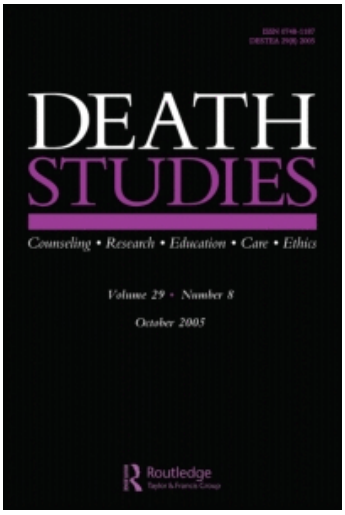

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Death and Dying Anxiety Among Elderly Arab Muslims in Israel

Faisal Azaiza[a]; Pnina Ron[a]; Meyrav Shoham[b]; Ibrahim Gigini[a]
[a] School of Social Work, The University of Haifa, Haifa, Israel [b] The Jewish-Arab Center, The University of Haifa, Haifa, Israel

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DEATH AND DYING ANXIETY AMONG ELDERLY ARAB MUSLIMS IN ISRAEL

FAISAL AZAIZA and PNINA RON
School of Social Work, The University of Haifa, Haifa, Israel
MEYRAV SHOHAM
The Jewish–Arab Center, The University of Haifa, Haifa, Israel
IBRAHIM GIGINI
School of Social Work, The University of Haifa, Haifa, Israel

Death and dying anxiety were examined among elderly Arab Muslims in Israel. A total of 145 people aged 60 and over were interviewed using a standardized questionnaire. Nursing home residents reported higher death anxiety than others; women and uneducated participants reported greater levels of fear of death and dying than others. There were no differences based on religiosity. Death anxiety was related to gender and education for elderly living in the community, but social support and self-esteem were additional correlates for those living in nursing homes. The results of this study indicate that fostering a sense that one has a supportive social and familial network is important in decreasing death and dying anxiety among elderly Arab people. It would also be beneficial to provide information and knowledge that might relieve some of the anxiety they experience.

With the number of older persons in the population of most countries growing, researchers have increasingly turned their attention to attitudes toward death and factors related to them (Tomer, 2000). Correlates of death and dying anxiety have received considerable attention in the literature (see Fortner & Neimeyer, 1999; Neimeyer, Wittkowski, & Moser, 2004, for reviews). The majority of this research, however, has been done in Western, Christian populations; there are indications that death anxiety in older people may vary based on religiosity and ethnicity (Neimeyer et al., 2004).

Received 12 May 2008; accepted 30 October 2008.
Address correspondence to Prof. Faisal Azaiza, School of Social Work, The University of Haifa, Mount Carmel, Haifa 31905, Israel. E-mail: azaiza@research.haifa.ac.il

The current study seeks to shed light on death and dying anxiety among elderly Arab Muslims in Israel. The Arab population of Israel numbers approximately 1.4 million people, mostly Muslims; 3.3% were over the age of 65 in 2006 (Central Bureau of Statistics, 2007). Arab society in Israel has been undergoing modernization and change affecting the older population. Although the family still retains much of its importance, the authority and prestige enjoyed by elderly Arab men has declined, and the once-prevalent norm of children or close family acting as sole caregivers of the elderly person is losing its prominence. Nursing homes are an entirely new concept for Arab society, but people are viewing external care-giving more positively (Azaiza, Lowenstein, & Brodsky, 1999). Still, although many need assistance, only 0.7% of elderly Arabs reside in an institutional setting (Azaiza & Brodsky, 2003). Elderly residents of retirement homes serving the Arab population are comparatively young, unmarried, and childless, possibly reflecting an insufficient informal support system (Azaiza et al., 1999).

Neimeyer (1997–1998) described *death anxiety* as a term encompassing a cluster of death attitudes, characterized by fear, threat, unease, discomfort, and other negative emotional reactions, along with anxiety as a kind of diffused fear with no clear object (anxiety in the psychodynamic sense). The term *fear of dying* refers to the fear of undergoing a violent or painful death; as the process of dying is a prerequisite of actual death, it has been suggested that studying death and dying together is beneficial in attempting to understand the fear they generate (Cicirelli, 1999). Neimeyer et al. (2004) argued that persons who accept both the dying process and the prospect of eventually being dead as a natural part of their lives display a less intense fear of dying and death than others.

