THIRD EDITION

ROUTLEDGE

DEATH, DYING, AND BEREAVEMENT IN A CHANGING WORLD

ALAN R. KEMP

"Dr. Kemp gently disarms the Western instinct to look away from death. By exploring how other cultures honor dying, grief, and remembrance, he offers the safe distance of an observer—until we realize we are looking at ourselves. In witnessing how others grieve openly and keep the dead present in community life, we see how deeply our own culture denies mortality, that closure, and how much that denial costs us. Our funerals seem to be more of a ritualistic stacking up all of our grief/loss in one place, on one person or family. So we can compartmentalize. In a society that treats death as failure and mourning as indulgence, Dr. Kemp offers a quiet redirect. He shows that feeling loss fully is not weakness or a detriment, but participation in life. With honesty, warmth, and humor, he makes the ever-present fear driving so much of human behavior tangible, even approachable. His work in thanatology reminds us that remembering is its own form of healing—and that acknowledging death as a natural consequence of having been gifted a short time on earth, restores life to its full meaning."

Dr. Ricky Pendergrass, *D.O., Primary Care Physician*

"A Cancer diagnosis brings the reality of death right to the front of one's consciousness. *Death, Dying, and Bereavement in a Changing World* is more than a textbook. I am using it to navigate my own Cancer journey. The chapter information is current and far reaching, even extending to the subject of grief and bereavement on the loss of our beloved animal companions. The activities, suggested readings and online links are especially helpful to me, as I use this book as a working guide. I suggest that readers answer the questions and do the exercises at the end of each chapter for a personalized learning experience on a challenging topic."

Anonymous Cancer Patient

"*Death, Dying, and Bereavement in a Changing World* goes beyond anything I have read on this subject. Dr. Kemp's exploration into thanatology, the study of death, dying and bereavement is written as a textbook, but it is more than that, it is a guidebook on to how to live, die and grieve in today's world. It delves into the social, spiritual, psychological and human experience throughout history and across many different cultures and religions. It also touches on challenging topics, such as suicide, death due to violence, pandemics, medical assistance in dying, alternative death care and much more. My favorite chapter is the last chapter 'Learning to Live Until We Die'. It is a reminder to embrace life fully. I highly recommend this book to everyone."

Susan O'Brien, *Medical Education Consultant*

"Dr. Kemp's comprehensive background as an educator and human services professional is clearly evidenced as he applies developmental theory and research combined with sociological data and analysis to explore the breadth of ways humans at various stages of life experience death, dying and bereavement. His work provides critical foundational information for the practice of professionals who support those anticipating or experiencing actual loss and death.

While Dr. Kemp focuses on the needs of individuals across the span of a full lifetime, his sensitive handling of the unique challenges presented by the young are particularly insightful and helpful. He explores the ways children form concepts of death and permanence through the lens of well-substantiated theory and research relative to cognitive limitations in the early years of development and includes strategies and activities to stimulate conversation, relieve stress and process emotions. He clarifies the impact of maturation and experience on an individual's ability to process and ultimately comprehend profound and permanent loss. Dr. Kemp's broad treatment of the full range of human responses to the inevitable and universal experience of permanent loss includes attention to each developmental domain: emotional, physical, cognitive, social, and spiritual. His

work provides a significant contribution to the field of study for professionals who would journey with those experiencing the ravages of loss."

Judy DeJardin, *Chair Emerita, Social Science Division, Pierce College*

"On February 10, 2026, Canada experienced its first secondary-school mass-shooting, at Tumbler Ridge, British Columbia. My first response of shock was followed by pondering the question, 'Where do professionals turn when they need guidance in assisting with community healing following such an unimaginable tragedy.' I was reminded of the work that Alan shared with me during the rewrite of his book, *Death, Dying, and Bereavement in a Changing World*. I am thankful for the existence of this resource, as it is one that educates and offers guidance to our present and future care providers. This current edition is more than a revision. It is a presentation of current issues and challenges facing a world that is indeed changing."

Elizabeth Warren, RN, BSc., MBA,
Healthcare Administrator and Consultant

"Ever since Dr. Elizabeth Kulber-Ross published her ground breaking book, *On Death and Dying*, there has been an increasing amount of research and interest in this subject. Dr. Kemp's 3rd edition is a comprehensive and contemporary addition. His book explores the topic of approaching death not usually found in texts. I applaud Dr. Kemp's depth of research and his clearly written approach. This is an important contribution to the death and dying scholarly literature."

Arthur J. Tirotta, *Licensed Mental Health Counselor* (Retired)

"This textbook is as broad and informative as the topic of death and dying is deep and wide. Many educators and practitioners will value the way Dr. Kemp weaves together how our body, heart, mind and spirit are called upon to participate in this journey … In my decades of teaching and practicing in gerontology and thanatology, few have achieved Dr. Kemp's level of mastery in teaching, research, writing, counseling, and spiritual guidance. This textbook is a wonderful resource as an introduction to the complexities and the many rewards of exploring the topic of death and dying. I highly recommend it to you and your students."

Leon Khalsa, *Professor of Psychology and Sociology, Pierce College*

"By applying the sociological imagination to the study of death, dying, and bereavement, Alan Kemp shows us that while death is a personal tragedy it is also a social event intertwined with culture, history, and at times social inequality. His book reminds us that every individual's death – like their life – is embedded in a social context."

Dr. Cullen Clark, *Ph.D., Director, Online MA Program in Applied Sociology and Associate Teaching Professor, University of Alabama at Birmingham*

"In his analysis of the current movements around alternative death care, author Alan Kemp takes on the shifting needs and desires of an aging population raised on ethics of environmentalism and authenticity that is in some ways the antithesis of a generation of funeral consumers before them. Kemp does a remarkable job of synthesizing and ordering the complex social, cultural, and technological changes that are rapidly evolving in U.S. funeral practices today."

Lee Webster, *Funeral Reform Advocate, and Author,* The After-Death Care Educator Handbook *and* Changing Landscapes: Exploring the Growth of Ethical, Compassionate, and Environmentally Sustainable Funeral Service

Death, Dying, and Bereavement in a Changing World

In this introductory text on thanatology, Alan R. Kemp takes on the central question of mortality: the ubiquitous presence of death despite the very human propensity to deny its relevance to oneself, personally. Drawing on the work of pioneering anthropologist Ernest Becker, *Death, Dying, and Bereavement in a Changing World* provides a multidisciplinary and multidimensional introduction to the study of death, dying, and bereavement, putting extra emphasis on how we understand and experience it in a rapidly changing world.

This new, third edition includes the most up-to-date coverage of the research, data, and figures related to death, dying, and bereavement. It includes coverage of new research on the alternative death care movement, the impact of the COVID-19 pandemic, suicide, homicide, mass shootings, as well as terrorism and domestic extremism. Also covered is discussion about the use of cannabis to help address the effects of treatments for life-threatening illnesses, like cancer, clinical studies on the use of psychedelics to help with end-of-life-distress, updated information on medical assistance in dying, as well as the latest research on the experience of bereavement, grief, and mourning. But, perhaps most importantly, it includes an entirely new final chapter on learning how to live until we die.

Written to be an accessible and expansive overview of our changing encounters with death, dying, and bereavement, the third edition remains a reflective and deeply insightful book for students across specialized fields in psychology, sociology, human services, social work, counseling, and theology.

Alan R. Kemp is Professor Emeritus of Sociology at Pierce College, where he enjoyed a 30-year career teaching human service and sociology courses, including his popular death, dying, and bereavement course. He was the recipient of the Outstanding Faculty Award at Pierce in 2016 and a recipient of the Albert Nelson Marquis Lifetime Achievement Award in 2018. He currently serves as Rector and Professor of Applied Theology at Ascension Theological College.

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Alan R. Kemp

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To Claudia, Isa, Mimi, and Milo

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About the Author

Alan R. Kemp is Professor Emeritus of Sociology at Pierce College, where he enjoyed a 30-year career teaching human service and sociology courses, including his popular death, dying, and bereavement course. He was the recipient of the Outstanding Faculty Award at Pierce in 2016 and a recipient of the Albert Nelson Marquis Lifetime Achievement Award in 2018. He currently serves as Rector and Professor of Applied Theology at Ascension Theological College.

An early draft of this text served as the project part of the required project-dissertation for a doctorate at St. Stephen's College, University of Alberta, then amalgamated with its sister college, St. Andrew's College, University of Saskatchewan. He is an ordained priest and consecrated bishop within the independent sacramental movement. He is also a licensed mental health professional with over 40 years of experience in a variety of clinical and program management roles, including as a qualified clinical supervisor.

He is the author of two other peer-reviewed textbooks, *Abuse in the Family: An Introduction* and *Abuse in Society: An Introduction.* During the pandemic, he used his time at home to complete an online graduate program in applied sociology at the University of Alabama at Birmingham, an innovative program which culminated in a pilot study done in his own, small, rural community of Key Peninsula, Washington, on what people want to know about death, dying, and bereavement.

He was a U.S. Navy, Vietnam combatant craft crew member, by virtue of having served as one of the last American advisors aboard "swift boats," PCFs (Patrol Craft Fast), accompanying Vietnamese forces on patrol operations. He was his wife, Claudia's, caregiver when she was dying of kidney cancer. As of this writing, he is himself a prostate cancer patient, which the VA presumes was caused by exposure to Agent Orange in Vietnam. He is a member of the Board of the Longbranch Cemetery Association, Key Peninsula, Washington, which has now designated a portion of its cemetery for green burial.

Preface

Death, dying, and bereavement are different today than in times past. As Dorothy in *The Wizard of Oz* said, "I don't think we're in Kansas anymore, Toto." Before modernization, life was different. Industrialization ushered in a new world of technology. Today, we are arguably on the cusp of yet another change, a postmodern world, in which information technology, globalization, and new ways of relating loom big. The world in which we live has changed. "Back in the day," as they say, someone might reasonably expect to die the "good death," at home, cared for by family and friends. With the arrival of industrialization and advances in medical technology, it has become far more likely to die in a hospital or nursing home, surrounded by the latest medical technology.

Today, we are not always even sure what death is. Do we mean being "clinically dead"—unable to breathe on one's own and have a heart that is still beating? Or do we mean "brain dead," sometimes called being a "heart-beating cadaver"? When I began working on this project, I felt there was a need for a book that tried to provide a context for understanding our changing encounters with death, dying, and bereavement.

I also believed there was a need for a book that helps students integrate the various dimensions of experience with death, dying, and bereavement. Indeed, something else I am very concerned about is assisting readers in understanding the topic from a multidimensional perspective. This includes approaching it in an integrated way, looking at the physical, psychological, social, and spiritual dimensions.

Ernest Becker (1973) is credited with coining the term *denial of death* to describe modern-day attitudes toward death. To use the term *denial* also implies that we human beings are somehow at odds with consciousness about the unpleasant reality of death. Although it may be true that human societies engage in all kinds of practices that are designed to protect us from coming too close to this grim eventuality, death's profound presence is never very far away. Regardless of how we choose to relate to it, birth and death are the most universal of all human experiences.

People in all places and at all times have found ways to relate to death and dying. Beliefs, attitudes, and practices about the end-of-life issues are integral to virtually all human cultures. In the modern technological world in which we live here in North America, there exists a highly evolved system of health care that attempts to combat disease of all kinds and ward off death. Our educational system is rooted in a model of "scientific empiricism" that demands that we try to control the variables we study in order to establish cause-and-effect relationships between them. Because of advances in knowledge, technology, and medicine, life expectancy has been increased to a remarkable degree, at least in the technologically advanced parts of the world.

Modern approaches to mental health and self-help promote ways to help people get the most out of life and live it to its fullest. Despite all this, the end of life remains a pervasive part of the human experience. It is not my intent to be morbid in what I have said here. Life is rich, and

precious, and wonderful. It is to be appreciated all the more because our days are numbered. The possibilities in life are replete and its dimensions are many. I hope we can find ways to bridge the gaps in our understanding and integrate what we know about life and its counterpart, death. To do so, we explore the relationships that exist between the many facets of living and dying. For me, this means delving into beliefs and meaning; aspirations and what people feel drawn to; human experience and emotion; courage, hope, and growth; ritual and spiritual practices; what it means to live in the fellowship of communities; and what it means to exist within the social institutions that are so integral to society.

What Is in This Book?

Death, Dying, and Bereavement in a Changing World has five parts and a total of 16 chapters. Part I has four chapters that provides context for understanding the topic. Chapter 1, Introduction to Thanatology, opens with the topic of "lifting the pall." The pall, a cloth placed over the casket during a funeral, is a metaphor for the "denial of death." The chapter introduces thanatology, the study of death, dying, and bereavement; reviews key events in the development of the field; discusses the multidisciplinary nature of the field; introduces the four-facet model (with physical, psychological, social, and spiritual dimensions); and explores the conversation between theory, research, and practice. Chapter 2 focuses on our changing experience as shaped by social forces: society, science, and technology. Whereas in times past people ideally died at home, surrounded by friends and family, today seven out of ten people die in a hospital or nursing home. Science has increased average life expectancy by 30 years in just a century, and our industrialized and bureaucratized healthcare system has changed how we die. In Chapter 3, we will look at death and human development, exploring encounters with death across the life span, the nature of children's consciousness about death, and what happens when the life cycle naturally concludes. Chapter 4 focuses on cross-cultural and interfaith dimensions. I use the French-Canadian term *Coureurs de Bois*, which denotes the idea of travelers sharing stories about all the places they have been and things they have seen. We will look at the relationship between culture, spirit, and death; review theoretical perspectives on the role of spirituality and religion; and survey five key religious perspectives.

The four chapters of Part II examine death itself. Chapter 5, Traditional Death Care, takes a historical and cross-cultural look at death. It begins with a discussion of clinical death and looks at what happens when the heart stops beating, breathing stops, the body cools, rigor mortis sets in, and the body begins to decay. The text reviews burial practices from ancient times to the emergence of the modern "funeral service industry." Chapter 6, Alternative Death Care, begins with a discussion of our contemporary "death system" but extends it's lens to include criticisms of "McDeath," the corporate commercialization of death. It explores the use and abuse of the Amended Funeral Rule. It also examines alternatives: funeral consumers' societies; home funerals; green burial; alkaline hydrolysis; and human composting. Chapter 7, Traumatic Death—Part 1: Trauma, Pandemics, Natural Disasters, Suicide, and Homicide, opens discussion of traumatic death—that is, death that is sudden, violent, and/or inflicted. Within this context, we will explore death from pandemics, including the recent COVID-19 pandemic, natural disasters, murder, and suicide, including youth suicide, within the U.S. context. Chapter 8, Traumatic Death—Part 2: Terrorism and Domestic Extremism, addresses traumatic death, which covers the topic of terrorism and domestic extremism. Included is a new concept, stochastic terrorism, which emerged in the public lexicon. It refers to the use of vague, "coded," or indirect language by a public person, which is intended to incite violence against a targeted person or group.

Part III is concerned with dying, or the process of "getting dead." This Part has four chapters. Chapter 9, Facing Death, looks at what is involved in facing death and what it means to make the transition from feeling "temporarily immortal" to being "terminal." The chapter looks at death trajectories; discusses Elisabeth Kübler-Ross's classic stages of dying; explores a task-based approach to dealing with dying; and introduces the pioneering work of sociologist, Lyn Lofland's work on "the craft of dying." Included is Dr. William Bartholome's experience with the "Angel of Death." In Chapter 10, Hospice and Palliative Care, we learn about "intensive caring," a term used when discussing modern hospice and palliative care. We discuss its evolution and key players. As our conversation here draws to a close, we explore the pitfalls and falling through the cracks. Chapter 11 explores medical assistance in dying (MAiD), i.e., physician-assisted dying and voluntary euthanasia. We learn that physician-assisted dying is now legal in 13 U.S. states plus the nation's capital, the District of Columbia. Typically, the physician prescribes a drug that the patient takes themselves to end their life. Some patients, however, such as those suffering from ALS, Lou Gehrig's disease, may not be able to act on their own. This serves as a segue to a discussion of the issue of voluntary euthanasia, what happens when someone else takes steps to end the life of a patient who wants to die. Although illegal in all U.S. jurisdictions, it is legal in 6 Australian states plus the capital territory and 10 other countries. Chapter 12 addresses the issues of withdrawing life-support and organ transplantation. The text reviews "brain death" and harvesting human organs and also discusses people in a "persistent vegetative state," "coma," or "locked-in syndrome." New to this edition is a section on the organ procurement, allocation, and transplantation system in the United States.

