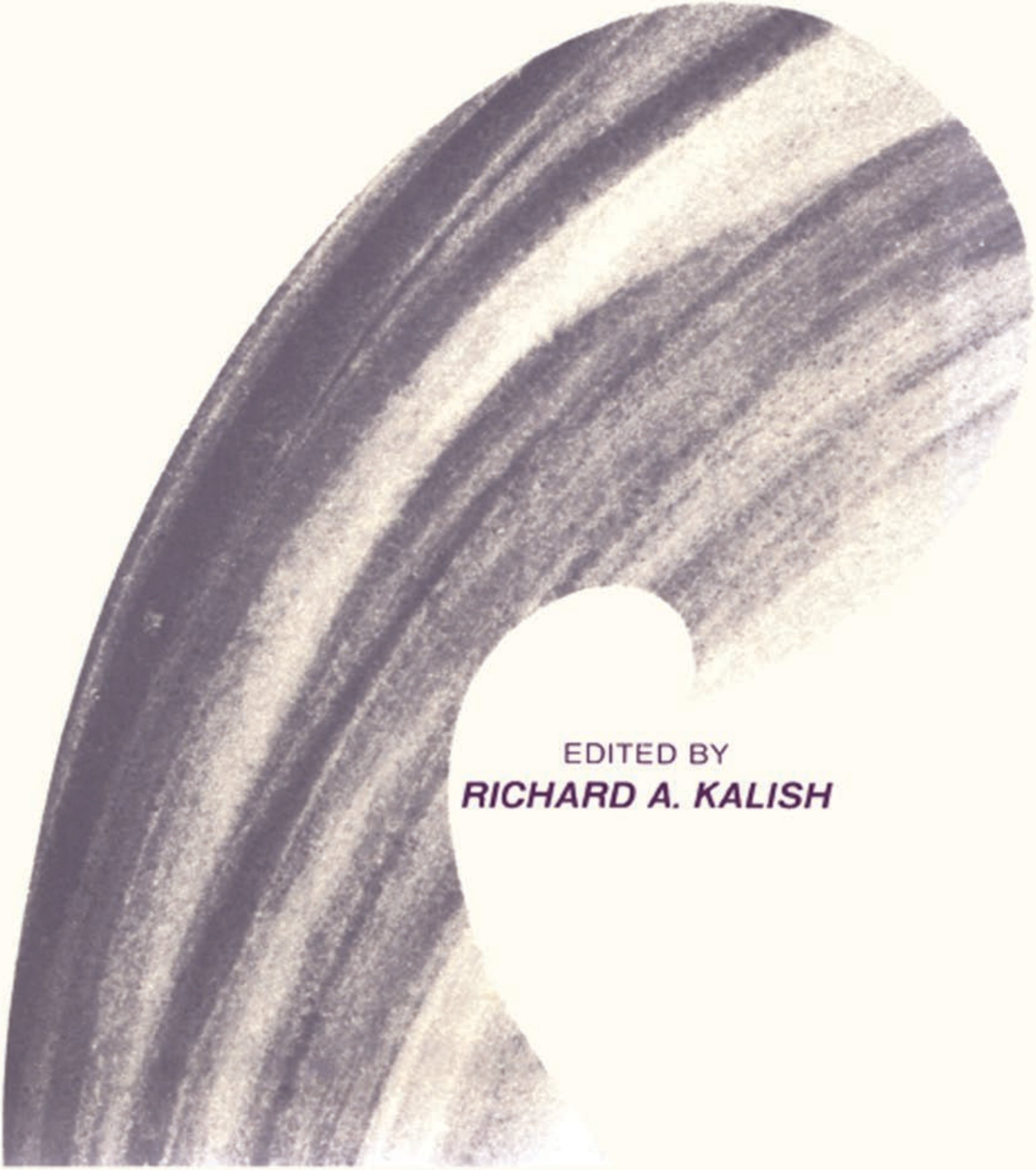
PERSPECTIVES ON DEATH AND DYING Series 5

THE FINAL TRANSITION



EDITED BY

RICHARD A. KALISH

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Editor's Preface

Another reader on death and grief? Well, yes and no. Aren't there already enough such readers? Well, yes and no. Is this one really needed? Does it really add something to what is already available? Well, yes and yes.

This volume is not just "another reader on death." Rather, it is a carefully-developed book, created specifically for those persons whose major interests are either death education, death counseling, or, of course, both. The audiences which this book addresses include (1) persons who have had either experience in death counseling or education or previous academic work; (2) those who are contemplating professional work in the field or who are already in the process of developing this area as one of their fields or competence; and (3) individuals who are already either counselors or educators or otherwise involved in the fields of mental health or education and who wish to learn more about the relationship of death and grief to their work. The book is not for beginners or for the casual reader, unless it is used to supplement a more basic reading, such as Kastenbaum's *Death, Society, and Human Experience, 2nd edition* (St. Louis: Mosby Publishing Company) or my own *Death, Grief, and Caring Relationships, 2nd edition* (Monterey, CA: Brooks/Cole Publishing Company).

In addition to the Preface, this volume consists of five major parts and an appendix that, itself, consists of several brief parts. Following an introductory section, which discusses the basic issues of death, dying, and grief, is a section on institutional care of the dying and a section on death and grief in a cross-cultural context. The final two sections cover counseling and psychotherapy and death education. An epilogue and an appendix, which details the kinds of classroom and non-classroom activities that would make a course or even an individual reading of the book more valuable, close the volume.

It is the two final sections and the appendix that we believe are unique among readers that deal with death and grief. The counseling and education sections total twelve chapters, almost half of the book, and the various chapters discuss relevant issues, offer applications, are concerned with evaluation and effectiveness, and provide programmatic ideas that can be modified for agencies and communities.

The appendix offers suggestions as to how the ideas discussed in the twenty-seven chapters can be tested in the world of practice and how people can expand their horizons and gain experience. The various sections of the appendix include volunteer opportunities, places to visit, ideas for developing further information, topics for discussion groups, and exercises that can be used in a classroom or in the community.

In addition to the contributions of numerous authors and to the practical suggestions in the Appendix, I have introduced each section, and each chapter within the sections, with my own comments. The nature and the length of these comments vary considerably, sometimes more focused on providing a transition between chapters and sometimes more concerned with expressing some of my own thoughts. I hope that they offer both integration and a sense of cohesion about the individual chapters, with the epilogue offering a final commentary.

This volume is certainly not to be viewed as a series of final answers. Instead, we hope that it will open up ideas for thought, provide a variety of kinds of understanding and knowledge, and encourage critical awareness. Some chapters were selected to provide breadth of knowledge and understanding of death, dying, and grief, or of counseling or education; others were included to offer depth of knowledge and understanding on a particular issue; and still others were provided to serve as the basis for future applications.

Both the editor and the publisher would like to thank all the authors who have provided materials for this book, as well as all the unnamed people who contributed to individual chapters or to the volume as a whole. Recent knowledge concerning death and grief comes from many sources, represents many disciplines, arises from many kinds of experience. *The Final Transition* is evidence of this.

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Table of Contents

Introduction

Although the Twentieth Century is certainly an era of specialization, there is danger inherent in over-specialization. The boundaries of personal and vocational interests need to be broad enough to encompass related sources of information and understanding. Thus, those individuals who wish to become death educators need to know about educational processes; those individuals who wish to become death counselors need to know about counseling and psychotherapy. And both groups need to know about the meaning of death, the process of dying, and grief and bereavement.

There is also great advantage in viewing one's interests within appropriate contexts. And two kinds of context seem especially relevant: a cultural context and a historical context. The first section, limited to one chapter only, provides an initial basis for both cultural and historical understanding.

People who wish to work with the dying and the grieving, like most other practitioners, frequently want practical information. And they ask questions like "When I was working in the hospital, the wife of a dying man came up to me and asked . . . And I said . . . Did I say the right thing?" Or "The patient asked me whether he was going to die, and the doctor had told me the patient didn't know, and . . . What should I have said?" Or "When my mother said she wanted to be cremated, my brother became furious with her. I was there, but I didn't know what to say. Was there something I should have said and can I do anything about it now?"

Specific answers to such questions are often impossible without knowing a great deal about the particular situation and about the particular individuals involved. However, it is possible to gain a general background and understanding from experience, from reading, and from talking with others. This general background doesn't answer questions directly, but it can provide a framework and a knowledge-based philosophy on which some answers to the questions emerge.

