

**"DEATH ANXIETY AND COPING STRATEGIES"**

**Principal Investigator:**

*Dr. Profaina Christian.*

**Associate professor, department of psychology,  
St. Xavier's College (Autonomous),  
Ahmedabad.**

**SUBMITTED TO**

**UGC**

**Regional office,**

**PUNE.**

**MARCH, 2015**

**UNIVERSITY GRANTS COMMISSION**

**Ministry of Human Resource Development, Govt. of India.  
Western Regional Office, Ganeshkhind, Pune- 411007**

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**FINAL REPORT OF THE WORK DONE ON THE  
MINOR RESEARCH PROJECT**

1. Title of the Project:: **Death Anxiety and coping strategies.**
2. Name and address of the Principal Investigator: **Dr. Mrs. Profaina Christian**
3. Name and Address of the institution: **Department of Psychology. St. Xavier's College (Autonomous), Ahmedabad, Gujarat.**
4. UGC Approval Letter No. and Date: **23-420/12.(WRO). Dt.15.3.2013**
5. Date of Implementation: **15-3- 2013.**
6. Tenure of the Project: **Two Years (March 2013 to March 2015)**
7. Total Grant Allocated: **Rs. 145,000/-**
8. Total Grant Received: **Rs.110, 000/-**
9. Final Expenditure: **Rs. 102,785/-**
10. Title of the Project: **Death Anxiety and coping strategies.**
11. Objectives of the Report:-
  1. To study the death anxiety between healthy people and patients having chronic illness.
  2. To study the coping strategies used by healthy people and patients having chronic illness.
  3. To know if the gender, age, and educational status make any difference in healthy people and patients having chronic illness on death anxiety and coping behaviour?
  4. To assess the relation between death anxiety and coping strategies in healthy people and patients having chronic illness.

12. Whether objectives were achieved: **Yes.**

13. Achievements from the Project :Field Work has been done in different hospitals and residential places of Ahmedabad city.Collected samples from normal and chronically ill patients from these different areas, analysis have been done and also write a review of literature regarding topic. Also send a research paper for Publications.

14. Summary of the findings: **Copy attached.**

16. Whether any Ph.D. enrolled/produced out of the project : **No**

17. No. of publications out of the project:-Total one papers are sent for publication but not yet published. After publishingthey will be uploaded on the college website.

**Dr. Profaina. Christian**

Principal Investigator  
St. Xavier's college (Autonomous),  
Ahmedabad, Gujarat.

**Principal**

St. Xavier's college (Autonomous),  
Ahmedabad, Gujarat.

Seal

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## 1. INTRODUCTION

Every chapter has its own important in research. The research report is a most important aspect of research. It includes every aspect, right from the statements of problem to the findings of the study. The purpose of the research reports to communicate the result and discussion with readers. For that this is a required to be narrated in the form of a brief summary. It is only through this interpretation that the researcher can expose relations and process that underline the findings. The present study is a hypothesis testing study, if hypothesis are tested and upheld several times, the researcher may arrive at generalization.

According to J.C Colman modern era is ERA OF ANXIETY. Life is more complicated because of competition, poverty, unemployment, pollution, and over-population. All these leads level of stress and psycho somatic disorder. Man in this technological era experiences various types of anxieties, which result in the experience of confusions and stress. From the various anxieties that are experienced, the one related to death in strongly in nature. Life and death are two side of coin. All organisms are bound to be dying. Human being is unique in nature as compare to other organism. The concept of death and that the body goes back to the dust is only there in human being. Death scares people because it is omnipresent, powerful, unknown and mysterious. All living organisms die: there are no exceptions. Death is the only certainty in the life.

In modern era Coronary heart disease (CHD) and diabetes are devastating disorders striking large number of people all across the world almost like epidemics and causing deaths in substantially large number of young people at their most productive year in the Indian subcontinent. A recent statistics reveals that CHD are major cause of mortality and disease in the Indian subcontinent, causing more than 25% of death. Death anxiety increase complain of a general lose of interest and an inability to concentrate or think. It is exhibit considerable daily fluctuations in severity. Death anxiety is in short abnormal fear or thought of dying. A change in human perception is seen especially when one suffers from some chronic illness or from old age. This further creates a feeling of discomfort and inactivity, which make death anxiety more acute in nature.

Robert Langs distinguishes three types of death anxiety (Langs R., 2004):

- 1) **Predatory death anxiety:** Predatory death anxiety arises from the fear of being harmed. It is the most basic and oldest form of death anxiety, with its origins stemming from the first unicellular organisms' set of adaptive resources. Unicellular organisms have receptors that have evolved to react to external dangers and they also have self-protective, responsive mechanisms made to guarantee survival in the face of chemical and physical forms of attack or danger. In humans, this form of death anxiety is evoked by a variety of danger situations that put the recipient at risk or threatens his or her survival. These traumas may be psychological and/or physical. Predatory death anxieties mobilize an individual's adaptive resources and lead to fight or flight, active efforts to combat the danger or attempts to escape the threatening situation (Castano et.al., 2011).
  
- 2) **Predation or predator death anxiety:** Predation or predator death anxiety is a form of death anxiety that arises from an individual physically and/or mentally harming another. This form of death anxiety is often accompanied by unconscious guilt (Langs,1997). This guilt, in turn, motivates and encourages a variety of self made decisions and actions by the perpetrator of harm to others (McDonald, 1996).
  
- 3) **Existential death anxiety:** Existential death anxiety is the basic knowledge and awareness that natural life must end. It is said that existential death anxiety directly correlates to language; that is, language has created the basis for this type of death anxiety through communicative and behavioral changes (Langs,1997). Existential death anxiety is known to be the most powerful form. There is an awareness of the distinction between self and others, a full sense of personal identity, and the ability to anticipate the future. Humans defend against this type of death anxiety through denial, which is effected through a wide range of mental mechanisms and physical actions many of

which also go unrecognized. While limited use of denial tends to be adaptive, its use is usually excessive and proves to be costly emotionally (Sterling, 1985).

It is very important for people to learn how to cope with this type of anxiety. Coping is defined as an attempt to remove the feeling of discomfort. The people cope with stress and anxiety in many ways like individual, social. Coping strategies contribute to wellness--- good health, productive, life satisfaction and personal growth.

**Schregardus (1976)** proposed two major styles of coping namely '*Repression*' and '*Sensitization*'. He also found that patterns of defensive style were related to the perception of stress and to subsequent patterns of coping and adjustment. Individuals differ in their adjustment to both acute and chronic illness, however. Coping efforts have been proposed as one means of accounting for these differences in adaptation, and numerous studies have documented the importance of individual coping efforts in helping ill adults maintain reasonable levels of emotional well-being (Cohen & Lazarus, 1979; Moos, 1982). These studies have found typical coping strategies to include: denial, selective ignoring, information seeking, taking refuge in activity, avoidance, learning specific illness-related procedures, engaging in wish-fulfilling fantasy, blaming others, and seeking comfort from others.

Studies considering stresses other than of physical illness have also provided evidence that adults' choices of coping strategies influence the emotional outcome of stressful events (Menaghan, 1982; Pearlin, Lieberman, Menaghan, & Mullan, 1981; Pearlin & Schooler, 1978). They used longitudinal data to confirm that coping affected depression in reaction to involuntary job disruption: People who coped by making positive comparisons of their situations with others' and by devaluing the importance of monetary success

were more successful in avoiding economic strain, loss of self-esteem, and depression.

