DISABILITY SALIANCE AS AN INDICATOR OF LOSS ANXIETY: AN ALTERNATIVE EXPLANATION FOR THE FUNDAMENTAL FEAR OF HUMAN BEINGS

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ABSTRACT

DISABILITY SALIENCE AS AN INDICATOR OF LOSS ANXIETY: AN ALTERNATIVE EXPLANATION FOR THE FUNDAMENTAL FEAR OF HUMAN BEINGS

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The aim of the present research was to investigate the issue of loss anxiety within the framework of disability and terror management theory. A questionnaire package was administered to 217 participants twice to examine the effects of mortality salience and disability salience. Besides mortality salience, paralysis salience was found to be effective. Highly conservative participants were becoming more conservative in the paralysis salience and mortality salience conditions. Content analysis was also conducted relating the participants' accounts. It was concluded that death and disability were both inducing sadness for the participants. However, this sadness experience could have two different formats. The relation between experimental manipulations and global sadness accounts was not significant. However, the relationship between experimental manipulations and individual sadness accounts was significant. Participants in the mortality salience condition were experiencing less individual sadness than expected. In contrast, participants in the paralysis salience condition were experiencing more individual sadness than expected. It is concluded that death may not be the one and only fundamental fear as terror management theory suggests. Disability might be as fearful as death. A

theoretical model is proposed for the alternative experimental manipulation in terror management theory studies. According to this conceptualization, an experimental manipulation could be successful if it satisfies the following three conditions: moderately fearful, highly imaginable/easily available and highly self-relevant. Any kind of loss which satisfies these conditions might result in cultural worldview defense. The threatening nature of disability might provide one more reason relating the importance of a disability-friendly environment.

Keywords: Terror Management Theory, Models of Disability, Mortality Salience, Disability Salience, Loss Anxiety.

ÖZ

KAYIP KAYGISININ GÖSTERGESİ OLARAK ENGELİN HATIRLATILMASI DURUMU: İNSANLIĞIN TEMEL KORKUSU ÜZERİNE ALTERNATİF BİR AÇIKLAMA

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Bu çalışmanın amacı engel ve dehşet yönetimi çatısı altında kayıp kaygısının incelenmesidir. Bu kapsamda engel ve ölüm, nicel ve de nitel olarak karşılaştırılmıştır. Engelin ve ölümün hatırlatılması manipülasyonlarının etkileri katılımcıların (N=217) vereceği cevaplarda iki kez uygulanan anket formları arayıcılığıyla ölçülmüştür. Ölümün hatırlatılmasının yanında felcin hatırlatılması koşulunun da etkili olduğu görülmüştür. Muhafazakârlık seviyeleri yüksek katılımcıların, ölümün hatırlatılması ve felcin hatırlatılması koşullarında daha muhafazakâr oldukları görülmüştür. Ayrıca, deney koşullarındaki katılımcıların söylemleri içerik analizine tabii tutulmuştur. Hem ölümün hem de engelin katılımcılarda üzüntü yarattığı sonucuna varılmıştır. Bu üzüntü genel ya da kişisel olabilir. Deney koşulları ile genel üzüntü söylemleri arasındaki ilişki anlamlı değildir. Ancak, deney koşulları ile kişisel üzüntü söylemleri arasındaki ilişki anlamlıdır. Ölümün hatırlatılması koşulundaki katılımcıların beklenenden daha az kişisel üzüntü yaşadıkları görülmüştür. Bunun yanında felcin hatırlatılması koşulundaki katılımcılar beklenenden daha çok kişisel üzüntü yaşadıklarını ifade etmişlerdir. Ölümden farklı olarak katılımcıların olası bir felç durumunda kendileri için üzüldükleri görülmüştür. Bu sonuçlar, dehşet yönetimi kuramının söylediği gibi

ölümün tek ve en temel korku olmadığı sonucuna varılmasına neden olmuştur. Engel de en az ölüm kadar korkutucu olabilir. Tüm bunların ışığında dehşet yönetimi kuramı çalışmalarında kullanılabilecek alternatif deney manipülasyonları ile ilgili bir teorik model önerilmiştir. Buna göre bir deney manipülasyonu şu üç koşulu sağlarsa dehşet yönetimi kuramı çerçevesinde başarılı olabilir: orta düzeyde korkutucu, yüksek seviyede hayal edilebilir/kolayca elde edilebilir ve kişi ile yüksek seviyede alakalı. Bu üç koşulu yerine getiren her tür kayıp olgusu kültürel dünya görüşünü savunma davranışına neden olabilecektir. Engelin korkutuculuğu engelle barışık ortamlar yaratmanın gerekliliği konusunda bir neden daha ortaya koyabilmektedir.

Anahtar Kelimeler: Dehşet Yönetimi Kuramı, Engel Modelleri, Ölümün Hatırlatılması, Engelin Hatırlatılması, Kayıp Kaygısı

To the two important men in my life:

To my dearest husband Murat and lovely daddy Mengüç.

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TABLE OF CONTENTS

LIST OF TABLES

TABLES

LIST OF FIGURES

FIGURES

CHAPTER 1

OVERVIEW

The dissertation aims to enlighten the issue of loss within the framework of disability and Terror Management Theory [TMT]. Disability is defined as a human condition (Shakespeare, 2006). However, it is neither chosen nor desired. Disabled people constitute one of the largest minority groups in most countries (e.g. Mostert, 2009). For Turkey it is (at least) 8.5 million people (Başbakanlık Özürlüler İdaresi Başkanlığı, 2007). Different than other stigmatized groups, such as ethnic minorities, they are not socialized accordingly (Murphy, Scheer, Murphy, & Mack, 1988). Most disabled people have non-disabled parents (Shakespeare, 2005). However, in Turkey it is indicated that 25.7 % of the disabled university students indicate having a disabled family member (Koca-Atabey, Karancı, Dirik, Aydemir, 2011). This proportion might be lower in more developed countries.

Disability would be defined according to the social model which argues that not the impairments but the society is disabling (e.g. Barnes & Mercer, 2004). Terror Management Theory argues that death is the primary fear for human and death is tried to be overcome by the means of cultural worldview defense or self-esteem alleviation (e.g. Greenberg, Solomon, & Pyszczynski, 1997).

Especially in terms of consequences death and disability could be described in a similar vein: Death (Disability) is “an (in)evitable fact of life, a reality that we believe has profound influences on virtually everything that think, feel, say and do” (Solomon, Greenberg, Pyszczynski, 1997, p.70). Acquiring a disability is an interesting concept; it is not death, not illness and not an end, however, it is a health condition, a life transformation and a difficult but new beginning.

The current research utilizes TMT both conceptually and empirically. Death and disability is going to be compared at the conceptual level as mortality salience and disability salience will be examined empirically.

The thesis aims to prove the fact that death is not the only and the most "threatening" concept for today's people. It is true that death is a major problem of humankind (Pyszczynski, Greenberg, Solomon, Arndt, & Schimel, 2004), but acquiring a disability might be another one which could be much more fearful. Therefore, as in the case of mortality salience, participants might show worldview defense reactions in the disability salience conditions.

"You will die at best…"

CHAPTER 2

INTRODUCTION

2.1 Terror Management Theory

Terror management theory originates from the writings of Becker (1973), who argues that human intellectual capacity leads to awareness about human mortality. This knowledge creates an irresistible terror. There are two main approaches that TMT offers for alleviating this fundamental fear; adopting a cultural worldview that gives meaning to reality which is a shared knowledge or strengthening self-esteem that reduces anxiety in response to threats (Solomon, Greenberg, & Pyszczynski, 2000; Solomon, et al., 1998; Jones & Fischer, 2006). According to terror management theory, when people are reminded about death, they defend or validate their cultural worldviews (mortality salience hypothesis), alternatively, they may try to maintain or enhance their self-esteem (self-esteem hypothesis). (Greenberg, et al., 1997).

TMT suggests that the need for self-esteem and faith in a cultural worldview affect almost all forms of human behavior. It should be also noted that the protection that is provided by culture and self esteem are symbolic and experiential rather than a rational process, meaning that people show worldview defense when they are in gut level thinking but not in a rational mode of thinking (Pyszczynski, Greenberg, & Solomon, 2000). It is argued that mortality salience effects occur when death thoughts are accessible but outside of consciousness (Greenberg, Pyszczynski, Solomon, Simon, & Breus, 1994).

2.1.1 Mortality Salience and Cultural Worldview Defense

There are numerous studies conducted in many different countries, which are in line with the basic hypothesis that reminding one's own mortality results in

adherence to cultural worldview. During the mortality salience manipulation, participants are receiving questions which make death salient for them. Parallel questions regarding “failing from an important exam”, “experiencing dental pain” or “watching television” are asked to control group participants. Rather than any other condition, it is discussed that only death reminders cause the worldview defense (e.g. Greenberg et al., 1990; Greenberg, Simon, Jones-Harmon, Solomon, Pyszczynski, & Lyon, 1995; Florian, Mikulincer, & Hirschberger, 2001; Weise et al., 2008). Several types of mortality reminders are also used in the literature. For instance, after reminding recent terrorist attack worldview defense reactions are measured (e.g. Landau, et al., 2004; Jonas & Firscher, 2006). A different method for reminding mortality might be field experiments. Participants of a mortality salience study are chosen from the people who are walking through a cemetery (e.g. Gailliot, Stillman, Schmeichel, Maner, & Plant, 2008; Pyszczynski, Wicklund, Floresky, Gauch, Koch, Solomon, & Greenberg, 1996). Other types of mortality reminders can be a word-stem completion task (Hirschberger, Florian, & Mikulincer, 2005), subliminal exposure to death-related stimuli (e.g. Landau et al., 2004; Castano, 2004), reading a child’s death story (Norenzayan & Hansen, 2006) or answering a death questionnaire (Martens, Greenberg, Schimel, & Landau, 2004). The different mortality salience reminders might be categorized as essay questions, subliminal prime, survey questions or others (e.g. slide show) (Burke, Martens, & Faucher, 2010).

The effects of mortality salience are various. After reminding about own mortality, participants are more punitive to a moral transgressor such as a prostitute and they are also found to be more rewarding towards a hero (Rosenblatt, Greenberg, Solomon, Pyszczynski, & Lyon, 1989). It is also demonstrated that mortality salience manipulation leads people to support martyrdom attacks or extreme military interventions (Pyszczynski, Abdollahi, Solomon, Greenberg, Cohen, & Weise, 2006). Studies asserts the point that after reminding their own mortality Christian subjects favor Christians as opposed to Jews and Americans show negative reactions to an anti-American author (Greenberg et al., 1990).

Mortality salience manipulation is also found to increase stereotypical thinking towards out-groups (Schimel, et al., 1999). However, for women (but not for men) death primes result in increased compassion towards disabled people (Hirschberger, et al., 2005). Moreover, Gailliot et al. (2008) assert that incidents of assisting confederate in a wheelchair increases after death reminders. However, Hirschberger et al. (unpublished manuscript) claim the opposite. Participants are more likely to help more to a confederate who is in a wheelchair when death was not salient (cited in Hirshberger, 2008). It is also indicated that participants distance themselves from a cancer victim after a mortality salience manipulation (Mosher & Danoff-Burg, 2007). From a study about the elderly, it is indicated that elder adults are associated with death by the younger participants. Distancing themselves from the elderly and derogation might be examined after mortality salience manipulation. It is argued that elderly are also experiencing a physical deterioration of the body which is regarded as a signal of death (Martens, et al., 2004). It is also found that younger adults give harsher responses towards moral transgressors as compared to older participants. This can be explained with different coping mechanisms relating death that is adopted by the elderly people or increasing the levels of death tolerance by age (Maxfield et al., 2007).

From a different perspective, mortality salience effects are investigated in relation to the number of children desired. It is concluded that the desire of having an offspring is significantly higher for the mortality salient subjects than the mortality non-salient ones (Fritsche, et al., 2007). Similarly, it is also found that mortality salience effects lead to an increased interest in the physical aspects of sex and increased identification with one's body among high body-esteemed participants (Goldenberg, McCoy, Pyszczynski, Greenberg, & Solomon, 2000).

There might be some factors, which could alter the effects of mortality salience manipulations. For instance, death primes given together with a pro-egalitarian (versus a neutral) essay are resulted in reduced prejudice towards blacks (Gailliot, et al., 2008). Similarly, a belief in literal immortality would reduce the

needs for symbolic forms of immortality. It is revealed that after mortality salience manipulation romantic commitment tends to increase whereas it may also act as an anxiety-buffer and lessen the effects of mortality salience on social transgressors (Mikulincer, Florian, & Hirschberger, 2003). Another issue that weakens the effects of mortality salience could be eating. Participants who eat a piece of candy just after the manipulation give milder punishments to social transgressors (Hirschberger & Ein-Dor, 2005).

As the mortality salience hypothesis suggests one's cultural worldview acts as a buffer against the anxiety that stems from death awareness; the conceptualization of cultural worldview defense however is subjective in nature (Paulhaus & Trapnell, 1997; Liberman, Arndt, Personius, & Cook, 2001). People need constant support and validation for their worldviews. This is not a simple issue, since people do not always share the same beliefs. In order to be effective mortality salience should be directed to the essential part of the self. A striking example is as follows; young men who perceive driving as self relevant engage in more reckless driving after mortality salience manipulation than men who do not perceive driving as self relevant (Taubman-Ben-Ari, 2000).

In addition to mortality salience, it is found that uncertainty salience would result in cultural worldview defense. Van den Bos (2001) states that uncertainty salience affects the reactions to perceived fairness. It is also noted that the effects of uncertainty salience are stronger than mortality salience (Van den Bos, Poortvliet, Maas, Miederna, & Van den Ham, 2005; Yavuz & Van den Bos, 2009). On the other hand, it is found that not uncertainty salience but mortality salience manipulation lead Christian medical students to make more serious risk assessment for Christian patients (Arndt, Vess, Cox, Goldenberg, & Ladge, 2009). In line with that, as compared to mortality; uncertainity salience is not effective in terms of future orderliness (Landau, Greenberg, & Sullivan, 2009). Even though there are studies which find out that uncertainty salience act in accordance with any other

control manipulations, it is a successful attempt which questions the death issue within the terror management perspective.

2.1.2 Death Anxiety and Terror Management Theory

According to Becker (1973) fear of death is innate and important. The underlying fear that TMT addresses is death anxiety. However, what is actually meant by the death anxiety is a question that goes unanswered. It is thought that the term death anxiety is self explanatory. In addition, there is a tacit assumption that death anxiety is a unidimensional construct (Benton, Christopher, & Walter, 2007). However, death anxiety is conceptualized as a multidimensional construct (e.g. Florian & Kravetz, 1983; Henley & Donovan, 1999a; Depola, Griffin, Young & Neimeyer, 2003; Martz, 2004a). It is argued that a number of dimensions of death might be more fearful than the others. Death of a loved one might be more fearful than the death of self (Henley & Donovan, 1999a). In addition, fear of being destroyed, fear of premature death, fear of unknown, fear of conscious death or fear for the body after death are listed among the dimensions of death anxiety (see Depola et al., 2004 for a discussion). Two different types of death anxiety are also suggested. Existential death anxiety which is conceptualized as unknown death anxiety (i.e. what happens after someone dies) and tangible death anxiety is referred as known death anxiety (i.e. what happens to the body when someone is dying or after death) (Benton, et al., 2007). A recent study which uses fMRI techniques in order to investigate the effects of mortality reveals that neural responses to mortality threat were greater than to pain threat in the certain parts of the brain (Quirin, Loktyushin, Arndt, Küstermann, Lo, Kuhl & Eggert, 2011).

Death anxiety is investigated through a number of studies involving participants with differential characteristics. For instance, Martz (2004b) states that among individuals with spinal cord injuries death anxiety predicts significant levels of post-traumatic stress. Similarly, death anxiety and post-traumatic stress disorder are experienced by people living with HIV/AIDS (Safren, Gershuny, & Hendriksen,

2003). Knowledge of diagnosis of HIV or AIDS by family and partners is also positively correlated with the death anxiety for patients (Hintze, Templer, & Cappelletty, 1993). Another finding in relation to death anxiety is that women with high death anxiety are found to distance themselves from cancer patients (Mosher & Danoff-Burg, 2007). Similarly, patients with brain tumor and their spouses are found to show existential terror and death anxiety although these feelings are not always expressed directly (Adelbratt & Strang, 2000).

Benton et al. (2007) point out that fear of loss and concern about physical appearance concerns are related to death anxiety among the elderly. Morse (2007) argues that during a normal life span death becomes a reality when a person reaches his or her 60s which is when family members, friends, acquaintances, celebrities tend to die or get sick. It is also indicated, however, a significant number of adolescents who experience the death of a grandparent show death anxiety (Ens & Bond, 2005). In line with that, younger Chinese participants are found to be more death anxious than older ones (Tang, Wu, & Yan, 2002). This demonstrates that death anxiety is a universal phenomenon, regardless of language, religion, culture and situation (Abdel-Khalek & Thomas-Sabado, 2005).

It is discussed that the attitude towards death has changed radically during the twentieth century. In the past, death was conceptualized as a natural process. Many people experienced *quick deaths.* Today, however, many people are suffering from *slow deaths* accompanied by severe symptoms (Adelbratt & Strang, 2000). Similarly, Long (2004) concludes that many healthy adults hope for an easy death without much suffering or pain. In modern societies, death is regarded as a failure. It is a great journey and the beginning of a great loneliness (Elias, 1985; Greenberg, 1986). The people who survive are considered to be victors (Little & Sayers, 2004) and the ones who die are victims.

2.1.3 Terror Management Theory in Turkey

A number of studies in Turkey adopt the terror management perspective. Aslıtürk (2001) find that mortality salience manipulation would result in higher punishment for social and personal transgressors. Compared to control group participants; participants in the mortality salience condition favored heroes more. Death primes are also found to be effective in increasing the reports regarding health-promoting behaviors among younger participants (Bozo, Tunca, & Şimşek, 2009). Kökdemir and Yeniçeri (2010) state that as compared to control group participants the participants in the mortality salience group show in-group bias. It is also found that as compared to existential ones defensive believers become more conservative after mortality salience manipulation (Koca-Atabey & Öner-Özkan, in press). On the other hand, Yavuz and Van den Bos (2009) show that both mortality salience and uncertainty salience are effective in Turkey. Şimşek's (2005) modeling in terms of TMT reveals that the most important factor of psychological counseling with regard to death-related phenomena is attachment. Even though the results failed to reach the significance level, Çamlı (2010) discusses that as compared to a control manipulation, mortality salience manipulation tended to lead supporters of headscarf to evaluate both religious and secular essay more favorably yet, the liberal essay less favorably.

2.2. Models of Disability

There are two competing models of disability. The older one is the medical model and the newer one is the social model. The medical model emphasizes the biological as opposed to the social conditions. It regards disability as an illness which should be conceptualized within clinical terms (Ong-Dean, 2005; Oliver, 1996). The social model of disability originated in early 1970s (Shakespeare, 2005), with the simple realization that disability is a product of social organizations more than of personal limitations (Oliver, 1996). Hence, the social environment that a

person lives in is the main cause of his or her disability (Davis & Green, 1999). Therefore, disability is a socially constructed phenomenon (Kelley-Moore, Schumacher, Kahana, & Kahana, 2006).

