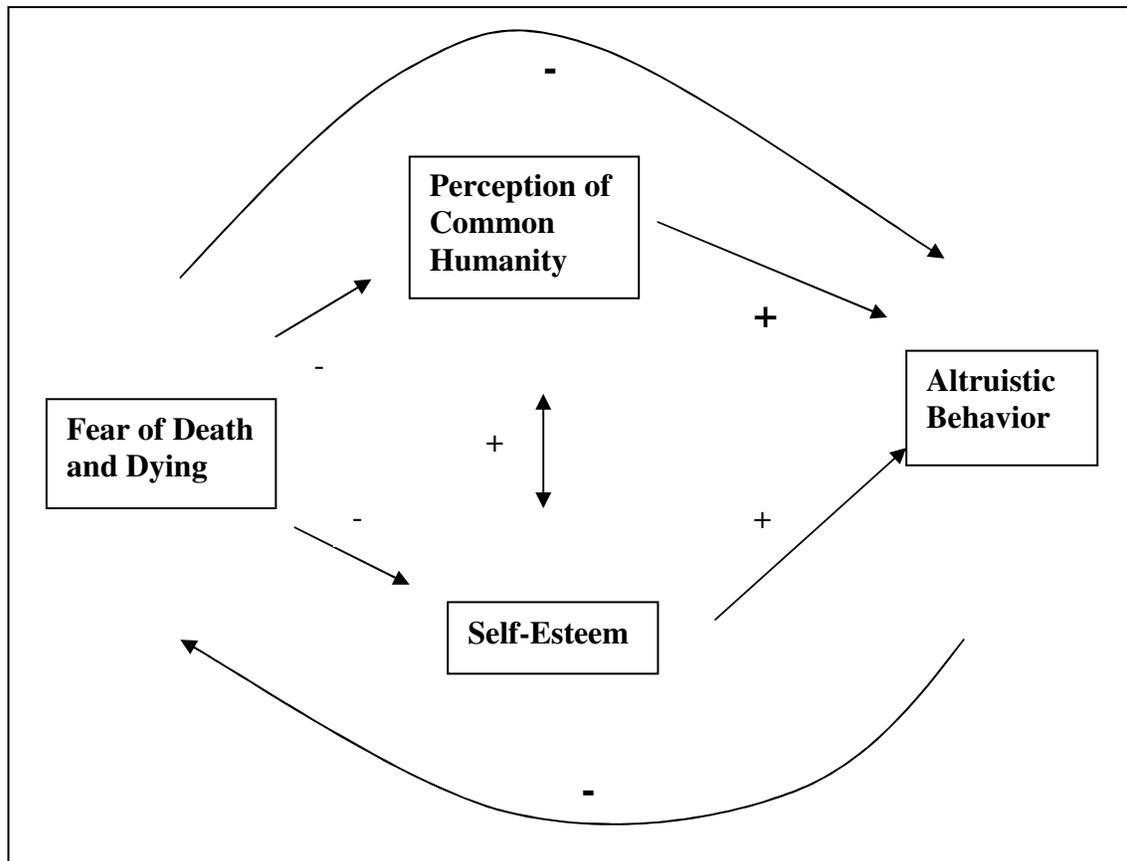


Figure 1.2: Model of the relationship between fear of death and dying and altruism.

The path model in Figure 1.2 is illustrative of the supportive research previously mentioned. As the research by Hessing and Elffers (1985) suggests, the fear of death (F) is negatively associated with altruistic behavior (A). Perception of common humanity (P) is positively associated with A; as outlined by Monroe, doing good for others is not distinguished from doing good for the self. P is negatively associated with F, indicating that the more fearful one is of death and dying, the less connected one feels to humanity. Self-esteem (S) is positively associated with P, which is also implied in the research of Hessing and Elffers, Monroe, and Sorokin in that to recognize a shared humanity is to

identify with all others regardless of their places in the world. Therefore, to encompass a love of humanity is to love oneself, which in turn creates a positive relationship with A.

CHAPTER 2: REVIEW OF RELATED LITERATURE

On Death and Dying

The literature on the fear of death and dying is quite expansive and covers many aspects of the subject. Examples to note are (a) death and dying among the aging, (b) how to cope with the dying of the self or the death of a loved one, (c) personal attitudes toward death and dying, and (d) the fear of death and dying as a social construct—including the media’s influence and, of course, psychoanalytic theories of the fear of death and dying. Despite this range, very little, if any, research has been devoted to the examination of the relationship between the fear of death/dying and altruistic behavior. There are exceptions to note, and those would include the work of Kristen Renwick Monroe (1996). Her research into the field of altruism has contributed a bit of knowledge on how fears may affect one’s behavior, particularly altruistic behavior, by altering one’s perception of humanity, specifically one’s perception of common humanity.

In contemporary Western society, to avoid the finiteness of death and the process of dying, we go so far as to take drastic measures to prolong life (either our own or those of elderly family members for whom we care). New medicines are invented; new cures and therapies are applied to the diseased. With technology, proper nutrition, and medical advancements, we now live longer, even once a terminal illness is diagnosed. We find, however, that as one enters old age, fears and anxieties about death, as well as our perceptions of death, tend to change. Rather than fearing it, we begin to view death as an inevitable experience. Why then, do we continue to give very old and/or very sick patients curative treatments? That is to ask, why do we maintain a “cultural proclivity to deny death and employ heroic means to sustain life?” (Prigerson 1992, p. 380).

Of special interest in this regard is the work of Holly Gwen Prigerson (1992) in which the “social determinants of death acknowledgement and treatment among terminally ill geriatric patients” (p. 378) were investigated. Her research indicated, among other things, that if a patient’s caregiver was unaccepting of death, the patient was less likely to come to terms with dying. Such patients were also less likely to receive the palliative care that they deserved, and instead received curative, life-extending treatments.

The idea of the fear of death/dying as a social construct introduces the notion that our attitudes and fears of death/dying are shaped and reinforced by our social and economic, as well as historical environments. If we were to live in a society that regarded death and dying as a rite of passage, an avenue to the next stage of being, a society that appreciated the aged, we would be more accepting and less fearful. Unfortunately, we do not. We live in a society that appreciates youth and beauty, a society that glorifies violence, and a society that promotes fearfulness to its members. Barry Glassner’s work *The Culture of Fear* (1999) gives many examples of how Americans are misled by media publications, politicians, and advocacy groups. Research into the influence of the media on death/dying anxiety has indicated that exposure to death-related media is positively correlated with participants’ overt and covert death fears (King and Hayslip 2002).

Other important work in the field of death and dying research, or thanatology, is that of Elisabeth Kübler-Ross. It was her landmark work, *On Death and Dying* (1969), that brought the subject of death and dying to the forefront and opened us up to a better understanding of this inevitable phenomenon. In this 1969 study, Kübler-Ross theorized

that the dying pass through a series of five stages of grief, those five stages being denial, anger, bargaining, depression, and acceptance. It was also during this time, as people became more comfortable with the topic of death and dying and there became a greater desire for more humane treatment of the terminally ill, that the first hospices emerged in the United States. Although there are those who refute Kübler- Ross' contributions to our understanding of death and dying, her relentless efforts to bring acceptance and surrender to this most personal and difficult subject are immense and should be commended.

We need to teach the next generation of children from day one that they are responsible for their lives. Mankind's greatest gift, also its greatest curse, is that we have free choice. We can make our choices built from love or from fear.

(Kübler-Ross 2004)

We as a society have a great fear of the unknown, and death is considered by many to be the greatest unknown. People who claim to have died and miraculously come back from it fascinate us; we want to hear their tales of what it was like. We fear not only the permanence of death, but the process of dying as well. The topic leaves us to wonder about the possibility of pain and the effect it will have on others, as well as the uncertainty of when it will come.

It is a fear of the unknown, an annihilation of self, of the process of dying with loss of function, dependence on others, incapacity to tolerate the pain involved, a fear of being alone, and the fear of loss of beloved ones. (Abdel-Khalek 2002:670)

The culture that we live in is in large part shaped by the media. Therefore, our fears and insecurities are greatly influenced and manipulated by these media, in particular television. We are inundated by violent images via television on a daily basis. The feel-good messages of helping behavior and altruistic acts are overshadowed and outnumbered by images of violence. We participate emotionally in these violent acts simply by sitting back and relaxing on our couches. How does all of this violence affect us as human beings, our perceptions, actions, and reactions to reality? What kind of message are we sending our children?

Nine years ago, the American Academy of Pediatrics issued a health warning to its doctors that “exposure to violence in media [poses] a significant risk to the health of children and adolescents” and contributes to “fear of being harmed.” The story is similar for adults. According to the American Psychiatric Association, “Individuals with greater exposure to media violence see the world as a dark and sinister place . . . and overestimate their chance of being involved in violence.” (Shister 2004:27)

Research more specifically examining the media’s effect on our fear of death reveals that

in some cases, general references to death by the media may bring death fears into consciousness and have no effect on the unconscious, yet specific, real-life examples may increase both unconscious and conscious death fears. In general, conscious and unconscious death fears increased with greater death related media exposure. (King and Hayslip 2002:37)

In *The Denial of Death* (1973), Ernest Becker translated the psychoanalytical works of Freud, Kierkegaard, Otto Rank, and others into existential terms. Becker argues that it is the fear of death that serves as the basic motivator for all human behavior. Classic Freudians assign this function to the libido. Because this fear is so overwhelming, we must spend an incredible amount of time and energy to repress it and keep it at the unconscious level. Becker divides the schools of thought on the fear of death into two categories: (1) "the healthy minded" and (2) "the morbidly minded" (pp. 13-20). The former conceives of the fear of death as unnatural and not universal. This position is well supported. For example, until the age of 3 to 5, children appear not to have a concept of death. From this perspective, the fear of death is created by society in order to keep people in submission.³ On the other hand, "the morbidly minded" see the fear of death as "natural. [It] ... is present in everyone, that is the basic fear that influences all others, a fear from which no one is immune, no matter how disguised it may be" (Becker, 1974: 15).

The latter position (with which Becker identifies) suggests that whereas the fear is universal, it is not an absolute. That is, like altruism, the fear of death/dying exists in degrees that vary from individual to individual and across cultures. Moreover, it may well vary with age, all else being equal. Thus, the fear is not really absent in young children, but it exists at a relatively low, and largely imperceptible, level. In contrast, older people experience it vividly and can be seriously disturbed by it, to the point of neurosis.

³ Alternatively, one can argue that society creates other fears and unattainable expectations, which in turn create low self-esteem and alter one's perception of common humanity.

On Altruism

There are many scholars who would like to deny the existence of altruistic behavior altogether. Popular culture, too, would have us believe that altruistic behavior is dangerous not valuable and that it is perhaps impossible to act altruistically. Although this may be the position of many, it is not the position that is taken by this researcher. Therefore, careful attention must be paid to research that supports the existence of altruistic behavior.

The economic analysis of altruistic behavior begins with the assumption that we act out of self-interest in order to increase their own well-being or wealth. We can now ask whether or not altruistic behavior would be beneficial to the wealth of the whole society if acts that are aimed toward improving the lives of others were the norm rather than the exception? This can be a complicated question. On the one hand, if we were to consider the altruistic act of volunteering one's time, we would say yes. Through the donation of one's free time as opposed to being compensated for it, one economically benefits someone (increasing someone's wealth because without the volunteer, that person would have to pay for such services). On the other hand, if one were to consider the altruistic act of giving directions to someone whom is lost,⁴ in which there is no economic exchange taking place, we would have to say no. Perhaps the difficulty lies in the definition of an altruistic act.

The field of biology also falls short in its explanation of altruistic behavior. Whereas it has supported arguments for altruistic acts toward kin, near kin, or community

⁴ Volunteering and giving directions are included in the Self-Report Altruism Scale used to measure altruistic behaviors.

members, it is lacking in its explanation of altruistic acts between non-relatives as well as members of different communities.

These (biological)⁵ approaches teach us that to understand altruistic actions, we should examine the individual in connection with the composition and norms of the society in which he lives. (Sobel 2002:1)

In an article reviewing various literature relating to altruism theory and its schools of thought, Jane Allyn Piliavin and Hong-Wen Charng (1990) discuss a shift in the way that we look at and study altruism. More specifically, the authors carefully discuss, through the evaluation of social psychology and economic, political, and sociobiological literature, the evidence that supports the position that altruism does indeed exist and is not necessarily borne out of egoistic motives.

The concept of an altruistic personality has been extensively researched, and because of the continuum on which altruistic behavior exists, Piliavin and Charng find it futile to describe a specific altruistic personality. This assessment is reinforced by the research on the altruistic personality by Oliner and Oliner (1988) that uncovered little variation in personality characteristics between those who participated in the rescue of Jews during World War II (the rescue activity being the altruistic act) and those who did not.