Part IV, Bereavement, focuses on bereavement, which includes the experiences of grief and mourning. It has two chapters. Chapter 13, Bereavement, Grief, and Mourning, considers "normal" bereavement, grief, and mourning. We look at the classic "grief-work" model first articulated by Sigmund Freud and further elaborated by a whole generation of theorists. Then, we explore the "new science of bereavement research," which has turned old ideas on their heads. Chapter 14 focuses on complicated grief—what happens when grief is experienced too intensely or that lasts too long. We explore the evidence that supports newer approaches to treating both chronic and trauma-related forms of complicated grief. Indeed, what the late grief expert, Colin Murray Parkes, called chronic complicated grief is now recognized by the American Psychiatric Association (APA) as Prolonged Grief Disorder (PGD). The traumatic form of complicated grief is not recognized by the APA, although a category called complex-PTSD is recognized by the International Society for the Study of Trauma and Dissociation ISSTD), and is included in the current 11th edition of the International Classification of Diseases (ICD-11). The conflicted form of complicated grief, the third category of complicated grief first articulated by the late Colin Murray Parkes, has never been empirically validated.

Part V, The Path Ahead, contains two chapters. Chapter 15, Life After Life?, addresses a single question, but it is a big one: What lies ahead of us? According to terror management theory, discussed in Chapter 1, human beings are different from other animals in that we can conceptualize our own deaths, leading to death anxiety and a host of other problems. Also, according to *TMT*, we have come up with two strategies to deal with it: culture (including religion) and self esteem or self-efficacy, the sense of personal empowerment. Most religions tell us that part of us survives death. In this chapter, we explore in some detail what the major religious traditions have to say about what lies ahead. We also explore the so-called near-death experience (*NDE*), including the recent literature. Chapter 16 looks at what we can do to live as fully as possible until we die, including a discussion of "blue zones," parts of the world where a high proportion of people live especially long and productive lives, and which involves healthy living practices, like diet, intellectual stimulation, exercise, family, having a faith community, and experiencing good social relationships.

What's Changed in the Third Edition

For this third edition, the material from the previous editions has been thoroughly reviewed, polished, and revised. We've added new content and have gotten rid of some of the old.

- The scholarly literature has, of course, been completely reviewed and all citations have been updated to reflect this.
- Part I, Introduction and Contexts, has four chapters. Chapter 1, Introduction to Thanatology, has a new name to reflect how the field appears to be moving into the mainstream. It includes new introductory content but retains much of the bullworks from the old, including the introduction of the "Object Exercise" and experiential learning; the importance of self-care when dealing with matters about death; Ernest Becker's concept of denial of death, and the empirical research on his denial of death thesis using terror management theory. Also retained is the section on theory, research, and practice, although we acknowledge that doing original research on this topic is beyond the scope of an introductory text. That said, understanding the rationale and practice of both quantitative and qualitative research is the domain of all scholars, and enhances the ability to use critical thinking skills. Beginning with Chapter 1, we introduce new sections on "End-of-Chapter Resources" and "Online Learning." In addition, all chapter review guides now use Bloom's Taxonomy as a guide (Bloom et al., 1956).
- The material in Chapter 2, on death, dying, and bereavement in a changing world, has been simplified and polished for greater clarity. In addition, we've added entirely new sections on the "problem of time" and the Eastern experience with death, dying, and bereavement, which were not covered in previous editions.
- The material in Chapter 3, on death and human development, has been thoroughly updated to reflect new data and changes in how the U.S. CDC tracks this information. The brief profile of Morrie Schwartz's life and death from *ALS* has been retained, but additional information in Chapter 9 supports this discussion as a "tie back." In addition, there is new content on gun violence and mass shootings, now a leading cause of death among young people.
- The material in Chapter 4, relating to culture and religious belief, has been reviewed, polished, and updated.
- Part II, Death, has four chapters. The material in Chapter 5, Traditional Death Care, contains updated content on trends in burial and cremation; new sample general price list and sample casket price list; updated information on cremation; and new resources for Online Learning.
- Chapter 6, Alternative Death Care, a favorite of mine, contains new content on "McDeath," the acquisition of family-run funeral homes by publicly traded and privately owned funeral service conglomerates, or "funeral service" chains. We discuss "innovations" of the alternative death care movement, which seems to have evolved out of the counterculture zeitgeist of the 1960s and 1970s. For the first time in this edition, we introduce the work of pioneering sociologist of death, Lyn Lofland, and her classic work, *The Craft of Dying*. We conclude with a review of the aspirations, accomplishments, and assessment of the alternative death care movement.
- Chapter 7, Traumatic Death–Part 1, covers the topics of trauma, pandemics, natural disasters, suicide, and homicide. It includes new content on trauma and the use of trauma theory; the impacts of pandemics, including the COVID-19 pandemic; and the effects of natural disasters using innovative modeling. The content on suicide and homicide has been updated, with special attention to problem of youth suicide. The material on international and domestic terrorism, previously in this chapter, has been moved to an entirely new chapter, Chapter 8, see below.
- Chapter 8, Traumatic Death–Part 2: Terrorism and Domestic Extremism, is a new stand-alone chapter. It includes fresh content on the history of extremism, the impact of slavery, the American Civil War, Reconstruction, Jim Crow, the civil rights movement; the war in Vietnam, and

civil unrest at home. It includes a sampling of terrorist events, and their perpetrators in the United States prior to and after 9/11. Also covered for the first time is a look at what counterterrorism experts say about today's domestic extremist threats; radicalization; and extremist links to political figures and law enforcement officials.

- Part III, Dying, has four chapters. Chapter 9, now titled "Facing Death," includes an expanded discussion of conventional medical treatment of life-threatening conditions, for example, cancer. It includes discussion of integrative medicine. There is new discussion on the use of cannabis to treat neurodegenerative diseases, like *ALS*. We discuss its use to help with the side effects of anticancer treatment, like nausea and fatigue, and indeed, we explore its potential effects on the various cancers themselves. Also included is new discussion on the use of psychedelic substances to help alleviate end-of-life distress, called psychedelic-assisted therapy (PAT).
- Chapter 10 includes new content on hospice and palliative care, particularly expansion of palliative care into nonhospital settings. New to this edition, is content on Emily Abel's remarkable article recounting the evolution of the modern hospice movement (Abel, 1986). It suggests there is a striking resemblance between this social movement and the free schools, food cooperatives, and communes, that emerged out of the ethos of the counterculture zeitgeist of the 1960s and 1970s. We observe how this same social movement caught the eye of pioneering sociologist of death, Lyn Lofland, inspiring her to write, *The Craft of Dying* (1978, 2019).
- Chapter 11, Medical Assistance in Dying (MAiD), has a new name. The chapter has been edited to reflect changes in the contemporary landscape. For example, several additional U.S. states have legalized physician-assisted dying since the publication of the first edition. As discussed above, voluntary euthanasia is now legal in 6 Australian states plus the capital territory and 10 other countries. It occurs when physicians directly administer a lethal dose of medication with the patient's permission with the intent to end the person's life. As reported in earlier editions, only Belgium, Luxembourg, and the Netherlands initially permitted it.
- The material in Chapter 12, on withdrawing life support and organ transplantation, has been reviewed, polished, and updated. It includes new content on the organ procurement, allocation, and transplantation system in the United States.
- The two chapters that previously comprised Part V, "Physician Assisted Death," and "Withdrawing Life Support and Organ Transplantation" have been moved to Part III, "Dying," since these two topics fall naturally and logically into to broader category of "dying." The section on legal and ethical borderlands has been removed, although content on legal and ethical issues has been integrated throughout the text.
- Part IV, Bereavement, has two chapters. The material in Chapter 13, "Bereavement, Grief, and Mourning," has been expanded to include a new section on companion animal loss.
- The material in Chapter 14, "Complicated Grief," has been reviewed and updated to reflect developments in the field, including discussion of the inclusion of the diagnostic category of *prolonged grief disorder (PGD)* to the *Diagnostic and Statistical Manual, DSM*, of the APA. We also include content on the existence of trauma-related grief, although it is not recognized as a diagnostic category within the current edition of the American Psychiatric Association's influential *Diagnostic and Statistical Manual, Fifth Edition, Training Revised, DSM-5-TR*. We discuss posttraumatic stress disorder (*PTSD*), which is included in the *DSM-5-TR*, and a category of *complex-PTSD*, which isn't included. We observe, however, that it is included in the current edition of the *International Classification of Diseases, ICD-11*.
- Part V, The Path Ahead, includes two chapters. The material in Chapter 15, on the question of whether or not there is life after life, has been reorganized and includes new research on the near-death experience, including the so-called "distressing near-death experience." This updated discussion includes sections on neuropsychological and psychosocial explanations for the NDE, and even considers the possibility that such experiences are real.

- The material in Chapter 16 addresses the topic of learning to live until we die. We discuss "blue zones," parts of the world in which people disproportionately live to be 100 years of age. Within the context of learning to live until we die, we explore the roles of family, diet, exercise, meditation, intellectual stimulation, participating in a faith community, and social engagement on both one's years of living and quality of life.

Holistic and Integrated Approach

The field of thanatology is multidimensional and multidisciplinary. It is an enterprise that strives to integrate diverse perspectives and facets of life (Canadian Hospice Palliative Care Association, 2004, 2013; Corr, 1992; Ferris et al., 2002; Last Acts, 2003a, 2003b). This makes it unique in academia.

Parker Palmer, an academically trained sociologist, is now more renowned as a social commentator and educational revolutionary. He is among a growing number of educators, spiritual leaders, and researchers advocating for a more integrated, or holistic, approach to education generally (Griffiths & Edwards, 1989; Miller, 2000; Palmer, 1993, 1998). Palmer suggests that, in our need to specialize (e.g., psychology, sociology, and thanatology), we have also carved up the pursuit of knowledge, dividing rather than uniting (Palmer, 1993). One of his concerns is that in doing so we have also separated ourselves from each other and become less appreciative of the mysteries of life in general.

Perhaps in an effort to put the whole venture of education into context, Palmer (1993) observes that higher education can trace its origins to the monasteries of medieval Europe, where monks emphasized three key areas of activity: (1) reading scripture, (2) praying and contemplating, and (3) developing spiritual community. He suggests that of these came three key values of academia: (1) respect for the body of scholarly literature, (2) an emphasis on research and analysis, and (3) respect for a collegial community of scholars. Palmer observes that scholars and monks alike had in common a dedication to study, contemplation, and a deep interior life. He laments that, when society rejected the excesses of the medieval period and adopted a more scientific approach to knowing, we may have also inadvertently lost something.

With the advent of science, technology, and industrialization came an emphasis on action. Palmer (1993) suggests that in a renewed effort to uncover greater meaning in life, we may want to strike a balance between doing and being. Today, average life expectancy has increased dramatically and infant mortality has declined. However, we may need to ask if how we live and die has really improved.

In pursuit of uncovering new wisdom about life from the study of death, this text intends to both build on contemporary scholarship and endeavor to reclaim our humanity. I like the parallels Palmer makes between academia today and the monastic traditions that gave rise to it. In the following table, I draw some parallels between monastic and academic traditions and extend the model to include several learning tools, or activities, used throughout this text.

This book is committed to the idea that in our quest to uncover wisdom about life through the study of death, we should make it one of both mind and heart. It should, of course, include all the rigors of any other academic pursuit, but also honor our deeply personal quest to understand.

To complement the scholarly literature, I have integrated the concept of *story*, some related to individual experience, others that are more cultural. To balance an exploration of research and analysis, I invite you to *reflect*. I will at times *share* the results of experience and reflections and encourage you to do the same. Although the emphasis in academia today is on the building of a body of knowledge and a collegial community of scholars, I hope we can also cultivate our own community of learners.

A review of the literature can inform us about what others have uncovered; the exploration of story makes us participants. Research and analysis lead to the discovery of new truth; reflection may well lead us to uncover hidden truths about ourselves and events. Interaction within the community of scholars leads to the growth of new knowledge, but sharing experience with each other may contribute to the growth of new understanding.

A Comparison of Academic and Monastic Traditions and the Learning "Tools" Integrated into This Text

Monastic Heritage	*Academic Tradition*	*Text Learning "Tool"*
Sacred scripture	Body of literature	Story
Prayer and contemplation	Research and analysis	Reflection
Spiritual community	Collegial community of scholars	Sharing that fosters a community of learners

As we all know, story is one of the most engaging ways to bring ideas to life. It is also among the most ancient and natural ways to learn. To complement the literature, I plan to weave stories generously throughout the text. Some, like the snippets I have already shared, come from my own experience. Some come from the experiences of people I have spoken with or from stories I have heard.

Reflection, for the purpose of this text, is the process of exploring one's own experience in conversation with the literature, research, story, and experience of others (for a discussion of theological reflection, see Killen & De Beer, 1999). It should be a give-and-take dialog. Reflection can confirm, challenge, clarify, or expand understanding. It is intended to lead to new truth or meaning. I will share my reflections and at various times invite you to explore your own.

Sharing is central to cultivating the kind of mutual respect and understanding that can lead to building a community of learners. If you do the "object exercise" I suggest in Chapter 1, you will have an experience of the kind of sharing I am talking about here. When people tell about a meaningful object connected with an experience with death, they enhance the understanding of others. I have never ceased to be impressed by the richness of experience that learners bring with them. When sharing occurs, I get the sense that, rather than merely hearing about others, we actually have an opportunity to experience a little bit of their lives. What we learn is not usually restricted to a few tidbits of data in a narrow range of "icebreaker" topics. With this comes respect for, and understanding of, the people with whom we journey.

Key Features

I hope that *Death, Dying, and Bereavement in a Changing World* will serve as an introductory text to be used by a general population of students, in addition to students of specialized fields like psychology, sociology, human services, social work, medicine, nursing, chaplaincy, and ministry. I believe it provides a venue in which students can do both a personal and academic exploration of the subject. In addition to a "student-friendly," conversational tone, each chapter presents a chapter preview, special feature "boxes" (e.g., with vignettes, stories, or anecdotes), visual data display (tables and charts), photos, chapter summaries, key terms, suggested activities, and suggested reading. A special section on "online learning" tools had been added to this edition. The approach we are taking includes:

- *Holistic/integrated approach:* We explore a variety of dimensions, each to be respected for itself, yet treated within a framework that attempts to uncover the relationships that exist between them.

- *Multilevel fabric:* The entire piece of work attempts to delve into the drama from a variety of vantage points. For example, you will find individual experiences of people not unlike yourself, as well as stories about people who seem quite different from your identity; explorations of life and death in distinct communities, subgroups, and special populations; and broader social issues that are played out at the societal level.
- *Story:* It is my contention that stories help bring concepts to life. These chapters weave the accounts of the personal stories of real people into the text.
- *Symbol and myth:* Symbols, myths, and archetypes are interlaced into the text, at appropriate points, in order to arouse the imagination and bring you into contact with a world of enduring themes.
- *Mind–body–spirit:* This book gives respectful coverage of the mind–body–spirit connection, including the influence of such dimensions as hope and faith on health and recovery.
- *Reflections:* The chapters include original research on what people want to know about death, dying, and bereavement.

Gratitudes

It was not until I had finished writing this book that I realized just how many people deserved a heartfelt "thank you." First of all, kudos go to my deceased wife, Claudia, and the rest of my family. Her memory is a blessing. During work on the second edition, she was diagnosed with stage four renal cell carcinoma, underwent cancer treatment, and was ultimately served in hospice. I am eternally grateful for all she taught me about life, both living and dying.

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Pierce College, where I taught for over 30 years, also deserves my thanks for its commitment to professional development and for granting me a sabbatical so I could conduct my original research, reflect, and renew. Several colleagues at Pierce have provided feedback over the years: Dr. Denise Arnold, Ph.D., Dr. Jo Anne Geron, Ph.D., Dr. Tom Link, Ph.D., and to Leon Khalsa, Marty Lobdell, Dale McGinnis, and my friend Dennis Morton, who I dearly miss.

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Finally, I'd like to thank the rest of my band of informal reviewers: my anonymous cancer buddy, who contributed many thoughtful reflections; Susan, my neighbor and wife of our handy person, John, who provided a medical education perspective on the subject. Dr. Ricky Pendergrass, D.O., offered his observations about what physicians learn and don't learn in medical school about death and dying; Arthur, my longtime friend, offered many insightful observations and suggestions; my friend, Pam, who like me, is dealing with her own late-life challenges; and Elizabeth, a friend of over 50 years and a career healthcare professional, who knew me during parts of the counterculture era of the 1960s and 1970s, including that time soon after I returned from Vietnam. While working on this edition she helped me navigate some of my own health challenges.

Alan R. Kemp
Key Peninsula, Washington

Part I

Introduction and Contexts

Photo 0.1 Experiences with death, dying, and bereavement can be among the most poignant we experience.

This part consists of four chapters that introduce *thanatology*—the study of death, dying, and bereavement—and the physical, psychological, social, and spiritual contexts in which we encounter them.

