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Comparison of Death Anxiety between Clinical and Non-Clinical Population

***Afreen Faiza and Dr. Anila Amber Malik**
Department of Psychology, University of Karachi, Karachi

The aim of the present study was to compare the level of death anxiety among individuals with psychological disorders and healthy individuals (N=150). Individuals with psychological disorders (n=75) were approached from different branches of Karachi Psychiatric Hospital, Karachi Pakistan and healthy individuals (n=75) were approached through purposive convenient sampling technique. The participants of both groups were matched on the basis of several demographic variables (Age, Education, Gender, Religious Inclination & Socio-Economic Status). Indigenous Death Anxiety Scale (Faiza & Malik, 2017) was used to assess death anxiety. An independent sample t-test supported the hypothesis for differences between two groups. An overall higher level of death anxiety was found in individuals with psychological disorders as compared to healthy individuals. Comparison between individuals of the clinical group, diagnosed with neurotic and psychotic disorders yield significant differences in the level of death anxiety. Furthermore, results showed that patients suffering from neurotic disorders experience higher levels of death anxiety. Significant differences were also found in individuals with psychological disorders on the basis of their level of religiosity. Findings suggest that patients with higher religious interest showed higher death anxiety as compared to patients with lower religious interests. Current study has important implications for mental health professionals.

Keywords: Individuals with psychological disorders, healthy individuals, Indigenous Death Anxiety Scale, mental health professionals

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*Correspondence concerning this article should be addressed to Afreen Faiza, Department of Psychology, University of Karachi, Karachi, Pakistan. Email:afreenfaiza2014@gmail.com / afreenfaiza@hotmail.com

Death and life are two retracting forces that chase us throughout the lifespan. Human beings are "*forever shadowed by the knowledge that we will grow, blossom, and inevitably, diminish and die*" (Yalom, 2008, p.1). Death is an inherent but also a distressing reality for most. People exhibit varying degrees of apprehensions when confronted with the topic of death. Kastenbaum (2003) stated that no individual is capable to completely eliminate death anxiety and each one of it experiences it at different levels. Belsky (1999) defined death anxiety as "*thoughts, fears and emotions about that final event of living that we experience under more normal conditions of life*" (p. 368). Everyone faces the agony of death anxiety to some extent (Belsky, 1999) however, there are individual differences in the perceived level (Carmel & Mutran, 1997).

Death anxiety plays a pivotal role in our lives. Researchers noted that death fears are linked with the development of healthy as well as unhealthy coping approaches (Menzies, 2012; Mikulincer, Florian, & Hirschberger, 2003). Higher levels of death anxiety hamper the normal functioning capacity of individuals in everyday life (Niemiec & Schulenberg, 2011).

Recently it was proposed that fears of death are present in a wide range of mental health diseases. Death anxiety is a core feature in the presentation of somatoform disorders (Iverach, Menzies & Menzies, 2014) and obsessive-compulsive disorders (Menzies, Menzies, & Iverach, 2015). A number of investigations showed relationships between death anxiety and psychological disorders (Abdel-Khalek, 2001, 2005; DePaola, Griffin, Young, & Neimeyer, 2003; Moreno, DeLa, Solana, Rico, & Fernandez, 2009). A study carried out by Eshbaugh and Henninger (2013) contended that death fears are inversely linked with the wellbeing of the individual. In order to treat psychological disorders, it is crucial to focus on death fears among the patients suffering from augmented levels of death anxiety (Iverach et al., 2014).

It is a common practice for mental health professionals to witness patients who battle with the idea of death (Yalom, 2008). In Western cultures, more attention has been paid towards incorporation of an existential segment as a vital component for enhancement of emotional wellbeing among patients (Josephson & Peteet, 2004). Researchers emphasized that mental health

professionals ought to participate in dialogues about their death fears to help patients to acknowledge their own death (Doka, 2009; Kübler-Ross, 1969).

On the other side, death is a forbidden topic in therapeutic settings. It is noted that every society has a different way to handle the issues accompanied with death and dying (Rycroft, 2005). Neimeyer, Moser, and Wittkowski (2003) believed that there are different perspectives towards death in different social frameworks. In order to know how they shift from western social views, it is crucial to understand the diversity from the point of view of other's social perspectives. Some societies are highly death denying in nature (Zimmermann & Rodin, 2004; Howarth, 2007). For instance, in western societies death is denied to a greater extent and people witness few mortality cues (Martz & Livneh, 2003).

Eastern cultures perceive the ideas of death differently than western cultures. In a study carried by Schumaker, Barraclough and Vagg (1988) it was revealed that participants who hold western cultural beliefs show higher level of death anxiety as compared to individuals with eastern cultural values. Religious background is a notable facet which possesses relevance for the handling of fears related to death. Research conducted by Parsuram and Sharma (1992) concluded that Christians showed a higher level of death anxiety as compared to Muslims and Hindus.