A few regularities do occur: people high in self-esteem, high in competence, high in internal locus of control, low in need for approval, and high in moral development appear to be more likely to engage in prosocial behaviors. (Piliavin and Charng 1990:31)

⁵“(biological)” was added by the author to clarify the subject matter.

Pitirim A. Sorokin, Kristen Renwick Monroe, and Sam Oliner would also have us believe that altruism and altruistic acts performed by ordinary people are important, if not necessary, to the good of society. As stated by Sorokin in *Altruistic Love*,

Great altruists alone cannot supply even the very minimum of love and mutual help necessary for any surviving society...it is furnished by thousands and millions of our plain “good-neighbors”. Each giving a modest contribution of love, in their totality they produce an enormous amount of “love energy”. Without this moral foundation of the deeds of “good neighbors” no society can be satisfactory. (1950:10)

One of the most important contemporary contributions to the field of altruism is that of Kristen Renwick Monroe, specifically her discovery of a key cognitive orientation, the perception of a common humanity.

While there are clear cognitive influences on altruism, the influence does not take the form traditionally suggested in the literature. Instead, the relevant cognitive component centered more on altruist’s world views and canonical expectations about what constitutes normal behavior and on their perceptions of a shared humanity. (Monroe 1996:197)

Monroe’s observations about what it means to perceive a shared or common humanity are crucial. To make clear that it is a universally achievable worldview, Monroe goes on reinforce the idea of common humanity.

It is not any mystical blending of the self with another; rather it is a very simple but deeply felt recognition that we all share certain characteristics and are entitled to certain rights, merely by virtue of our common humanity. (Monroe 1996:206)

Another contemporary scholar of altruism, Sam Oliner, has revealed the heroic and true acts of courage displayed by ordinary people. Through his historical review of altruists throughout the times and the illustration of their tales of extraordinary acts, he shows us that altruistic acts, big or small, are meaningful and transpire more than we are aware.

Yet we human beings can and often do extend ourselves with unfathomable degrees of caring and compassion. There are many people—ordinary folks, just going about their business of living who risk their own lives in order to rescue others—oftentimes complete strangers—in emergency situations. (Oliner 2003:91)

His examination of the views of what he considers *moral leaders* is also important to note. A common thread in the voices of each of the moral leaders discussed is the idea that mankind is connected and that justice is achievable through nonviolent means. Through the teachings of the Dalai Lama, Gandhi, Martin Luther King, Jr., Nelson Mandela, Elie Weisel, and many others, we come to understand the dangers of indifference, the effect of fear on action, and the importance of compassion. The Rev. Dr. Martin Luther King Jr. has so eloquently captured the essence of altruism and the power we humans have to choose our path with the following quote:

Every [person] must decide whether to walk in the light of creative altruism or the darkness of selfishness. This is the judgement. Life's most persistent and urgent question is what are you doing for others? (Ozinga 1999:Preface)

With an abundance of research to support the existence of altruistic behavior, what then could serve as a barrier to altruistic behavior and have the power to alter one's

perception of a shared or common humanity? On the basis of the observations of current and past research, we can contend that the fear of death and dying and altruism must be related to some degree.

Barriers to Altruism

There are scholars who have addressed barriers to altruistic behavior, most notably James Ozinga. In *Altruism* (1999), Ozinga devotes an entire section to the matter. The idea that the addictive brain may interfere with one's altruistic behavior is discussed, providing us with a biochemical explanation for one person's tendency to behave altruistically, whereas another person may not act in a manner that serves to benefit the greater good.

This exploration can create an appreciation for the difficulties some of us have acting on the basis of our altruistic impulses from within. We are definitely not equal in this regard, and some of us have a much harder road to follow than others, and this needs to be understood. (Ozinga 1999:45)

Another potential barrier to "freely acted out altruism" (p. 57) discussed by Ozinga is rigid religious and ideological organizations. The power of religion is twofold: it has the ability to free one's spirit through creative expression while also providing us with moral guidelines, more specifically, the principle of the Golden Rule. This principle makes the concept of common humanity possible. On the other hand, it serves to separate us with its feuding views on what/whom God is and how it/he should be worshipped. It serves as a barrier to altruistic behavior through its exclusion (explicit or implicit) of those who do not fit the necessary mold. We become fearful of not belonging, and if we are outcast, we become fearful of the repercussions of not

belonging, that is, death. The idea of common humanity is not present; therefore, the ability to act altruistically is for the most part absent.

The problem arises when the religion or ideology is institutionalized, thus the freedom to soar or dream is no longer valued, even though leaders say it is....Free thought is seen as the danger, not its suppression....The freedom to think for oneself is exchanged for the dubious advantage of belonging. (Ozinga 1999:57-8)

The third barrier to altruism discussed by Ozinga is that of absolute goals. The way in which we perceive altruism is such that we deny its possibility and belittle the every day acts of altruism. We have come to hold altruism to a virtuous, unreachable ideal that is only possible in a perfect world; therefore, we don't even try. Obviously, altruism and virtue alike have come to be greatly misunderstood.

The remedy it seems, for both Ozinga and Sorokin, lies in religion. For Ozinga, not everything in life can or should be explained, and his prescription is as follows:

First, tolerate ambiguity in others to the highest degree possible and seek as few definitions as possible. It is far more important to implement God than to define God, and it is far more significant to *live* sisterhood or brotherhood than to write about it. There is, particularly in the Western world an incredibly seductive addiction to definition and abstraction that allows mental gymnastics to replace actual exercise. Seek commonalities rather than differences and recognize the right of others to differ from yourself. (Ozinga 1999:71-2)

Sorokin's remedy is a complicated prescription for the implementation of a universal religion and is outlined in his work *Reconstruction of Humanity* (1948). The first sections of the book are devoted to a critique of the ways in which our modern-day

Western, sensate culture has continually failed at achieving lasting peace and harmony. In part five, “Personal Factors of Creative Altruism,” Sorokin says that altruism and creativity require hard work. It takes constant effort to keep it up. He also says that we really don’t know enough about altruism and that if we did, we could be more altruistic, more peaceful. Some fail to acknowledge the existence of altruism altogether; it is difficult mentally to grasp organic phenomena. To achieve and maintain a peaceful idealistic society, we need to spend our time and energy in increasing our knowledge of such phenomena. Sorokin lays out three remedies for doing this:

1. Increasing Study of the “Energies of Man”
2. Structure of Personality: unconscious, bioconscious, conscious sociocultural energies, and superconscious
3. Constructive use of the Existing Knowledge of Man’s Transformation (Sorokin 1948:196-207)

In the sixth and final part, “Ways of Realization of the Plan,” Sorokin stresses that this revolution must not be violent, that violence is not necessary.

Only if God saves humanity from well-intentioned instigators of bloody revolutions and wars has mankind any chance of overcoming its difficulties and of enjoying at least a modicum of international and domestic peace. (Sorokin 1948:231)

To sum up Sorokin’s recommendations on how to achieve an idealistic culture, we must look at the masters of altruism, moral exemplars like Gandhi, Mother Theresa, and Elie Weisel. Efforts must be made to make altruism a habit. It will not come easily,

but by looking back at our past (to the ideational) and learning from it and appreciating it, we can one day become a peaceful, harmonious, creative culture.

Neither scholar mentions fear of death and dying as a barrier to altruism; however, on the basis of the prescriptions for religion set forth by both men, one can assume that the fear of death and dying must be an underlying factor. For if one had a true faith and held spirituality in high esteem, the fear of death and dying would not be a barrier; it would not exist at a level at which it would interfere with our consciousness. It would also serve that humanity would then be viewed as common, shared, or one, and altruistic behavior would be commonplace.

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

Measures

Quantitative measures. To operationalize the previously outlined model, the following quantitative measurement scales were used:

- The Self-Report Altruism Scale
- The Rosenberg Self-Esteem Scale
- The Collett-Lester Fear of Death Scale (Revised)
- Perception of Common Humanity Scale

These scales are discussed in greater detail below, and the entire survey document can be found in Appendix B.

Acting as the dependent variable is altruistic behavior, a term that shall be defined using the definition set forth by Sorokin in *Reconstruction* (1948).

[W]hen an individual freely sacrifices his rightful interests in favor of the well-being of another, refraining from harming him, even though his legal right entitles him to do so, and helping him in various ways, though no law demands of him such action...altruistic conduct is always free from any external compulsion. It is freely chosen and it is also the purest form of free conduct known. (pp. 58-9)

The intensity of altruism ranges from a minor act of sympathy, perhaps motivated by the expectation of pleasure or profit, to the boundless, all-giving, and all-forgiving love formulated in the Sermon on the Mount. (p. 61)

As stated in Sorokin's definition of altruism and in Monroe's research, altruistic behavior can be measured along a continuum. Specifically, for this particular study, altruistic behavior will include but not be limited to donating blood or money;

volunteering time; performing various helping behavior; and lending personal items and does not necessarily require a threat to the actor's life. The premise here is that for any behavior to be considered altruistic, the actor must act with no expectation of a reward of any kind.

The independent variable for this model is the fear of death/dying, which, as indicated by the work of Becker (1973), also exists along a continuum. Meanwhile, considerations are given for intervening variables such as self-esteem and perceptions of humanity. These intervening variables link the fear of death/dying and altruistic behavior by serving as an intensifier for either the independent variable or the dependent variable. That is to say, if one were to have a high fear of death and dying, as well as a closed perception of humanity, it may very well be that that individual also does not act as altruistically as a person whose perception of humanity is more connected.

The *Self-Report Altruism Scale* (1981), developed by Rushton, Chrisjohn, and Fekken, is a scale that consists of 18 questions that inquire about the frequency of altruistic behavior, such as charity volunteer work and giving directions. It is scored on a scale ranging from one to five, one being *never* and five being *very often*. The *Self-Report Altruism Scale* was developed for adults and was rated *easy* in administration and scoring, *high* in reliability, and *high* in validity.⁶

In order to make this scale more appropriate for the purpose of this exploratory study, the item *I find it sometimes amusing to upset the dignity of teachers, judges, and "cultured" people* was removed. This item was the only one that was intended for reverse scoring, and it did not seem to fit with the rest of the questionnaire. Another significant

⁶ According to The Character Education Partnership (2004)

alteration to this scale was the change in the span of time in which the altruistic behavior occurred. In the original scale *Please indicate the number of times in the past month you have performed the following actions...* was asked. In the altered scale used for this research project, subjects were asked to indicate the number of times in the past year various altruistic acts were performed.

The *Rosenberg Self-Esteem Scale* is a 10-question survey tool used to measure self-esteem using a four-point Likert scale. At the recommendation of a pilot study participant, a *neutral* category was added to make it a five-point Likert scale. Subjects were asked to respond to items such as *I feel that I have a number of good qualities* on a scale that ranged from *Strongly Agree* to *Strongly Disagree*, with *Neutral* added in the middle. It is not known what the effect on reliability and validity this category addition had.

This scale was chosen because it is widely used and accepted in the field of social science. There have been many studies regarding the validity and reliability of this instrument. Originally developed for use with adolescents, it has been used for many groups and has demonstrated good validity across many populations, including the elderly.

The *Collett-Lester Fear of Death Scale* (revised) is a 32-item scale that measures one's level of anxiety with respect to the one's own death, one's own dying, the death of others, and the dying of others. However, the item *the total isolation of death* was omitted because of its ambiguous nature.

Through the research using this instrument, among other findings, no relationship between having had near-death experiences and test scores was reported. Lester (1990)

also notes that research has indicated no differences in the fear of death between patients with cancer and a healthy control group, nor were there any associations indicated for self-esteem. A final correlate noted by Lester (1990) indicated no gender difference for those with a high death anxiety versus those with a low death anxiety. Finally, in test-retest reliability, the revised scale reports a Pearson Correlation of .85, .79, .86, and .83 for the fear of death of self, the fear of dying of self, the fear of death of others, and the fear of dying of others, respectively.

The *Perceptions of a Common Humanity Scale* is a 5-item scale that investigates how one sees oneself in relation to others. Does one feel connected to or disconnected from fellow humanity? This 7-point Likert scale was developed specifically for this project and is based on questions on the Self-Report Altruism scale. For example, participants were asked to indicate to whom they would give assistance to if there were an obvious need. The range of possible responses was *immediate family only to strangers and all of the above*.⁷

For the purposes of this study, the questions from all four scales were combined to create one survey instrument. Respondents recorded answers directly on the instrument in the location of their choice and subsequently mailed the completed forms in self-addressed, stamped envelopes provided by the researcher.