Chapter 1 provides an introduction to *thanatology*. A key metaphor used in the chapter is the concept of the *pall*, a cloth covering placed over the casket during a funeral. To "lift the pall" is to uncover that which is beneath—death—so that we might see it for what it is. The metaphor of the pall is also connected to anthropologist Ernest Becker's thesis on *The Denial of Death* (1973), the title of the Pulitzer Prize-winning book he wrote just one year before his own death.

Becker believed that the pervasive denial of death in our culture is at the root of many of society's most pressing problems. Chapter 1 introduces thanatology as an emerging academic discipline. We discuss the multidisciplinary, multidimensional nature of contemporary thanatology.

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We also focus on the topic of death education, which can be both a formal and informal area of study, and learn about a few key figures in the death awareness movement. We take note of tensions in the field, particularly between practitioners and academics, and we explore the "conversation" between practice and research. We also look at terror management theory, *TMT*, which evolved from the interest of three graduate students in the ideas of Ernest Becker. To test TMT, this team, whose members became experimental social psychologists, used rigorous experimental method, yielding very strong support for TMT and Becker's pioneering ideas.

Chapter 2, "Death Dying, and Bereavement in a Changing World," focuses on how our changing experience with death is shaped by social forces, science, and technology. And, we should not forget to mention the COVID-19 pandemic, which spread across the world beginning in 2019. In industrial parts of the world, like the United States and Europe, the healthcare system attempted to meet the challenge with difficulty. And, ordinary people attempted to limit contact with others, isolated with friends and family, and wore masks (or didn't).

In the classic deathbed scene, the dying individual has taken to bed and is surrounded by family and loved ones until the last breath. This kind of death may have been common "back in the day." During COVID, people often died alone in the hospital, without the emotional support of friends and family, often hooked up to respirators. The availability of vaccines was a boon for many, although others, particularly in the United States, were concerned about the encroachment of the government on personal choice.

Even before COVID, people in industrialized countries most often died in hospitals or nursing homes. Medicine was more an art than a science in previous eras. In Chapter 2 we note that with the assistance of modern science the field of medicine has been able to add 30 years to average life expectancy. On the downside, with industrialization came bureaucratization, including in healthcare. The chapter argues that people today are experiencing accelerated social change, and that we are moving into a postmodern era. With it comes new malaise. Futurist Alvin Toffler called it "future shock."

In Chapter 3, "Death and Human Development," we look at how the developing person learns to think about and relate to the experience death. We begin by taking note of the advances of modern medicine discussed in Chapter 2. As a result, numerically fewer young people and a greater proportion of old people are dying. We then survey encounters with death across the life span, first looking at common causes of death in infancy, toddlerhood, and middle childhood. Next, we examine the nature of children's emerging consciousness about and understanding of death. We discuss the experience of gravely ill children, taking note that their experiences seem to differ quite markedly from how healthy children think about death. Turning our attention to older youth, young adults, adults, and elders, we look at the common causes of death and explore the relationship between social development and the experience of death. Finally, we come to the final stage of life. To do so, we use the work of Erik Erikson and what he accomplished in collaboration with his wife, Joan, on their final project, *The Life Cycle Completed* (Erikson, 1982; Erikson & Erikson, 1997). They observed that people who live into their eighties and nineties, as he and Joan did, that the very strengths it takes a lifetime to build all too often unravel, often sending elderly people into a state of despair. According to the Eriksons, a lucky few may achieve *gerotrancendence*, a state of equanimity and peace, before death finally arrives.

Chapter 4, Cross-Cultural and Interfaith Dimensions, uses a French-Canadian expression, *Coureurs de Bois,* which connotes the idea in Canadian culture of travelers sharing stories about all the places they've been. Indeed, the very concept of culture helps us understand that the knowledge, beliefs, values, language, customs, and material objects passed down from one generation to the next. This brings us to the topics of spirituality and religion. The chapter introduces a few basic conceptual tools for comparing cultural experiences. In particular, we look at the relationship

between culture, spirituality, and death. We review a few theoretical perspectives about spirituality and religion before surveying five key religious perspectives on death: Judaism, Christianity, Islam, Hinduism, and Buddhism. There we explore the concept of pilgrimage, using a metaphor from Joseph Campbell's work, the "hero's quest." Finally, we partake in a "Chautauqua," or a sampling of teaching stories about death. Woven in are short excerpts from interviews I conducted when doing my early field research on death, dying, and bereavement. These excerpts are from interviews I conducted with three religious leaders: His Holiness the Dalai Lama, Hindu holy man Sri Sri Swami Jitatmananda, and Islamic teacher Abdul Kareem. And I share the example of Father Francis Mahieu, the late abbot of Kurisumala Trappist Ashram, with whom I spent time when in South India.

1 Introduction to Thanatology

Photo 1.1 Objects placed on an impromptu classroom altar concretizes the experiences of class members with death, dying, and bereavement.

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Introduction

Welcome to this introductory text on **thanatology**—the study of **death**, **dying**, and **bereavement**. All of us who worked on this edition of the book are delighted that you're here. Being willing to take on a potentially emotional topic like this is a courageous step in itself. However, we believe you will be rewarded for doing so not only by what you learn about death, dying, and bereavement, but by what you learn about life, living, and the experience of joyfulness that can result from studying their opposites. Emerging as it did in the latter half of the twentieth century, modern *thanatology* is a fairly new field of study when compared to more established social science disciplines, like anthropology, psychology, and sociology. The term "thanatology" itself is derived from two Greek terms, "Thanatos," the Greek God of death (Liddell & Scott, 1940) and "logos," the term used to denote "the study of."

What we mean by *death* changed in the mid-twentieth century as a result of our ability to artificially resuscitate cardiac arrest victims and to help people with polio breath using artificial devices, called "iron lungs." So, death no longer means today what it once did (also see Chapter 12). The old method of defining *death*—the absence of heartbeat and breath—no longer works. This tried and true method can still signify what we now call **clinical death**—the presence of spontaneous breathing and heartbeat (and non-responsiveness to pain and light, body cooling, the presence of rigor mortis, and body decomposition). A new category called **brain death** had to be created for individuals whose bodies could be maintained artificially but whose brains were no longer viable. It is significant because keeping the heart beating and blood circulating we made it possible to harvest the person's organs. However, defining this newly created category of death is actually somewhat more complicated (also see Chapter 12; Magnus, Wilfond, & Caplan, 2015; Shaw, 2016; Lizza, 2018). In the United States, for example, the term *brain death* is now used to denote the irreversible cessation of the activity of the whole brain (brain stem and neocortex), the brain stem, or the higher brain (neocortex) (Lizza, 2018; Magnus et al., 2015; Shaw, 2016).

By "dying" we mean the process that results in death. Let me introduce you to Dr. William Bartholome, a physician, death educator, and pediatric medical ethicist. I learned of him and his work when he was profiled in a documentary series on dying that aired over 25 years ago (Moyers & Moyers, 2000). As he explained in his segment in the series, as a death educator, physician, and ethicist he felt he was particularly well suited to deal with what he called, "getting dead," and what we're calling *dying*. Dr. Bartholome's profile in that series inspired me to dig a little deeper into his life and work. He kept a journal from which he developed a series of meditations on his experience of dying, which may be helpful to others. If you Google him, you should be able to find these meditations, but we will summarize them in Chapter 9. He was closely associated with what was called the Midwest Bioethics Center, but which is now called the Center for Practical Bioethics. In addition, the American Pediatric Association each year awards the William C. Bartholome Award for Ethical Excellence, which recognizes persons and groups who significantly impact public discussion of ethical issues in pediatric medicine.

Although the terms *bereavement*, *grief*, and *mourning* are sometimes used almost interchangeably, the terms actually signify quite different things (see Chapter 13). The word *bereavement* has old English roots connoting the idea of being despoiled or left destitute (Onions, Friedrichsen, & Burchfield, 1966). Today, the term is used to indicate the objective fact, or reality, of a loss sufficiently severe to cause significant disruption in the lives of those who are left behind. How a person experiences the thoughts, feelings, and behaviors that result from the loss is what we're referring to as *grief*. In the West, this usually occurs as a result of the death of a family member, companion animal, or close personal friend. In this text, we are using the term *mourning* to refer to the culturally patterned ways in which grief is expressed within a group, for example, wearing black (or white) clothing, sitting Shiva, celebrating a funeral mass, going to the "viewing," or even getting drunk at the wake, if that conforms to the group's norms.

Encounters with *death, dying*, and *bereavement* can be the most powerful experiences we have. They can also be the most personal. Everyone dies. And, before then, most will have someone or something they care about die. When dealing with a topic as sensitive as this, it may be helpful to get a sense of the depth of one's experience. In the courses I teach, I like to do an activity I call "the object exercise." In this activity, we create an "altar in the round"—a table we put in the center of the room with a cloth covering and a lit candle, to symbolize that something important is taking place. Each participant has already been asked to bring an object to the session that symbolizes for them death, dying, or bereavement. I explain the activity. When they feel ready to do so, each student places his or her object on the table in the center of the room and explains to the rest of the group why that object was chosen. It is a powerful experience that usually creates a bond. By the time everyone has shared, the participants are often moved by the depth and breadth of personal experiences brought to the activity. It is a poignant way to begin, and well worth it in terms of group solidarity. Read more about it in "the object exercise" activity shown in Box 1.1.

Box 1.1 The Object Exercise

In order to help build a sense of community and give students an opportunity to express themselves about their experiences with death, dying and bereavement, I've adapted an exercise I learned in my own studies of death, dying, and bereavement. I ask my students to bring in a tangible, physical object to class that symbolizes for them personally their experience with death, dying, and bereavement.

When the activity leader is ready to begin, it is nice to ring a bell to indicate the beginning and end of the activity. It is nice to have a lit candle on the table, if permitted by facility rules. The activity leader should establish the ground rules and advise the group that they will be available to anyone who wants to chat after the session to debrief. One person at a time is to approach the table, place their object on the table, introduce themself, and then explain to the class the relationship between their object and their experience with death, dying, or bereavement. No one else is to speak when it is another student's turn to share. The room is to remain silent except for the student who is placing their object, who may or may not include music as part of their presentation. No applause, statements of support, or comments of any kind. The attention needs to be on the students who present and their objects. When the person placing their object is done, they return to their seat. The room remains silent until the next student places their object (the silence can be awkward but that's okay), then the next, and next, until the end. Once it is clear that everyone who wishes to present has done so, the activity leader should blow out the candle and ring the bell to conclude presentations.

It always amazes me how, by making the subject concrete this way, the class is able to partake in the rich experiences of its members. Students have a chance to share in a personal way. I've found that the exercise tends to foster a sense of trust and camaraderie, which deepens the classroom experience.

Self-Care

Before exploring this new discipline of *thanatology*—the study of death, dying, and bereavement—let's take just a few moments to address the importance of self-care. A colleague who uses this

book shared what they told a student when asked about potential "trigger warnings" for any particular part of the course. My colleague explained to the student that this was a death and dying course and that any topic we covered could act as a trigger. I believe that is true. Human beings are diverse along so many dimensions, and it is hard to know what experience, or what topic, is likely to trigger an emotional response. But, what we do know is that many of the topics can be emotionally sensitive. So, we ask you to monitor your own emotional reactions and if you need assistance, please ask.

Students may decide to take a course on death and dying for a variety of reasons. For some, it may be a way to come to terms with an unresolved loss. For others, the subject is important for a career goal, like becoming a physician, psychologist, counselor, social worker, chaplain, or pastor. And, for still others, the course simply fulfills a requirement, one we hope will also enrich. Whatever the reasons, when venturing into territory like this, it is wise to approach the topic respectfully. The topic of death and dying touches on poignant human experience and may expose readers to emotionally charged thoughts and feelings that lie just below the surface.

One of the things the object exercise makes abundantly clear is that *death* is a pervasive human experience. Every reader, and every student, has been and will be touched by it. For some, grief about an important loss lies close to the surface. If this is the case for you, you can expect that delving into the subject will expose your memories, thoughts, and feelings—an experience that can have both positive and negative dimensions. I encourage you to use your own support system of close friends, loved ones, and perhaps even a favorite teacher, counselor, or pastor. Don't let the tender nature of your feelings hold you back.

Just as you are likely to have been touched in some way by death and have had to find ways to handle its impact, people in all places and at all times have found ways to come to terms with death and dying. A friend and colleague, Dale McGinnis, was an anthropologist. I often sat in on his classes. I can recall him saying on several occasions, "Death is something that all cultures have to deal with in one way or another." Referring to funerals, I also remember him saying, "One day we'll all be the star of that show." How prophetic were his words, for Dale, one of the most gifted teachers I've ever known, was battling terminal cancer at the time. He died less than a year later. Fully in character, however, he refused to be the star of "that show" by simply not showing up. He had the last word by requesting that there be no service.

> It's not that I am afraid to die. It's just I don't want to be there when it happens.
>
> Woody Allen

Denial of Death

From the beginnings of modern *thanatology*, scholars have observed that people in Western society seem to have difficulty in relating to death but that failing to facing up to it may have adverse consequences (Becker, 1973; Feifel, 1959; Kübler-Ross, 1969; Strack, 1997). There is an expression, "Elephant in the Room" that refers to any obvious problem that people refuse to acknowledge. Each of the three leading thanatology textbooks on the market today deals directly with our reluctance to address or even talk about death. One team of thanatology authors share Richard A. Kalish's essay, "The Horse on the Dining Room Table" (Kalish, 1998, cited in Corr, Nabe, & Corr, 2003). In the essay, Kalish tells of being invited to a dinner party in which 10–12 guests have been invited. On the dinner table, with the food, is a small horse, but neither the hosts nor any of the guests explicitly mentions it. They must move around the horse to serve themselves, so they have to take the horse's presence into account. But no one says anything. As Kalish tells it, the hosts apparently felt that mentioning the horse to their guests might make them uncomfortable, so they

didn't. And so as not to upset their hosts, none of the guests mentioned it either. But, everyone was uncomfortable because of the horse's *presence* and that no one would, or felt that they could, *acknowledge* it. Like the elephant in the room, the horse of course is a metaphor for *death*. In the original edition of another leading thanatology text, the authors note, "Of all human experiences none is more overwhelming in its implications than death, yet for most of us, death remains a shadowy figure whose presence is only vaguely acknowledged" (DeSpelder & Strickland, 1983, p. 5).

Ernest Becker (1973), a cultural anthropologist, coined the term **denial of death** to describe modern death-denying attitudes about death. To Becker's thinking, when people cover up the realities of death, they shield themselves from it by using a process called *denial*—something that temporarily shields them from the unpleasant realities of death but which also has the potential of eclipsing poignant, and important, truths about life. When you emotionally "numb out" challenging content, it tends to be an "all-or-nothing" proposition. When we "dissociate," the technical term for pushing emotional content out of consciousness, we tend to do so with the whole experience, making none of it available to consciousness. The notion that Western society may be in *denial* about the realities of death should cause us to ask if we are having a hard time dealing with, or accepting it. Since death is part of life, it may also suggest that really we are having a hard time dealing with life. Perhaps we are losing out by not fully experiencing important parts of our own humanity, including our experiences with death. The late Robert Kastenbaum, another leading thanatologist comments,

> As a society we have tried not thinking about death… Not thinking about death was pretty much a failure. People continued to die, and how they died became an increasing source of concern. Survivors continued to grieve, often feeling a lack of understanding and support from others. Suicide rates doubled, then tripled among the young, and remained exceptionally high among older adults.
>
> (Kastenbaum, 2009, pp. 6–7)

Photo 1.2 Military pallbearers lift the pall, in this case an American flag, revealing the casket of a fallen comrade. The flag also evokes feelings of patriotism, which may help survivors find meaning in the experience of loss.

The metaphor I like to use for the denial of death is the "**pall**." A *pall* is a cloth covering that is often placed over the casket during a funeral service. The word is also used to describe a somber mood or tone that pervades a place, as in the expression "There was a pall covering the whole room." Metaphorically, we can visualize the pall as veiling the casket, symbolically shielding us from the full impact and reality of what lies beneath—death.

Box 1.2 Interchangeable Parts

When I was working on the first edition of this text, I was granted a sabbatical from the college where I taught. A very competent person was hired to replace me while I was gone. When I was working on the part of the text you are reading now, I thought of Dale McGinnis again. I recall him in his final years speaking to a class about death and the kind of society we live in. Referring to his own potential death, he told the class, "If I died today someone would be here the next day teaching in my place."

Dale retired the year prior to his death. The college advertised his position and formed a hiring committee. The following fall, someone new was teaching amid a classroom cluttered with the artifacts of years of Dale's teaching: handmade Indian masks, glass cases filled with model villages, canoe handles—you name it. Like an archaeological dig, none of the artifacts was situated in a neat, clean, or orderly way. Also like an archaeological site, you could trace Dale's evolution as a teacher through the things he left behind. Someone new was teaching in his place now. Gradually, the fame of this charismatic teacher receded into institutional memory. A scholarship in his name lives on, but those of us who knew him know life at the college was changed—his wit and humor are gone. Yes, the institution could fill the position but it could not replace the person.