According to the social model, *impairment* refers to the functional limitation(s) that affect(s) a person's body, whereas disability refers to the loss or limitation of opportunities owing to social, physical or psychological obstacles. For instance, an inability to move one's body is an impairment but an inability to get out of bed because of a lack of physical or technical assistance is a disability (Morris, 1993).

The term disabled and non-disabled are preferred instead of *people with disabilities* and *able-bodied* in order to emphasize the society's role (Morris, 1993). That is, the usage of the term *people with disabilities* implies that disability is like a piece of luggage that someone carries (Davis & Green, 1999). However, most disabilities are permanent and disabled people can not discard them. According to the social model, disability is a human rights issue and it is the responsibility of the society to provide accessibility for the disabled people (Isaac, Raja, & Ranavan, 2010).

The medical professionals are given the role of *experts* who would treat and/or rehabilitate disabled people. This understanding equates disability with illness or impairment which is a clear misconception (Oliver, 1996; French & Swain, 2004). According to the findings of a study conducted among children; ill, elderly and disabled people are equated (Skar, 2010). This equation is almost automatic and it is also evident in Turkey (e.g. see the report of Başbakanlık Özürlüler İdaresi Başkanlığı, 2009). It is true that some illnesses may have disabling consequences and many disabled people might get ill at various points in their lives. However, doctors can only stabilize the initial condition by treating the illness, which may or may not be related to disability (Oliver, 1996). In addition, the

attitudes of medical professionals are found to be disabling and frustrating. A wheelchair-user participant states that:

> It's like when you go to the hospital or the doctors, if you go with anybody because you're in a wheelchair they don't address you, they look over you and that really infuriates me (Sapey, Stewart & Donalson, 2005, p. 494).

The medical model is closely associated with the tragedy model. According to the tragedy model, a person who is blind is experiencing a personal tragedy, which is caused by not being able to see (Morris, 1991; Davis & Green, 1999). "The tragedy model is in itself disabling. It denies disabled people's experiences of a disabling society, their enjoyment of life, and their identity and self-awareness as disabled people" (Morris, 1991, p. 35). It is believed that disabled people are unhappy, ineffectual and feeling that they are worthless, ugly, asexual and inadequate (Morris, 1991; Vash, 1993; Tufan, 2008). Disabled people are expected to deny their impairment and be superhuman (French, 2004). Shakespeare (2005) states that valuing youth and beauty regardless of all costs would result in unhappiness and dissatisfaction in the society. .

Some researchers argue that together with the tragedy model, the medical model constitutes the individual model (Morris 1993; Oliver, 1996). According to this model, disability is an individual problem that requires professional dominance, care, control and individual adaptation. Social model, on the other hand, evaluates the disability as a social problem, values individual and collective responsibility, choice, rights and social change. Politics instead of policy and self-help instead of medicalization (Colucci, 2006) is highlighted (Oliver, 1996) (see Table 1 for a summary relating the medical and social model of disability).

Table 1. *The two main models of disability: Fundamental assumptions*

Source. Adapted from Oliver (1996, p. 34).

The Medical (Individual) Model of Disability	The Social Model of Disability
Personal Tragedy Theory	Social Oppression Theory
Personal Problem	Social Problem
Individual Treatment	Social Action
Medicalisation	Self-Help
Professional Dominance	Individual & Collective Responsibility
Expertise	Experience
Adjustment	Affirmation
Individual Identity	Collective Responsibility
Care	Rights
Control	Choice
Policy	Politics
Individual Adaptation	Social Change
Passive	Active
Institualization	Participation
Abnormal	Different

Rock (1996) argues that since we are not living in a hunters and gatherers type of society any more, it is possible to take on the responsibility for the needs of disabled people. However, in general, disabled people are forced to live in a *nonsustainable* physical (Casas, 2007) and a *prejudiced* social environment (Hahn, 1988). The exclusion that the disabled people experience can have many different forms. Not being consulted, feeling that they are causing burden, being restricted about the age-related extracurricular activities (e.g. going to cinema for teenagers), being harassed or suffering from poverty might be listed among the examples

(Morris, 2001). In addition, disabled students have a longer journey towards education (Koca, 2005). Even though there are some enabling advancements in recent years (e.g. Roulstone, 2002), disabled adults are still having difficulty in finding jobs, even when they are employed they are generally underpaid and career-restricted (e.g. Ginsburg, 1985; Slappo & Katz, 1989). It should be also noted that, a disabled person might have extra costs for the issues such as transportation or payments for personal assistance hence at the same level of income a disabled person might achieve a lower standards of living than a non-disabled person (Burchardt, 2004). The condition for a disabled person is quite difficult in our country. Tufan (2008) argues that, in Turkey, disabled people are excluded in almost every area of the society. They are devalued regarding their physical environments, legal rights, and dependency on institutions. It is obvious that the general disability framework in our country is based on the medical model of disability, perceiving the disabled as a *repairable person* who is ill (Thimm, 1994; cited in Tufan, 2008). However, disability should be interpreted as a conception which rests upon social conditions (Tufan, 2007).

Tøssebro (2004) argues that disability could be conceptualized as a mismatch between the person and environment. In addition, he adds that disability is situational, meaning that a blind person is not disabled on the phone. Shakespeare (2004) states that everyone is impaired, to varying extents, and at different times. However, only some of them experiences disabling barriers or social oppression. A striking example is as follows; Stein (2010) breaks his right arm which is an already disabled limb. He argues that all the attitudes towards his right arm are transformed. It becomes socially legitimate. Nobody expects him to lift large objects or feel confused about providing help. He states that in terms of the functionality of his arm nothing has been changed. An actually disabling event, change the perceptions and make him non-disabled.

2.2.1 Limitations of the Social Model of Disability

It should not be assumed that social model can explain everything. Morris (1991) argues that:

> …there is a tendency within the social model of disability to deny the experience of our own bodies, insisting that our physical differences and restrictions are *entirely* socially created. While environmental barriers and social attitudes are a crucial part of our experience of disability- and do indeed disable us- to suggest that this is all there is to it is to deny the personal experience of physical or intellectual restrictions, of illness… (p.10).

Although the denial of the physical aspects of disability is a pragmatic attempt in order to emphasize society's role in the disability issue and provoke collective action (Oliver, 1996), this may not be always accurate. As stated by the social model, classifying disabilities according to the levels of physical impairments is regarded as unacceptable (Zarb, 1995). Assessing the physical impairments, however, is a crucial step in deciding what levels of assistance that disabled individuals need. It is also argued that within the tenets of social model, the number of disabled people is not relevant (Shakespeare, 2006); however it is especially important at least at the economical or political level. A classification regarding the disability impairment types might have practical advantage. For instance, Crow (2008) listed three different types of visual impairments; total blindness, low vision and color blindness. The type of visual impairment is especially important regarding the development of instructional web sites for online learning. On the other hand, although the loss discourse is obviously rejected by the social model, its therapeutic benefits among disabled adults are recorded (Watermeyer, 2009). Powdthavee (2009) argues that as compared to less severe ones adaptation to a severe disability might be incomplete. A recent study indicates that the severity and visibility of a person's disability (conceptualized as disability burden index) is an issue in terms of the psychological symptoms that is experienced by disabled university students

(Koca-Atabey, et al., 2011). If medical model is criticized on the basis of equating illness and disability; social model could be criticized in equating all different types of impairments. On the other hand, Shakespeare (2006) states that polarization and creating a dichotomy is in itself dangerous. It should not be forgotten that although social model is a revolutionary approach, it could be simplistic and misleading in some respects (Shakespeare, 2004).

It is clear that disability is social since living is not just breathing (Cankurt, 2009), it is a social issue. However, caution might be taken in order not to over generalize the social aspect and underestimate the physical and psychological aspects of disability. For instance the types of disabilities and the severity of the disability could not be disregarded in a society where the medical model of disability is dominated. Shakespeare (2006) argues that regardless of the level of accessibility that is provided by the society '…there will be always residual disadvantage attached to many impairments' (p.50). It is also stated that the hierarchy of impairments is important since the ones who ranked the lowest would face the most discrimination in the society (Deal, 2003).

A newer model, cultural model of disability is proposed since social model is evaluated as insufficient. It is argued that:

> Disability is socially and culturally constructed phenomenon. Its very existence is the result of a historical and political process in which it became relevant to separate disabled people from non-disabled people… The construction of disabilities in different societies is influenced by global ideas such as human rights but also by local meanings. Depending on these meanings, social behavior will result in rather including or excluding… (Devlieger, Renders, Froyen, & Wildiers, 2006, p.13)

Devlieger (2005) discusses that the existence of multiple models is much more effective than one dominant model. Smart (2009) also acknowledges the diversity of the models within the disability framework and offers an interactional model which possess the advantages of two or more models.

2.2.2 Disability Studies in Turkey

Apart from the literature regarding special education and medicine, disability studies in Turkey is a relatively new phenomenon. Tufan (2007) also acknowledges that issue and concludes that:

> There is no need to create myths to improve the social conditions of the disabled in Turkey. If researches revealing their objective life conditions are carried out, each disabled individual might be seen as a legendary hero in the views of the non-disabled since despite a number of abstraction mechanisms existing in society, their lives, themselves, remind us of legends. The only thing to be done is to inform society of their real-life conditions (pp. 177-178).

Although Tufan's (2007) argument could be evaluated within the framework of tragedy model, his point is important since the normal condition of disabled individuals in Turkey is extraordinary. In a different study, Tufan (2008) provides the fact that in order to improve the quality of life for disabled people; disability awareness training programs might be beneficial. A few numbers of studies are conducted regarding the university experience of disabled students. Disabled students indicate that they have problems in taking exams, using library, and utilizing cafeteria services (Dökmen & Tutarel-Kışlak, 2004). Burcu (2002) states similar problems and concludes that regarding their additional problem disabled university students should be supported. Koca-Atabey (under revision) discusses that the lack of a formal, well-established support system for disabled university students is listed among one of the major problems. This problem is tried to be managed by the social support network (i.e. families and friends) of students. However, most of the time, this effort becomes insufficient both quantitatively and qualitatively. A more disability-friendly environment together with a well-established, formal support system is necessary in order to empower disabled university students (Koca-Atabey, et al., 2011). Bezmez and Yardımcı (2010) discuss about the disability within the framework of related organizations and conclude that unfortunately a rights-based approach is not

dominant in these organizations. In the future, the charity-based approach might become more powerful among these organizations. Although it is depicted as the worst possible outcome, the authors acknowledge a risk.

2.3 Death Anxiety and Disability

In disabling societies, the quality of a disabled person's life is usually poor. A physical disability is considered to affect the quality of a person's life profoundly (Rokach, Lechcier-Kimel, & Safarov, 2006). These societies do not allow disabled members to live successful and meaningful lives so it becomes difficult to achieve a *good death.* Conversely, even the *premature death* of a disabled person is viewed as merciful (Priestly, 2003). On the other hand, Martz (2004c) argues that disabled individuals may experience existential crises triggered either by disability or by disability-related stigmatization. Existential anxiety is described as the threat of potential loss of functional capabilities by the non-disabled. People may vocalize such concerns: 'I would rather be dead than live as a paraplegic (or blind, deaf or immobilized)' (Hahn, 1988, p. 43). The main reason of this conceptualization might be that a youthful appearance is associated with certain positive characteristics (Benton, et al., 2007) and health has been identified as a marker of social status (Twaddle, 1974; cited in Kelley-Moore, et al, 2006). Disabled person might also experience a negative halo effect (see Abikoff, Courtney, Pelham, & Koplewicz, 1993 for a discussion) due to his or her condition. It might be also conceptualized as spread. For instance, '… physical disability is perceived as other physical aspects of a person. Thus a blind person cannot see it is sometimes taken for granted that he cannot hear.' (Wright, 1960, p.118).

Fish (1986) argues that a physically disabled person is evaluated as having progressed further than non-disabled people on the journey towards death. According to Weinberg (1972) just the sight of disabled people might be a conscious or unconscious reminder about own mortality (cited in Beaulaurier &

Taylor, 2001). Similarly, it is stated that a physically disabled person could act as a reminder of one's own mortality. It is found that death anxiety is positively associated with psychological and physical rejection of physically disabled people (Livneh, 1985). Furthermore, disability might be regarded as a *living death* condition (Greenberg, 1986). On the other hand, disabled people, themselves, (e.g. multiple sclerosis patients) might also adopt a prejudiced, isolated and passive life style due to their fear of death (Thornton & Lea, 1992). Similarly, Morris (1991) mentions that even disabled people themselves might think that their lives are not worth living.

It is argued that there are similarities between the attitudes towards dying and the attitudes towards physically disabled (Livneh, 1985). Fish (1986) argues that there is a negative relationship between the attitudes toward disabled people and the levels of death anxiety. His study reveals that counselor trainees who were master's degree students who have higher levels of death anxiety have less favorable attitudes towards disabled people.

It is possible to divide disabilities into two basic categories; congenital and acquired ones. A disrupted body image, functional limitations, loss and trauma might be experienced after acquiring a physical disability (Livneh & Antonak, 2005). One other category relating disabilities might be about hidden disabilities. Although they have the *advantage* of choosing between being and not being disabled they may also feel to fit in a gray category and have difficulty in expressing themselves (Valeras, 2010). Siebers (2004) also states that; as a person with polio, a gatekeeper in an airport told him that; he has to use a wheelchair in order to be accepted as disabled. He argues that this kind of exaggeration is nothing but a masquerade. These *in between* status is also appraised by the people who have episodic disabilities (e.g. heart condition, diabetes or asthma) they usually think that they are not disabled enough (Lightman, Vick, Herd, & Mitchell, 2009). In Turkey, this is also applicable to the situation of people who are disabled but their condition does not let them to get a 40 % disability-report.

Parkes (1975) claims that the loss of a limb and the loss of a spouse are comparable conditions. They both involve an unwanted loss. In addition, the two experiences are resulted in similar emotions such as preoccupied thoughts, visual memories, difficulty in believing what happened, and avoidance of reminders. Grief, denial and missing are also seen both in amputees and widows.

Death and disability share a number of common characteristics. For instance, both death and most of the disabilities are permanent and irrevocable. Morris (1991) points out that it is a misconception to believe that disabled people *crave* to be normal and never *give up hope* of a cure. In fact, many disabled people do not think that they are abnormal and do not constantly look for cures. Moreover, both death and disability involves loss. Loss of a body part, loss of functionality or loss of life… Since, disability does not involve a total loss it may appear to be easier to tolerate. However, since we are living in *prejudiced* societies in which beauty is so much valued, many people may prefer death to disability (e.g. Hahn, 1988). It is possible to discuss disability in relation to death (the medical model). Since disability is a type of illness, it may be argued that it might be a pre-condition of death. Conversely, according to the social model death and disability have nothing in common. This perspective argues that disability is *a fact of life*, a different life experience which might be interesting and affirmative (see Morris, 1991; Oliver, 1996; French & Swain, 2004).

An important distinction between death and disability is that the degree of certainty and the fairness of each issue. Death might be regarded as more certain as and fairer than disability. In the case of death, recovery is impossible and there is the only chance of symbolic resurrection. Although most disabilities are permanent or have long-term effects (e.g. Greenberg, 1986), disability is conceptually less certain than death. Similarly, only some people (a minority in number) are disabled but everyone dies which makes death fairer than disability (see Table 2 for a conceptual comparison between death and disability)

Table 2. *Death & Disability: A comparison.*

DEATH	DISABILITY
Permanent	Most of them are permanent or have long term effects
Irrevocable	Most of them are irrevocable
Total loss	Loss of body part and/or functionality *Loss of quality of life, loss of status, loss of significant others, loss of job*
Uncertain	Relatively certain
Fair (all people die)	Not fair (only some people are disabled)
May or may not include suffering	Includes suffering especially in certain environments
No hope for recovery (expect life after death or reincarnation)	Relatively hopeful
Inevitable	Some of them are evitable

The underlying reason for the disability anxiety might be the cultural representations of disability which are terrifying. Brisenden (1986) argues that people failed to see the person behind the image of disability. A disabled person is represented as childlike and lacking the adult attributes (Priestly, 2003). For instance, Black and Pretes (2007) argue that there are a number of films which depict physically disabled persons as excluded from the society. In such films the characters do not engage in daily living tasks such as working or going to shopping. Regarding disabled people if not visible invisible barriers (Shannon, Schhoen, & Tansey, 2009) persist in societies. One of the key features of such disabling society is the psychocultural representation that it provides. This type of representation is mostly evident through the prejudiced terminology. *Visual handicap, sightless* and *the blind* might be the examples of such terms (Bolt, 2005). It is argued that the negativity in the society relating disabilities is due to the media which shapes and reflects the society (Hargreaves & Hardin, 2009). Being an issue which terrifies people, it could be argued that similar to death, disability might be an existential problem. Although people who prefer death over suffering are regarded as exceptional (Solomon, et al., 1997) it should be also discussed that for a number of people, death might be preferred over disability (e.g. Hahn, 1988).

TMT discusses death as an existential fear (Becker, 1973) and people try to overcome this problem. Religion, for instance, solves the problem of death with promising for heaven (Becker, 1973; see Lerner, 1997 for a discussion). Although it is beyond the scope of this dissertation, the interaction between the religious beliefs and TMT is widely investigated (e.g. Jonas & Fischer, 2006; Beck, 2004; 2006). Even if religious coping might be used by disabled people or their significant others (e.g. Bennett, Deluca, & Allen, 1995; Dura-Vila, Dein & Hodes, 2010) or provide personal relief and avoid repelling (Bezmez & Yardımcı, 2010), it does not provide a complete answer. Neither religion nor medicine could solve the disability problem. For instance, Hull (2001a, 2003a) argues that although Christianity acknowledges disabilities; it is in the form of marginalization which excludes a different human body. According to this view, Bible is written for sighted people

(Hull, 2003b). It could be further concluded that death may not include suffering but disability includes suffering especially in certain environments. Therefore, as death anxiety is a culture-free phenomenon (e.g. Abdel-Khalek & Thomas-Sabado, 2005), disability anxiety might be a culture-bond issue.

2.4 Disability Anxiety

The models of disabilities are discussed at the collective level. These models might be adopted and applied by groups of people. However, one should also study the individual representations of disability within the light of these models. A person who might adopt a medical perspective or somehow influenced by the medical model towards disabilities may experience disability anxiety. On the other hand, a participant who might believe in social model or somehow influenced by the social model may or may not show disability anxiety depending on the environmental conditions. A person who adapts the social model perspective and who lives in a disability-friendly environment would have either no disability anxiety or a minimal level of disability anxiety. If such person is living in a disability-unfriendly environment he or she might experience disability anxiety (see Figure 1). Therefore, the term disability anxiety utilized in order to refer to the anxiety that a non-disabled person might feel when exposed to a possible/future disability. The present dissertation would concentrate upon the consequences of disability anxiety in Turkey where the medical model is dominant.