Pakistani society is collectivistic in nature and dominantly represented by Muslim Population. In Islam, the concept of death is interwoven. Islamic teachings are heavily focused upon life after death and Muslims adherently belief that each will be rewarded or punished in accordance with his/her good or bad deeds. In Quran, it is eluded *"To Allah we belong and to Him we shall return"* (Surah Al-Baqarah 2:156).

Pakistan is a developing country. The mental health facilities in this region are still in their developmental stages. According to an earlier study, there are a limited number of psychiatrists, psychologists and social workers for treatment of individuals having mental illness issues in Pakistan (Khalily, 2010) However, mental health issues are reported by both urban and rural residents of the country. The population represents the diverse

range of mental health issues which encompasses higher prevalence of depression and anxiety disorders (David & Malik, 2000) followed by bipolar affective disorder, schizophrenia, psychosomatic disorders, obsessive-compulsive disorder (Gadit, 2007) and post-traumatic stress disorders (Khalily, Fooley, Hussain & Bano, 2011).

It is a notable fact that, during the past few decades psychiatric issues have been increasing drastically in Pakistan (David & Malik, 2000; Gadit, 2005). This can be attributed to the unpredictable political and social scenario of the country which is assumed to influence negatively upon the psychological health of individuals (Khalily et al., 2011). It can be speculated that such a social scenario provides fertile ground for differences in the level of death anxiety among Pakistani Muslim population.

In addition to that, Socio-demographic features possess relevance for individual levels of death apprehension. Literature suggested that age is inversely related with fear of death (Kastenbaum, 2003); women tend to possess a higher level of death anxiety as compared to men (Schumaker, Barraclough, & Vagg, 1988); religiosity has twisted effect for apprehensions associated with death and dying (Neimeyer, Wittkowski, & Moser, 2004; Harding, Flannelly, Weaver, & Costa, 2005); educational level is inversely linked with fear of death among older individuals (Cicirelli, 1997; Mutran, Danis, Bratton, Sudha, & Hanson, 1997); higher socioeconomic status is associated with lower levels of death anxiety (Agras, Sylvester & Oliveau, 1969).

In Pakistan, the socio-political situations, mental health conditions, cultural and religious background are sharply different from western culture. Review of previous studies reveals that death fears form the backdrop of the majority of mental disorders. This provides an impetus to carry out the present study considering the Muslim population. The present study is important as there are a limited number of studies which have investigated differences in death anxiety among normal and mentally ill population considering culturally specific assessment tool. The present investigation aspired to seek the differences in the level of death anxiety among healthy adults and individual with psychological problems in Pakistani society. It also aims to identify the differences in death anxiety among individuals with psychological

disorders on the basis of nature of psychological illness and comparison of differences in death anxiety in individuals with psychological disorders on the basis of the level of religiosity. The present investigation is valuable from the point of view of psycho-diagnosis, assessments, precautions and interventions in clinical settings.

In the light of above-mentioned discussion, following hypotheses were formulated:

1. There is a significant difference in the level of death anxiety between individuals with psychological disorders and healthy individuals.

2. There is a significant difference in death anxiety between psychotic and neurotic groups of individuals with psychological disorders.

3. There is a significant difference in death anxiety in individuals with psychological disorders on the basis of the level of religiosity.

Method

Research Design

For the current research, quantitative comparative survey research design was used. The two groups that are individuals with psychological disorders and healthy individuals were approximately matched on the basis of several demographic variables (Age, Education, Gender, Religious Inclination & Socio-Economic status).

Participants

The total sample comprised of N=150 Pakistani Muslims belonging to Karachi. The participants were approached through convenient purposive sampling technique and were comprised of two independent groups, healthy individuals (n=75; Age M=35.5) and individuals with psychological disorders (n=75; Age M = 27.7) with an age range of 16-54 years. The individuals with psychological disorders were approached from different branches

of Karachi Psychiatric Hospital, Pakistan. The inclusion criteria for the individuals with psychological disorders was based on the diagnostic criteria of DSM-V and ICD -10 by their respective clinicians. It was also made sure that individuals with psychological disorders were not experiencing active symptoms during the course of the study. Moreover, those individuals with psychological disorders who had any other physical disease or had comorbidity for other mental disorders were excluded from the study. The healthy individuals were asked whether they had been treated or received the diagnosis of any psychological or physical disorders through a self-report demographic sheet. The participants in both groups were approximately matched for several demographic variables. The details of the demographic variables are given below in the table 1.