Photo 1.3 There is a spot reserved for each of us.

Although it may be true that people today as inhabitants of the modern (or arguably postmodern) world engage in all kinds of behavior intended to psychologically protect themselves from getting too close to consciousness about death, its presence is never too far away. There is an American adage attributed to Benjamin Franklin that says there are two things in life that are unavoidable: death and taxes. Well, some may be able to find ways to evade taxes—but *nobody* avoids death. As a funeral director once told me, "Really, everyone's a customer."

> But in this world nothing can be said to be certain except death and taxes.
>
> Benjamin Franklin

If we cannot avoid death, perhaps we might try to understand it, which is the purpose of this book. To lift the pall, then, is to take that potentially scary step into the unknown.

Although one may think of the "denial of death" and the notion of confronting fears about death as particularly relevant to life today, it is not exactly new. To make the point, let's recount an ancient story of a young man—a prince, in fact—whose father attempted to shield him from the unpleasant realities of the world. He lived in his father's palace and was showered in luxury. His father's servants were ordered to make sure that the young prince wasn't exposed to any of the unpleasant realities of life. One might envy being in this privileged position, but the young man eventually began to sense that there was more to life than what he understood, and he wanted to learn about it. Ultimately, his father arranged for an excursion, a procession, into a nearby town, but ordered his servants to keep any fearful experiences from his son. Wanting to understand, the young man looked beyond the greetings of the "beautiful people" who were allowed close to the procession. Escaping from his father's servants one day, he encountered a feeble old man. Next, he met a terribly ill and diseased person. Then, he came upon a funeral procession and learned that what was under the pall was none other than the body of a dead person. The name of the young man in our story is Gautama Siddhartha. Most know him by the name Buddha, or "enlightened one," a name given to him later. Most scholars believe he was born in the year 563 BCE at Kapilavastu, near the India–Nepal border. He is acknowledged as the founder of Buddhism, one of the world's great religions (Boeree, 1999; Conze, 2007; Mahathera, 2006, 2017).

What young Siddhartha discovered on his trek outside the palace were three basic truths about human life: We age. We experience illness. Eventually we die. In addition, Siddhartha chanced on a fourth person, an ascetic, or holy man, who symbolizes a fourth realty—spirituality or the quest to uncover greater wisdom, understanding, and truth.

As we embark on our own journeys, perhaps we might wish to consider that the understanding we seek about death may actually be the quest to uncover higher truth about life and living. Siddhartha, having made those initial discoveries, could no longer remain within the guarded confines of the palace. He ventured out. So shall we.

Death Education

Growth of Contemporary Death Education

Death education is a way to "lift the pall." Contemporary *Thanatology* did not begin to emerge as an academic discipline until the late 1950s and 1960s, when the work of such pioneers as psychologist Herman Feifel (1959) and psychiatrist Elisabeth Kübler-Ross (1969) first began to appear.

Herman Feifel was an Army Air Corps psychologist during World War II when he witnessed the *Enola Gay* take off to unleash a nuclear bomb on the Japanese city of Hiroshima. He later described this and the death of his mother in 1952 as being integral to his interest in the study

of death. In 1959, early in his career as a psychologist for what used to be named the Veterans Administration, he edited his groundbreaking book on the topic, *The Meaning of Death*, which most authorities now believe sparked the present-day scholarly interest in the topic. A significant contribution by Feifel is the concept of **death anxiety**, or fear of death, which has been the focus of much of the research done in death education ever since.

Ten years later, Elisabeth Kübler-Ross, a Swiss-born psychiatrist who had emigrated to the United States, was teaching at the University of Chicago's medical school and working with terminally ill patients. As a result of the interest she developed while doing so, she published her own groundbreaking book, *On Death and Dying* (1969). At a time when medical practitioners didn't want to deal with the realities of death, Kübler-Ross taught a seminar intended to help medical students learn how to listen empathically to their patients and thus provide them with better care.

In the intervening years, sociologist Robert Fulton offered the first modern-day course on death studies in 1963 at the University of Minnesota (Strack, 1997). In 1969, he founded the Center for Death Education. Upon his retirement, Fulton renamed it the Center for Death Education and Bioethics, moving its operation to the University of Wisconsin–La Crosse. It continues today as The Center for Death Education—a resource center for persons interested in the subject. In 1969, Edwin Schneidman, a clinical psychologist, developed a course at Harvard (Corr, 2015b) and soon thereafter began to teach a course at UCLA, the University of California at Los Angeles, which he taught for the next 20 years (Sneidman, 1991, cited in Servaty-Seib & Chapple, 2021).

Primary and Secondary Education. According to the current edition of the ADEC *Handbook of Thanatology*, see below, the existing research on death education in U.S. public schools is sporadic and often dated (Servaty-Seig & Chapple, 2021), which could suggest a waning of interest. As sometimes happens in higher education, death education in the public schools may depend more on the interest of individual educators than on national, regional, or local educational priorities. That being said, I am unaware of any current wide-scale efforts to promote death education in the public schools. As may also be true in higher education, popular thanatology courses too often cease to be taught when the faculty members who taught them retire.

American Colleges and Universities. At American colleges and universities, courses on death are taught in a variety of academic disciplines (e.g., anthropology, psychology, sociology). In 1976, a group of educators and mental health professionals formed the Forum for Death Education and Counseling, which evolved into **ADEC**, the Association for Death Education and Counseling (Balk, Wogrin, Thornton, & Meagher, 2007). This organization continues today as the oldest interdisciplinary association dedicated to the study of death, dying, and bereavement (Servaty-Seig & Chapple, 2021).

Although the terminology varies from institution to institution, in undergraduate education in the United States, there are four general categories of classes that are required in order to earn a bachelor's degree: *distribution requirements* (e.g., *quantitative reasoning*, *composition*, *natural sciences*, *social sciences*, and *humanities*), courses accepted within the students' *major*, *transferable electives*, and *general electives*. According to the available information, thanatology courses have mostly been offered as general education courses (*distribution*) or *electives* (Corr, 2015; Noppe, 2007, 2008, 2010, 2013 cited in Servaty-Seib & Chapple, 2021). This is not all bad. When courses are accepted within the general education *distribution*, it tends to increase demand and enrollment in the course, which is desirable because it makes it more likely the institution will continue to offer the course.

When a course is only taught as an elective, there is less demand, which makes it less likely that the course will find a home within the curriculum. Another potential "snag" can be who is assigned to teach the course. Tenured and tenure-track faculty members have the greatest job security and faculty status within an institution. Part-time, "adjunct" faculty have the least. Approaching this

from the perspective of someone who is an advocate for death education, I think it is far preferable to have full-time faculty members teach thanatology courses, especially if they have a passion for the topic. Unfortunately, death education courses have often been, " …taught by disinterested junior faculty members who were minimally prepared …" (Servaty-Seig & Chapple, 2021). Lamenting higher education's neglect of death education, the late Robert Kastenbaum may have said it best, "Death has received an adjunct appointment to the university" (Kastenbaum, 1982, p. 162, cited in Servaty-Seib & Chapple, 2021).

Medical Education. According to the ADEC *Handbook of Thanatology* (Servaty-Seig & Chapple, 2021, p. 472)

> In 2000 the Liaison Committee on Medical Education (a cooperative effort of the American Medical Association and the Association of American Medical Colleges) required all accredited medical schools in the United States and Canada granting the degree of Doctor of Medicine (MD) degree to teach end-of-life care.

Exactly what is to be included in the curriculum, how much, and how the requirement is to be satisfied was left up to the institution granting the degree.

It happened that as I was working on the revisions for this edition, I learned that a former student from one of my death and dying classes had just graduated from medical school. I was curious about what he got out of his medical education about death and dying. So, in addition to congratulating him on the degree he had just earned I asked him what he learned in medical school about end-of-life care. Here is what he messaged me, "The extent we actually studied death and dying in class (first two years are just crammed with book learning) if I am honest, I don't think very much … I know we DID have a couple days where we specifically talked about death and dying … so, not a ton." (Pendergrass, 2024). I commented that he seemed to have gotten more in my undergraduate course, than he got in medical school and he said, "Yes, pretty much." He also commented, "I feel like, yes in medicine, we are specifically working to deny death, and it can be a challenge when it's winning is inevitable."

But, as I reflect on the problem, I'm not sure that just setting standards and requiring specific curriculum content for medical school end-of-life caring is sufficient. Sure, what we teach future doctors is critically important. But perhaps, we should remember there are an increasing number of other categories of providers giving direct care: nurses, nurse practitioners, and physician assistants, not to mention pharmacists, physical therapists, occupational therapists, and various categories of mental health providers. As we envision end-of-life care, perhaps we may not want to focus only on physicians, but on healthcare providers more generally. And, perhaps a few questions are in order. How can we increase the number of healthcare professionals we reach? What do they need to know that could make a difference? How can we support them in using this knowledge to improve patient care?

Standards in Death Education. Over the years, I've consulted the ADEC *Handbook of Thanatology* when working on my own death and dying text (Balk et al., 2007; Meagher & Balk, 2013; Servaty-Seib & Chapple, 2021). In the current edition of the ADEC *Handbook*, I've noticed an increased interest in standards for death education. Indeed, the 2021 edition refers to an outline for a "body of knowledge" developed by ADEC personnel (Chapple et al., 2017). Since the mid-twentieth century, the field has been dynamic, and evolving. Whether the field is sufficiently well developed to justify operationalizing content areas into specific learning activities, with measurable outcomes, remains to be seen.

The contents of this text, and other introductory thanatology texts, seem to line up fairly well with the proposed body of knowledge, as outlined by ADEC (Chapple et al., 2017). In this text, we will be using *Bloom's Taxonomy*, which has been well-accepted in the field of education, to

state our end-of-chapter learning "objectives," now most often called "outcomes," at various levels of understanding: knowledge, comprehension, application, analysis, synthesis, and evaluation or assessment (Bloom et al., 1956).

Didactic and Experiential Learning

There are two key approaches to death education: the **didactic** and **experiential**. In the *didactic* approach, an instructor imparts the knowledge, values, and skills believed to be beneficial to student learning through direct teaching. This might involve the use of lectures, DVDs, audio recordings, and so forth. In the *experiential* approach, the facilitator directly engages participants in real-life activities designed to evoke one's feelings and perhaps even change attitudes. Earlier in this chapter, I outlined an experiential activity—the object exercise. If you participated in that exercise, you have already engaged in experiential learning.

Sometimes, the most powerful of all educational experiences is the **teachable moment**, or real-life experience related to death, that opens one to learn about death in a personally meaningful way. For example, children often learn about death when a companion animal or grandparent dies. Although neither planned nor desired, such experiences are generally moving and intimate.

A Multidisciplinary, Multidimensional Emphasis in the Field

The pioneers of death education came from a very broad range of professions and academic disciplines—medicine and nursing; psychology and counseling; anthropology, sociology, and social work; theology and chaplaincy; and many others. From its beginnings, the field has always been rather multidisciplinary. It embraces diverse views and experiences. For many, this is part of its appeal.

There is an often-quoted Hindu parable about a group of blind men who are asked to describe an elephant. The first approaches the elephant and grabs its tail. He says the elephant is like a rope. The second puts his arms around a leg and says an elephant is like the trunk of a tree. Then the third man grabs the snout at exactly the same moment the elephant shoots a stream of water, so he says the elephant is like a water hose. The fourth grasps an ear and says an elephant is like a fan that circulates the air. The moral is that each is both correct and incorrect. Correct because the account, as far as it goes, is accurate; incorrect because none was able to understand the totality of the elephant. A solution to the paradox only becomes apparent when one recognizes that the descriptions are really complementary, not contradictory.

The field of *thanatology* is **multidisciplinary** because people from diverse fields and professions join its ranks. It is **multidimensional** because its practitioners recognize that dealing with death, dying, and bereavement requires them to work with whole persons—body, mind, and spirit—and not only them but also their families, their faith communities, and their networks of friends and colleagues.

Since graduate programs that train thanatologists are not yet common, most people in the field have completed graduate education in other disciplines, each with its own body of literature and preferred research methods: medicine, nursing, social work; anthropology, psychology, sociology, and so forth. This makes a unified, or integrated, approach in thanatology a near impossibility, even if it was desirable, unless it be one that is very multidimensional and open to diverse people, ideas, experience, and methods, which I believe to be the case.

Another commentator on death studies (e.g., Corr, 1992, 1993) has suggested that there are at least four fundamental dimensions of coping with dying: the physical, psychological, social, and spiritual. I think we can expand the use of these concepts to craft a more integrated, multidimensional, approach to thanatology more generally. In this text, we have adopted the term **Four-facet Model** (see Table 1.1).

Table 1.1 Four-Facet Model (Four Key Facets of the Death and Dying Experience)

Physical	The physical dimensions of living: bodily needs and physical distress. Material existence is experienced directly with the senses.
Psychological	The entirety of human subjective experience: thinking, feeling, behaving, relating, and aspiring.
Social	Includes all of one's relationships (i.e., with family, friends, community, culture, and society).
Spiritual	The dimension of life that reflects the need to find meaning or connectedness to a universe greater than oneself, and to a sense of transcendence.

Within our *four-facet model*, we can think of the **physical facet** as pertaining to those aspects of material existence that we experience directly with the senses. It includes the complexities of the human body, survival needs, bodily functions, processes associated with wellness and illness, and how the body adapts to stress and illness. We can include the experience of pain, loss of breath, toileting, and other bodily functions as being part of this facet. We should not think of this, or any facet, however, as being independent of the others, for each one is integral to the whole.

The **psychological facet**, the second dimension of coping with dying, includes that most intangible of human phenomena, *human consciousness*, as well as the thoughts, feelings, and behaviors that are integral to human experience. This facet in many ways is more subtle than those discussed so far. The human psyche can inspire the imagination. In many respects, our society is psychologically savvy, deeply interested in all things related to the mind, including the desire to understand end-of-life issues.

We can think of the **social facet** as the dimension of human experience concerned with social relations—family, groups, communities, the culture, social institutions, and the society itself. The family, perhaps the most basic of social institutions, is where people come together out of mutual care, where children are reared, and where end-of-life issues are played out. More broadly, the social facet includes all the complex social institutions, customs, and practices that shape our social interactions (e.g., Macionis, 1999, p. 93; Henslin, 2001, p. 150; Lindsey & Beach, 2002, p. 99). Within the context of death education, the social facet can be thought to include our **death system** (Kastenbaum, 2009)—the people, places, times, objects, and symbols that taken together provide a society with a way to address our experiences with death, dying, and bereavement.

Culture, which one can think of as everything that is part of the "social environment"—the language, beliefs, values, norms, behaviors, and material objects that are passed on from generation to generation. Another way to think of culture is to think of it as including everything about a collective way of life that is often taken for granted. As anyone who has ever traveled to a foreign country can attest, we are often unaware of the pervasive influence of culture until in the midst of an unfamiliar one. So, we can also think of culture as being like the air we breathe. We might not even notice it until it's not there.

Spirituality can be thought of as a sense about that which is beyond the ordinary. It is often linked to thanatology, perhaps because of widespread speculation about what, if anything, happens to one after death. Although **religion**—a set of organized beliefs and practices about the supernatural—embraces the spiritual dimension, not all people who regard themselves as spiritual are religious in a formal sense. In anthropology and sociology, we sometimes use the term *simple supernaturalism* to denote the belief that supernatural forces help shape the course of human events, without making explicit recourse to specific religious beliefs. George Fitchett, currently a professor and director of research in the Department of Religion at Rush University, defines

spirituality as "the dimension of life that reflects the need to find meaning in existence and in which we respond to the sacred" (Fitchett, 1993, p. 16). So then, we can think of the **spiritual facet** of experience as the dimension of human living that is concerned with trying to understand death within the context of intuition about a reality that transcends ordinary experience.

In Chapter 10, we explore **hospice**, a model that is considered the "gold standard" when it comes to providing care to the dying. It reflects the multidisciplinary and multidimensional emphasis in thanatology. It is multidimensional because it attempts to address each of the four facets, as previously discussed. It is multidisciplinary because professionals from diverse fields are brought together with one goal in mind: providing high-quality, compassion-driven care. These individuals include doctors, nurses, counselors, social workers, chaplains, and even everyday people who volunteer to help.