One factor studied in relation to death and dying anxiety is living arrangement. Nursing home residents, even if relatively healthy, are exposed to disability, death, and dying, which may lead to feelings of vulnerability and anxiety (Iecovich & Lev-Ran, 2006; Ron, 2004). Fortner and Neimeyer (1999) found that death anxiety tends to be significantly higher among elderly people in nursing homes than among those living in more independent settings, but only when using liberal methods of analysis. Institutionalization may also be the result of other processes that can

be linked to death anxiety, such as physical or psychological problems, or lack of an informal support system (Azaiza et al., 1999; Davis, Thorson, & Copenhaver, 1990).

Another factor is gender. Some research indicates that older women display higher levels of death anxiety than older men (Cicirelli, 1999; DePaola, Griffin, Young, & Neimeyer, 2003). Research in Arab populations also supports this (Abdel-Khalek, 2007; Suhail & Akram, 2002), although those studies were not done exclusively with elderly individuals. In contrast, other research indicates no gender differences in death anxiety (Fortner & Neimeyer, 1999).

Another factor is education. Older individuals with a higher level of education are less likely to desire that their life be prolonged than those with lower levels of education (Cicirelli, 1997; Mutran, Danis, Bratton, Sudha, & Hanson, 1997) providing indirect support for the possibility that higher levels of education are associated with less fear of death.

Still another factor is religion, though the relationship appears to be complex. Fortner and Neimeyer (1999) did not find religiosity to predict death anxiety among the elderly, possibly due to uniformity in religiosity in their sample. Neimeyer et al. (2004) suggested that deeper religious belief may predict lower death anxiety but superficial religious behavior does not. Belief in God's existence and belief in the afterlife are related to decreased death anxiety and greater acceptance of death (Cohen et al., 2005; Harding, Flannelly, Weaver, & Costa, 2005). In Islam, the religion of most Arab people, Allah creates death and life; death is God's will, a transition from a temporary life on earth to immortal life, whether in paradise or in hell (Al-Sabwah & Abdel-Khalek, 2006). Religiosity appears to be inversely associated with death anxiety among Muslims (Al-Sabwah & Abdel-Khalek, 2006; Suhail & Akram, 2002), though past studies did not focus on older populations.

A final factor considered here is social support. Social support was linked with death anxiety and fear of the unknown in Mullins and Lopez's study (1982), but not with fear of dying and fear of the known (Cicirelli, 1999, 2002). Close relationships can increase self-esteem and may be a buffer against death anxiety, whereas disruption of such relationships may lead to death awareness and concerns (Mikulincer, Florian, Birnbaum, & Malishkevich, 2002). However, Cicirelli (2002) found only a weak effect for self-esteem in predicting death anxiety among older adults.

Thus, the existing literature is not always clear but suggests that death anxiety in general and among the elderly in particular may be predicted by living arrangement, gender, religiosity, education, social support, and self-esteem. However, research in Arab and Muslim populations is limited and has not focused specifically on the elderly. Our study is designed to extend the knowledge on death and dying anxiety by focusing on elderly Arab Muslims in Israel. We hypothesized that nursing home residents would express higher levels of death and dying anxiety and have lower social support and self-esteem than persons living in the community, women would express greater levels of anxiety than men, religiosity would be negatively related to death anxiety, better educated people would express less death and dying anxiety, and social support and self-esteem would be inversely related to death and dying anxiety.