Section I provides the basis for this background, with chapters that describe the process of dying, the meanings of death, and the impact of loss on the survivors.

PART 1

Death, Dying, and Grief: The Basic Issues

Fifteen years ago, a chapter with this title would begin by lamenting the scarcity of written materials available, then would make reference to the taboo nature of the topic. Today, scarcity has given way to abundance, and death as taboo has been replaced by death as fad or fashion, although good practice still lags far behind acceptable rhetoric.

There are many ways of coping with death. The famous psychiatrist and author, Elisabeth Kübler-Ross, describes five: denial, anger, bargaining, depression, and acceptance. A later author (McCoy, 1974) adds defiance, fear, laughter, tears, and a search for meaning. We might also include regression, curiosity, search for spiritual well-being, hurrying the process, and panic. The list could continue on.

It appears logical that we cope with our own foreseeable death in much the same manner that we cope with other highly stressful situations, although each source of stress brings its own unique components to bear, and the prospect of death—whether imminent or eventual—certainly does the same. In fact, how far in the future we see as the timing of our own death may very well influence our forms of coping.

This chapter will focus on the meanings of one's own death as well as a discussion of significant tasks for people as they cope with their deaths. Also included will be implications for practitioners and for others who are brought into personal contact with individuals for whom death is a pressing concern.

Editor's Note: The introduction to this chapter is extracted from portions of the first three pages of Richard A. Kalish, Coping with Death, in *Living and Dying with Cancer*, Paul Ahmed (ed.), Elsevier, New York, pp. 223-239, 1981. An additional segment of pages 224-225 has been deleted. Reprinted with permission of the publisher.

CHAPTER
1

Coping with Death

Richard A. Kalish

Is there a "best" style of dying or a "best way" to cope with death? The initial response to this question must be another question: Best for whom? For health professionals? Health professionals, especially those providing direct and ongoing care, seem to prefer people who cope with death quietly, cheerfully, and self-sufficiently. If the death occurs in a health facility, the health professionals may also prefer that the patient have a support system of family members and friends who attend in small numbers, speak quietly, and make minimal demands on the staff.

Best for society at large? The response might then be in terms of dying inexpensively, to reduce costs to taxpayers and strain on health facilities. And dying with minimal disruption of others, so that the general stress level of the community does not rise as a result of the death. If the ways in which the fatally ill person copes with death take too severe a toll on the family members, they may do less well on their jobs, in their child rearing, and with their relationships with others.

Best for family members? The patient's style of coping with death should, one hopes, not be guilt inducing nor too disruptive of other tasks that need to be done. Remaining contacts should be rich, full, and relaxed. And, if at all possible, financial costs should be covered by health insurance.

Of course the previous paragraphs are unnecessarily cynical, but the kernel of truth in each setting should be familiar. When we discuss the best way of coping with death, we are referring implicitly to best for the patient, but we can persuade ourselves easily that what is best for us, the family member, the close friend, the physician, nurse, social worker, or chaplain, is also best for the patient. We need to keep in mind that cancer patients are aware of the needs and wants of other important individuals, and many patients, made vulnerable through their illness, will seem to agree with the implicit or explicit message they are receiving as to how they should cope with death, rather than risk the premature loss or abandonment of such significant persons.

Even if we accept the definition of best as meaning best for the needs and wants of the patient, with relatively little regard for our own needs and wants, we are still confronted with a complex situation. Each dying person is unique, both in what is brought into the situation from the past and in the nature of the immediate life-threatening situation itself.

Thus, styles of coping with death are influenced by experiences, values, and expectations of the fatally ill person; by available relationships and resources outside of the health setting; by the tolerance for pain, discomfort, and uncertainty; by financial status and sense of previous accomplishments; by prior expectations for future life and accomplishments; by age and sex and ethnicity. In addition, coping styles are affected by what is being coped with: pain, loss of capacity, need for hospitalization, much reduced life expectancy, kinds of treatment recommended and undertaken.

Underlying all else is the personality of the patient. In using this term, I am including the fatally ill persons' needs and wants, their values and beliefs, their ways of interacting with others, their cognitive competence and cognitive styles, their methods of expressing themselves, and related characteristics.

Fortunately, as service providers and care takers, we do not need to know everything about a person to accomplish our own job. Since we cannot know everything and since we are not accomplished mind readers, it becomes necessary to do a lot of listening, to keep two-way communication free and open, to remain flexible in our own thinking as to appropriate procedures, to avoid viewing coping from a doctrinaire, ideologic point of view.

AGE AND STAGE AS FACTORS IN COPING WITH DEATH

The age of the person confronting death is certainly one major factor in the response to death. Younger people often believe they have not been given their allocated time for living, and they feel angry and cheated; middle-aged persons have many responsibilities and are often immersed in plans and projects that will now remain unfinished. In fact, the evidence is fairly consistent that older people are less fearful of their own deaths than are either middle-aged or younger individuals, with the middle-aged probably being most anxious [1].

There are many reasons for this. The elderly have had more opportunity to learn to cope with their own deaths because they have been required to cope with the deaths of many other persons. Also, in many instances their futures hold less allure and excitement than the futures of younger people; they know that if *this* illness does not cause their death soon, *that* illness will cause it a little later. Further, they may already have suffered so many losses, often irreplaceable ones, that they do not see death as taking so much from them. And they are less likely to be involved in long-term plans and projects that require their active participation [2].

Stage refers to an entirely different matter: stages occur during the living–dying interval, i.e., that period beginning when the person becomes reasonably aware of a fatal prognosis and ending at death [3]. The best known stage approach, proposed by Kübler-Ross [4], describes five consecutive, somewhat overlapping, steps in the living–dying interval, from denial to acceptance. The stages can also be interpreted as five ways of coping with death, each way being appropriate to a particular duration of time, beginning with denial that occurs at the initation of the living–dying interval.

The validity of Kübler-Ross's stages has come under serious questioning [5, 6]. However, whether you accept these stages as gospel, use them as a framework, or reject them as misleading, the idea of stages in the process of coping with dying and death serves as a reminder that styles do not remain the same throughout the living-dying interval. The prior comments on age serve as a similar reminder that styles do not remain the same throughout the life span.

A fifty-year-old cancer patient may find ways to cope with her own death that are quite different than that same individual would have found useful, had the cancer occurred when she was twenty years younger or twenty years older. In the same way, methods of coping with death that develop immediately following awareness of being fatally ill may be highly effective at that time, but may be replaced by other coping procedures six months later that are equally effective for the changed nature of the situation.

To sum up, then, the styles of coping with death vary as a function of the individual's prior experiences, the nature of the life-threatening disease, the unique personality characteristics, age and other demographic factors, and the ways in which the dying person is experiencing the living–dying interval.

COPING

What Do We Cope With?

Coping with death is an on-going process that begins early in life, as soon as a child begins to conceptualize death, and continues throughout the life span. It is a movie, not a snapshot, although we frequently discuss it as though it were a number of disconnected frames. There is some controversy about how young children view death: how long it is seen as reversible, how responsible children feel when their parent dies. There is no longer any controversy regarding the idea that awareness of death as loss and departure begins very early in life and that a mature understanding of the meaning of death is completed by the age of nine years and perhaps earlier [7, 8].

When death becomes reasonably predictable in the foreseeable future or, even more to the issue, when death becomes imminent, the demands of coping with death become greater. Throughout life, coping with death involves accomplishing some significant tasks that become more salient and more stressful when death is close at hand. Some of these appear to be especially important.

- *First,* coping with death is coping with an unknown.
- *Second*, coping with death means coming to grips with the meaning of death and, therefore, with the meaning of what death destroys: life. It also

means dealing with what comes after death, whether this is self-aware existence, nonaware existence, or nonexistence; whether it involves the original body, a new and ideal body, or no body at all; whether the basis for the belief is a leap of faith or an attempt to apply the scientific method.

- *Third*, to cope with their own death, people must handle the pain arising from the losses that will occur at death, especially the losses involving social roles and personal relationships.
- *Fourth*, a dying person, both in the living–dying interval and in anticipation of death, usually wishes to make appropriate practical arrangements for the people, the groups, and often the ideologies and even the things left behind.
- *Fifth*, effective coping with death most frequently requires some form of communication with others in an open awareness context, i.e., a setting in which both dying people and those in their social milieu are knowledgeable about the prognosis and both know the other is knowledgeable.
- *Sixth*, as people die, they need to reconcile the conflicting pressures to let go of life and die and to hold on to life and retain every moment of existence possible.
- *Seventh*, as people face their own death, they need to find ways to continue to live in as pleasurable and satisfying a way as possible, pressing their demands of themselves and of others to, and perhaps beyond, their anticipated limitations.