Theory, Research, and Practice

A detailed discussion of theory, research, and practice is well beyond the scope of an introductory text on thanatology. However, it is common practice in established social sciences, like anthropology, psychology, and sociology, for introductory texts to include a chapter on research. My own sense is that as the field continues to evolve we will see an increasing emphasis on research. Although it is unlikely that an undergraduate student would be asked to conduct original research in an introductory course, having a basic understanding of research methods may well help the reader achieve a greater understanding of the literature. We also believe it will complement and supplement the material on research students encounter in their other social science courses. *Academic disciplines* (e.g., anthropology, psychology, and sociology) are often defined by the body of theory they have and the research methods they use; *professional disciplines* (e.g., medicine, nursing, and social work) are usually defined by theory, the research methods they use, and practice. It is both a blessing and a challenge for this relatively new field that its practitioners come from such diverse backgrounds—a blessing because its diversity makes it so rich, a challenge because its body of theory seems so diffuse and its research methods are still evolving.

This having been said, we should also point out that the research originally done in thanatology has enhanced the knowledge of research more broadly. For example, the pioneering research done by sociologists Anselm Strauss and Barney Glaser (1965, 1968) on the experience of dying patients in San Francisco led to the development of a whole new way to approach qualitative research, called *grounded theory* (Glaser & Strauss, 1968).

Carol Wogrin, a practicing psychologist and well-respected grief educator, commented that even in the field of thanatology there is a divide between its practitioners, researchers, and theoreticians (Wogrin, 2007). Practitioners in the trenches sometimes have a hard time seeing the relevance of the research to their day-to-day work. And researchers sometimes complain that the folk wisdom spun off by practitioners don't always contribute much to a scientific understanding of death, dying, and bereavement. So, then, let's take a few moments to explore the relationship between them.

The Theory–Research Cycle

One way to begin this discussion is to introduce the **theory–research cycle**. Think of a **theory** as a tentative explanation for some phenomenon. It is a set of logically interrelated statements that attempts to describe, explain, and sometimes predict behavior. Theories make assertions about how things work. For example, Kübler-Ross (1969) theorized that dying people go through predictable stages as they approach death.

Although a theory may lead to, or guide, **research**, it doesn't in and of itself constitute evidence, or provide proof, of its own claims. This is the job of *research*, which is a systematic process. In what is sometimes referred to as the *classical research method*, the experiment, researchers test theory to see if it holds up. In contemporary practice, the investigator typically reviews the literature, conducts an experiment, gathers data, and analyzes the data in the search for new knowledge. Without evidence to support it, a theory is just that—a theory.

Theory and research are interdependent. They rely on each other. Although theory often guides research, research is the accepted process for testing current theory, confirming or disconfirming it, which in turn leads to changes in theory or the development of new theory. Walter Wallace (1971) describes the relationship between theory and research as being that of a continuous cycle. For a graphic depiction of the theory–research cycle, see Figure 1.1.

According to the research–theory cycle, the investigator can begin with either a theory or direct observations. If one begins with a theory, the investigator designs research to test it, observes what happens, analyzes it, and then tries to arrive at conclusions, or generalizations, about what it means. This is called the **deductive approach**—i.e., one starts with a general idea and then attempts to deduce a conclusion. Later, we look at a body of research done on terror management theory (TMT) using the experimental method, an example of the deductive approach.

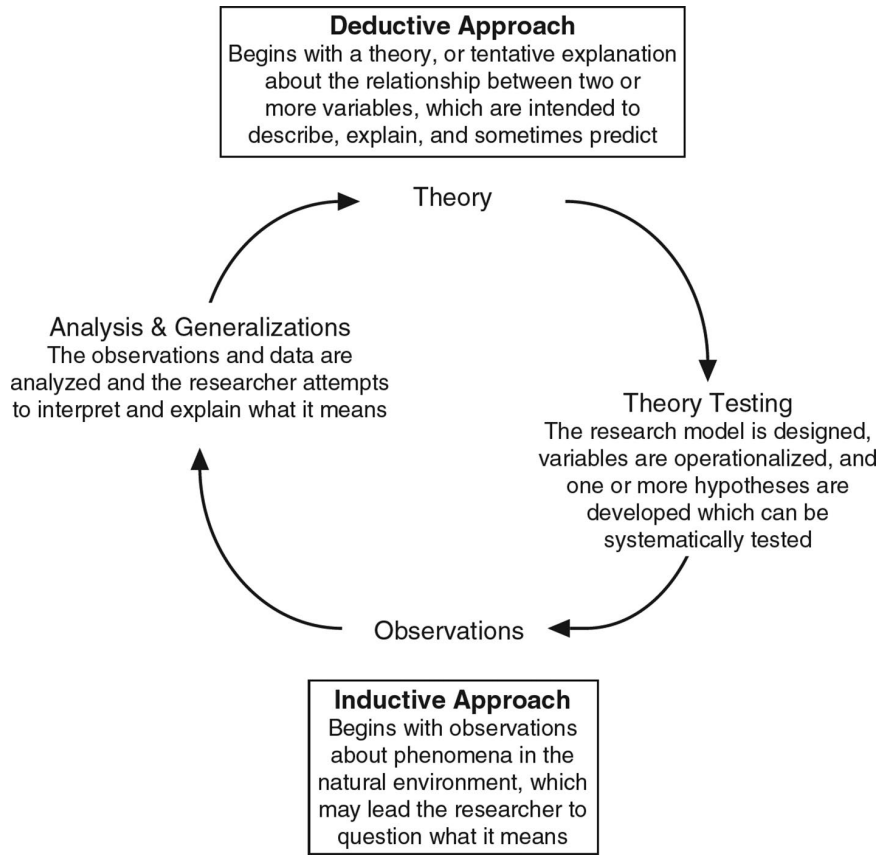

Figure 1.1 Theory–research cycle.

One can also start on the opposite side of the cycle, starting with direct observation. Someone makes an observation that gets them wondering. The researcher generalizes what they think it means, which might then develop into a theory. This is called the **inductive approach**. For example, Herman Feifel, the pioneering psychologist who coined the term *death anxiety*, became interested in the topic as a result of his observations of doctors who he thought behaved nervously when dealing with dying people. To him, they seemed *anxious* when dealing with death and dying (Neimeyer & Fortner, 1997).

Diverse Research Methods

In addition to the general deductive or inductive approaches to research, there are many specific research methods: the experiment, survey, field study, participant observation, historical analysis, case study, and secondary analysis of existing data. Examples of each are integrated throughout this or any good text on death, dying, and bereavement. Why? It is because the methods of research are important to understand, and researchers from diverse disciplines have used a variety of approaches in this quest. Some methods are better than others depending on what it is we're trying to learn. In the experiment, sometimes called "classical" or "hard" research, the investigator attempts to establish a cause-and-effect relationship between two or more variables using the scientific method. This is a benchmark in academia by which other research methods tend to be judged. For a summary of the key elements of the scientific method, see Table 1.2 (Gauch, 2003; Reiff, Harwood, & Phillipson, 2002; Tang, Coffey, Elby, & Levin, 2010).

Table 1.2 Basic Elements of Scientific Method

Description	Information about the phenomena being studied must be both valid (accurately related to the focus of inquiry) and reliable (repeatable; i.e., consistently yields similar results when following the same procedures).
Prediction	The results of experimentation should be predictable based on the theory used and the hypothesis tested.
Control	The researcher should be able to control at least one variable (the independent variable) in order to test the effect on at least one other variable (the dependent variable). This helps determine if a cause-and-effect relationship exists between the two.
Understanding	Specific criteria must be met before the phenomena under study are said to be understood: Covariation of events—The predicted variation of one variable (the dependent variable) in response to the manipulation of the other (the independent variable) must occur as predicted. Sequence—The hypothesized cause (the independent variable) must in fact precede in time the observed effect (the dependent variable). Elimination of alternative explanations—Steps must be taken to ensure that some other intervening variable did not cause the observed effect.

There are also **qualitative methods** of research, i.e., nonnumeric approaches in which the researcher attempts to understand phenomena, perhaps by interviewing people or observing how they behave in real life. **Quantitative methods** are often associated with the deductive approach and involve the use of measurement. Qualitative methods are associated with the inductive approach and involve the use of words. Table 1.3 summarizes a few distinguishing characteristics of deductive and inductive approaches; quantitative and qualitative research; and the general placement of various research methods on a continuum from deductive, quantitative, and explanatory, to inductive, qualitative, and exploratory.

Table 1.3 Comparing Approaches to Research

Deductive	*Inductive*
begins with theory forms hypothesis makes observations—tests hypothesis generalizes results modifies theory	begins with observations makes generalizations results may help give shape to new theory
Quantitative Research	Qualitative Research
deductive explanatory emphasis on determining cause-and-effect attempts to control variables natural science worldview examines behavior of individual variables goal: determine cause-and-effect focus is on objective reality positivistic outcome oriented reality can be observed and measured	inductive exploratory emphasis on exploration of phenomena naturalistic—no attempt to control variables anthropological worldview holistic goal: understand actor's view focus is on actors' subjective reality phenomenological process oriented reality is subjective
General Placement of Selected Research Methods	
experiment survey research secondary analysis of existing data	field research participant observation historical analysis ethnography case studies

What About the Denial of Death?

Earlier in the chapter, we discussed Ernest Becker's concept, denial of death, and suggested that in "lifting the pall" we take the scary step of gazing into the void. But is it true that the denial of death and death anxiety are really that important?

This section will try to answer that question by looking at some interesting theory and research. Beginning in the 1980s, Becker's original work inspired three experimental social psychologists, then graduate students at the University of Kansas, Tom Pyszczynski, Sheldon Solomon, and Jeff Greenberg, to seriously study the denial of death. They took Becker's ideas and tested them in an array of classical, empirical research studies (e.g., Greenberg, Pyszczynski, & Solomon, 1986; Greenberg et al., 1993; Greenberg, Arndt, Simon, Pyszczynski, & Solomon, 2000; Pyszczynski, Greenberg, Solomon, & Hamilton, 1990; Pyszczynski, Greenberg, & Solomon, 1999a; Pyszczynski, Solomon, & Greenberg, 2003, 2015; Pyszczynski et al., 2006; Solomon, Greenberg, & Pyszczynski, 1991, 2003; Solomon, Laor, & McFarlane, 1996). As a result, they extended Becker's thinking into a theoretical model known as **terror management theory (TMT)**. We introduced TMT in the first edition of this text (Kemp, 2014). The theory was developed in social psychology but also seems to be gaining in acceptance within contemporary thanatology (Wittkowski & Menzies, 2021).

In the four-plus decades since Pyszczynski, Solomon, and Greenberg began their work, they have developed TMT and amassed an impressive body of research to support the theory. Indeed, they believe the denial of death may be one of the most important psychological principles yet discovered. After the events of 9/11, these researchers published a remarkably jargon-free book,

explaining their work, the research, and how it might be useful in explaining events like what happened on 9/11 (Pyszczynski et al., 2003).

Building on the early work of Becker (1971, 1973, 1975), the trio observed that human beings, like all living beings, share a biological predisposition to self-preservation (Pyszczynski et al., 2003). This is necessary to promote the survival of the species. We humans are also extremely social and highly intelligent, such that our gregarious nature fosters the ability to cooperate with one another, engage in complex social behavior, and develop the kind of social institutions—political, economic, military, and religious—that make collective survival possible. What makes us different from other animals is our large and very well-developed brains, which give us the capacity to do more than just respond reflexively to the environment. We can consider alternatives, reflect, and even imagine desired outcomes.

Not only are we able to imagine; we are also conscious and self-conscious (Pyszczynski et al., 2003, 2015). There are certain cognitive abilities that come with this faculty, such as the ability to reflect on the past and anticipate the future. With this self-awareness comes both awe and dread—awe at the wonders of life and being alive, and the dread that comes from the unsettling awareness, to recall the story of Siddhartha, that we age, experience illness, and one day die. We understand we are corporeal beings—a mixture of flesh and body fluids, which Pyszczynski and colleagues note "makes us vulnerable to potentially overwhelming terror at virtually any given moment" (Pyszczynski et al., 2003, p. 16).

According to TMT, what saves us from becoming overwhelmed by the awareness of our mortality and corporality are **culture** and **self-esteem** (Pyszczynski et al., 2003). In the fields of anthropology and sociology, *culture* is understood as having both material and nonmaterial elements. Material culture includes all the physical artifacts of a people, from the iPhones, laptops, and hybrid vehicles of today's culture to the arrowheads, burial masks, and cooking pots of a bygone era. Nonmaterial culture includes all the nonphysical elements of a people—the customs, beliefs, norms, and values that give them a sense of meaning and identity and that help them deal with their environment so as to make it possible to survive. *Self-esteem*, according to TMT, involves the ability of individual members of a society to see themselves as valuable and significant players. One might also use the term self-efficacy.

At the core of TMT is the notion that culture gives people a way of managing the potential terror of death by helping us see ourselves as having enduring significance (Pyszczynski et al., 2003, 2015). Two key implications of this proposition are that we must:

1 Sustain our faith in culturally derived worldviews that give reality a sense of meaning, order, and purpose; and
2 Maintain a sense of personal worth—the conviction that we really play significant roles in the unfolding drama.

A problem with this twofold strategy for dealing with the fear of death is that we live in a world with diverse cultures, with varying ways of dealing with the problems of living. According to TMT, when differing cultures come in contact with each other, there is the risk they will pose a challenge to each other (Pyszczynski et al., 2003, 2015). If the culturally derived worldviews protect a people from the realities of death, then coming into contact with people with other views can threaten belief in the perceived truth of it. Pyszczynski and colleagues suggest that this is why it is so hard to coexist peacefully, and why cultures clash—the strife between American and Arab cultures that erupted in the attacks of 9/11 and the subsequent "War on Terror" being examples of how problematic it can be (Pyszczynski et al., 2003, 2015; Yum & Schenck-Hamlin, 2005).

In addition to the challenges posed by culture clash, Pyszczynski and colleagues suggest that, since culture is a socially constructed way of coping with the physical problem of death, it is utterly

dependent on social consensus. Because social consensus is "socially constructed" and subject to change, it is inherently unstable. As a result, it is never able to completely resolve our fear of death. From the standpoint of TMT, this death anxiety, although it is repressed, is always with us. Pyszczynski et al. (2003, 2015) suggest that the challenges to one's own worldview are generally countered by five basic strategies:

1 *Convert:* Change one's worldview when one's existing perspective does not adequately fulfill this need for self-esteem and a sense of meaning.
2 *Derogate:* Belittle or undermine the worth of alternative worldviews.
3 *Get others to assimilate:* Get others to adopt one's own worldview.
4 *Accommodate:* Incorporate appealing aspects of alternative worldviews into one's own perspective while divesting any of the potentially threatening dimensions of it.
5 *Annihilate:* Endeavor to destroy those who persist in keeping their own cultural worldviews.

Empirical Evidence and Key Elements

Now that we have reviewed a few key principles of TMT, let's briefly turn to the research that supports it. For over 40 years, Pyszczynski, Greenberg, and Solomon have conducted hundreds of peer-reviewed studies supporting TMT using the experimental method (Greenberg et al., 1986; Greenberg et al., 1993, 2000; Pyszczynski et al., 2003, 2015; Pyszczynski et al., 1990, 2006; Pyszczynski et al., 1999a; Solomon et al., 1991, 2003; Solomon et al., 1996). Indeed, the very large volume of empirical research they have amassed on the theory is beyond the space available to review here.

Let it suffice to cite a few important studies and key concepts. Pyszczynski et al. (2003, 2015) use the term **mortality salience** to denote the influence of death awareness on human behavior. They use their "classic mortality salience treatment" to accomplish this. This involves asking research participants to describe their feelings when they consider their own death, write down what they think will occur when they themselves go through the dying process, and what they think will happen once dead.

The TMT team describes two general modes of reacting to terror, which they call the **dual-defense model** (Pyszczynski, Solomon, & Greenberg, 1999b, 2003, 2015). The two types of

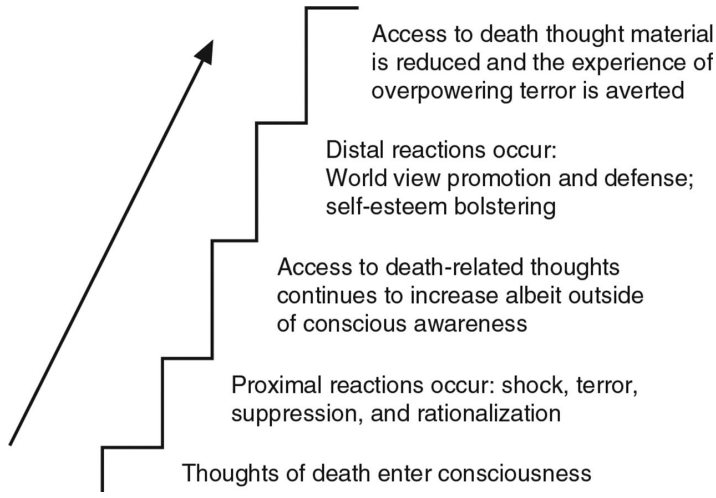

Figure 1.2 Steps in the terror management process.

reactions are *proximal* and *distal*. **Proximal reactions** are likely to occur right away in response to an explicit threat, such as those that occurred in the wake of 9/11 (Yum & Schenck-Hamlin, 2005). These are conscious and rational but may have elements of shock and horror. They tend to deny one's vulnerability by indulging in such strategies as distracting oneself or making attempts to understand the situation by relying on logic and evidence. **Distal reactions** are longer term and more likely to emerge over time. Terror management theorists believe these kinds of reactions operate at the unconscious level. It is this type that strives to promote and defend one's cultural worldview and uses self-esteem-enhancing strategies. Figure 1.2 is based on TMT theory (Pyszczynski et al., 1999b). It graphically portrays the steps in the terror management process.