Folkman and Lazarus (1980) found that "palliative," or emotion-focused coping, was more likely to be used than "instrumental," or problem-focused coping, for health problems, especially when the problem was appraised as uncontrollable. Controllability is suggested as a critical property of stressors by this research and by several theories of coping (e.g., Baum, Singer, & Baum, 1981; Lazarus & Folkman, 1984). Controllability determines whether the strategies that prove most effective will be those that directly address the problem or those that aim at alleviating the emotional distress aroused by the problem. Uncontrollability limits the utility of coping efforts directed at the problematic situation. In stressful situations that are basically immutable, strategies that involve compromise with or temporary distortions of reality—strategies that might be considered inferior by traditional psychological theories (e.g., Haan, 1977; Vaillant, 1977) might well be effective efforts at adaptation (Lazarus & Folkman, 1984; Mechanic, 1974; White, 1974).

Information seeking has been described as one of the most universal forms of coping (Cohen & Lazarus, 1979; Hamburg & Adams, 1967) and one particularly valuable in recovery and adjustment to illness (Cohen, 1980; Moos & Tsu, 1977). Wish-fulfilling fantasy was among the emotions focused coping strategies found to be important in explaining psychological adjustment among rheumatoid arthritis (Lambert, 1981) and is theoretically important as a typical "attention deployment" coping strategy (Lazarus, Averill, & Opton, 1974).

In psychology, **coping** is expending conscious effort to solve personal and interpersonal problems, and seeking to master, minimize or tolerate stress or conflict (Weiten, & Lloyd, 2008; Cummings et.al., 1991; Lazarus & Folkman, 1984). The effectiveness of the coping efforts depend on

the type of stress and/or conflict, the particular individual, and the circumstances.

Psychological coping mechanisms are commonly termed coping strategies or coping skills. Subconscious or non conscious strategies (e.g. defense mechanisms) are generally excluded. The term coping generally refers to adaptive or constructive coping strategies, i.e. the strategies reduce stress levels. However, some coping strategies can be considered maladaptive, i.e. stress levels increase. Maladaptive coping can thus be described, in effect, as non-coping. Furthermore, the term coping generally refers to reactive coping, i.e. the coping response follows the stressor. This contrasts with proactive coping, in which a coping response aims to head off a future stressor.

Thorson, Powell and Samuel [1998] studied about 135 African and American ladies on their age and death anxiety and they found young female experience high death anxiety.

Keller, et.al [1984] studied death anxiety among 874 people with different age and they found that young male had experience more death anxiety.

Broota and Kumari [1998] studied death anxiety and depression between suffering from clinical symptoms and normal females, they found that the clinical group female experience more death anxiety compared to normal female. Nehrke (1978) studied death anxiety on male and female and he noted no sex difference in death anxiety. Jogsan [2004] studied on death anxiety suffering from chronic illness and normal male and female. He found that male and female who is suffering from illness experience more death anxiety compared to normal people.

Vipani [2004] had studied death anxiety and neurosis in heart patient and he found that the death anxiety higher in heart patient. Broota and Medha [2004] reported significant positive co-relation between spirituality and death anxiety.

Shahil [2001] studied death anxiety, spirituality and physical health in Pakistan he found them high level of death anxiety and significant relation between physical health and death anxiety.

Dinesh Nagar and Pragma Shukla [2012] reported that significant difference between categories of illness and death anxiety. Heart and diabetics reported high death anxiety. A decade old study (Goetsch, 1994) shows that the glucose level is higher on stressful or solicitant days than on a normal uneventful day – subjects are less active in stressful days and have a lower compliancy in what regards eating restrictions. Common depressive symptoms among diabetic patients are: fatigue, sleep disorders, lack of hope and decrease of libido.

A relatively recent study (Pawaskar, 2007) shows that depression is more likely to appear among middle aged people who suffer from chronic diseases such as diabetes. Chances for a diabetic patient to develop depression are higher than for other patients. Research has shown that approximately 30% of the people suffering from diabetes are depressed, and 10% are in major depression. Both diabetes and depression are important factors that have contributed to the functional incapacity of middle aged people. Among diabetic patients, both minor and major forms of depression are associated with the increase of mortality. Women that live alone are more prone to develop diabetes as a result of embracing a risky behavior such as smoking, alcohol, inobservance of diet, etc. (Lidfeldt & Agardh, 2005).

It is more likely for diabetic patients to have depressive symptoms than control groups and they have experienced many more psycho traumatic events over a period of 6 months before they developed the disease (Roy et.al., 1994).

Depression in diabetic patients is associated with low metabolic control, faulty self management and higher risks of complications. Female diabetic patients are more exposed to depression than male patients and consequently, more exposed to potential complications. Their life partners experiment the same levels of

distress, or even higher levels than the actual patients, especially when there is a female life partner who tends to be more involved emotionally and more sensitive to the psychosocial aspects of the marriage than men (Fisher et. al., 2002). Felton Barbara J. Revenson Tracy.A ( Journals of consulting and clinical psychology1984) studied on illness controllability and the influence of the coping strategies on psychological adjustment, results showed that cognitive strategies are related to positive affect while emotional strategies are related to negative effect, lower self- esteem and poor adjustment to illness.

A study by A.A,Kaptein, weinman, and others ( Journal of psychosomatic research 1998) studied on illness perception and coping in patient with rheumatoid arthritis, chronic obstructive pulmonary disease and psoriasis. Results shows that coping by seeking social support and belief in controllability of the disease were significantly related to better functioning. M. Pilar Mathud (Journal of personality and individual differences 2004) studied on gender difference in stress and coping styles, result show that the women score significant higher than the man on the emotional and avoidance coping style and lower on relational and detachment coping. Women used more emotion focused coping than man. Maria. Forns, Teresa, Judit and Juan (2012) studied on difference between genders in coping. The result found that the girls showed more coping efforts than boys to face interpersonal relationship problem and personal illness.

Gender differences in coping strategies are the ways in which men and women differ in managing psychological stress. There is evidence that males often develop stress due to their careers, whereas females often encounter stress due to issues in interpersonal relationships (Davis et. al., 1999). Early studies indicated that "there were gender differences in the sources of stressors, but gender differences in coping were relatively small after controlling for the source of stressors" (Billings, 1981); and more recent work has similarly

revealed "small differences between women's and men's coping strategies when studying individuals in similar situations" (Brannon & Feist, 2009).

In general, such differences as exist indicate that women tend to employ emotion-focused coping and the "tend-and-befriend" response to stress, whereas men tend to use problem-focused coping and the "fight-or-flight" response, perhaps because societal standards encourage men to be more individualistic, while women are often expected to be interpersonal. An alternative explanation for the aforementioned differences involves genetic factors. The degree to which genetic factors and social conditioning influence behavior, is a subject of an ongoing debate (Washburn-Ormachea et. al., 2004).

Hormones also play a part in stress management. Cortisol, a stress hormone, was found to be elevated in males during stressful situations. In females, however, cortisol levels were decreased in stressful situations, and instead, an increase in limbic activity was discovered. Many researchers believe that these results underlie the reasons why men administer a fight-or-flight reaction to stress; whereas, females have a "tend-and-befriend" reaction (Wang, 2007). The "fight-or-flight" response activates the sympathetic nervous system in the form of increased focus levels, adrenaline, and epinephrine. Conversely, the "tend-and-befriend" reaction refers to the tendency of women to protect their offspring and relatives. Although these two reactions support a genetic basis to differences in behavior, one should not assume that in general females cannot implement "fight-or-flight" behavior or that males cannot implement "tend-and-befriend" behavior.

The present research work is trying to study that whether people suffering from any kind of chronic illness are more prone to death anxiety compared to that normal people.

Another question which is raised is does the level of death anxiety vary when it is related to the coping strategies that are used.

Another variable i.e. under study is whether the gender, age, and educational status are contributing factors towards death anxiety and coping strategies that are used?