With an Unknown

We can speculate about, make assumptions concerning, or have faith in our ideas regarding the nature of the event of death and the state of being dead. Sometimes faith is so strong that, for some, the unknown is really known. Nonetheless, for most, having to cope with death means that we have to cope with what is unknown and, presumably, unknowable during this life. Conversely, we can know a great deal about the dying process. We can observe people who are dying; we can talk to people who are dying and ask them about themselves; we can read what they have written or view them on film. Although systematic research is sparse, there are rich clinical and literary writings describing the dying process from medical, psychologic, and social points of view.

This means we can provide people who are dying with information that may help them cope more effectively with the dying process and with their fatal condition. They can gain a sense of what to anticipate, both in terms of the course of the disease and in terms of their possible feelings, attitudes, and behavior. They can do some planning for their own future, within whatever restrictions are required by their health, income, and other resources. This permits them to maintain at least some control over their own lives and, presumably, helps reduce some of their fears and anxieties.

We can also work out some implicit or even explicit contracts, i.e., understandings, with people who are dying. We can assure them that we will control their pain or that we cannot control the pain as much as we would like; we can assure them that we will visit them, or that we will not visit them as much as we would like; we can assure them their insurance will cover financial costs of the illness, or that it will not cover as many of their costs as we would like.

We do not have comparable kinds of information about the realities of death. People have not written about what it is like to be dead; we cannot talk to a person who has experienced death; we cannot watch a person be dead; we cannot tell people what to anticipate when they are dead and help them do some planning; we cannot offer them control over their existences after they are dead; we cannot work out any kind of contract about what we will do for them after they are dead (although we can work out contracts about funerals or survivors).

Some people, of course, have a religious faith strong enough to know what death means and what follows death. Others have such an intense belief in the permanent existence of the human soul and of individual consciousness that, without having any internalized theologic belief system, they have an abiding faith in their perpetual existence. The popularity of recent books on this topic is good evidence of this [9].

But for the most part we cannot help a person cope with death itself in the same way that we can help a person cope with the dying process or with the fatal health condition. There is no generally accepted series of empirical observations about the nature of death nor do we have the kind of indirect evidence available that might be compared to the assumptions eventually verified in the development of atomic theory.

With the Death of Self

Cancer patients coping with death need to incorporate the awareness that their death is now fairly foreseeable and fairly predictable into the self. This does not require that they give up either hope or life. Too many cancer patients given a fatal diagnosis have toasted the memory of their departed medical diagnosticians; others need not give up all hope, although the time will eventually arrive when the last flutter of hope is gone. And too many cancer patients have continued to be engaged thoroughly with their own activities and with the activities of those around them to assume that the initial prognosis of fatal cancer need terminate meaningful life.

The death of the self has many possible meanings. It can be viewed as an ending, as a beginning, as a transition or rite of passage, or as all three. It can be viewed as a reward or as a punishment or as partaking of both. It can be perceived as a base from which a series of losses develop: loss of people, loss of experiencing, loss of control, loss of competence, loss of capacity to complete plans and projects, loss of body, loss of things [2]. And it can be perceived as a gain: gain of release from the stresses of this world, gain of abiding with God, gain of enriched consciousness or of absolution from consciousness in some form or state in a subsequent existence.

It is an unusual adult who has not spent at least a few moments, and frequently many hours, contemplating the meaning of personal death, why it occurs, what it is that occurs. This is part of coping with death. When death becomes imminent, as with a diagnosis of terminal cancer, what has existed at a theoretical or "some day" level becomes totally personal and meaningful.

One way of coping with death is to develop an acceptable belief in what comes after death. The more intrinsic this belief, the more likely it seems that death will lose its fear-arousing capability, assuming that the intrinsically maintained belief does not create the spector of a frightening death or hellish afterlife.

Many individuals derive both comfort and strength from a deeply held belief that some form of personal, self-aware existence will follow death. Others appear to find equivalent satisfaction from believing death leads to total extinction. And a few persons view the entire matter as either unknowable or irrelevant or both. Those who are most fearful of death appear to be those who are most uncertain as to what death brings and who care that they do not know.

Personal and self-aware existence is not the only type of immortality or continuity possible. Continuity of the self can occur through achievements, through residing in people's memories, through descendents, through being inscribed in the *Guiness Book of Records* or on a tombstone. These kinds of secular immortality, although lacking permanence, can still offer many individuals a sense of continued presence in the world.

A firm belief in what happens after death, whether it is something or nothing, eliminates some of the difficulties that make coping with death so difficult. For example, death no longer leads to an unknown: it leads to something that is known. Second, the meaning of one's own life does not cease with the end of life: it continues, either in sacred form or in secular form or both. Third, for those who espouse a self-aware after-life, death does not erase all possibility for experiencing or eliminate the uniqueness and beauty of the human soul or existence: it is a passage to another form of experiencing and existing.

With the Pain of Loss

Each of us performs many roles: spouse, co-worker, lover, car pooler, political party member, taxpayer, child, home owner, church member. Through each of these roles, we have many relationships, some obviously overlapping. And to an appreciable extent our personal identity emerges from these roles and relationships.

When we become aware we have also been thrust into the role *terminal cancer patient* and its related relationships, we do not suddenly cease being all other things to concentrate on the "dying role." Rather, as with any system, the components of the human system restructure to integrate the new component. We do not stop being spouse or car pooler, nor sever the relationship with our spouse or our carpool companions. However, our new identity as terminal cancer patient now influences our role and our relationships as spouse and as car pooler.

Dying people must cope emotionally with the losses to come with their impending death, with the loss of others and with the loss of themselves, as well as with the interpersonal relationships that will be on-going during the living–dying interval. They will no longer be mothers or fathers, lawyers, pianists, friends, or anything else. They will no longer have relationships with their children, fellow lawyers, concert-goers group, friends, or anyone else. They need to deal with this eventuality, now no longer posited as in an indefinite future, and they need to deal with both its emotional aspects and its practical demands.

The pressures to cope with the stresses of the living–dying interval add their weight. Perhaps dying patients will have to help others become able to help them; they may need to free others from their guilt in not giving sufficient attention; patients are likely to confront the possibility of being isolated by those who cannot handle their death or their dying process; since time is limited by coming death, decisions must be made about priorities in relationships with others. Thus, once again, the dying person simultaneously is coping with the losses to be brought about by death and those already brought about by dying and by fatal illness.

With Practical Arrangements

Making appropriate practical arrangements with and for others produces some similar difficulties. Arrangements must be made for what will occur as a result of death: funeral, burial, providing for family members, disposition of property, seeing that wills and trusts are taken care of. Other arrangements are required by the nature of the illness: cancelling out of the Saturday morning golf game; making decisions concerning giving up the apartment; seeing that the cat is cared for; getting the library books returned; making certain that someone else understands the notations in the checkbook and the record system for the income tax file. Then arrangements may need to be made for paying medical and hospital costs, for getting to and from medical offices, for seeing that any dependent children receive proper care.

Some of these tasks concerning roles and relationships would need to be performed if the health problem were mononucleosis or a broken leg; or, perhaps more salient, cancer from which recovery was extremely probable. Other concerns either occur because death is foreseeable or are altered in their effects for the same reason.

It is important that dying people cope reasonably well with emotional pain of anticipated losses and with the practical considerations. Then they will find it easier to devote time and energy to whatever life is left. Because, in the final analysis, people are living until they are dead and it is at least as important to use time wisely for personal satisfaction when it is in very short supply as it is when time seems almost endless.

OPENING COMMUNICATION

Until about a decade ago, the most familiar attitude about coping with death was that the patient would be best off not knowing the prognosis until as late in the course of the disease as possible. The assumption was that, in many instances, patients already knew or would learn on their own and had no need to discuss death, while in other instances, being confronted with the knowledge of having a fatal condition would be tantamount to a death sentence and would only serve to eliminate all hope and lead to depression.

