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When we Talk about Neutral Acceptance... and When We Talk About the Fear of Death of Others...

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ABSTRACT

Is the way we measure fear of death correct?

When we talk about "Neutral Acceptance", what we really want to say is denial?

These two questions will be addressed in an original bibliographic review in which the possibility is argued that the study of attitudes towards death should be reoriented.

The fear of death is inherent to the human condition. It is also important for survival.

Introduction

In the past, it was socially acceptable to talk about death. However, things in modern society are different since death is hidden, as well as the dying person and the mourner [1].

Talking about death is of no interest... since it is not polite. Since it is scary. It is unpleasant. This is the way in which the death taboo is present in our daily life. In addition, this fear can also be found in the professional field as evidenced by the fear to talk about death with children [2-4], or by the conspiracy of silence [5-6].
There are many examples of the death taboo.

After the 2004 terrorist attack in Madrid, firemen and emergency services were recognized as heroes. However, there was no mention of the 1,000 people who worked for funeral services and made it possible to identify many of the bodies [7].
If we were to make a list... it would be endless.

The question we should be asking ourselves is to what extent is the way we measure fear of death correct? We may know a lot about attitudes toward death nowadays. In fact, many papers have been published on this issue, which essential since it is currently being investigated the link between fear and different constructs that might help us understand attitudes toward death and its variables. Having said that, are we sure our conclusions are more accurate?

We know this is an emerging field, which is too complex to be sure about anything and, as usual when we address scientific knowledge, we need to take some basic steps first. What we have to do now is consider whether there are any ideas that must be called into question with the sole purpose of improving our understanding. These ideas, reviews, discussions or different views of the same subject are merely that, different interpretations which, not being exclusive, help us see the current knowledge in perspective, from another angle that is so uncertain or clear and so full of doubt as the previous one. Even so, this step is necessary.

Under this premise, for instance, it is striking that the dimension of the Death Attitude Profile-Revised (DAP-R) in which the majority of the subjects of the studies reviewed scored the most is "Neutral Acceptance" (Table 1), with an average of 5.6 points out of 6 vs. the following dimension, which is Fear of Death with 4.04 out of 6.

We do live in denial of death nowadays! [1,3-4,8-16]. On the one hand, it is curious that "Neutral Acceptance" is the one with the highest score in a society in which infant death is anecdotal and the elderly die in nursing homes at an age that seems far away, in which death is reserved for the nuclear family [1], in the hospital, where, for reasons such as cremation, the body disappears, and in which it is impolite to talk about death.

On the other hand, given its role in psychological well-being [17-22], we should be glad that it is the one with the highest score. It is because of this last-mentioned reason that "Neutral Acceptance" is an important attitude whose promotion should be incorporated into programs on the "optimization of attitudes toward death".

Not without first taking into account a very basic question that needs to be further explored: are we talking about acceptance? Perhaps, when we talk about "Neutral Acceptance", what we really want to say is denial? This does not mean that both constructs are the same; they are obviously not. Could there be a secondary assessment of the DAP-R items made by the subject? In other words, do these reagents provoke such assessment? For instance, when subjects are asked:

Should death be viewed as a natural, undeniable, and unavoidable event? (DAP-R item 6) and they agree with the statement but… they are afraid of saying so.

Then the answer might be affirmative. Therefore, why should we think about it? It is out of control!

In addition, this would explain the negative correlation between fear of death and neutral acceptance [19,20-25], which can usually be found in scientific literature (Table 2).