Table 1

Frequency and Percentage of Demographic Variables of Individual with Psychological Disorder and Healthy Individuals (N=150)

Demographic Variables	Individuals with Psychological Disorder		Healthy Individuals	
	f	%	*f*	%
Age Range (years)				
16-25	15	20.0	25	33.3
26-35	30	40.0	20	26.6
36-45	13	17.3	18	24.0
46-54	17	22.7	12	16.0
Education				
Illiterate	27	36.0	01	1.3
Matriculation	28	37.3	07	9.3
Intermediate	09	12.0	08	10.6
Graduate	05	06.7	49	65.3
Masters & above	06	08.0	10	13.3
Gender				
Male	25	33.3	09	12
Female	50	66.6	66	88

Demographic Variables	Individuals with Psychological Disorder		Healthy Individuals	
	f	%	*f*	%
Religious Inclination				
Low	48	64.0	53	70.7
High	27	36.0	22	29.3
Socioeconomic Status				
Lower Class	32	42.7	02	02.7
Middle Class	32	42.7	14	18.7
Upper Class	11	14.7	59	78.7
Death of Loved One (Past 6 Months)				
No	37	49.3	50	66.7
Yes	38	50.7	25	33.3
Psychological Disorders				
Schizophrenia	32	42.7		
Bipolar Affective disorder	09	12.0		
Depressive Disorder	32	42.7		
Obsessive compulsive disorder	02	02.7		

Table 1 shows frequency and percentages of demographic variables of participants.

Measures

Following measurement tools were included in this study:

Demographic Information Sheet. It included information related to age, gender, education, socioeconomic status and religious interest of the participants. The presence of physical and psychological illnesses was also mentioned in the form along with basic information of diagnosed disorders.

Indigenous Death Anxiety Scale (IDAS). It comprises of 63 statements and is a self-report measure designed for Pakistani Muslim population. Each statement is responded on a four-point Likert scale ranging from *always to never*. The scale comprised of five subscales: a) Punishment after Death, b) Loss of Personal and

Social Identity, c) Finality of Death, d) Lack of Control and e) Helplessness and General Death of Self. The correlation coefficients of items ranged between 0.30-0.71 (p<.01); Cronbach alpha for 63 items was =.97 and a 15 days test –test reliability was found to be r=.81 (p<.01) representing higher internal consistency and temporal reliability. The convergent validity of IDAS with Templer's Death Anxiety Scale was r=.60 (p < .01) and discriminant validity of IDAS with Revised Life Orientation Test (r= - .61, p < .01) showed high validity indices (Faiza & Malik, 2017).

Procedure

A permission letter was attained prior to data collection from the management of Karachi Psychiatric Hospital, Pakistan. Individuals with Psychological Disorders were approached from indoor and outdoor patient services from different branches of Karachi Psychiatric Hospital while healthy individuals were approached through personal referrals. All participants were communicated about the purpose of the study and their right of confidentiality was assured prior to the participation in the study. They were told that they have the full right to leave this study at any time without any penalty. Only those participants who showed willingness to participate were included in the study and handed over study forms which included written Informed Consent, Demographic Information Sheet and IDAS. All participants were warmly thanked for their participation in the present study. The data was entered and analyzed on SPSS.

Results

Data analysis was carried out using the Statistical Package for Social Sciences (SPSS) version 22. Independent sample t-tests were utilized to analyze the hypotheses of the study. The results of the analysis are mentioned in the following tables.

Table 2

Independent Sample t-test for the Comparison of Death Anxiety between Individuals with Psychological Disorders (IPD) and Healthy Individuals (N=150)

	Individuals with Psychological Disorders(*n=75)*		Healthy Individuals (*n=75)*			
Variables	*M*	*SD*	*M*	*SD*	*t*	*p*
IDAS	144.76	41.62	130.45	41.92	2.09	.03
PAD	045.60	12.67	040.63	14.05	2.27	.02
LPASI	033.05	13.10	032.99	12.27	0.03	.97
FOD	031.24	09.46	025.81	9.05	3.58	.00
LOCAH	017.57	07.02	015.28	6.38	2.09	.03
GDS	017.29	05.58	015.75	5.61	1.69	.09

Note. IDAS=Indigenous Death Anxiety Scale; PAD = Punishment after Death; LPASI= Loss of Personal and Social Identity; FOD= Finality of Death; LOCAH= Lack of Control and Helplessness; GDS= General Death of Self

Table 2 shows significant differences in the level of death anxiety among individuals with psychological disorders and healthy individuals. The results suggest a higher level of death anxiety among individuals with psychological disorders as compared to healthy individuals. All the results are significant except subscale of death anxiety related to Loss of Personal and Social Identity (LPASI) and General Death of Self (GDS).

Table 3

Independent Sample t-test for the Comparison of Death Anxiety between Individuals with Neurotic and Psychotic Disorders in Individuals with psychological disorders (N=75)

Measures	Psychotic Disorders (n=41)		Neurotic Disorders (n=34)			
	M	*SD*	*M*	*SD*	*t*	*p*
IDAS	122.93	43.71	148.32	42.625	2.53	.01
PAD	037.39	14.62	47.68	13.78	3.11	.00
LPASI	032.10	13.38	36.56	12.20	1.49	.13
FOD	024.07	09.32	29.26	09.01	2.44	.01
LOCAH	014.78	06.95	16.62	06.55	71.7	.24
GDS	014.59	05.44	18.21	05.88	73.0	.00

Note. IDAS= Indigenous Death Anxiety Scale; PAD = Punishment after Death; LPASI= Loss of Personal and Social Identity; FOD= Finality of Death; LOCAH= Lack of Control and Helplessness; GDS= General Death of Self

Table 3 shows significant differences in the level of death anxiety among psychotic and neurotic individuals with psychological disorders. Results show a higher level of death anxiety in neurotic patients as compared to psychotic patients. All the results are significant except subscales of death anxiety related to Loss of Personal and Social Identity (LPASI) and Lack of Control and Helplessness (LOCAH).