In this fashion, the patient, physician, and family would establish either closed awareness or mutual pretense [10]. The former refers to a situation in which the dying person does not know the prognosis; the latter describes a setting in which both patient and others in the patient's milieu are aware that the condition is fatal, but each pretends with the other that improvement or cure is imminent. Both of these situations, especially closed awareness, are likely to change as the condition worsens.

Of course, in both situations, open communication is impossible, which means that the tasks involved in effective coping with death become much more difficult and sometimes impossible to carry out. Since according to the pretense, the person is not going to die, there is no basis for doing anything that would suggest death as a possibility.

For the past decade, academic, professional, and popular literature has been inundated with books and articles attacking the earlier position. Although the prior view is still maintained in many instances, a countervailing trend has developed: there are those who appear so eager for dying people to communicate about their dying and death that they focus people more on their death than on the functional life that they retain.

The issue for me, then, is to provide a mutual awareness context, in which both the fatally ill and those important to them are all aware that death is probable and are able to communicate this awareness to each other [10]. This does not *require* communication regarding death. It means that such communication can occur any time either party desires and that the desire is not inhibited by anxiety about whether the dying person is emotionally prepared for death.

Conversely, if the dying person actually never becomes aware that death is going to occur (and sometimes, as with a sudden coronary or an automobile accident or delayed visit to the physician, this becomes unavoidable), there is no opportunity to complete unfinished business, to attend to the practicalities of arrangements, or to develop some of the truly rich, albeit painful, emotional experiences that can take place when separation and loss are imminent.

Similarly, dying people who learn the condition is fatal, but too late to attend to whatever they might have wished to accomplish, are likely to feel deceived and cheated. A frequent outcome is considerable anger, since the message is only too clear: they were considered insufficiently competent to take care of their own stress and, as with children or confused people, needed someone to make decisions for them.

The mutual pretense context also calls for deceit, except that each party is attempting to deceive the other. Once again, patients are told they lack the competence to handle stress, but this time they say the same thing to others. That is, the implicit, unstated message is that "I don't trust you to be strong enough to handle my knowing that I'm dying; therefore, let us continue the game."

When there is no communication, people can only relate at shallow levels. Thus, the wife of a dying husband, given open awareness, can hold him and weep, and he will understand and try to hold her also. The experience is painful, but can be enriching. If the same couple is engrossed in mutual pretense, the wife dare not weep, for fear she would be communicating the very message she wishes to avoid giving, nor may her husband show any unexpected affection since that might give him away. The husband in this situation is going to have to cope with his own death alone, without the kind of loving support that his wife might otherwise offer. The wife may feel guilty about not being supportive of her husband when he most needed it.

ACCEPTANCE AND "LETTING GO"

The power and influence of Kübler-Ross's five stages have made it virtually axiomatic that the optimum way of coping with death is that of acceptance [4]. This can be seen as both appropriate and "natural;" that is, if people are given the proper medical and psychologic care, they will eventually come to accept their death. This means they will stop fighting death and hanging on to life, although it in no way implies that they will become eager to die or become weary of life. It does seem to suggest that they will disengage rather extensively from previous attachments, including people, while retaining only those relationships most important to them.

Enabling people to accept their own death has become an implicit goal of many, probably most, people who work with the dying. Frequently it is also an explicit goal. In fact, it often is assumed as the operational definition of "coping with death."

Similarly, people who work with the dying speak about enabling a dying person to "let go." People are frequently not ready to die because they have unfinished business, perhaps with other people or perhaps within themselves. This might reflect an intimate relationship that is still deeply involving, an incomplete project that has not lost its allure, or some other undone task. Sometimes it may be a special date, such as Christmas or a birthday, for which a person will hold on to life; there is statistical evidence that this indeed occurs [11].

In effect, then, people hang on to life because there is still something they need to do or to experience, and this need is sufficiently strong to enable them to stay alive. Obviously, hanging on is not an infinite possibility, but it can extend life for a period of time. Further, it will sometimes extend life when it would otherwise appear to be to dying persons' best interests to die. These people cannot accept death (enter the acceptance stage) until it is possible to let go of whatever is binding them to continued life. Therefore, their capacity to cope effectively with death cannot be made complete, since one or more unresolved issues requiring continued life keep getting in the way.

Counselors and others who work with the dying are likely to help clients deal with whatever is pressing them to hang on to life, so the issue can be resolved and the dying can then relax their hold on life and die. The reward for acceptance and letting go is optimum peace of mind, a quiet and peaceful death that is as comfortable as the health condition permits. Death is neither urgently sought nor fervently fought.

In a sense also, accepting death is a reflection of perceived reality. As energy ebbs, the dying person is capable of fewer interactions with fewer persons. After a lengthy period of not circulating in previous social circles and work settings, the individual is likely to find many earlier social relationships have become less frequent and less intense. Disengagement, which has been widely condemned when it occurs in healthy elderly people and also with institutionalized elderly people, is often approved when a dying person is involved [12]. Thus, the dying person retreats both physically and psychologically from the social environment, which simultaneously constricts its options for the dying person.

The individual can thus cope with death by reducing affective involvement in life and attachments to others, so that life shades into death by degrees instead of by quantum leaps. People who meditate long hours every day or who are frequent users of certain psychotropic drugs often report similar blurring of the line between life and death. In fact, most of us have known people who dealt with their entire lives by keeping their affective engagement so minimal that they were virtually beyond emotional pain, and similarly beyond joy.

Acceptance (or letting go) is certainly adaptive for many dying persons. It is even more adaptive for persons who are, either professionally or personally, involved with dying persons. It becomes all too simple for health and social service professionals to make the implicit assumption that the best possible method for coping with death requires entering the acceptance stage and being able to let go of attachments. Through books and articles and, more powerfully, through verbal, nonverbal, and indirect messages, these professionals effectively program dying persons to follow their dictates, while sanctimoniously proclaiming that they are winning victories for humanity.

I personally believe that accepting death is an excellent way of coping with death, and I hope that, when I reach that point in my life, I am able to accept my death. I am less certain that I want to disengage from most of my attachments, but I recognize that my health condition may require it of me. Nonetheless, in addressing those who care for dying cancer patients, I am pressing you to take a position that avoids prejudging how another person wishes to cope with death. There is a strong tendency to hold acceptance and letting go as ultimate goals, rather than as intermediate goals that frequently lead to the ultimate goal: that of enabling fatally ill patients to die in the style they desire, at least to the extent that this is possible.

MAKING THE BEST USE OF TIME

When death is imminent, people often reduce both their number of attachments and the intensity of these attachments to other individuals, to groups, and to whatever other involements they had had. To some extent this disengagement is caused by reduced energy; to some extent, it results from being pressed by limited time to develop priorities; to some extent, it arises from working through the pain of the coming losses, to the point where the loss has been accepted and the tie to the relationship has diminished.

It can be uniquely difficult to make good use of the time when there is little left, whether or not options are further limited by illness and by treatment regimens. Most people are so oriented to anticipating a future and planning their daily lives with this future in mind that refocusing their thinking to a very brief future becomes an extremely difficult task. Nonetheless, it does happen: people confronting their own death frequently do become capable of focusing on the present and living in that present, not by excluding awareness of the future nor by denial of coming death but by having found an acceptable style of coping with the death that permits significant attention to be given to what is available, rather than having all energy drained in attending to what will not be available.

People vary considerably in what they consider optimum use of time, and this is just as true for the dying as for others. When 434 residents of the greater Los Angeles area were asked how they would spend their remaining six months, if that was what their prognosis offered, the greatest number (26%) said they would make no major changes in their life patterns. More than 20 percent stated that they would spend time with people they loved or indicated some other involvement with others. Another 20 percent would focus on inner life, such as prayer or meditation; 17 percent believed they would undertake some activity that would provide a marked change in their lives, such as traveling or doing something they had always wanted to do but had never had the opportunity; slightly under 10 percent said that they would complete some project they were working on; and the rest gave responses that could not be categorized [1].

The research participants were not completely typical of Los Angeles: approximately 75 percent of them were black, Japanese American, or Mexican American; their income and educational levels were slightly below that of the general area, and older people were somewhat overrepresented. Nonetheless, even though the percentages for each response category would differ in other respondent groups, the results provide some clues as to how people not presently facing death believe they would best spend their time if they were facing death.

In the final analysis, no one can cope with someone else's death for that person. No matter how deeply involved we are, no matter how fervently we feel, no matter how intense our professional motivation, we can only hover around the person who is coping with death. We can sometimes make the task easier, more pleasant, less stressful, less frightening. We can sometimes make it richer, fuller, more meaningful. But we cannot do it for someone else.