In the present research, the attempt has been made to a comparative study of death anxiety and coping behaviour between chronically ill and healthy/ normal male and female with different age and different educational status. The statement of the present research is

**“A study of Death Anxiety and Coping strategies between  
chronically ill and healthy people”**

**2. OBJECTIVES OF THE STUDY.**

1. To study the death anxiety between healthy people and patients having chronic illness.
2. To study the coping strategies used by healthy people and patients having chronic illness.
3. To know if the gender, age, and educational status make any difference in healthy people and patients having chronic illness on death anxiety and coping behaviour?
4. To assess the relation between death anxiety and coping strategies in healthy people and patients having chronic illness.

### **3. NULL HYPOTHESES.**

1. There is no significant difference between chronically ill and healthy people on death Anxiety.
2. There is no significant difference between chronically ill and healthy people on death Anxiety with reference to gender.
3. There is no significant difference between chronically ill and healthy people on death Anxiety with reference to different age.
4. There is no significant difference between chronically ill and healthy people on death Anxiety with reference to educational status
5. There is no interaction effects between gender, age and educational status in chronically ill and healthy people on death Anxiety.
6. There is no significant difference between chronically ill and healthy people on coping strategies.
7. There is no significant difference between chronically ill and healthy people on coping strategies with reference to gender.
8. There is no significant difference between chronically ill and healthy people on coping strategies with reference to different age..
9. There is no significant difference between chronically ill and healthy people on coping strategies with reference to educational status.
10. There is no interaction effects between gender, age and educational status in chronically ill and healthy people on coping strategies.
11. There is no relation between death Anxiety and coping strategies in chronically ill and healthy people.

#### 4. THE VARIABLES OF THE STUDY.

| Sr. no | Name of variable   | Sign | Type of variable | Number of level | Name of levels  |
|--------|--------------------|------|------------------|-----------------|---|
| 1      | Group of people    | A    | Independent      | 2               | A1- chronically ill<br>A2- Healthy                    |
| 2      | Gender             | B    | Independent      | 2               | B1-male<br>B2- female                                 |
| 3      | Age                | C    | Independent      | 2               | C1- below 45yrs.<br>C2 – 45yrs.& above                |
| 4      | Educational status | D    | Independent      | 3               | D1- non graduate<br>D2- graduate<br>D3- post graduate |
| 5      | Death anxiety      |      | Dependent        | -               | -   |
| 6      | Coping strategies  |      | Dependent        | -               | -   |

#### 5. THE SAMPLE OF SELECTION.

The present research is chiefly a quantitative study and not a qualitative one. Quantitative research has a two types – Experimental and Non-experimental. This research is based on the latter type i.e. non-experimental research. In the study, a 2x2x2x3 factorial design was used. The present research work was conducted on total 360 people. The randomized sampling techniques were used for the selection of sample. The number of respondents were kept equal

(n=15) in all the cells. The people were selected from various areas and hospitals of Ahmedabad city.

### THE NATURE OF THE SAMPLE

| Total sample = 360 |          |          |          |          |           |          |          |          |
|--------------------|----------|----------|----------|----------|-----------|----------|----------|----------|
| A1<br>180          |          |          |          |          | A2<br>180 |          |          |          |
|                    | B1<br>90 |          | B2<br>90 |          | B1<br>90  |          | B2<br>90 |          |
|                    | C1<br>45 | C2<br>45 | C1<br>45 | C2<br>45 | C1<br>45  | C2<br>45 | C1<br>45 | C2<br>45 |
| D1                 | 15       | 15       | 15       | 15       | 15        | 15       | 15       | 15       |
| D2                 | 15       | 15       | 15       | 15       | 15        | 15       | 15       | 15       |
| D3                 | 15       | 15       | 15       | 15       | 15        | 15       | 15       | 15       |

A1= Chronically ill people

A2= Healthy people

B1= Male

B2= Female

C1= 45 yrs below

C2= 45 yrs & above

D1= Non graduate

D2= Graduate (in any discipline )

D3= Post graduate (in any discipline)

### 6. RESEARCH DESIGN:

The present research design was planned into following two sections:

## **SECTION 1:**

In the first section, independent variable like the group of People , gender, age and educational status were selected and Death anxiety and coping strategies selected as a dependent variable. For this purpose, 2x2x2x3 factorial design prepared with equal number of subjects in each cell. The independent variable at two levels: chronically ill and healthy people. The gender and age of the people varied at two levels: male and female as well as 45 below – 45 & above and educational status varied at three levels: non graduate, graduate and post graduate for the factorial design. For this, according to the null hypothesis 1-10 was formed. To test these hypotheses it was decided to use The statistical method Analysis of Variance (ANOVA).

## **SECTION 2 :**

In second section it was planned to study the relations between death anxiety with coping strategies of ill and healthy people. For this, according to the null hypothesis 11 was formed. To test these hypotheses it was decided to use correlation technique.

## **7. PSYCHOLOGICAL TOOLS USED IN PRESENT STUDY.**

For the purpose of this study, the following three tools were used:

- 1) **PERSONAL DATA SHEET:** A personal data sheet was specially prepared to collect the relevant personal facts of each subject especially their gender, age, educational status and their health details.
  
- 2) **DEATH ANXIETY SCALE:** Death anxiety questionnaire developed by lonetto and Templer's (1983) (Gujarati version by Suvera [2001] was used to measure death anxiety. It contained 15 items where 8 are positive and 7 are negative with yes and no response. The maximum possible score is 15 and minimum is 0, high score indicate high level of death anxiety.

**3) COPING CHECK LIST:** Coping Check List developed by Rao [1986].The coping check list (CCL) has subscales developed on an A priority basis and validated in a normal, adult, community sample by Rao, 198. It is open-ended consists of 76 items relating to things that people do in time of stress in general, and is scored on a yes-no format. For each YES response 1 score is to be given. The test-retest reliability is 0.74 and the internal consistency (alpha coefficient) is 0.83 indicating adequate reliability.

## **8. THE PROCEDURE OF WORK.**

The main purpose of the present research was to find out the relations between death anxiety and coping strategies in ill and healthy people. For this, study sample was selected from Ahmedabad city it was decided to select 360 people (180 ill and 180 healthy). Initially, to prepare the list of various areas of Ahmedabad city, accordingly various areas and places visited for data collection. In the beginning 360 (180 ill -180 healthy) people were selected. For this selection randomization technique was used. Then personal data sheet along with death anxiety inventory, and coping check list were administrated to them. On the basis of research design, two groups of people were classified that is 180 ill and 180 healthy . Among each group of 180 people , 90 male and 90 female were categories, out of 90 people 45 samples age of 45 below and age of 45 & above were selected, each having 15 from no graduate, 15 from graduate and 15 from post graduate were selected.

The investigator obtained helping getting necessary co-operation from samples, and assured them that responses would be kept strictly confidential and would be utilized for research purpose only. After that the data were collected according to their convenience.

## **9. THE STATISTICAL ANALYSIS.**

Collected data were analyzed by appropriate technique. To study the impact of ill and healthy groups, gender, age and educational status on death anxiety and coping strategies mainly factorial design was prepared. To test the hypotheses number 1-10, framed from this factorial design, analysis of variance ANOVA was used so as to study the influence of main and interactional effects of the three main independent variables on dependent variables.

Karl Pearson's product moment correlation technique was used to assess the relationship between death anxiety and coping strategies for that hypotheses no. 11 was framed.