Implications

Concurring with preeminent psychotherapist Irving Yalom (1980), proponents of TMT suggest that the fear of death may be far more important than previously imagined (Pyszczynski et al., 2003, 2015): it has been associated with schizophrenia, phobias and obsessive–compulsive disorders, neuroticism; depression; and posttraumatic stress disorder. On a practical level, members of the core TMT team suggest three basic strategies that may be useful in helping people deal with their fear of death (Pyszczynski et al., 2003, 2015), as discussed in Box 1.3.

Box 1.3 Focus on Practice: Helping People Cope with the Reality of Their Finitude

Based on their research on terror management, Pyszczynski et al. (2003) recommended three strategies for helping people with mortality salience in other words, the awareness of mortality. Mortality salience can be expected to increase at times of threat, serious illness, trauma, or loss. Anyone wanting to help others may wish to consider the implications of this research.

1 *Provide social support and caring:* This is something friends and family do naturally; professionals do this from their deep commitment to helping people.
   - Strategies, such as person-centered therapy, or just "thick listening," that focus on listening intently to the experience of the individual, may be particularly helpful.

2 *Help people achieve a sense of meaning and purpose:* This involves going beyond helping people "connect the dots" to helping them make sense of tragedy and strive to achieve a sense of ultimate purpose.
   - Depending on the person's background, frame of reference, and worldview, anyone wishing to support someone with this may want to consider supporting the religious or spiritual traditions of the individual, perhaps partnering with those who have expertise in this area. Logo therapy and narrative therapy may be well suited to help individuals achieve a greater sense of meaning or purpose.

3 *Provide opportunities for heroism and self-esteem building:* Find ways to help people see themselves and their contributions as valuable to a purpose beyond just themselves.
   - Help engage the person in any practical task or service that assists others or helps resolve a problem—for example, volunteer work, mentoring, or even political action.

Discussion

Death is paradoxically an integral part of life. How people relate to it is both a highly personal and social matter. In the West, people have related to it differently over time. As we discuss in Chapter 2, the modern era, which is characterized by Newtonian science, the application of technology, industrialization, urbanization, and the rise of capitalism, death moved away from the home and into the hospital, with all its bureaucratic and scientific accouterments. As a result, people have become separated from the dying and began experiencing death from a distance, something that became especially prominent during the COVID-19 pandemic.

I taught for just one academic term after the beginning of the pandemic lockdown and before I retired from full-time teaching, as had been previously announced. After retiring, I completed additional graduate work and an original pilot study in my own community about what people wanted to know about death dying and bereavement (Kemp, 2022). I was familiar with what was included in my own text, and reasonably familiar with what is in the other major texts on the topic (Corr, Corr, & Doka, 2019; DeSpelder et al., 2020; Kastenbaum & Moreman, 2018). I was unable to find any original research addressing the topic of what people actually wanted to know.

In the pilot study I conducted, I asked participants (sample, $n = 94$, out of a pool of 8,700) to respond to a mixed-methods survey that included some basic demographic information, one open-ended narrative question about what they'd like to know, and some closed-ended questions about topics generally covered in the extant texts. To make sure that our questions were internally reliable, I compared the results with items from a "tried and true" instrument, the Templer (1970) Death Anxiety Scale. The results suggested that our survey questions stacked up well against those of the Templer, with Cronbach Alpha coefficients of about .87 for the numerically rated topics of interest questions compared to .82 for the Templer items. Participants were *most* interested in four topics: facing one's own impending death, end-of-life decision-making, alternative ways of disposing of human remains, and understanding and addressing the experiences of bereavement, grief, and mourning. Participants were *least* interested in two topics: traditional ways of disposing of human remains and religious perspectives on what happens to us after we die (Kemp, 2022). It is noteworthy, that people were interested in what happens after we die but were not particularly interested in learning about what institutional religions had to say on the subject.

As a team, yours truly, various allies and consultants working with me, and the group from Routledge, operating from New York and London, are committed to providing you with the best text possible, with best available material; addressing the topics with the greatest interest, relevance, and importance; presented in a clear relatable manner; which is solidly grounded in the literature; and that respects our basic humanity and personhood.

Conclusion

This chapter began with a few words about the importance of self-care and suggested a classroom exercise that might deepen our understanding through the telling of our own story and listening to the stories of others. I shared a couple of short reflections about a friend and colleague—some snippets of insight he related before his own death from cancer—before discussing one of the book's central themes: The idea that learning about death is like "lifting the pall," or the covering that shields us from the full significance of death's reality. We briefly introduce the pioneering work of cultural anthropologist Ernest Becker, who coined the term *denial of death* to describe Western, particularly North American, attitudes about death. The death-denying proclivity is not exactly new or unique to our own culture. To emphasize, we briefly recounted the story of Siddhartha Gautama, who would become known as the Buddha, and how, as a prince living in a palace, his father attempted to shield him from the harsh realities of life. As the story goes, he happened on four people on a journey

outside the palace. Three of them represented unpleasant realities of life (i.e., we age, become ill, and ultimately die). The fourth figure, the hermit, represents spirituality or the spiritual path.

We briefly explored the field of thanatology, including an introduction to the work of psychologist Herman Feifel, psychiatrist Elisabeth Kübler-Ross, sociologist Robert Fulton, and clinical psychologist, Edwin Schneidman. In this context, we explored several concepts important to the field, including death anxiety, didactic and experiential approaches to death education, and the teachable moment. We also explored a four-facet model of death education that organizes the various aspects of death, dying, and bereavement into the physical, psychological, social, and spiritual facets.

The relationship among theory, research, and practice was our next topic, beginning with the introduction of the theory–research cycle. We compared deductive and inductive approaches to research, noting that the deductive, classical, empirical, and scientific methods are the "gold standard" when it comes to academic research. This section made brief mention of various specific research methods.

Following our survey of research, theory, and practice, we looked at TMT, with an eye to answering the question "Is the denial of death really that significant?" We briefly discussed the key tenets of the theory, the research supporting it, and the implications of this work.

In the Conclusion, I briefly share my own experience with the COVID lockdown and discuss how a pilot study I did during the lockdown helped inform us about what people would like to know about death, dying, and bereavement (Kemp, 2022).

End-of-Chapter Resources

Suggested Activities

1 If you do not already do so, start keeping a daily journal. You might wish to use the journal to process your reactions, insights, and reflections as you move through this text but start by writing about your own experiences with death or, if you prefer, your inclinations to push such thoughts out of your head.
2 For one week, keep a log of examples of how people you observe respond to topics or experiences related to death.
3 Select an elderly family member or friend and conduct a taped interview (audio or video) with this person about his or her life and whatever reflections the person might wish to share about the future end of his or her life. These kinds of interviews can be powerful bonding experiences. The elderly person has the opportunity to fulfill a mentoring role. Not only will you gain valuable insights but also you'll have a permanent audio or video recording of the interview with your loved one.

Suggested Reading and Viewing

- Becker, Ernest. (1973). *The denial of death*. New York: Free Press.
  This wonderful, classic book did much to awaken people to the need to pay attention to death. Since the years following its first release it has played an important role in arousing professional awareness.
- Hesse, Herman. (1951). *Siddhartha*. New York: Bantam Books.
  Although this beautifully written novel isn't factually correct about the human being who would be regarded by millions as "Buddha," this book is a wonderful read about the spiritual journey.

- Shen, Patrick (Director). (2005). *Flight from death: The quest for immortality*. Go-Kart Records.
  This insightful documentary is built around the ideas of Ernest Becker, especially the notion that a great deal of human striving and culture revolves around our denial of death and our ambition to make a mark on our world. Available for rent from YouTube.
- Tolstoy, L. & Edmonds, R. (Trans.). (1960). *The death of Ivan Ilyich and other stories*. New York: Penguin.
  This is a poignant, classic, story of a dying man who desperately wants people to stop denying what is happening to him so that he can die in peace.

Links and Internet Resources

- **Association for Death Education and Counseling** *www.adec.org*
  This website is one of the oldest interdisciplinary organizations dedicated to the study of death, dying, and bereavement. It includes information of interest to professionals as well as to links to resources.
- **Encyclopedia of Death and Dying** *www.deathreference.com*
  This extensive, and searchable, online database will take you to a variety of well-written articles on death, dying, and bereavement.
- **Ernest Becker Foundation** *www.ernestbecker.org*
  Exclusively devoted to the work of Ernest Becker, this site provides a glimpse into the impact of his work. A description from this website: "To cultivate and support scholarly work that explores and extends Becker's insights; to disseminate to the public and its institutions the understandings which emerge; to apply these principles to the mitigation of violence and suffering."
- **Kearl's Guide to Sociological Thanatology** *http://faculty.trinity.edu/mkearl/death.html*
  Although dated, the late Dr. Michael Kearl's original guide at Trinity University, near Austin, TX, may be helpful in gaining a uniquely sociological perspective on death and dying, sometimes quirky.

Online Learning

Online learning as a modality has both advantages and disadvantages. During COVID, we learned that one of the advantages is that it can be done from remote locations. New to this edition of *Death, Dying, and Bereavement in a Changing World* is this section specifically focusing on online learning.

Online Education: Hello, Goodbye?

https://www.youtube.com/watch?v=Ddt3Vn_k-eQ

After negative experiences with emergency remote education during COVID, it may understandable why many people aren't fans of online learning. The speaker in this TEDx video, Gino Camps, challenges us to look beyond the trauma and start thinking about how to more effectively use and evolve this new modality. Based on insights from memory research, in this video clip we explore how students and teachers can optimize their learning and teaching processes.

What We're Learning from Online Education

https://www.youtube.com/watch?v=U6FvJ6jMGHU

Daphne Koller, a third-generation PhD, is enticing top universities to put their most intriguing courses online for free—not just as a service, but as a way to research how people learn.

With *Coursera* (cofounded by Andrew Ng), each keystroke, quiz, peer-to-peer discussion and self-graded assignment builds an unprecedented pool of data on how knowledge is processed.

Online Classes: A Survival Guide

https://www.youtube.com/watch?v=HsWYxfVzX_U

https://nebula.tv/videos/thomas-frank-online-classes-a-survival-guide (add free version)

Thomas Frank offers five tips from a student's perspective on how to be successful in online classes. It has good production value. Good content, writing, filming, and editing.

Rethinking Death: Exploring What Happens When We Die

https://www.youtube.com/watch?v=_18UdG4STHA&t=385s

This is a link to the full version of Parnia's Lab's premiere film, *Rethinking Death: Exploring What Happens When We Die*. In this video, scientists, physicians, and survivors of cardiac arrest explore the liminal space between life, death, and the great beyond. They break down perplexing scientific breakthroughs to tell a remarkable, scientific, story of what happens after we die. In relation to the text, this video has some very good discussion about the differences between the concepts of 'death,' 'clinical death,' and 'brain death,' which were introduced in an early part of this chapter.

Review Guide (Using Bloom's Taxonomy)

Please note: we have included the use of Bloom's Taxonomy (Bloom et al., 1956) as a way to review and summarize the material provided in this chapter. It is but one model, with advantages and disadvantages. However, it has been well-received within education over the years. It is our hope is that the taxonomy will give the reader a clear and understandable way to review, think about, and summarize what they learn in the chapter.

Knowledge—*Is able to define the key terms used in this chapter, paying special attention to the following:*

Key Terms

Comprehension—*Demonstrates the ability to grasp the meaning/significance of the material*

- Discuss why the concept of "denial of death" is important to understanding the importance of death in our lives.

- According to the text, why is self-care is important when taking a course, like this?
- What does the term "pall" refer to and what is its symbolic significance?
- What are the differences between didactic and experiential education?
- Why do we say that contemporary thanatology is both multidimensional and multidisciplinary?
- Summarize the "four-facet model." What kinds of relationships do you see between each of these dimensions? Do some seem more important than others? To what degree do your responses to this question correspond with your own biases and lifestyle choices, and/or values?
- What is hospice? Today, who participates on the hospice team?
- What is the relationship between theory, research, and practice in thanatology?
- What is the theory–research cycle?
- What are the differences between the deductive and inductive approaches to research?
- What research has been done on Becker's concept, "the denial of death"?
- What is TMT? What two basic ways do we try to manage our own death anxiety? What are the implications of this? What are the five basic strategies for countering challenges to our worldviews?
- What is "mortality salience"? What is the "classic mortality salience treatment?"
- What is the dual defense model? What are proximal and distal reactions?
- What are the implications in our society if the assertions of TMT really area true?
- In our quest to find a more human, holistic, and integrated approach to studying thanatology, what three activities did we suggest might be usefully employed to complement the contemporary academic ones?

Application—*Demonstrates the ability to use the content in real-life situations*

- How might you use the material presented in this class so far if you, or someone you love, were to be diagnosed with a life-threatening condition?

Analysis—*Demonstrates the ability to break down the material, including its models, into their component parts and show how they can be understood.*

- Summarize the main point in the story about Prince Siddhartha. What four figures did he encounter on his journey outside the palace? What is the significance of each? Why is this story remembered today?
- Who are Herman Feifel, Elisabeth Kübler-Ross, Robert Fulton, and Edwin Schneidman, and why are they important persons in the history of contemporary thanatology?

Synthesis—*Demonstrates the ability to use parts of the material(s) to form a new whole.*

- How could you use the information from a variety of academic (or professional) disciplines you have taken courses in, or might like to take, to understand an issue you have faced, or might face in the future, in relation to death, dying, and bereavement?

Evaluation—*Demonstrates the ability to assess the value of the material for a given purpose.*

- Based on the material presented in the text so far, how would you assess the effectiveness of society in helping people address the issues of death, dying, and bereavement that they will inevitably have to face?

2 Death, Dying, and Bereavement in a Changing World

Photo 2.1 It's a changing world: A view of earth taken from the far side of the moon by Artemis II, April 6, 2026. In this photo, the dark portion of Earth is experiencing nighttime, while Australia and Oceania are in the daylight. NASA, U.S. Government Photo, in the public domain.

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> Change is the hallmark of our lives in the twentieth century. All about us we find signs of a thoroughgoing reappraisal of the social patterns, customs, and attitudes inherited from past generations. … Underlying this quest for integrity and meaning is a search for essential values that can inform the way we choose to live.
>
> (DeSpelder & Strickland, 1983, p. 5)

Introduction

Change continues to be a hallmark of our lives into the twenty-first century. As we discuss in Chapter 1, modern thanatology is a relatively new field of study. Indeed, the first modern textbook to appear on the subject, *The Last Dance: Encountering Death and Dying,* was not published until 1983 (DeSpelder & Strickland, 1983). The photo opener for the first chapter of that text is the W. Eugene Smith photo, "… In a Spanish village, neighbors and relatives peer through the doorway upon the deathbed scene of a villager" (p. 4).

That photo captured an image of the so-called classic deathbed vigil (DeSpelder & Strickland, 1983). It goes something like this (and picture in your mind, if you will, the faces): The critically ill person has "taken to bed" in their own home to await death. It has become increasingly obvious to everyone that the person is near death. So, family, friends, and neighbors gather around the "deathbed" to pay their respects. It is an intimate, personal drama that gives the dying person and loved ones one last chance to reminisce, perhaps make amends, say goodbye, and "I love you." In an earlier day, this kind of death was perhaps common in some parts of the world and during some historical periods (Ariès, 1974, 1981). Indeed, in premodern Europe, we think most people died at home, often in the company of an **extended family** that included family members from several generations. Throughout Western history, home has been, until recent years, the customary place of passing (Ariès, 1974, 1981). This is still the kind of "good death" many of us imagine.

Institutional Deaths

By the mid-twentieth century, more and more people were dying in the hospital or a long-term care facility. By 1993, nearly 80% of persons dying in the United States did so in an institutional setting (Sankar, 1993). In the year 2000, institutional deaths slowed somewhat to about 71%, with 48% occurring in a hospital and 22.9% in a long-term facility, like an inpatient hospice, nursing home, or assisted-living facility (Olaisen, 2020). In 2018, the total percentage of people dying in institutional settings dropped again to 61.9%, with hospital deaths going down to 35.1% and long-term-care facility deaths going up to 26.8% of the total (Olaisen, 2020). A decrease in institutional deaths from about 80% to 62% is significant. And then, the COVID-19 pandemic hit and our hospital system became strained with an influx of COVID-19 patients (Figure 2.1).