Reference/year	Country	Sample	FD	AD	NA	AA	EA
[32] 2013	Jordan	51 nurses 20-29 years old	3.67(.65)	3.09(.53)	3.56(.56)	3.36(.61)	2.83(.64)
		65 nurses >40 years old	3.22(.58)	3.03(.63)	3.87(.37)	3.86(.46)	3.56(.63)
[33] 2009	Colombia	150 subjects 13-20 years old	4.14(n.a)	4.35(n.a)	5.4(n.a)	4.95(n.a)	4.19(n.a)
		125 subjects 21-40 years old	3.72(n.a)	4.25(n.a)	5.63(n.a)	5.12(n.a)	4.09(n.a)
[34] 2016	Iran	324 medical students	3,76(1,2)	3,54(1,3)	5,14(.9)	4,66(1,0)	3,73(1,3)
[35] 2008	USA	28 psychology students	3.73(1,4)	3.73(1,5)	5.84(.7)	5.65(1,1)	4.69(1,6)
[36] 2017	USA	157 psychology students	4,21(1,4)	4,40(1,6)	5,68(.86)	5,47(1,3)	4,50(1,7)
[37] 2007	USA	74 nurses	4,87(1,3)	5.73(1,3)	2.16(.7)	2.69(1,4)	4.13(1,4)
		32 doctors	5.2(1,0)	6.06(.5)	1.95(.6)	4.48(1,7)	3.8(1,5)
		29 social workers	4.42(1,3)	5.13(1,2)	3.12(1,5)	3.57(1,2)	4.16(1,0)
[38]2017	Greece	34 health care professionals	4,02(.58)	4,31(.36)	5,36(.58)	3,75(.39)	4,22(.47)
		Pre/post 150-hour training	4,14(.38)	4,40(.30)	5,78(.65)	3,70(.34)	4,40(.30)
		49 idem Control Group	4,16(.69)	4,18(.74)	5,12(.55)	3,54(.28)	4,25(.42)
[39] 2018	Malaysia	65 haemodialysis nurses	4,3(.9)	3,4(1,1)	5,4(.7)	4,9(.9)	3,7(1,2)
[40] 2017	Brasil	1005 health care students	3,87(1,3)	3,71(1,4)	5,34(.8)	4,66(1,2)	3,9(1,4)
[41] 2005	USA	58 nurses	3.77(n.a)	2.53(n.a)	5.69(n.a)	4.17(n.a)	5.49(n.a)
[28] 2018	Iran	135 members National Library	4,76(1,6)	4,52(1,9)	4,44(1,2)	4,15(1,2)	4,16(1,6)
[42] 1987	USA	300 young adults	3.03(n.a)	2.91(n.a)	5.57(n.a)	4.95(n.a)	4.45(n.a)
[31] 2008-9	USA	300 adults 23-87 years old	3.2(1,3)*	3.2(1,4)*	5.77(.9)*	5.7(1,4)*	5.1(1,5)*
[43] 2003	USA	91 Americans >60 years old	2.33(n.a)	2.2(n.a)	4.39(n.a)	4.07(n.a)	3.47(n.a)
	China	87 Chinese >60 years old	2.35(n.a)	3.51(n.a)	4.45(n.a)	3.48(n.a)	3.7(n.a)
[44] 2006	U. K.	56 Disaster workers	3(1,3)*	2,13(1)*	5,9(.8)*	3,7(1,8)*	4(1,5)*
[45] 2011	Greece	150 nurses	4.9(1,9)	4.9(1,5)	5.6(.9)	4.2(1,2)	2.9(1,6)
[46] 2014	Iran	100 women with diabetes T.II	4.53(1,3)	4.13(1,7)	5.68(.78)	5.19(.77)	3.98(1,28)
[47] 2007	Spain	316 subjects >65 years old	4.1(1,4)*	5.7(1,7)*	5.7(1,2)*	4.9(1,4)*	4.2(1,7)*
		100 university students	3.97(n.a)	3.98(n.a)	5.28(n.a)	3.54(n.a)	3.01(n.a)
[48] 2013	Iran	105 healthy subjects	4.34(1,3)	3.88(1,6)	5.7(.7)	5.46(.8)	3.93(1,4)
		108 subjects with diabetes T.II	4.45(1,3)	4.08(1,7)	5.69(.8)	5.22(.8)	3.97(1,3)
		87 subjects with cancer	4.45(1,4)	4.4(1,7)	5.88(.7)	5.51(.9)	4.1(1,5)
[49] 1999	USA	67 teachers	4.17(.52)	3.68(.39)	2.36(.63)	4.42(.29)	4.41(.62)
[50] 2004	USA	53 subjects pre TV program	4.1(1,0)*	4.1(.6)*	5.3(1,0)*	3.8(.4)*	3.9(.6)*
		123 subjects after TV program	3.9(1,2)	4.5(.9)	2.6(.88)	3.2(1,2)	4.5(1,3)
[51] 2010	Spain	224 parents of 8-12-year-old students	3.95(1,5)	4.3(1,8)	5.52(1,3)	3.82(2,7)	3.48(1,5)
		15 student teachers	2.91(1,1)	3.77(1,3)	5.3(1,3)	4.69(3,4)	4.19(1,5)
[52] 2008	Colombia	175 Male 18-88 years old	2.53(1,0)	3.19(1,4)	4.53(.5)	4.28(.8)	4.48(.6)
		168 Female 18-88 years old	2.73(1,2)	3.58(1,2)	4.38(.6)	4.5(.5)	4.49(.8)
[53] 2017	China	365 university students	3,51(1,4)	3,23(1,3)	5,45(1,2)	3,9(1,3)	3,48(1,3)