The statistical method Analysis of Variance (ANOVA) and correlation was used to analyze the collected data

## **10. RESULTS AND DISCUSSION.**

### **1. Death anxiety (DA) and coping Check list (CCL.) according to various variables.**

The main objective was to study death anxiety and coping behaviour of people with different health status, gender, age and educational status. For these purpose,  $2 \times 2 \times 2 \times 3$  factorial design was framed. Keeping in a view this design, in total 24 cells were framed where by number of respondents was kept equal (n=15) in all the cells. Based on the data collection, respondents were

categorized in two groups: healthy and chronically ill. Each of this group was categorized into two groups: male and female, and 45above and45 below age. Again in these two groups was sub-divided into three sub-groups: no graduation-graduate- post graduate. The total sample comprised of 360 people. To prove that, null-hypothesis (No 1 -11) was framed for this phase and the statistical technique Analysis of variance (ANOVA) was used. Conclusions were arrived based on F-values.

### **Impact of the group of person , gender, age and educational status on death anxiety .**

Obtained data were analyzed by four way analysis of variance (ANOVA) and interpreted in term of group of person , gender , age and educational status on death anxiety. For that, null-hypothesis (no- 1 to 5) was framed. According to 2x2x2x3 factorial design for all 24cells, the mean score and SD of death anxiety are reported in **table -1**

#### **Table -1 The mean score and SD of death anxiety**

|                 | Gender | Age | Streams       | Mean  | S.D.  | N  |
|-----------------|--------|-----|---------------|-------|-------|----|
| Chronically ill | Male   | 45- | No graduate   | 9.8   | 1.66  | 15 |
|                 |        |     | Graduate      | 8.67  | 0.74  | 15 |
|                 |        |     | Post-graduate | 9.2   | 3.53  | 15 |
|                 |        |     | total         | 9.29  | 7.09  | 45 |
|                 |        | 45+ | No graduate   | 8.9   | 2.15  | 15 |
|                 |        |     | graduate      | 9.7   | 1.94  | 15 |
|                 |        |     | Post-graduate | 10.13 | 0.99  | 15 |
|                 |        |     | total         | 9.6   | 9.17  | 45 |
|                 | Female | 45- | No graduate   | 10.2  | 1.82  | 15 |
|                 |        |     | graduate      | 10.67 | 1.29  | 15 |
|                 |        |     | Post-graduate | 10.67 | 1.23  | 15 |
|                 |        |     | total         | 10.51 | 4.04  | 45 |
|                 |        | 45+ | No graduate   | 9.87  | 1.60  | 15 |
|                 |        |     | graduate      | 9.45  | 1.41  | 15 |
|                 |        |     | Post-graduate | 11.33 | 1.05  | 15 |
|                 |        |     | total         | 10.22 | 14.74 | 45 |
| Healthy         | Male   | 45- | No graduate   | 3     | 1.13  | 15 |
|                 |        |     | graduate      | 2.67  | 0.82  | 15 |
|                 |        |     | Post-graduate | 2.33  | 1.05  | 15 |
|                 |        |     | total         | 2.67  | 5.00  | 45 |
|                 |        | 45+ | No graduate   | 2     | 0.85  | 15 |
|                 |        |     | graduate      | 3     | 1.00  | 15 |
|                 |        |     | Post-graduate | 2.67  | 1.35  | 15 |
|                 |        |     | total         | 2.56  | 7.64  | 45 |
|                 | Female | 45- | No graduate   | 1.33  | 0.72  | 15 |
|                 |        |     | graduate      | 1     | 0.38  | 15 |
|                 |        |     | Post-graduate | 1.2   | 0.68  | 15 |
|                 |        |     | total         | 1.18  | 2.52  | 45 |
|                 |        | 45+ | No graduate   | 1.67  | 0.82  | 15 |
|                 |        |     | graduate      | 1.47  | 0.52  | 15 |
|                 |        |     | Post-graduate | 0.8   | 0.41  | 15 |
|                 |        |     | total         | 1.31  | 6.81  | 45 |

**Table : 2 showing result of ANOVA on Death Anxiety (n=360)**

| <b><u>Source of variance</u></b> | <b><u>Df</u></b> | <b><u>Sum of squares</u></b> | <b><u>Mean square</u></b> | <b><u>F-value</u></b> | <b><u>Sig. level</u></b> |
|----------------------------------|------------------|------------------------------|---------------------------|-----------------------|--------------------------|
| A (groups)                       | 1                | 5728.04                      | 5728.04                   | 2983.35               | **                       |
| B (Gender)                       | 1                | 4.44                         | 4.44                      | 2.31                  | NS                       |
| C (Age)                          | 1                | 0.01                         | 0.01                      | 0.005                 | Ns                       |
| D (Education)                    | 2                | 2.82                         | 1.41                      | 0.73                  | Ns                       |
| AxB                              | 1                | 117.89                       | 117.89                    | <b>64.40</b>          | **                       |
| AxC                              | 1                | 0.01                         | 0.01                      | <b>0.005</b>          | Ns                       |
| AxD                              | 2                | 16.54                        | 8.27                      | <b>4.31</b>           | *                        |
| BxC                              | 1                | 0.72                         | 0.72                      | <b>0.38</b>           | NS                       |
| BxD                              | 2                | 1.81                         | 0.91                      | <b>0.47</b>           | Ns                       |
| CxD                              | 2                | 11.34                        | 5.67                      | <b>2.95</b>           | NS                       |
| AxBxC                            | 1                | 3.99                         | 3.99                      | <b>2.08</b>           | NS                       |
| AxBxD                            | 2                | 5.16                         | 2.58                      | <b>1.34</b>           | NS                       |
| AxCxD                            | 2                | 8.14                         | 4.07                      | <b>2.12</b>           | NS                       |
| BxCxD                            | 2                | 14.70                        | 7.35                      | <b>3.83</b>           | *                        |
| AxBxCxD                          | 2                | 6.69                         | 3.35                      | <b>1.74</b>           | NS                       |
| SSE                              | 336              | 645.2                        | <b>1.92</b>               |                       |                          |
| SST                              | 359              | 6567.5                       |                           |                       |                          |

\*\* P < 0.01   \* P < 0.05   NS = Not significant

**Table: .3 Showing mean and mean difference on the death Anxiety.**

| <b>Independent Variable</b> | <b>N</b>   | <b>Mean</b> | <b>Mean Difference</b>       |
|-----------------------------|------------|-------------|------------------------------|
| <b>Ill patient (A1)</b>     | <b>180</b> | <b>9.91</b> | <b>7.98</b>                  |
| <b>Healthy person(A2)</b>   | <b>180</b> | <b>1.93</b> |                              |
| <b>Male (B1)</b>            | <b>180</b> | <b>6.03</b> | <b>0.22</b>                  |
| <b>Female (B2)</b>          | <b>180</b> | <b>5.81</b> |                              |
| <b>Age 45-(C1)</b>          | <b>180</b> | <b>5.91</b> | <b>0.01</b>                  |
| <b>Age 45+(C2)</b>          | <b>180</b> | <b>5.92</b> |                              |
| <b>No graduate (D1)</b>     | <b>120</b> | <b>5.85</b> | <b>D1-D2</b><br><b>0.01</b>  |
| <b>Graduate (D2)</b>        | <b>120</b> | <b>5.86</b> | <b>D1-D3</b><br><b>0.19</b>  |
| <b>Post-Graduate(D3)</b>    | <b>120</b> | <b>6.04</b> | <b>D2- D3</b><br><b>0.18</b> |

**Table -4 Showing mean score of death Anxiety (AXB)**

| <b>Groups</b> <br><b>Gender</b>  | <b>Ill<br/>(A1)</b> | <b>healthy<br/>(A2)</b> |
|--|---------------------|-------------------------|
| <b>Male (B1)</b>   | <b>9.44</b>         | <b>2.61</b>             |
| <b>Female (B2)</b>   | <b>10.37</b>        | <b>2.36</b>             |