What we must do is permit other people to face their own death. An appropriated death is seldom an appropriate death [13]. We can give the dying person what that person wishes and asks for, in the process of coping with death. And we have the option to let the dying person teach us what it is like to cope with death, so that when we must cope directly and existentially with our own death, we can build on the skills of a knowledgeable teacher.

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The title of Herman Feifel's book, the one that sparked so much interest in the issues of death and dying over a quarter century ago, was The Meaning of Death. *It was not "the meaning of dying," although most of the increased attention in the area of death awareness has been to the concerns of the dying. This is understandable, since the plight of the vulnerable, suffering, dying person cries out for immediate attention. Nonetheless, although we are all, at various times in our lives, affected by concerns of the dying, we are all, at all times in our lives, affected by the meanings of death. And we should not permit the very legitimate demand to provide better care for dying persons to distract from the importance to all of us of gaining a better understanding of the meanings of death.*

Each of us has our own view of the meanings of death. These views may be specific or general, sharply outlined or vague, closely tied to a known religious ideology or largely unrelated. And many of us are troubled by our view of death. When David Meagher and I asked some 150 Brooklyn College undergraduates why they registered for a credit course on death, around half of them indicated that coping with their own fears and concerns regarding death was their major reason.

Chapter Two describes the findings of a research study conducted in Los Angeles a number of years ago. Although the data are not new, there has not been a comprehensive, community study conducted since, and I believe that the statistics would be similar if the study were to be conducted today. Those who wish to look into the methodology more carefully can review the original book;[1] *for present purposes it seems sufficient to state that the information was obtained by at-home interviews of 434 persons, conducted by professional interviewers. The study's participants were approximately equally divided among 1) four ethnic groups (Blacks, Japanese, Hispanics – designated as Mexican Americans – and Anglos), 2) three age groups (20-39, 40-59, and 60+), and 3) men and women. Reasonably good controls were used to avoid strong socioeconomic biases.*

[1] *Death and Ethnicity: A Psychocultural Study*, by Richard A. Kalish and David K. Reynolds, published by Baywood Publishing Company, 120 Marine Street, Farmingdale, N.Y. 11735.

CHAPTER
2

An Overview of Death Attitudes and Expectations

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Two eternal truths about human beings are, first, that people differ from each other and, second, that people are similar to each other. Any attempt to communicate psychological insights must straddle these two truths, with a bow to one truth often incurring a buffet to the other. In this chapter, probably more than any other in this book, we defer to the latter. We will emphasize the overall data with only modest attention to the role of such groupings as sex, age, education, and religiousness, which are discussed in other chapters.

ENCOUNTERING THE DEATH OF OTHERS

Relatively few people have not had some encounter with the death or dying of other persons (see Table 1). Only 18 percent of the entire sample did not know anyone who had died in the two years prior to the interview, while almost that many knew personally at least eight persons who had died. Most of the deaths encountered were from natural causes, but nearly one-third of the respondents had known at least one accident victim during the previous two years, although only a handful knew people who had died from suicide or homicide.

Over one-third of the respondents had visited or talked with at least one dying person during the previous two years, and two-thirds had attended at least one funeral during the same time interval, while one person in twelve had gone to eight or more funerals. About 60 percent had been to a funeral during the previous year, compared to 55 percent of a primarily Anglo American sample over a decade ago [1], and only 22 percent of a large British sample covering adults of all regions and socio-economic classes [2]. Visiting the grave (other than during funeral services) was less common, over half not having made such a trip during the past two years (Table 1). A fifty-nine-year-old Anglo man expressed one extreme reaction: "Don't keep running there. There's nothing there. I guess it's okay on Decoration Day." A Japanese American woman

Table 1

	B (%)	*J (%)*	*M (%)*	*A (%)*
How many persons that you knew personally died in the past two years?				
None	10	17	19	26
8 or more	25	15	9	8
How many persons who were dying did you visit or talk with during the past two years?				
None	62	58	61	68
2 or more	16	17	15	18
How many funerals have you attended in the past two years?				
None	33	16	40	45
8 or more	9	17	2	4
How often have you visited someone's grave, other than during a burial service, during the past two years?				
None	71	36	56	59
4 or more	4	39	17	15

provided the counterpoint with an explosive "Twice a week! *Important* to visit the grave!"

Two points strike us as especially significant in this context. First, except for visits to the grave, the Anglos are obviously less in contact with the dying and with death than are the other ethnic groups. Second, and more meaningful, death and dying are very much a part of the experience of adults. Druing a two-year period, over two out of three adults have attended at least one funeral, and more than 25 percent have attended three or more; most adults have been friendly with at least two persons who died, and 25 percent have known five or more, and nearly 40 percent have visited or talked with at least one dying person. Perhaps—and only perhaps—we have denial mechanisms that exclude the affective impact of death and dying, but we most certainly do not escape continuing contact with this ultimate reality of life. Even the intimacy of touching the body at the funeral was considered acceptable by a majority of all groups except for the Japanese (B–51%, J–31%, M–76%, A–51%), and, although Blacks and Japanese would hold back, over half the Mexicans and one-third of the Anglos would be likely to kiss the dead person. One woman explained, "I don't know why—I just couldn't do it—touch the body." (Kiss the body?) "Oh, no." She paused a moment. "I don't even like to kiss him *now*."

In 1915, G. Stanley Hall could write, ". . . it appears that the first impression of death often comes from a sensation of coldness in touching the face or hands of the corpse of a relative, and the reaction is a nervous start at the contrast with the warmth which cuddling and hugging were wont to bring" [3, p. 551]. Hall's data had been gathered some two decades earlier. Although much reduced in frequency, such experiences are undoubtedly still not uncommon. These findings, and others to be discussed later, cause us to believe—with Donaldson [4]—that we have proclaimed this to be a death-denying society too often, and that the concept should either be effectively operationalized or else discarded.

The term *denial* is used both sociologically and psychodynamically, with relatively little overlap between the two usages. We will use the term in this chapter only when there is evidence that the individual is utilizing defense mechanisms to protect himself against awareness of death or something death-related. We will use the term *death-avoiding* to cover—we feel with more precision—such acts as not liking to go to funerals. Parsons and Lidz also question the common assumption that ours is a death-denying society, stating, "American society has institutionalized a broadly stable, though flexible and changing, orientation to death that is fundamentally not a 'denial' but a mode of acceptance appropriate to our primary cultural patterns of activism" [5, p. 134]. And Kastenbaum and Aisenberg ask why we so fear the fear of death [6].

In integrating these findings, we see that Anglos are likely to have the least contact with the dying and the dead, are probably more death-avoidant, although they do not admit to greater fear of death. Perhaps more salient, our data suggest that the avoidance of death is not a global concept, but must be restricted to more specific occurrences, i.e., what kind of avoidance behavior to what kinds of death for what reasons.

Attendance at funerals correlates significantly with having visited a dying person, and the correlation is substantial ($r = 0.41$), but neither of these variables correlates substantially with willingness to inform a person of his own death ($r = 0.17$ and 0.19 respectively). Both individual uniqueness and cultural roles contribute to the variance. Thus, although age, sex and ethnicity are predictive of reliable differences in how one responds to each of the numerous kinds of death-related encounters, considerable variability is evident even within these categories. In short, being Black, being old, and being female all help predict how an individual will respond to each of several kinds of death-encounters, while being an elderly Black woman will be even more predictive. However, considerable individual variation does exist among elderly Black women. Furthermore, knowing how a person will react to one kind of death setting (e.g., attending funerals) provides only limited predictive accuracy in determining how they will react to another setting (e.g., informing a dying person).

Before leaving this issue, we should point out that for *some* individuals, death-avoidance is sufficiently pervasive that they do exhibit avoidant behavior in a wide variety of situations. Even when their overt behavior does not appear consistent with such avoidance, they pay a penalty in anxiety or extensive use of defense mechanisms. Sometimes they display counter-phobic behavior through a virtually ritualistic attendance to planning their own funeral or establishing their own claim to immortality. Probing this issue would require depth interviews or similar methodologies.