Table 4

Independent Sample t-test for the Comparison of Death Anxiety in Individuals with Psychological Disorders Based on their Level of Religiosity (N=75)

Measure	Low *(n=48)*		High *(n=27)*			
	M	*SD*	*M*	*SD*	*t*	*P*
IDAS	126.42	45.17	148.70	41.11	2.11	.03

Note. IDAS= Indigenous Death Anxiety Scale

Table 4 shows significant differences in the level of religiosity among individuals with psychological disorders. Results show greater death anxiety in Individuals with Psychological Disorders having higher level of religiosity as compare to individuals with lower level of religiosity.

Discussion

The results of the current study supported the main hypothesis of the present study that there is a significant difference in the level of death anxiety between individuals with psychological disorders and healthy individuals. Results showed individuals with psychological disorders possess a higher degree of death anxiety as compared to healthy individuals. The findings are consistent with earlier researches which indicated higher levels of death anxiety among individuals with psychological disorders than normal participants (Gilliland & Templer,1985); patients with mental illness tend to be more apprehensive towards death than healthy individuals and there is a positive correlation between level of death anxiety and emotional troubles (Feifel & Hermann,1973).

The findings of the study inferred an important role of death anxiety for psychological disorders in the present clinical sample. Researchers believed that fear of death is a core feature which is responsible for formation, continuation and course of numerous mental disorders (Arndt, Routledge, & Goldenberg, 2005; Strachan, Schimel, Arndt, Williams, Solomon, &, Pyszczynski, 2007). This is too evident by several Western investigations which revealed the presence of death anxiety in several mental health problems which included depressive disorders, manic-depressive disorder, schizophrenia, obsessive-compulsive disorders, post-traumatic stress disorders and eating disorders (Cheung, Dennis, Easthope, Werrett, & Farmer, 2005; Giles, 1995; Khanna, Khanna, & Sharma, 1988; Strachan et al., 2007; Thorson & Powell, 2000).

Higher levels of death anxiety among individuals with psychological disorders in the current study can be explained by Terror Management Theory (TMT) which holds the premise that, human beings possess knowledge about their ultimate demise and an instinctual tendency towards self-preservation. This creates death anxiety (Rosenblatt, Greenberg, Solomon, Pyszczynski & Lyon, 1989). Also, human beings adopt coping strategies to overcome the fear of death. However, for some individuals, stressful conditions threaten their health conditions or the health of significant others because of unhealthy coping strategies

(Kastenbaum, 2000; Yalom, 1980; 2008). The heightened level of death awareness corrodes defense mechanisms that shield individuals to squarely address death anxiety (Greenberg, Koole, & Pyszczynski, 2004). Findings for greater levels of death anxiety in psychiatric patients in contrast with healthy individuals possibly indicate a higher death consciousness along with fragile defense mechanisms.

Moreover, according to the dual process model (Pyszczynski, Greenberg, & Solomon, 1999), conscious death thoughts activate proximal defense mechanisms which includes denial and suppression of thoughts accompanied with death while unconscious death thoughts elicit distal defense systems. Whether death anxiety is conscious or unconscious, psychological disorders are outcomes of maladaptive coping strategies of individuals (Furer & Walker, 2008; Menzies, 2012; Strachan et al., 2007); numerous researchers agreed that ineffective coping strategies with awareness of death results into psychological disorders (Maxfield, John & Pyszczynski, 2014; Strachan, Pyszczynski, Greenberg, & Solomon, 2001; Strachan et al., 2007; Yalom, 1980). In conclusion, it can be inferred that psychiatric patients utilize inadequate coping strategies to manage death terror as compared to healthy individuals.

An increased level of death anxiety among individuals with psychological disorders as compared to healthy individuals in the present study is possibly attributed to several psychological factors. Positive connections have been detected for death anxiety, cognitive disturbances, sadness, guilt feelings, low self-esteem, pessimism learned helplessness among individuals with psychological disorders (Gilliland & Templer, 1985-1986). Other factors accounted for greater death apprehensions in psychiatric patients including but not limited to life-threatening encounters, the death of loved ones, childhood trauma. A study concluded that experiencing life-threatening incidents augments the level of death anxiety which is responsible for the development of symptoms of post-traumatic stress disorder (PTSD; Cheung et al., 2005). Similarly, life-threatening encounters associated with one's self or loved ones are a core feature in the formation of phobic disorders and death terrors displaced in the form of obsession symptoms (Meyer, 1975). Unresolved conflicts in childhood serve as a foundation of death anxiety (Langs, 2004; Meyers, Golden, &,

Peterson, 2009). An in-depth exploration of psychological factors is necessary, to obtain a holistic understanding of the higher level of death fears among individuals with psychological disorders in future studies.