**Table -5 Showing mean score of death Anxiety (AXD)**

| <b>Groups</b> <br><b>Education</b>  | <b>Ill<br/>(A1)</b> | <b>healthy<br/>(A2)</b> |
|---|---------------------|-------------------------|
| <b>No Graduate (D1)</b>   | <b>9.7</b>          | <b>2.00</b>             |
| <b>Graduate (D2)</b>  | <b>9.98</b>         | <b>2.03</b>             |
| <b>Post graduate (D3)</b>   | <b>10.33</b>        | <b>1.75</b>             |

**Table -6 Showing mean score of death Anxiety (B x C x D)**

| Groups <br>Education  | Male (B1) |          | Female (B2) |          |
|---|-----------|----------|-------------|----------|
|   | Age (C1)  | Age (C2) | Age (C1)    | Age (C2) |
| No Graduate (D1)  | 6.4       | 5.47     | 5.77        | 5.77     |
| Graduate (D2)   | 5.77      | 6.37     | 5.83        | 5.47     |
| Post graduate (D3)  | 5.77      | 6.4      | 5.93        | 6.07     |

**Death Anxiety With reference to the group of person . ( Ill and healthy)**

The results of ANOVA on death anxiety table -2 is consulted and it is found that F-ratio is 2983.35, which is significant at 0.01 levels. That means ill group significantly differ on death anxiety as compare to healthy group. According to Table -3 the mean score of ill group is 9.91 which is high level of death anxiety and healthy group exhibited 1.93 which is low level of death Anxiety . The mean Difference between two group is 9.98. It is clearly said that significant difference find between ill and healthy group of persons on death anxiety. Thus the null-hypothesis-1 is rejected.

In the present result revealed that the ill groups experience more death anxiety compare to healthy group. In modern society, the person is always experiencing competition, frustration, pressure and different types of anxiety, it is well known fact that these type of environments leads to variety of health hazards or impairments. Also it is linked to low psychological well-being or ill-health and

depression. All these situations lead to chronic emotional states, which responsible for hypertension, diabetes arthritis and so on.

**Death Anxiety (DA) with reference to gender. (Male-female).**

To check the effects of gender on DA, the null-hypothesis no-2 was framed. The result of ANOVA on DA, table -2 is consulted and it is found that the F-ratio is 2.31 , which is not significant at any level of significance. That means gender is not affect on DA. In Table -3, the mean score of male group is 6.03 and female is 5.81. Difference between mean score of two groups are 0.22 which is very less. It can be said that no significant difference existed between male and female groups, thus the null-hypothesis is accepted.

**Death Anxiety (DA) with reference to Age.. (45 below & 45 and above)**

To check the effect of age on DA null hypothesis no-3 was framed. The result of ANOVA on DA, in table -2, it is found that F-ratio is 0.005 which in not significant at any level of significance. That means the age do not differ on death anxiety. Thus, the null-hypothesis is accepted . according to Table -3 the mean difference of two groups is 0.01 which is very less.

**Death Anxiety (DA) with reference to educational status.. (no graduate, graduate and post graduate.)**

To check the effect of age on DA null hypothesis no-4 was framed. The result of ANOVA on DA, in table -2, it is found that F-ratio is 0.73 which in not significant at any level of significance. That means the level of education is do not differ on death anxiety. Thus, the null-hypothesis is accepted .

according to Table -3 the mean difference between no graduate and graduate groups is 0.01, no graduate and post-graduate groups is 0.19 and graduate and post-graduate groups is 0.18 , which is very less.

**Death Anxiety (DA) with reference to interaction of the Ill and healthy groups, Gender age and educational status..**

The main advantage of using ANOVA technique is that is not only provides the information of main effect but also provides information about the interactive effect of independent variable taken into consideration. In real life situation various factors have complex relationship with each other while exerting influence on some other factors. So the present research decided to go for identifying such interactive effect between the Ill and healthy groups, Gender, age and educational status on total score of death Anxiety. .

To check the interaction effect of the group of person, gender , age and educational status on total score of death Anxiety .null-hypothesis no-5 was framed.

There are eleven interaction effect were found, these are,  $AxB$ ,  $AxC$ ,  $AxD$ ,  $BxC$ ,  $BxD$ ,  $CxD$ ,  $AxBxC$ ,  $AxBxD$ ,  $AxCxD$ ,  $BxCxD$ , And  $AxBxCxD$ . The result of ANOVA on DA is consulted and it is found that only three interaction effects on total score of DA found to be statistically significant which is  $AxB$ ,  $AxD$  and  $BxCxD$ . Other eight interaction effects were did no found to be significant.

The F-ratio of group of person and gender ( $AxB$ ) is 64.40 , which is significant at 0.01 level of significance. that means the group of person and gender interact each other on DA. Table No -4 shows that the mean score of the male suffering from illness is 9.44 and female suffering from illness is 10.37, and the mean score of healthy/ normal male and female according to 2.61 and

2.36. according to results we can clearly say that the female who suffering from illness is experienced highest level of death anxiety compare to normal male and female.

The F-ratio of group of person and educational status (AxD) is 4.31, which is significant at 0.05 level of significance, that means group of person and educational status interact each other on DA. Table No -5 shows that mean score of the not graduate person suffering from illness is 9.7, graduate person who suffering from illness is 9.98 and , post graduate person who suffering from illness is 10.33, and the mean score of healthy not graduate, graduate and post graduate person are 2.00, 2.03 and 1.75 respectively. According to results we can say that the post graduate person who suffering from illness is experienced more death Anxiety compare to healthy post graduate person.

The F-ratio of gender, age and educational status ( BxCxD) is 3.83, which is significant at 0.05 level of significance. That means gender, age and educational status interact each other on DA. Table No 4.6 shows the mean score of the 45 yrs below non-graduate male and 45yrs above post graduate male experienced more DA compare to non-graduate 45yrs above male and graduate 45yrs above female.

### **Impact of the group of person , gender, age and educational status on coping checklist (CC).**

Obtained data were analyzed by four way analysis of variance (ANOVA) and interpreted in term of group of person , gender , age and educational status on CC. For that, null-hypothesis (no- 6 to 10) was framed. According to 2x2x2x3 factorial design for all 24cells, the mean score and SD of death coping behaviour in **table -7**