Table 1: Scores in the referenced scientific literature in the DAP-R questionnaire (means and standard deviations). Source: compiled on the basis of the results from the bibliography references.

FD: Fear of Death AD: Avoidance of Death NA: Neutral Acceptance AA: Approach Acceptance EA: Escape Acceptance

n.a: not available

The dimensions with higher score are marked in red

The dimensions with the lower score are marked in blue

*Authors who have assessed the scores as the aggregate of the items in each dimension. Since the questionnaire instructions recommend dividing the total scale score by the number of items forming each dimension, the calculation has been made and it is shown in this table so that it has the expected clarity and meaning.

Author	Dezutter [23]	Tomer [25]	Bellali [27]	Snaashar [28]	Göriş [29]	Dezutter [30]	Kopp[31]
NA/FD	-.47**	-.22*	.02	-.59*	-.103	-.25**	-.193**

Table 2: Correlation between Fear of Death and the rest of DAP-R dimensions. Source: compiled on the basis of the results from the bibliography references.
*p<.05; **p<.01; ***p<.001; FD: Fear of Death NA: Neutral Acceptance

Reference/year	Country	Instrument/version	My death	My process	Other people's death	Other people's process
[58] 2013	Spain	Nursing students 1st	22.82	26.18	29.03	24.71
		Nursing students 2nd	22.35	24.98	27.59	24.83
		Nursing students 3rd	22.61	25.63	27.22	23.12
[55] 2010	Australia	Collet-Lester/Lester and Abdel	21.33(6,58)	22.71(6,80)	26.94(4,81)	24.01(6,03)
[56] 2005	Spain	Collet-Lester/Bayés and Limonero				
		With Catalan nursing students	18.75(4,62)	21.65(3,43)	22.86(2,67)	22.15(3,25)
		With Andalusian nursing students	18.41(4,73	21.06(3,70)	22.55(3,04	21.83(3,27)
[61] 2011	Spain	Collet-Lester/Tomás-Sábado				
		Male	20.31	24.55	25.93	21.28
		Female	22.93	25.89	28.45	24.72
[62] 2011	Chile	Collet-Lester/Tomás-Sábado	17.59	20.76	23.45	20.27
[63] 2009	Chile	Collet-Lester/Tomás-Sábado Adolescents	21.6	23.69	28.39	25.62
[20] 2013	USA	Collet-Lester (Lester, 2004)	3.29	3.68	n.d.	n.d.
		Male	2.96	3.28	n.d.	n.d.
		Female	3.48	3.90	n.d.	n.d.
[64] 2014	Spain	Collet-Lester/Tomás-Sábado				
		Unpleasant images	23.3	23.5	27.5	24.4
		Death images	23.6	24.6	27.4	26
[65] 2015	Mexico	Collet-Lester/Tomás-Sábado	2.71** (18.97)	3.21** (22.47)	3.52** (24.64)	3.28** (22.96)
[47] 2007	Spain	Original C.L. > 65 años	20.59	30.14	29.09	31.75
		Original C.L. university students	22.53	28.9	29.82	29.35
[57] 2009	Iran	Colet-Lester Iranian version	26	29	33	31
		Male	25	31	31	30
		Female	27	34	34	33
[66] 2013	Spain	15 nurses social and health centre	26.55	30.09	29.64	27.82
[67] 1994	Spain	Collet-Lester/Urraca*				
		Partners of ICU patients	32.95	34.47	29.58	35.4
		Partners of outpatients	34.5	37.41	24.91	33.78