Kastenbaum (personal communication) offers an alternative way of viewing these variables. Rather than utilizing only the concept of death-avoidance, he suggests applying the approach-avoidance mode of traditional psychology. Thus any given behavior could be viewed as the result of the interaction between the motivation to approach and the motivation to avoid. Not visiting graves could then be interpreted as having a low approach value rather than a high avoidance value. This strikes us as an important refinement and may help avoid some non-parsimonious assumptions about motivation when the root of the behavior (or lack of behavior) can be viewed as an absence of felt need.

COMMUNICATING WITH THE DYING

Ever since Glaser and Strauss published their monograph, *Awareness of Dying*, the issue of whether the patient should be made aware of his coming death has been discussed—sometimes heatedly—among physicians, nurses, clergymen, behavioral scientists, and others [7]. More than half our respondents felt that a dying person (described as approximately the same age and of the same sex as the interviewee) should be told that he is dying, but many more Anglo Americans favored this approach than members of other ethnic groups (B—60%, J–49%, M—37%, A—71%). One black American stated, "I think the person would want to know. Those things should not be kept a secret unless they are too old and can't stand the shock." An older Anglo man explained, "Yes, but in a roundabout way. No two people are alike, so you can't treat them all the same. I know one person who was told, but the doctor was too blunt and it about killed the whole family. He should have done it in a more roundabout way—gradually—work up to it." A woman presented the opposite position: "I wouldn't want to know. If she knows, she would worry."

The task of communicating was left primarily to the physician, with some member of the family listed as the second most appropriate choice. All ethnic groups responded in this fashion. For example, "The doctor, assuming the guy can take it. Also have to take into account how well the doctor knows the patient, how much confidence the patient has in the doctor, the ability of the doctor to relate to the patient, what the family members think. . . . Cannot say definitely any one person." Although survey data often do not reflect it, respondents constantly express the need to approach matters individually, to take individual differences into account.

Although over half the respondents felt that dying friends should be informed, three-fourths wish, themselves, to be informed. Only among Mexican Americans does this drop to as low as 60 percent (B–71%, J–77%, M–60%, A–77%). Each ethnic group has a higher proportion of persons wishing themselves to be informed than feeling that others should be told. The two groups that are most familistic, the Japanese Americans and the Mexican Americans, show the greatest discrepancy between their own desire to know and willingness to let others know, reflecting a strong desire to protect and a note of paternalism perhaps.

Physicians are also much less likely to feel patients should be informed than the patients are, while both physicians and laymen, according to several studies, are more likely to want to be told themselves than to feel others should be told [8, 9].

The results of other studies do not differ appreciably from ours. Hinton reviews four studies in which patients and their relatives were asked whether a cancer patient should be enabled to learn about his condition: the results were overwhelmingly affirmative, ranging from 66 percent to 89 percent. Feifel and Jones found 77 percent wished to be informed, drawing from both physical and mentally ill and normals [10]; Vernon in a primarily youthful sample found a 71 percent favorable response [11].

Numerous authors make a very strong case for informing a terminally ill person [12]. Koenig has gone so far as to tabulate the articles that provide the pros and cons, and ends up with a distinct majority favoring some method of permitting the dying to become aware of their impending death [13].

That the task of informing the dying is not an easy one is attested to by the admission of the respondents that only a handful (between 4% and 7% of each group) had ever told anyone he was dying and that fewer than half of the remainder felt capable of serving as informant in such a situation (B–51%, J–47%, M–19%, A–52%). An elderly Black American woman answered, "I don't think I could tell anyone. I'd just tell him when the Lord's ready, He will call him." An ex-medical technician was forced by circumstances to answer a man who "was literally almost cut in half . . . I told him that it didn't look too good but that we were taking him to the hospital where he would get the best of care. He never made it to the hospital." Of 295 Catholic and Unitarian women who were asked whether they were afraid of encountering a dying friend, Chenard found that equal thirds were "a great deal," "some," or "a little or not at all" afraid [14]. There was no difference between the two religious groups.

GRIEF AND MOURNING

The loss of others through death is immensely painful. Such loss gives rise to sadness and melancholy, anger, resentment, guilt, fear and anxiety, and sometimes to a search for meaning, a turning toward or against God, the desire to lay blame on someone or something, the attempt to find a reason for the death.

The death of another disturbs us in several ways. First, it may remind us of our own finite nature, of the obvious but avoided truth that we too shall come to a termination of our existence on earth—which, for some, means termination of all existence. Second, the death of someone close removes something from our own lives—we no longer can relate to that individual, no longer receive his warmth, friendship, support, no longer depend upon him or gain pleasure from his depending upon us. This is object loss—it is also objective loss. Sometimes the loss removes from the family, the business, the institutions, the community, an important part of that structure. The tragedy of the loss is often related to how much dislocation and upset occur in the lives of the survivors.

Third, the intricate set of social obligations and interactions that death brings to a close are often not ready for total finality. The survivors may be angry at being deserted and attribute the death, in an unconscious and mystical fashion, to willfulness on the part of the deceased (this response may be intense following a suicide). They may feel overwhelming guilt in their real or fantasized role in his death, for their perceived failures in offering attention or concern or—in some instances—for their relief that the death has finally occurred. Things undone and unsaid can no longer be compensated for, although the funeral service may offer some opportunity for self-absolution. Expressions of guilt have come up spontaneously in all subgroups, i.e., ethnic, age, sex, education.

In describing the feelings of a wife subsequent to her husband's heart attack, Schoenberg and Stichman point out that the woman often berates herself for not having made certain that her husband had eaten more moderately, worked less intensely, exercised more, and worried less [15]. Or, in the case of the wife that had done these things, the self-condemnation would be for having nagged her husband unduly and thus raised the tension level of the home. The double bind is evident in many instances following loss.

Although the ability to express one's grief openly is frequently encouraged by professionals in the mental health field, our respondents displayed considerable reluctance to do so. Fewer then half would worry if they could not cry (except for Mexican Americans, 50 percent of whom responded in the affirmative). Three-fourths of the Blacks, Japanese, and Anglos would "try very hard to control the way (they) showed (their) emotions in public," although less than two-thirds of the Mexicans agreed to this. Nonetheless, a great majority of all groups and almost all of the Mexican Americans would "let (themselves) go and cry (them)selves out" in either private or public (B–64%, J–71%, M–88%, A–70%). Apparently emotional expression is appropriate, even encouraged, in private, but is expected to be constrained in public. One woman explained her feelings about the entire matter: "I would do whatever felt natural." Here, however, our observations indicate a real discrepancy between expressed norms and observed behavior in the Black American community. Perhaps attempts are made to control public expression of feeling, but they do not appear successful, since crying, moaning, wailing and fainting are commonly observed.

Two-thirds of the Black Americans and over 80 percent of the others would carry out their spouse's last wishes even if they were felt to be senseless and inconvenient. Such responses might arise from guilt, but we feel that the motivation is more from a sense of obligation, a recognition of the importance of the dead person and perhaps a kind of denial (we would not assume this to be emotionally unhealthy) that the relationship has been severed. Simmons describes how effectively final wishes can bind the survivors in some cultures [16].

A family member would usually be sought for comfort and support in time of bereavement, although clergymen were also cited with moderate frequency. Less often selected was a friend, and about 8 percent of the respondents said they would not turn to anyone for comfort. Support for the bereaved is not only emotional, however. The death of a spouse requires practical help, such as keeping the household going. Most people would seek this help from relatives (B–50%, J–74%, M–65%, A–45%), but friends, neighbors, and fellow church members were picked by nearly one-fourth (B–42%, J–9%, M–14%, A–45%). Previously we found the Anglos least likely to participate in rituals for the dead; now we find that they have fewer expectations of their family in times of crisis. It would appear that the mutual obligation structure is weakest in Anglo families in the Los Angeles area.

The extent to which a particular death is perceived as tragic seems to vary as a function of the age, the sex, and the kind of death involved (Table 2). And the different ethnic groups differ considerably in their evaluations. Particularly striking were the strong Anglo feelings about slow deaths and about the deaths of infants and children, and the relative unanimity about the meaning of the deaths of the elderly.

Death and loss are not only personal matters. They are also social. Society prescribes standards for grief and mourning, and each individual grieves not only from his personal sorrow, but in a style which is the product of early socialization and later social dictates. This is especially obvious in the length of time the mourner is expected to refrain from returning to usual behavior patterns. Although nearly one-fourth of the respondents felt that the widow(er) could appropriately remarry at any time after the death of his spouse, over half the Japanese Americans and Mexican Americans felt at least one year's wait was necessary, many feeling that two years or more would be preferable and some stating that remarriage was never appropriate. Since the question (and those following) was asked in terms of the age, sex, and ethnicity of the respondent, answers to this item were related to age, i.e., many of those who said remarriage was inappropriate were speaking of an older person remarrying (see Table 3).