**Table -7 Mean score and SD of coping behaviour**

| Group of person        | Gender        | Age        | Streams       | Mean  | S.D.   | N  |
|------------------------|---------------|------------|---------------|-------|--------|----|
| <b>Chronically ill</b> | <b>Male</b>   | <b>45-</b> | No graduate   | 18.93 | 4.43   | 15 |
|                        |               |            | Graduate      | 23.27 | 2.66   | 15 |
|                        |               |            | Post-graduate | 32.13 | 5.38   | 15 |
|                        |               |            | total         | 24.78 | 153.31 | 45 |
|                        |               | <b>45+</b> | No graduate   | 31.2  | 4.97   | 15 |
|                        |               |            | graduate      | 27.27 | 6.93   | 15 |
|                        |               |            | Post-graduate | 30.33 | 6.02   | 15 |
|                        |               |            | total         | 29.6  | 188.14 | 45 |
|                        | <b>Female</b> | <b>45-</b> | No graduate   | 24.8  | 5.06   | 15 |
|                        |               |            | graduate      | 41.53 | 4.37   | 15 |
|                        |               |            | Post-graduate | 28.6  | 7.47   | 15 |
|                        |               |            | total         | 31.64 | 259.19 | 45 |
|                        |               | <b>45+</b> | No graduate   | 28.93 | 5.14   | 15 |
|                        |               |            | graduate      | 31.53 | 7.48   | 15 |
|                        |               |            | Post-graduate | 31.33 | 8.85   | 15 |
|                        |               |            | total         | 30.6  | 251.67 | 45 |
| <b>Healthy</b>         | <b>Male</b>   | <b>45-</b> | No graduate   | 44    | 6.96   | 15 |
|                        |               |            | graduate      | 52.93 | 4.08   | 15 |
|                        |               |            | Post-graduate | 57.0  | 1.50   | 15 |
|                        |               |            | total         | 51.52 | 376.10 | 45 |
|                        |               | <b>45+</b> | No graduate   | 46.87 | 6.59   | 15 |
|                        |               |            | graduate      | 47.67 | 7.72   | 15 |
|                        |               |            | Post-graduate | 52.67 | 3.94   | 15 |
|                        |               |            | total         | 49.07 | 47.45  | 45 |
|                        | <b>Female</b> | <b>45-</b> | No graduate   | 60.73 | 3.09   | 15 |
|                        |               |            | graduate      | 51.73 | 4.08   | 15 |
|                        |               |            | Post-graduate | 60.6  | 3.33   | 15 |
|                        |               |            | total         | 57.69 | 77.37  | 45 |
|                        |               | <b>45+</b> | No graduate   | 49.93 | 8.61   | 15 |
|                        |               |            | graduate      | 54.8  | 5.45   | 15 |
|                        |               |            | Post-graduate | 59    | 3.68   | 15 |
|                        |               |            | total         | 54.58 | 68.06  | 45 |

**Table -8 Showing Results of ANOVA on coping behavior**

| Source of variance | df  | Sum of squares | Mean square | F-value      | Sig.level |
|--------------------|-----|----------------|-------------|--------------|-----------|
| A<br>(groups)      | 1   | 52080.28       | 52080.28    | 1684.90      | **        |
| B<br>(Gender)      | 1   | 2151.1         | 2151.1      | 69.59        | **        |
| C<br>(Age)         | 1   | 17.78          | 17.78       | 0.58         | NS        |
| D<br>(Education)   | 2   | 2063.72        | 1031.86     | 33.38        | **        |
| AxB                | 1   | 82.19          | 82.19       | <b>2.66</b>  | NS        |
| AxC                | 1   | 489.70         | 489.70      | <b>15.84</b> | **        |
| AxD                | 2   | 542.87         | 271.44      | <b>8.78</b>  | **        |
| BxC                | 1   | 240.10         | 240.10      | <b>7.77</b>  | **        |
| BxD                | 2   | 481.68         | 240.84      | <b>7.79</b>  | **        |
| CxD                | 2   | 301.5          | 150.75      | <b>4.88</b>  | **        |
| AxBxC              | 1   | 152.40         | 152.40      | <b>4.93</b>  | *         |
| AxBxD              | 2   | 1190.60        | 595.3       | <b>19.26</b> | **        |
| AxCxD              | 2   | 752.11         | 376.06      | <b>12.17</b> | **        |
| BxCxD              | 2   | 827.22         | 413.61      | <b>13.38</b> | **        |
| AxBxCxD            | 2   | 843.92         | 421.96      | <b>13.65</b> | **        |
| SSE                | 336 | 10384.73       | 30.91       |              |           |
| SST                | 359 | 72601.9        |             |              |           |

\*\* P < 0.01 \* P < 0.05 NS = Not significant

**Table -9 Showing Mean and Mean differences on coping behaviour .**

| <b>Independent Variable</b> | <b>N</b>   | <b>Mean</b>  | <b>Mean Difference</b> |
|-----------------------------|------------|--------------|------------------------|
| Ill patient (A1)            | 180        | <b>29.16</b> | <b>19.73</b>           |
| Healthy person(A2)          | <b>180</b> | <b>48.89</b> |                        |
| Male (B1)                   | <b>180</b> | <b>38.74</b> | <b>4.89</b>            |
| Female (B2)                 | <b>180</b> | <b>43.63</b> |                        |
| Age 45-(C1)                 | <b>180</b> | <b>41.41</b> | <b>0.45</b>            |
| Age 45+(C2)                 | <b>180</b> | <b>40.96</b> |                        |
| No graduate (D1)            | <b>120</b> | <b>38.76</b> | <b>D1-D2 2.58</b>      |
| Graduate (D2)               | <b>120</b> | <b>41.34</b> | <b>D2-D3 2.99</b>      |
| Post-Graduate(D3)           | <b>120</b> | <b>44.33</b> | <b>D1-D3 5.57</b>      |

**Table -10 Showing mean score of coping behaviour (AXC)**

| <b>Groups</b>  | <b>Ill</b><br><b>(A1)</b> | <b>healthy</b><br><b>(A2)</b> |
|---|---------------------------|-------------------------------|
| <b>Age</b>     |                           |                               |
| <b>45 below (C1)</b>  | <b>28.11</b>              | <b>54.6</b>                   |
| <b>45 &amp; above (C2)</b>  | <b>30.1</b>               | <b>51.82</b>                  |

**Table -11 Showing mean score of coping behaviour (AXD)**

| <b>Groups</b>     | <b>Ill</b><br><b>(A1)</b> | <b>healthy</b><br><b>(A2)</b> |
|--|---------------------------|-------------------------------|
| <b>Education</b>  |                           |                               |
| <b>No Graduate (D1)</b>  | <b>25.97</b>              | <b>50.38</b>                  |
| <b>Graduate (D2)</b>   | <b>30.9</b>               | <b>51.78</b>                  |
| <b>Post graduate (D3)</b>  | <b>30.6</b>               | <b>57.47</b>                  |

**Table -12 Showing mean score of coping behavior (BXC)**

| gender <br>Age  | Male<br>(B1) | female<br>(B2) |
|---|--------------|----------------|
| 45 below (C1)   | 38.14        | 44.67          |
| 45 & above (C2)   | 39.33        | 42.59          |

**Table -13 Showing mean score of coping behaviour (B x D)**

| gender s <br>Education  | Male (B1) | Female (B2) |
|---|-----------|-------------|
| No Graduate (D1)  | 35.25     | 41.1        |
| Graduate (D2)   | 37.78     | 44.9        |
| Post graduate (D3)  | 43.18     | 44.88       |

**Table -14 Showing mean score of coping behaviour (C x D)**

| Age <br>Education  | 45 below Age | 45 & above Age |
|--|--------------|----------------|
|  | (C1)         | (C2)           |
| No Graduate (D1)   | 37.12        | 39.23          |
| Graduate (D2)  | 42.37        | 40.32          |
| Post graduate (D3)   | 44.73        | 43.33          |

**Table -15 Showing mean score of coping behaviour (AXBXC)**

| Groups & gender <br>Age  | Ill (A1)     |                | healthy(A2)  |                |
|--|--------------|----------------|--------------|----------------|
|  | Male<br>(B1) | female<br>(B2) | male<br>(B1) | female<br>(B2) |
| 45 below (C1)  | 24.78        | 31.64          | 51.51        | 57.69          |
| 45 & above (C2)  | 29.6         | 30.6           | 49.07        | 54.58          |

**Table -16 Showing mean score of coping behaviour (AXBXD)**

| Groups & gender  | ill (A1)  |             | healthy (A2) |             |
|---|-----------|-------------|--------------|-------------|
|   | Male (B1) | female (B2) | male (B1)    | Female (B2) |
| No Graduate (D1)  | 50.13     | 53.73       | 90.87        | 110.67      |
| Graduate (D2)   | 50.53     | 73.07       | 100.6        | 106.53      |
| Post graduate (D3)  | 62.47     | 59.93       | 110.27       | 119.6       |