Method

Participants

We used a convenience sample of 145 (98 women, 47 men) people aged 60 and over (95% of whom were 65 years old or more) from northern Israel, who were interviewed during the first half of 2007. Of these, 80 were living in their communities and 65 were from five nursing homes. The average age was 74, with no significant age, gender, or education differences between those living in the community and those residing in nursing homes. Most had no education. Differences did emerge in the following variables: rural vs. urban, marital status, number of children, religiosity, traditionalism, and income level. Table 1 presents key characteristics of the sample. Most community residents were rural, widowed or married, religious, had at least four children, and had relatively higher income. Most nursing home residents were urban, widowed or single, secular or traditional (*traditional* refers to a person who follows some religious customs but does not identify as religious), had fewer than four children, and had relatively lower income. These differences reflect the demographic correlates of the decision regarding placement.

Instruments

The questionnaires were translated from the original language—English or Hebrew—to Arabic, translated back to English or

TABLE 1 Characteristics of the Sample, by Living Arrangement

Variable	Community		Nursing home		Total		Difference
	n	%	*n*	%	*n*	%	
Age	*M* = 73.29 (*SD* = 7.59)		*M* = 73.91 (*SD* = 7.67)		*M* = 73.57 (*SD* = 7.61)		$t_{(143)} = 0.49$
Gender							
Men	26	32.5	21	32.3	47	32.4	$Z = 0.03$
Women	54	67.5	44	67.7	98	67.6	
Place of residence							
Urban	27	33.8	51	78.5	78	53.8	$Z = 5.35^{***}$
Rural	53	66.3	14	21.5	67	46.2	
Marital status							
Widowed	53	66.3	29	44.6	82	56.6	$Z = 2.61^{**}$
Married	24	30.0	11	16.9	35	24.1	
Single	2	2.5	18	27.7	20	13.8	
Divorced	1	1.3	7	10.8	8	5.5	
No. of children							
0	8	10.0	28	43.1	36	24.8	$Z = 4.90^{***}$
1	6	7.5	4	6.2	10	6.9	
2–3	10	12.5	12	18.5	22	15.2	
4 or more	56	70.0	21	32.3	77	53.1	
Religiosity							
Secular	15	18.8	19	29.2	34	23.4	$Z = 2.71^{**}$
Traditional	7	8.8	25	38.5	32	22.1	
Religious	58	72.4	11	16.9	69	47.6	
Very religious	–	–	10	15.4	10	6.9	
Education							
No education	65	81.2	54	83.1	119	82.0	$Z = 0.30$
Less than high school	8	10.0	7	10.8	15	10.3	
High school	4	5.0	1	1.5	5	3.5	
Post-high school	3	3.8	2	3.1	5	3.5	
Academic	–	–	1	1.5	1	0.7	
Income							
Very low	11	13.8	19	29.2	30	20.7	$Z = 3.72^{***}$
Low	14	17.4	24	36.9	38	26.2	
Medium	51	63.8	19	29.2	70	48.3	
High	4	5.0	2	3.2	6	4.1	
Very high	–	–	1	1.5	1	0.7	

**Significant at $p < .01$; ***Significant at $p < .001$.

Hebrew, and re-translated to Arabic by another professional. The two Arabic versions were reviewed by a native speaker of Arabic, a research professional, and minor changes were then introduced for clarification purposes.

Income level was measured as a subjective question on a 5-point Likert scale from 1 (*very low*) to 5 (*very high*). Religiosity was defined as 1 = secular (not observing religious rules), 2 = traditional (observing some religious rules), 3 = religious (observing most religious rules), 4 = very religious (orthodoxy—observing all religious rules).

The Self Esteem Scale (Rosenberg, 1965) includes 10 items (e.g., I am able to do things as well as most other people), scored from 1 (*low self-esteem*) to 5 (*high self-esteem*). The scale has been used and validated in Israel (alpha of .80 in Carmel, 2001). Alpha in the present study was 0.77.

The Social Support Scale (based on Carmel, 2001) includes six items (e.g., "To what extent is your relationship with your partner close?"), each assessing the respondent's relationship with different persons (partner, son, daughter, other family members, friends, and significant others). Each item is scored from 1 (*very distant relationship*) to 5 (*very close relationship*), so higher scores indicate greater support. Alpha in the present study was 0.79.