COVID-19

From the beginning of the COVID-19 pandemic, late 2019/early 2020, through the end of 2023, a worldwide total of 7,054,080 COVID deaths were reported to the World Health Organization (WHO, 2024). In the United States, a provisional total of 1,195,175 COVID fatalities were reported to the U.S. Centers for Disease Control and Prevention through July 20, 2024 (Fess et al., 2024). These numbers are believed to be low estimates. Recent studies of "excess deaths" suggest that the actual impact from COVID may be much greater (e.g., Weinberger et al., 2020).

For the first time since 1996, the average life expectancy in the United States actually declined, by 2.4 years between 2019 and 2021, see Figure 2.2 (Arias, Tejada-Vera, Kochanek, & Ahmad,

2022). Recent research on the impact of COVID on average life expectancy suggests that the decline can be attributed to the appearance of COVID (Huang et al., 2023, 2024). Overall, the United States experienced the largest reduction in average life expectancy of the 27 countries studied (Huang et al., 2023, 2024). More people died than expected, average life expectancy was

Figure 2.1 Institutional Deaths 1900 to 2018.

Source: Centers for Disease Control and Prevention (2020b)

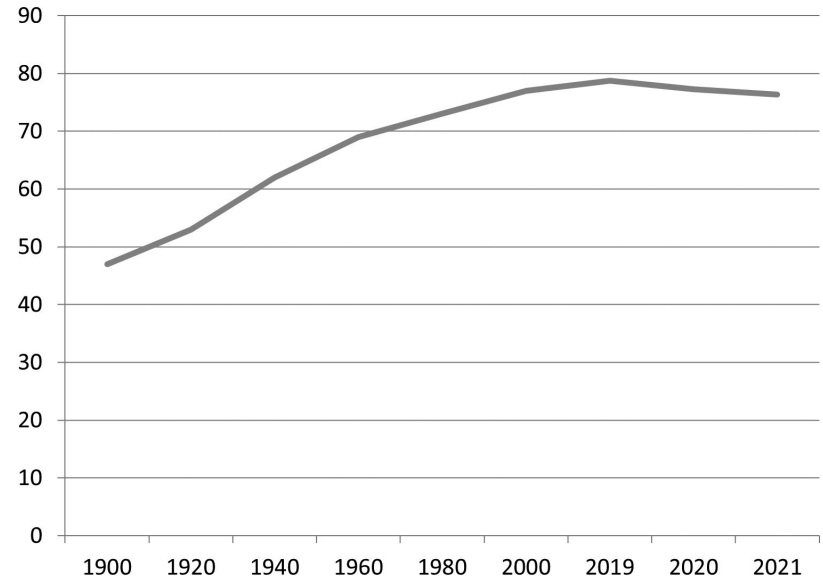

Figure 2.2 Average Life Expectancy by Year of Birth.

Source: Centers for Disease Control and Prevention (Arias et al., 2003, 2022)

Photo 2.2 Older people who encounter life-threatening emergencies are often hospitalized and given the latest in medical technology.

impacted, and how people died also changed. In particular, COVID patients were dying alone in the ICU, isolated from loved ones, and often on ventilators unable to speak (Campos-Rudinsky, 2022; Hernandez-Fernandez & Meneses-Falcon, 2023; Morgan et al., 2023).

Advances in Medicine

The late Michael Kearl, a pioneer in the sociology of death (1989, 1996), commented that until about a century ago, Western medicine was a relatively powerless profession, and physicians often did as much harm as good. Beginning in the latter half of the nineteenth century, with the dawning of industrialization and advances that came with the use of the scientific method, modern medicine began to make significant advances in what became a battle with disease. In 1858, Pasteur refined his method of sanitizing foods; in 1864, Lister theorized that doctors spread infection by the microorganisms they carried on their hands; and the germs responsible for such diseases as cholera, tuberculosis, and rabies were identified, which would lead to the diseases themselves being subdued (Goldberg, 1998). By 1935, sulfa, the world's first antibiotic drug, appeared on the market. Within another ten years, penicillin would follow. An effective treatment for tuberculosis, one of the most lethal diseases of all time, was discovered in the 1950s, a decade that would also usher in the first polio vaccine (Goldberg, 1998). By the 1930s, the shift in the usual place of death, from home to hospital, would begin. The trend continued, culminating in the 1950s in a pattern that is consistent with what we know today. This shift is also one of the most commonly cited explanations for our changing perspectives about death (see, for example, Ariès, 1974, 1981; DeSpelder & Strickland, 2017). At an intuitive level, this makes a great deal of sense, since our entire experience with death has changed. We encounter it less often and, when it does occur, it most often happens out of view. We can attribute much of this to the availability of effective treatments and the technological advances that sprang out of an era of booming postwar industrialization and that made theretofore undreamed-of inroads possible. Modern science and technology revolutionized the treatment of disease and increased

life expectancy, and as a hallmark of our culture, they also helped bring about substantial changes in the way we think, how our families are organized, and how we relate to each other socially.

As you can see from a quick perusal of Figure 2.2, life expectancy in the United States rose dramatically from 1900 to the year 2000. The average person born in 1900 could expect to live about 47 years, whereas those born in the year 2000 could expect to live to about 77 years, depending on race and gender. Not only had life expectancy increased but also advances in medicine appear to have influenced the kind of death we encounter. Whereas in previous eras child deaths were quite common, this is much less true today in developed parts of the world, largely because of the availability of drugs for treating infectious diseases that are highly effective and because sophisticated technology is increasingly effective in fending off premature death. As a consequence, the most usual category of persons to die in North America and Europe today is the elderly. And, as we previously discussed, because technology is so integral to the way we treat the seriously ill as well as the gravity of their disabilities by the time of death, they often die in an institutional setting. The less common deaths, those that occur among non-elderly people, happen in a variety of settings and by a number of causes, including accidental injury (see Chapter 3).

The Problem of Time

The image of dying at home, with loved ones present, and dying in an ICU, isolated, and hooked up to a respirator provides quite a contrast, quite a change, to how people had previously died. And, to think about change means we also need to think about **time** and **space**, since the way we observe and measure change is through differences that occur in *time* and *space*. So, let's begin with the concept of *time*. Easy, right? Wrong. As it turns out, despite all the advances in science over the course of a half millennium or so, scientists of all kinds—anthropologists, archaeologists, ethnologists, historians, psychologists, physicists, and sociologists, among others—continue to be baffled by the so-called problem of time.

We previously adopted a *four-facet model* for looking at the physical, psychological, social, and spiritual dimensions of death, dying, and bereavement (see Chapter 1). Below, we briefly survey selected work on the problem of time in the fields of physics, psychology, anthropology, archaeology, sociology, history, and theology using our four-facet model as a template.

Physical

In classical, Newtonian physics, *time* is considered to be a **scalar quantity**, i.e., a physical something that can be completely described by its magnitude, e.g., length, mass, and charge. In the case of *time*, that would be seconds, minutes, hours, days, weeks, and so on. And, because of this, we can speak about the amount of time it takes to accomplish a task, the length of time we must wait, or even when we might expect to arrive at a particular destination. All we have to do is make the calculations and look at the clock. According to Newton (Bergmann, 1992), *time* is an absolute that always moves in one direction. This gave rise to the idea that *time* is a constant that moves from the past to the present, and into the future, the so-called P-P-F "arrow" of time. As recounted by a senior writer for *Wired*,

> … one neuroscientist, sounding much like a physicist–the realm of science that routinely slices time into slivers of seconds–describes the universe a trillionth of a trillionth of a second after its birth, yet doesn't have a clue how to think about it.
>
> (Cole, 2019)

Photo 2.3 "Time is what the clock says" – Albert Einstein.

Physicists today, speaking at a practical level, tell us that *time* is the language we use that allows us to say when events take place and *space* is the language that allows us to say where (Greene, 2023). But this really only describes how we use the concept of *time*, not what *time* itself actually is. The field of physics understands this but, for practical reasons, has chosen to define time by how it is measured not what it is. And today, physicists measure time by clocks. The standard for measuring time is the **second**. And, the International System of Units defines a *second* as the transition of 9,192,631,770 cycles of radiation from caesium-133 as measured by an atomic clock (BIPM, 2019). There is a quote attributed to Albert Einstein when he was asked what time is, "Time is what the clock says." And, as it turns out, it's an atomic clock.

> Time is what the clock says.
>
> – Albert Einstein

According to Cole (2019), "Time is a notorious trickster, evading the best efforts of scientists to pin it down for thousands of years." If we wish to understand *time*, we may also need to consider what it isn't. In contrast to Newton, who viewed time as a single finite constant that can be measured, Einstein asserts that it is not a separate reality that moves in only one direction, disconnected from space, but is joined with space in a single unity, or reality, he called **spacetime**, or *space-time*, if you prefer. As it turns out, it may well be the very fabric of the universe itself (Webb, 2018, 2022). Also, according to Einstein's theories of "relativity," past, present, and future can exist simultaneously (Greene, 2023). And, in this unified existence with space, time is lesser when space is greater, and vice versa. One is relative to the other, and both are influenced by motion and gravity.

One of the more intriguing wrinkles in this whole story about time is that based on Einstein's theories, physicists think that some sort of time travel may be theoretically possible, even if practically unlikely. Although physicists believe the universe is expanding, we paradoxically need to consider **entropy**, or the disintegration of matter, which as it turns out is also a way to measure the "passage of time," theorized as beginning with the "Big Bang" some 13.8 billion years ago, and continuing with the process of steady, predictable *entropy* ever since. *Everything Everywhere All at*

Once, the 2022, seven-time Oscar Award-winning film, including best picture, explores an array of perplexing, dramatic, and comedic themes related to *time* and *space* … which according to the promotional material occurs at a "time" when things aren't exactly as they seem (Russo et al., 2022). Echoing that 2022 film, or rather the other way around (sequence really does matter), Einstein is quoted as saying, "Time is what keeps everything from happening at once" (Webb, 2018, 2022).

Psychological

Psychology is the study of human thinking, feeling, and behavior and is not much concerned with ultimate reality. The specialty within psychology that is concerned with time is called **time perception**, the subjective sense of time, as measured by one's own perception of the duration of events (Glicksohn, 2022). The *perceived* time interval between two successive events is referred to as **time duration**. *Time duration* tends to be long and slow when you're young (it takes forever for summer vacation to arrive) and to fly by as you age (where did all the time go?).

Time duration is also affected by emotional experience, like fear and awe. Imagine if you will that you actually went back in time and found yourself in a pistol duel, say in the early 1800s. Two-armed individuals standing a few yards apart (space) and on the count of three (time), each is expected to take aim at the other and fire. Imagine how long that count of three might seem. And imagine your perception of *time duration* when you pull the trigger and wait (it could feel like an eternity) to find out if you will live, die, or be maimed forever.

Social

The fields of anthropology and sociology are also concerned with time. Archaeology is a specialty within anthropology, sometimes called "anthropology of the past," which concerns itself with the study of human societies using physical evidence. In addition to the radiocarbon dating of artifacts and sites (sometimes called carbon-14 dating), which many lay people have heard about, a number of other quite sophisticated scientific methods are used in archaeology for dating a range of things, even rocks and trees (Cochrane, Doelman, & Wadley, 2013; Michels, 1972; Weiner, 2007). Although anthropologists are increasingly interested in social behavior that takes place in contemporary human populations, the distinction between anthropology and sociology is often one about the eras of time they study.

Anthropologists tend to focus on preliterate, preindustrial societies. Sociology, which emerged in the late nineteenth and early twentieth centuries, is more concerned with modern (industrial) and postmodern (postindustrial) societies, as we discuss later in the chapter. It can be understood as the study of society and human interaction (Kendall, 2017), beginning with industrialization and the rise of capitalism. Among its most influential founders is Emile Durkheim, who coined the term **social fact**. A *social fact* can be understood as patterned ways of thinking, feeling, and behaving that exist outside an individual but which exerts social control over everyone in the group or society (Durkheim, 1912/1995).

In my introductory sociology courses, the example of a *social fact* I like to use is the typical American classroom. In my classes, I prefer the horseshoe arrangement to rows, with the instructor at the podium in front of the white board (or if you're "old school," chalkboard) with the students positioned around the walls facing each other and me at the podium. I like to point out how everyone came into the class the first day, looked to see who was already there, chose a seat, took out their notebooks (paper or digital), and then waited for the time for class to begin (time helps us synchronize our activities). I point out that no one came up to the front of the class and took a place at the podium. I never told students they needed to take notes. And, everyone in class just *assumed*

I was their instructor, perhaps because they thought I looked and behaved like one (I'm also older and gray). And I point out, not a single student asked to see my ID or definitively establish my identity as their professor.

The students' behavior was directed by their **status** as students as well as the classroom situation, and of course, other factors (including conditioning). My behavior, walking to the podium and media center, writing my name, class title, and office hours on the board, is consistent with my **role** as their professor. So, we can understand *status* as having to do with the social position a person occupies within a group. *Role* has to do with the behavior they engage in as a result of occupying that position. By the time we go over the syllabus and have some informal chat, the first day of class is nearly done. But wait, I tell my students, as they begin to put their books and bags away. "I have one last thing to share before we go." I point out that we also happen to have a state mental hospital down the hill from the college. I point out that for all they knew, I could have been one of the patients from the hospital who wandered up the hill. "See you all tomorrow," I close.

Emile Durkheim also introduced the concept of **social time** (Bergmann, 1992). According to Durkheim, *social time* is collective in nature, not individual, and lies outside of individual consciousness (in contrast to *time duration* as understood subjectively in psychology) (Konig, 1976). And, if Durkheim and his successors (e.g., Marcel Mauss, Henri Hubert, and Maurice Halbwachs [cited in Bergmann, 1992]) are correct, the experience of time will vary from place to place, situation to situation, and era to era. Durkheim's ideas were further developed in France by modern sociologists George Gurvitch (1964, 1973), Pierre Bourdieu (1963), and Bourdieu and Zanotti-Karp (1968), as well as a group of historians associated with the journal, *Annales* (cited in Bergmann, 1992). Two contemporary sociologists working in the sociology of time are Andrew Abbot (2001) and Eviatar Zerubavel (2003).

Sociologist Sally Raskoff (2014) writes in her blog, Everyday Sociology, "… In Hawaii, there's always more time, you can wait before you go somewhere, just relax and take it as it comes." The sun is out, Auntie or Uncle might be dropping by, the beach is near, the surfboard is leaning against the fence, and the beach is down the road. She adds, "… A New York minute is just an instant. Not even 60 seconds! Things happen fast: the pace is quick of both legs and language." And she observes,

> Alaska is an odd mix of both urgency and laid-back slowness of time. In the winter, it may be somewhat busy indoors but the cold and dark seem to make people move more slowly. In the summer, with so much light and free to be out of doors, there is an urgency to daily life.

For our purposes, the field of history is the obvious social science discipline for exploring how people in the past understood and experienced death and dying (also sometimes taught as humanities courses). History can be understood as the branch of knowledge that endeavors to record and explain past events and that provides a chronological record of those events (Merriam-Webster, 2024). In this chapter, we lean on the work of French historian, Phillipe Ariès (1974, 1981). He uniquely focuses on changes in attitudes about, and the experience with death, in various periods of time in Europe, which he believed were largely shaped by religious forces (see below).

Spiritual

In Chapter 4, we discuss in some depth the cross-cultural and interfaith dimensions of death and dying. In the context of learning to understand the spiritual dimension as it relates to death, here we briefly distinguish between *spirituality* and *religion*. *Spirituality* and *religion* are somewhat related in that both concern themselves with what are believed by adherents to be spiritual or

supernatural dimensions of experience. However, spirituality has more to do with a subjective sense of connection, or allure, with that which is associated with the spiritual, broadly speaking—a force greater than oneself, if you will—without explicit reliance on formal religious beliefs, doctrines, or practices. Indeed, one often hears people today say that they are spiritual but not religious. In sociology, we sometimes use the term **simple supernaturalism** to describe the belief that supernatural forces have the power to affect people's lives either positively or negatively (Kendall, 2017).

Religion, on the other hand, can be understood as a **social institution**, which are enduring systems of social patterns, norms, and relationships designed to meet fundamental societal needs, provide structure, and maintain order. *Religion* as a *social institution*, includes a set of organized beliefs and rules that guides how societies, groups, and individuals within a society meet their basic spiritual needs with a unified system of beliefs, symbols, and rituals (based on some sacred or supernatural realm) that serves to guide human behavior, give meaning to life, and unite people into a community of believers (Durkheim, 1912/1995; Kendall, 2017).