Qualitative measures. Qualitative data were collected through interviews, which were conducted with several participants in the quantitative survey. Subjects were recruited through an added question at the end of the survey instrument: *Would you be willing to participate in a 30-45 minute face-to face confidential interview with the*

⁷ *All of the above* encompassed immediate family, extended family, friends, neighbors, coworkers and club affiliates, acquaintances, and strangers.

researcher consisting of several questions like the ones you have just answered? If they were interested, subjects provided contact information.⁸ Several participants responded with interest by providing either telephone numbers or email addresses. The interview consisted of the following questions⁹:

- *Can you tell me a little about yourself? Upbringing, family values, etc.* Here I wanted to know about background such as family relationships and upbringing, history of any life-threatening health problems, proximity to a loved one who may have died, etc.
- *Some people believe that people should be independent and be able to live without help from others. Others feel that people should lend help in times of need. Where do you feel that you fit in? Can you give some examples?* I wanted to further investigate altruistic behavior and the potential motivations for barriers to such behavior. More specifically, I was interested in finding out if such behavior had to be solicited, or if it came freely. I feel that this line of questioning was particularly important because the items on the Self-Report Altruism Scale were very narrow in terms of who would have the opportunity to participate in the specific behavior listed on the questionnaire. Examples included, donating blood, house-sitting, carrying groceries, giving up one's seat on a bus or train, etc.

⁸ To ensure participants' anonymity, identity was limited to title and last initial, for example, Ms. C.

⁹ These are the same questions that were intended for the interview. See Appendix C for interview document.

- *How do you feel about the prospect of people close to you dying? Is it a natural process; does it cause you great concern? How about your own death? Where do you feel that these feelings come from, or what are they influenced by?* The questions above were designed to allow the participant to speak more completely about how they felt about death and dying, not only of the self but of others as well.
- *Some feel very good about themselves. Others feel very badly about themselves. How do you feel about yourself? What do you feel has influenced or does influence the way you feel about yourself?* This series investigates self-esteem and potential societal effects on self-esteem.
- *Do you feel that the boundaries that are created between groups of people are important? What, if anything, has affected where you perceive such (if any) boundaries?* Here I wanted to inquire more about the participant's view of common humanity. Does the participant see "you" and "me," or does she/he perceive humanity as one?

Qualitative data can be a very important tool in the quest for sociological knowledge. For this particular investigation, the interconnection between altruism, fear, self-esteem, and perception of common humanity became clarified through the opportunity to answer openly the interview questions.

Sampling and Survey Procedures

A specialized convenience sample was collected that consisted of two groups: (1) healthy individuals and (2) those who have been diagnosed with cancer. The latter population was chosen because the nature and prognosis of the disease is often uncertain,

with death likely being imminent. Perhaps having to face one's own death in this way changes one's perception of humanity and opens the door to more altruistic behavior. Every attempt was made to match samples by age and gender.

An email was sent to family, friends, and personal and professional contacts outlining the research project, describing the need for both healthy participants over the age of 18 and cancer survivors, either currently in remission or in treatment for the disease, also over the age of 18. Recipients of the aforementioned email were asked to respond, if they were interested, by providing their mailing address. When interest was expressed, several self-addressed, stamped survey packets containing an informed consent form¹⁰ and a survey¹¹ were mailed. Participants were then asked to recruit eligible individuals in their own lists of contacts.

Participants were also solicited through a message board posting containing information regarding the project and my contact information at a center for cancer survivors and their families. The center is located in the metropolitan Detroit area. Aforementioned materials were either sent via postal mail or emailed as an attachment to interested individuals.

A total of 32 participants completed the quantitative instrument between July 1, 2004, and September 30, 2004. Of that 32, 13 were reported cancer survivors/sufferers (research group) and 19 were reported as healthy (control group). A total of four participants completed the interview.

Participants were instructed to read each of the survey items and circle the

¹⁰ See Appendix A for complete form.

¹¹ See Appendix B for complete survey.

best-fitting answer quickly on the basis of their first impression. The environment in which the surveys were completed was of each participant's own choosing.

Human Subjects Safeguards

Approval for the use of human subjects was granted on June 8, 2004 (see Appendix D). Participants were given an informed consent form (see Appendix A). Participation was fully voluntary, and individuals were free to withdraw without negative consequences if conditions became too emotionally uncomfortable. Confidentiality was guaranteed in that no names were recorded or used in the written findings or in quantitative or qualitative data collection or analysis. Data gathered from the interviews do not reveal the participants' true identities; all questionnaire respondents were asked to give a fictitious identity. On the section of the quantitative measurement instrument that indicates an opportunity for an interview, subjects were be asked to provide only the first letter of the last name and an appropriate title, for example, Mr. C, or some other alias. All materials will be kept in a locked cabinet for a maximum of four years. Each participant has been offered the opportunity to receive the final results of this study.

When talking about death and fears, we open ourselves up to emotional stress. It is the view of this researcher that any possible emotional upsets that were incurred during the participation of this research were only temporary and did not exceed the levels of discomfort experienced in daily life. An indirect benefit to the participants is the knowledge that their participation provided invaluable information to the field of Sociology, as well as the chance for an increased understanding of their attitudes and motivations.

Having said that, I acknowledge that for some, the subject of death and dying may be more of a sensitive matter than for others. I also acknowledge that a support group may not provide enough therapy to be considered a safety measure. For this reason, all participants were provided the name and phone number of a qualified crisis intervention counselor who was willing to provide one crisis intervention and therapy referral should there have been a need.

CHAPTER 4: PRESENTATION AND ANALYSIS OF DATA

A total of 32 subjects were obtained for this exploratory study (N = 32), 19 non-cancer survivors, and 13 cancer survivors. Of those 32 subjects, 24 were female and 8 were male. Subjects ranged in age from 29 years old to 74 years old.

To quantitatively evaluate the data collected, the following statistical tests were performed with SPSS:

- Reliability Analysis using Chronbach's Alpha
- Pearson Correlation Matrix
- Two separate Independent samples *t* tests: (1) Cancer/Not and (2) Gender
- Path Analysis

Quantitative Analysis

The Collett-Lester Fear of Death scale comprises of the following four axes, and the following abbreviations apply to this analysis: death of self (DTHSLF), dying of self (DYNGSLF), death of others (DTHOTH), and dying of others (DYNGOTH). For the independent samples *t* tests and the path analysis, these four variables are combined and labeled total average fear (FEAR). The remaining components of the quantitative analysis tool are as follows: Rosenberg Self-Esteem Scale (ESTEEM), the Self-Report Altruism Scale (SRAS), and the Perceptions of Common Humanity Scale (PERC).

Reliability analysis. Reliability Analysis allows one to decipher whether or not the items on a questionnaire (or a section of a questionnaire) are related to each other. With this analysis, an index of internal consistency is obtained. Chronbach's Alpha reliability analysis provides an alpha (ranging in value from 0 to 1) based on the average interitem correlation. For the purposes of this analysis, alpha values for each of the four

axes of the Collett-Lester Fear of Death Scale, Rosenberg Self-Esteem Scale, Self-Report Altruism Scale, and the Perceptions of Common Humanity Scale were calculated.

Results are presented in Table 4.1 below:

Table 4.1. Reliability Analysis: Alpha (α) Values

Variable	Alpha
DTHSLF	0.8556
DYNGSLF	0.8781
DTHOTH	0.8237
DYNGOTH	0.8203
ESTEEM	0.9422
SRAS	0.8265
PERC	0.7234

According to George and Mallery (2003: 231), the following rule of thumb scale applies when interpreting alpha values:

- $\alpha > .9$ — excellent
- $\alpha > .8$ — good
- $\alpha > .7$ — acceptable
- $\alpha > .6$ — questionable
- $\alpha > .5$ — poor
- $\alpha < .5$ — unacceptable

Through the use of the scale set forth by George and Mallery, it can be said that the scales used in the quantitative measurement instrument have an interitem correlation ranging from acceptable (Perceptions of Common Humanity Scale, $\alpha = .7234$) to excellent (Rosenberg Self-Esteem Scale, $\alpha = .9422$). The “death of self” axis of the Collett-Lester Fear of Death Scale has an interitem correlation within the good range ($\alpha = .8556$), as do the remaining three axes. More specifically, “death of self” has an alpha value of .8781, “death of others has an alpha value of .8237, and dying of others has an alpha value of .8203. The Self-Report Altruism scale also had an interitem correlation within the *good* range ($\alpha = .8265$).

What does all of this mean? It indicates that each of the scales used to measure fear of death and dying, self-esteem, perceptions of common humanity, and altruistic behavior are indeed measuring the same underlying construct. In other words, each of the questions included in the fear of death of self axis of the Collett-Lester Fear of Death Scale is indeed measuring the fear of death of self; the fear of dying of self axis is measuring the fear of dying of self, the fear of death of others is measuring the fear of death of others, and the fear of dying of others is measuring the fear of dying of others. It can be said that the questions on the Rosenberg Self-Esteem Scale are also accurately measuring self-esteem, that the questions on the Self Report Altruism scale are measuring altruistic behavior, and that the Perceptions of Common Humanity Scale is measuring perception of humanity. On the basis of our alpha values, as discussed above, it can also be said with some degree of confidence that the aforementioned scales have relatively good reliability.

t test. In an analysis of an independent samples *t* test, a comparison was made between the experimental group (cancer), and the control group (non-cancer). The *t* test was performed to explore whether on the basis of quantitative data collection there resulted in a difference in the averages of reported scores on altruistic behavior, fear of death and dying, self-esteem, and perception of humanity. Results are outlined in Table 4.2.

Table 4.2. Independent Samples *t* test: No Cancer/Cancer

Dependent Variable	Grouping Variable	N	Mean	SD	SE of Mean
Total Fear ¹²	No Cancer	18	3.03	0.6432	0.1516
	Cancer	13	2.5	0.9253	0.2566
Perception of Common Humanity ¹³	No Cancer	18	5.09	0.6552	0.1544
	Cancer	13	4.86	1.2258	0.34
Altruism ¹⁴	No Cancer	17	3.2	0.4931	0.1196
	Cancer	13	2.88	0.5583	0.1548
Self-Esteem ¹⁵	No Cancer	17	3.12	0.9311	0.2258
	Cancer	12	3.33	0.6312	0.1822

Table 4.2 indicates that for the variable *Total Fear* (calculated by combining the four axes of the Collett-Lester Fear of Death Scale and averaging the score), the mean score for the 18 noncancer survivors was 3.03 and the mean score for the 13 cancer survivors was 2.50. For the variable *Perception of Common Humanity*, the mean score for the 18 noncancer survivors was 5.09, and the mean score for the 13 cancer survivors was 4.86. For the variable *Altruism*, the mean score for the 17 noncancer survivors was 3.2, and the mean score for the 13 cancer survivors was 2.88. For the variable *Self-Esteem*, the mean score for the 17 noncancer survivors was 3.12, and the mean score for the 12 cancer survivors was 3.33.

These differences between the means of the four variables, *Total Fear*, *Perception of Common Humanity*, *Altruism*, and *Self-Esteem*, seem on the surface very inconsequential and potentially statistically insignificant. Table 4.3 illustrates the results.

¹² On a 5-point Likert Scale

¹³ On a 5-point Likert Scale

¹⁴ On a 5-point Likert Scale

¹⁵ On a 7-point Likert Scale

Table 4.3. *t* test for Equality of Means: No Cancer/Cancer

	Variances	Levene's test for equality of variances		<i>t</i> values	df	Sig. (2-tailed)	Mean Difference
		F	Sig				
Total Fear	Equal	1.117	0.299	1.868	29	.072	.5253
	Unequal			1.763	20.108	.093	.5253
Perception of Common Humanity	Equal	5.508	0.026	0.668	29	0.509	0.2274
	Unequal			0.609	16.954	0.551	0.2274
Altruism	Equal	0.378	0.544	1.697	28	0.101	0.3263
	Unequal			1.668	24.143	0.108	0.3263
Self-Esteem	Equal	4.117	0.052	-0.650	27	0.521	-0.2015
	Unequal			-0.694	26.981	0.493	-0.2015

Table 4.3 indicates that there is no significant difference at the $p < .05$ level between the means of cancer survivors and those without cancer for the variables *Total Fear* ($p = .072$), *Perception of Common Humanity* ($p = .551$)¹⁶, *Altruism* ($p = .101$), or *Self- Esteem* ($p = .521$).

In a second independent samples *t* test analysis, a comparison was made between women and men in the sample. The *t* test was performed to explore whether on the basis of quantitative data collection there resulted in a difference in the means of reported scores on altruistic behavior, fear of death and dying, self-esteem, and perception of humanity. Results are outlined in Table 4.4.

¹⁶ Because Levene's test did show significant differences for the variable Perceptions of Common Humanity, it was necessary to use the unequal variance test.