**Table -17 Showing mean score of coping behaviour (AXCXD)**

| Groups & Age  | ill (A1) |          | healthy (A2) |          |
|--|----------|----------|--------------|----------|
|  | Age (C1) | Age (C2) | Age (C1)     | Age (C2) |
| No Graduate (D1)   | 43.73    | 60.13    | 104.73       | 96.8     |
| Graduate (D2)  | 64.8     | 58.8     | 104.67       | 102.47   |
| Post graduate (D3)   | 60.73    | 61.67    | 118.2        | 111.67   |

**Table -18 Showing mean score of coping behaviour ( BXCXD)**

| Groups & Age<br>Education | Male (B1)<br>Age |       | Female (B2)<br>Age |       |
|---------------------------|------------------|-------|--------------------|-------|
|                           | (C1)             | (C2)  | (C1)               | (C2)  |
| No Graduate (D1)          | 62.93            | 78.07 | 85.53              | 78.87 |
| Graduate (D2)             | 76.2             | 74.93 | 93.27              | 86.33 |
| Post graduate (D3)        | 89.73            | 83    | 89.2               | 90.33 |

**Table -19 Showing mean score of coping behaviour (AXBXCXD)**

| Groups & gender<br>Education | (A1)  |       |       |       | (A2)  |       |       |       |
|------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|
|                              | B1    |       | B2    |       | B1    |       | B2    |       |
|                              | (C1)  | (C2)  | (C1)  | (C2)  | (C1)  | (C2)  | (C1)  | (C2)  |
| No Graduate (D1)             | 18.93 | 31.2  | 24.8  | 28.93 | 44    | 46.87 | 60.73 | 49.93 |
| Graduate (D2)                | 23.27 | 27.27 | 41.53 | 31.53 | 52.93 | 47.67 | 51.73 | 54.8  |
| Post graduate (D3)           | 32.13 | 30.33 | 28.6  | 31.33 | 57.9  | 52.67 | 60.6  | 59    |

### **Coping behaviour/coping checklist (CC) With reference to the group of person .**

The results of ANOVA on coping behaviour table -8 is consulted and it is found that F-ratio is 1684.90, which is significant at 0.01 levels. That means ill group significantly differ on CC as compare to healthy group. According to Table -9 the mean score of ill group is 29.16 and healthy group exhibited 48.89. The mean Difference between two group is 19.73. It is clearly said that significant difference find between ill and healthy group of persons on CC. Thus the null-hypothesis-6 is rejected. In the present result revealed that the healthy groups experience more coping behaviour compare to ill group.

### **Coping behavior/coping checklist (CC) with reference to gender.**

To check the effects of gender on CC, the null-hypothesis no-7 was framed. The result of ANOVA on CC, table -8 is consulted and it is found that the F-ratio is 69.59 , which is not significant at 0.01 level of significance. That means gender is affect on CC. In Table -9 the mean score of male group is 38.74 and female student is 43.63. Difference between mean score of two groups are 4.89. female used more coping compare to male. It can be said that the significant difference exited between male and female groups, thus the null-hypothesis is rejected. About female, we can say that the social support is a major factor in successfully dealing with stress. Simon (1995) said that, the women tend to have larger and tighter network that an able them to seek support from many sources. Psychological reviews (2000) reported that female were more likely to deal with stress by tending and befriending, that is nurturing those around them and reaching out to others. It protects the self and promotes safety and reduces distress. Girls rely more heavily upon their support network during time of stress. Also may be due to certain personality traits tend themselves well to getting along with others and being able to open up to people

such as extraversion and openness. Also we says, that the female cope with stress by seeking social support and use catharsis more then did male.

### **Coping behaviour/coping checklist (CC) with reference to Age.**

To check the effect of age on CC null hypothesis no-8 was framed. The result of ANOVA on CC, in table -8, it is found that F-ratio is 0.58 which in not significant at any level of significance. That means the age do not differ on CC. Thus, the null-hypothesis is accepted . according to Table -9 the mean difference of two groups is 0.45 which is very less. That means age did not affect on coping strategies.

### **Coping behavior/coping checklist (CC) with reference to educational status.**

To check the effect of educational status on CC, null hypothesis no-9 was framed. The result of ANOVA on CC, in table -8, it is found that F-ratio is 33.38 which is significant at 0.01 level of significance. That means the level of education is differ on CC. Thus, the null-hypothesis is accepted . according to Table -9 the mean difference between no graduate and graduate groups is 2.58 graduate and post-graduate groups is 2.99 and no graduate and post-graduate groups is 5.57.

### **Coping behaviour/coping checklist (CC) with reference to interaction of the Ill and healthy groups, Gender age and educational status..**

The main advantage of using ANOVA technique is that is not only provides the information of main effect but also provides information about the interactive effect of independent variable taken into consideration. In real life situation

various factors have complex relationship with each other while exerting influence on some other factors. So the present research decided to go for identifying such interactive effect between the Ill and healthy groups, Gender, age and educational status on total score of coping checklist. To check the interaction effect of the group of person, gender, age and educational status on total score of death Anxiety .null-hypothesis no-5 was framed.

There are eleven interaction effect were found, these are,  $A \times B$ ,  $A \times C$ ,  $A \times D$ ,  $B \times C$ ,  $B \times D$ ,  $C \times D$ ,  $A \times B \times C$ ,  $A \times B \times D$ ,  $A \times C \times D$ ,  $B \times C \times D$ , And  $A \times B \times C \times D$ . The result of ANOVA on coping checklist (CC) is consulted and it is found that only one interaction effects on total score of CC found to be statistically not significant which is  $A \times B$ . Other ten interaction effects were found to be significant.

According to table -8, The F-ratio of group of person and age ( $A \times C$ ) is 15.84, which is significant at 0.01 level of significance. that means the group of person and age interact each other on CC. Table No -10 shows that the mean score of the 45 yrs below ill group is 28.11 which is very low and the mean score of 45yrs below healthy group is 54.6. According to results we can clearly say that the 45yrs below healthy group used more coping behavior compared to 45yrs below ill group.

According to table 4.8, The F-ratio of group of person and educational status ( $A \times D$ ) is 8.78, which is significant at 0.01 level of significance, that means group of person and educational status interact each other on CC. Table No -11 shows that mean score of the non graduate ill group is 25.97 which is lowest score and mean of post graduate healthy group is 57.47. That means non graduate person who suffering from illness is less used coping behavior compare to post graduate healthy groups. According to results we can say that

the higher education helps to people to cope with anxieties. May be educated person are more understand the situation and able to handle the crises. Also they can try to take scientific solution regarding their problems. Other words, more education make them more practical towards life.

According to table -8, The F-ratio of gender and age (BxC) is 7.77 , which is significant at 0.01 level of significance. that means the gender and age interact each other on CC. Table No -12 shows that the mean score of the 45 yrs below female group is 38.14 which is very high and the mean score of 45yrs below male group is 44.67. According to results we can clearly say that the 45yrs below female group used more coping behavior compared to 45yrs below male group.

According to table -8, The F-ratio of gender and educational status (BxD) is 7.79, which is significant at 0.01 level of significance, that means gender and educational status interact each other on CC. Table No -13 shows that mean score of the non graduate male group is 35.25 which is lowest score and mean of graduate female group is 44.90. That means non graduate male is used very less coping behavior compare to graduate female groups.