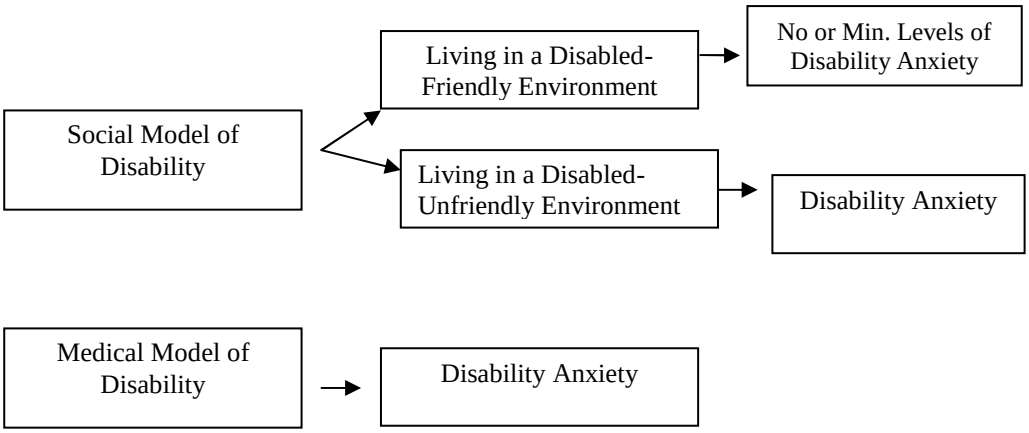


Figure 1. The possible antecedents of Disability Anxiety

A closer look at the disability representations reveals that disabled people might be conceptualized as forming a unique group of people (e.g. Shevlin, Kenny & McNeela, 2004) who are continuously suffering. It is also believed that nothing could be gained from the disability experience (Morris, 1991). When people think of disability, the first thing that comes to minds is generally a visualization of a wheelchair. Wheelchairs are the symbols of disability even though only a small minority of disabled individuals, less than 10 %, uses them. A wheelchair user is conceptualized as a dependent person (Sapey, et al, 2005), signifying loss rather than death. Although this sort of understanding could be an indication of medicalization of disability, it also points out that disability might lead to a different kind of fundamental fear.

It is argued that the underlying fear behind the disability issue is the fear of loss. Loss of the quality of life, loss of the status, loss of job or loss of loved ones. However, the amount of loss for a disabled person depends on the environmental circumstances, as a disabled person I might be more disabled in Africa but less disabled in Europe. Since each disabled person has his or her own condition (Beaulaurier & Taylor, 2001) the assessment of the surrounding conditions should be argued at the perceptual sense. In line with that, Varni and Setoguchi (1996) also

argue that the objective rating of limb loss is not correlated with perceived physical appearance among adolescents.

TMT suggests that the only explanation of the cultural worldview defense is death awareness and anxiety. It might be discussed that disability salience might produce the same or stronger effects regarding the worldview defense than mortality salience. Further research is needed in order to clarify the underlying reason behind the disability anxiety. Especially for people living in *prejudiced* societies (Hahn, 1988) disability salience manipulation might lead people to remember something which are different and possibly worse than death. The examples might be continuous suffering or total dependency. If disability salience and mortality salience are compared when the effects of death anxiety are controlled then *loss anxiety* might appear to be a more fundamental. Henley and Donavan (1999) argue that it is a mistake to compare death threats with non-death threats, since death is a *special case* that is qualitatively different. Currently, TMT research compares death anxiety with other types of anxieties such as exam failure or dental pain (e.g. Pyszczynski et al., 1997; Solomon, et al., 2000). Although there are a number of studies which use different control conditions such as intense physical pain (e.g. Florian et al., 2002; Landau, et al. 2004) or social exclusion (e.g. Schimel et al., 1999), they also do not result in worldview defense reactions. If research proves the point that disability anxiety and death anxiety are distinct fears or that disability anxiety is a fear that stems from death anxiety, then, it would be a further support for TMT. However, research could also indicate the point that similar to mortality salience, disability salience also results in worldview defense reactions. In that case, it would be essential to discuss about a more fundamental fear such as anxiety that relates to uncertainty as Van den Bos (2001) argues; or *loss anxiety* as this dissertation suggests. Whichever is the case, more appropriate solutions for the disability problem might be provided. This might be beneficial for both disabled and non-disabled individuals.

Uncovering the elements of disability anxiety could make it easier to address with the negative attitudes towards disabled people. Although there are studies, which emphasize the role of contact, education or disability awareness programs (e.g. Daruwalla & Darcy, 2005); a more comprehensive solution to the disability issue may be provided after the roots of disability are revealed. One of the main intentions of TMT research is to answer the following question: "Why do people have such a hard time getting along with each other, especially those who are different from themselves?" (Pyszczynski, 2004, p. 827). The issue relating disabled people might provide an answer to this basic issue.

2.5 Disability Salience in the Literature

In the literature, the term *disability salience* is used as synonyms to the visibility of disability. Diamond and Hestenes (1996) state that preschool children differentiate disabilities and they are more aware of the physical disabilities which are more salient. Similarly, if a student appears in a wheelchair in the first day of the class, everyone in the room is likely to form an impression that is mostly influenced by the fact of person's physical disability. Clothing, hair style, and perhaps even age, race and sex will all be secondary (Taylor, Peplau, & Sears, 2000). This argument is experimentally tested and it is revealed that targets with disability (i.e. using a wheelchair) are immediately described by disability independent of gender and ethnicity, whereas targets without disability (i.e. riding a bike) are primarily identified by gender and ethnicity (Rohmer & Louvet, 2009).

"Salience…simply means that the disability is most important, or the only important, aspect of the individual" (Smart, 2001, p. 88; cited in Roach, 2003). So, it could be concluded that disability is identified as a superordinate social category in an asymmetric manner. Meaning that, participants never described targets without disability as able-bodied (Rohmer & Louvet, 2009). The salience of disability might

also negatively affect disabled people themselves. For instance, disabled university students respond negatively to functional clothing when the special feature relating the disability is made salient (Wingate, Kaiser, & Freeman, 1986).

2.6 Terror Management Theory and Disability

Disability and TMT is only associated in a few studies. For the women participants death primes result in increased compassion towards disabled people however for men they result in decreased compassion (Hirschberger, et al., 2005). It is also suggested that death primes led to a more negative evaluation of the confederate in a wheelchair in the individual task condition. However, this effect was attenuated in the collaborative task condition. It is argued that these effects confirm the death-disability rejection link (Ben-Naim, Aviv, & Hirschberger, 2008). Adolescents are found to report more positive attitudes towards a disabled peer after mortality salience manipulation. This effect also becomes evident after the induction of a positive affect (Taubman-Ben-Ari, Eherenfreund-Hager, & Findler, 2011).

The prospect of being paralyzed (i.e. paralysis salience) is used as a control condition in one study (experiment-3) (Arndt, Greenberg, Solomon, Pyszczynski, Schimel, 1999). This study reveals that although only participants in the mortality salience condition respond to the dependent variable which is social projection, paralysis salience act different than the other control condition (i.e. dental pain); it has differentiating effects on creativity which is the second independent variable of the study (Arndt, et al., 1999). Arndt (January 11, 2011, personal communication) indicates that they have not found that paralysis differs from other aversive control topics, however they have not really focused on whether or what unique effects paralysis may have. Burke et al. (2010) argue that either negative-threatening or nonnegative control topics provide similar results; so they concluded that death is qualitatively; not just quantitatively a unique phenomenon. However, the present dissertation aims to argue against this issue. More specifically, it is argued that

being qualitatively different disability and death could provide similar levels of threats and terror. Furthermore, it is discussed that the effectiveness of disability is even higher than death.

Disability is also depicted as the reminders of death in the literature (e.g. Beaulaurier & Taylor, 2001; Morris, 1991; Greenberg, 1986). However, the current study is arguing that a variable, "loss anxiety," might comprise both of death and disability (see Figure 2). Alternative models related to the loss anxiety, which offer different conceptualizations, might also be available. Figure 3 depicts the three possible alternatives. There could be an overlap (with differential degrees) between death anxiety and disability anxiety (see Figure 3-A and 3-B). One other possible solution is that, death anxiety might totally comprise disability anxiety, then the presence of the loss anxiety concept become vague and questionable (see Figure 3-C).

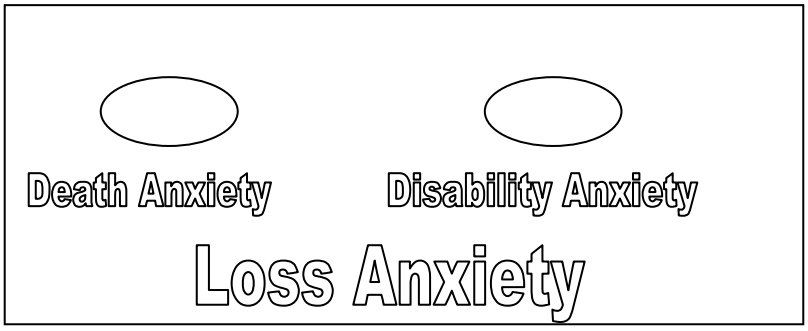
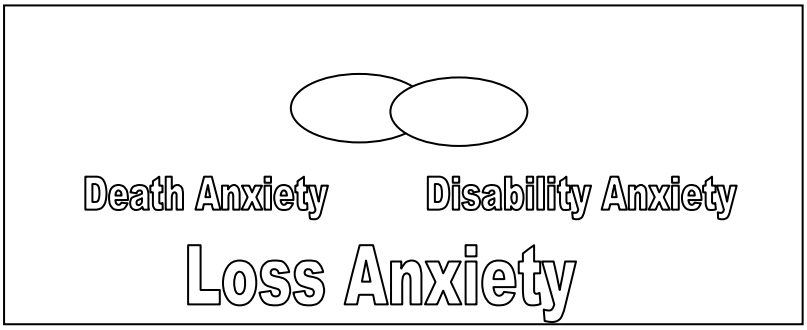
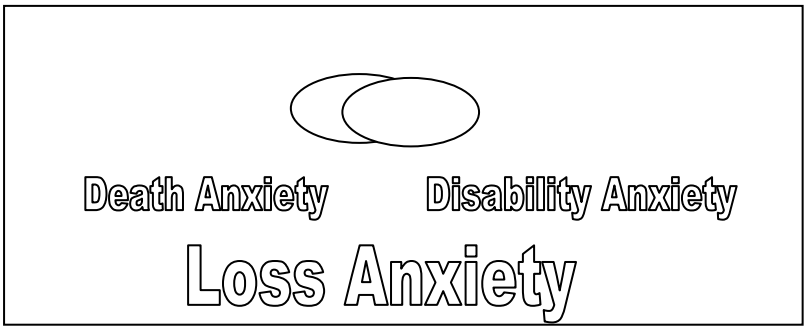


Figure 2. The proposed conceptualization of Loss Anxiety

A



B



C

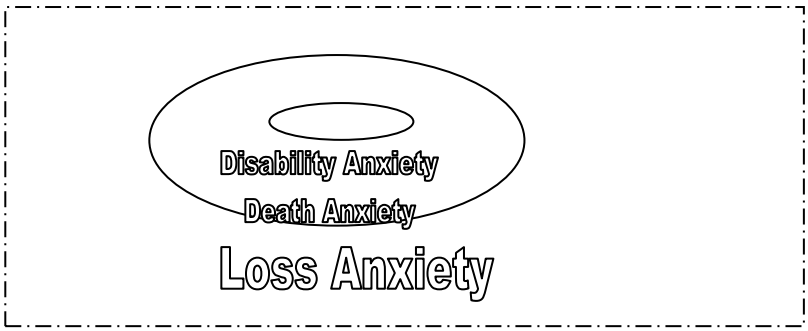


Figure 3. Alternative conceptualizations of Loss Anxiety

It might be valuable to discuss the negative reactions of non-disabled individuals towards disability. Disability is being used as synonyms to inability and perceived for instance as incompatible with the image of a physician (Wainapel, 1999; Amosun, Volmink, & Rosin, 2005). It is also argued that person's disability is often perceived as a negative trait (Amosun et al., 2005). On the other hand, wheelchair users are depicted as happy and contented with the *sick role* (Sapey, et al., 2005). Also, non-disabled people may behave an adult wheelchair user as a child (Liesener & Mills, 1999). This attitude is summarized as 'Does he take sugar?' approach which derogates and devalues disabled people (Pain & Wiles, 2006; Quicke, 1988). A participant mentions that: 'They think that because you are in a wheelchair you haven't got a brain.' (Pain & Wiles, 2006, p. 1215). All the examples revealed are the depictions of obsessive, disabling societies which adopt the medical model of disability.

According to Hahn (1988), for a non-disabled person, the anxiety of a future/possible disability is higher than the death anxiety. Death which is inevitable might be preferred over disability which is more evitable. There might be other circumstances which lead people to choose death. For a person who has a terminal illness, endures abject pain; the ultimate terror is not death but the continuation of life (Snyder, 1997). Muraven and Baumeister (1997) argue that death can not be the master motive for human beings because people may choose to die. The issue relating suicide and disability is also important to further explore. Miller (1993) argues that the society encourages suicide for disabled people (see also Holroyd, 2003; Burcu 2003; Priestly, 2003). According to this view, suicide is not a preference but a rational act for them which verify the fact that disabled people are living in obsessive environments. Actually, it is a misconception to conceptualize disabled people at continuous suffering (Morris, 1991) which may lead them to commit suicide. It seems that, people might commit suicide when other options are available and if that is the case then one may question death as an existential fear.

2.7 Hypotheses of the Study

It is assumed that as a comprehensive framework loss anxiety might underlie both death anxiety and disability anxiety. If that is the case, then both mortality salience and disability salience conditions would produce similar effects in terms of terror management theory. It might even be possible that there might be instances where disability salience would be more effective than mortality salience. Therefore, it is thought that not just as mortality salience; but also disability salience (i.e. paralysis salience and blindness salience) would be effective on worldviews. Meaning that, participants would demonstrate worldview defense reactions in mortality salience, blindness salience and paralysis salience conditions. Additionally, it is thought that, participants' prior beliefs relating the specific worldview would be essential. The current study would further explore whether there are any qualitative and/or quantitative differences between death and disability. In line with these, the following hypotheses are going to be tested:

H1: The participants whose initial conservatism/personal transgression/social heroism/attitudes towards disabled people scores were low; would score lower in mortality salience, blindness salience and paralysis salience conditions as compared to participants in the control condition.

H2: The participants whose initial conservatism/personal transgression/social heroism/attitudes towards disabled people scores were high; would score higher in mortality salience, blindness salience and paralysis salience conditions as compared to participants in the control condition.

H3: Blindness salience and paralysis salience conditions would be more effective than the mortality salience condition.

H4: Disability (i.e. blindness and paralysis) would be qualitatively different than death.

H5: Blindness and paralysis would be qualitatively similar.

The study would utilize conservatism, personal transgression, social heroism and attitudes towards disabled people scales as the independent (Time 1 assessment) and dependent (Time 2 assessment) measures since they are widely used in the TMT literature (e.g. Rosenblatt, et al., 1989). For instance, participants show diminished appreciation to modern artwork after mortality salience manipulation (Landau, Greenberg, Solomon, Pyszczynski, Martens, 2006). Similarly, Chinese participants are found to evaluate birth control policies negatively after mortality salience reminders (Zhou, Liu, Chen, & Yu, 2008). These dependent measures are the indicators of conservatism. Another study indicates that death reminders increase political conservatism and support for President Bush among Americans (Landau et al., 2004). It is also stated that as opposed to liberals conservative participants show intolerance towards a dissimilar (i.e. liberal) target (Greenberg, Simon, Pyszczynski, Solomon, & Chatel, 1992). The applicability of these measures was already tested in Turkey (Aslitürk, 2001; Koca-Atabey, 2010). These dependent variables were also thought to be conceptually relevant to the disability issue.

CHAPTER 3

METHOD

3.1 Participants

Data was collected from 278 undergraduates from three different universities in Ankara namely Hacettepe, Gazi and Middle East Technical University [METU]. They were between the ages of 18-27 with a mean of 20.19 (SD: 1.24). There were 181 females (65.1 %) females and 97 (34.9 %) males. Most of the participants indicate their income level as moderate (88.8 %). There are 173 sophomores and 84 juniors as compared to 15 seniors and 5 freshmen.

3.2. Instruments

Two packages of questionnaires were administered to participants with two weeks interval.

3.2.1 Demographic Information Sheet

The Demographic Information Sheet consists of nine items including basic demographic questions such as age, gender, university-department, income level. In addition, a single item question was asked in order to assess an existing disability. Participants were also asked about the perceived severity of different disability types (1 = lightest, 5 = most severe) (see Appendix A).

3.2.2 Social Heroism Scale

Social Heroism Scale [SHS] was developed by Aslıtürk (2001) with the rationale that mortality salience leads to an increase in rewards offered to heroes. Nine items (2 added for the present study) with an 11-point likert scale (1 = very little reward, 11 = very much reward) (e.g. 'The person who found a wallet and returned it to its owner.') was administered. The reliability coefficient of the scale for the current sample was .77 (split-half reliability was .82) for the longer version of the scale and .76 (split-half reliability was .74) for the shorter (original) version (see Appendix B). The longer version of the scale was used in the analysis.

3.2.3 Personal Transgression Scale

Personal Transgression Scale [PTS] was developed by Aslıtürk (2001) in order to measure the effects of mortality salience reaction to direct moral transgressors. Nine items (2 added for the present study) were scored by the participants with an 11-point likert scale (1 = very light punishment, 11 = very heavy punishment) (e.g. 'The father who abandons his wife and children.'). The reliability coefficient of the scale for the current sample was .70 (split-half reliability was also .70) for the longer version and .66 (split-half reliability was .74) for the shorter (original) version (see Appendix C). The longer version of the scale was used in the analysis.

3.2.4 Attitudes towards Disabled People Scale

The Attitudes towards Disabled People Scale [ADPS] was a 19-items scale with a .76 alpha reliability. There were 17 reversed items (e.g. Contact with a disabled person reminds me of my own vulnerability.) and the scale was rated on 6 point scale (1 = strongly disagree, 6 = strongly agree). Higher scores indicate a more positive attitude towards disabled people (Koca-Atabey, 2010). The alpha reliability for the current sample was .67 and the split-half reliability was .74. A five-factor

solution of the scale is able to mention about four different disability-related areas; which are individual contact, social contact, feeling uneasy and unsure about disability, the consequences of living with disability and beliefs about disability. The factor structure points out that the scale is content valid since it comprehends different aspects of the disability phenomenon (Koca-Atabey, 2010) (see Appendix D).

3.2.5 Conservatism Scale

The Conservatism Scale [CS] was a 50-items scale developed by Wilson and Patterson (1968). The alpha reliability of the scale was .83. The adaptation of the scale was conducted by Koca-Atabey and Öner-Özkan (in press) with a 47-items solution (e.g. Birth control should be applied). Odd-numbered questions (yes = 2, no = 0, uncertain = 1) and even-numbered questions (yes = 0, no = 2, uncertain = 1) added to achieve a conservatism score for each participant. Higher scores indicate higher levels of conservatism. The internal consistency was found as .87. For the current study, even number questions were reversed and all questions were coded similarly (yes = 3, no = 1, uncertain = 2). As in the original case higher scores indicate higher levels of conservatism. The alpha reliability for the current sample was .82 and split-half reliability was .85. Similar to Wilson and Patterson's procedure (1968), the scale was validated by a known group analysis. The participants studying theology were found to be more conservative than the regular university students. Similarly the participants who reported to vote for right-wing parties were found to be more conservative than the participants who voted for left-wing parties (Koca-Atabey & Öner-Özkan, in press) (see Appendix E).