Present study showed greater death anxiety in clinical population for subscales related to punishment after death, the finality of death and lack of control and helplessness as compared to healthy individuals. Possible explanations for higher death apprehensions related with punishment after death in Muslim patients infers the notion that teachings of Islam focused upon punishment and rewards after death on the basis of good/ bad deeds. In the Quran, it is eluded "*Every soul shall taste death and you will be paid in full only on the Day of Resurrection. Whoever is kept away from the Fire and admitted to the Garden will have triumphed. The present world is only an illusory pleasure*" (Quran, 3:185). Moreover, it is observed that people with mental issues feel guilt and experience a negative perception of their illness. They perceive that their illness is a result of punishment from God. Mental illness taken as a punishment from God leads to a higher level of psychological distress (Phillips & Stein, 2007). This may contribute towards a higher level of apprehensive feeling about the punishment after death among individuals with psychological disorders.

A higher level of death anxiety for subscales of finality of death and lack of control and helplessness in individuals with psychological disorders infers that in our Pakistani society there are different negative stereotypes attached with mental problems Corrigan and Penn (1999) contented this fact as "*stigma's impact on a person's life may be as harmful as the direct effects of the disease*" (p. 765). Research carried out by Jonson, Wijk, Skarsater, and Danielson, (2008) showed that individuals with psychological disorders showed fear of inability to achieve goals and manage daily lives. They possess concerns related to unemployment, dependency on others and maladjustments in interpersonal and social relationships. Some patients deal with uncertainties via avoidance of making future plans and whereas others endorsed that preoccupation with death thoughts as a way out to deal with uncertainty. These factors along with negative societal perceptions tend to foster negative feelings among individuals with

psychological disorders and possibly contribute towards a greater level of death anxiety for the facet related to finality of death and lack of control and helplessness among individuals with psychological disorders than healthy individuals. It was a notable finding that psychiatric patients and normal individuals possess uniform death apprehensions for domains related to loss of personal and social identity and general death of self which demands further probing in clinical and non-clinical settings in our Pakistani cultural settings.

Clinical population recruited for present investigation was on psychotropic medicines. The study carried out by McCann and Clark (2004) explored that schizophrenic patients showed fears related to side effects of medications which created a negative impact on body image. This leads to decreased self-confidence, disturbed interpersonal relationships and an uncertain future about functional capabilities. This possibly leads to an increased level of death anxiety as compared to healthy individuals as research indicated that apprehensions about the body conditions give rise to death anxiety (Gray, Elkins, & Frank, 2012).

The findings of the present study supported the assumption that there will be a significant difference in death anxiety between individuals suffering from psychotic and neurotic illnesses. Results showed a greater level of death anxiety among neurotics as compared to psychotics. This is in congruence with prior investigations which eluded that patients with neurotic disorders tend to show greater death-related thoughts as compared to patients with psychotic illnesses (Feifel & Hermann, 1973).

The plausible reasons for an elevated level of death anxiety among patients with neurotic disorders explained by an earlier study suggests that neurotic patients possess repeated occurrence of death related thoughts whereas in psychotic individuals death ideas are manifested in form of hallucinations (Boisen, Jenkins, & Lorr, 1954). Another possible factor for the lowered level of death anxiety among psychotic individuals can be that the present study utilized a self-report measure of death anxiety which accesses conscious levels of death anxiety. Findings showed that when exposed with death-related words schizophrenic patients responded with denial mechanism (Graftieaux, & Kiely, 1979).

A greater level of death anxiety among neurotic patients can be possibly explained by the notion that death anxiety includes common facets with other anxiety disorders as they both signify negative emotions (Abdel-Khalek, 2005).

The results of the study also supported the assumption that there will be a significant difference in death anxiety of individuals with psychological disorders on the basis of the level of religiosity. Interestingly, outcomes showed that individuals with psychological disorders with higher religious interest tend to possess greater death anxiety as compared to patients with lower religious interest. This is in contrast with studies which declared an inverse linkage between death anxiety and religious beliefs (Feifel & Branscomb, 1973; Feifel & Nagy, 1981; Neimeyer & Fortner, 1995; Powell & Thorson, 1991).Presence of higher death anxiety among individuals with greater religious interests is explained by the results of a study conducted by Koeing, (2009) which suggests that psychotic patients hold religious delusions and their engagement in religious practices has the least impact on the reduction of their anxiety and feelings of isolation .

The sample for the present study comprised of a Muslim Population and the dominant themes in the Islamic teachings include details of the punishments in the hereafter and torments in the grave thus possibly fostering greater death fears among Muslim individuals who are already suffering from negative symptoms of psychological disorders. Feifel (1959) identified that "*the religious person, when compared to the nonreligious individual, is personally more afraid of death' as death fears include cessation of life along with fears about life after death* (p. 121). Outcomes of the study show an important role of understanding religiosity from the perspectives of patients which is crucial for the intervention of death anxiety among Muslim individuals with psychological disorders.