Death and Dying Anxiety (two scales based on Carmel & Mutran, 1997) includes six death anxiety and six dying anxiety items (e.g., "I am very scared of death, I am afraid of the suffering that is related to dying"), with responses on a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Higher scores indicate greater anxiety. Alphas were 0.71 and 0.76, respectively, among elderly Jews in Israel (Carmel & Mutran, 1997), and 0.83 and 0.80, respectively, in the present study.

Procedure

Participants living in the community were recruited from day centers offering services to the elderly in several locations in northern Israel. Other participants lived in three nursing homes in the same geographical area. Consent for the study was obtained from the elderly themselves as well as from the head of each nursing home. Participants were interviewed in private by a graduate student in gerontology or by nursing home employees, all of whom were trained regarding the structure of the questionnaire and modes of clarification of its items. In the nursing homes, nurses working at the facilities prepared participants for the research in

order to reassure them and make them comfortable with the interview process.

Results

As expected, death and dying anxiety were significantly correlated in the full sample and in both separate living arrangement groups ($r = .44$ to $.56$, $p < .001$), as were social support and self-esteem, as can be seen in Table 2.

Elderly nursing home residents had higher death anxiety, but not dying anxiety, than elderly community residents, $F(1,141) = 15.59$, $p < .001$, $\eta^2 = .10$. Women were higher than men on both death anxiety, $F(1,141) = 6.03$, $p < .05$, $\eta^2 = .04$, and dying anxiety, $F(1,141) = 4.44$, $p < .05$, $\eta^2 = .03$. Participants with no education were higher on both death anxiety, $F(1,141) = 6.70$, $p < .05$, $\eta^2 = .05$, and dying anxiety $F(1,141) = 4.09$, $p < .05$, $\eta^2 = .03$ (than those with at least elementary education). No differences occurred on religiosity (see Table 3). In addition, both social support, $F(1,142) = 27.59$, $p < .001$, $\eta^2 = .16$, and self-esteem, $F(1,142) = 16.53$, $p < .001$, $\eta^2 = .10$, were higher among elderly community residents than elderly nursing home residents (see Table 4).

Finally, partial correlations were conducted, controlling for gender and education. These were significant for nursing home residents: social support and death anxiety ($r = -.28$, $p < .05$), and self-esteem and death anxiety ($r = -.35$, $p < .01$). Higher social support and higher self-esteem, for elderly nursing home residents, were related to lower death anxiety, beyond gender and education. No significant correlations were found for dying anxiety or for elderly community residents.

Discussion

The present study investigated differences in death and dying anxiety among elderly Arab Muslims in Israel, a previously unstudied population. As expected, death anxiety was indeed higher for nursing home residents than community residents. However, unexpectedly, no significant difference between nursing home and community residents emerged in regard to dying anxiety. It is possible that, due to relatively low rates of institutionalization in Arab society (Azaiza & Brodsky, 2003), elderly people

TABLE 2 Means, Standard Deviations, and Correlations Among the Study Variables

Variable	*M* (*SD*)	Gender	Education	Religiosity	Social support	Self-esteem	Death anxiety	Dying anxiety
Total sample ($n = 145$)								
Gender	0.32 (0.47)		.48***	−.43***	.18*	.14	−.20*	−.17*
Education	0.18 (0.38)			−.26**	.01	.07	−.22**	−.17*
Religiosity	0.54 (0.50)				.08	.06	−.05	.10
Social support	3.47 (1.16)					.48***	−.24**	−.15
Self-esteem	3.65 (0.74)						−.28**	−.16*
Death anxiety	2.31 (1.11)							.48***
Dying anxiety	3.83 (1.06)							
Community ($n = 80$)								
Gender	.33 (0.47)		.69***	−.77***	.23*	.27*	−.27*	−.16
Education	.19 (0.39)			−.64***	.18	.17	−.28*	−.21
Religiosity	.73 (0.45)				−.22*	−.22*	.19	.14
Social support	3.88 (0.92)					.46***	.01	−.19
Self-esteem	3.86 (0.68)						−.06	−.14
Death anxiety	1.99 (1.04)							.44***
Dying anxiety	3.82 (0.96)							
Nursing homes ($n = 65$)								
Gender	.32 (0.47)		.22	−.13	.16	−.01	−.14	−.19
Education	.17 (0.38)			.13	−.20	−.06	−.15	−.14
Religiosity	.32 (0.47)				.01	.08	−.02	.09
Social support	2.95 (1.22)					.36**	−.26*	−.12
Self-esteem	3.39 (0.72)						−.35**	−.20
Death anxiety	2.69 (1.07)							.56**
Dying anxiety	3.85 (1.18)							