3.2.6 Mortality, Disability & Control Salience Measures

Participants in the mortality salience [MS] condition were asked to indicate answers to the following questions (a) Please briefly describe the emotions that the thought of your own death arouses in you and (b) Jot down, as specifically as you

can, what you think will happen to you as you physically die and once you are physically dead.(Appendix F). For the participants in the TV salience [TS] condition (control condition), participants were asked to indicate answers to questions (a) "Please briefly describe the emotions that the thoughts of watching television arouses in you," and (b) "Jot down, as specifically as you can, what you think will happen to you physically as you watch television and once you physically watched television (Appendix G) (e.g. Greenberg et al., 1990; Goldenberg, Pyszczyniski, Greenberg, Solomon, Kluck, & Cornwell, 2001). In the blindness salience [BS] condition, students were asked to indicate answers to: (a) Please briefly describe the emotions that the thought of becoming totally blind arouses in you and (b) "Jot down, as specifically as you can, what you think will happen to you if you become totally blind (Appendix H). In the paralysis salience [PS] condition, students were asked to indicate answers to two parallel questions as (a) Please briefly describe the emotions that the thought of becoming totally paralyzed in lower extremities arouses in you and (b) "Jot down, as specifically as you can, what you think will happen to you if you become totally paralyzed in lower extremities and once you physically became totally paralyzed in lower extremities (Appendix I).

3.2.7 Positive and Negative Affect Scale

Positive and Negative Affect Scale [PANAS] (Watson, Clark, & Tellegen, 1998) was used to assess any mood changes after mortality salience manipulations (e.g. Dechesne et al., 2003). The scale consisted of 10 positive (PA) and 10 negative (NA) adjectives answered on a 5-point likert scale (1 = very slightly or not at all, 5 = extremely). The PANAS was adapted to Turkish by Gençöz (2000), who found two internally consistent factors using a factor analysis with.83 and .86 internal consistencies, relatively. In the present sample, internal consistencies were .91 for PA and .87 for NA. For the criterion-related validity of the scale, Positive Affect states correlations of -.48 and -.22 with Beck Depression Inventory and Beck Anxiety Inventory. The correlations for the Negative Affect were .51 and .47, respectively (Gençöz, 2000) (see Appendix J).

3.2.8 Word Search Puzzle

Research indicates that mortality salience affects were better after a delay (e.g. Greenberg, et al., 1994; Arndt, Greenberg, Solomon, Pyszczynski, & Simon, 1997). A word search puzzle provided from a newspaper was used in the study. It was a relatively easy puzzle which took few minutes to solve. The participants were asked to write down five words each consisted of five letters (see Appendix K).

3.3 Procedure

Initially ethical approval was received from Human Participants Ethical Committee at Middle East Technical University. The study was conducted during regular class hours at three different universities. Participants were told that the study is about 'attitudes on various topics' they were asked to sign the informed consent form and provide a pseudonym for the second administration (see Appendix L). Voluntary participation was essential. A questionnaire package including Demographic Information Sheet, Conservatism Scale, Attitudes towards Disabled People Scale, Personal Transgression Scale and Social Heroism Scale were administered. The scales were provided in counter-balanced order. After two weeks time, the participants were approached again. The second administration involves a brief version of demographic information sheet (see Appendix M), the experimental (i.e. mortality salience, blindness salience, paralysis salience) or control (i.e. television salience) manipulations. After the manipulations participants were provided PANAS for assessing mood changes and a word search puzzle as a delay. The four scales (i.e. CS, ADPS, PTS and SHS) were administered in a counter-balanced order. For the disability salience conditions, the reminders of death were tested with a single item question: 'When answering the questions about disability, did the concept of death come to your mind?' (1 = never come to my mind, 5 = always in my mind) for the other questions the filler question was: 'Did you feel any distress when answering the questions?' (1 = I did not feel any distress, 5 = I feel distressed all the time) (see Appendix N). After completing the questionnaire

package participants were debriefed about the aims of the study and probed for suspicion. No suspicion was reported.

CHAPTER 4

RESULTS

The analysis of the data was conducted after checking the data for the assumptions. (see Tabachnick & Fidell, 1989). The data for the participants who did not answer the salience manipulations were also excluded. The hypotheses were tested among the remaining 217 participants. Transformations were only conducted for social heroism scores. The data of the participants' who declare a disability or a medical condition (n = 12) were also excluded from the analysis.

4. 1 Descriptive Statistics

The participants were students from three different universities. There were 53 students from Gazi University, 84 from Hacettepe University, and 78 students from METU. Two of the participants did not report information about their university. There were 142 females and 75 males and with a mean age of 20.18 (SD = 1.21). Demographic characteristics of the participants were summarized in Table 3.

Table 3. *Demographic Characteristics of the Participants*

Variables	N (Percent)	Mean	Standard deviation	Range
Age (years)	216	20.18	1.21	18-27
Gender	217			
Female	142 (65.4)			
Male	75 (34.6)			
Level of income	216			
Low	17 (7.8)			
Middle	198 (91.2)			
High	1 (0.5)			
University	215			
Gazi U.	53 (24.4)			
Hacettepe U.	84 (38.7)			
METU	78 (35.9)			
Department	215			
ECON	24 (11.1)			
FIN	12 (5.5)			
FLE	54 (24.9)			
PA	53 (24.4)			
PHIL	17 (7.8)			
PSY	24 (11.1)			
SOC	31 (14.3)			
Residence type	216			
Dormitory	129 (59.4)			
w/ family	44 (20.03)			
w/ friends	38 (17.5)			
w/ relatives	1 (0.5)			
Other	4 (1.8)			
Grade	216			
Freshmen	5 (2.3)			
Sophomore	136 (62.7)			
Junior	65 (30)			
Senior	10 (4.6)			
Other	1 (0.5)			
Perceived severity of disability types	170 (78.3)			
Hearing		2.31	1.02	1-5
Mental		4.31	1.40	1-5
Mobility		2.51	1.32	1-5
Speaking		2.38	1.17	1-5
Visual		3.51	0.93	1-5

The participants were also asked to indicate the perceived severity level of 5 different conditions relating disabilities. The perceived severity of different types of conditions was compared through Wilcoxon Signed Ranks Test. The perceived severity a Mental Problem (*Mdn* = 5.00) was higher than the perceived severity of a Mobility Problem (*Mdn* = 3.00), $Z = -7.84$, $p < .001$ and similarly higher than perceived the severity of a Visual Problem (*Mdn* = 4.00), $Z = -6.70$, $p < .001$. On the other hand, the perceived severity of a Mobility Problem was not significantly different than a Speaking Problem (*Mdn* = 2.00), $Z = -.84$, p = ns and a Hearing Problem (*Mdn* = 2.00), $Z = 1.55$, p = ns. The perceived severity of a Hearing Problem was lower than a Mental $Z = -8.63$, $p < .001$ and Visual Problem $Z = -7.84$, $p < .001$. However there was no significant difference between a Hearing and a Speaking Problem $Z = -.64$, p = ns. A Visual Problem was regarded as more severe than a Speaking Problem $Z = -6.96$, $p < .001$, but the perceived severity of a Speaking problem was lower than a Mental Problem $Z = -7.38$, $p < .001$. Lastly, the perceived severity of a Visual Problem was higher than a Mobility Problem $Z = -6.15$, $p < .001$

The means regarding the perceived severity of different disability-related conditions provided a similar pattern (see Figure 4).

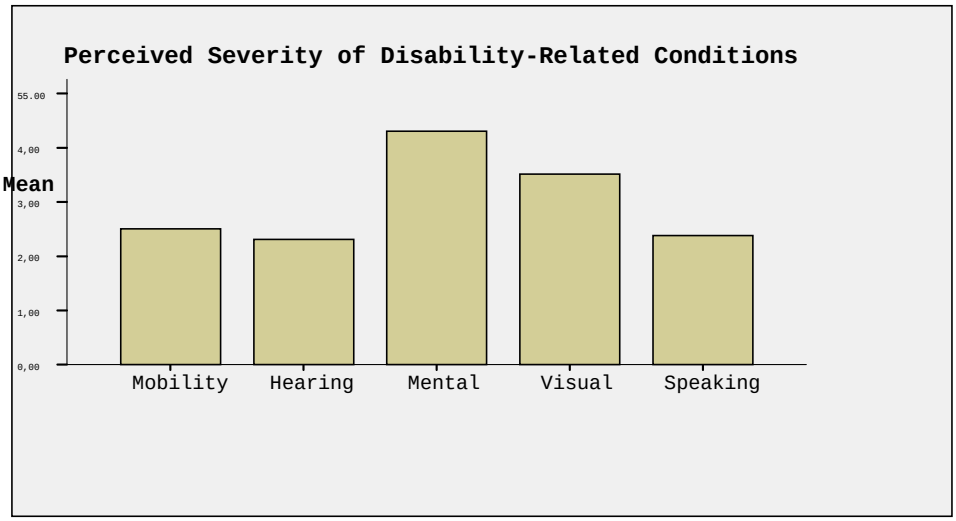


Figure 4. Perceived severity of 5 different disability-related conditions.

The descriptive statistics relating study variables were depicted in Table 4, the correlation matrix was presented in Table 5.

Table 4. *Means, standard deviations, obtained ranges and possible ranges of the study variables*

Variables	Mean	Standard deviation	Obtained range	Possible range
Personal Transgression at Time 1	60.14	11.12	9-88	9-99
Personal Transgression at Time 2	61.14	11.67	9-95	9-99
Conservatism at Time 1	84.26	11.98	56-107	47-141
Conservatism at Time 2	83.76	12.15	58-109	47-141
Attitudes towards Disabled People at Time 1	79.28	9.96	55-108	19-114
Attitudes towards Disabled People at Time 2	78.65	10.45	51-107	19-114
Social Heroism at Time 1	72.72	12.44	28-99	9-99
Social Heroism at Time 2	70.74	13.67	24-99	9-99

Table 5. *Correlations among the study variables*

Variables	1	2	3	4	5	6	7	8
1.Personal Transgression at Time 1	1	.66**	.38**	.32**	-.11	.01	.42**	.43**
2. Personal Transgression at Time 2		1	.35**	.29**	-.09	-.02	.48**	.54**
3. Conservatism at Time 1			1	.91**	-.30**	-.16	.22**	.27**
4. Conservatism at Time 2				1	-.26**	-.17	.17*	.25**
5. Attitudes towards Disabled People at Time 1					1	.75	-.06	-.15*
6. Attitudes towards Disabled People at Time 2						1	.07	-.09
7. Social Heroism at Time 1							1	.73**
8. Social Heroism at Time 2								1

Note. * Significance at $p < .05$; ** Significance at $p < .01$

4.2 Testing the Hypotheses

4.2.1 Quantitative Analysis

In order to test the first three hypotheses, the participants were initially grouped according to their conservatism scores at Time 1. There were three groups; indicating the participants with low levels of conservatism (M = 70.89, SD = 6.86), moderate levels of conservatism (M = 85.43, SD = 5.15) and high levels of conservatism (M = 95.26, SD = 7.23).

Since the gender distribution of the sample was unbalanced, A 3 (Conservatism Levels at Time 1: Low, Moderate, High) X 4 (Manipulation: Mortality Salience; Control Salience; Blindness Salience; Paralysis Salience) between subjects ANCOVA with gender as a covariate was performed on conservatism scores on Time 2. Although a main effect of conservatism levels at time 1 was obtained, F (2, 201) = 228.64, $p < .001$, $\eta^2 = .70$, the main effect of manipulation type was not significant F (3, 201) = 1.92, p = ns. Also the effect of gender was not significant F (1, 201) = 2.97, p = ns. However, a significant interaction effect was found F (6, 201) = 3.36, $p < .05$, $\eta^2 = .09$. To reveal the nature of this interaction effect, post hoc pair-wise comparisons were conducted by using Bonferroni analyses. Accordingly, although for the participants whose conservatism scores were low or moderate at Time 1, no significant differences among experimental or control manipulations were obtained; for those with high Time 1 conservatism scores important manipulation differences were observed. Specifically, for those with high conservatism scores on Time 1, as compared to control salience manipulation, both mortality salience and paralysis salience manipulations led to higher Time 2 conservatism scores; though for the blindness salience manipulation, Time 2 conservatism scores did not significantly differ from other types of manipulations. Moreover as expected, Time 1 and Time 2 conservatism scores were in accordance with each other for all manipulation groups; that is Time 2 conservatism scores were lowest for the participants with low Time 1

conservatism scores; and highest for the participants with high Time 1 conservatism scores. The only exception to this is that; no significant difference in relation to Time 2 conservatism scores was obtained between the control group participants with moderate and high levels of Time 1 conservatism scores (see Table 6).

Table 6. *Means and Standard Deviations of Conservatism Scores at Time 2 for the Mortality, Control, Blindness and Paralysis Salience Conditions.*

		Low Conservatism Scores at Time 1	Moderate Conservatism Scores at Time 1	High Conservatism Scores at Time 1
Mortality Salience	M	70.65_{a}	87.03_{b}	96.01_{c}
	SD	5.49	5.86	6.43
	N	17	28	26
Control Salience	M	70.14_{a}	85.37_{b}	89.98_{bd}
	SD	7.63	4.32	7.61
	N	14	18	12
Blindness Salience	M	73.10_{a}	82.46_{b}	94.80_{cd}
	SD	7.89	3.97	4.69
	N	19	13	21
Paralysis Salience	M	69.53_{a}	85.07_{b}	99.39_{c}
	SD	6.29	4.66	7.47
	N	20	13	13

Note. The mean scores on the same row or on the same column that do not share the same subscript are significantly different from each other.

Time 1 variable, relating the attitudes towards disabled people was not spitted due to unequal sample sizes between groups; consequently, one-way ANOVA was performed on attitudes towards disability scores on Time 2. A main effect for manipulation type was also found, F (3, 95) = 3.00, $p < .05$, $\eta^2 = .09$. Tukey's post-hoc indicated that, the attitudes of participants in the blindness salience were more positive than the participants in the mortality salience condition (significance at marginal levels, p = .055). In addition, although the difference between blindness salience and control salience was not significant, it could be argued that there is a trend (p = .067). (Due to the unbalanced participant distributions across conditions, the results should be interpreted cautiously).

A 3 (Social Heroism Levels at Time 1: Low, Moderate, High) X 4 (Manipulation: Mortality Salience; Control Salience; Blindness Salience; Paralysis Salience) between subjects ANCOVA with gender as a covariate was performed on social heroism scores on Time 2. The results regarding the social heroism scores did not support the hypothesis. For the longer version of the scale; only a main effect of social heroism levels at time 1 was obtained, F (2, 194) = 70.54, $p < .001$, $\eta^2 = .42$. The main effect of manipulation type and the interaction effect was not significant F (3, 194) = 1.52, p = ns; F (6, 194) = 0.94, p = ns, respectively. The effect of gender was not significant either, F (1, 194) = 0.33, p = ns. Similarly, A 3 (Personal Transgression Levels at Time 1: Low, Moderate, High) X 4 (Manipulation: Mortality Salience; Control Salience; Blindness Salience; Paralysis Salience) between subjects ANCOVA with gender as a covariate was performed on personal transgression scores on Time 2. The results regarding the personal transgression did not support the hypothesis. For the longer version of the scale; only a main effect of personal transgression levels at time 1 was obtained, F (2, 203) = 41.31, $p < .001$, $\eta^2 = .29$. The main effect of manipulation type and the interaction effect was not significant F (3, 203) = 0.78, p = ns, F (6, 203) = 1.01, p = ns, respectively. The effect of gender was not significant either, F (1, 203) = 0.60, p = ns.

The last question aims to test for any death-related thoughts for the disability salience conditions. No significant difference was found between blindness salience (M = 2.43, SD = 1.45) and paralysis salience (M = 2.40, SD = 1.50) conditions in terms of the death-related thoughts, $t(96) = 0.02$, p = ns. Also, the filler question for the mortality salience (M = 2.37, SD = 1.21) and control salience (M = 2.11, SD = 1.06) conditions reveal no significant difference, $t(113) = 1.14$, p = ns. The results were in line with the analysis regarding the PANAS scores; which indicates that in terms of mood changes there was not a significant difference between conditions, $F(3, 211) = 0.26$, p = ns for the positive affect and $F(3, 210) = 0.75$, p = ns for the negative affect.

The results indicated partial support for Hypotheses 2, for the paralysis salience and mortality salience conditions and for the conservatism measure (see Appendix O for the study design and see Appendix P for the participant distribution across conditions). Hypotheses 1 and Hypotheses 3 were not supported.

4.2.2 Qualitative Analysis

In order to provide evidence to the issue that death and disability is qualitatively different concepts (Hypothesis 4) and reveal that blindness and paralysis are similar (Hypothesis 5) the accounts of the participants in the experimental conditions were analyzed through content analysis. Content analysis provides the advantage of converting qualitative data into a quantitative form (Wilkinson, 2003). The numbers and percentages relating the thematic units regarding the three salience conditions (i.e. mortality, blindness and paralysis salience) were depicted in Table 7. In order to protect anonymity participants are referred with numbers.

In the qualitative part of the study, six most-cited thematic units were analyzed for experimental conditions (mortality salience, blindness salience and paralysis salience) since the volume of the accounts differed, comparison was based

on a relative base. If the same participant mentioned a theme more than once, it is only counted once.