Table 4.4. Independent Samples *t* test: Women/Men

Dependent Variable	Grouping Variable	N	Mean	SD	SE of Mean
Total Fear	Women	28	2.8912	0.8698	0.1775
	Men	8	2.5268	0.4246	0.1501
Perception Common Humanity	Women	28	4.9500	1.0030	0.2047
	Men	8	5.0750	.6135	0.2169
Altruism	Women	23	3.1228	0.4752	0.0909
	Men	8	2.9265	0.6865	0.2427
Self-Esteem	Women	22	3.2727	0.8972	0.1913
	Men	8	3.1000	0.5071	0.1793

Table 4.4 indicates that the mean score for the variable *Total Fear* for the 28 women respondents was 2.8912 and the mean score for the 8 male respondents was 2.5268. Women in the sample had a marginally higher fear of death and dying. The mean score for the variable *Perception Common Humanity* for the 28 women respondents was 4.9500, and the mean score for the 8 male respondents was 5.0750. Here, men had a slightly more open view of humanity. The mean score for the variable *Altruism* for the 23 women in the sample was 3.1228, and the mean score for the 8 male respondents was 2.9265, indicating that women in this sample participated in more altruistic acts than did the men sampled. For the variable *Self-Esteem*, the mean score for the 22 women respondents was 3.2727, and for the 8 male respondents the mean score was 3.100. This indicates that women reported feeling better about themselves (slightly). These results are further analyzed in Table 4.5.

Table 4.5. *t* test for Equality of Means: Women/Men

	Variances	Levene's test for equality of variances		<i>t</i> values	df	Sig. (2-tailed)	Mean Difference
		F	Sig				
Total Fear	Equal	4.334	.046	1.132	30	.267	.3644
	Unequal			1.567	25.246	.130	.3644
Perception of Common Humanity	Equal	.859	.361	-.330	30	0.743	-.1250
	Unequal			-.419	20.159	0.680	-.1250
Altruism	Equal	3.975	.056	.896	29	0.378	.1963
	Unequal			.749	9.444	0.472	.1963
Self-Esteem	Equal	2.733	.109	.512	28	0.613	.1727
	Unequal			.659	22.352	0.517	.1727

Table 4.5 indicates that there is no statistically significant difference at the $p < .05$ level between the means of women and men for the variables *Total Fear* ($p = .130$)¹⁷, *Perception of Common Humanity* ($p = .743$), *Altruism* ($p = .378$), and *Self-Esteem* ($p = .613$).

These findings are consistent with those of Lester (1990), who also reported no significant differences in reported levels of Fear of Death and Dying (using the Collett-Lester Fear of Death Scale) between cancer survivors and noncancer sufferers or between men and women.

¹⁷ Because Levene's test did show significant differences for the variable Total Average Fear, it was necessary to use the unequal variance test.

Table 4.6. Pearson Correlation Matrix¹⁸

		PCHUM	SRAS	ESTEEM	DYOTH	DTHOTH	DYSLF	DTHSLF
PERC	Pearson	1.000	0.168	0.068	0.358*	-0.271	-0.111	-0.137
	Sig	.	0.365	0.722	0.044	0.134	0.547	0.454
	N	32	31	30	32	32	32	32
SRAS	Pearson	0.168	1.000	0.021	0.029	0.217	0.033	-0.130
	Sig	0.365	.	0.914	0.875	0.241	0.860	0.487
	N	31	31	29	31	31	31	31
ESTEEM	Pearson	0.068	0.021	1.000	-0.372*	-0.461*	-0.491**	-0.463**
	Sig	0.722	0.914	.	0.043	0.010	0.006	0.010
	N	30	29	30	30	30	30	30
DYOTH	Pearson	0.358*	0.029	-0.372*	1.000	0.740**	0.740**	0.502**
	Sig	0.044	0.875	0.043	.	0.000	0.000	0.003
	N	32	31	30	32	32	32	32
DTHOTH	Pearson	-0.271	0.217	-0.461*	0.740**	1.000	0.818**	0.626**
	Sig	0.134	0.241	0.010	0.000	.	0.000	0.000
	N	32	31	30	32	32	32	32
DYSLF	Pearson	-0.111	0.033	-0.491**	0.740**	0.818**	1.000	0.714**
	Sig	0.547	0.860	0.006	0.000	0.000	.	0.000
	N	32	31	30	32	32	32	32
DTHSLF	Pearson	-0.137	-0.130	-0.463**	0.502**	0.626**	0.714**	1.000
	Sig	0.454	0.487	0.010	0.003	0.000	0.000	.
	N	32	31	30	32	32	32	32

*Significant at the $p < .05$ level (2-tailed)

**Significant at the $p < .01$ level (2-tailed)

Pearson correlations. The correlation matrix above suggests several statistically significant relationships. For one, there is a statistically significant positive relationship between the fear of others' dying and perception of common humanity ($r = .358$, $p < .05$), indicating that the more one feels connected to fellow humanity, the more one tends to fear others' dying.

In the matrix we also see that there is a statistically significant negative correlation between self-esteem and all four axes of death and dying (dying of others: $r = -.372$, $p < .05$; death of others: $r = -.461$, $p < .05$; dying of self: $r = -.491$, $p < .01$; and

¹⁸ PERC (perception of common humanity), SRAS (self-report altruism scale), ESTEEM (self-esteem), DYOTH (fear of others dying), DTHOTH (fear of death of others), DYSLF (fear of dying of self), DTHSLF (fear of death of self)

death of self: $r = -.463$, $p < .01$). More specifically, the more one is afraid of death and dying, the lower one's self-esteem is.

As expected, the four axes of the Collett-Lester Fear of Death Scale are positively correlated with a p value of $< .01$. Fear of death of self is positively correlated with fear of dying of others ($r = .502$, $p < .01$), fear of death of others ($r = .626$, $p < .01$), and fear of dying of self ($r = .714$, $p < .01$). This indicates that if one has a higher fear of death of self, it is likely that one would also have a higher fear of dying of others, death of others, and dying of self. This positive relationship exists throughout the scale and is indicated by the following remaining significant correlations: dying of self and dying of others: $r = .740$, $p < .01$; dying of self and death of others: $r = .818$, $p < .01$; death of others and dying of others: $r = .740$, $p < .01$.

Path analysis. Because the goal of this research is exploratory and because the model outlined in Figure 1 is nonrecursive, inverse, mediated, and dynamic, five path models are discussed. Perhaps this seems excessive and certainly noncustomary in path evaluations, but it is a necessary process in order to illustrate and explore the relationships between the 4 variables, that is, fear of death and dying, altruism, self-esteem, and perception of common humanity.

The following figures depict the relationships between the 4 variables fear of death and dying, self-esteem, perception of common humanity, and altruistic behavior:¹⁹

¹⁹ Where F=Fear of death and dying, PCH=perception of common humanity, A=Altruistic Behavior, and SE=Self-Esteem

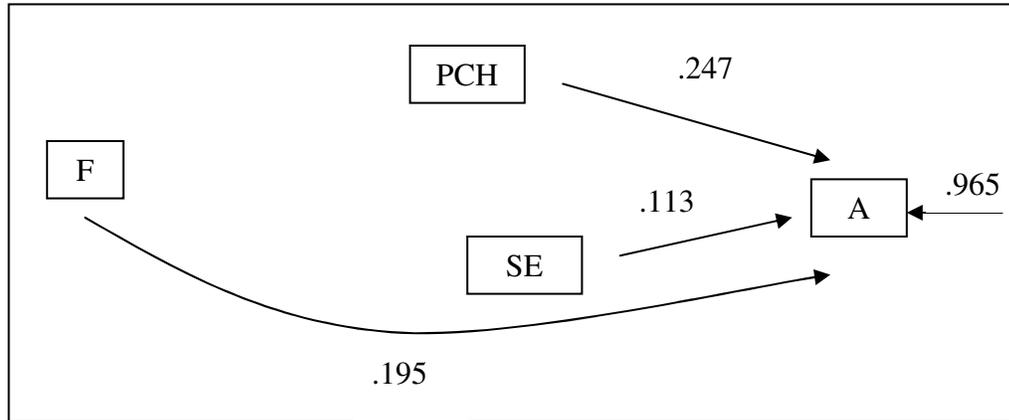


Figure 4.1: Altruistic behavior as dependent variable.

Figure 4.1 illustrates the causal relationship between the independent variables *fear of death and dying* (F), *perception of common humanity* (PCH), and *self-esteem* (SE) and the dependent variable *altruistic behavior* (A).

This model is specified by the following path equation:

$$\text{Altruism} = .247(\text{PCH}) + .113(\text{SE}) + .195(\text{F}) + \sigma \text{ est}^{20}$$

On the basis of the calculations provided in figure 4.1, perception of a common humanity (PCH) has a relatively weak positive effect on altruistic behavior (A), indicated by the Beta value .247. Fear of death and dying (F) has a somewhat weaker positive effect on altruistic behavior (A), indicated by the Beta value .195, and self-esteem (SE) has an even weaker positive effect on altruistic behavior (A), as indicated by the Beta value of .113. The residual, or unmeasured variables, for this particular model, is .965 (calculated using the equation $\sqrt{1-r^2}$). This indicates that the model is far from perfect and leaves much to be explained by variables other than fear of death and dying, perception of common humanity, and self-esteem.

²⁰ Where $\sigma \text{ est} = \sqrt{\sum(ya-yp)/n}$

Needless to say, on the basis of the positive values in Figure 4.1, it is safe to say that the more open a view of common humanity one possesses, the more one tends to participate in altruistic behavior. The same can be said for self-esteem. A person with a higher self-esteem reported a higher number of altruistic acts. The positive relationship between fear of death and dying and altruistic behavior indicates that those who reported being more fearful of death and dying participated in a higher number of altruistic acts. Note that this last relationship is the opposite of what the theoretical model shows.

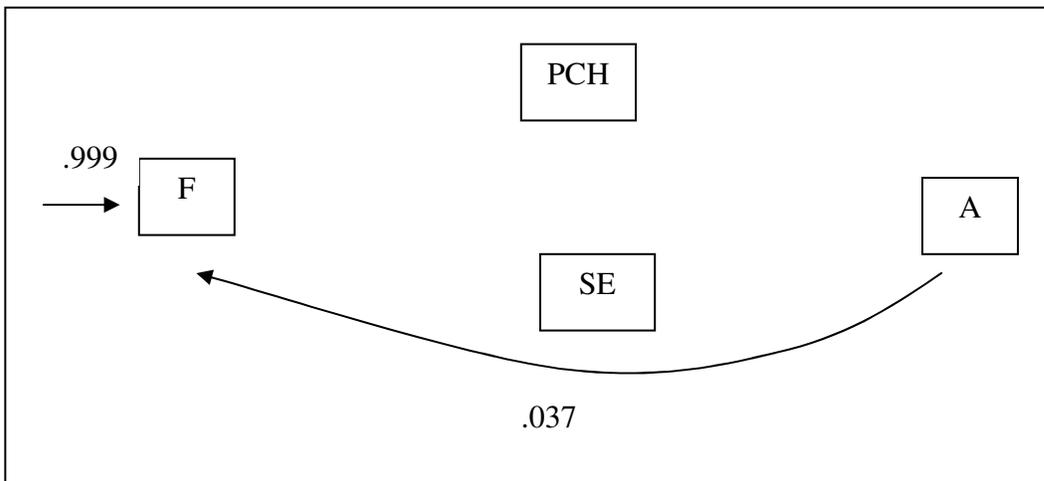


Figure 4.2a: Fear of death and dying as dependent variable.

Figure 4.2a represents the direct causal relationship where *altruistic behavior* (A) is the independent variable and *fear of death and dying* (F) is the dependent variable. The Beta value .037 indicates that there is virtually no causal relationship and that there must be other variables involved. On the basis of the above data, altruistic behavior has relatively no causal effect on the fear of death and dying. The Beta value .037, as well as the residual value of .999, indicates this lack of causality.

This model is specified by the following equation:

$$\text{Fear of Death and dying} = .037(A) + \sigma \text{ est}$$

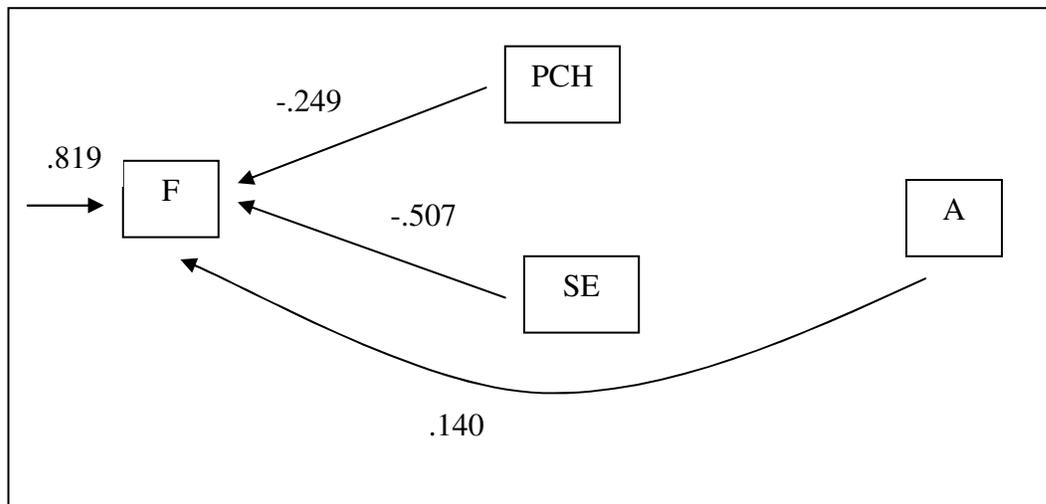


Figure 4.2b: Fear of death and dying as dependent variable.