Note. Gender (0 = female, 1 = male); education (0 = no education, 1 = some education); religiosity (0 = non-religious, 1 = religious).
*$p < .05$. **$p < .01$. ***$p < .001$.

TABLE 3 Means, Standard Deviations, and *F* Tests for Death and Dying Anxiety by Living Arrangement, Gender, Education, and Religiosity

Variable	Living arrangement			Gender			Education			Religiosity		
M (*SD*)	Community ($n=80$)	Nursing home ($n=65$)	$F(1,141)$ (η^2)	Male ($n=47$)	Female ($n=98$)	$F(1,141)$ (η^2)	No education ($n=119$)	At least elementary education ($n=26$)	$F(1,141)$ (η^2)	Secular, traditional ($n=66$)	Religious, very religious ($n=79$)	$F(1,141)$ (η^2)
Death anxiety	1.99	2.69	15.59***	1.99	2.46	6.03*	2.42	1.79	6.70*	2.36	2.26	1.06
	(1.04)	(1.07)	(0.10)	(1.10)	(1.10)	(0.04)	(1.11)	(0.93)	(0.05)	(1.07)	(1.14)	(0.01)
Dying anxiety	3.82	3.85	0.03	3.57	3.96	4.44*	3.91	3.44	4.09*	3.72	3.92	1.73
	(0.96)	(1.18)	(0.001)	(1.23)	(0.95)	(0.03)	(0.98)	(1.31)	(0.03)	(1.17)	(0.96)	(0.01)

Note. For living arrangement, $F_{(2,142)}=9.86$, $p<.001$, $\eta^2=.12$; for gender, $F_{(2,140)}=3.55$, $p<.05$, $\eta^2=.05$; for education, $F_{(2,140)}=7.38$, $p<.001$, $\eta^2=.10$; and for religiosity, $F_{(2,140)}=0.95$, n.s., $\eta^2=.01$. Gender, education and religiosity were examined with living arrangement in the analysis, which explains the different degrees of freedom.

*$p<.05$. ***$p<.001$.

TABLE 4 Means, Standard Deviations, and *F* Tests for Social Support and Self-Esteem, by Living Arrangement

	Community ($n=80$)		Nursing homes ($n=64$)		
Variable	M	SD	M	SD	$F(1,142)$
Social support	3.88	0.92	2.95	1.22	27.59^{***} ($\eta^2=.16$)
Self-esteem	3.86	0.68	3.38	0.72	16.53^{***} ($\eta^2=.10$)

Note. $F(2,141)=15.94$, $p<.001$, $\eta^2=.18$.
$^{***}p<.001$.

who live in the community are exposed to people in ill health, resulting in similar levels of dying anxiety for both populations. Furthermore, because those who are institutionalized often have serious medical problems and require considerable assistance (Azaiza & Brodsky, 2003), they may view the dying process as an extension of the difficulties they already face.

Also as expected, death anxiety and dying anxiety were higher among women. These gender differences are in line with research done among non-elderly Muslim and Arab samples (e.g., Abdel-Khalek, 2007; Suhail & Akram, 2002) and may reflect, to some extent, cultural norms that encourage women to express emotions such as fear, and discourage men from doing so. We also found a link between level of education and death and dying anxiety, as expected based on past studies that provided indirect evidence for this possibility (e.g., Cicirelli, 1997; Mutran et al., 1997). Non-educated people were more likely to experience death and dying anxiety than those with at least some education. These findings may overlap because women are less educated than men on average in this group.