Table 7. *Thematic units for the different salience conditions*

Salience Condition	Thematic Units (n) (percent)
Mortality Salience	1-Sadness that would be experienced by significant others (especially the mother and father). (25) (35.21 %) *"When I think about my death …I think about the sadness that would be experienced by my family and the ones who love me. It would be devastating for them" (Participant # 130).* *"I fear about my own death because I think about the ones that I would leave behind. It is dreadful to think that they would feel sad for me" (Participant # 188).* 2-Obscurity. (19) (26.76%) "*In terms of death, I am not sure about the things waiting for me" (Participant # 147).* *"It might be peace or a big fear and loneliness, it is not possible to guess them (what will happen after death) (Participant # 40).* 3- "I am a Muslim" (19) (26.76 %) "*My funeral ceremony was conducted according to (the rules and regulations) of Islam and then I will be buried" (Participant # 94).* *"According to the religious practices of the society I live in and my family's religious beliefs, they wash my dead body and bury accordingly" (Participant # 110).* 4- Absence or presence of fear and anxiety. (19) (26.76 %) *"I know that I am a nice person, I do not behave unjust so I do not have a fear (regarding death)" (Participant # 117).* *"I will fear a bit" (Participant # 226).*

Table 7. *Thematic units for the different salience conditions (continued)*

Salience Condition	Thematic Units (n) (percent)
Mortality Salience	5- Thoughts and emotions relating afterlife, hell and heaven (both positive and negative). (18) (25.35 %) *"I will go to the hell or the heaven depending on my sins. When my punishment in the hell has been finished, I would be transferred to the heaven" (Participant # 123).* *"After death, we will wait for a while and then resuscitate, we will go the heaven or the hell. Most probably, I will go the heaven and live a peaceful life" (Participant # 259).* 6-Regret (14) (19.71 %) *"If I couldn't attain my goals, I feel regret" (Participant # 46).* *"I think about… the things I couldn't able to do. I wish I do this and that" (Participant # 3).*

Salience Condition	Thematic Units (n) (percent)
Blindness Salience	1-Experiencing considerable sadness for self. (19) (29.63 %) *"Sadness …I feel defeated … deficient in the society" (Participant # 119).* *"It is very devastating … even thinking about it" (Participant # 178).* 2-Try to accept and adapt. (19) (29.63 %) *"I fear … from not being able to adapt my new life" (Participant # 132).* *"If there is no hope for recovery, I accept the situation and try to adapt" (Participant # 174).*

Table 7. *Thematic units for the different salience conditions (continued)*

Salience Condition	Thematic Units (n) (percent)
Paralysis Salience	1-Experiencing considerable sadness for self. (19) (40.43 %) *"I feel very bad…Since I feel inferiority as compared to others, I feel sad" (Participant # 4).* *"When I first learn about it, I feel sad. Being different than others would be insulting" (Participant # 96).* 2-Try to accept and adapt. (9) (19.15 %) *"It would take time for me to accept the situation…I try to make my condition less disabling" (Participant # 106).* *"I won't believe it…If there is no hope, out of necessity, I accept the fact" (Participant # 83).* 3-Becoming/feeling depressed. (8) (17.02 %) *"I will have a severe depression. Life becomes meaningless" (Participant # 108).* *"After a severe depression, I think I would start to adapt…" (Participant # 71).* 4-Life would be difficult.(7) (14.89 %) *"Life would become difficult for me, for my family and for the people around. My goals become impossible" (Participant # 58).* *"There would be a number of difficulties, the environment is not adapted accordingly … also there would be financial difficulties" (Participant # 93).*

Table 7. *Thematic units for the different salience conditions (continued)*

Salience Condition	Thematic Units (n) (percent)
	5- Get support from family (especially from the mother and father). ′(14.89 %)
	"I will depend on others …for my all life and possibly it would be my mother" (Participant # 6).
Paralysis Salience	*"The support that I will get from my family and the ones I love is very important" (Participant # 86).*
	6-"I would like to die." (7) (14.89 %)
	"When I hear about the issue, I would like to die" (Participant # 113).
	"It would make me very sad. I may think about committing suicide" (Participant # 170).

A chi-square test of independence was performed in order to examine the relation between the type of experimental manipulation and participants' sadness accounts. The term *Global Sadness* is defined as any kind of sadness (relating the person or significant others) accounts that are reported by the participants. On the other hand, the term *Individual Sadness* refers participant's self-relevant sadness accounts. The relation between experimental manipulations and global sadness accounts was not significant, χ^2 (2, N = 172) = 0.56, p = ns (see Table 8).

Table 8. *Crosstabulation of Manipulation Type and Global Sadness*

Manipulation Type		Global Sadness	
		Sadness	**No Sadness**
Mortality Salience	Count	31	40
	Expected Count	28.9	42.1
	% of Total	18.0 %	23.3 %
	Std. Residual	0.4	-0.3
	Adjusted Residual	0.7	-0.7
Blindness Salience	Count	20	34
	Expected Count	22.0	32.0
	% of Total	11.6 %	19.8 %
	Std. Residual	-0.4	0.3
	Adjusted Residual	- 0.7	0.7
Paralysis Salience	Count	31	28
	Expected Count	28.9	47.0
	% of Total	18.0 %	16.3 %
	Std. Residual	0	0
	Adjusted Residual	0	0

However, the relationship between experimental manipulations and individual sadness accounts was significant, χ^2 (2, N = 172) = 19.00, $p < .01$, (see Table 9). Participants in the mortality salience condition were experiencing less individual sadness than expected. On the contrary, participants in the paralysis salience condition were experiencing more individual sadness than expected. The frequency of individual sadness experienced by blindness salience participants was not significantly different than the expected.

Table 9. *Crosstabulation of Manipulation Type and Individual Sadness*

Manipulation Type		Global Sadness	
		Sadness	**No Sadness**
Mortality Salience	Count	6	65
	Expected Count	18.2	52.8
	% of Total	3.5 %	37.8 %
	Std. Residual	-2.9**	4.3
	Adjusted Residual	-4.3	1.7
Blindness Salience	Count	19	35
	Expected Count	13.8	40.2
	% of Total	11.0 %	20.3 %
	Std. Residual	1.4	-0.8
	Adjusted Residual	2.0	-2.0
Paralysis Salience	Count	19	28
	Expected Count	12.0	47.0
	% of Total	11.0 %	16.3 %
	Std. Residual	2.0*	-1.2
	Adjusted Residual	2.7	-2.7

Note. * Significance at $p < .05$; ** Significance at $p < .01$

Chi-square tests of independence were performed to examine the relation between the disability salience (i.e. paralysis salience and blindness salience) conditions and perceived possibility of adaptation/acceptation relating to a future/possible disability, perceived difficulty of a future/possible disability and the possible support provided by significant others, death-related or depression experienced in these conditions.

The relation between disability salience conditions and perceived possibility of adaptation/acceptation of disability was not significant, χ^2 (1, N = 101) = 3.23, p = ns. Similarly, the relationship between disability salience conditions and perceived difficulty of to a future/possible disability was not significant, χ^2 (1, N = 101) = 0.24, p = ns. Also, there is no relationship between death-related thoughts and disability salience conditions, χ^2 (1, N = 101) = 0.06, p = ns. Depression and disability salience conditions is not related either, χ^2 (1, N = 101) = 0, p = ns. Finally, it could be stated that the relationship between disability salience conditions

and the support provided by significant others was not significant, χ^2 (1, N = 101) = 0.32, p = ns.

The results indicate that death and disability are qualitatively different concepts. However, this does not mean that they are independent. Furthermore, although blindness and paralysis are similar they are not equated (Hypotheses 4 and Hypotheses 5 are partially supported).

CHAPTER 5

DISCUSSION

5.1. Overview

The analyses reveal that the hypotheses of the study were partially supported. Both mortality salience and paralysis salience seems to be effective for the participants whose initial conservatism scores were high. However, this is not the case for the blindness salience, although one might mention about a trend regarding towards the more positive attitudes towards disabled people. On the other hand, both mortality salience and paralysis salience effects appeared only when the initial level of conservatism was high. This finding is in accordance with the suggestions of the literature. For the participants who perceive driving as self-relevant; mortality salience manipulation results in risky driving behaviors (Taubman-Ben-Ari, Florian, & Mikulincer, 1999). Similar studies indicate that only for young men who perceive driving as self-relevant, mortality salience condition results in reckless driving (Taubman-Ben-Ari, 2000; Taubman-Ben-Ari & Findler, 2003). Miller and Taubman-Ben-Ari (2004) also conclude that among divers who have low self-esteem and low self-efficacy mortality salience would result in risky diving behaviors. We may conclude that since conservatism is self-relevant for the participants whose initial conservatism scores were high, mortality salience and paralysis salience manipulations were found to be effective. The results regarding the blindness salience should also be evaluated further. Although there is a trend, the study failed to find robust blindness salience effects. Research indicates that when a message arouses too much fear then its persuasiveness decrease (Taylor, et al., 2000; Rutter, Abraham, & Kok, 2001). For instance, Witte (1991/1992) argues that higher levels of fear may deteriorate condom use intentions and are not effective for AIDS prevention. Henley and Donovan (1999a) make a distinction between fear appeals which are regarded as more emotional and threat appeals which are more cognitive. They conclude that in order to be effective a message

should be threatening but not fearful. Fear arousals might increase the level of anxiety, sense of helplessness and depression among the audience (Henley & Donovan, 1999b). In line with these findings one may argue that since paralysis is not that much fearful (but threatening) as compared to blindness, paralysis salience was effective but blindness salience was not. Since current participants rated visual problem as the second most severe impairment (the most severe one was the mental problem) and mobility as significantly less severe than visual problem, this reasoning might be valid. The relative negativity of a mental problem as compared to physical ones that is found in the current study is also in line with the literature. For instance, it is found that the attitudes towards people with intellectual disabilities are more negative than people with physical disabilities among nursing and non-nursing students (ten Klooster, Dannenberg, Taal, Burger, & Rasker, 2009).

5.2. A Comparison between Death and Disability

We are living in a mortality salient world. Thus, it is not so difficult to make people mortality salient. This is the case especially in Turkey. While death is everywhere -on TV, in newspapers, on the road-, however, disability is hidden. It is something embarrassing and not easily available. It is not as salient as death. Perhaps, in the minds of individuals the traffic accident survivors or wounded veterans are all healed as media coverage might not focus on the aftermath of the wounded. Thus, the concepts relating disability might be generally ignored and avoided. Therefore, it might be more difficult to make people “disability salient”. Availability heuristic states that the probability of an event is judged by the ease with which instances of an event come to mind (Katapodi, Facione, Humphreys, & Dodd, 2005). Bath (2010) states that people always ask two questions to themselves about their death: When? and How? Regarding a future/possible disability these questions are never asked, it is regarded as a misfortune. In addition, in most cases the society disregards disabled people. These might be the reasons of not having more robust disability salience findings.

5.3. Terror Management Theory and Death: Is death a sine qua non for TMT?

The findings of this study arises a question: Is TMT only an issue of death or is it a more global issue and death is just a convenient example? If death is accepted as a convenient example for testing terror management theory then disability might be another one. Both cases involve high degree of loss. Similar to that, Murphy et al. (1988) argue that the experience of acquiring a disability might be conceptually similar to the experience of people who experience acute loss of income.

Although it is a bit contradictory, it might be discussed that imagining paralysis might be easier than imagining blindness. Hull (2001b) argues that sighted people do not have the brain of blind people. It seems easy to simulate blindness however since blindness is something more than losing sight so it could not be easily pretended. A sighted person who closes his/her eyes would still have the shapes, colors and figures in mind. Similar to Hull's (2001b) conceptualizations it could be discussed that with some technical aids a person who has a total paralysis in lower extremities can become mobilized with a wheelchair (although access might be limited due to disability-unfriendly environment). However, there is not a device which provides or restores some sort of sight for the people who are totally blind. White canes are just for mobility. Therefore, together with hearing impairment; blindness might be classified as a brain related/cognitive impairment (Hull, 2001b). Talaslı (2003, personal communication) also emphasizes this issue and argues that human brain functions with rehearsal which emphasizes the importance of hearing in terms of brain's performance. He pointed that although this point might be disregarded it is the origin of most problems faced by people who have hearing impairments.

If one would argue that death is not a sine qua non for TMT then, three important conditions should be satisfied for the effective manipulation. The self-relevance of the dependent variable was already explored in the literature (e.g. Taubman-Ben-Ari, 2000; Miller & Taubman-Ben-Ari, 2004; Koca-Atabey & Öner-

Özkan, in press). However, this condition is not sufficient per se. The experimental manipulation should also be self-relevant. Since death is *relevant* to almost everyone (see Solomon, et al., 1997; McGregor, 2006; for a discussion) there was not such a problem, but when one changes the manipulation item than its relevance to the study population should be carefully evaluated. For instance, if senior high school students in Turkey would be tested with a 'failing from the university entrance examination (i.e. YGS)' condition, cultural worldview defense reactions might be obtained, since in Turkey, the importance given to university entrance examination is immense. The second issue regarding the experimental manipulation is that it should be imaginable or easily available. As in this case, paralysis could be much more imaginable than blindness so it is much more effective. A broken leg might be much more imaginable than injured eyes. Similarly, using a wheelchair is much more imaginable (maybe more probable) than using a white cane. The third issue regarding the experimental manipulation is that it should provide a tolerable amount of fear in order not to be disregarded. Being a relatively local condition, blindness would have more total effects (see Hull, 2001 for a discussion) than paralysis which might lead the participants to ignore the situation (see Figure 5 for a depiction of the proposed theoretical model). Therefore, it is argued that any other (loss) condition which satisfies these three conditions would give rise to worldview defense reactions.

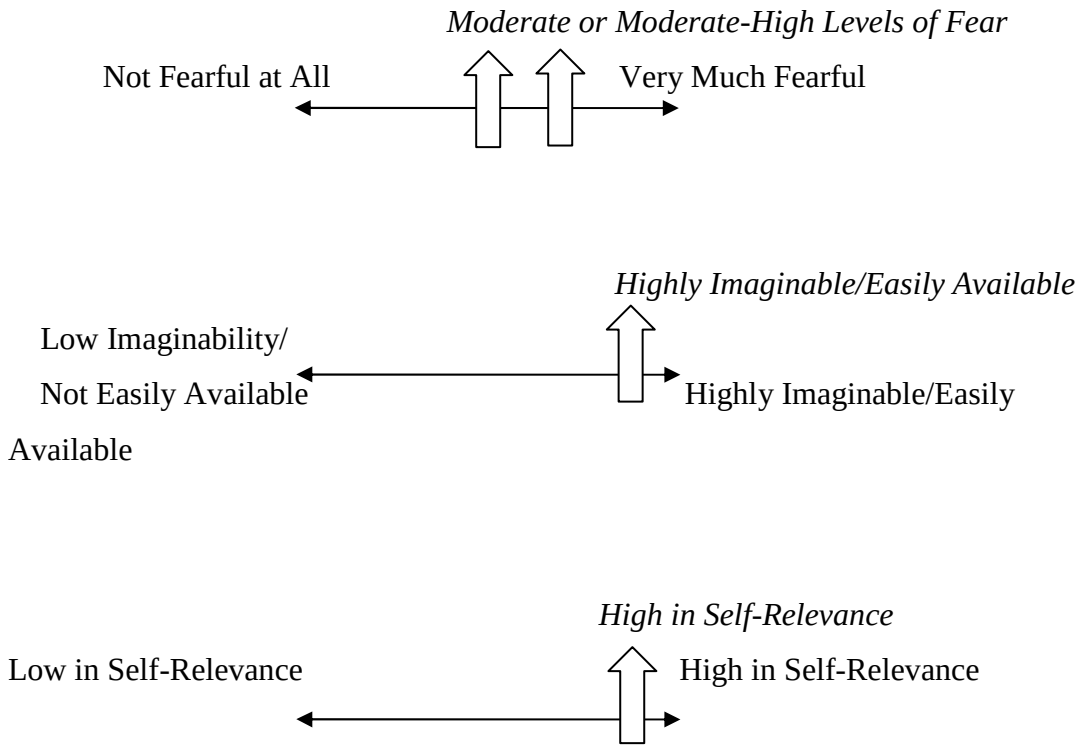


Figure 5. Theoretical model derived from the current study: Three necessary conditions for an alternative experimental manipulation in TMT studies

Death satisfies all these three conditions; it is imaginable/easily available, induces fear and it is self-relevant. However, mortality salience measures uses *natural course of death* as an experimental manipulation. Dying might occur in other forms. Dying because of a fire or a drowning might be the examples of dying forms which could include intense fear. Dying young might also induce higher amounts of fear. Research regarding these conditions might also be valuable. The control conditions used in mortality salience studies could be evaluated within this perspective. Dental pain is not that much fearful, it may or may not be self-relevant and imaginable/easily available. Exam failure contains relatively lower amounts of fear may or may not be self-relevant and imaginable/easily available. On the other hand, TV watching is self-relevant, imaginable/easily available but not fearful. Another example might be about having a traffic accident. It is found that after watching a videotape regarding a traffic accident, college students show

nationalistic bias regarding blame assignment as compared to control group participants who watch a driver's education video (Nelson, Moore, Olivetti, & Scott, 1997). A similar study is conducted among young Israeli soldiers. After watching a traumatic car accident film, participants who think driving as self-relevant would show reckless driving intentions or behaviors (Taubman-Ben-Ari, Florian, & Mikulincer, 2000). Conceptually having a traffic accident would be fearful to most people. However, for a group of people who live in a village and who do not have any concern about traffic, although having a traffic accident is fearful and easily available/highly imaginable for them (due to watching traffic accidents on television for instance) since it is not self-relevant it might not cause the intended reactions. Similarly, for a group of people who strongly believe that traffic accidents happen to *other people,* the possibility of having a traffic accident would not be that much fearful and therefore would not cause cultural worldview defense.

Yavuz (2007) finds that although mortality salience and uncertainty salience was effective for college students; they are not found to initiate cultural worldview defense among elderly participants. Similarly, Bozo et al. (2009) state that as compared to younger participants' reports no significant difference was found in terms of older adults' reports of health promoting behaviors in the death anxiety condition. Maxfield et al. (2007) explain older participants' unresponsiveness by the fact that as at old age people become more tolerant to moral transgressions. Another point that they raise is that for elderly death is a normative notion. The death anxiety literature regarding the elderly is twofold, there is either higher levels of fear together with a denial (e.g. Kimsey, Roberts, & Logan, 1972; Baum & Boxley, 1984) or acceptance of death and disappearance of fear (e.g. Falkenhain & Handal, 2003; de Raedt & Van der Speeten, 2008). Therefore, the fear that is experienced by the elderly participants might be higher or lower than the optimal level (see Figure 5); which might be the reason of not achieving mortality salience effects.

Death is taken for granted in TMT as the source of existential anxiety as the basis of the theory: However, not an existential anxiety relating to self but the anxiety of losing what is existed related to self might be the basis of that terror. The actual self after a future/possible disability might be left away from the ideal one. This is also in line with the discussion that cultural wordview and self-esteem are linked (Pyszczynski, et al., 2004). Within this framework, the uncertainty salience concept (e.g. Van den Bos, 2001) can also be evaluated as an example of loss. It is the loss of knowledge, planning ability or control…

5.4. Death is sometimes positive, Disability never…

An important distinction between death and disability is that, death might be regarded as positive related to religious or spiritual beliefs (e.g. heaven, reunion). However for disability it is rarely positive, especially for non-disabled people. Having a positive approach towards a future/possible disability is not that probable. Weiss (1997) argues that families might behave their disabled children as non-person, a creature or as a pet. Wilson (2006) states that disabled people might feel like prisoners in their own body. Additionally, an impairment might be seen as a threat to existence since it reminds the fragility and vulnerability of the body. The results of this study support these arguments. Positive accounts related to a future/possible blindness or paralysis is barely evident. In fact, disability may be viewed as a different life experience (French, 2004) and it could be conceptualized as rewarding but that is generally argued only by disabled activists and academicians. For instance, Oliver (1996) states that before the accident which is ended up with a spinal cord injury, he had a boring clerical job and a macho life style. However, after becoming disabled, he finished a sociology doctorate and became an academician. In line with that the discourses of disabled people are not always negative. They might include words such as joy, happiness, freedom, successful and respect (Sunderland, Catalano, & Kendall, 2009). Morris (1991) mentions about a more meaningful life after becoming a wheelchair user. These results are not surprising regarding the post-traumatic growth phenomenon (e.g.