Implications

The findings of the present study hold significance for mental health professionals. The results suggest that clinicians need to address death fears among individuals with psychological disorders in counseling and other psychotherapeutic techniques as

this can lead to an overall improved well-being of individuals with psychological disorders.

Limitations and Future Suggestions

The findings of the present study should be generalized with caution because the sample was solely from one hospital; all the participants were on psychotropic medicines and they were all Muslims. However, the findings will be fruitful to conduct related investigations in the future because it provides an idea about the differences in the level of death anxiety among patients diagnosed with the psychological disorders and healthy individuals.

It is recommended to replicate future studies with bigger sample size including patients from inpatient and outpatient services from different hospitals, the inclusion of participants from different religious backgrounds can also enhance generalizability of present findings. It is also recommended to strictly match the demographic variables of the comparison groups.

References

Abdel-Khalek, A.M. (2001). Death, anxiety and depression in Kuwaiti undergraduates. *Omega: Journal of Death and Dying, 42*(4), 309-320. doi: 10.2190/NJJN-FHHU-3WWQ-928V

Abdel-Khalek, A. M. (2005). Death anxiety in clinical and non-clinical groups. *Death Studies.* 251–259. doi: 10. 108 0/07 481180590916371

Agras, S., Sylvester, D., & Oliveau, D. (1969). The epidemiology of common fears and phobia. *Comprehensive Psychiatry, 10* (2), 151-156. doi: 10.1016/0010-440X(69)90022-4

Arndt, J., Routledge, C., Cox, C. R., & Goldenberg, J. L. (2005). The worm at the core: A terror management perspective on the roots of psychological dysfunction. *Applied & Preventive Psychology, 11*, 191–213. doi: 10.1016 /j .appsy.2005.07.002.

Belsky, J. K. (Ed.). (1999). *The psychology of aging: Theory, research, and interventions.* Pacific Grove, CA: Brooks/ Cole.

Boisen. A, Jenkins, L. G., & Lorr, M. (1954). Schizophrenic ideation as a striving toward the solution of conflict. *Journal of Clinical Psychology, 10*, 389-391.

Carmel, S., & Mutran, E. (1997). Wishes regarding the use of life-sustaining treatments among elderly persons in Israel: An explanatory model. *Social Science & Medicine, 45*, 1715-1727. doi: 10.1016/S0277-9536(97)00104-4

Cheung,M. C., Dennis, I., Easthope, Y., Werrett, J., & Farmer, S. (2005). A multiple-indicator multiple-cause model for posttraumatic stress reactions: Personality, coping, and maladjustment. *Psychosomatic Medicine, 67*, 251–259.

Cicirelli, V. G. (1997). Relationship of psychosocial and background variables to older adults' end-of-life decisions. *Psychology & Aging, 12*, 72–83. doi:10.1037//0882-7974.12.1.72

Corrigan, P. W., & Penn, D. L. (Eds.). (1999). *Social cognition and schizophrenia.* Washington, DC: American Psychological Association Press.

David, D.B., & Malik, M.H. (2000). Stress and psychiatric disorder in Urban Rawalpindi, community survey. *The British Journal of Psychiatry, 177*, 557–62. doi: 10. 11 92 / bjp. 177. 6.557

DePaola, S.J., Griffin, M., Young, J.R., & Neimeyer, R.A. (2003). Death anxiety and attitudes toward the elderly among older adults: The role of gender and ethnicity. *Death Studies, 27,* 335-354. doi: 10.1080/07481180302904

Doka, K. J. (2009). *Counseling individuals with life-threatening illness.* New York, NY: Springer Publishing Co.

Eshbaugh, E., & Henninger, W. (2013). Potential mediators of the relationships between gender and death anxiety. *Individual Differences Research, 11*, 22–30.

Faiza, A., & Malik, A.A. (2017). Reliability and validity of Indigenous Death Anxiety Scale. *International Journal of Innovation and Scientific Research, 32*(2), 246–250.

Feifel, H. (1959). *The meaning of death.* New York: McGraw-Hill.

Feifel, H., & Branscomb, A.B. (1973). Who's afraid of death? *Journal of Abnormal Psychology, 82*, 282-288.

Feifel, H., & Hermann, L. J. (1973). Fear of death in the mentally ill. *Psychological Reports, 33*, 931-938.

Feifel, H., & Nagy, V.T. (1981). Another look at fear of death. *Journal of Consulting & Clinical Psychology, 49*, 278-286. doi: org/10.1037/0022-006X.49.2.278

Furer, P., & Walker, J. R. (2008). Death anxiety: A cognitive–behavioral approach. *Journal of Cognitive Psychotherapy, 22*, 167–182. doi: 10.1891/0889-8391.22.2.167

Gadit , A.A.M. (2005). Disaster, mental health and rescuing medical professionals. *Journal Ayub Medical College Abbottabad, 17*(4), 1–2.