Respondents were understandably more lenient in stipulating how long the bereaved should wear black. Over 40 percent of the Japanese Americans and over half of all other groups felt that black clothing was unimportant and need not be worn. In a major study of bereavement in England, Gorer interviewed over 350 men and women who had lost a close relative during the previous five

Table 2. Which Seems More Tragic?

	B (%)	*J (%)*	*M (%)*	*A (%)*
Sudden Death	39	43	41	20
Slow Death	58	50	50	68
Equally Tragic	3	7	9	12
(Don't Know)	(–)	(–)	(–)	(6)
Man's Death	10	34	9	16
Woman's Death	38	29	36	25
Equally Tragic	50	36	55	52
Other	2	2	0	7
(Don't Know)	(6)	(–)	(5)	(13)

	Most Tragic	*Least Tragic*	*Most Tragic*	*Least Tragic*	*Most Tragic*	*Least Tragic*	*Most Tragic*	*Least Tragic*
Infant's Death (0-1 year old)	14	24	8	18	13	25	17	14
Child's Death (around 7)	26	5	24	2	25	1	44	0
Youth's Death (around 25)	45	2	43	1	48	0	32	2
Middle-aged Person's Death (around 40)	8	2	22	2	6	5	5	1
Elderly Person's Death (around 75)	6	67	1	74	6	69	0	82
Other	1	1	3	3	3	1	1	1
(Don't Know)	(2)	(–)	(–)	(–)	(4)	(–)	(2)	(–)

years [2]. Of these, 37 percent wore no symbolic clothing or armband, and only 20 percent wore anything for longer than three months. Relatively few of our respondents felt that black should be worn beyond six months, but we have no data directly corresponding with those of Gorer. Similarly, a majority of all ethnicities felt that a week or less was ample time to remain away from work, roughly half of these indicating that the bereaved person should be able to return to work as soon as he wished.

Going out with others of the opposite sex was treated more conservatively, although a young Mexican American woman made the point that this would be all right "As soon as you felt no guilt about it." Less than one-fourth felt that waiting was unimportant, with the median response being between six months and a year. The Blacks and the Anglos were consistently more casual than the Mexicans and the Japanese, seeming to form a pattern in keeping with funeral attendance and other family interactions. About 30 percent of those who responded stated that they would begin to worry that mourning was extended too long if crying and grieving lasted as much as a couple of weeks; a slightly larger proportion would not be concerned for at least six months; while

Table 3. In General, After What Period of Time Would You Personally Consider it All Right for a (Person of Respondent's Age Group, Ethnic Group, Sex)

	B (%)	*J (%)*	*M (%)*	*A (%)*
To remarry?				
Unimportant to wait	34	14	22	26
1 week–6 months	15	3	1	23
1 year	25	30	38	34
2 years or more	11	26	20	11
Other/DK/Never	16	28	19	7
To stop wearing black?				
Unimportant to wait	62	42	52	53
1 week–1 month	24	26	11	31
6 months	6	7	7	5
1 year or more	5	14	28	1
Other/DK	4	11	3	11
To return to place of employment?				
Unimportant to wait	39	22	27	47
1 day–1 week	39	28	37	35
1 month or more	17	35	27	9
Other/DK	6	16	9	10
To start going out with other men/women?				
Unimportant to wait	30	17	17	25
1 week–1 month	14	8	4	9
6 months–1 year	24	22	22	29
2 years or more	11	34	40	21
Other/DK	21	19	18	17

the remainder opted for an intermediate period, usually between one and three months.

How do you know when grief is not normal? Around 30 percent did not know, but the remainder displayed considerable variability. Half the Blacks indicated that they would look for abnormal behavior, compared to 27-29 percent of the others; one-third of the Blacks and one-fourth of the Anglos (compared to 15-16% of the others) would look for withdrawal and extreme apathy. The Mexicans were alert to the bereaved under-reacting, i.e., not showing any overt signs of grief or, as one said, "When they can't cry" (34% compared to under 10% of the others). Two out of five Japanese gave answers that could not be coded in our available categories. The issue needs to be pursued, because it gives promise of major differences in expectations of the various ethnic groups.

ENCOUNTER WITH THE DEATH OF SELF

Do people fear death? We don't know. All we can say with certainty is that study after study has shown that people *say* they do not fear death. How valid are these comments? Again, we don't know. University students displayed the same reaction time lags to death words that they did to sex words, while their galvanic skin responses and reaction times to death words were significantly and substantially greater than to neutral words [17]. But does this suggest greater fear? It could imply excitement, fascination, or even response to the unexpected.

Most studies of fear of death have been conducted with specific age groups, especially with either university students or the elderly. These are discussed in the chapter on age, so that comparisons can be made with proper age groups. However, a few investigations have cut across age lines. Neither Scott [18] nor Hall [19] asked directly about fear of death in their questionnaires, although Hall did say twenty years later, "We long to be just as well, strong, happy, and vital as possible, and strive against everything that impedes this wish or will. . . . We love life supremely and cannot have too much of it . . . while we dread all that interferes with it" [19, p. 569]. Feifel and Jones combined the seriously ill, the chronically ill and disabled, the mentally ill, and normals into one sample, with roughly equal numbers in each category [10]. Of this conglomerate, 71 percent verbalized no fear of death.

In Hinton's observations of the terminally ill, he felt that "as many as two-thirds of those who died under fifty-years of age were clearly apprehensive, whereas less than a third of those over sixty years were as anxious" [8, p. 84]. Of Chenard's Catholic and Unitarian women, 11 percent were very much afraid, 21 percent were not at all afraid, and the rest were split between some fear and little fear [14].

In a recent national survey, conducted by the Harris Poll organization under the auspices of the National Council on the Aging, individuals in a large sample were asked to respond to the open-ended question: What are the worst things about being over sixty-five years of age? Fear of death was given as an answer by 9 percent of the total sample, but by only 6 percent of those fifty years of age and older. This compares with 62 percent of the sample who indicated that poor health was one of the worst things about being old and 33 percent who stipulated loneliness. Blacks mentioned fear of death only 2 percent of the time, compared to 10 percent for the non-Blacks (other ethnic groups were not represented in sufficient numbers for breakdowns) [20]. When the same respondents were asked to list what they considered to be very serious problems of old age, fear of death was not among the twelve most common concerns listed either by those between eighteen and sixty-four or by those sixty-five and over.

Riley (in Riley *et al.*, 1968) reports that only 4 percent of his national survey sample "gave evidence of fear or emotional anxiety in connection with death" [21, p. 332]. Other studies, although based upon samples limited by geography, age, or education, found comparable results ranging up to around 10 percent or so indicating fear of death. Our respondents were either more frightened of death–or more truthful in their responses. We asked, "Some people say they are afraid to die and others say they are not. How do you feel?" The interviewer coded the response in the categories *terrified/afraid, neither afraid nor unafraid*, or *unafraid/eager*. Only two people could be clearly categorized as *eager*, and about 2 percent gave responses classified by the interviewer as *terrified*. Because of these small numbers, we combined those categories with adjacent ones, as indicated just above.

Using this approach, over a quarter of all respondents were classed as afraid of dying (B–19%, J–31%, M–33%, A–22%), while just over half were unafraid (B–50%, J–50%, M–54%, A–53%). About 2½ percent were uncodable, and the rest were classified as neither afraid nor unafraid. Why we received such a low proportion of persons claiming to be unafraid is difficult to say. Perhaps their having already participated in some thirty minutes of death-related discussion heightened their anxieties–or perhaps it enabled them to reply with greater honesty. To be consistent with our policy of assuming face validity of any statements, unless substantial evidence suggests otherwise, we propose that our data represent accurately the feelings of the respondents at the time the question was asked.

One respondent commented, "So many say they are ready (to die), but I don't feel near ready. Judging from the way I got frightened at the earthquake, I'm not near ready." A Mexican American man said, "I *say* I'm unafraid, but if I had time to think about it, and I knew I would die shortly, I don't know–I guess I would certainly be concerned." And an Anglo American man put his view succinctly: "You are *nuts* if you aren't afraid of death."