Tedeschi, Park, & Calhoun, 1999). In line with that it is stated that disabled university students could experience stress-related growth which is found to be associated with problem-solving coping (Koca-Atabey, et al., 2011). It is argued that rather than emphasizing the negative aspects of disability, concentrating more on the strengths and capacities of a disabled person might be advantageous. According to this positive psychology perspective it is essential to optimize (rather than normalize) disabled people's lives (Naidoo, 2006). However, this line of reasoning needs a well-established support system and non-prejudiced environment which could not be generally found in Turkey.

In line with the literature, the results of the qualitative analysis indicate that, although mortality as a concept could result in quite a few positive accounts (e.g. going to heaven, feeling relief, eternal happiness); for the themes of blindness and paralysis there were not any positive accounts reported by the participants. While the sadness that is experienced by possible future death is generally related with significant others (*e.g. "My family would get the news, they feel very sad and mourn (after my death)" (Participant # 272))*, the sadness for a possible/future paralysis conditions are reported to consider directly for the person him/herself *(e.g. "I feel a deep sadness. Why did it happen to me?" (Participant # 54)).* Consequently we may argue that paralysis salience might be regarded as a more personal threat as compared to death. Although they are both sorrowful events, as death provides less individual sadness than expected; paralysis provides more… Everybody is expected to die but not everybody is expected to become disabled. Thus, death could be considered to be a more normative issue than disability. On the other hand, for a small number of participants (see Table 7) death and disability are almost equated. When we compare death and disability (i.e. blindness and paralysis), there are instances where disability is considered to be more negative than death *(e.g. "I would rather die than become paralyzed" (Participant # 173)).* Besides, death and disability can not be regarded as independent from each other at least for some individuals *(e.g. "Becoming blind is not different than death" (Participant # 11)).*

It could be concluded as compared to disability; that people are more ready for death. They may even prefer death to disability. In fact, this is not contrary to the fundamental assumptions of TMT. It is argued that the underlying assumption of TMT is the struggle for a meaningful life (see Ryan & Deci, 2004 for a discussion). As disability includes high degree of loss; it affects the meaning of life which makes it a fearful concept.

5.5. Contributions of the Current Study

In relation to conservatism, the results of the current study contribute to the literature with providing two-fold support. Initially, it is found that as a personality trait conservatism is relevant to TMT (i.e. highly conservative participants react to mortality salience and paralysis salience manipulation) and secondly it is revealed that as a dependent variable general conservatism measure was effective (i.e. there is an increase in conservatism scores after mortality salience and paralysis salience manipulation).

The study reveals that disability anxiety is an issue which is somewhat related but largely independent from death anxiety (somewhat similar to Figure 3-A). At this point loss anxiety becomes as a comprehensive framework. If that is the case, disability and attitudes towards disabled people might be reevaluated vis-à-vis the loss concept.

The current study might be a step for proving a conceptual map regarding different kinds of losses. The findings state that at least for some situations disability salience works out just the same as mortality salience manipulation. Thus death anxiety might not be the one and only fundamental fear as TMT suggests. We argue that loss anxiety might underline both death and disability anxiety. The future studies might reflect upon the hierarchy, mapping and conceptualization of different anxieties within the framework of loss anxiety. One other important feature is that loss anxiety should be evaluated on an individual basis. For instance, losing her

beauty might induce higher amounts of loss for a beauty queen. Heretofore, dental pain and exam failure were effective as control conditions since they induce minimal levels of loss. However one may argue that as the amount of embedded loss within an experimental manipulation increases, the cultural worldview reactions would also increase. The proposed theoretical model (see Figure 5) might be evaluated in this respect. We suggest that, any kind of loss phenomenon which satisfies these three conditions (i.e. moderately fearful, highly imaginable/available, highly self-relevant) would be effective within the TMT framework.

Using Time 1 measures within the framework of terror management theory could be evaluated as a statistical and methodological strength. Although providing Time 1 measures might increase the demand characteristics, since the statistical outcomes still indicated a mortality salience and a paralysis salience effect, we might argue that there is strong evidence in relation to their presence.

5.6. Limitations and Suggestions for Future Research

The study is limited in providing only two specific disability salience conditions (i.e. paralysis salience and blindness salience). Future studies might utilize different disability salience conditions such as hearing, speaking or a combination of both. The severity of the possible/future disability might also be manipulated. In addition, a general disability salience condition which let the participants freely interpret the condition might also be valuable. Rather than indicating a certain condition, participants might answer a general disability salience condition and than disclose the condition that comes to mind. Using alternative dependent variables might also be fruitful for future research. Behavioral measures relating disabilities could also provide remarkable results. Helping behavior towards a disabled person, conducting a job interview with a disabled candidate or assessing the attractiveness of a disabled man/woman might be listed among examples.

Future studies might also test disability salience in relation to significant others. Rather than death, people might prefer a disability for the ones who are important for them. Furthermore, the present study tries to assess loss anxiety in a more indirect way. Future studies might utilize a loss salience condition.

5.7. Conclusion

Terror management theory provides a fruitful framework which can be applied to numerous social psychological conceptualizations. With utilizing TMT, the present thesis provides an understanding to the underling concern behind the disability issue. Disability and death is found to be similar in terms of their threatening nature but they are different in relation to the conceptualizations and attached emotions. It is concluded that due to the higher degree of possible/future loss, acquiring a disability is fearful for individuals. This might lead negative attitudes, stereotypes or prejudices related to the disabled people. In order to overcome this problem, a disability-friendly environment is mandatory. The environment should be regarded in physical, social and psychological sense. In such an environment since disability anxiety reduces, the negativity towards disabled people would also minimize.

‘Yes, it is not the best thing that I come across but it is not the worst either….’

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APPENDIX A

DEMOGRAPHIC INFORMATION SHEET

RUMUZ:…….

Lütfen Aşağıdaki Soruları Cevaplayınız:

1. Cinsiyetiniz: Kadın □ Erkek □

2. Yaşınız: ….

3. Doğum yeriniz: .....

4. Üniversiteniz/ Bölümünüz:

.....

5. Sınıfınız:

Hazırlık □ 1. Sınıf □ 2. Sınıf □ 3. Sınıf □ 4. Sınıf □

Lisansüstü (Yüksek Lisans ya da Doktora) □ Diğer □ (Lütfen belirtiniz)

….....

6. Nerede yaşıyorsunuz?

Yurtta □ Evde (ailemle birlikte) □ Evde (arkadaşlarımla) □

Bir akrabamın yanında □ Diğer □ (Lütfen belirtiniz) .....

7. Lütfen size göre gelir grubunuza uygun seçeneği işaretleyerek belirtiniz:

Düşük □ Orta □ Yüksek □

8. Herhangi bir engeliniz var mı?

Evet □ Lütfen belirtiniz……..

Hayır □

9. Aşağıdaki engel çeşitlerini en ağırdan *(5)* en hafife *(1)* doğru sıralayınız:

Yürüme Engeli:..….. Duyma Engeli:……. Zihinsel Engeli:…..

Görme Engeli:… … Konuşma Engeli:……

APPENDIX B

SOCIAL HEROISM SCALE

Sizden, çoğu toplumlarda genelde takdir ile karşılanan davranışları değerlendirmeniz istenmektedir. Bu şekilde davranan aşağıdaki kişilere **ödüller** vermeniz istense hangi düzeyde ödüllendirmek isterdiniz. Lütfen ödülleri aşağıdaki dereceli ölçeğe göre dağıtınız. Lütfen uygun gördüğünüz rakamı ilgili cümlenin önündeki boşluğa yazınız.

Çok az ödül Orta derecede ödül Çok fazla ödül

1.....2.....3.....4.....5.....6.....7.....8.....9.....10.....11

1.____ Depremden sonra üç gün boyunca uyumadan, enkaz altında çalışan genç.

2.____ Sokakta bulduğu cüzdanı sahibine iade eden kişi.

3.____ Çalıştığı şirketi her gün altı saat fazla mesai yaparak kurtaran çalışan.

4.____ Kan kanseri çocuklar yararına dört yıl şehir şehir gezerek yardım arayan gönüllü.

5.____ Trafik kazasından ağır yaralı olarak çıkan birisine kan veren vatandaş.

6.____ Komşusunu her gün işine (ücretsiz) taşıyan Ankaralı memur.

7.____ Suçluyu teşhis etmesi için polise tanıklık eden kişi.

*8.____ Savaş alanına gönüllü giden doktor.

*9.____ Teröristlerle girdiği mücadeleden gazi olan kişi.

* Added items.

APPENDIX C

PERSONAL TRANSGRESSION SCALE

Aşağıda çoğu toplumlarda sıklıkla görülen suç ve suçlu örnekleri sıralanmıştır. Sizce bu suçlulara ne ölçüde **ceza** verilmelidir. Aşağıdaki dereceli ölçeği kullanarak yanıtlayınız. Lütfen uygun gördüğünüz rakkamı ilgili cümlenin önündeki boşluğa yazınız.

Çok hafif ceza Orta ceza Çok ağır ceza

1.....2.....3.....4.....5.....6.....7.....8.....9.....10.....11

1.____ Bir banka hortumcusu.

2.____ Ölüme sebebiyet veren sürücü.

3.____ Hafif yaralanmaya sebebiyet veren sürücü.

4.____ Tiner kullanıp hırsızlık yapan çocuk.

5.____ Arazi anlaşmazlığı nedeniyle akrabasını öldüren kişi.

6.____ Bakkaldan sakız ve şeker çalan çocuk.

7.____ Karısı ve çocuklarını terk eden baba.

*8.____ Yasal çalışmayan hayat kadını.

*9.____ Kendisini aldattığı şühsesiyle sevgilisini öldüren kişi.

* Added items.

APPENDIX D

ATTITUDES TOWARDS DISABLED PEOPLE SCALE

Aşağıda engellilik durumu ve engelli bireylerle ilgili genel ve özel ifadeler yer almaktadır. Lütfen her maddeyi dikkatle okuyarak ne derece katılıp katılmadığınızı gösteren şıkkı ifadenin yanına yazınız.

1	2	3	4	5	6
Hiç Katılmıyorum	**Oldukça Katılmıyorum**	**Biraz Katılmıyorum**	**Biraz Katılıyorum**	**Oldukça Katılıyorum**	**Tamamıyla Katılıyorum**

____ *1. Yardım etmem gerektiğinde engelli kişiye nasıl yaklaşmam gerektiğini bilemem.
____ *2. Engelli bir insanla bir arada olmak bana kendi korunmasızlığımı hatırlatır.
____ 3. Eğer bir gün engelli olursam ne hissedeceğimi merak ederim.
____ *4. Engelli bir kişi ile bir arada bulunmak böyle bir sorunum olmadığı için şükretmeme neden olur.
____ *5. Engelli biriyle evlenmem.
____ *6. Engellilerle bir arada bulununca kendimi gergin hissederim ve gevşemekte zorlanırım.
____ 7. Engelli insanların karşılaştığı sorunların farkındayım.
____ *8. Engelli birey muhtaçtır.
____ 9. Engelli kişilere nasıl davranacağımı bilmediğimden kararsızlık hissederim.
____ 10. Engellilerin başa çıkma becerilerini takdir ederim.
____ *11. Engelli birini görünce ona bakıp durmaktan kendimi alamam.
____ 12. Engelli kişi ile sıklıkla bir arada bulunduktan sonra engeli değil de kişiyi fark etmeye başlarım.
____ 13. Engellilerin problemleri tüm toplumun sorunudur.
____ *14. Engelli kişinin yüzüne bakmaya çekinirim.
____ *15. Engelli olmak acınası bir durumdur.
____ *16. Engelli insanlarla irtibatımı kısa tutmaya ve görüşmelerimi mümkün olduğunca çabuk bitirmeye çalışırım.
____ *17. Bir gün engelli olabileceğim düşüncesi beni dehşete düşürür.
____ *18. Allah kişiyi engelli yarattıysa bunun mutlaka bir nedeni vardır.
____ 19. Türkiye'de engellilerin yaşam alanı kısıtlıdır.

*Reversed items.

APPENDIX E

CONSERVATISM SCALE

Lütfen aşağıdaki maddelere ne derece katılıp katılmadığınızı ya da inanıp inanmadığınızı düşünüp**, EVET (E), HAYIR (H), KARARSIZIM (?)** şeklinde bir değerlendirme yapınız.

1. Ölüm cezası uygulanmalıdır **E H ?**	25. Bekaret korunmalıdır **E H ?**
2. Evrim teorisine inanırım **E H ?**	26. Pijama partileri yapılabilir **E H ?**
3. Okul üniformaları gereklidir **E H ?**	27. Diktatörlükler kurulabilir **E H ?**
4. Striptiz gösterileri düzenlenebilir **E H ?**	28. Kadınlar hakim/yargıç olabilmelidir **E H ?**
5. Dini günlere riayet edilmelidir (örn: müslümanlarda cuma, musevilerde cumartesi, hristiyanlarda pazar) **E H ?**	29. Geleneksel giyim tarzını onaylarım **E H ?**
6. Hipiler zararsızdır **E H ?**	30.Gençler araç kullanabilmelidir **E H ?**
7. Vatanseverlik **E H ?**	31. Irk ayrımı yapılabilir **E H ?**
8. Modern sanat anlayışına inanırım **E H ?**	32. Çıplaklar kampı düzenlenebilir **E H ?**
9. Kişi nefsinden feragat etmelidir **E H ?**	33. Dini kurumların otoritesi uygulanmalıdır **E H ?**
10. Annelerin çalışmasını onaylarım **E H ?**	34. Silahsızlanmak gereklidir **E H ?**
11. Burçlara inanırım **E H ?**	35. Sansür uygulanabilir **E H ?**
12. Doğum kontrolü uygulanmalıdır **E H ?**	36. Beyaz yalanlar söylenebilir **E H ?**
13. Askerlik yapılmalıdır **E H ?**	37. Dayak atılabilir **E H ?**
14. Karma (kız-erkek beraber) eğitim yapılmalıdır **E H ?**	38. Farklı ırk, din, vb. kişilerin evliliği uygundur **E H ?**
15. Dini yasalar uygulanmalıdır **E H ?**	39. Katı kurallar konulmalıdır **E H ?**
16. Sosyalizmle ilgili olumlu düşüncelere sahibim **E H ?**	40. Caz müziği dinlenebilir **E H ?**
17. Beyaz ırk üstündür **E H ?**	41. Deli gömlekleri kullanılabilir **E H ?**
18. Kuzenlerin birbirleriyle evlenmesi uygundur **E H ?**	42. Gündelik/resmi olmayan bir yaşam biçimini onaylarım **E H ?**
19. Ahlak eğitimi verilmelidir **E H ?**	43. Arapça öğrenmek gereklidir **E H ?**
20. İntihar kabul edilebilir bir davranıştır **E H ?**	44. Boşanmak kabul edilebilir bir davranıştır **E H ?**
21. Kürtaj yasal olmalıdır **E H ?**	45. İnsanlar doğuştan var olan bir vicdana sahiptirler **E H ?**
22. İmparatorluk kurma fikrine olumlu bakarım **E H ?**	46. Mültecilik gerekli bir kurumdur **E H ?**
23. Eşek şakaları yapılabilir **E H ?**	47. Kutsal kitabın gerçeklerine inanırım **E H ?**
24. Bilgisayar müziği dinlenebilir **E H ?**	

APPENDIX F

MORTALITY SALIENCE MANIPULATION

Lütfen ölmekte öldüğünüzde size neler olacağını anlatınız. (Lütfen tüm satırları doldurmaya çalışınız).

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Lütfen kendi ölümünüzün sizde uyandıracağı duygulardan bahsediniz. (Lütfen tüm satırları doldurmaya çalışınız).

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APPENDIX G

TELEVISION SALIENCE MANIPULATION

Lütfen televizyon seyrettiğinizde size ne olduğunu anlatınız. (Lütfen tüm satırları doldurmaya çalışınız).

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Lütfen televizyon seyrettiğinizi düşünmenin sizde uyandırdığı duygulardan bahsediniz. (Lütfen tüm satırları doldurmaya çalışınız).

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APPENDIX H

BLINDNESS SALIENCE MANIPULATION

Lütfen eğer bir gün ağır engelli olursanız örneğin, gözlerinizi kaybederseniz ve bir daha hiç göremeyeceğinizi öğrenseniz neler olacağını anlatınız. (Lütfen tüm satırları doldurmaya çalışınız).

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Lütfen ağır engelli olmanın, örneğin gözlerinizi kaybetmenin ve bir daha hiç görememenin sizde uyandıracağı duygulardan bahsediniz. (Lütfen tüm satırları doldurmaya çalışınız).

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APPENDIX I

PARALYSIS SALIENCE MANIPULATION

Lütfen eğer bir gün ağır engelli olursanız, örneğin belden aşağınız tutmazsa ve bir daha yürüyememeğinizi öğrenseniz neler olacağını anlatınız. (Tüm satırları doldurmaya çalışınız).

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Lütfen ağır engelli olmanın, örneğin belden aşağınızın tutmamasının ve hiç yürüyememenin sizde uyandıracağı duygulardan bahsediniz. (Tüm satırları doldurmaya çalışınız).

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APPENDIX J

POSITIVE AND NEGATIVE AFFECT SCALE

Aşağıda farklı duygusal durumları niteleyen sözcükler bulunmaktadır. Lütfen, her bir sözcüğü okuyarak, aşağıdaki ölçekte anlamları tanımlanmış sayılardan uygun gördüğünüz birini **yanındaki boş kutuya** yazınız. **Şu anda** kendinizi nasıl hissettiğinizi, diğer bir deyişle, her bir duyguyu ne ölçüde yaşadığınızı düşünün ve değerlendirmenizi buna göre yapın.

1	2	3	4	5
Hiç/Çok az	Biraz	Orta düzeyde	Oldukça fazla	Aşırı derecede

1. Hevesli	
2. Sıkıntılı	
3. Heyecan dolu	
4. Üzgün	
5. Güçlü	
6. Suçlu	
7. Ürkek	
8. Kızgın	
9. Coşkulu	
10. Onurlu	

11. Huzursuz-tetikte	
12. Canlı	
13. Kendinden utanan	
14. Şevkli	
15. Gergin	
16. Kararlı-azimli	
17. İlgili	
18. Sinirli	
19. Aktif	
20. Korkmuş	

APPENDIX K

WORD SEARCH PUZZLE

Aşağıdaki tabloda gizlenmiş sözcükler bulunmaktadır. Bu sözcüklerden en az **5 harfden oluşan 5 sözcük** bulunuz ve sırasıyla yazınız.

A	Ö	T	A	L	Ö	Ç	B	N	Ü	B	R	Ü	D	Ü
R	N	S	R	A	N	T	A	H	E	V	E	S	L	İ
A	A	İ	M	D	C	E	Z	N	O	T	P	İ	R	K
P	S	L	A	N	E	L	İ	Y	R	Ü	Z	G	A	R
M	İ	A	Ğ	A	L	E	L	U	T	P	Ü	R	E	P
I	H	N	A	R	İ	K	İ	Ğ	R	E	L	E	S	O
Z	A	İ	N	E	K	S	K	U	A	R	A	Y	N	K
K	T	F	A	V	Ç	İ	A	R	D	V	K	İ	E	A
M	A	B	E	Y	İ	N	I	L	N	A	E	T	K	N
K	İ	L	L	İ	H	A	C	U	A	N	R	R	L	İ
R	G	E	Z	İ	N	T	İ	K	T	E	D	A	İ	Ç
L	A	N	İ	J	İ	R	O	N	S	A	A	J	T	K

Bulunan Sözcükler:

1.