Gadit, A.A.M. (2007). Mental Health Model: Comparison between a developed and a developing country. *Journal of Medicine 2*(1). Retrieved from http:// www. Scientific journals. org/ journals 2007/ articles/1047.htm.

Giles, A. H. (1995). Death anxiety toward self and mother in clients with anorexia nervosa. Dissertation Abstracts International, Section B: *The Sciences and Engineering, 56*, 0522. doi: 10.1017/bec.2016.11

Gilliland, J.C., & Templer, D.I. (1985-1986). Relationship of Death Anxiety Scale factors to subjective states. *Omega: Journal of Death & Dying, 16*, 155-167. doi: 10. 21 90 /Y9 Y8-RG 8N -8E UH -VJV4

Graftieaux, P. C., & Kiely, M. C. (1979). Le déni de la mort dans la schizophrénie [Abstract]. *Canadian Journal of Behavioral Science, 11*(2), 130-139.

Gray, R., Elkins, A. & Frank F. (2012). Relationship of physical anxiety to death anxiety and age. *The Journal of Genetic Psychology, 137* (1), 147-148. doi: 10. 1080 /002 213 25. 1980.10532811

Greenberg, J., Koole, S. L., & Pyszczynski, T. (2004). *Handbook of experimental existential psychology*. New York: Guilford.

Harding, S. R., Flannelly, K. J., Weaver, A. J., & Costa, K. G. (2005).The influence of religion on death anxiety and death acceptance. *Mental Health, Religion & Culture, 8*, 253–261. doi: 10.1080/13674670412331304311

Howarth, G. (2007). *Death and dying: A sociological introduction.* Cambridge: Polity.

Iverach, L., Menzies, R. G., & Menzies, R. E. (2014). Death anxiety and its role in psychopathology: Reviewing the status of a transdiagnostic construct. *Clinical Psychology Review, 34,* 580–593. doi: 10.1016/j.cpr.2014.09.002

Jonsson, P. D., Wijk, H., Skarsater, I., & Danielson, E. (2008). Persons living with bipolar disorder—their view of the illness and the future. *Issues in Mental Health Nursing, 29,* 1217-1236. doi: 10.1080/01612840802370764.

Josephson , A.M., & Peteet, J.R. (2004). *Handbook of spirituality and worldview in clinical practice.* Arlington (VA): American Psychiatric Publishing.

Kastenbaum, R. (2003). *Anxiety and fear.* In R. Kastenbaum (Ed.), Macmillan encyclopedia of death and dying (Vol. 2, pp. 29-32). New York: Macmillan Reference USA.

Kastenbaum, R. (Eds.) (2000). *The psychology of death.* Springer: New York.

Khalily M.T. (2010). Developing an integrated approach to the mental health issues in Pakistan. *Journal of Interprofessional Care, 24* (2), 168–72.

Khalily, T.M., Fooley, S., Hussain, I., & Bano, M. (2011). Violence, psychological trauma and possible acute post-traumatic interventions in Pakistani society. *Australasian Journal of Disaster & Trauma Studies, 1,* 1–9.

Khanna, N., Khanna, R., & Sharma, R. G. (1988). A study on death anxiety. *Journal of Personality & Clinical Studies, 4,* 47–51.

Koenig, H. G. (2009). Research on religion, spirituality, and mental health: A review. *Canadian Journal of Psychiatry.* Geriatric Research, Education and Clinical Center Durham V.A. Medical Center, Durham, North Carolina. doi: 10.1177/070674370905400502

Kübler-Ross, E. (1969). *On death and dying.* New York: Macmillan.

Langs, R. (2004). Death anxiety and the emotion-processing mind. *Psychoanalytic Psychology, 21*(1), 31-53. doi: 10. 1037/0736-9735.21.1.31

Martz, E., & Livneh, H. (2003). Death anxiety as a predictor of future time orientation among individuals with spinal cord injuries. *Disability & Rehabilitation, 25,* 1024–1032. doi: 10.1080/0963828031000159646 9

Maxfield, M., John, S., & Pyszczynski, T. (2014). A terror management perspective on the role of death-related anxiety in psychological dysfunction. *The Humanistic Psychologist, 42*, 35–53.

McCann, T., & Clark, E. (2004). Embodiment of severe and enduring mental illness: Finding meaning in schizophrenia. *Issues in Mental Health Nursing, 25*, 783-798. doi: 10. 10 80 /01612840490506365

Menzies, R. G. (2012). *The dread of death and its role in psychopathology.* Keynote Address, 35th National Conference of the Australian Association for Cognitive and Behaviour Therapy, Queensland, Australia.

Menzies, R. G., Menzies, R. E., & Iverach, L. (2015). The role of death fears in obsessive compulsive disorder. *Australian Clinical Psychologist, 1,* 6–11.

Meyer, J. E. (1975). The theme of death and the origin and course of obsessional neuroses. *Psychotherapies & Medizinische Psychologie, 25*, 124–128.

Meyers, K., Golden, R. N., & Peterson, F. L. (2009). *The truth about death and dying*. New York: Facts on File.