Table 3: Score by dimensions in CL-FoDS. Source: compiled on the basis of the results from the bibliography references.
*Two scores are shown: firstly, the way in which the authors presented them and secondly, the standard way.
* 36-item version, therefore the higher scores.
**These authors divide the total scale score by the number of items.
The dimensions with higher score are marked in red and the dimensions with the lower score are marked in blue.

The Terror Management Theory [26] suggests that denial is a mechanism that helps us cope with the anxiety that certain death causes in all human beings. So far, the most plausible explanation of the negative correlation between "Neutral Acceptance" and "Fear of Death" found in the researches that use DAP-R [23,25,27-31] was that truly believing that death is a natural event (Neutral Acceptance) reduced the fear of death.

However, it could be argued that, even though this fact could be true, this might not be what is happening with our results and the increase in "Neutral Acceptance" might be a way to avoid thinking about death, to leave it aside, as a buffer or damper.

Both are tentative scenarios but we believe they deserve scientific attention. Perhaps researching in this field could help clarify this point, which we consider important, especially if our aim is to implement educational and training programs on attitudes toward death.

A second result that we believe deserves special attention, due to its phenomenology, basic scientific implications and consequences on an existential, relational, clinical and pedagogical level, is the Fear of Death Scale (CL-FoDS) by Collet and Lester (1969) [54].

After repeated application of this instrument [20, 55-58] it can be stated that the CL-FoDS dimension with the highest score in 16 out of the 20 reviewed samples is the "Fear of Other People's Death" and this occurs both to students and health care professionals.

More than your own fear of death, more than the fear of dying yourself and even more than the fear of dying of others!
Let's make a detailed analysis of the fear of death.

Basset, McCann and Cate [35] (2008) conducted a study which concludes that with regard to the death of a typical person, the majority of subjects (56%) chose a cold-remote image of death (instead of three other typical images: grim-terrifying, gentle-comforting and robot-like images), and 51% of participants in the personal death condition personified death as a gentle-comforting image. These authors endorse Tomer's explanation about it being easier to face death with stoical resignation when you think about the inevitability of other people's death as part of the natural order of things than when you think about your own death. That is to say, it seems like one's own death should be scarier that the death of others.

However, this is not what occurs with Collet and Lester's instrument. What occurs to health care and medical professionals and students, as well as students of non-health-related degrees, civilians, teenagers and patients, is that other people's death is scarier than one's own death, than one's own dying process and the dying process of others.

As for the health care professionals or students, considering that, to a greater or lesser extent, they take care of people who will eventually die, it might seem logical that they have a professional predisposition to these people. Why are they more afraid of other people's death then? The answer is not within the scope of this research. However, it is possible to reason the answer from two complementary points of view. The first one addresses the reasons why people study a degree focused on the provision of care to people. We know that the motivation to choose a degree in nursing is mainly vocational [59], and the distress caused by other people's death might be higher for people who are more sensitive in this respect. The second point of view addresses the modern concept of medicine and nursing [60], which focuses on healing and considers the death of patients more like a failure than the logical end to a long or short-term process. However, the reality is that this phenomenon does not only affect health professionals, nor people from other country or culture, the research goes beyond that and suggests that it is a universal phenomenon.

This might be the key to understand why the “fear of the dying process of others” scores the least and these results could also become new lines of research to learn more about therapeutic obstinacy. In other words, if I worry more about death itself than the dying process, maybe professionals and relatives are more inclined to postpone that moment, which unnecessarily makes the process longer, torpid or difficult to control from a semiological point of view.

Furthermore, this result could help us understand some aspects of the conspiracy of silence since we could tentatively argue that if other people's death is scarier than one's own death, then the best option, from a selfish perspective, would be to deny death so it would be a good idea to investigate whether by denying it to the patient we are actually acknowledging it.

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