Figure 4.2b depicts the relationship between *fear of death and dying* (F), *perception of common humanity* (PCH), *self-esteem* (SE), and *altruistic behavior* (A), where fear of death and dying is the dependent variable. This model was created because of the lack of a direct causal relationship between altruistic behavior and fear of death and dying.

From the path model above, we can deduce several things. First, those from the sample who have a more open view of humanity, that is, a perception of common humanity, are slightly less likely to have a high fear of death and dying. By embracing a love for all of mankind, we find that death and dying are not as frightening. This relationship is indicated by the value $-.249$. Second, those in the sample who scored higher on the self-esteem scale had a tendency to score lower on the fear of death scale. This relationship is indicated by the value $-.507$. In the model above, again we encounter a relationship that is different than the one outlined in the theoretical model when looking at the relationship between the fear of death and dying and altruistic behavior. The relationship between altruistic behavior and the fear of death and dying in the model

above is a positive one (.140); in theory, it should be negative. Therefore, those in the sample who perceive a common humanity and have a higher self-esteem have a lower fear of death and dying. The amount of variance unexplained, or residual, is .819; thus, the effect of unmeasured variables is relatively high.

This model is specified by the following equation:

$$\text{Fear of Death and Dying} = -.249(\text{PCH}) + -.507(\text{SE}) + .140(\text{A}) + \sigma \text{ est}$$

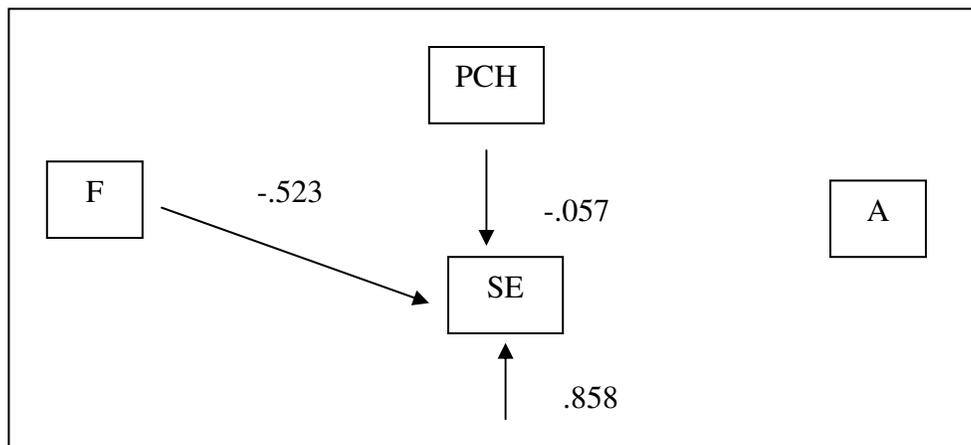


Figure 4.3. Self-esteem as dependent variable.

The model above represents the relationship between the *fear of death and dying* (F), *perception of common humanity* (PCH), and *self-esteem* (SE) where self-esteem is the dependent variable.

This relationship is such that the fear of death and dying has a negative effect on self-esteem. This is indicated by the Beta value -.523. In other words, if one has a high fear of death and dying, we deduce that one also has a lower self-esteem. Perception of common humanity, on the other hand, has a very low negative (-.057) effect on self-esteem. Note that this also differs from the theoretical model. The residual value of .858, again, indicates that there must be other unmeasured variables involved.

This model is specified by the following equation:

$$\text{Self-Esteem} = -.523(\text{F}) + -.057(\text{PCH}) + \sigma \text{ est}$$

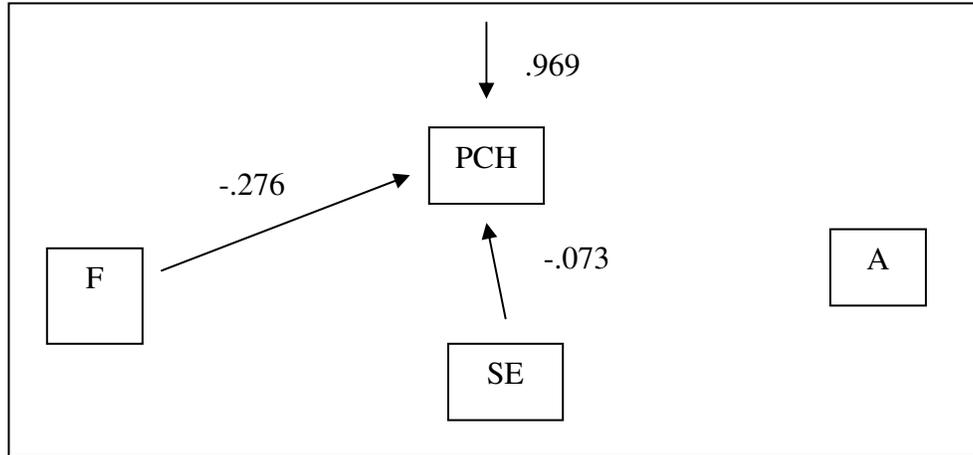


Figure 4.4. Perception of common humanity as dependent variable.

Figure 4.4 outlines the relationship between *fear of death and dying* (F), *perception of common humanity* (PCH), and *self-esteem* (SE), where perception of common humanity is the dependent variable.

On the basis of the information in the above path model, the fear of death has a negative impact on perception of common humanity and is represented by the Beta value -.276. This indicates that for those with a higher fear of death and dying, their perception of humanity will tend to be more closed off. The relationship between self-esteem and perception of common humanity is such that self-esteem has a very small negative impact on perception of common humanity. This is represented by the Beta value -.073. The negative value here also differs from the theoretical model. The high residual value of .969 indicates the existence of other unmeasured causal variables.

This model is specified by the following equation:

$$\text{Perception of Common Humanity} = -.276(\text{F}) + -.073(\text{SE}) + \sigma \text{ est}$$

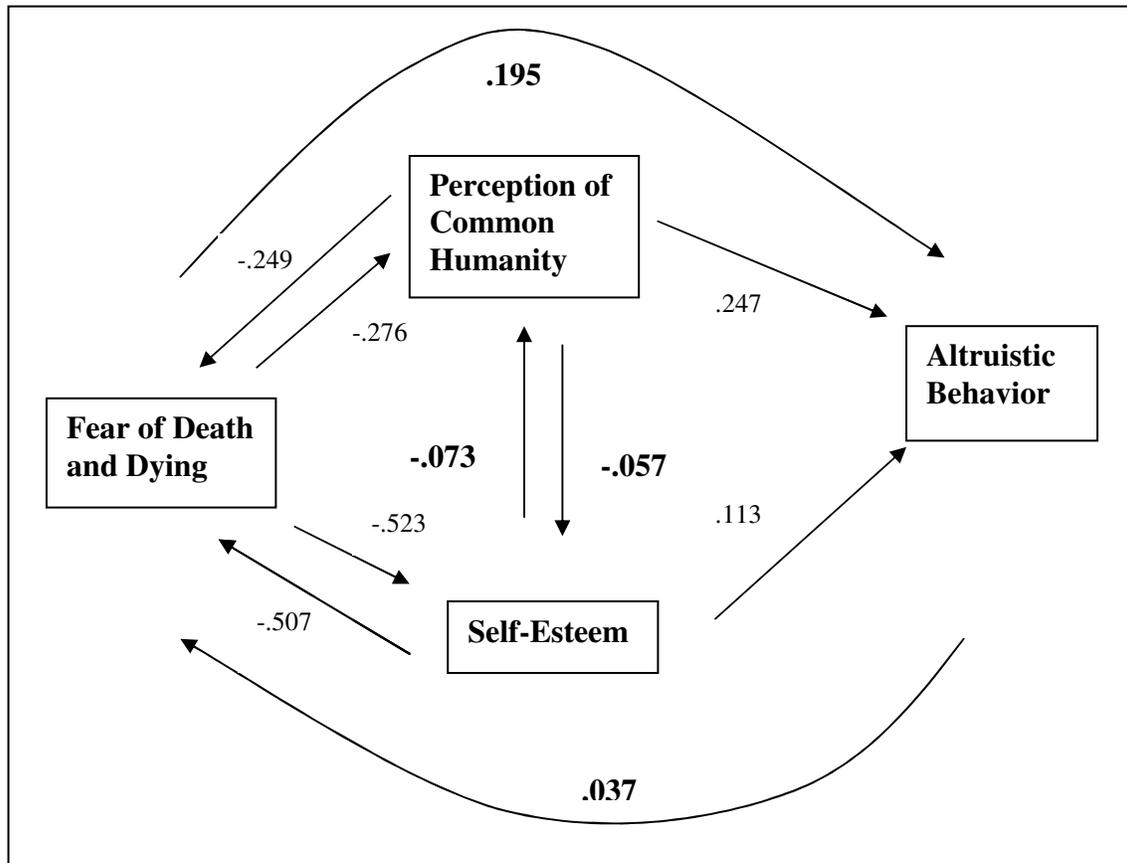


Figure 4.5. Theoretical path model.

Figure 4.5 reintroduces the theoretical model outlined in Chapter 1, with the addition of the information presented in Figure 4.2b. The calculations in bold indicate the values that disagree with the theoretical model. On the basis of the path model, the following indirect effects can be calculated:

$$(1) F \rightarrow PCH * PCH \rightarrow SE * SE \rightarrow A$$

$$(2) F \rightarrow SE * SE \rightarrow PCH * PCH \rightarrow A$$

The indirect paths produce the following calculations:

$$(1) -.276 * -.057 * .113 = .0018$$

$$(2) -.523 * -.073 * .247 = .0094$$

From this, we can calculate the total indirect effect of fear of death and dying on altruistic behavior by adding the calculations from (1) and (2) above, arriving at .0112.

Strengths and Limitations of the Quantitative Data

There are several strong points that are important to note with regard to the quantitative data collection and analysis. They are as follows:

- Utilization of a clear and concise survey format
- Employment of the “snowball” method of data collection, allowing for a greater range of participants
- Thorough statistical examination of the data

A few of the strengths listed may be viewed by some as weaknesses. However, for the time being, they continue to be considered beneficial to the completion of this exploratory research project.

Limitations of the quantitative data collection and analysis include the following:

- Extensive use of path analysis
- Lack of an appropriate altruism scale
- Small, nonrandomized sample

Qualitative Analysis

Although there are only four cases to discuss in the qualitative portion of this exploratory study, it is important not to discount the value of such data. When people have the chance to speak or write about how they feel about sensitive subject matter, it becomes possible to extract a lot of rich, meaningful data that otherwise may not be available.

The small number of interview participants is attributed to both personal circumstance and the time of year in which the data was collected. The initial plan was to schedule interviews late in the summer of 2004 with those who had expressed interest by providing contact information. However, as the results of personal matters, changes of heart by survey participants, a limited amount of time and resources, and the fast-approaching holiday season, only four interviews were conducted. Of the 32 survey respondents, the following expressed initial interest in following up with an interview:

Cancer survivor/sufferer:

- 3 males
- 4 females

Noncancer survivor/sufferer:

- 1 male
- 8 females

As I mentioned previously, four of the 32 total subjects, or 12.5 percent, chose to respond to the five questions in the interview. Of those four, three were female non-cancer survivors, and the remaining participant was a male cancer survivor.

The settings in which the interviews were conducted differed among the four cases, and the methods employed were of the participants' choosing. Mary's and Catherine's interviews were conducted over the telephone and lasted roughly 40 minutes each. Responses were recorded on paper and subsequently typed up and referenced for analysis. Susan was available for a face-to-face interview, which was conducted at a local restaurant and lasted about 45 minutes. Again, her responses also were recorded on paper and later typed for future reference. Because Doug was a last-minute participant, it

was decided that for the sake of time and convenience that sending the questions via an email attachment was sufficient, provided that if need be, he could be contacted for further comment.