This leads to the question, how stable are attitudes toward death? Ivey and Bardwick have shown that death anxiety of women varies as a function of their menstrual cycle–as do other kinds of anxiety [22]. We know of no other evidence on this issue. However, we suggest no mystique for death attitudes–they undoubtedly vary as a function of situation, mood, experience, and shifting cultural milieu, just as all other attitudes vary.

Whatever a person's attitude might be regarding death, what has influenced these feelings? For this question we provided the respondent a card with ten alternatives, plus an eleventh, "OTHER (SPECIFY)." Over one-third of the respondents selected the statement, "The death of someone close," as having influenced them the most (B–26%, J–41%, M–39%, A–35%). "My father died when I was 5-and-a-half years old. I was very close to him, and when I heard of his death, I ran away from home and went into the woods. I was gone for 2-and-a-half days. I felt as if my whole world had collapsed, as if I had no one to turn to any longer. I was desperate. I cried a lot." Second most frequently selected was, "Your religious background" (B–40%, J–13%, M–21%, A–25%). Nearly 19 percent stated that having been close to their own death, or believing themselves to be, was their greatest influence. Reading, conversations, the death of an animal, mystical experiences, funerals or other rituals, the media, were all listed by only 5 percent or less of the sample.

Shneidman's survey, while not drawing from a comparable sample, obtained some parallel results. Of his respondents, 35 percent stated that introspection and meditation most influenced their attitudes toward death; we did not include that alternative, but we doubt whether many of our respondents would have selected it. Second and third most frequently mentioned by Shneidman's sample were the death of someone else and religious upbringing (19% and 15% respectively); these fit quite well with our data. Over one-third of Shneidman's group stated that existential philosophy influenced their present attitudes toward their own death more than such concerns as pollution, violence, television, war, poverty, and so forth. We believe that very few of our respondents would have selected that alternative.

Although 19 percent of the respondents felt that either actually being close to death or thinking they were close to death had the greatest impact upon their attitudes, over twice that many had–at least once–believed that they were close to dying (B–48%, J–31%, M–49%, A–37%). Of these, exactly half of the Blacks and Japanese asserted that the experience had affected their lives, slightly under half of the Mexicans and Anglos agreeing also. Unfortunately, responses to the question of how the experience affected them were so scattered, that the categories became too small for serious consideration. Here, too, the response to near death was highly individualistic, varying with circumstances, cultural background, and other experiences before and after the event.

Do people often think about their own death? Kennard informs us that the Hopi "man who thinks of the dead or of the future life instead of being concerned with worldly activities, is thereby bringing about his own death" [23, p. 492]. Simmons does not mention any other example of this, but a number of respondents in our study–proportionately more Black Americans than others–referred to being worried that talking about death would bring it about [16]. Scott's sample of 226 adults indicated that only 7 percent never "dwelt on death or suicide," while 60 percent responded in such fashion that they obviously gave at least some thought to the matter [18]. Vernon's student sample showed only 45 percent who said they thought only "rarely" or "very rarely" about their death [11].

Additional studies add numbers, but little insight. Feifel and Jones in their investigation of a primarily mentally or physically ill sample, found that 44 percent thought of death "rarely" and 42 percent occasionally [10]. Fulton, using a mail survey with a limited percent of response, also found that 40 percent rarely or never thought about death, while 12 percent dwelled on it frequently or all the time [1]. And in 1963, Riley's national sample splits into almost equal thirds, stipulating "often," "occasionally," and "hardly ever/never" [24]. Shneidman found 5 percent of his respondents thought of their death once a day, while 21 percent contemplated it no more than once a year [25]. In a study of persons forty-five years of age and older, drawn from Black, Mexican, and Anglo American samples also in Los Angeles, 33 percent stated they thought about their own death "not at all," 58 percent "occasionally," and 9 percent "frequently" [26]. Interviews in retirement communities found that fewer than 10 percent stated that they thought of death very frequently, while nearly 15 percent claimed not to think of their own death at all.

How do our respondents compare? Sadly, almost none of the studies produced directly comparable data. Nonetheless, there is reasonable consistency. Over one in six thinks daily about his death, while over one in four contemplates his termination at least once a week (B–34%, J–10%, M–37%, A–25%). On the other hand, 25 percent say they never think of their own death, and over twice that proportion claim that once a year is the most often that thoughts of personal death arise (i.e., combining "Never," "Hardly Ever," and "At Least Yearly") (B–41%, J–69%, M–38%, A–47%). One person makes the valuable point that, "One does think about death, but doesn't remember how often."

If conscious thoughts of one's own death are highly variable in terms of frequency, dreaming about one's own death is much less common, with less than 30 percent admitting that they ever have such dreams. Middleton's university students reported equivalent figures, only 37 percent indicating such dreams [27].

Another much-discussed aspect of the process of dying is that of the efficacy of the will-to-live or, conversely, the will-to-die. Weisman and Hackett discussed the post-operative deaths of six persons, all of whom anticipated their subsequent deaths and none of whom died from obvious medical causes [28]. The professional and popular literature is filled with other examples [29]. Except for the Mexican Americans, the overwhelming majority of each group agreed that "People can hasten or slow their own death through a will-to-live or a will-to-die" (B–88%, J–85%, M–62%, A–83%).

One Japanese American funeral director suggested a statistical study to verify his own observations that a highly disproportionate number of deaths occur within one month of the deceased person's birthday. Such research has, in a sense, been conducted. Phillips and Feldman found a significant reduction in deaths during the month prior to the birth month and a substantial increase in deaths during the month of birth and the month following; this was verified on several independent samples, apparently confirming the perceptions of the funeral director [30]. This information suggests that the dying person has some control over the actual time of his demise. A most graphic case described to the senior author was by a young woman studying for her doctorate whose mother was terminally ill. Although the older woman had been seriously ill for several months, she appeared in good spirits and alert until the day following her daughter's doctoral preliminary orals (the most demanding single day of her graduate program), when the mother died peacefully in her sleep. She had frequently expressed the double concern of wanting to know that her daughter had been successful (she was) and of not wanting to place the burden of a death on her during the immensely important event.

Many supernatural and mystical feelings surround death. Thus nearly half of all respondents were affirmative in answering, "Have you ever experienced or felt the presence of anyone after he had died?" (B–55%, J–29%, M–54%, A–38%), and one-fourth of these were manifested while awake and were perceived through the senses. This issue and the data are discussed at greater length elsewhere [31]. Pursuing feelings of mysticism surrounding death, over one-third of the Mexicans and between 12 percent and 15 percent of the other groups had experienced the "unexplainable feeling that (they) were about to die." We explicitly eliminated from our count instances in which these feelings occurred during dreams.

Even more persons had had such a feeling about someone else (B–37%, J–17%, M–38%, A–30%), and over 70 percent of these respondents stated that the presentiment was validated by actual death on at least one occasion. We feel strongly that these data have an important message to professionals who work with the dying and the bereaved: mystical feelings, "being in touch with his ether," "sensing the vibes," or actually having vivid and realistic contact with the dead, all these experiences are commonplace to large segments of the American public, and it is time they cease being approached as inevitably pathological.

In some settings, people routinely express their desire to die, e.g., at the Japanese American nursing home, nurses told us that nearly all the patients express such a wish at some time or other during their stay. Other than those suffering severe physical or emotional anguish, however, extremely few people wish to die, whether or not they state that they fear death. What is there about life that they cherish? Diggory and Rothman described seven values destroyed by death, and they obtained ratings of the importance of these values from over 500 respondents [32]. Shneidman administered the same questions in his *Psychology Today* study. (Shneidman also reports on the same items administered to 120 Harvard and Radcliff students.) Although the Diggory-Rothman sample was not limited to college students, about two-thirds were under twenty-five years old, two-thirds were unmarried, and one-fourth were Jewish. Diggory and Rothman also presented the values on a matched pair basis, the respondent being required to select the alternative felt to represent the greatest loss, while we had our respondents indicate whether they felt the value was "very important," "important," or "not important." Results are, thus, not directly comparable to our study (see Table 4).

Our respondents were most concerned by the possibility of causing grief to their friends and relatives (based upon combining "very important" and "important"). Diggory and Rothman also found this to be the most important, but it ranked fifth for Shneidman, perhaps due to the different family roles of his subjects. Over half the Blacks and 75 percent each of our other groups also listed not being able to care for dependents as "important" or "very important," but