Mikulincer, M., Florian, V., & Hirschberger, G. (2003). The existential function of close relationships: Introducing death into the science of love. *Personality & Social Psychology Review, 7,* 20–40. doi: 10. 1207/ S1532 7957 PSPR 0701_2

Moreno, R.P., DeLa, F., Solana, E. I., Rico, M. A., & Fernandez, L. M. (2009). Death anxiety in institutionalized and non-institutionalized elderly people in Spain. *Omega: Journal of Death and Dying, 58*(1), 61-76. doi:10.2190/OM.58.1.d

Mutran, E. J., Danis, M., Bratton, K. A., Sudha, S., & Hanson, L. (1997). Attitudes of the critically ill toward prolonging life: The role of social support. *The Gerontologist, 37*, 192-99. doi: 10.1093/geront/37.2.192

Neimeyer, R. A., Moser, R. P., & Wittkowski, J. (2003). Assessing attitudes toward dying and death: Psychometric considerations. *Omega: Journal of Death & Dying*, 47, 45–76. doi: 10.21 90/EP4R-TULM-W52G-L3EX

Neimeyer, R. A., Wittkowski, J., & Moser, R. P. (2004). Psychological research on death attitudes: An overview and evaluation. *Death Studies*, 28, 309–340.doi: 10. 10 80 /07 48 11 80490432324

Neimeyer, R.A., & Fortner, B.V. (1995). *Death anxiety in the elderly.* In G. Maddox (Ed.), Encyclopedia of aging (2nd ed.) (pp. 252-253). New York: Springer.

Niemiec, R. M., & Schulenberg, S. E. (2011). Understanding death attitudes: The integration of movies, positive psychology, and meaning management. *Death Studies, 35*, 387–407. doi:10.1080/07481187.2010.544517

Parsuram, A., & Sharma, M. (1992).Functional relevance in belief in life-after-death. *Journal of Personality & Clinical Studies, 8* (1-2), 97 - 100.

Phillips, R.E., & Stein, C.H. (2007). God's will, God's punishment, or God's limitations? Religious coping strategies reported by young adults living with serious mental illness. *Journal of Clinical Psychology, 63*(6), 529–540. doi: 10. 10 02 /jc lp. 20364

Pollak, J.M. (1979). Correlates of death anxiety: A review of empirical studies. *Omega: Journal of Death & Dying, 10*, 97- 121. doi: 10.2190/4KG5-HBH0-NNME-DM58

Powell, F.C., & Thorson, J.A. (1991). Constructions of death among those high in intrinsic religious motivation: A factor-analytic study. *Death Studies, 15*, 131-137. doi: 10. 10 80/ 0748118910 8252418

Pyszczynski, T., Greenberg, J., & Solomon, S. (1999). A dual process model of defense against conscious and unconscious death- related thoughts: An extension of terror management theory. *Psychological Review, 106*, 835–845.

Rosenblatt, A., Greenberg, J., Solomon, S., Pyszczynski, T., & Lyon, D. (1989). Evidence for terror management theory: The effects of mortality salience on reactions to those who violate or uphold cultural values. *Journal of Personality & Social Psychology, 57,* 681–690. doi: 10.1037/0022-3514.57.4.681

Rycroft, P. (2005). Touching the heart and soul of therapy: Surviving client suicide. *Women Therapy, 28*(1), 83-94. doi:10.1300/J015v28n01_07

Schumaker, J. F., Barraclough, R. A., & Vagg, L. M. (1988). Death anxiety in Malaysian and Australian university students. *The Journal of Social Psychology, 128,* 41-47. doi: 10. 10 80 /00 22 4545.1988.9711682

Strachan, E., Pyszczynski, T., Greenberg, J., & Solomon, S. (2001). *Coping with the inevitability of death: Terror management and mismanagement.* In C. R. Snyer (Ed.), Coping with stress: Effective people and processes (pp. 114–136). Oxford, UK: Oxford University Press

Strachan, E., Schimel, J., Arndt, J., Williams, T., Solomon, S., &, Pyszczynski, T., et al. (2007). Terror mismanagement: Evidence that mortality salience exacerbates phobic and compulsive behaviors. *Personality & Social Psychology Bulletin,* 33, 1137–1151.doi: 10.1177/0146167207303018

Thorson, J. A., & Powell, F. C. (2000). *Death anxiety in younger and older adults.* In A. Tomer (Ed.). Death attitudes and the older adult: Theories, concepts, and applications (pp. 123-136). New York, US: Brunner-Routledge.

Yalom, I. D. (1980). *Existential psychotherapy.* New York: Basic Books.

Yalom, I. D. (2008). *Staring at the sun: Overcoming the terror of death.* San Francisco: Jossey Bass.

Zimmermann, C. & Rodin, G. (2004). The denial of death thesis: sociological critique and implications for palliative care. *Palliative Medicine, 18,* 121-128. doi: 10. 11 91/ 026 9216304pm858oa