Information gathered in the interviews as follows is presented in a discussion format. Supportive highlights from the interviews are placed in block quotes to differentiate interviewee statements from the discussion. Again, all names have been changed to protect participants' confidentiality.

Mary's Story. The first respondent, Mary, is a 70-year-old noncancer survivor; however, she has been and still is very close to many that are survivors and/or sufferers. Mary grew up in a small, rural farming community. She has two older brothers and a younger sister. Mary was raised as many girls were (and perhaps still are); she was taught how to help her mother in the kitchen and with sewing chores. Growing up, she never really felt that it was important to "keep up with the Joneses" as far as conspicuous consumption was concerned. There are two striking things about Mary's upbringing and family values that seem to have really shaped the way she acts in the world today: her faith in God and the importance of doing her best. The following excerpts from her interview express her feelings:

I have been filled with deep gratitude for God's mercy, love, and faithfulness in guiding us.

...we were encouraged to do our best. If something is worth doing, it is worth doing well to the best of our ability.

One of Mary's responses with regard to her family's expectations of her and how these expectations have perhaps shaped her behavior in later life struck me as interesting.

It seems that for Mary, if she does not feel confident that she can excel at a task, she will back away from it. “When I don’t do well, I don’t often pursue long.”

When asked about how she feels about helping others in times of need, she was quick to respond with concern about people “taking advantage of society and the agencies that offer help.” Although she does not approve of people taking such advantage, she would rather err on the side of helping (if asked) than not help unless she knew for certain that the person in need was indeed abusing the system. As for helping without being asked, she feels that she is poor at seeing need when others do not specifically ask. Moreover, Mary discussed occasionally being a bit hesitant with regard to offering help to others. Her concern was that she would perceive a need and offer help when, indeed, there was no actual need. Therefore, not only does Mary perceive a risk of offending another’s integrity, but she also perceives a risk for personal rejection.

As for behaving altruistically, Mary is very giving of her time and talents (as long as she is confident that her services are needed). This seems to have followed her from her childhood:

I have cooked a meal and delivered it to someone just out of the hospital. When I was a young girl, my father did some custom shelling of corn and thrashing of oats for neighbors. When he was going to be working at a place where the wife would be serving a meal to the men and she was alone, I would go along and help her with the meal. I always enjoyed working in the church or 4-H food booths at fairs, etc. I am currently making arrangements to volunteer as massage therapist with Hospice. God has been good to me in my life, and I would like to use my skills helping others that might get benefit for what I could provide. In church and organizations I am pretty good at seeing what needs to be done and just doing it, and so I do quite a bit of volunteer work through church.

It seems that Mary’s altruistic behavior is guided by whether or not she feels safe in her environment and confident in her ability.

Her faith and perhaps her life experiences seem to have served as a guide for Mary's attitude toward death and dying. Mary scored low on all four axes of the Collett-Lester Fear of Death Scale and on the basis of her responses in the interview, I feel it is safe to say that she indeed possesses a healthy-minded view of death and dying. She said,

I believe dying is a natural process. It is hard to watch people you know well and care about deteriorate through sickness, and I don't like to see anyone suffer, but it is a fact of life that we all will die....I believe all my feelings regarding death are rooted in faith in Our Lord Jesus Christ....As much as I know this, it may seem ironic that I am not in a hurry....I figure as long as the Lord lets me live on this earth I have a mission to live it the best I can.

Mary's sentiments about disliking watching people suffer as they are dying is also reflected in her slightly higher score on the "fear of dying of others" axis on the Collett-Lester Fear of Death Scale.

When it comes to self-esteem, Mary reports feeling good about herself. Good friends and a husband who loves her unconditionally support her along the way. Two things, however, can be inferred from her responses regarding both family upbringing and altruistic behavior: (1) Mary is often not confident enough to offer help, and (2) if she feels that she will not be successful at something, she either does not try at all or gives up once she feels she is not good enough. Mary may have had a high score on the Rosenberg Self-Esteem Scale, but it is clear that there may be some instances when her self-esteem, or lack thereof, holds her back from behaving altruistically.

In terms of perception of common humanity, Mary believes that if people were to live by the Golden Rule and ignore the boundaries that have been created by man, the world would be a better place. As far as living by the Golden Rule herself, on the basis of the information that she provided, I believe that Mary does the best she can with the

talents that she has. She is most certainly an altruistic person who is perhaps held back not by a fear of death and dying but, rather, by a fear of failure and rejection.

Susan's Story. Susan is a 29-year-old mother of two young children, married, and a noncancer survivor. Susan's parents divorced when she was relatively young, and her mother abused drugs and alcohol. When Susan was 13 years old, she and her sister were removed from the home and put into foster care. Although she now has a relationship with her biological mother and father, there was a long period in Susan's life when she did not.

When it comes to helping others, Susan believes that "definitely, people should help in times of need" and that the need does not have to be explicitly stated. Having come from a troubled home, Susan knows firsthand what it is like to need help. She is currently studying to be a school social worker, so, in a way, she is devoting her life to helping kids in need. Susan also regularly donates money and clothing to her church for needy families. For Susan, as with Mary, the principle of the Golden Rule is an important one to live by, and she too applies it to her own living.

Susan's discussion of death and dying is an interesting one, and it differs somewhat from Mary's in that Susan has young children and also lacks the experience with death and dying that Mary has had (because Mary is much older). There is also a considerable difference in their scores on the Collett-Lester Fear of Death Scale, as Susan scored much higher than Mary. Susan's sentiments regarding death and dying center on her children. Looking a little deeper, however, we can see that there is more to it than just her children.

Although Susan acknowledges that death and dying is a natural process, the idea of living without her children seems impossible. She says that the thought of “children dying is awful,” and that in order to get through it, she would have to turn to her faith. Of her own death, Susan said,

My death seems sad because my children are so young, and I would be so sad to miss out on their lives. If I am older, I think I might be more prepared.

Who would be their mommy?

Here, Susan clearly seems more concerned with her own missing out on her children’s lives and the prospect that someone else could replace her in the lives of her children. This is a more egoistic view of death and dying than the altruistic surrender that Mary seems to possess.

When I inquired about how Susan felt about herself, she reported feeling good and possessing a high self-esteem most of the time. As far as what helps her to feel good about herself, Susan says that being a nice, helpful person and a good friend, mother, and wife are important elements. The feeling of accomplishment that going to school gives her is also important. There are many things that Susan feels good about; however, there are external influences that do have the power to make her feel like she does not measure up.

More specifically, the following statements from Susan express the negative influence that the media can have on one’s self-esteem:

I am not super-skinny like TV models and some of my friends.

Money—we do not have a house; our children share a bedroom, which is not really common now.

The media also influences Susan's beliefs regarding the boundaries (ethnic, religious, age, gender, etc.) that serve to divide people socially and economically. She reports being more comfortable helping a female than helping a male, more specifically a white female, rather than a black female or black man. Her personal boundaries are fairly closed in this respect, as somewhere along the way she learned that unfamiliar men are dangerous and that unfamiliar black men pose even more of a threat than white men do.

It is fairly safe to say that Susan does not describe herself as embracing a view of "common humanity," which is also reflected in her lower score on the Perception of Common Humanity Scale. This lower result can be attributed to a combination of social expectations and the media and a relatively rural upbringing. It also may be that her elevated fear of death and dying serves as a contributing factor to this seemingly closed perception of humanity. In other words, to accept those that she perceives as a threat would put her at a higher risk of danger and, therefore, a higher risk of death. Susan also states that she feels that "life experiences definitely alter (one's) view of the world."

In sum, Susan seems to behave altruistically toward those with whom she is familiar, those in her circle of safety. Acting altruistically helps Susan to feel good about herself, which may be helpful in combating the external pressures that she feels with regard to money and her body.

Catherine's story. Catherine, a 31-year-old healthy woman, is married and, like Susan, is the mother of young children. She was raised by her mother and stepfather, as her parents divorced when she was only four years old. Although her biological father also remarried and divorced two more times, they remained close until he was killed suddenly in a car accident six years ago.

Catherine mentions feeling generally cared for as a child, by her mother and stepfather, but not overly loved and/or supported. She was, on the other hand, cherished by her biological father. "I was very loved by my father, but he was an alcoholic, and our relationship was hardly traditional." The lack of affection and experience with divorce in her upbringing drives Catherine to cherish her children openly and gives her the motivation to work at her relationship with her husband so that her children do not have to experience divorce the way she did.

Catherine reported feeling "that most people at one time or another need help and are worthy of that help." She reflected on times when she and her husband were just starting out and needed financial help occasionally and how their families would often help them. Now that Catherine and her husband are more secure financially, she feels that "it's important to help others." Catherine currently is the chairperson of the junior women's league in her community, which is an organization that provides assistance to those in need, ranging from sick children to the elderly and the needy.

Because of the unexpected death of her father, Catherine adds an interesting perspective to this study. Having experienced the sudden loss of a loved one, she knows firsthand that life goes on without him/her, but that the pain of the death never really

leaves. Having said that, Catherine, much like Susan, finds the thought of losing her husband and/or children terrifying. She says of her own death, however, that

I don't think about my own death very much. I don't worry about how or when I will die. I don't have plans to take my own life, and I lead a pretty healthy lifestyle, so I figure how and when I die is not really up to me, so why worry about it. I worry more that if I were to die young, how that would effect my kids. I know that it's hard to grow up without a parent, and I would be sad for them. I know that my husband would be sad and miss me too, but I hope that he too could move on.

These differences in how she feels about the death and dying of others (higher) and her own death and dying (lower) is also reflected in her scores on the Collett-Lester Fear of Death Scale.

Catherine's view of herself has been greatly influenced by her mother. Because her mother is a strong, independent, and confident woman, Catherine is also strong and confident. Catherine has chosen to surround herself with people that make her feel good about herself. As for what outside influences may affect how she feels about herself, she says, "I feel influenced by the way my children and I interact, the way my husband and I interact, and also by how I feel valued by other people."

Catherine reported a seemingly open view of humanity, which is expressed in her statement, "At the end of the day we're all just people." Given that, in combination with other information she provided in her interview, I think that Catherine has a perspective of death and dying that is probably found among people older than she.

Doug's story. Doug is a 38-year-old survivor of Hodgkin's Disease, a type of lymphoma. He is the oldest of three sons raised in a conservative Catholic home. His parents divorced when he was 11 years old. Doug's father died of a heart attack when

Doug was 25, and his stepfather died of cancer eight years ago. He remains very close to his mother.

Doug lends an interesting perspective not only with respect to his surviving cancer but also in his beliefs regarding helping others. He says, “I believe that *I* should be independent and be able to love without help from others,” a common sentiment among American men. Doug has a difficult time accepting help from others, and he also has trouble communicating his needs to others. Because of this, Doug considers himself “the first guy to step up when a friend needs help.” He volunteers his time and energy helping others who have cancer and provides support to those close to him during times of need.

Doug’s experience with both the prospect of his own death and dying and the deaths of his father and stepfather gives him a seemingly “older” view of death and dying. He says of his stepfather’s dying,

I have had the great dissatisfaction of praying for my stepfather to die. He was in a coma after surgery to remove a brain tumor. Our family chose to pull the plug after it was apparent he would not survive in the long run. After the plug was pulled, his body stayed alive for another day. I just wanted him to be all right. I envisioned his coma as a cell, and I wanted his spirit to be free to do what it needed to.

Even though Doug prayed for the death of his stepfather, he understood that what he was actually praying for was the end of the process of dying.

I do not look forward to anyone around me dying, but I am aware that death is inevitable. All I want is for my loved ones to have a good quality of life before they die, and when they die, I hope that it is under positive circumstances. What I mean is that they do not fear it and do not regret their lives.

When it comes to his own death, Doug says that there are two questions that concern him and really motivate him to be the best person he can be:

- (1) “Will I be willing to give up the false sense of control I feel that I have over my life?”
- (2) “Will I feel like I made a positive impact on the world?”

Again, because Doug has had to come face to face with mortality himself, he has a different approach to life than Mary, Susan, and Catherine do. Doug’s attitudes about life and living seem to place control somewhere other than within himself; he acknowledges that our lives are often beyond our control.

How Doug feels about himself is made stronger by what he does for others. He has a strong belief in principle of The Golden Rule and makes every attempt to live by that rule. Doug says, “If I can go to bed having no doubts whether I made a positive impact that day, then I tend to feel good about myself.” Having said that, Doug also acknowledges that he may expect too much from himself and also admits that he is not very self-confident.

I have little self-confidence in my looks (I am overweight, for starters). Prior to having cancer, I had NO self-confidence and often felt very bad about myself (my dad used to hassle me about my weight a lot as a kid). Cancer taught me how meaningless it was to berate myself and that I deserved to treat myself better.

Because Doug does not feel good about his external self, he compensates by doing good for others and being the best person he knows how to be.