2.

3.

4.

5.

APPENDIX L

INFORMATION SHEET

Sayın Katılımcı,

Bu çalışma üniversite öğrencilerinin çeşitli konulardaki tutumlarını araştırmayı amaçlamıştır. Çalışma kimi bireyler için rahatsızlık içerebileceğinden katılım tamamıyla gönüllülük esasına dayanmaktadır. Eğer katılmak istemiyorsanız bu durumu araştırmacıya bildirmeniz yeterli olacaktır.

Elinizdeki soru formunun ilk sayfasında belirtilen bölüme bir **RUMUZ** yazmanız istenecektir. Bu rumuzlar, bugünkü formlar ile yaklaşık iki hafta sonra dağıtılacak olan formların eşleştirilmesinde kullanılacağından araştırmanın amacına ulaşmasında büyük önem taşımaktadır. Lütfen bu bölüme sırasıyla adınızın ilk harfini, annenizin adının ilk harfini, babanızın adının ilk harfini ve doğum tarihinizi yazınız.

ÖRNEK:

Adınız: **M**ine

Annenizin Adı: **S**elma → → → **RUMUZ:** MSE7

Babanızın Adı: **E**rol

Doğum Tarihiniz: **07** Ocak 1987

Sorulara samimi cevaplar vermeniz araştırmada elde edilen sonuçların geçerli ve güvenilir olmasını sağlayacaktır. Vereceğiniz tüm bilgiler saklı tutulacak ve sadece araştırma amaçları doğrultusunda kullanılacaktır. Veriler toplu olarak değerlendirileceğinden kimliğinizin belirlenmesi mümkün olmayacaktır.

Lütfen cevaplarınızı size sunulan formdaki sıra ile veriniz.

Yardımlarınız için şimdiden teşekkürler.

Müjde KOCA-ATABEY. ODTÜ Psikoloji Doktora Öğrencisi,

e125431@metu.edu.tr

Danışman: Prof. Dr. Bengi ÖNER-ÖZKAN, bengi@metu.edu.tr

APPENDIX M

DEMOGRAPHIC INFORMATION SHEET

(Second Administration)

RUMUZ:…….

Lütfen Aşağıdaki Soruları Cevaplayınız:

1. Cinsiyetiniz: Kadın □ Erkek □

2. Yaşınız: ….

3. Doğum yeriniz: .....

4. Üniversiteniz/ Bölümünüz:

.....

5. Sınıfınız:

Hazırlık □ 1. Sınıf □ 2. Sınıf □ 3. Sınıf □ 4. Sınıf □

Lisansüstü (Yüksek Lisans ya da Doktora) □ Diğer □ (Lütfen belirtiniz)

….....

6. Nerede yaşıyorsunuz?

Yurtta □ Evde (ailemle birlikte) □ Evde (arkadaşlarımla) □

Bir akrabamın yanında □ Diğer □ (Lütfen belirtiniz) .....

7. Lütfen size göre gelir grubunuza uygun seçeneği işaretleyerek belirtiniz:

Düşük □ Orta □ Yüksek □

APPENDIX N

DEATH CHECK QUESTION-FILLER QUESTION

***Engel ile ilgili sorulara cevap verirken ölüm düşüncesi hiç aklınıza geldi mi?**

1	2	3	4	5
Hiç aklıma gelmedi		**Kararsızım**		**Hep aklımdaydı**

* Question for the paralysis salience and blindness salience conditions.

****Sorulara cevap verirken sıkıntı hissettiniz mi?**

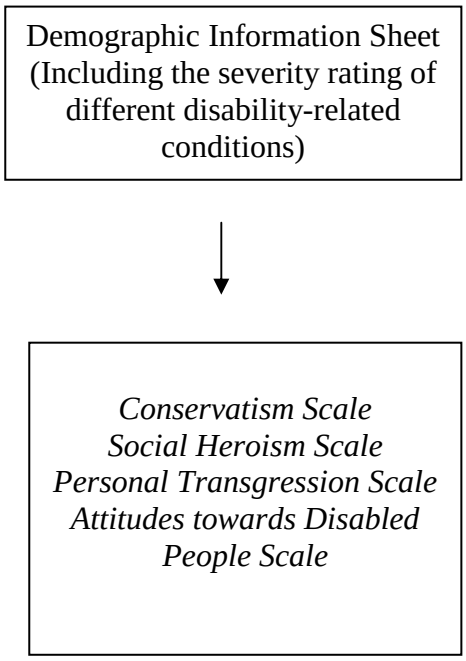
1	2	3	4	5
Hiç hissetmedim		**Kararsızım**		**Çok hissettim**

** Question for the mortality salience and control salience conditions.

APPENDIX O

DESIGN OF THE STUDY

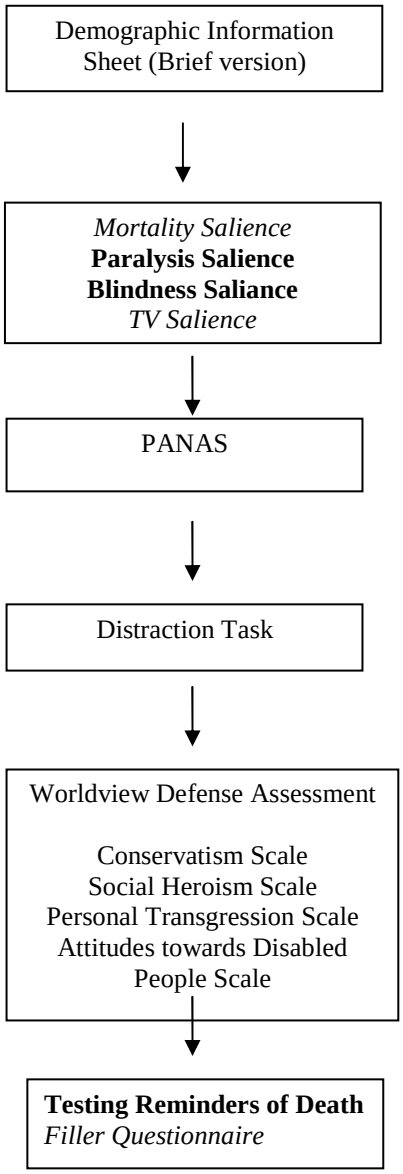
Time 1 Assessment



APPENDIX O

DESIGN OF THE STUDY (continued)

<u>Time 2 Assessment</u> (after 2 weeks)



APPENDIX P

Participant Numbers across Conditions

DV: Social Heroism Levels at Time 2

Manipulation Type	**Social Heroism Levels at Time 1**	**N**
Mortality Salience	Low	21
	Moderate	17
	High	30
	Total	68
Control Salience	Low	19
	Moderate	13
	High	12
	Total	44
Blindness Salience	Low	16
	Moderate	21
	High	15
	Total	52
Paralysis Salience	Low	14
	Moderate	15
	High	14
	Total	
Total	Low	70
	Moderate	66
	High	71
	Total	207

APPENDIX P

Participant Numbers across Conditions (continued)

DV: Personal Transgression Levels at Time 2

Manipulation Type	Personal Transgression Levels at Time 1	N
Mortality Salience	Low	24
	Moderate	29
	High	18
	Total	71
Control Salience	Low	13
	Moderate	13
	High	18
	Total	44
Blindness Salience	Low	16
	Moderate	16
	High	22
	Total	54
Paralysis Salience	Low	18
	Moderate	11
	High	18
	Total	47
Total	Low	71
	Moderate	69
	High	76
	Total	216

APPENDIX P

Participant Numbers across Conditions (continued)

DV: Attitudes towards Disabled People at Time 2

Manipulation Type	**N**
Mortality Salience	44
Control Salience	14
Blindness Salience	24
Paralysis Salience	17
Total	99

APPENDIX Q

CURRICULUM VITAE

PERSONAL INFORMATION

Surname, Name: Koca-Atabey, Müjde
Nationality: Turkish (TC)
Date and Place of Birth: 19 January 1981, Ankara
Marital Status: Married
Phone: +90 312 468 53 00/2608
email: mujde.atabey@tubitak.gov.tr, kocamujde19@hotmail.com

EDUCATION

Degree	Institution	Year of Graduation
MS	University of Liverpool	2006
BS	METU Psychology	2004
High School	Büyük Kolej, Ankara	1999

WORK EXPERIENCE

Year	Place	Enrollment
2007-Present	TUBITAK-SOBAG	Scientific Programmes Assistant Expert
2004	Association for the Protection of Children Who Can be Educated	Psychologist

FOREIGN LANGUAGES

Advanced English, Basic German

PUBLICATIONS

1. Koca-Atabey M. (revision submitted). Reflecting on the experiences of disabled university students in Turkey and the UK. *Disability & Society.*

2. Koca-Atabey M. & Oner-Ozkan, B. (in press). Defensive or existential religious orientations & mortality salience hypothesis: Using conservatism as a dependent measure. *Death Studies.*

3. Koca-Atabey, M., Karanci, A. N., Dirik, G. & Aydemir, D. (2011). Psychological well-being of disabled Turkish university students with physical impairments: An evaluation within the stress-vulnerability paradigm. *International Journal of Psychology, 46,* 106-118.

4. Koca-Atabey, M. (2009). The Annan Plan for Cyprus as a prisoner's dilemma game. *Bilig, 50,* 1-14.

5. Koca-Atabey, M. (2007). Flow experience and intrinsic versus extrinsic motivation among graduate students: An interpretative phenomenological analysis. *PRIME Journal, 2,* 111-121.

6. Koca, M. (2006). The problems faced by disabled students in higher education: An ethical perspective. 'Current research on moral education and development in Europe. Mosaic 2005 Conference Research Review.' (extended abstract) *Journal of Moral Education, 35,* 129-136.

PRESENTATIONS

1. Koca-Atabey, M. (2010). Determining the factors relating attitudes towards disabled people: Frequent contact or having a family member? *16th National Psychology Congress,* 14-17 April 2010, Mersin, Turkey.

2. Koca-Atabey, M. (2009). The Annan Plan for Cyprus as a prisoner's dilemma game. (Poster presentation). *III. Postgraduate Psychology Students Congress,* 24-28 June 2009, Istanbul, Turkey.

3. Koca-Atabey, M., Karanci, A. N., Aydemir, D., Dirik, G. (2008). Psychological stress and stress-related growth among disabled university students. *15th National Psychology Congress,* 3-5 September 2008, Istanbul, Turkey.

4. Koca-Atabey, M. (2008). The social value of higher education for disabled university students: A comparison between Turkey and the UK. *Postgraduate and Newer Researchers Conference,* 8 December 2008, Liverpool, UK.

5. Koca-Atabey M. & Oner-Ozkan, B. (2008). Different religious orientations, existential or defensive: A terror management perspective. *II. Postgraduate Psychology Students Congress,* 26-29 June 2008, Kastamonu, Turkey.

6. Koca, M. (2006). Flow experience and intrinsic versus extrinsic motivation among graduate students: An interpretative phenomenological analysis. *26th International Congress of Applied Psychology,* 16-21 July, Athens, Greece 2006.

7. Koca, M. (2005). The problems of disabled students in higher education: An ethical perspective. *Moral and Social Action Interdisciplinary Colloquium Annual Conference, 20-22 July 2005,* Konstaz, Germany.

8. Koca, M. (2005). Disability for whom? Disability definitions according to the social model. *National Psychology Students Congress,* 4-7 July 2005, Mersin, Turkey.

9. Hewertson, H., Koca, M., Leneham, B., Leung, F., Musto, J. & Withers, L. (2005). Why students fail: A learning and teaching model. *Pedagogical Action Research Symposium: 'Learning and teaching: insights, innovations and interventions',* 16 June 2005, Liverpool, UK. (Equal contribution, alphabetical order).

SCHOLARSHIP

TUBITAK, National Scholarship Programme for PhD Students. (ceased). 01.09.2006-09.07.2007.

TUBITAK, National Scholarship Programme for MSc Students. 01.03.2005-31.08.2006.

HOBBIES

Literature, cinema & swimming

APPENDIX R
TURKISH SUMMARY

Kayıp Kaygısının Göstergesi Olarak Engelin Hatırlatılması Durumu: İnsanlığın Temel Korkusu Üzerine Alternatif Bir Açıklama

GENEL BAKIŞ

Bu tez engel ve Dehşet Yönetimi Kuramı [DYK] çerçevesinde kayıp olgusunu araştırmayı amaçlamaktadır. Engel insana özgü bir durumdur (Shakespeare, 2006). Ancak seçilmiş veya istenmiş değildir. Türkiye'deki engelli kişi sayısı (en az) 8,5 milyondur (Başbakanlık Özürlüler İdaresi Başkanlığı, 2007).

Engel sosyal modele göre tanımlanır, buna göre kişiyi engelli kılan var olan sorun değil toplumdur (örn. Barnes & Mercer, 2004). Dehşet Yönetimi Kuramı ise insanlar için en temel korkunun ölüm olduğunu ve bu korku ile başa çıkmanın kültürel dünya görüşlerini savunma ya da öz saygıyı arttırma yolu ile mümkün olabileceğini iddia eder (örn. Solomon, Greenberg, & Pyszczynski, 1998).

Bu tez, günümüzde ölümün tek ve en "korkutucu" kavram olmadığını kanıtlamayı amaçlamıştır. Engelli olmak daha korkutucu olabilir. Bu nedenle, ölümün hatırlatılması koşulunda olduğu gibi engelin hatırlatılması koşulunda da katılımcılar kültürel dünya görüşlerini savunma tepkisi vereceklerdir.

"En iyi ihtimalle ölürsün…"

GİRİŞ

Becker'in (1973) çalışmalarından ilham alan Dehşet Yönetimi Kuramı insan zekâsının kişiye ölümlülüğü ile ilgili bir bilinç kazandırdığını savunur. Bu bilgi dayanılmaz bir korku yaratır. DYK, bu korkuyla başa çıkmak için iki temel yol önerir; gerçeği anlamlandırmaya yardımcı kültürel dünya görüşüne sarılmak ya da

tehlikeler karşısında kaygıyı azaltması için öz saygıyı güçlendirmek (Greenberg, Pyszczynski, Solomon, & Rosenblatt, 1990; Solomon, Greenberg, & Pyszczynski, 2000; Solomon, Greenberg, & Pyszczynski, 1998; Jones & Fischer, 2006). Dehşet yönetimi kuramına göre, insanlar ölümlülüğün hatırlatılmasının ardından kültürel dünya görüşlerini savunurlar ya da doğrularlar (ölümlülüğün hatırlatılması hipotezi); veya öz saygılarını korur ya da güçlendirirler (öz saygı hipotezi) (Greenberg, Solomon, & Pyszczynski, 1997).

Ölümün Hatırlatılması ve Kültürel Dünya Görüşünü Savunma

Literatürde pek çok farklı ülkede yapılmış oldukça fazla sayıda çalışma, şu temel hipotezi desteklemektedir: kişiye kendi ölümü hatırlatılması kültürel dünya görüşüne sarılma sonucunu doğurmaktadır. Kontrol grubundaki katılımcılara ise "önemli bir sınavda başarısız olma", "diş ağrısı çekme" ya da "televizyon seyretme" ile ilgili sorular sorulur. Her hangi başka bir koşulun aksine yalnızca ölümün hatırlatılmasının ardından dünya görüşünü savunma davranışı gösterirler (örn. Greenberg, Simon, Jones-Harmon, Solomon, Pyszczynski, & Lyon, 1995; Florian, Mikulincer, & Hirschberger, 2001).

Ölümlülüğün hatırlatılması durumunun etkileri oldukça çeşitlidir. Kendi ölümlülüğünün hatırlatılmasının ardından katılımcıların ahlak kurallarını ihlal eden birine örneğin bir hayat kadınına karşı daha fazla ceza, bunun yanında bir kahramana ise daha fazla ödül verdikleri görülmüştür (Rosenblatt, Greenberg, Solomon, Pyszczynski, & Lyon, 1989). Ölümlülüğün hatırlatılması manipülasyonunun ardından insanların politik olarak daha muhafazakârlaştıkları da bulunmuştur (Landau ve ark., 2004). Çalışmalar ölümlülüklerinin hatırlatılmasının ardından Hıristiyan katılımcıların Yahudilere kıyasla Hıristiyanları tercih ettikleri ve Amerikalıların Amerika karşıtı olan yazara negatif tepki verdiklerini göstermiştir (Greenberg ve ark., 1990). Ölümlülüğün hatırlatılması manipülasyonunun dış gruplara yönelik basmakalıp düşünceleri de arttırmaktadır (Schimel, ve ark., 1999).Örneğin ölümün hatırlatılmasından sonra (yalnızca) kadınların engellilere

gösterdikleri sevecenliğin arttığını göstermiştir (Hirschberger, Florian, & Mikulincer, 2005). Bunun yanında, Galliot ve arkadaşları (2008) ölümün hatırlatılmasının ardından tekerlekli sandalye kullanan anlaşmalı deneğe yapılan yardımın arttığını ortaya koymuştur. Hirsberger ve arkadaşları (basılmamış çalışma) ise tam tersini iddia etmektedirler. Ölümün hatırlatılmadığı durumda katılımcıların tekerlekli sandalye kullanan bir anlaşmalı deneğe daha çok yardım ettiğini göstermiştir (aktaran Hirsberger, 2008). Katılımcıların ölümüm hatırlatılmasının ardından kanser hastası kişilerden uzaklaştıkları bulunmuştur (Mosher & Danoff-Burg, 2007).

Ölümlülüğün hatırlatılmasının etkisini istenilen çocuk sayısıyla ilişkili olarak da incelenebilir. Ölümlüğün hatırlatıldığı durumda, hatırlatılmadığı duruma kıyasla evlat sahibi olma isteğinin anlamlı bir şekilde arttığı görülmektedir Fritsche, ve ark., 2007).

Ölüm Kaygısı ve Dehşet Yönetimi Kuramı

Becker'e (1973) göre ölüm korkusu doğuştan gelir ve önemlidir. DYK'nın altında yatan korku ölüm kaygısıdır. Ancak ölüm kaygısı ile neyin kastedildiği cevaplanmamış bir sorudur. Kavramın kendini açıkladığı düşünülür. Ayrıca, ölüm kaygısının tek boyutlu olduğu yönünde bir varsayım vardır (Benton, Christopher, & Walter, 2007). Fakat, ölüm kaygısı çok boyutlu bir kavramdır (örn. Florian & Kravetz, 1983; Henley & Donovan, 1999; Depola, Griffin, Young & Neimeyer, 2003; Martz, 2004). Bazı boyutların diğerlerinden daha korkutucu olduğu düşünülür. Örneğin sevdiğiniz birinin ölümü kendi ölümünüzden daha korkutucu olabilir (Henley & Donovan, 1999). Bunun yanında, harap edilmek, erken ölmek, bilinmeyenin korkusu, bilinci yerindeyken ölmek ya da öldükten sonra bedenin durumu ile ilgili korku ölüm kaygısının boyutları arasında sayılabilir (bu konudaki tartışma için bkz. Depola ve ark., 2004). İki değişik çeşit ölüm kaygısından da bahsedilmektedir. Varoluşçu ölüm kaygısı bilinmeyen ölüm kaygısı (ölen kişiye ne olacaktır) ve somut ölüm kaygısı ise bilinen ölüm kaygısı (kişi ölürken ya da öldüğünde bedenine ne olacaktır) olarak kavramsallaştırılır (Benton, ve ark., 2007).