Contrary to our expectations, religiosity was not related to either death or dying anxiety. Although such a relationship was hypothesized, past research does indicate that religiosity has a complex effect on death and dying anxiety (e.g., Neimeyer et al., 2004; Harding et al., 2005). Our measures might not have been sufficiently sensitive to those elements of religious belief that affect death and dying anxiety. The relatively high levels of religiosity among Arab Muslims in Israel, reflected in our sample, may have also contributed to the non-significant results. About half the present sample rated themselves highly on religiosity—3 on a scale from 1 (*not religious at all*) to 4 (*very religious*). Finally, the traditional

belief that fate, health, and illness are in the hands of God, characteristic of Arab society regardless of religion (Al-Krenawi & Graham, 2000; Cohen & Azaiza, 2007), could have been a confounding factor.

As hypothesized, both social support and self-esteem were higher among elderly living in the community than among those living in nursing homes. Institutionalization and reliance on formal support systems are not the preferred alternative in Arab society, whose members usually turn to their family in times of need (Al-Krenawi & Graham, 2000; Azaiza, Rimmerman, Araten-Bergman, & Naon, 2006). It seems likely that elderly persons whose network of family and friends is large and supportive would be able to rely on them for assistance, eliminating the need for an institutional solution. It should be noted that participants living in the community had a significantly larger number of children than those living in nursing homes in this study; these children are most likely able to help their parents (Ron, 2008). The positive link between social support and self-esteem has been established by Commerford and Reznikoff (1996) among nursing home residents. The relationship was also significant in our sample, regardless of living arrangement. Krause (1987) suggested that receiving reassurance of worth, caring, love, and trust from significant others reinforces self-esteem in older adults. As we found decreased social support among our institutionalized participants, it is not surprising that their self-esteem is also lower.

Social support and self-esteem were negatively related to death and dying anxiety among nursing home residents but not among elderly persons residing in the community. As noted previously, Arab nursing home residents in Israel tend to be more disabled than Jewish nursing home residents (Azaiza & Brodsky, 2003); decreased social support can be a cause for institutionalization (Azaiza et al., 1999). It is possible that nursing home residents fall into two categories: some lack extensive support networks, whereas others require a very high burden of care because of severe medical problems. For those whose disabilities are too much for their families, family members may nonetheless remain a source of support and companionship. If this is indeed the case, it would seem likely that those nursing home residents who enjoy their family's support and who have higher self-esteem would express lower levels of death and dying anxiety. Meanwhile, most elderly people in the community already enjoy significant social

support and higher self-esteem, leaving these two factors with less predictive value in that segment of the population. Additional research may shed light on this issue.

The limitations of this research include reliance on self-report, which may reflect self-presentation issues or difficulty understanding the questions. Even though every effort was made to clarify the items to the participants, we cannot be certain that this was always successful. Furthermore, the physical and mental functioning of the participants was not measured and might have affected the results. An additional limitation is the nature of the sample, which included Arab Muslims from a small geographical area. Although we have no reason to expect that they were different from elderly Arabs in other parts in Israel, a broader study may yet yield different results. Such a study may also benefit from the inclusion of a Jewish comparison group. Whether or not the findings from this study can be generalized to other Elderly Arabs populations in the Middle East or to Arabs living in western countries also remains an open question at this point.

Several practical implications can be derived from the findings of this study. Finding ways to foster a sense that one has a supportive social and familial network is important in decreasing death and dying anxiety. Health and welfare professionals working with elderly Arabs should take special care to create good relationships with the families of their patients/clients and to encourage them to spend time with their loved ones. In addition, elderly persons both in the community and in nursing homes may benefit from activities and social clubs. Offering activities in which elderly people can engage may also leave less time to ruminate about negative thoughts. Such activities could take an educational approach, providing information and knowledge that might relieve some of the anxiety elderly people experience. In sum, sensitivity to unique needs and creativity in tailoring activities and support systems are of paramount importance for practitioners dealing with elderly people who are vulnerable to death and dying anxiety.

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