Doug holds the principle of the Golden Rule as very important when it comes to accepting all people. Because of his upbringing and personal values, he holds himself accountable for his actions and perhaps may also be more aware of the manipulative nature of today’s media.

I sometimes find myself manipulated by the media, television and newspapers in particular. It angers me to see the media manipulate not only me but everyone else too...and it embarrasses me that so many people allow themselves to get sucked into it.

Doug's statement about his sentiments toward the media indicates that the media threaten not only his ability to perceive of a "common humanity" but others' perceptions as well. It (the media) challenges our ability to see one world by creating and perhaps exploiting differences rather than celebrating similarities.

Strengths and Limitations of the Qualitative Data

Strengths in the collection and analysis of the qualitative data include the following:

- Participant's choice of communication technique. This acknowledges that each person is different in communication style.
- Use of questions designed to reify the connection between the key concepts of altruistic behavior, fear of death and dying, perceptions of a common humanity, and self-esteem
- Age range of participants

Limitations to the qualitative data collection and analysis include the following:

- Small sample size
- Sample limited to one cancer survivor

CHAPTER 5: DISCUSSION

The goal of this research project was to explore possible answers to five specific questions:

- Does the fear of death and dying have a negative effect on altruistic behavior?
- What role does self-esteem play in relation to the fear of death and dying and altruistic behavior?
- What role does perception of common humanity play in relation to self-esteem, the fear of death and dying, and altruistic behavior?
- Are there significant gender differences in altruistic behavior, perception of common humanity, self-esteem, and/or fear of death and dying?
- Do those personally affected by cancer differ in their perception of common humanity, behavior, and/or fear of death and dying?

Addressing the Research Questions

On the basis of the statistical evaluation of quantitative data provided by 32 participants, along with the objective evaluation of qualitative data provided by four participants, several conclusions are made. As with most social research, however, it is safe to say that new questions have manifested themselves through the process of seeking answers to the aforementioned questions.

First, does the fear of death and dying have a negative affect on our measure of altruistic behavior? According to the results generated by this analysis, no. We must therefore accept the null hypothesis set forth in chapter one. The path model illustrates that our measure of the fear of death and dying has virtually no effect on the variable altruistic behavior, when taken to consideration alone. The relationship strengthens in a

positive direction when self-esteem and perception of common humanity are added as independent variables. This is also illustrated in the lack of a significant Pearson Correlation between the two variables. Through examination of the interview data, however, it is evident that one may want to consider the possibility of the fear of rejection and failure being an important variable(s) in future research.

This pilot research provides an answer for the second question posed, *What role does self-esteem play in relation to the fear of death and dying and altruistic behavior?* as well. On the basis of the findings, self-esteem had a significant negative effect on all four axes of the Collett-Lester Fear of Death Scale. Those who reported having a lower self-esteem also had a higher fear of death and dying, both of the self and of others. This relationship is shown not only in the Pearson Correlation table but in the path model as well.

Self-esteem was not significantly associated with altruistic behavior in the Pearson Correlation table; therefore, we must accept the null hypothesis that there is no significant relationship between self-esteem and altruistic behavior. However, through the examination of the qualitative data, it becomes evident that the two are quite possibly related to some degree. Interview respondents reported not feeling comfortable offering help to someone who may need help out of fear of rejection. It is also clear from the interview data that for some, the idea of helping others may be an uncomfortable one when the required assistance is something that is perceived as difficult (fear of failure). Not only does our self-esteem limit our capacity to have a healthy-minded view of death, it also limits our capacity to behave in an altruistic way if that altruistic act requires us to step outside of our comfort zones.

The role of our measure of perception of a common humanity in relation to self-esteem, the fear of death and dying, and altruistic behavior is such that, according to the data gathered for this pilot research, as with self-esteem, there is a difference between the quantitative data and the qualitative data. The data presented in the Pearson Correlation matrix indicates a significant positive correlation between the perception of common humanity and the fear of others' dying. What this tells us is that the more one perceives humanity as common, the more the idea of another human being going through the process of dying provokes anxiety. In other words, there is a greater concern for fellow man and a greater potential for one to act altruistically.

A review of the data in the path analyses indicates that our measure of perception of a common humanity is positively related to altruistic behavior. Those who have a perception of humanity that is more open are apt to behave more altruistically. Monroe found this to be true in her research as well. The principle of The Golden Rule was deemed a driving force in the interview participants' lives and served to guide them in their perception and treatment of others.

When it comes to self-esteem and perception of common humanity, the data just do not support the theoretical supposition that there is indeed a mutually positive relationship between the two. Data gathered for this project indicate that the two are negatively related (although a very weak negative at best). The qualitative data do not really support either a negative or a positive relationship.

Were there gender differences when it came to the fear of death and dying, self-esteem, altruistic behavior, and/or perception of a common humanity? According to the *t* test data presented in chapter four, none were found. In the interviews, the only

perceptible difference between the female respondents and the male respondent was that for Doug, asking for help was difficult even when the need was truly desperate. This difference is certainly influenced by not only the media but our American culture as well. Men are supposed to remain strong and refrain from showing emotion, which is often considered a sign of weakness. One must, however, consider that assumptions based on data from one male participant are premature.

Did the presence of cancer in the participants' lives have any effect on the measures of altruistic behavior, perception of common humanity, self-esteem, or the fear of death and dying? According to the quantitative analysis, again the answer is no. Survivors showed few, if any, differences from the "healthy" sample.²¹ In the analysis of the interview data, it was found that Doug really did not have a different perspective because of his experience with cancer. Each of the interviewees reported having had some experience with personal tragedy of one kind or another.

Although as a result of the limits of sample size we cannot say with any degree of certainty how this data applies to the world at large, it is important to understand the benefits to articulating and clarifying our theoretical model. The goal of this research was to explore the possibility of the relationships outlined in the theoretical model. This is not to deny the importance of this project; the clinical applications for this model are important, but clearly a more systematic, funded, in-depth, randomized research project is required to uncover the answers that are so greatly needed.

²¹ Refer to Tables 4.2 and 4.3 for clarification.

Discussion of the Commonalities Found in the Data

When it comes to the concepts of fear of death and dying, altruism, self-esteem, and perceptions of a common humanity, the four cases outlined in the qualitative data analysis yield some important information. For instance, in terms of behaving in ways that benefit others, each of the participants seems to be more comfortable when their helpfulness is aimed at persons/groups with whom they are familiar. They are willing to make small sacrifices for those near and dear to them. To illustrate, both Mary and Susan are active in their religious organizations and give freely of their time and money to benefit programs sponsored by their churches. In the same respect, Catherine volunteers her time to organizations within her community that provide assistance to those in need, but when it comes to financial help, she limits that to her family. Doug donates his time and energy to a cancer support center, a place where he is comfortable and feels valued.

Given this information, it is necessary to ask *Isn't it likely that the participants would be acting in ways in that benefit their communities regardless of their cognitive disposition, fear (or lack thereof), and self-esteem?* At this point, it would be simple to say yes. However, families, communities, the workplace, and even churches are riddled with people who are considered bystanders, whereas only a handful act in ways that benefit the greater good. The question to ask then is *What sets the altruist apart from the bystander?*

When discussing death and dying, commonalties can be found, for example, in the fact that none of the four participants wanted to feel that their time was up too soon. Susan and Catherine voiced concerns about how their children and spouses would handle their deaths, and also about how if they were to die, they would miss out on the lives of

their children. Mary was also concerned about missing out on grandchildren's and great-grandchildren's lives. The realization that life goes on without us upon our death is a lot to bear and can, as is illustrated in the discussions, cause great concern.

Commonality was found in "common humanity" in that the perception that one possesses is greatly affected by our society and the media. For Susan, it is how she perceives strangers. "Stranger danger" has been firmly planted into the brains of many Americans, and it has served to separate us into categories, making altruistic behavior seem risky and fear the norm. Mary is reluctant to help those who do not ask for help because she is afraid of rejection. She is also somewhat reluctant to help those outside of her circle because of the perception (certainly influenced by our media) that many that do ask for help are simply abusing the system.

In terms of self-esteem and common ties, we see that for Susan and Doug, helping others gives them a good feeling that serves to counteract insecurities like weight and money. Catherine and Mary also reported that their interactions with those close to them and how valued they perceive themselves to be influence how they feel about themselves. Participants felt good through their positive interactions with others.

It is through these commonalities that we see that fear of death and dying and altruism are not exclusively related. Self-esteem and perceptions of a common humanity, along with fear of death and dying (as well as fear of rejection), are key components in the questions previously raised, namely, *What are the forces that guide one person to act out of self-interest, whereas another may choose to act altruistically?* Obviously, to attempt to give such a question a definitive answer on the basis of this research would be

premature. Future, more substantive research, beginning with the development of an appropriate altruism scale, is needed before such general conclusions can be made.

CHAPTER 6: CONCLUSION

What are the factors that contribute to this disagreement between the aforementioned data and the implications taken from the literature when it comes to altruistic behavior and its relation to the fear of death and dying? I believe that the failure lies within the measurement scale used in this project. The question as to whether or not the fear of death can have an effect on altruistic behavior implies that the altruistic act may pose a threat to the actor's life. Although threat is certainly not a requirement for an act to be considered altruistic, it would have to be required to answer the question at hand. Therefore, the Self-Report Altruism Scale, which consists of questions addressing the frequency of nonlife-threatening, very time/place/opportunity-specific altruistic acts, seems a bit inadequate. Some of the items on the scale, such as donating blood, for instance, do not apply to all populations. To be more specific, according to the American Cancer Society's website, "in certain cases cancer survivors may not be allowed to donate blood for other people" (American Cancer Society 2005). Although the American Red Cross employs very specific guidelines, other donation centers may not follow the same standards, which can be not only frustrating for eager donors but confusing as well.

Other questions, such as the following, require that a person come into contact with that specific situation, some of which are very limiting and situational:

- I have delayed an elevator and held the door open for another (requires the presence of an elevator).
- I have helped another with a homework assignment when my knowledge was greater than hers/his (older persons may not come into contact with school-aged persons in need of help).

- I have voluntarily looked after another's plants, pets, house, or children without being paid for it (this opportunity does not present itself often, if at all, in the lives of many).
- I have helped another to move her/his possessions to another room, apartment, or house (this implies that participant is well/able enough to perform such a task).
- I have offered my seat in a crowded room or on a train/bus to someone who was standing (in our culture, this is traditionally an act reserved for men).

For the fear of death and dying to have a direct effect on our measure of altruistic behavior, it may very well be that the everyday acts of kindness that are measured by the Self-Report Altruism Scale are insufficient. Because altruistic behavior exists along a continuum, acts can be as benign as helping someone carry groceries or as risky as rescuing a drowning person; a measure that accounts for this range may be more appropriate.

With respect to the findings made by Monroe (1996) in terms of altruism being related to perception of a common humanity, the findings from this study do not strongly confirm such a relationship. Based on the path analysis, there is a small causal relationship, but there was no significant correlation in the Pearson Correlation Matrix (Table 4.6).

The data presented in the Pearson Correlation table as well as in the path analysis confirm the information presented by Hessing and Elffers (1985) in that self-esteem does indeed influence our fear of death and dying. Results of this exploratory study indicate that those who reported fearing death and dying less also had higher measures of self-

esteem. Of the interview participants, it was Mary, age 70, a noncancer survivor, who not only had the highest score on the self-esteem scale but the lowest score on our measure of the fear of death and dying. The reasons for this connection could be many, including the role of faith and the lack of media influence during her formative years (she grew up in an era when television was not mainstream and in a rural farming area of the Midwest).

Who Benefits from Our Acts of Kindness?

Through the examination of the interview data, it was found that when participants did choose to perform acts of kindness or behave altruistically, the beneficiaries of such acts were, at the very most, acquaintances. Whether they be church members, neighbors, family members, classmates/coworkers, and/or friends, it was rare that a complete stranger was the target of an altruistic act. For Mary, it was a fear of rejection that would cause her to hesitate when it came to helping someone unfamiliar to her. For Susan, it was the notion of “stranger danger,” and for Doug, it was a lack of self-esteem in terms of his physical appearance.

Implications of the Data

The results of this exploratory pilot study, as well as the data that have been provided by other researchers (Hessing and Elffers, 1985; Midlarsky and Kahana, 1994), lend insight into potential clinical applications. Because it holds that self-esteem has an inverse and dynamic relationship to the fear of death and dying and that doing good for others has a positive effect on self-esteem, the following recommendations can be made:

- Provide the opportunity for those at the end of life to do good for others.
Doing good for others allows for higher self-esteem. Research indicates that individuals possessing a higher self-esteem have a lower death anxiety.
- Suggest that those seeking assistance for a low self-esteem or those displaying signs of depression participate in altruistic acts. In so doing, the likelihood for a higher self-esteem increases, death anxiety will decrease, and one will begin to perceive humanity as common.