Yirminci yüzyılda ölümle ilgili tutumların değiştiği tartışması yaşanmaktadır. Geçmişte ölüm doğal bir süreç olarak görülürdü. Pek çok insan *çabuk ölüm* yaşardı. Ancak günümüzde pek çok kişi ağır semptomların eşlik ettiği *yavaş ölümler* yaşıyorlar (Adelbratt & Strang, 2000). Long (2004)'a göre ise pek çok sağlıklı yetişkin fazla acı ve ıstırabın olmadığı kolay ölümler umuyorlar. Modern toplumlarda ölüm bir başarısızlık gibi algılanıyor. Muhteşem bir yolculuk ve büyük bir yalnızlığın başlangıcı olarak (Elias, 1985; Greenberg, 1986). Bu durumda hayatta kalanlar kahraman (Little & Sayers, 2004) ölenler de kurban olarak nitelendiriliyor.

Engelin Modelleri

Birbirleriyle yarışan iki engel modeli vardır. Eskisi tıbbi model yenisi ise sosyal modeldir. Tıbbi model sosyal koşullara karşı biyolojik koşulları savunur. Bu modele göre engel bir hastalıktır ve klinik terimlerle tanımlanır (Ong-Dean, 2005; Oliver, 1996). Sosyal model 1970'lerin başlarında (Shakespeare, 2005), engelin kişisel sınırlılıklardan ziyade sosyal yapının bir ürünü olduğunun anlaşılmasıyla doğar (Oliver, 1996). Bu nedenle insanın yaşadığı sosyal çevre, engelinin ana nedenidir (Davis & Green, 1999). Tüm bu nedenlerle engel sosyal bir yapıdır (Kelley-Moore, Schumacher, Kahana, & Kahana, 2006). Sosyal modele göre vücudunu hareket ettirememek bir fiziksel sorunsa fiziksel ve teknolojik imkânsızlıklar nedeniyle yataktan kalkamamak engeldir (Morris, 1993).

Tıbbi model, trajedi modeline oldukça benzemektedir. Bu modele göre kör bir insan görememesinden dolayı kişisel bir trajedi yaşamaktadır (Morris, 1991; Davis & Green, 1999). "Trajedi modeli başlı başına engelleyicidir. Bu model insanların engelleyici bir toplumla ilgili deneyimlerini, hayattan aldıkları zevki, kişiliklerini ve engelli bir insan olarak özfarkındalıklarını yok sayar" (Morris, 1991, p. 35). Engelli insanların mutsuz, aciz olduklarını, değersiz, çirkin ve yetersiz hissettiklerini kabul eder. Shakespeare (2005) tüm götürülerine rağmen gençlik ve

güzelliğe bu kadar değer vermenin toplumda mutsuzluk ve memnuniyetsizlik yaratacağını söyler.

Bazı araştırmacılar tıbbi model ile trajedi modelinin bireysel modeli oluşturduğunu söylerler (Motris, 1993; Oluver, 1996). Bu modele göre engel kişisel bir sorundur ve profesyonel hâkimiyet, bakım, kontrol ve kişisel adaptasyon gerektirir. Diğer yandan sosyal model ise engeli sosyal bir problem olarak görür, kişisel ve toplumsal sorumluluğu, seçimi, hakları ve sosyal değişimi değerli kılar. Politikalar yerine politikacılığı, tıbbileştirme (Colucci, 2006) yerine kendi kendine yetmeyi vurgular (Oliver, 1996).

Sosyal modelin her şeyi açıklayabildiği yargısına da varmamak gerekir. Sosyal model engeli tamamen sosyal bir kavram olarak tanımladığından fiziksel farklılıkları ve bedenle ilgili deneyimleri reddeder (Morris, 1991). Bu toplumun rolünü belirginleştirmeyi amaçlayan bilinçli bir durum (Oliver, 1996) olsa da her zaman doğru değildir. Shakespeare'e (2006) göre tıbbi-sosyal model ikilemi kendi başına tehlikelidir. Sosyal model çığır açan bir yaklaşım olsa da kendi içinde basite kaçan ve yanıltıcı olduğu da göz ardı edilmemelidir (Shakespeare, 2004)

Ölüm Kaygısı ve Engel Kaygısı

Fish (1986) fiziksel engelli insanların engeli olmayanlara kıyasla ölüme daha yakın olarak algılandıklarını söyler. Kimi zaman engel *yaşayan ölüm* durumu olarak da nitelendirilir (Greenberg, 1986). Ölüm ve engelin benzeştiği ve ayrıştığı pek çok nokta vardır. Örneğin ölüm kalıcıdır, pek çok engel de uzun süreli veya kalıcıdır. Ölüm belirsizken engel nispeten daha belirlidir. Bunun yanında ölüm adildir çünkü herkes ölür ama engel adil değildir çünkü sadece bazı insanlar engellidir. Ölüm tam bir kayba neden olurken engel vücudun bir bölümünün ya da fonksiyonelliğinin kaybıdır. Ancak bu durum hayat kalitesinin, statünün, değer verilen kişilerin, işin kaybedilmesi anlamına da gelebilir.

İnsanları korkutan bir olgu olduğundan ölüm gibi engelin de varoluşçu bir korku olduğu düşünülebilir. Ölümü ıstıraba tercih edenler istisna olarak görülse de (Solomon, Greenberg, & Pyszczynski, 1997) pek çok insanın ölümü engelli olmaya tercih ettiği de unutulmamalıdır (örn. Hahn, 1988).

DYK, ölümün varoluşçu bir korku olduğunu söyler (Becker, 1973), insanlar da bu korkunun üstesinden gelmeye çalışırlar. Örneğin din ölüm sorunsalını cennet sözü vererek çözmüştür (Becker, 1973; bu konuda bir tartışma için bkz. Lerner, 1997). Dini başa çıkma yöntemleri engelli insanlar ve yakın çevreleri tarafından kullanılsa (örn. Bennett, Deluca, & Allen, 1995; Dura-Vila, Dein & Hodes, 2010), kişisel bir rahatlama sağlasa ya da isyan etmeyi engellese de (Bezmez & Yardımcı, 2009), engelle ilgili tam bir çözüm sunmaz. Ne din ne de tıp engel problemini çöz(e)memektedir.

Hahn'a (1988) göre engelsiz bir insan için (gelecek/muhtemel) bir engelin yarattığı kaygı ölümün yarattığından fazladır. Kaçınılmaz olan ölüm daha kaçınılır olarak nitelendirilen engele tercih edilir. Pek çok durumda insanlar ölümü tercih edebilir. Örneğin ölümcül bir hastalığı olan ve sürekli acı çeken bir kişi için en büyük korku ölüm değil hayatın devam etmesidir (Snyder, 1997). Muraven ve Baumeister'a (1997) göre ölüm insanlar için en büyük güdü olamaz çünkü insanlar başka seçenekler de mevcutken ölmeyi tercih edebilir. Miller (1993) toplumun engelli insanları intihara sürüklediğini söyler. Bu bakış açısına göre intihar bir tercih değil kısıtlayıcı ortamlarda yaşamaktan kaynaklanan akılcı bir davranıştır. Bunun yanında, Clark (1992) hayatlarına son veren pek çok insanın sağlık durumlarının iyi olduğunu söylemektedir.

Çalışmanın Hipotezleri

Ölümlülüğün hatırlatılması koşulunun yanında, engelin hatırlatılmasının da kültürel dünya görüşleri açısından etkili olduğu düşünülmektedir. Katılımcıların ölümlülüğün hatırlatılması, körlüğün hatırlatılması ve felcin hatırlatılması

durumlarında dünya görüşlerine sarılacakları varsayımı yapılmaktadır. Ayrıca, katılımcıların söz konusu dünya görüşü ile ilgili önceki tutumlarının da önemli olduğu düşünülmektedir. Ayrıca ölüm ve engelin nitel ve nicel olarak farlılaşıp farklılaşmadığı da araştırılmıştır. Aşağıdaki hipotezler test edilmiştir:

H1: Muhafazakârlık/Kişisel Suçlar/Sosyal Kahramanlık/Engellilere yönelik tutumlarla ilgili ilk puanları düşük olan katılımcıların aldıkları puanlar, ölümlülüğün hatırlatılması, körlüğün hatırlatılması ve felcin hatırlatılması koşullarında kontrol koşulundaki katılımcılara kıyasla daha düşük olacaktır.

H2: H1: Muhafazakârlık/Kişisel Suçlar/Sosyal Kahramanlık/Engellilere yönelik tutumlarla ilgili ilk puanları yüksek olan katılımcıların aldıkları puanlar, ölümlülüğün hatırlatılması, körlüğün hatırlatılması ve felcin hatırlatılması koşullarında kontrol koşulundaki katılımcılara kıyasla daha yüksek olacaktır.

H3: Körlüğün hatırlatılması ve felcin hatırlatılması koşulları ölümlülüğün hatırlatılması koşulundan daha etkili olacaktır.

H4: Engel (körlük ve felç) niteliksel açıdan ölümden farklılaşacaktır.

H5: Körlük ve felç nitel olarak benzeşecektir.

YÖNTEM

Veriler Ankara'daki 278 üniversite öğrencisinden toplanmıştır. Öğrencilerin yaşları 18-27 arasındadır ortalama yaş ise 20.19'dur (SS: 1.24). Araştırmada, Sosyal Kahramanlık Ölçeği, Kişisel Suçlar Ölçeği (Aslıtürk, 2001) Engelli Kişilere Yönelik Tutumlar Ölçeği (Koca-Atabey, 2010). Muhafazakârlık Ölçeği (Wilson & Patterson, 1968; Koca-Atabey & Öner-Özkan, baskıda) kullanılmıştır. Pozitif ve Negatif Duygu Durum Ölçeği (Watson, Clark, & Tellegen, 1998; Gençöz, 2000) hem duygu durumu değişikliklerini ölçmek hem de bulmaca ile birlikte erteleme sağlamak için kullanılmıştır (örn. Greenberg, Pyszczynski, Solomon, Simon, & Breus, 1994; Arndt, Greenberg, Solomon, Pyszczynski, & Simon, 1997).

Çalışmada, ölümlülüğün hatırlatılması (örn. Greenberg et al., 1990; Goldenberg, Pyszczyniski, Greenberg, Solomon, Kluck, & Cornwell, 2001) körlüğün hatırlatılması ve felcin hatırlatılması durumları ile ilgili ikişer soru sorulmuştur. Kontrol grubuna ise televizyon izleme ile ilgili paralel iki soru sorulmuştur.

İŞLEM

Bu çalışma Ankara'daki üç üniversitede yürütülmüştür. Katılımcılara iki hafta ara ile ikişer kez ulaşılmış ve "çeşitli konulardaki tutumlar" ile ilgili olan bu araştırmaya katılmaları istenmiştir. Katılımda gönüllülük ilkesi esastır. İkinci oturumun sonunda, engelin hatırlatılması koşulundaki katılımcılara engel ile ilgili soruları cevaplarken ölümün akıllarına gelip gelmediği de sorulmuştur (1 = hiç aklıma gelmedi, 5 = hep aklımdaydı). Diğer katılımcılara boşluk dolduran bir soru sorulmuştur. Çalışmanın sonunda katılımcılar bilgilendirilmiştir.

BULGULAR

Analizler veriler kontrol edildikten sonra (bkz. Tabachnick & Fidell, 1989), 217 katılımcı ile gerçekleştirilmiştir. Katılımcıların ortalama yaşı 20.18'dir (SS: 1.21); 142 kadın ve 75 erkek bulunmaktadır.

Katılımcıların 5 değişik engel grubuyla ilgili değerlendirmeleri Wilcoxon Signed Ranks Test aracılığıyla karşılaştırılmıştır. Buna göre, görme engelinin algılanan şiddeti (*Mdn* = 4.00), yürüme engelininkinden fazladır (*Mdn* = 3.00), $Z = -6.15$, $p < .001$.

Hipotezlerin Test Edilmesi

Niceliksel Analiz

Nicel analizler sonucunda anlamlı sonuçların çıktığı tek bağımlı değişken muhafazakârlıktır. Katılımcılar Zaman1'deki muhafazakârlık seviyelerine göre üç

gruba ayrılmışlardı; muhafazakârlık seviyeleri düşük olanlar (*M* = 70.89, *SD* = 6.86), orta olanlar (*M* = 85.43, *SD* = 5.15) ve yüksek olanlar (*M* = 95.26, *SD* = 7.23). Zaman 2'deki muhafazakârlık seviyeleri üzerinde 3 (Zaman 1'deki Muhafazakârlık Seviyeleri: Düşük, Orta, Yüksek) X 4 (Manipülasyon: Ölümlülüğün Hatırlatılması, Kontrol, Körlüğün Hatırlatılması, Felcin Hatırlatılması) cinsiyetin kovaryant olduğu ANCOVA yapılmıştır. Bulunan ortak etki anlamlıdır, F (6, 201) = 3.36, $p < .05$, $\eta^2 = .09$. Ortak etkiyi incelemek için Bonferroni analizi ile ikili karşılaştırmalar yapılmıştır. Zaman 1'deki muhafazakârlık seviyeleri yüksek olan katılımcıların Zaman 2'de de ölümlülüğün ve felcin hatırlatılması koşullarında katılımcıların kontrol koşuluna kıyasla daha yüksek muhafazakârlık gösterdikleri saptanmıştır. Ölüm ile felç arasında ise herhangi bir fark bulunmamıştır.

Bağımlı değişkenin engellilere yönelik tutumlar olduğu durumda ise gruplar arası dengesiz dağılımdan dolayı Zaman 1'deki değişken gruplandırılamamış ve Zaman-2'deki değişken üzerinde tek yönlü ANOVA yapılmıştır. Manipülasyon temel etkisi bulunmuştur F (3, 95) = 3.00, $p < .05$, $\eta^2 = .09$. Yapılan Tukey testi sonucunda Ölümlülük ile körlük arasındaki fark marjinal seviyede anlamlıdır (p = .055), körlük ile kontrol koşulları arasında da anlamlı bir fark bulunmasa da bir eğilim olduğu söylenebilir (p = .067). Sosyal kahramanlık ve kişisel suçlar ile ilgili analizlerde ise hipotezler ile ilgili anlamlı farlılıklar bulunamamıştır, F (6, 194) = 0.94, $p > .05$ ve F (6, 203) = 1.01, $p > .05$. Nicel analizler sonucunda araştırmanın ilk üç hipotezi test edilmiştir.

Niteliksel Analiz

Hipotez 4 ve 5'i test etmek için içerik analizi (Wilkinson, 2003) yapılmıştır. Ortaya çıkan en önemli tematik birimlerden biri katılımcıların bahsettikleri "üzüntü" lerdir. Deney gruplarındaki "üzüntü" seviyelerini beklenen düzeylerle karşılaştırmak için ki-kare testi yapılmıştır. Buna göre deney grupları ile genel üzüntü seviyeleri arasındaki ilişki anlamlı değildir χ^2 (2, N = 172) = 0.56, p = ns. Bunun yanında

deney grupları (ölümün, felcin ve körlüğün hatırlatılması) ile kişisel üzüntü seviyeleri arasındaki ilişki anlamlıdır χ^2 (2, N = 172) = 19.00, p < .01.

TARTIŞMA

Ölümlülüğün sürekli hatırlatıldığı bir dünyada yaşıyoruz. Bu nedenle özellikle insanlara ölümlülüğü hatırlatmak çok zor olmamalı. Çünkü ölüm her yerde, televizyonda, gazetelerde yolda… Hâlbuki engel gizli, utanç duyulan ve zaten çokça da karşılaşılmayan bir durum. En azından ölüm kadar hatırlanır değil. Trafik kazalarından kurtulan ya da gazi olan yaralılar iyileşiyor ve sonsuza kadar mutlu yaşıyor! Ancak, ne yazık ki gerçek süreç böyle işlemiyor. Bu nedenle insanlara engeli hatırlatmak daha zor olabilir. Bu durum çalışmada niçin sadece bir değişkende anlamlı sonuçlar bulunduğunu anlamamıza yardımcı olur. Bath (2010) insanların ölümle ilgili olarak şu iki soruyu sürekli sorduklarını söylüyor: Ne zaman? Ve nasıl? Olası bir engelle ilgili bu tip sorular sorulmaz, o sadece kötü bir talihtir.

Bu çalışmanın sonuçları şu soruyu sormamıza neden oluyor: Acaba dehşet yönetimi kuramına göre ölüm özel bir durum mu yoksa sadece uygun bir örnek mi? Eğer ölüm uygun bir örnekse, o zaman zengin bir iş adamı/iş kadını için iflas etmek, bir süper model ya da sporcu için kilo almak da benzer sonuçlar doğurabilir. Bu nokta da engel uygun bir örnektir çünkü engelli olmayan tüm insanlara uygulanabilir.

Dehşet yönetimi kuramını temelinde varoluşçu bir kaygı değil var olanı kaybetme korkusu vardır denebilir. Bu noktada belirsizliğin hatırlatılması (van den Bos, Poortvliet, Maas, Miedema & van den Ham, 2005) durumu da bir kaybetme örneği olabilir. Bilgiyi, planlama kabiliyetini ve kontrolü kaybetme…

Üzerinde durulması gereken önemli bir nokta da ölüm ile engelin ayrıştığı noktalardır. Bu çalışmada yapılan niteliksel analizlerden çıkan sonuçlara göre,

engelli olan kişi kendi için üzülürken, ölüm hatırlatılan kişi yakınları için üzülür. Bunun yanında ölüm ile engel birbirlerinden tamamıyla farklı kavramlar da değildir. Çalışmada bazı katılımcıların körlük ve felci ölümle ilişkilendirdiği de görülmüştür.

Çalışmanın sonuçları "engellilik" kavramı ve engelin algılanışı ile ilgili önemli ipuçları vermektedir. Engellilerle ilgili tutumların iyileştirilmesi çalışmalarında yol gösterici olabilecektir. Engel, yarattığı korku nedeniyle insanları rahatsız eder. Bu durumu ortadan kaldırmak ve engelli insanların kişilerarası ilişkilerde yaşadıkları sıkıntıları en aza indirmek ancak engelin korkunçluğunu azaltarak gerçekleştirilebilir.

Çalışmada ölümün yegâne temel korku olmadığı hipotezi irdelenmiş ve tezde edinilen bulgular ölümden daha temel olarak kayıp korkusunun olabileceği yönünde işaretler vermiştir. Bu da Dehşet Yönetimi Kuramını sorgulayan bir açıklamadır. Öte yandan DYK'nın temelinde anlamlı bir hayat arayışının yattığını düşünürsek (tartışma için bkz. Ryan & Deci, 2004), yüksek derecede kayıp içereceği düşünülen olası bir felç durumu hayatın anlamını sarsacaktır. Bu durum engelle barışık ortamların gerekliliğini bir kez daha ortaya koymaktadır.