Theology exists as an educational branch of religion and as an academic discipline in its own right (perhaps the first Western academic discipline). It is concerned with the study of our relationship, or absence of one, with a deity, deities, or the supernatural. "Theo" is the Greek word root for God. And, of course, "ology," from "logia," is the designation used for "the study of." So literally, *theology* is the study of God or religion. Anselm of Canterbury is credited with coining perhaps the most influential and widely used definition of theology used in Christian theological education today, *fides quaerens intellectum* (Williams, 2023). In English, this roughly translates as "faith seeking reason." It is confessional, in that it starts from a position of "faith," a term which has Latin roots related to the concept of "trust," and an "insider" point of view that seeks to understand itself. This stands in contrast to a social scientific approach, which attempts to study it from an "outsider's," objective, or even scientific, point of view.

And finally, we come full circle to the concept of **cosmology**. In physics, *cosmology* is the subfield that addresses the nature of the universe. And we now know, physicists believe the universe began with the "Big Bang" almost 14 billion years ago. Depending on how one looks at it, perhaps that assertion is not all that much different from the perspectives applied in the spiritual domain. Indeed, indigenous peoples from the world over have their own creation and destruction stories (e.g., Lincoln, 1986; Suzuki & Knudtson, 1992). And, creation stories play a pivotal role in the Jewish holy book, *Torah*, aka the Pentateuch, the first five books of Hebrew scripture, particularly Genesis (Hazony, 2012). In Christian *cosmology*, there is the idea of the universe as having been created *ex nihilo*, i.e., "from nothing" (Jackelén, 2006). In the Abrahamic tradition of religions (Judaism, Christianity, and Islam, see Chapter 4), there is also the idea of an end time, sometimes thought of as an "apocalypse" or time of destruction. Indeed, a subfield of theology, known as **eschatology**, concerns itself with expectations about the future, personally and collectively. **Personal eschatology** explores ideas about what happens to us individually after we die. And, among the Abrahamic tradition, there is the concept of a larger, **general eschatology**, i.e., prophetic teachings about the collective future of humanity and the "world" (Carroll, 2000; Menn, 2013).

Western Experience

The Family

In the United States, before the beginning of the twentieth century, when our society was more agriculturally based, living in an extended family was common—a family pattern in which grandparents, parents, and children all lived in the same home, or at least in the same community. As

we became industrialized, the **nuclear family** emerged—a family pattern in which only parents and their children live together (see, for example, Puschmann & Solli, 2014; Williams, Sawyer, & Wahlstrom, 2021). In these families, once the children grew up, they generally left home to attend college, take jobs, or start their own families, often far from home. As they became established in their own lives, this often meant not being nearby as their parents became elderly. Other social changes contributed to death's move from the home to hospital, including the rise of modern medicine. Today in the West, largely because of social changes that include a high divorce rate, binuclear families, in which children reside with each of their divorced parents for part of the year, and blended families, in which children live with a mix of biological and step-family members, have become common (Kendall, 2017; Williams et al., 2021).

History and Culture

With the shift in how we experience death has come a shift in our perspectives about it. Philippe Ariès (1974, 1981), a French historian who was among the first to conduct historical analysis on Western attitudes about death, comments that, although attitudes have always undergone change, it has invariably been gradual—that is, until now.

> In our day, in approximately a third of a century, we have witnessed a brutal revolution in traditional ideas and feelings . . . an absolutely unheard of phenomenon. . . . Death, so omnipresent in the past that it was familiar, would be effaced, would disappear. It would become shameful and forbidden.
>
> (Ariès, 1974, p. 85)

Although a thorough discussion of Ariès's work is beyond the scope of the present discussion, his work does offer a glimpse into perceptions about death that were once experienced as culturally "real" in Western Europe. I hope this recognition also reminds us that our own beliefs and perceptions are conditioned by culture and experience. The five historical perspectives, as outlined by Ariès, are the **tame death**, the **death of self**, the **remote and imminent death**, the **death of others**, and **invisible death**.

The time of the *tame death*, according to Ariès, may be the most benign of all with respect to the beliefs and attitudes people had about death. Taking place during the early-Middle Ages, this was a time when death was experienced as a community event. When someone died, everyone was somehow involved. The dying invariably accomplished the person's final act at home, surrounded by family, friends, and neighbors. The religious vision underlying the tame death reflected the theology expressed in the Gospel of Matthew, where death was seen as a time of sleep before Christ's second coming. In Ariès's description, this was also a fairly benign occasion with respect to expectations of what would happen in an afterlife. Ariès tells us that people during this era believed salvation came not so much as a result of their deeds but by virtue of their baptism and membership in the Church.

The Work of Phillipe Ariès

During the late-Middle Ages, the time of *death of self*, Ariès (1974, 1981) tells us of a highly individualistic age in which people paid a great deal of attention to how they lived their lives. Saint Benedict, considered by many the father of Western monasticism, suggests, "Keep death daily before you" (Delatte, 1950, pp. 72–74). His message seemed to be that life is all the more precious because the number of our days is numbered. It was a time of personal responsibility. Western

Table 2.1 Five Historical Perspectives on Death in Western Society

Perception	*Historical Period*	*Theme, Emphasis, and Theology*
Tame death	Early Middle Ages	• Death is an unavoidable (sixth–eleventh centuries) and normal part of life • Death is a community event • Members of the Church go to Heaven • Gospel according to Matthew—we sleep until the "Second Coming"
Death of self	High Middle Ages (twelfth century) to Renaissance	• Personal accountability and responsibility for one's life are crucial • Individuals attempt to master their own deaths through the practice of *Ars moriendi*, the art of dying • Apocalypse of John—judgment day; Heaven or Hell
Remote and imminent death	Renaissance (fourteenth–seventeenth centuries)	• Death is paradoxical—both near and distant; both enticing and to be feared • God is imminent and transcendent
Death of other	Enlightenment period (eighteenth–nineteenth centuries)	• A romantic period in which the focus is on the one loved and lost • Death of others is experienced emotionally and sentimentally • Death is a family affair • Evil exists, but outside self
The invisible death	Twentieth century onward	• Medicine successfully battles disease • Death itself becomes invisible in day-to-day life • Human beings perceive selves as masters of their own fate

Source: This table is based on Ariès (1981).

society was still very much intertwined with the ethos of the Christian religion, but, in contrast to the era of the tame death, the vision of this next era was more reflective of the kind of *eschatological* (last things) thinking expressed in the Revelation of John, with its imagery of Christ on his judgment seat. It was during this era that Dante Alighieri (1265–1321) wrote *The Divine Comedy* (Alighieri, 1982), with its allegorical vision of the afterlife, which some believe was both the culmination and a reflection of the medieval worldview. Influenced by the theological currents of the time, people in Europe during this era were quite concerned about whether they would spend eternity in Heaven or Hell.

In Ariès's (1974, 1981) scheme, the *remote and imminent death* is characteristic of the period of time from roughly the beginning of the Renaissance period through the seventeenth century or a little beyond. During this era, Ariès tells us, people paradoxically attempted to push death out of consciousness yet were also strangely fascinated by it. The attitudes during this time, he suggests, were similar to those of the present era.

Ariès (1974, 1981) describes the *death of others* as an eighteenth- and nineteenth-century attitude toward death that was highly sentimental. It focused not so much on the dead as on the survivors, emphasizing the emotional experience of bereavement.

The type of attitudes toward death we are now encountering in the developed West, Ariès (1974, 1981) calls the *invisible death* or *death denied*. Possibly compounded by the youth-oriented nature of society, it is an attitude toward death that sees it as being ignominious and taboo. Ariès contrasts it with the perspectives of earlier eras, which he tells us experienced death as a more common, accepted, visible, and visceral part of everyday life. Table 2.1 visually summarizes key elements in each of the five Western historical perspectives on death, as outlined by Ariès (1974, 1981).

Eastern Experience

When we think of the eastern experience, we are largely thinking of cultures, not culture, since there are significant cultural differences in various parts of the East, e.g., between the cultures of Japan, Korea, China (and various regions of this huge nation), the Southeast Asian countries of Thailand, Cambodia, Laos, Vietnam, Myanmar (Burma), Indonesia (the largest Islamic country in the world), Singapore, and the Philippines, not to mention the South Asian countries (Pakistan, India, Sri Lanka, and Bangladesh) as well as the many African and Middle-East nations, each of which has a unique history, its own indigenous populations, culture, subcultures, and social structure.

The Family

Because of globalization and interaction with the West, many cultures, including Asian cultures, have been affected by **culture contact**—the experience of two or more cultures coming into contact with each other through conquest, immigration, mass media, trade, or travel (Open Education Sociology Dictionary, 2024). We have relatively little information about differences in family structure and dynamics between Western and Asian families, although we may be able to make a few cautious generalizations. Asian cultures seem to place more emphasis on the group (collectivism) rather than the individual (individualism) (Cheng, Rizkallah, & Narizhanaya, 2020). In contrast to Western families, relationships within these families may be more hierarchical, or "vertical," in terms of who wields power (Dinn & Caldwell-Harms, 2016). Asians may also be more likely to live in homes with more than two generations living there, despite there being no actual economic need (i.e., living by choice in *extended families* as opposed to *nuclear* or binuclear families, as is more common in the West) (Chadda & Deb, 2013; Kamo & Zhou, 1994; Khatri, 1988; Reyes, 2018).

History and Culture

To our knowledge, there is no comprehensive, integrated history that traces the development of perspectives about death, dying, and bereavement in "the East." However, this does not mean there has been no work done in this area, just that we don't have a single comprehensive body of work like what Ariès (1974, 1981) has produced on the West. Indeed, this chapter section was overlooked in previous editions. We should probably also consider what we mean by East. Below, we briefly discuss one effort to apply Ariès' work in a middle-eastern country, Iran. In Chapter 4, we discuss cross-cultural and interfaith dimensions, where we also explicitly discuss in some detail the direct and indirect influence of Islam, especially as it relates to the perspectives of middle-eastern peoples. Although we begin by looking at the application of Ariès' work to Iran, we explore the eastern experience through the eyes of four Asian immigrant groups in Hawaii.

Iran

Kiarash Aramesh (2016) is a former associate professor of medical ethics and history at the Tehran University of Medical Sciences. Currently, he serves as director of the Bioethics Institute at Edinboro University of Pennsylvania. In a 2016 journal article, he compares historical trends in the West using Ariès' work and how death attitudes evolved in Iran. He notes that in Western history, thinking and attitudes about death were influenced by Roman and Greek culture, then Christianity, medieval schools of thought, the Enlightenment, and modernity.

In the history of Persian-speaking people, Aramesh (2016) suggests that the attitudes were at first influenced by Zoroastrianism (the dominant religious tradition prior to the rise of Islam), then Islam, especially its Shi'a and Sufi sects. While Ariès looked to the Christian scriptures and contemporary European literature, including the then-new form, the novel, Aramesh looks to *Persian Poetic Wisdom*, a large body of poems, which he suggests carry the collective wisdom and historical experiences of Persian-speaking people. In Persian-speaking countries, he suggests, enlightenment theories were not introduced until the last decades of the nineteenth century. Based on this analysis, Persian-speaking countries passed through two major periods. The first, he suggests, can be thought of as an amalgamation of Ariès' "tame death" and "death of self." The second is an amalgamation of what we're calling Ariès' "death of other" and "invisible death."

Asia

Braun and Nichols (1997) explored cultural variations in the experience of death, dying, and bereavement among four Asian-American populations living in Hawaii: Chinese, Vietnamese, Japanese, and Filipino. They used "key informants," a religious leader and a bilingual health or social service worker from the community, who assisted them in recruiting participants for focus group interviews. In the focus groups, they explored the influence of philosophical traditions, burial and memorial customs, bereavement, suicide, euthanasia, advanced directives, organ donation, and changes over time.

Chinese-Americans–The Chinese-Americans living in Hawaii were largely influenced by the philosophical traditions of Confucianism, Taoism, and Buddhism. Braun and Nichols (1997) note that with Confucianism, veneration of elders and ancestor worship are emphasized. In Taoism, longevity and healthy living practices seemed to dominate. And in Buddhism, the emphasis was on right living in one's present life so as to increase the chances of earning a good reincarnation in the next. Among the Chinese-American community, they did not remove the body until eight hours after death, burned paper money for use in the next life, and wore white at funerals. Suicide was thought to be unacceptable. With respect to euthanasia, "pulling the plug" or using too much pain medication was sometimes seen as acceptable. More westernized Chinese-Americans were open to advanced directives. Organ donation was not generally accepted. And with respect to change, focus group participants thought that many Chinese-Americans were becoming westernized.

Vietnamese-Americans–Although there has been historical enmity between Vietnam and China, Vietnamese society has nevertheless been strongly influenced by Chinese culture and traditions (Fitzgerald, 2009). With French colonization, many Vietnamese people adopted Catholicism. Indeed, when the French withdrew from Vietnam and the country was divided in 1954, a socialist, anti-religious government was established in the North, and a Western-style government in the South. Many Catholics living in the North moved to the South when the French left the country (Fitzgerald, 2009).

Although we should of course distinguish between Buddhist and Catholic Vietnamese-Americans, focus group participants reported that an auspicious day was generally sought for the funeral, coffee and tea were placed in the casket to preserve the body, and white was worn at services but would pin a black piece of cloth to their clothing to indicate they were in mourning. Suicide was considered wrong because it was seen as an attempt to by-pass karma. Euthanasia was seen as killing. Few participants were familiar with the concept of advanced directives. Participants did not generally agree with organ donation because of fear they might be reborn without the organ. And, in terms of cultural change, participants reported that children were becoming more westernized.

Japanese-Americans–Japan is a predominantly Buddhist nation with many different sects that practice Buddhism in diverse ways (Braun and Nichols, 1997). However, Japanese-American Buddhists generally believed that death is a natural, cyclical part of life. Consistent with how Buddhism is practiced in other parts of the world, they reported that the belief in reincarnation and karma were central. The hope was that one's next life would be better than the present one. As in Japan, Japanese-Americans living in Hawaii observed the annual Oban season, which celebrates the lives of the dead. The pillow sutra (chant) was performed at the bedside of the dying. Cremation was preferred over burial. They had a compassionate, tolerant attitude about suicide. Passive euthanasia was supported by the concept of *akirameru* (leave things as they are). People were encouraged to plan for death. Organ donation was not considered acceptable. And, in terms of cultural change, participants commented that many Japanese-Americans converted to Christianity during World War II and that fewer Buddhists were now able to attend memorial services.

Filipino-Americans–According to Braun and Nichols (1997), Filipino-American participants identified Catholicism as having a significant influence on the way death, dying, and bereavement were experienced. As in the West, Filipino-Americans embraced the religious teachings of Jesus that would result in resurrection with Christ and new life in the kingdom of God. Those who didn't were believed destined for purgatory or hell. A nine-day Novena prayer service was customary, personal belongings were buried with the deceased, and black was worn when a family member died, although white was worn for the funeral of a child. Suicide was considered wrong because it violates the Fifth Commandment prohibition against killing. Among better-educated Filipinos, passive euthanasia was sometimes considered acceptable. Those who had lived in Hawaii for some time were open to having advance directives. They did not generally agree with organ donation. And, in terms of cultural change, participants felt that traditional customs were being lost among third and fourth-generation Filipino-Americans.

Modern Trends

> But our machines have now been running seventy or eighty years, and we must expect that, worn as they are, here a pivot, there a wheel, now a pinion, next a spring, will be giving way; and however we may tinker them up for a while, all will at length surcease motion.
>
> Letter of Thomas Jefferson (age 71) to John Adams (age 78), July 5, 1814
> (Nuland, 2000, p. 44)

We often regard Thomas Jefferson, the author of the earlier quote and a founding father of the United States, as a visionary figure. Although the technological age did not fully kick into gear in the United States, so to speak, until about the mid-nineteenth century, the words Jefferson put to paper in 1814, with their mechanistic metaphor, have a prophetic ring, presaging the dawning of an industrial age—a hallmark of life in the modern era.

In the United States, widespread adoption of modern science and research in medicine was facilitated by the publication of the **Flexner Report** in 1910 (Cooke, Irby, Sullivan, & Ludmerer, 2006; Duffy, 2011; Kendall, 1980, 2015). Its author, Abraham Flexner, met with a group of faculty from Johns Hopkins School of Medicine to develop a model of medical education. This established the principle that a medical education should be a scientific endeavor that occurs in medical schools that are financially sound, make use of the scientific method, and have state-of-the-art research facilities, a major university affiliation, and a teaching hospital in which their candidates can practice. The report served as a guide for evaluating all 155 medical schools then conducting medical education in the United States.