According to table -8, The F-ratio of age and educational status (Cx D) is 4.88, which is significant at 0.01 level of significance, that means age and educational status interact each other on CC. Table No -14 shows that mean score of the non graduate below 45 age group is 37.12 which is lowest score and mean of post graduate 45 above age group is 44.73. That means non graduate below 45 age group is used very less coping behavior compare to post graduate above 45 age group.. According to results we can say that the higher education helps to people to cope with anxieties. May be educated person are more understand the situation and able to handle the crises. Also

they can try to take scientific solution regarding their problems. Other words, more education make them more practical towards life.

According to table -8, The F-ratio of group of person, gender and age (AxBxC) is 4.93, which is significant at 0.01 level of significance. that means the group of person, gender and age interact each other on CC. Table No -15 shows that the mean score of the 45 yrs below ill male group is 24.78 which is very low and the mean score of 45yrs below healthy female group is 57.69. According to results we can clearly say that the 45yrs below healthy female group used more coping behavior compared to 45yrs below ill male group.

According to table -8, The F-ratio of group of person, gender and educational status (AxBxD) is 19.26, which is significant at 0.01 level of significance. that means the group of person, gender and educational status interact each other on CC. Table No -16 shows that the mean score of the non graduate ill male group is 50.13 which is lowest score and the mean score of post graduate healthy female group is 119.6 which is highest score.. According to results we can clearly say that the post graduate healthy female group used more coping behavior compared to non graduate ill male group. Also we can see that the healthy female used more coping whether they are much educated or not.

According to table -8, The F-ratio of group of person, age and educational status (AxCxD) is 12.17, which is significant at 0.01 level of significance. that means the group of person, age and educational status interact each other on CC. Table No -18 shows that the mean score of the non graduate 45 yrs below ill group is 43.73 which is lowest score and the mean score of post graduate 45 yrs below healthy group is 118.2, which is highest score.. According to results we can clearly say that the post graduate 45 yrs below healthy group used more coping behavior compared to non graduate 45 yrs

below ill group. Also we can see that the compare to all scores the healthy group of person used more coping behavior with both the level of age.

According to table -8, The F-ratio of group of person, age and educational status (BxCxD) is 13.38 , which is significant at 0.01 level of significance. that means the group of person, age and educational status interact each other on CC. Table No -18 shows that the mean score of the non graduate 45 yrs below male group is 62.93 which is lowest score and the mean score of post graduate 45 yrs below female group is 90.33, which is highest score.. According to results we can clearly say that the post graduate 45 yrs below female group used more coping behavior compared to non graduate 45 yrs below male group. Also we can see that the post graduate male and female used more coping behavior.

According to table -8, The F-ratio of group of person, gender, age and educational status (AxBxCxD) is 13.65 , which is significant at 0.01 level of significance. that means the group of person, gender, age and educational status interact each other on CC. Table No -18 shows that the mean score of the non graduate 45 yrs below ill male group is 18.93, which is lowest score and the mean score of non- graduate 45 yrs below healthy female group is 60.73, which is highest score.. According to results we can clearly say that the non graduate 45 yrs below healthy female group used more coping behavior compared to non graduate 45 yrs below ill male group. Also we can see that the post graduate healthy 45yrs below and above male and female used more coping behavior than other groups. We can see that the healthy male and female with both age groups used more coping whether they are highly educated or not compare to ill groups.

## **11. RESEARCH FINDINGS :**

On the basis of the results and discussions following conclusions can be drawn.

### **1. Impact of the group of people, gender, age and educational status on Death Anxiety. (DA)**

- a. There is significant difference found between chronically ill and healthy persons on death Anxiety.
  - Chronically ill people experience higher amount Death Anxiety compare to healthy / normal people.
- b. There is no significant difference found between chronically ill and healthy male and female on death Anxiety.
- c. There is no significant difference found between chronically ill and healthy different age people on death Anxiety.
- d. There is no significant difference found between chronically ill and healthy people on death Anxiety with different educational status.
- e. The interaction effect between group of person, gender, age and educational status, out of eleven interactions, group of person and gender, group of person and educational status and third interaction gender, age and educational status had significant affect on death Anxiety.
  1. The female who suffering from illness experienced more death anxiety compare to healthy female. (AxB)
  2. Post graduate person who suffering from illness experienced more death anxiety than post graduate healthy person. (AxD)
  3. 45 yrs below non-graduate male and 45yrs above post graduate male experienced more DA compare to non-graduate 45yrs above male and graduate 45yrs above female. (BxCxD)

**2. Impact of the group of persons , gender , age and educational status on Coping checklist / behaviour. (CC).**

a. There is significant difference found between chronically ill and healthy persons on Coping checklist / behavior (CC).

1. Healthy person used more effective coping behaviour compare to ill person.

b. There is significant difference found between chronically ill and healthy male and female on coping checklist.

1. The Female used more coping behaviour compare to the male.

c. There is significant difference found between chronically ill and healthy persons on coping checklist with reference to age.

1. A person who below 45 yrs used more coping behaviour compare to more than 45yrs of age.

d. There is significant difference found between chronically ill and healthy persons on coping checklist with reference to educational status.

1. Post graduate person used more coping compare to non graduate and graduate person.

e. The interaction effect between group of person, gender, age and educational status, out of eleven interactions, only one group of person and gender is not significance, other ten interaction had significant affect on coping.

1. 45yrs below healthy person used more coping than 45yrs below ill patients.(AxC)

2. 45yrs below healthy person used more coping than 45yrs below ill patients.(AxC)

3. Post graduate healthy person used more coping and non-graduate ill person used less coping (AxD)
4. A female below 45yrs used more coping than 45yrs below male.(BxC)
5. A graduate female used more coping than non graduate male.(BxD)
6. Post graduate 45yrs below person used more coping and non-graduate 45yrs below person used less coping (CxD)
7. 45yrs below healthy female used more coping and 45yrs below ill male used less coping. (AxBxC)
8. Non-graduate healthy female used more coping and non-graduate ill male used less coping. (AxBxD)
9. 45 yrs below post-graduate healthy person used more coping and 45 yrs below non-graduate ill person used less coping. (AxCxD)
10. 45 yrs below graduate female used more coping and 45 yrs below non-graduate male used less coping. (BxCxD)
11. 45 yrs below non-graduate healthy female used more coping and 45 yrs below non-graduate ill male used less coping (AxBxCxD)

### **3. The Correlation between Death Anxiety and coping behaviour.**

1. The death Anxiety had found significant negative correlation with coping strategies between chronically ill and healthy persons .

## **12. Implications of the study.**

- 1) This study will help in medical field for distinguished the symptoms and treatment regarding illness. Also, it helps to take sound medical decision, choice about treatment and follow up.
- 2) This study will help in health psychology to communicate with health providers is an important skill which they have to learn.
- 3) It is useful in counseling psychology to reduce distress and helps to use effective coping strategies.
- 4) It will help in clinical and social psychology to develop their potentialities and to achieve an optimal level of personal happiness and social usefulness.
- 5) It will also develop home assistant program which provide family or society people with specific information about way to help their anxiety.
- 6) It will help in field of spirituality to enhance coping skills to prevent depression, suicide or self-distractive behaviour and cope with the death anxiety.

## **13. The limitations of the present study.**

It is rightly remarked that in research, the research not only describe his/her successes but also mentions his/her failures. The drawbacks, loops, holes, failures and limitations should be paid attention. No research endeavor is perfect in all aspects. Every Research has its some limitations. In the present study in spite of careful attention certain limitations were found. The limitations are as under.

1. The sample was selected only from Ahmedabad city.
2. Sample size of each group was very small (n=15) so that findings of study cannot be generalized on large population.
3. Sample was not divided by different illness. ( heart, diabetics, arthritic)
4. Type of family, religions, cast, residence etc was not controlled in present study.
5. Only total score was counted from the inventory.

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