Other contributions made by this exploratory study include the development of an innovative theoretical model outlining the cumulative and cyclical relationship between the fear of death and dying, altruistic behavior, perception of a common humanity, and self-esteem. In a period in history where one's own well-being is often considered more important than the well-being of others, it is important to begin to understand how to create change to a more global, less fearful way of thinking and acting. Although further, more substantive research is needed to reassert such a theoretical model, this study serves as a pilot investigation. Confirmatory evidence for this model is possible with the utilization of an improved survey technique, development of a more fitting altruism scale, a larger interview sample, and collaboration with others in the field of social psychology.

Questions for Future Research

As previously stated, new questions for further research have been generated out of this project. The first is *Is there a tendency to direct our altruistic behavior at those familiar to us?* To be more specific, *If we are more apt to behave altruistically to those within our own personal circle, do we assume that the needs of others are already taken care of by (or are the responsibility of) those persons that exist within their own circles?*

By making such an assumption, we permit ourselves to be bystanders (without guilt, of course) and to close ourselves off from “others,” providing a justification for ignoring the needs of others and thus limiting our capacity to perceive of a common humanity.

Another question for further research is *What effect does the media have on our ability to perceive of a common humanity?* Recall Susan, one of the interview participants. She clearly expressed a tendency for helping those with whom she was familiar but was reluctant when it came to behaving altruistically toward a stranger.

One last question to address is that of a better measure of altruistic behavior. What are the components of a good measure of altruistic behavior? Would there have been a relationship between the fear of death and dying and altruistic behavior if a more suitable measure were available? To provide an answer to these questions requires a coming together of those in the field of altruism research and social psychology. We would all greatly benefit from not only a universal understanding of the concept of altruism but an improved way of measuring altruistic behavior as well.

This exploratory investigation may not indicate a direct relationship between the fear of death and dying and altruistic behavior, but according to the data there is a negative relationship between our measures of the fear of death and dying and self-esteem. The data also indicate that there is a negative relationship between our measures of the fear of death and dying and perceptions of a common humanity. It follows, too, that there is a positive relationship between our measures of self-esteem and altruistic behavior, as well as our measures of perceptions of a common humanity and of altruistic behavior. Therefore, we can conclude that fear of death and dying does indeed affect the way that we feel about ourselves and the way we perceive ourselves in relation to others,

which in turn guides how we act in the world and at whom our actions/behavior are aimed.

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APPENDICES

Appendix A: Informed Consent

Dear Participant,

My name is Jennifer Haskin Corwin. I am a student in the Department of Sociology, Anthropology & Criminology at Eastern Michigan University. I am inviting you to participate in several surveys about fears and behaviors. This research is being conducted for my Master's Degree Thesis project.

The survey consists of a scale that is designed to examine attitudes about life, death, the self and others. Please fill them out completely. Completing these surveys may cause some emotional discomfort. This is the only foreseen risk for participating in this study. The discomfort risk just described should not exceed that encountered in daily life for most individuals. A direct benefit to you, as participants, is that by answering the survey, you may increase your awareness with regards to your behaviors and perhaps become more conscious of your motivations. An indirect benefit to you is knowing that your participation will provide very valuable information. There is also an opportunity to participate in a confidential interview with the researcher.

If for any reason related to the participation in this project you feel the need for a crisis intervention/referral service, a phone number of a qualified professional is provided at the bottom of this form.

Confidentiality is fundamental to this research project. There is no request for your name. The materials from this study will be kept in a locked file cabinet for at least four years from the completion of the project and consequently destroyed. Your answers are anonymous and I will be the only person having access to them.

Your participation is completely voluntary and you can discontinue at any time. If you decide to participate, keep this letter for reference. **Returning a completed questionnaire will mean that you understood this letter and agreed to participate.** If you decide not to participate, please return the materials, as they can be distributed to another participant. **Upon completion, please place all materials in the addressed, stamped envelope provided.**

I will be glad to answer any questions you have concerning this study and I am willing to share the results of the study once it is completed. **Any shared or published data will be anonymous—that is, not connected with any individuals, or organizations.** If you would like to get a summary of the results or if you have any questions regarding this research, please contact me at:

Jennifer Haskin Corwin
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Dept. of Sociology, Anthropology & Criminology
712 Pray Harrold
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(734) 487-0012
Email: jcorwin@emich.edu

Thank You!

Crisis intervention/referrals
Cathy Antkowiak-Howard, MSW (734)-544-6836

Appendix B: Survey Instrument

My name is Jennifer Haskin Corwin; the following questionnaire is a part of the work that I am doing for my Master's Thesis project at Eastern Michigan University. I am currently studying Sociology, and have an undergraduate degree in Psychology. I am interested in looking at attitudes about life, death, the self and others. The following Attitude Scale was designed to help do just that.

At the end of the survey, there is an opportunity to participate in a short interview with me. It will consist of 4-5 questions of the same nature, and take about 30-45 minutes. Participation in the interview is strictly anonymous, and voluntary. If you wish to participate, feel free to fill in your contact information (please limit contact name to the first letter of your last name and an appropriate title, for example: Mr. C or Ms. K). You may use a false name if you wish. Any identity you give will be kept confidential and will not be revealed in any way.

Thank you for participating in this study. Please answer all questions to the best of your ability. Read each item and answer it quickly. Your first impression is very important, do not spend too much time thinking about each item. There are no right or wrong answers, just your answers. The answers, including your identity are confidential, and will not be revealed in any way. Your honesty is important to the integrity of this project.

Age: _____ Gender: M F Cancer Survivor (Current or Remission): YES NO

Based on the following scale, how much do the following items disturb you or make you anxious:

	Not at all	Somewhat	4	Very	
	1	2	3	5	
The shortness of life	1	2	3	4	5
Missing out on so much after you die	1	2	3	4	5
Dying young	1	2	3	4	5
How it will feel to be dead	1	2	3	4	5
Never thinking or experiencing anything again	1	2	3	4	5
The possibility of pain and punishment during life after death	1	2	3	4	5
The disintegration of your body after you die	1	2	3	4	5
The physical degeneration involved in slow death	1	2	3	4	5
The pain involved in dying	1	2	3	4	5
The intellectual degeneration of old age	1	2	3	4	5
That your abilities will be limited as you lay dying	1	2	3	4	5
The uncertainty as to how bravely you will face the process of dying	1	2	3	4	5
Your lack of control over the process of dying	1	2	3	4	5
The possibility of dying in a hospital away from friends and family	1	2	3	4	5

The grief of others as you lay dying	1	2	3	4	5
The loss of someone close to you	1	2	3	4	5
Having to see their dead body	1	2	3	4	5
Never being able to communicate with them again	1	2	3	4	5
Regret over not being nicer to them when they were alive	1	2	3	4	5
Growing old alone without them	1	2	3	4	5
Feeling guilty that you are relieved that they are dead	1	2	3	4	5
Feeling lonely without them	1	2	3	4	5
Envious that they are dead	1	2	3	4	5
Having to be with someone who is dying	1	2	3	4	5
Having them want to talk about death with you	1	2	3	4	5
Watching them suffer from pain	1	2	3	4	5
Having to be the one to tell them that they are dying	1	2	3	4	5
Seeing the physical degeneration of their body	1	2	3	4	5
Not knowing what to do about your grief at losing them	1	2	3	4	5
Watching the deterioration of their mental abilities	1	2	3	4	5
Being reminded that you are going to go through the experience one day	1	2	3	4	5

Please answer the following questions according to the following scale:

SA= Strongly Agree, A= Agree, N= Neutral, D= Disagree, SD= Strongly Disagree

I feel that I am a person of worth, at least on an equal plane with others	SA	A	N	D	SD
I feel that I have a number of good qualities	SA	A	N	D	SD
All in all, I am inclined to feel that I am a failure	SA	A	N	D	SD
I am able to do things as well as other people	SA	A	N	D	SD
I feel I do not have much to be proud of	SA	A	N	D	SD
I take a positive attitude toward myself	SA	A	N	D	SD
On the whole, I am satisfied with myself	SA	A	N	D	SD
I wish I could have more respect for myself	SA	A	N	D	SD
I certainly feel useless at times	SA	A	N	D	SD
At times I think I am no good at all	SA	A	N	D	SD

Please indicate the number of times in the past **12 months** you have performed the following actions using the following scale:

- 1= Never**
- 2= Once**
- 3= More than Once**
- 4= Often**
- 5= Very Often**

I have assisted someone experiencing car trouble	1	2	3	4	5
I have given someone directions	1	2	3	4	5
I have made change for someone	1	2	3	4	5
I have given money to someone who needed (or asked for it)	1	2	3	4	5
I have done volunteer work for a charity	1	2	3	4	5
At times I find it amusing to upset the dignity of teachers, judges, and other "cultured" people	1	2	3	4	5
I have donated blood	1	2	3	4	5
I have helped carry another person's belongings	1	2	3	4	5
I have delayed an elevator and held the door open for another	1	2	3	4	5
I have allowed someone to go ahead of me in a line	1	2	3	4	5
I have given another a ride in my car	1	2	3	4	5
I have pointed out a clerk's error in undercharging for an item	1	2	3	4	5
I have let someone borrow an item of some value to me	1	2	3	4	5
I have helped another with a homework assignment when my knowledge was greater than hers/his	1	2	3	4	5
I have voluntarily looked after another's plants, pets, house or children without being paid for it	1	2	3	4	5
I have offered my seat in a crowded room or on a train/bus to someone who was standing	1	2	3	4	5
I have helped another to move her/his possessions to another room, apt, or house	1	2	3	4	5
I have retrieved an item dropped by another for her/him	1	2	3	4	5

Please indicate the most accurate response for you, in terms of the following items.
Please answer all of your questions to the best of your ability using the following scale:

- Immediate Family Only = **1**
(Spouse/Children/Parents)
- Extended Family & All of the Above = **2**
(Aunts, Uncles, etc.)
- Friends & All of the Above = **3**
- Neighbors & All of the Above = **4**
- Co-Workers/In-Group Members/Club Affiliates & All of the Above = **5**
- Acquaintances & All of the Above = **6**
- Strangers & All of the Above = **7**

Please indicate to whom you would <i>be willing</i> to lend money for a period of 1 month	1	2	3	4	5	6	7
Please indicate to whom you would give a ride in your car, if the need were to present itself	1	2	3	4	5	6	7
Please indicate to whom you would give assistance if they were stranded	1	2	3	4	5	6	7
Please indicate to whom you would give up your place in line	1	2	3	4	5	6	7
Please indicate to whom you would lend a valuable item (emotionally valuable or monetarily valuable)	1	2	3	4	5	6	7

Thank you for participating in my research project, your honesty, time and participation is greatly appreciated! Please refer to the contact information on your consent form should the need arise to contact either the crisis intervention specialist or myself.

Would you be willing to participate in a confidential face-to-face (or telephone) interview with this researcher consisting of about 5 questions, lasting from 30-45 minutes? Questions will be of the same nature as the ones above, with opportunity for discussion. I expect to be able to contact you to set up a convenient time/location within 10 days of the receipt of your completed survey. Please provide contact information below:

Phone #, or other preferred method of contact:

Best time to contact:

How should I address you when I call? (Example: Mr. C or Ms. D)

Appendix C: Interview

Thank you for agreeing to talk about some of the questions that you answered in the survey. Your time is greatly appreciated. All information discussed is confidential, and your identity will not be revealed to anyone.

Interview questions:

Can you tell me a little about yourself? Upbringing, family values, etc.

Some people believe that people should be independent and be able to live without help from others. Others feel that people should lend help in times of need. Where do you feel that you fit in? Can you give some examples?

How do you feel about the prospect of people close to you dying? Is it a natural process, does it cause you great concern? How about your own death? Where do you feel that these feelings come from, or what are they influenced by?

Some feel very good about themselves. Others feel very bad about themselves. How do you feel about yourself? What do you feel has influenced, or does influence the way you feel about yourself?

Do you feel that the boundaries (ethnic, religious, socioeconomic, etc.) that are created between groups of people are important? What if anything has affected where you perceive such (if any) boundaries?

Appendix D: Human Subjects Approval

June 8, 2004

Dear Ms. Corwin:

The CAS-Human Subjects Committee has considered your application, #2170, “Fear of Death/Dying Possible Barriers . . .”, and we consider it EXEMPT. This means that the proposal does not need further consideration by the University Human Subjects Committee and you may proceed with your research.

This letter should be presented with your thesis draft to the Graduate School as proof that you met the guidelines for research involving human subjects in the College of Arts and Sciences. Good luck with your endeavors, and your career.

Sincerely,
Michael J. Brabec, Chair
CAS-HSC